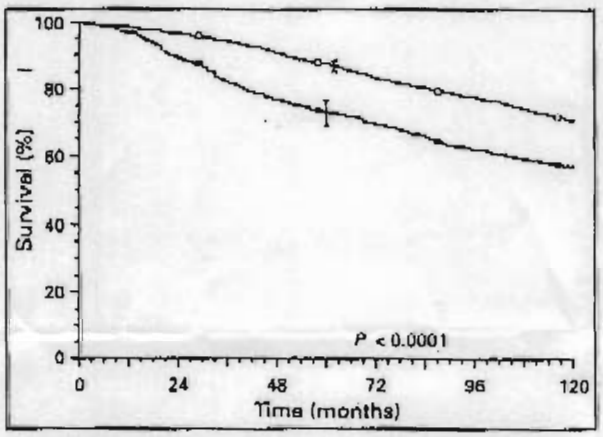
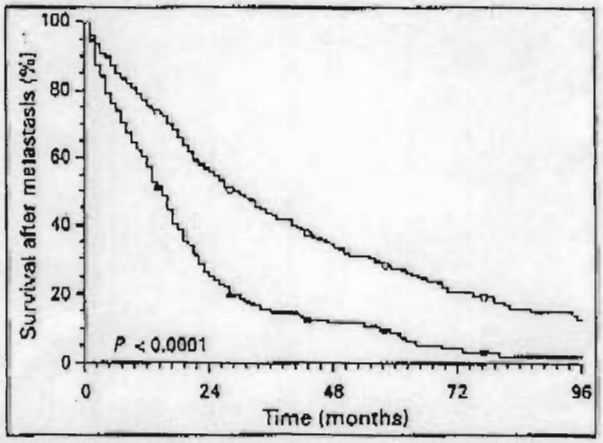
Breast Diseases



Overall survival according to estrogen receptor *(ER)* status. *Closed squares* indicate ER-negative; *open squares*, ER-positive (see Abstract 2–24).



Survival after a first metastasis according to estrogen receptor *(ER)* status. *Closed squares* indicate ER-negative; *open squares*, ER-positive (see Abstract 2–24).

- *National Cancer Data Base Report on Age and Outcome*
- *LCIS Results from NSABP Protocol B-17*
- *Pamidronate for Palliation of Bone Metastases*
- *Survival by Estrogen Receptor Status*
- *Breast-conserving Therapy After Augmentation Mammoplasty*
- *Necessity of Axillary Node Dissection*
- *Survival Impact of Radiation*
- *Legislative Mandates for Breast-conserving Surgery*

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induced neuropathy is also rare because most radiotherapists do not irradiate the axilla, particularly if the patient has had an axillary dissection. Third, pain caused by a stretching of the motor nerves in the chest, such as the thoracodorsal and pectoral nerves, is also rare in my experience. Fourth, problems with frozen shoulders and inability to elevate the arm are markedly decreased because axillary dissections are not as extensive as they were before and, in addition, the pectoralis major muscle is saved in every mastectomy. Finally, breast reduction patients are actually some of the most appreciative and satisfied of all patients with breast problems because of the severe discomfort they have preoperatively and the relief experienced by the great majority of patients who undergo a reduction mammaplasty.

L.O. Vasconez, M.D.

2–60

Reduction Mammaplasty With the Inferior Pedicle Technique: Early and Late Complications in 371 Patients

Mandrekas AD, Zambacos GJ, Anastasopoulos A, et al (Plastic Surgery Centre of Athens, Greece)

Br J Plast Surg 49:442–446, 1996

Background.—The inferior pedicle technique is one of the most popular reduction mammaplasty approaches. Patient satisfaction is high for this surgical technique. A total of 371 patients who underwent bilateral reduction mammaplasty with the inferior pedicle technique during a 10-year period were reviewed.

Methods.—Two patients had undergone a previous breast reduction. Liposuction of the breast was used in 24 selected patients as an adjunct at the beginning of surgery to make the breasts smaller and to decrease lateral breast fullness. The average patient age was 33.1 years (range, 15–67 years). The average distance from sternal notch to nipple was 30.4 cm (range, 21–43 cm). All patients received perioperative antibiotics and had suction drains until hospital discharge. Length of hospital stay was 12–24 hours.

Results.—The mean amount of breast tissue resected was 870 g per breast (range, 250–1,960 g). The mean liposuction volume removed was 160 cc (range, 100–400 cc). The amount of blood in the suction drains never exceeded 50 mL, and no blood transfusions were required. Mean operative time was 3.1 hours. The overall complication rate in this cohort was 11.4% (Table 1). The pathology examination revealed breast carcinoma in 1 breast each of 2 women (0.5%) aged 45 and 54 years. Both women were referred to a breast surgeon for evaluation. Of 18 women who gave birth after surgery, 13 (72%) were able to breast-feed with decreased capacity. The other 6 patients had either milk insufficiency or mastodynia; their lactation was suppressed pharmaceutically.

Conclusions.—Reduction mammaplasty with the inferior pedicle technique is a versatile method applicable to patients with a wide range of breast sizes. Breast contour, volume, nipple projection, nipple sensation, scar appearance, and the potential for lactation are comparable to or better than the outcome of other techniques, although the scar is longer. The complication rate

TABLE 1.—Results

	Patients
Early complications	21 (5.7%)
Haematoma	1 (0.3%)
Nipple and/or pedicle necrosis	3 (0.8%)
Wound dehiscence	17 (4.6%)
Late complications	21 (5.7%)
Fat necrosis	3 (0.8%)
Carcinoma	2 (0.5%)
Loss of sensitivity and erectility of the nipple	2 + 3* (0.5 + 0.8%)
Hypertrophic scars	12 (3.3%)
Dermoid cyst	1 (0.3%)
Marked fullness requiring secondary surgery	1 (0.3%)
Total complications	42 (11.4%)
No complications	329 (88.6%)
Total patients	371

Note: A total of 42 patients experienced 42 complications. None of the patients had more than 1 complication.

*The three patients with nipple necrosis.

(Courtesy of Mandrekas AD, Zambacos GJ, Anastasopoulos A, et al: Reduction mammaplasty with the inferior pedicle technique: Early and late complications in 371 patients. *Br J Plast Surg* 49:442–446, 1996.)

is low, and nipple sensation and lactation potential are usually maintained.

This well-written review of 371 patients who underwent inferior pedicle resection for breast reduction clearly outlines the advantages and disadvantages of this popular breast reduction technique. Since its description in 1977, the inferior pedicle technique has been well accepted among plastic surgeons as a safe and versatile method for reducing the breast. Although it is a technique that is relatively easy to teach and learn, it requires significant experience to perfect.

Other more recently described breast reduction techniques emphasize minimal scarring, but my impression is that patients are much more concerned with the overall correction of size, shape, and symmetry of the breasts. Surgeons are often more concerned with the scarring after breast reduction surgery than their patients seem to be. Furthermore, techniques such as the inferior pedicle technique, which leaves an "inverted T" scar at the base of the breast, can be designed and executed so that no portion of the horizontal limb of the incision is exposed at either the medial or lateral aspects of the inframammary fold.

Regardless of the technique used, the surgeon should choose 1 or 2 breast reduction techniques that are safe and reliable and develop a proficiency with them.

D.P. Goldberg, M.D.

2–61

The Tuberous Breast Deformity: Classification and Treatment

von Heimburg D, Exner K, Kruft S, et al
(St Markus Hosp, Frankfurt/Main, Germany; Johann Wolfgang Goethe Univ Teaching Hosp, Frankfurt/Main, Germany)

Br J Plast Surg 49:339–345, 1996

Background.—Several reports have offered descriptive terminology for the so-called tuberous breast deformity, and a number of different operative procedures have been proposed. There is no consensus on nomenclature for this deformity. The degrees of tuberous breast deformity and the results of operative correction were evaluated retrospectively.

Methods.—Forty patients with 68 tuberous breast deformities were operated on at 1 institution during a 20-year period. On the basis of preoperative photographs, the breasts were classified into 4 categories: type I, hypoplasia of the lower medial quadrant; type II, hypoplasia of the lower medial and lateral quadrants with sufficient skin in the subareolar region; type III, hypoplasia of the lower medial and lateral quadrants with deficient skin in the subareolar region; and type IV, severe breast constriction with a minimal breast base (Fig 1). At least 2 years' follow-up was available in 51 breasts of 31 patients.

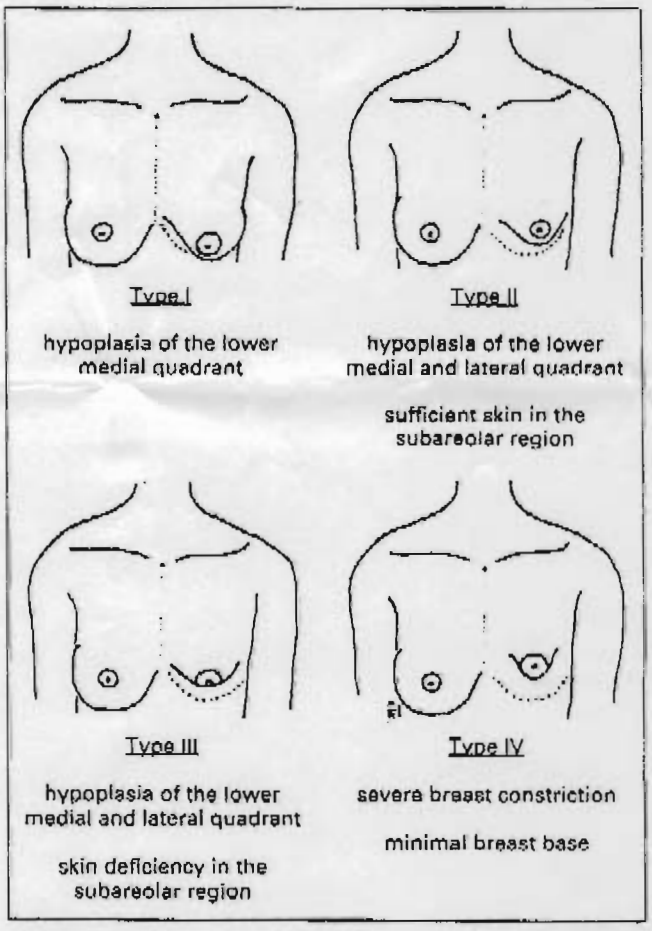

FIGURE 1.—Classification of tuberous breast deformities. (Courtesy of von Heimburg D, Exner K, Kruft S, et al: The tuberous breast deformity: Classification and treatment. *Br J Plast Surg* 49:339–345, 1996.)

Results.—In the study sample, 28% of breasts had type I deformities, 26% had type II deformities, 18% had type III deformities, and 28% had type IV deformities. Just 44% of breasts studied had areolar prolapse, which is typically