BREAST LIFT
INFORMATION BOOKLET

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INTRODUCTION

One of the more complex procedures to understand in cosmetic surgery is the breast lift, or mastopexy. The simplest way to think of the sagging breast is that there is too much skin for the amount of volume. That's why the corrective procedures may involve reducing the amount of skin which results in scars, increasing the breast volume with an implant, or both.

There are several variations of breast anatomy that can be treated with a lift. Likewise there are a wide variety of techniques that can be used to accomplish a lift. Often breast implants are recommended to accomplish the goal and a very important decision is whether to place the implants at the same as the lift or at a later operation. Since breast lift and augmentation are often performed together, you should also read the breast augmentation pages as well.

TABLE OF CONTENTS

BREAST ANATOMY

NORMAL BREAST ANATOMY
General breast anatomy is covered in the breast augmentation section

ANATOMY OF THE SAGGING BREAST
The medical term for sagging breasts is mammary ptosis. In the sagging breast there is too much skin for the amount of volume. Not only does the skin cover a larger area, but it is thinner and less elastic. The skin is also weaker and that is why it is unable to support the weight of the breast. Often the skin will show stretch marks (stria) which are tears in the deeper layer of the skin (dermis). Within the breast, the tissue has become more mobile and less cohesive or compact. The supporting ligaments of the breast are also stretched.

As a result of these internal and skin surface dynamics, the appearance of the breast is changed. The nipple and much of the breast gland hang over the inframammary fold. With this redistribution of volume the upper portion of the breast becomes flattened. The nipple sits low on the breast and is a longer distance from the landmarks of the upper chest such as the collarbone. Also just under the breast there is increased contact between the breast skin of the lower portion of the breast and the chest wall skin. This can often cause rashes and irritation.

CLASSIFICATION OF MAMMARY PTOSIS
There are varying degrees of mammary ptosis (sagging).

Minor ptosis – nipple at level of inframammary fold.
Moderate ptosis – nipple between the level of the inframammary fold and the lowest point of the breast.
Major ptosis – nipples at bottom of breast pointing downward; most of breast tissue below the inframammary crease.
Glandular ptosis – nipple above fold; some of the gland below the fold.
Pseudoptosis – nipple above fold; very little volume left, most of which sits below fold.

WHO IS A CANDIDATE FOR A BREAST LIFT?

There are a number of reasons for breasts to sag. It can occur following pregnancy, with or without breastfeeding. It can be due to the ageing process, obesity, or menopause. Gravity always plays a role in the development of sagging. Some women’s breasts will simply develop that way at a very young age.

If you look at your breasts and have to ask yourself whether or not you require a lift, there is a good chance that you do not need one. It seems that most women who to need a breast lift are aware that it is necessary before they come to the doctor's office. When I examine a breast it is sometimes very clear that a lift is not necessary, and sometimes clear that a lift is necessary. In a few instances, particularly when an implant is being used, it is difficult to determine whether or not a lift will be needed. In these instances the benefits and potential risks have to be weighed carefully against one another.

In general, if the nipple sits below the inframammary fold and a there is a significant portion of glandular tissue that lies below the fold, then a lift will be required. If the nipples are pointing downward, or there is no normal breast skin visible between the bottom of the areola and the lower contour of the breast, then a lift is needed. Sometimes lift techniques are used simply to reduce the size of the areola.

It is important to determine what the patient's goals are with regard to a breast lift? Improved shape with increased volume. Improved shape with the same volume. Improved shape with decreased volume.

The patient should also be prepared to answer the following questions:
Does the degree of lift justify the scar?
Does the placement of an implant to fill the upper pole justify its risk?
What is the desired size of the breast?

What is the desired shape of the breast?

One condition in which I do not recommend a breast lift is the normal appearing breast that sits low on the chest wall. I do not to believe that I can predictably and consistently reproduce the breast higher on the chest wall for the long-term.

Also, I will not perform a breast lift in a smoker who is unable to quit before and after surgery. Also one will not be allowed to use nicotine containing smoking cessation devices, because it is the nicotine, not the smoke, which is harmful. If you are unable to stop smoking for two weeks before and two weeks after surgery, then it may not be in your best interest to seek a mastopexy. If you need help quitting smoking, you should contact your primary care physician.

BREAST LIFT TECHNIQUES

The only way to accomplish a breast lift is through surgery. Breast lift techniques involve removal of skin, placing an implant, or both. The breast lift almost always involves raising the nipple. It reduces the size of the areola, the darker skin around the nipple. In planning a breast lift and one must identify how much excess skin needs to be removed, and how much volume, if any, needs to be removed or added.

BREAST AUGMENTATION
Augmentation alone

CRESCENT SCAR
Crescent of skin above nipple removed and nipple is raised

PERIAREOLAR SCAR
Skin removed all around nipple to reduce sagging skin and raise nipple

VERTICAL SCAR
Skin and breast tissue removed through vertical scar (violet)
Final scar is circle and vertical line (red)

VERTICAL AND HORIZONTAL SCAR
Skin only removed from lower part of breast (pink)
Skin and breast tissue removed from top and sides (violet)
Final scar in shape of anchor (red)

IMPLANTS AND LIFTS

Many women clearly require breast implants along with their lift. There are two scenarios in which this is commonly seen. The first is the patient who desires breast augmentation and on examination is found to have sufficient ptosis to require a lift. The other is a patient who initially consults for a lift and desires upper pole fullness or a larger breast.

The decision must then be made whether to perform the augmentation and lift at the same or at separate operations. In situations where only minor lifting is required, I find it acceptable to perform the procedures at the same time. However, in patients with moderate to major ptosis of the breast, I strongly believe that it is better to perform the mastopexy first, and then perform a breast augmentation three or more months later.

There are also situations where it is not so clear-cut that both operations are needed. In the case of a woman who wants larger breasts and has only minor sat sagging, it is perfectly acceptable to put the implants in first and then see how everything looks before determining whether or not perform a mastopexy. Frequently in

cases of severe ptosis, particularly when the patient wants the same size or smaller breast, a mastopexy will be performed at the initial stage. Many of these patients will elect to not even get implants so they do not have to deal with the potential complications and additional cost of those implants.

One of the more difficult situations that occurs is the case of a woman who has very large breasts, D or DD, who wants a lift but also wants to maintain or increase her size. This situation is even more difficult if she wants upper pole fullness. When the lift is initially performed the skin will be tight around the breast. However with the weight of the breast tissue the skin will stretch. As the skin stretches it becomes weaker. As the skin becomes thinner and weaker the breast will again sag. This will be compounded by the weight of an implant.

A breast augmentation performed alone has very few complications. A breast lift performed alone, has very few complications. However, when a breast lift and a breast augmentation are performed in a single operation, the incidence of complications seems to rise exponentially. There are several factors that contribute to this increased complication rate of the combined augmentation mastopexy. One is that women with mammary ptosis have weakened skin at the bottom of the breast. When an implant is added, the additional weight will further stretch and weaken the skin. If an incision is made at the bottom of the breast to perform a mastopexy then this further weakens the skin. The sutures may only strengthen it for a week or two until they began dissolving or cutting through the tissues much as a wire can cut through a slice of cheese. Also if the implants are placed under the muscle this will cause further downward pressure on the bottom of the breast where it can be least tolerated. Long-term this will often cause bottoming out of the breast.

The reasons for staging an augmentation and mastopexy are as follows:
It reduces the variables of each operation so that it becomes more predictable.
It decreases the complication rate.
The complications that tend to occur in staged operations are usually less severe complications.
The most severe complications are affection, capsular contracture, implant exposure.
There is less risk of bottoming out of the implant.
It allows for better muscle coverage at the second stage breast augmentation.
It reduces the risk of unplanned secondary operations.
It may prevent problems that are uncorrected all.

The unplanned secondary operation is one of the most distressing events in plastic surgery. It is distressing, physically, emotionally, and financially.

ABNORMAL BREAST SHAPES

CONSTRICTED BREAST
An abnormal breast shape that occurs with some frequency is the constricted breast. In this condition the inframammary fold is higher than normal and somewhat tight also. It also may be straighter across rather than curved. Often there is deficient breast volume in the lower part of the breast. There is also a very short distance from the nipple to the inframammary fold. Typically an implant is used and the nipple may also need to be moved. Also manipulation of the internal surface of the glandular tissue may be required to get the implant to sit in the pocket appropriately.

TUBEROUS BREAST
A more severe a variant of the constricted breast is the tuberous breast. In this situation, the inframammary fold is higher and tighter and the distance from the fold to the nipple is reduced. The areola is usually wider than normal. Most of the glandular tissue is concentrated around the areola creating a narrow breast. Because of the breast is narrowed the distance between the breasts are wide. The tuberous breast may consist mostly of fat or mostly of glandular tissue. The condition may be mild or severe. There may be a small amount or a large amount of breast tissue. There may be asymmetry between the two breasts.

This condition is treated by lowering the inframammary fold, reducing the areola size, and manipulating the internal glandular tissue. Since the tuberous breast is an unattractive breast shape and it is usually smaller than desired, an implant is often used to create a larger breast and given a more attractive shape.

RECOVERY AND HEALING

A breast lift, or mastopexy, is performed as an outpatient procedure under general anesthesia. The procedure typically lasts one to three hours. After one or two hours in the recovery room, the patient is discharged to home. Patients are instructed to relax, but bed rest is not necessary. In fact, we prefer that you move around some. You may eat anything you want right after surgery. You may shower that day or the next day. There is very little wound care needed.

The incisions are covered by strips of 1" paper tape. There is a large clear plastic dressing over the lower half of the breast. All of this will be removed approximately 10 days after surgery. There are usually only one or two sutures that need to be removed. The rest are buried under the skin and will eventually dissolve. Drains are typically not necessary. A surgical bra is worn for four weeks around the clock. Patients typically are off work for three to seven days. There are no restrictions after three weeks postoperatively. It usually takes 6 to 12 weeks for the breasts to achieve their final shape.

As one of the main concerns with mastopexy is scar quality, we have a special protocol that we use for the breast scars. When you are seen 10 to 14 days after surgery, we will remove the paper tape that we placed on the incisions in the operating room. Then we will apply a clear plastic dressing called Tegaderm to the scars. You will be instructed to leave this on as long as possible. We would like for you to use the Tegaderm for a total of three months. Usually it will require changing every three or four weeks. The Tegaderm applied to the scar at the fold beneath the breast may require changing more frequently than the Tegaderm applied around the nipple. We have found that the use of Tegaderm for three months after surgery significantly improves scar quality.

Pain after mastopexy is usually very moderate. Often non-narcotic analgesics are all that is required. This allows for a faster recovery and reduces the side effects that are often seen with narcotics such as Demerol and codeine.

OUTCOME

Early after surgery, the breast skin will be tight. The upper portion of the breast will be full, and perhaps rounded. The bottom portion of the breast will be flattened. This shape is temporary and as time goes on the upper portion will flatten the bottom portion will fill out. As it does so a more desirable shape will be achieved. Unfortunately, the skin may continue to stretch and the breast may continue to sag beyond this desired endpoint. However, it will not to get back to the position and shape that it started from before surgery.

Tightening the breast skin forces the tissue into a smaller volume. It becomes more dense or firmer. This firmness is due to the external compression by the skin instead of a gain of internal cohesiveness by the breast tissue. Since the skin is weak to begin with, the early tightness is only temporary. If an implant is used the resulting tightness of the breast will depend on how much of the final breast comes from natural tissue and how much comes from the implant.

BENEFITS OF BREAST LIFT

Women seek breast lift surgery for a variety of perceived benefits. Most simply want to improve the size, shape, and lift of the breast so that they look better in certain types of clothes or swimsuits, thus increasing their clothing options. Often it is because she wants to wear certain types of clothing without the need for a bra to support the breast. When a woman feels that she looks better in clothes it often makes her feel better about herself.

Along with improving the shape and size of the breast, other goals are just as important. Every effort is made to maintain breast function, softness, and sensitivity. It is also critical to minimize interference with breast cancer detection.

Other benefits are obtaining symmetry of the breasts, restoring youthful nipple position and size, and relieving the contact of chest skin with the underside of the breast skin. Most patients are very pleased with results. However, as always, the key to success is realistic expectations.

The satisfaction from mastopexy often depends on the answer to the two following questions:

1. Does the lift justify the resulting scar?
2. Does insertion of an implant to give upper pole fullness and shorten the scars justify the trade-offs associated with an implant?

RISKS OF BREAST LIFT

Risks of surgery fall into three categories. There are limitations, trade-offs, and complications. Limitations describe what a particular operation is not capable of doing. A trade-off is something possibly adverse that one must expect to occur in order to gain the desired goal. Side effects fall into this category. Complications are unwanted conditions that may be due to faulty judgment on the part of the patient or surgeon. They may also happen because of conditions that are outside of the control of either patient or surgeon.

LIMITATIONS

With current technology, there is not a way to lift the breast without creating scars. A breast lift does not remove stretch marks that occur outside of the area of skin that is removed. The breast will continue to sag with age. Some women have a normal shaped breast that is positioned low on to the chest wall. There is not a method that predictably and consistently elevates the position of the entire breast to a significant degree.

TRADEOFFS

The more breast skin that is removed, the longer the scars will be. The scars are permanent. They may be good-quality or poor quality. There is not a predictable and long lasting way to achieve upper pole fullness without an implant. If a woman chooses to have an implant to there is a number of trade-offs that go along with that implant. One should expect a higher incidence of interference with nursing and nipple sensation with a breast lift.

RISKS

CHANGE IN NIPPLE AND SKIN SENSATION

You may experience a change in the sensitivity of the nipples and the skin of your breast. Permanent loss of nipple sensation in one or both nipples can occur after a mastopexy.

SKIN SCARRING

All surgery leaves scars, some more visible than others. Although good wound healing after a surgical procedure is expected, abnormal scars may occur within the skin and deeper tissues. Scars may be unattractive and of different color than the surrounding skin tone. There is the possibility of visible marks in the skin from sutures. In some cases scars may require surgical revision or treatment.

FIRMNESS
Excessive firmness of the breast can occur after surgery due to internal scarring or scarring around a breast implant if one is used. The occurrence of this is not predictable. Additional treatment including surgery may be necessary.

UNSATISFACTORY RESULT
There is the possibility of a poor result from the mastopexy surgery. You may be disappointed with the results of surgery. Cosmetic risks would include unacceptable visible deformities, poor healing, and unacceptable breast shape. You may be dissatisfied with the size of your breasts after mastopexy.

DELAYED HEALING
Wound disruption or delayed wound healing is possible. Some areas of the breast skin or nipple region may not heal normally and may take a long time to heal. Areas of skin or nipple tissue may die. This may require frequent dressing changes or further surgery to remove the non-healed tissue. **Smokers have a greater risk of skin loss and wound healing complications.**

ASYMMETRY
Some breast asymmetry naturally occurs in most women. Differences in terms of breast and nipple shape, size, or symmetry may also occur after surgery. Additional surgery may be necessary to revise asymmetry after a mastopexy.

BREAST DISEASE
Breast disease and breast cancer can occur independently of breast lift surgery. It is recommended that all women perform periodic self-examination of their breasts, have mammography according to American Cancer Society guidelines, and to seek professional care should a breast lump be detected.

FUTURE PREGNANCY AND BREAST FEEDING
Mastopexy will not interfere with pregnancy. You should expect it to interfere with breast feeding. If you are planning a pregnancy, your breast skin may stretch and offset the results of mastopexy.