

Aesthetic Reconstruction of the Tuberous Breast Deformity

Discussion by Scott L. Spear, M.D., and Jason C. Ganz, M.D.

As Mandrekas et al. stated, “tuberous breast deformity” is defined as the combination of a constricted breast, both in length and width, with the herniation of breast tissue into a hypertrophied areola. This may or may not be combined with breast hypoplasia or asymmetry. Any attempt at correcting this deformity should address the breast diameter and the areola and should be aimed at making the breasts more proportionate and symmetrical.

The authors’ technique consists of a circumareolar mastopexy with division of the lower pole of the breasts, with or without the use of a subglandular or subpectoral implant. Their results are, by and large, good. Though they proclaim that their procedure has the benefit of avoiding the use of implants, they did use implants in eight of their 11 patients. In one of the three patients who did not receive implants, the authors do not show a frontal view of their postoperative results, which makes one wonder, “why not?” For the majority of the results, the areolas are still too large, though the herniation of breast tissue into the areola is improved.

In our experience, the correction that these surgeons have achieved can usually be attained by increasing the base diameter of the breast with an implant and by decreasing the areolar diameter with a circumareolar mastopexy. This begs the question, to what extent does vertical division of the breast help, especially if the authors proceed to suture the lower pole back together? It would seem evident that if vertical

transection of the lower pole of the breast helped to expand the breast diameter, one would not want to repair it and risk constricting the base diameter. If one is dividing the lower pole only to ultimately repair it, why do it in the first place? Could the effect of expanding the lower pole be achieved by the well-described technique of radially scoring the breast parenchyma without completely dividing the breast tissue? Incidentally, we are not convinced that radial scoring is necessary or beneficial, either. The authors’ technique would be more convincing if it were compared prospectively with the same operation without transection of the lower pole.

Our concern about repairing the vertical transection of the lower pole in a double-breasted fashion is that it would only serve to further decrease the breast diameter of a breast that is already constricted.

The authors give a good explanation of the problem of tuberous breast deformity and show reasonable results in most cases. What is not clear in their description is their reasoning for performing all of these steps. Though the authors’ technique requires further scrutiny, they should be commended for their thoughtful description of a problem that continues to pose a challenge to plastic surgeons.

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