

## **Innovative New Concepts in Augmentative Breast Surgery. Part II: Systematic and Drawing**

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**Abstract.** This paper presents a simple protocol to define the anatomic parameters for creating aesthetic augmented breasts using round silicone implants. This study completes our previous publication on augmentative breast surgery. We discuss the need for correct submuscular dissection and explain how to obtain the correct positioning of the inframammary fold via measurements. We also explain how we use radiological images to show the continuity of the submuscular dissection in the inferior border so that we can create a new submammary fold and thus preserve the central position of the nipple-areola complex.

**Key words:** Augmented breasts—Silicone implants—Submuscular dissection—Nipple-areola complex

A multitude of techniques, subtechniques, and materials have been developed to improve the cosmetic results of breast augmentation surgery, reconstructive breast surgery and aesthetic breast surgery since silicone gel-filled implants began to be used in the early 1960s by Cronin and Gerow [1].

This multitude of methods indicates that there is no universal technique for this type of surgery. The plastic surgeon must rely on his or her sense of beauty and artistic skill [2] and should be ready to make appropriate changes when needed. When we try to create aesthetic and symmetrically balanced breasts using implants, the surgical technique must be one that results in a soft, well-positioned, and mobile breast that responds to gravity and postural changes.

We have attempted to develop and improve our

knowledge and techniques in augmentative mammaplasty as shown by our published studies on this topic [3]. Our information is based on 20 years of experience with the use of silicone gel-filled implants (Fig. 1). During this time we have come to appreciate the importance of dissecting an extensive submuscular macropocket to contain the implant. This macropocket is based on a wide dissection of the inferior and inferio-lateral borders to allow correct positioning of the new inframammary crease and the nipple-areola complex.

In this paper we will try to establish parameters and measures for establishing the correct location of the new submammary crease of the augmented breast. It is important that the breast does not lie high on the thorax, that it has a conical to teardrop shape, and that the nipple-areola complex on the focal point of the breast is in the frontal view toward which all the contour lines flow.

### **Surgical Technique**

As we described at national and international meetings [3–5] and explained in a previous publication [6], the submuscular placement of the implants is fundamental for good results. The submuscular pocket where the implant is situated, a “macropocket,” is not reduced to the strict limits of insertion of the pectoralis major muscle. Through an inferior hemi-areolar incision we dissect vertically through the mammary parenchyma until we reach the pectoralis major. We then proceed to create a “macropocket” of the desired size beneath this muscle.

In the upper lateral and upper medial portions we dissect through the width of the pectoralis major to the second rib to establish a free space that allows implant mobility on the upper quarters. In the medial portion, we end the dissection 1–2 cm from the midsternal line. In the lower medial portion we dissect the origins of the pectoralis major muscle over the fifth, sixth, and seventh

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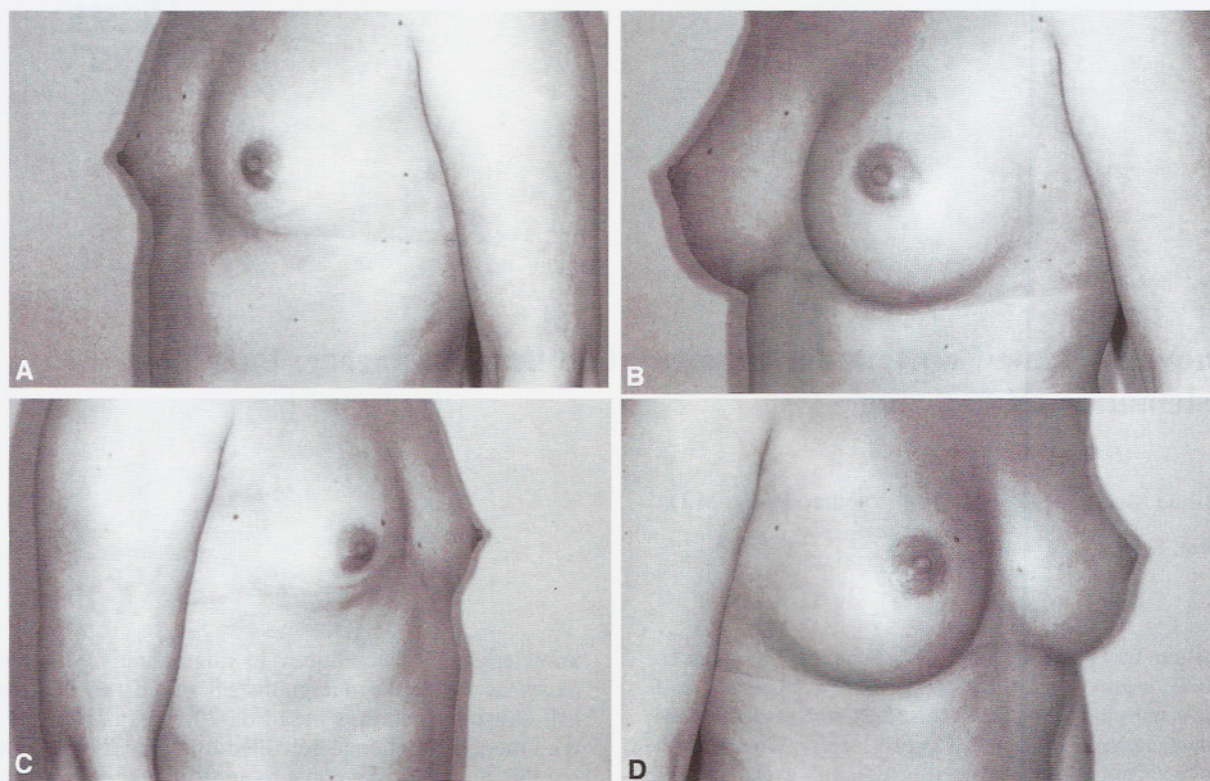


Fig. 1 (A-D). Pre- and postoperative lateral views of a 27-year old woman with 225 cc round silicone gel-filled implants.

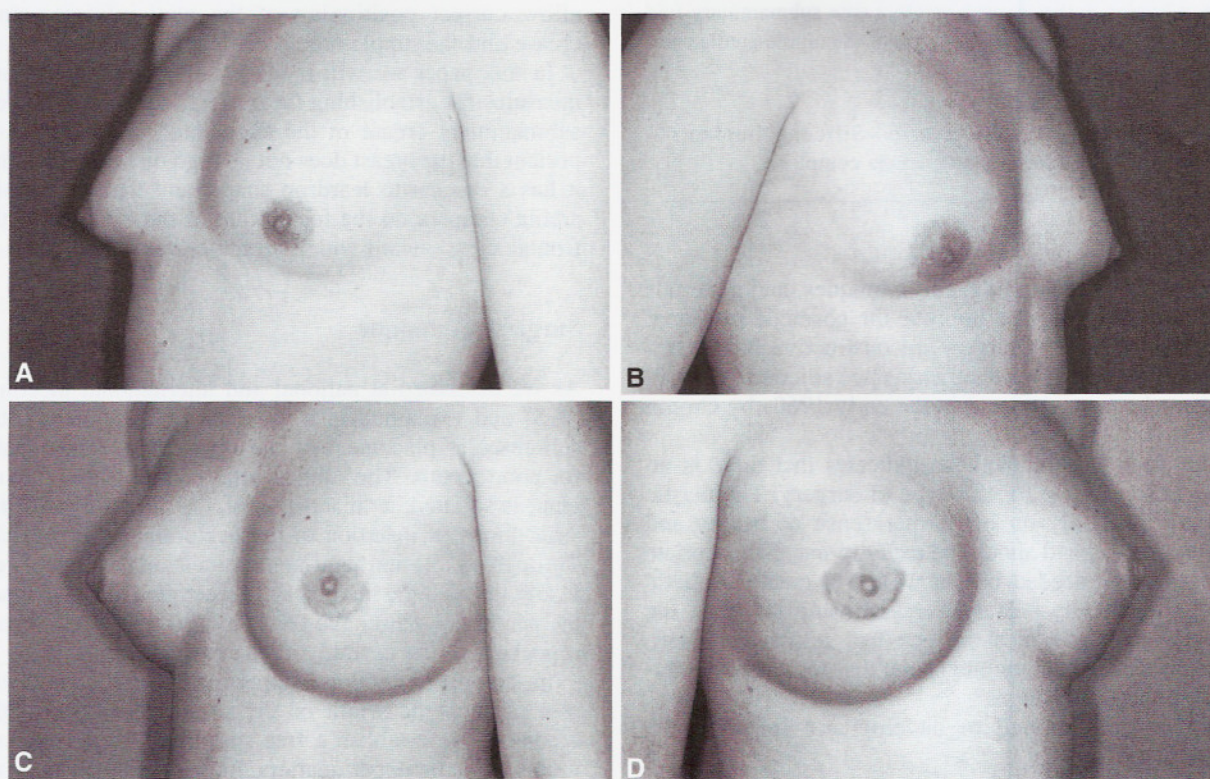
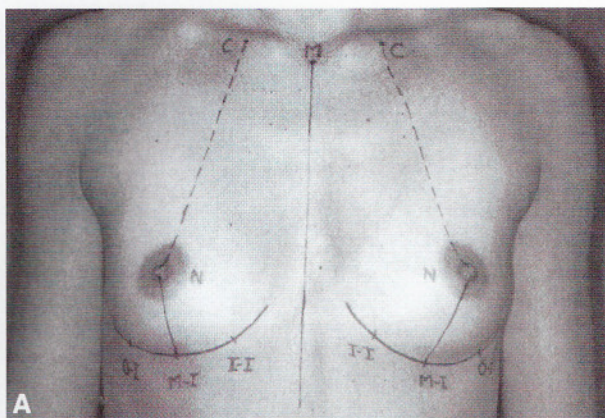
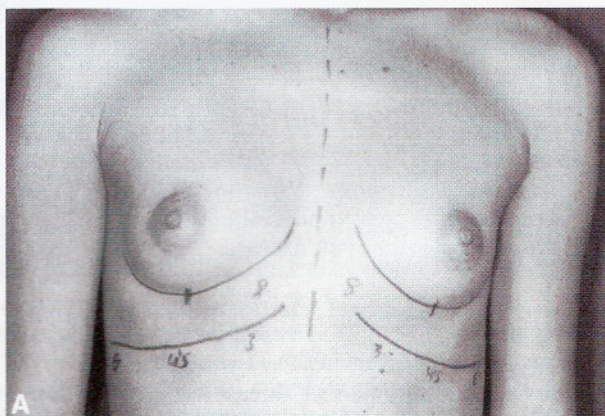
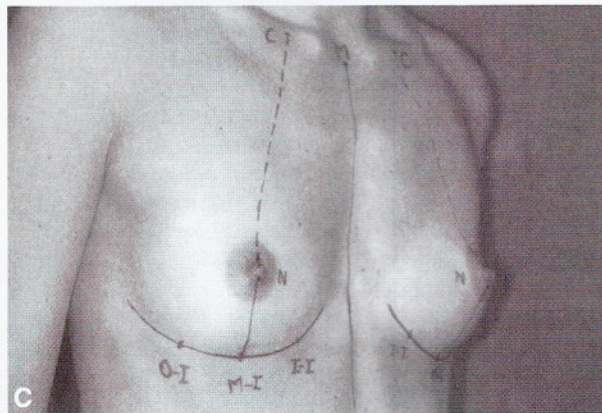
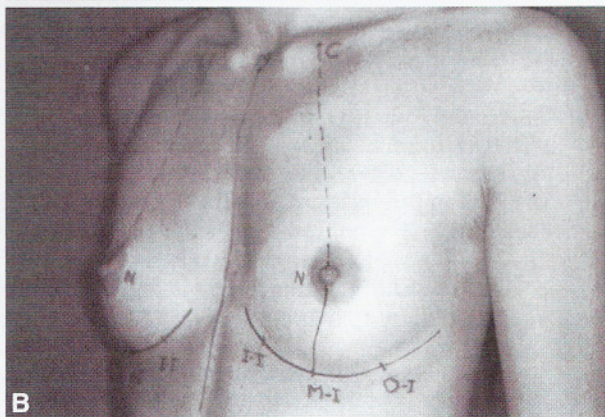


Fig. 2 (A, B). Lateral preoperative views of a 24-year-old woman. Note the short distance between the nipple-areola complex and the inframammary fold. (C, D) Postoperative lateral views: 250 round silicone gel-filled implants. Note the position of the inframammary crease, the position of the nipple-areola complex, and the increased distance between them.

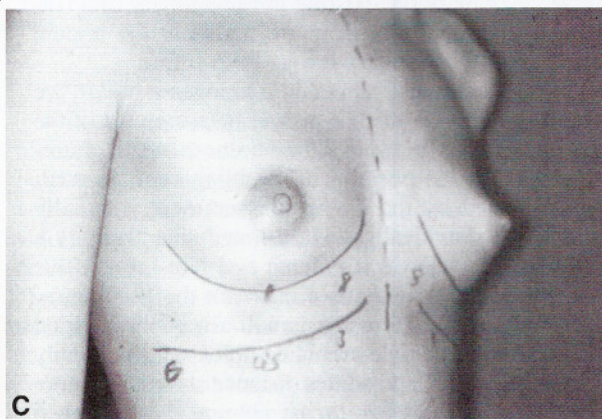
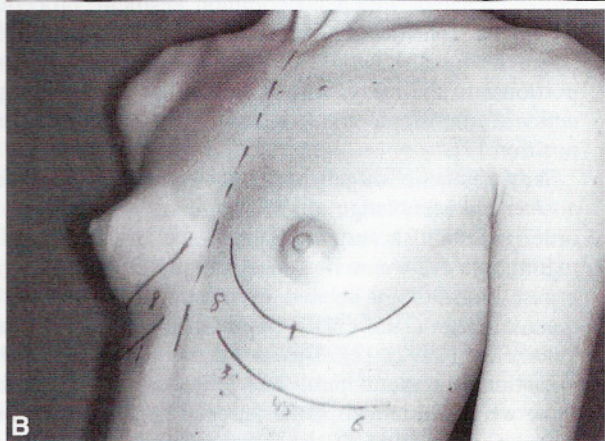




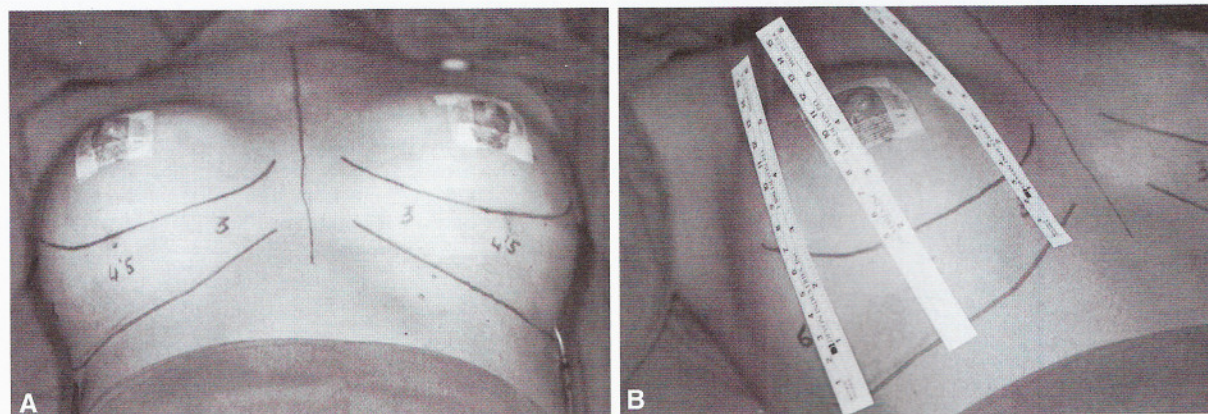
**Fig. 3 (A-C).** Preoperative measurements: frontal and lateral views. **M:** Suprasternal notch- Manubrium point. **C:** Clavicular point (5% cm lateral to M point) **C-Nip:** Vertical line from C to the nipple-areola complex. **Infra (I):** Existing inframammary fold. **Nip-Infra (N):** Vertical line from the nipple to the middle point of the inframammary fold. **Mid-Infra (M-I):** Middle point of the inframammary fold at a constant distance of 8 cm from the midsternal line. **Inn-Infra (I-I):** 4 cm from the midsternal line. **Out-Infra (O-I):** 4 cm from the Mid-Infra point.



**Fig. 4 (A-C).** Preoperative marks for the new inframammary fold, frontal and lateral views: 4.5 cm down from the Mid-Infra (M-I) point, 3 cm down from the Inn-Infra (I-I) point, and 6 cm down from the Out-Infra (O-I) point.







**Fig. 5 (A, B).** Intraoperative views. Note the position of the implants and the new submammary fold keeping the preoperative marked distance.

ribs, and those of the apical portion of the rectus abdominis fascia. We continue the dissection of the lower and lower external portions of the macropocket (our new submammary crease) by lifting the fascias of the anterior serratus and the external oblique muscles to reach the midaxillary line along the external border of the pocket.

The key point of our submuscular dissection is the location of the patient's submammary crease and the position to where it will be displaced by insertion of the implants. The two factors listed below must be considered when taking the inferior border of the dissection below the preexisting submammary crease in order to create a well-shaped augmented breast with correct position of the nipple-areola complex (Fig. 2):

- Location of the original submammary crease
- Existing distance between the nipple-areola complex and the submammary crease.

We make all linear measurements with the women standing in normal anatomical position, that is, with shoulders back and head straight ahead (Fig. 3). We mark the suprasternal notch-manubrium point (M) and the clavicular point (C) as points on the upper border of the clavicle 5.5 cm lateral to the M point. From C we draw a vertical line to the nipple-areola complex (C-Nip). We then mark the existing inframammary fold (Infra) and the vertical line from the nipple to the middle point of the inframammary crease (Nip-Infra).

When we draw these marks on a hypogenic breast, we invariably notice that there is a short measurement of the Nip-Infra distance (between 2 to 3.5 cm in our measurements) whereas the position of the Nipple-areola complex determined by the C-Nip measurement is usually normal. It is statistically demonstrated that there is a linear correlation between volume and Nip-Infra. If we placed the implants so that we maintain the existing inframammary fold, the prosthesis will always lie high on the thorax and the nipple-areola complex will invariably point downward. The Nip-Infra distance should therefore increase with increases in breast volume if we want to avoid problems.

We mark the middle point of the inframammary fold (Mid-Infra) at a constant distance of 8 cm from the mid-sternal line (mean measure of Infra: 16.86 cm). Keeping the semiespheric form of the crease, we mark two more points on it—one point 4 cm inner (Inn-Infra) and another 4 cm outer (Out-Infra). From these three points we lower the inframammary fold as follows (Fig. 4):

- 4.5 cm down from the Mid-Infra point
- 3 cm down from the Inn-Infra point
- 6 cm down from the Out-Infra point

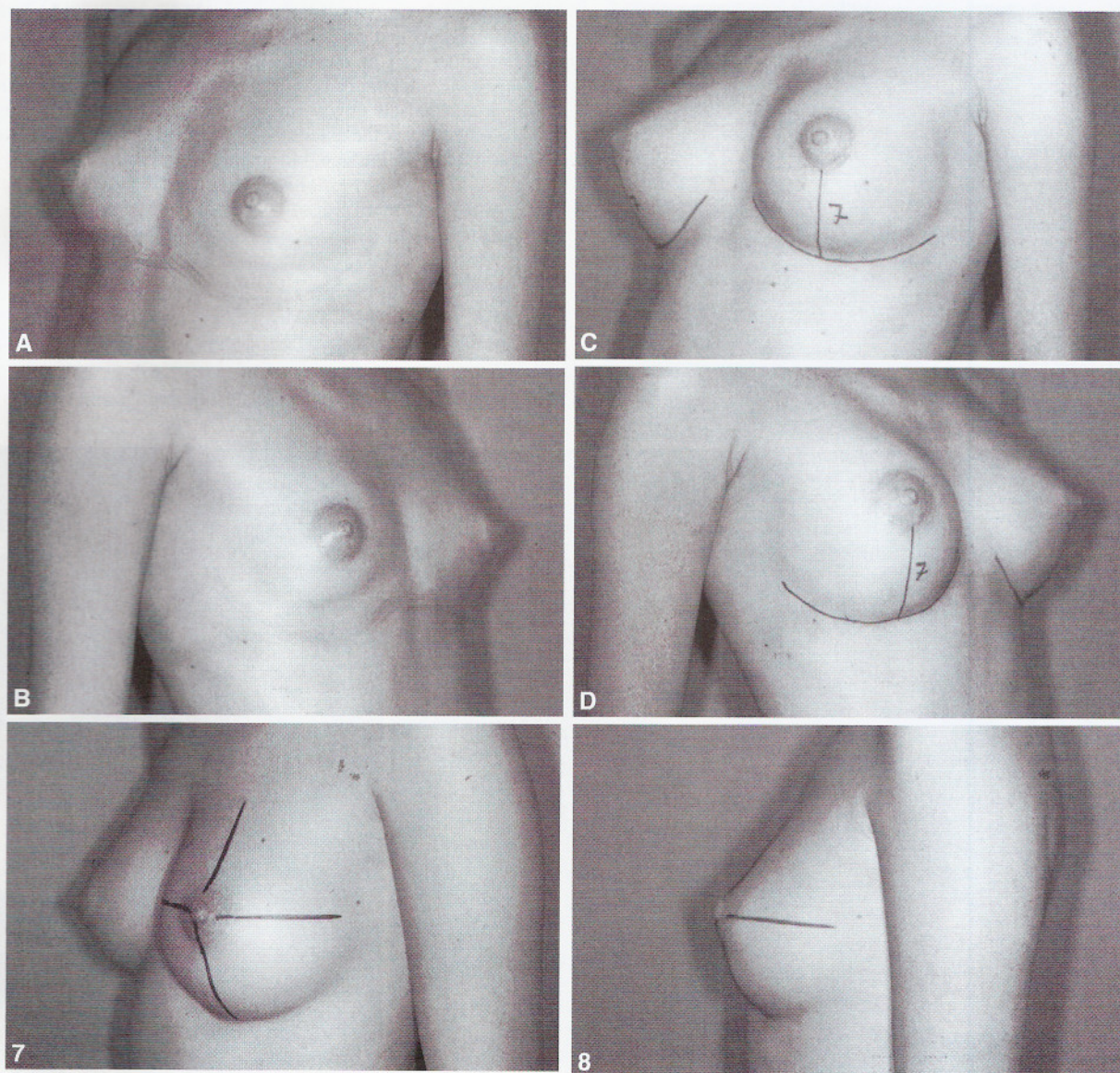
We then dissect our macropocket based on these marks. We lower the inframammary fold to the new marks, keeping the submuscular plane as previously explained. We are then ready to introduce the implant (Fig. 5). We always use round, moderate profile textured silicone gel-filled implants (Mentor®). We believe that with correct dissection and the proper lowering of the inframammary fold to give the breast a natural position and shape, anatomical implants are not necessary.

## Discussion

The "aesthetically perfect" breast was defined as a non-ptotic breast in which no common aesthetic procedure would be considered (excluding augmentation) to enhance its form. It would be of a size and fullness proportional to the body, with a conical to teardrop shape, and with the nipple-areola complex at the anterior-most position [7].

Any aesthetic surgery on the breast needs a perfect anatomical knowledge of the mammary region [8,9]. In order to establish surgical parameters for augmentative mammoplasty, we reviewed some previous reports on breast morphology related to plastic surgery such as those of Penn (1955) [10], Smith et al. (1986) [11], and Westreich (1997) [7]. Based on the anthropomorphic breast measurements published by these authors, we believe we can establish some parameters that will facilitate the positioning of the inframammary fold on aug-





**Fig. 6 (A-D).** Final result of patient in Figures 4 and 5. Pre- and postoperative lateral views (7 cm between the nipple-areola complex and the new inframammary fold).

**Fig. 7.** Aesthetic anatomic evaluation of the implants (oblique view). The transverse nipple line defines the hemispheres of the breast so that two-thirds of the total volume lies below the line and the other one-third above it.

**Fig. 8.** Aesthetic anatomic evaluation of the implants (Profile view). The projection of the breast flows down and outward as far as the areola and from there descends in a convex line to the inframammary fold.

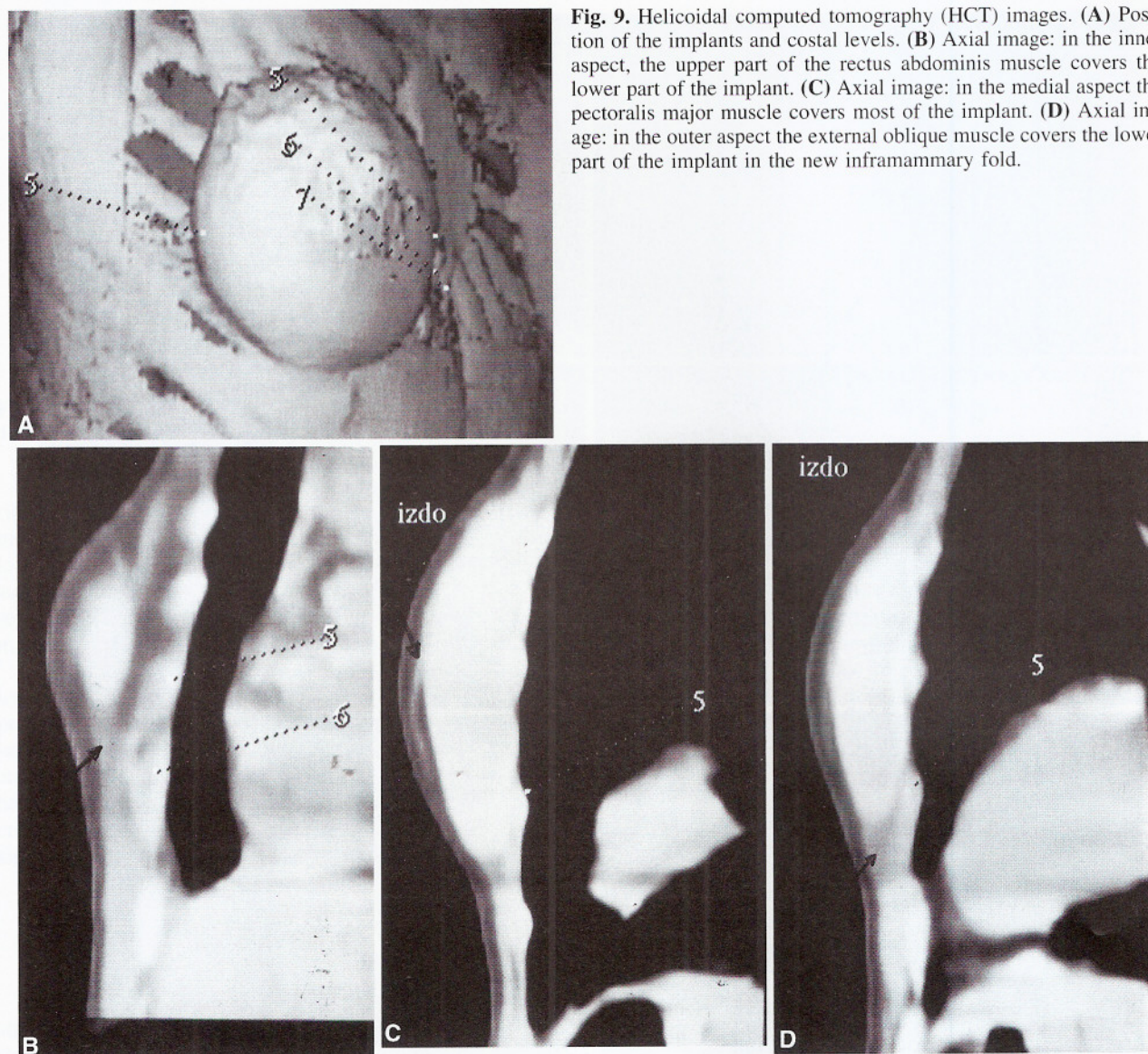
mented breasts to create aesthetically perfect implanted breasts.

When we draw our marks on the patient with hypogenic breasts we invariably notice that there is a short value for the Nip-Infra distance, between 2 to 3.5 cm, if compared with those published by Penn (6.74 cm) [10], Smith (6.46 cm) [11], and Westreich (6.95 cm) [7] for normal aesthetic breasts. The C-Nip distance in these hypogenic breasts is, however, similar to the published ones, with a mean value of 19.5 cm in our measurements, and from 18.8 to 20.63 cm in those published before [7,10,11].

It is easy to understand that if the nipple-areola complex of the hypogenic breast is at the standard position, but the inframammary fold is high because of the low volume of the hypogenic breast, an increase in breast volume without an increase in the Nip-Infra distance will result in a larger breast that lies high on the thorax. Most of the volume will lie over the transverse nipple line on the superior one-third of the breast and the nipple-areola complex will point down [12].

It has been statistically proven that there is a linear correlation between breast volume and Nip-Infra distance. This distance must be increased when we increase





**Fig. 9.** Helicoidal computed tomography (HCT) images. (A) Position of the implants and costal levels. (B) Axial image: in the inner aspect, the upper part of the rectus abdominis muscle covers the lower part of the implant. (C) Axial image: in the medial aspect the pectoralis major muscle covers most of the implant. (D) Axial image: in the outer aspect the external oblique muscle covers the lower part of the implant in the new inframammary fold.

breast volume to maintain proportions [7]. This is why it is important to make the correct dissection in the inferior border of the macropocket. It is necessary to lower the inframammary fold to avoid an implanted breast that is not esthetically pleasing.

Based on the measurements of the related anthropomorphic studies, we established our parameters to obtain a Nip-Infra distance of between 7 to 7.5 cm at the Mid-Infra point, with a centered position of the nipple-areola complex (Fig. 6). This value correlates with those published by Penn (6.74 cm) [10], Smith (6.46 cm) [11], and Westreich (6.95 cm) [7], taking into account that their measures are done on "normal breasts" (mean value of 282 cc). We submit that this distance should increase with an increase in volume [7].

When evaluating the aesthetic anatomic position of implants from the frontal and oblique views (Fig. 7), the transverse nipple line will define the hemispheres of the

breast so that two-thirds of the total volume lies below the line and the other one-third above the line. In the profile view (Fig. 8), the projection of the breast will flow down and outward as far as the areola, and from there will descend in a convex line to the inframammary fold [8,9].

Concerning the anatomical characteristics of the breast, no more than half the breast should cover the pectoralis major muscle surface. The rest of the breast should lie over the anterior serratus, the external oblique, and the rectus abdominis, all of which are covered by a deep fascia of interlaced fibers. We apologize for the dissection of a complete submuscular macropocket that goes beneath these muscles in the upper part to maintain a wide free space which allows free movement of the implant. The submuscular macropocket continues through the lower-medial, lower, and lower-external portions to insure perfect coverage of the implants. This



avoids the wrinkled appearance in the sternum where the skin is very fine and allows the inframammary crease to descend to its correct position. With proper technique it is possible to perform a complete submuscular dissection in the lower border without creating two dissection planes: one submuscular in the upper half and another subglandular in the lower half.

To verify our technique, we performed, in collaboration with the Radiology Department of our hospital, a helicoidal computed tomography (HCT) study on some of our patients. These images show that it is possible to maintain the submuscular plane along the most inferior part of the dissection thus creating a new inframammary submuscular fold that goes beneath the rectus anterior, the serratus, and the external oblique muscles (Fig. 9) [13,14].

During postoperative treatment, we are careful to preserve the "macropocket." We teach the patients how to self-massage the breast to prevent capsular contraction. Proper massage of the breast with full excursion of the implant throughout the macropocket helps maintain sufficient submuscular space for the implants. This in turn allows the breast to remain soft, optimum to the touch, and provides fluidity in movement [15,16].

We complete treatment using a special elastic bra which produces very soft pressure, and a velcro-elastic strap (Crisvi ®) that facilitates implant positioning. In early postoperative treatment we put the velcro strap on the upper part of the breast to maintain the new inframammary fold, the convexity of the inferior profile, and the position of most of the implant volume into the inferior breast hemisphere. Later on, if necessary, we put the velcro-strap over the inframammary fold after it has established its definitive position.

## Conclusions

It is important to correctly dissect the submuscular pocket in order to create satisfactory augmented breasts using silicon round implants. The basis of our surgical technique is the dissection of a submuscular macropocket followed by proper lowering of the inframammary fold maintaining the submuscular dissection plane, and keeping a free superior space to ease the implant movement.

We note the importance of understanding the anatomical proportions of the breast and the anthropomorphic measurements to understand the correct parameters that we define for lowering the inframammary fold, increasing the distance between it and the nipple as we increase the breast volume. In this way we maintain the nipple-

areola complex in its central position as the focal point of the breast toward which all the contour lines flow, and with the larger breast volume lying in the lower hemisphere, below the transverse nipple line.

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## Innovative New Concepts in Augmentative Breast Surgery

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**Abstract.** The female breast is seen as a badge of feminine beauty in our society. While it can vary over time and with fashions, the perfect breast will always be symmetrically balanced and proportionate to the rest of the body. To create an aesthetic and symmetrically balanced breast using implants to enhance them is not an easy task. Surgery must combine the concepts of an ideal breast with the desires of the patient in terms of size. The satisfactory breast should remain soft, well positioned, and mobile to respond to gravity and postural changes. In attempting to construct an "ideal breast," certain basic aesthetic anatomical proportions should be taken into account: natural positioning of the breast in the thorax; symmetry; the position of the nipple-areola complex as the focal point of the breast in the frontal view; a side profile of the breast with a natural soft fall; and, overall, the position of the new inframammary crease in the standing position, while lying down, and while moving.

**Key words:** Augmentation mammoplasty—Breast augmentation

### Anatomical Considerations

The aesthetic and natural appearance of the enhanced breast depends on correct positioning of the implants, and for this we consider good anatomical knowledge of the mammary region to be imperative [1,2].

Anatomically, the greater part of the mammary tissue extends between the third and the seventh intercostal spaces, from the sternal edge to the midaxillary line.

Almost 75% of the breast covers the pectoralis major muscle, mainly the upper and middle portions, while the lateral portion of the breast covers the third and fourth

digitations of the anterior serratus muscle, reaching in the midaxillary line the lateral edge of the latissimus dorsi, and the inferior portion lies over the anterior serratus, the external oblique, and the upper part of the rectus abdominis.

Below the dermis the breast lies between the superficial and the deep layers of the superficial mammary fascia, which continues upward to the cervical fascia and down to the fascia of Cooper.

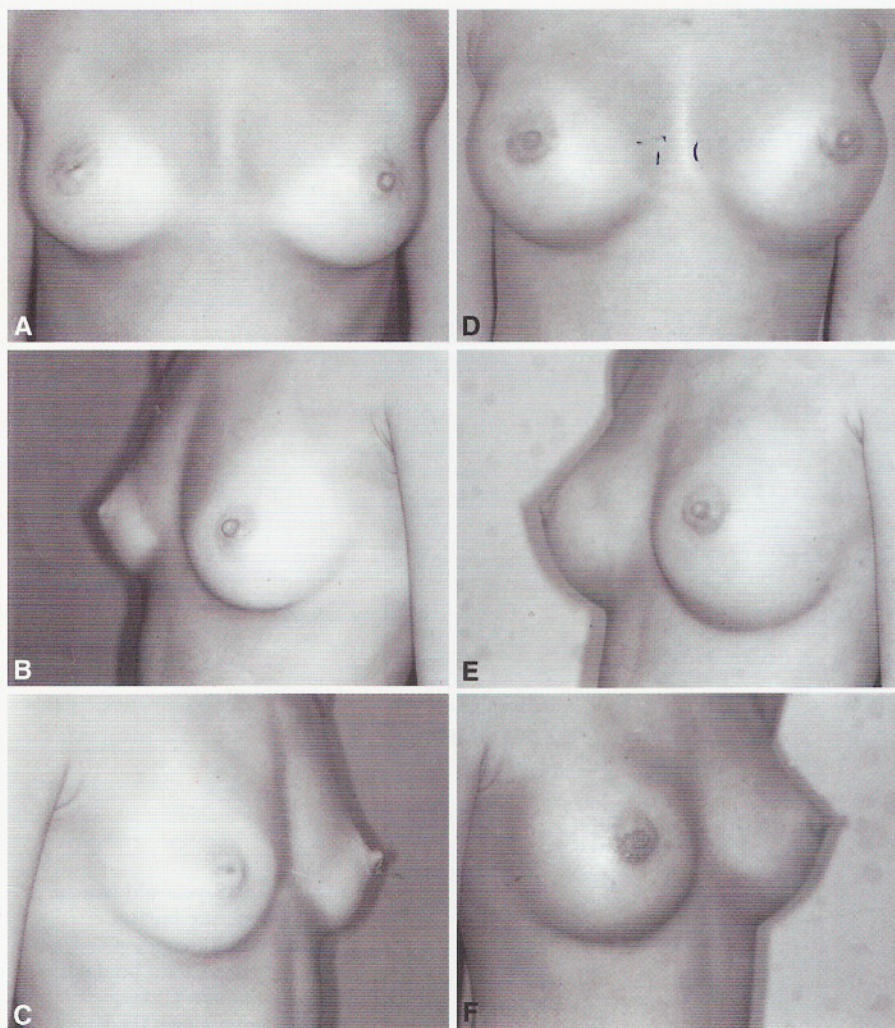
The deep layer of the superficial mammary fascia extends over the fascia which covers the pectoralis major muscle. The retromammary space between them is filled with soft tissue which allows the breast to move freely over the thoracic wall and supplies the anatomical base for the submuscular dissection which we use to place the implants.

### Surgical Techniques

We consider the submuscular placement of the implants to be fundamental to our results [3]. In our experience a higher incidence of breasts acceptable in form, position, and texture is obtained using this method (Figs. 1A and B). Other advantages of this submuscular placement include [4,5] the following.

- There is less contact of the prostheses with the mammary parenchyma and with the lactiferous sinus, which are basically contaminated.
- Separation of the mammary glandular tissue from its deep fascial cover is avoided, resulting in less destructuring of the breast.
- The physical and mammographic detection of mammary diseases is facilitated, and if necessary, biopsies or removal of tumors may be carried out without disturbing the implants [6].
- We preserve the continuity of the third, fourth, and fifth lateral intercostal nerves across the serratus





**Fig. 1.** A 24-year-old woman. Augmentation mammoplasty with 225-cm<sup>3</sup> subpectoral implants. Preoperative (A–C) and postoperative views (D–F).

digitations, important in conserving the sensitivity of the areola.

- There is a low incidence of postoperative hematoma if the musculofascial dissection is blunt and the hemostasis is meticulous.
- The cushioning action of the muscle, and the massage which spreads pectoral contraction over the implant, results in a lower incidence of capsular contraction.
- In case of opening of the cutaneous wound the prosthesis is protected by a barrier of muscle.

The submuscular pocket where we prefer to situate the implants is, in practice, a "macropocket" not reduced to the strict limits of insertion of the pectoralis major muscle. Although it is commonly presumed that the entire breast rests on the pectoralis major fascia, we have observed that no more than half of the breast covers this zone, while the rest lies over the anterior serratus, the external oblique, and the rectus abdominis, all covered by a deep fascia of intercrossing fibers.

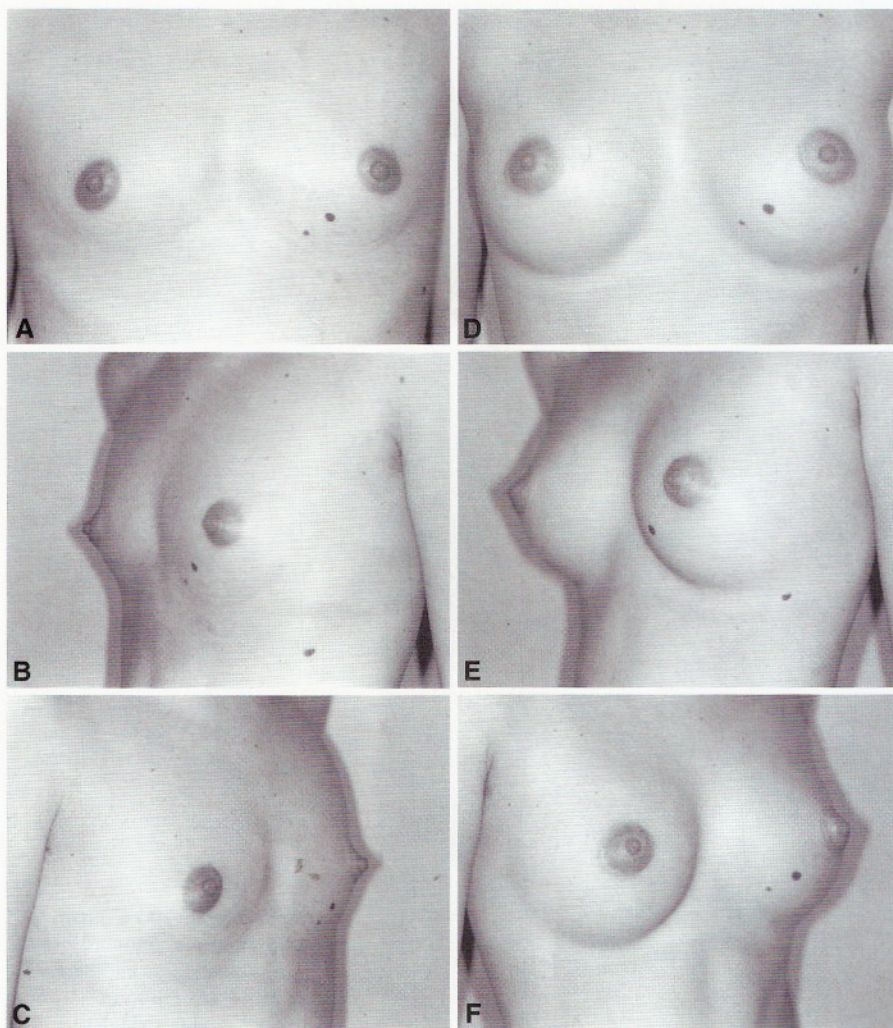
Using this anatomical basis the submuscular macropocket is prepared, extending the dissection upward to the second rib, laterally to the midaxillary line, and medially to the medial origin of the pectoralis major, taking care not to extend the dissection to the midsternal line.

The key point in our dissection is based on the location of the submammary crease of the patient and the position to which the new submammary crease created by the placement of the implants will be displaced. The main objective must be that the new breast does not lie high on the thorax in the anterior costal plane (Figs. 2A and B).

To achieve this the inferior border of the dissection is brought below the preexisting submammary crease as far as necessary, depending on the size of the implant which we are going to insert, the location of the original submammary crease, and the existing distance between the nipple-areola complex and the submammary crease (Figs. 3A and B).

The site of incision should depend on the individual patient. To most patients the resulting scar is not an issue once the redness has disappeared, as long as their breasts





**Fig. 2.** An 18-year-old woman with hypoplastic breasts. Augmentation mammoplasty with 225-cm<sup>3</sup> subpectoral implants. Preoperative (A-C) and postoperative views (D-F).

have remained soft and attractive: when the shape and size are satisfactory, the patient seldom complains about the scar; when they are not, nothing is right, even a good scar [7,8].

We generally choose an inferior hemiareolar site of incision, except in excessively hypoplastic breasts with a minimal areolar diameter, for which we prefer an axillary incision.

Once the incision has been made, we dissect down vertically through the mammary parenchyma until reaching the pectoralis major muscle and then proceed beneath this muscle over the costal layer until a "macropocket" of the planned size has been prepared.

This allows direct access to the subpectoral space, allowing a perfect view of the submuscular pocket which we wish to prepare.

Our dissection in the upper-lateral and upper-medial portions is therefore through the width of the pectoralis major, taking special care not to enter the pectoralis minor muscle, which can cause excessive bleeding and complicate the adequate dissection of the lower-lateral quarter.

We continue with the medial portion, taking care not to allow the pockets from each side to meet, while trying not to leave too large a intermammary crease. As a general guideline we end the dissection 1-2 cm from the midsternal line.

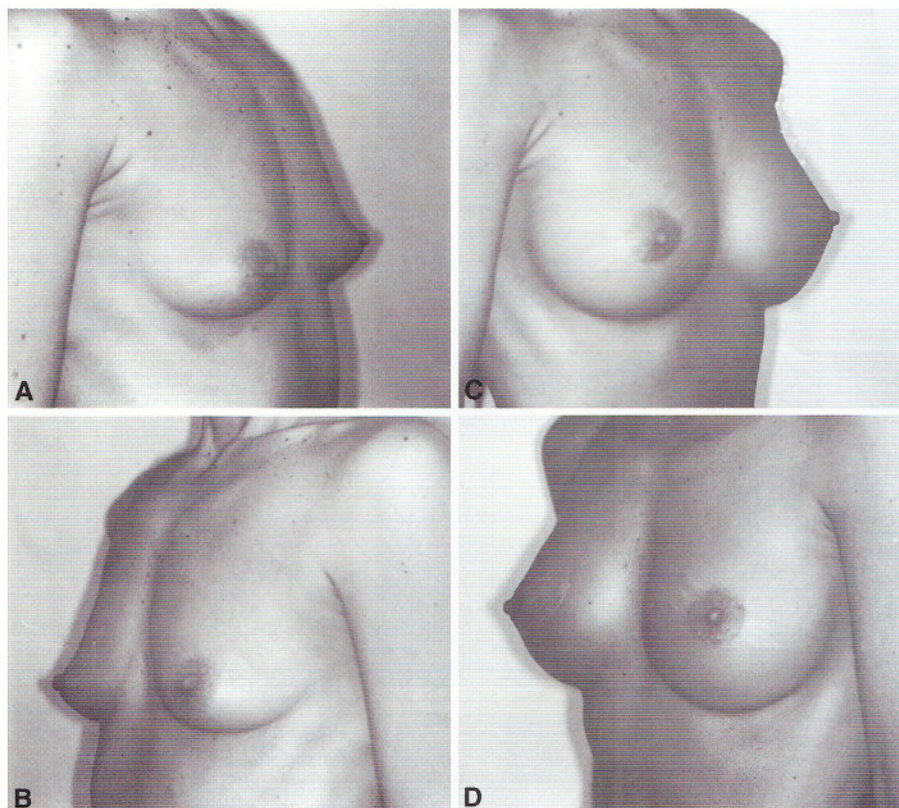
In this area we take care to avoid deviating from the submuscular plane because, if the skin is very fine, the edges of the implant may be noticeable, giving the external aspect a wrinkled appearance.

In the lower-medial portion we dissect the origins of the pectoralis major muscle over the fifth, sixth, and seventh ribs, and those of the apical portion of the rectus abdominis fascia, continuing the dissection of the lower and lower-external portions of the "macropocket" (our new submammary crease) by lifting the fascias of the anterior serratus and external oblique to reach the midaxillary line along the external border of the pocket.

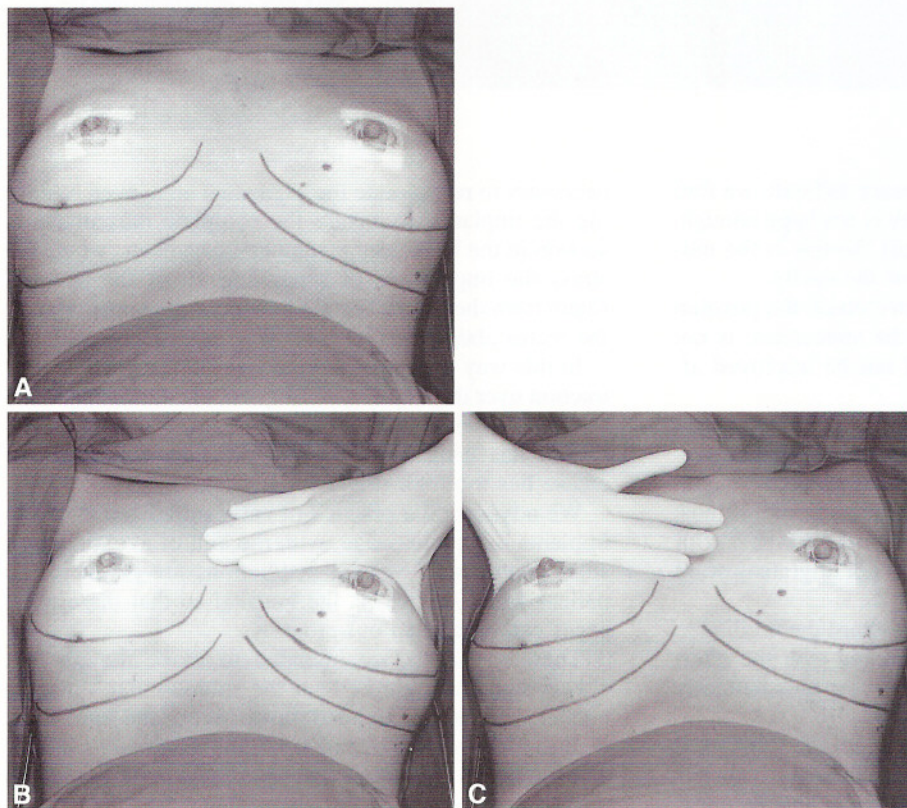
At this point we check hemostasis carefully. We are very particular about this, believing that prolonging the intraoperative time slightly at this moment can prevent postoperative complications.

Once the cavity has been prepared we insert an im-



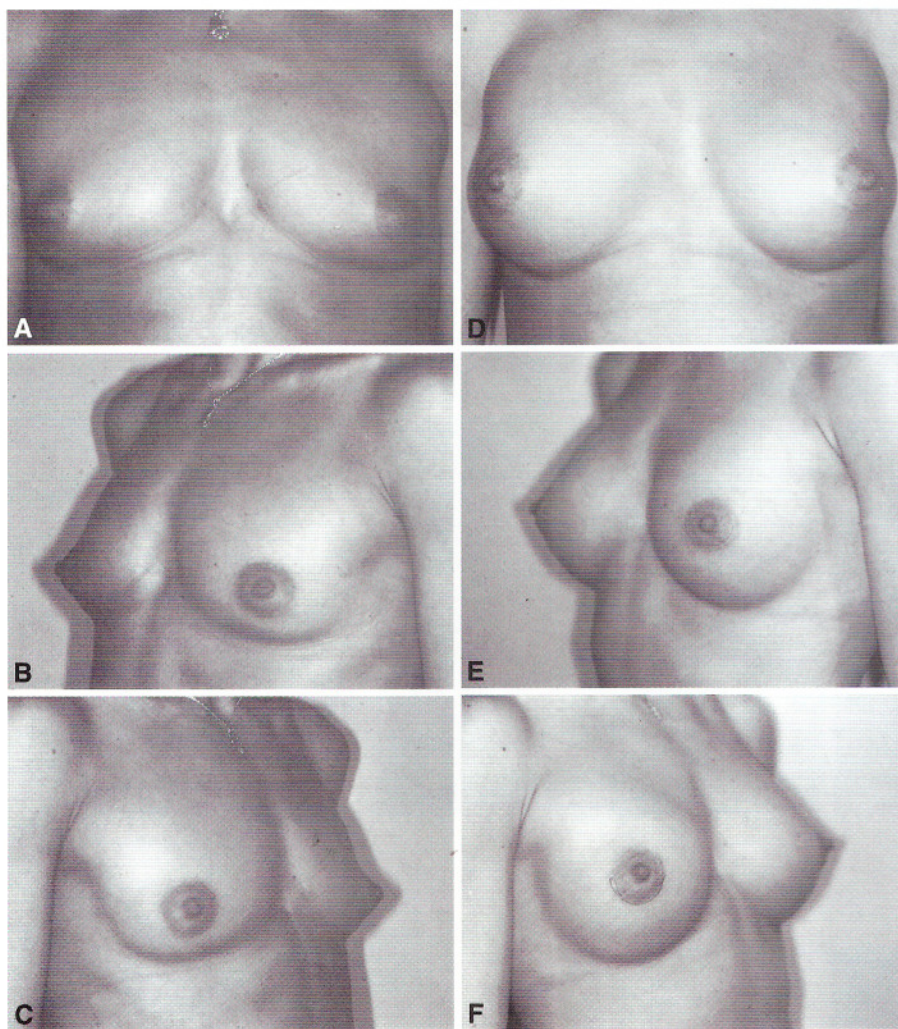


**Fig. 3.** A 37-year-old woman with ptotic-hypoplastic breast. Augmentation mammoplasty with 275-cm<sup>3</sup> subpectoral implants. Preoperative (A, B) and postoperative (C, D).



**Fig. 4.** Intraoperative views. (A) Note the position of the preoperative inframammary crease and the lower localization of the new one after positioning the implants (same patient as in Fig. 2). (B, C) Handling of the implants to check the lower border of the subpectoral macropocket.





**Fig. 5.** A 35-year-old sportswoman. Preoperative views with a strong development of the pectoral muscle and a high position of the submammary crease (A–C). Postoperative views with 250-cm<sup>3</sup> subpectoral implants. Note the position of the new inframammary crease and the absence of muscular contraction over the implants thanks to the correct descent of the inframammary border (D–F).

plant of the chosen size. If this appears difficult, we find that it is because the dissected cavity is not large enough, not because the incision is too small. So this is the moment at which to modify the size of the cavity.

When the implants are in place we check the position and symmetry of both breasts: if the appearance is not satisfactory during surgery, it will not be improved afterward.

We check the lower border of the subpectoral macro-pocket to ensure that the new submammary crease created is correctly positioned, by pressing with the hand on the upper part of the breast, just above the areola; if most of the implant can be compressed into the lower part of the pocket, we can be sure that it will not migrate upward postoperatively (Figs. 4A–C).

Similarly the breasts are pressed toward the midline to evaluate the symmetry and cleavage and over the intermammary crease to ensure that the breast falls naturally over the paraaxillary pockets.

If we find that the muscle pinches into the implant, it is a sign of inadequate muscular dissection or incorrect positioning of the implant in the pocket. In this case it is

necessary to reexplore the excavated area, even removing the implants, to ensure the complete muscular dissection in the lower and medial compartments, where we stress the importance of separating all of the pectoral fibers from their costal origin to expose the upper edge of the rectus abdominis.

In this way we can avoid the effects of muscular contraction over the implant, so frequent in culturist patients, observed when the dissection of the lower portion of the pocket has been incorrect and the new submammary crease lies too high (Figs. 5A and B).

We advocate the practice of early mobilization of the implants by automassage, with the aim of avoiding capsular contracture. Special instructions are given to the patient when she leaves the hospital so that these massages can be carried out properly.

These massages are intended to move the implant slowly but firmly throughout the submuscular "macro-pocket," ensuring extended movement of the implant as well as rounding and symmetry of the mammary contour. The movement should be forced in those zones which do not maintain a smooth peripheral line.



## Discussion

The biggest challenge in augmentation mammoplasty is the maintenance of the anatomic submuscular space created to contain the prosthesis, so that the breast does not lie high on the thorax when the patient is standing, maintains space for mobility in the upper region, descends naturally in the inferior and lateral planes, and falls laterally when the patient is lying down [9].

In order to achieve this, correct dissection of the submuscular pocket which will hold the implant is fundamental. The importance of the dissection of a submuscular "macropocket" which generously exceeds the lower limits of the pectoralis major muscle must be emphasized so that the new submammary crease is in the correct position, allowing a soft natural fall of the breast over the thoracic plane in accord with the ideal aesthetic proportions of the breast. Thus the nipple-areola complex will be the focal point of the breast toward which all the contour lines flow.

With appropriate positioning of the nipple-areola and of the new submammary crease, we will create a pleasing breast, full and rounded, with the larger volume lying in the lower portion. The profile of the breast will show a discrete concave line descending from the upper quarters to the projection of the nipple and a convex line continuing from this point to the submammary fold.

The nipple should sit over the fourth-fifth intercostal space, about 19–21 cm below the midclavicular point, on a line descending from it, and about 9–11 cm from the midsternal line (Fig. 6A).

In evaluating the aesthetic anatomic positioning of the implants from the frontal view, the transverse nipple line will define the hemispheres of the breast so that two-thirds of the total volume lies below this line and the other one-third above it.

In the profile view (Fig. 6B), the projection of the breast will begin at the second-third ribs, flowing down and outward as far as the areola, which projects out slightly from the surrounding mammary tissue, and from there the breast will descend in a convex line to the inframammary fold, which sits over the sixth-seventh intercostal space, where it joins the upper part of the abdomen.

In the oblique view (Figs. 6C and D), the breast should descend from the clavicle marking the anterior axillary fold, showing a fuller image in the lateral and inferior portions.

When the patient is standing with the arms raised, the breast will displace downward, so that the upper hemisphere is less evident and the lower one protrudes farther.

We are insistent with the patients, particularly during the first month after surgery, about the importance of the massages to achieve our objectives, so that we base the frequency of our consults on how persistently they follow our instructions. The patient should be made fully aware of the importance at this point of her active and interested participation in the recovery period by means of adequate, energetic, continuous, and prolonged massages (Figs. 7A and B).

This automassage maintains the amplitude of the macropocket, which allows natural movement of the breast with positional changes and prevents capsular contraction around the implant, favoring a sort of continued microcapsulotomy which allows the breasts to remain soft and optimum to the touch [10,11].

Occasionally in the third or fourth day of the postoperative period we have found breasts which are clearly inflamed and tense, with signs of fluctuation. As this phenomenon is generally bilateral, localized, and sudden, we are not concerned about hematoma but, rather, believe that this is caused by a lymphatic hypersecretion within the submuscular pocket, caused by the extensive dissection and by the early mobilization of the implants rubbing against the fascial layer [12]. In fact, even major subfusions of this type diminish in 24–48 h simply by the patient wearing a bra to maintain pressure and ceasing the massages, which we renew once the phenomenon has regressed without it recurring, maybe because during the rest period we have given time for the destructured lymphatics to stabilize.

## Conclusions

The basis of our technique is the dissection of an extensive submuscular macropocket which will contain the implant, with an extensive dissection of the inferior and inferolateral borders to allow correct positioning of the new submammary crease and of the nipple-areola complex.

Early and continued massage of the implants will help to maintain the amplitude of the submuscular pocket, allowing natural movement of the breast and helping to prevent capsular contraction.

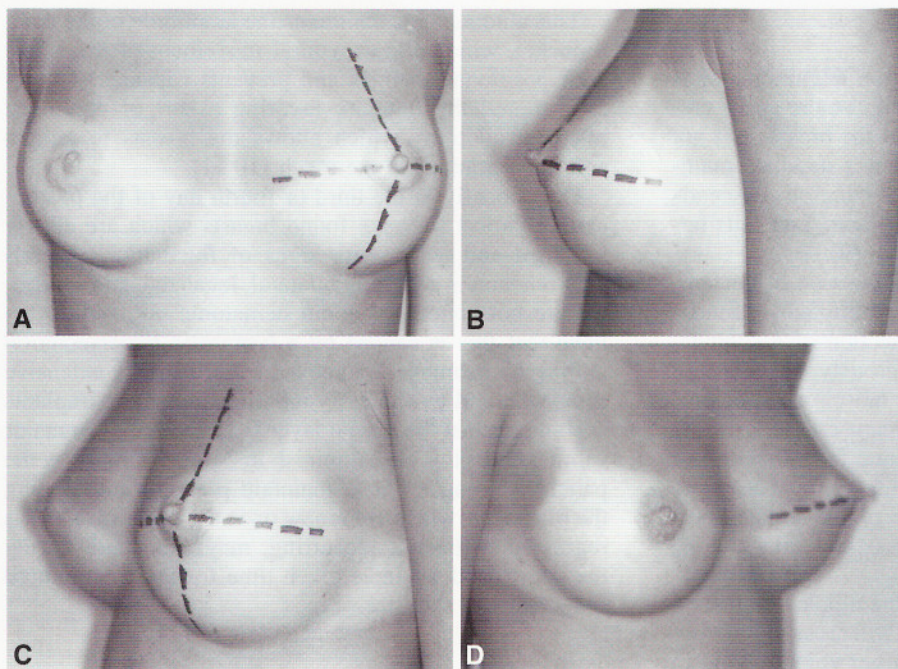
Occasionally we come across an insignificant amount of firming of the breasts. This generally does not affect the expectations or satisfaction of the patient, but is probably more significant in our own self-criticism.

With this technique we get an optimum aesthetic-anatomic positioning of the implants, which remain soft and with a natural range of movement, with practically no development of capsular contraction in our patients [13,14].

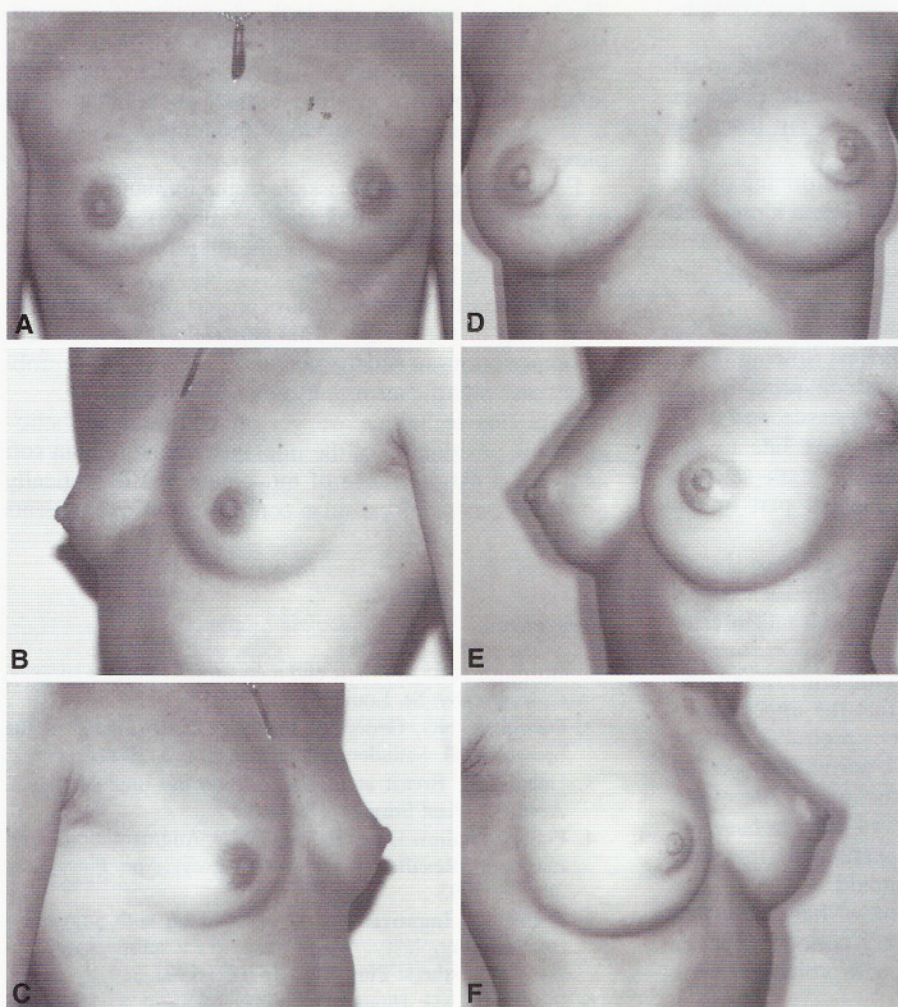
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**Fig. 6.** (A-D) Position and symmetry of the nipple-areolar complex in the augmented breast. Frontal, profile, and oblique views.



**Fig. 7.** A 32-year-old woman. Augmentation mammoplasty with 275-cm<sup>3</sup> subpectoral implants. Preoperative (A-C) and postoperative views (D-F).



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