BREAST LIFTING (MASTOPEXY)

(BREAST SKIN TIGHTENING)

INTRODUCTION

There are many reasons for breasts to droop. They may have been very big to start with and gravity and time then takes its toll. They may have become enormous over a short period (pregnancy and breast feeding) or over a longer period due to weight gain. Whatever the cause the skin of the breast stretches. In a few lucky women the skin is very elastic and shrinks again after pregnancy or weight loss but in most women it does not do this. Massage, oils, moisturisers, exercise, physiotherapy and firm bras don't help much although they may help psychologically. The droopiness may be progressive with each pregnancy. The breasts themselves may shrink in size because the breast tissue quietly disappears leaving mostly the fat in the breast. The milk making parts of the breast tend to shrink as soon as the person stops breast feeding. In some women the breasts change very little after the first pregnancy and remain attractive and shapely but then droop after the second or the third pregnancy.

METHODS OF CORRECTING DROOPY BREASTS

There are two main ways of correcting the droopiness of breasts.

1. To swell the breasts out again.
2. To tighten up the skin of the breasts by either cutting some away or making the skin shrink.

If the breasts have shrunk in size and you want them restored to the size they were before or larger, then the obvious way to correct the problem is to insert implants into the breast. If the breasts are unequal in size it may be possible to correct the difference by putting a larger implant into the smaller breast.

This breast enlargement can be done using quite a short scar in a fold underneath the breast where it won't be very noticeable.

In my experience, however, it is seldom possible to take up all the slack of the skin unless the breasts can be enlarged to something approaching the size when they were large before. If the breasts don't need enlargement then the only way to lift them is to take away skin.

SKIN TIGHTENING

No-one has invented a safe way of shrinking breast skin without producing scars on the skin of some kind. It would be very nice to be able to shrink breast skin by the same kind of laser techniques or chemical peels which are used for wrinkled faces. Unfortunately, the skin of the breasts cannot stand up to this form of treatment and the only way in which I have noticed any actual skin shrinkage has been following radiotherapy for breast cancer. The breast skin often shrinks significantly after radiotherapy, although it is not designed to have this effect. In fact it can be quite unfortunate in that one breast has radiotherapy and then shrinks, whereas the other one has no radiotherapy and stays droopy.

It would be very nice to be able to hitch the breasts up by taking a tuck out of the skin from the upper part of the breasts. This could work in a few women because there are some very lucky people who make superb scars despite the tension and the fact that the skin of the upper chest is notoriously bad for scar production. This method is never used routinely because of the awful scars it would produce in 90% of people and one cannot predict in advance who might be the lucky ones who wouldn't produce such bad scars.

The only other way of taking away skin cosmetically is to remove it as a circle around the nipple or to remove it from the lower part of the breasts below the nipple. One has to shift the position of the nipple in an upward direction so that one can pinch the skin together below it.

There are many different designs for doing this type of surgery very much along the same style of designing a new bra out of the slack skin.

One aims to produce the minimum number of seams and to place the seams where they won't be seen.

Nearly all of the methods require that a scar is left around the edge of the nipple (the areola, which is the brown part surrounding the nipple). In addition, most methods result in a scar which runs from the nipple down to the fold underneath the breast. In the more severe type of droopiness there may well have to be a transverse scar, ie, a horizontal one in or just above the groove below the breast.

Thus, in the worst cases the breast has to have a scar which looks like the shape of an old style anchor with a ring around the nipple, a vertical limb and a curved scar conforming to the groove underneath the breast.

This type of distribution of scars is the same kind as is often produced when making breasts smaller (breast reduction). In mastopexy however, the operation usually requires less radical surgery to the breast tissue itself. It usually consists more of undermining the skin and tightening this up at the same time as repositioning the underlying breast tissue.

The complications of this type of surgery are similar in nature to those with breast reduction. They are usually far less common and less severe than the complications of breast reduction because the surgery is less complicated.

PERI-AREOLAR SKIN REDUCTION

One can tighten up the skin of the breast by taking a circle of skin from around the areola. The more skin one removes the tighter the closure of the wound

will be and the tighter the breast will be. It will tend to lift the nipple in an upward direction by the amount of the width of the circle of skin ones removes. If there is a great deal of droop this method will not succeed in correcting all of the problem and should, therefore, be reserved only for the mild cases of breast droopiness.

The method can be very effective at producing the little bit of extra tightness needed to improve the appearance of a breast in which implants were being used to try and swell the breasts out and lift them. The scar around the areola is usually satisfactory in about 80% of women but in 10-20% the scar becomes rather thick and hard and red for several months and may take a long time to flatten and soften and look more acceptable.

The scar can sometimes widen and stretch and this method therefore has obvious risks of poor scarring, and it is almost impossible to predict whether or not any particular person is going to have this problem. A woman wanting this type of surgery has to be prepared to accept that there is a slight risk of a poor scar. It is unusual for the scar to be visible through a bra or a bikini and so it would only prove to be embarrassing when topless. This method is relatively straightforward from the surgical point of view because all that is being done is removal of the outer layers of the skin. It can usually be done under local anaesthetic if the patient is not afraid of injections and it can, therefore, usually be done as a day case and the only serious risks or complications are those of infection and sometimes interference with the feeling in the nipples.

MASTOPEXY OPERATIONS

In a mastopexy operation one aims to take as much skin away from the breast as possible to tighten it up and yet to leave an acceptable scar. Ideally one should raise the level of the fold underneath the breast so that the breast mound ends up at a much higher level than it was before. This can be

achieved by certain techniques but it does require quite a lot of dissection of the skin away from the breast tissue and the operation often takes as long as 2-2½ hours and the patient may well have to stay in hospital overnight afterwards. This type of surgery has much in common with breast reduction surgery and so the potential complications are very similar to those seen with breast reductions.

Some surgeons use conventional stitches on the outside of the skin which need to be removed. My own personal preference is to use buried or hidden dissolvable stitches which don't need removal. A standard mastopexy operation should not cause a significant amount of pain but it will make the breasts feel very tight and hopefully will leave them much higher and fuller than they were before. It is usual to try and over-correct the droopiness because no matter how high and tight one makes the breasts they will tend to droop again slightly. This will happen over a 1-2 month period after the surgery. Most women will feel relatively comfortable and able to get back to work within 2-3 weeks but this can vary a great deal. Some women take only a few days off work and some need a month or even two months.

It is usual for the breasts to need protective dressings along the wounds for 7-10 days, but it is possible to wear a support bra or a sports bra during this time provided it is not underwired. It is best to take showers rather than baths for the first 10-14 days while the wounds are healing. After this bathing and swimming should be possible unless there is an obvious weak point or problem with healing. It may be helpful to cream or Vaseline the wound to moisturise it for a month or so after the first week or so following surgery.

Some patients have very droopy, empty breasts which they would like to have not only enlarged but lifted as well. The only way to achieve satisfactory improvement is to combine enlargement with breast prostheses and also tightening of the skin by the mastopexy method.

The disadvantage of combining the two techniques is that it makes it more complicated and therefore open to more risks, the worst of which is the

potential for infection. Whereas the infection rate for pure breast enlargement with implants is very low indeed, ie, less than ½% of cases the risk of infection associated with a mastopexy is of the order of 2-3%.

It is vital that breast implants should not become infected because if they do they have to be removed and so the combination of enlargement and mastopexy is a riskier procedure than either of the two separately.

If you believe that the type of surgery you need will require breast enlargement with implants then please ask for the information sheet about breast enlargement. If you think you just need an adjustment of the skin then ask for the information sheet about breast reduction.

POTENTIAL COMPLICATIONS

The complications of surgery can be divided into ***general*** and ***particular***. The general complications are those which can occur with any kind of surgery and the particular complications are those which occur with the particular type of operation you have chosen to have.

GENERAL COMPLICATIONS

Operations under local anaesthetic:

If you are going to have an operation under local anaesthetic, you will have to face up to having injections of the local anaesthetic or local anaesthetic cream. You must be aware that it can sometimes be difficult to anaesthetise the skin and the breast tissue and you might need an extra injection during the operation. In addition, you are very likely to suffer pain as soon as the anaesthetic injection wears off. These are not strictly complications but they are the inevitable consequence of choosing local anaesthetic. There are a few people who are allergic to certain types of local anaesthetic and there are

some others who are totally insensitive to certain types of anaesthetic. It is usually possible nowadays to find a local anaesthetic which can be injected, which will suit. However, if you know that you have an insensitivity or an allergy you must tell the surgeon in advance. There are some people who are particularly sensitive to the use of adrenaline when having injections, in which case you must advise the surgeon of this as well.

Operations done under general anaesthetic:

The complications of having a general anaesthetic need to be discussed with the anaesthetist, especially if you have a great fear of having a general anaesthetic. If you are a fit person with no history of any serious heart or lung complaint, the risk of something going badly wrong as a result of a general anaesthetic is very small indeed (of the order of 1 in 100,000 cases). A general anaesthetic should not be given, however, if the person has a severe cold or chest infection.

A complication of infection in the wounds:

About 1-2% of all operations done in the apparent absence of any pre-existing infection go on to develop an infection of some kind. For breast surgery it is usually simply a nuisance and only rarely spoils the result. Only if it develops into an abscess is it likely to disrupt the wounds.

Some surgeons like to give an antibiotic at the time of the operation to reduce the risk of infection to a minimum but this unfortunately, is not foolproof and a few patients still develop an infection nevertheless. Infection usually takes the form of a red, pus-filled spot somewhere along the stitch line. It usually clears up by itself but it may help to keep a dressing on the area and to apply some antiseptic ointment to it. More serious infections within the breast cause pain, fever, swelling, redness, throbbing and need antibiotics as soon as the infection is diagnosed. If you suspect that you have an infection within the breast you must contact your doctor or surgeon as quickly as possible. It is very rare for anyone to develop a serious infection within the breast in less than 3 days after the operation but infections can occur any time after this.

Sometimes they appear within 5-6 days but sometimes they may appear out of the blue several months after the operation.

I see a case of serious infection like this only once every 3-5 years and so I don't think the risk of its occurrence should put you off from having the operation.

However, if you are one of the very rare and unlucky patients with a severe infection you have to realise that it can cause the wound to break down and then for the breast to take several weeks, sometimes months, to heal. The scars after a severe infection can widen and stretch and it may be necessary to have a second operation to try and improve the appearance of the scars.

Bleeding problems:

Bleeding problems are relatively uncommon in breast surgery in general and even rarer with mastopexy because the surgery doesn't delve particularly deeply into the breasts and so relatively few blood vessels are cut and so there is relatively little reason for blood clots to form inside the breasts. If you know you have a bleeding problem or taking a medicine like Warfarin, then you must tell the surgeon.

Women as they get older often bruise easily and so if you know that you are a bad bruiser you must realise that your breasts may bruise as well.

Some people believe that the homeopathic drug Arnica may reduce bruising and swelling and if you want to take it I know of no reason against its use. It is probable that it will work best if you start taking it before the operation and continue it afterwards for a week or two. An injection of the strong steroid Dexamethasone is often used in just the same way and is commenced at the time of the operation. There is strong scientific evidence for the benefit of steroid injection at the time of the surgery to reduce bruising but there is no scientific evidence in favour of Arnica.

Many medications are known to make bleeding more likely and these should be avoided for two weeks before the operation, unless this is going to cause a lot of problems for the individual, ie, worsening of arthritis for example, but it has to be discussed with the surgeon in advance.

The complication of thrombosis:

Anyone having a general anaesthetic for more than 10 minutes or so has a theoretical risk of suffering a blood clot in one of the large veins of the legs or pelvis. This is known as deep vein thrombosis (DVT). DVT is rare in fit young women but anyone over the age of 20 is a candidate. There may be a slightly higher risk in women taking the contraceptive pill and this risk may increase with age. We take routine precautions against this by fitting special firm stockings or inflatable pressure devices on the calves to stimulate the circulation in the legs. This reduces the chances of deep vein thrombosis very considerably. DVT's are usually painless and usually symptomless. They also usually dissolve away over a period of weeks and cause no harm. However, a small number are much more serious and can cause swelling of the leg.

Very rarely they can break away from the vein wall and then get carried with the blood stream up to the lungs where they cause sudden breathlessness because they interfere with gas exchange in the lungs. This is known as pulmonary embolism. Very occasionally this can be fatal. Fortunately, DVT and pulmonary embolism is very rare after cosmetic operations probably because the kind of patients having cosmetic surgery are fit and well. DVT and pulmonary embolism are a much more serious and common problem in patients who are desperately ill with cancer.

Problems specific to mastopexy:

Once you have discussed what type of operation will suit you, you need to discuss the particular problems associated with that choice. If it involves implants you must read the information sheet on breast enlargement because nowadays you have to understand what implants are and what they do inside

the body and what risks may be associated with them. If, however, the operation you are going to have does not involve implants you should read the information sheet about breast reduction because the complications of breast reduction are very similar to those of breast lift.

The most difficult thing for people to understand and to visualise is what the scars are going to look like. If it often helpful to see photographs before and after surgery, but of course photographs sometimes over emphasise and sometimes under emphasise what scars look like. Some women are absolutely horrified to have the minutest scar on their skin, whereas others don't care at all provided the shape of the breast is satisfactory.

It is important to realise that as soon as the skin has been cut a scar is going to form. If that scar is under great tension there will be a tendency for the new scar to stretch and to widen. The amount that it is going to stretch is very difficult to predict.

Some people make very fine narrow scars which don't stretch and they end up with almost invisible marks on the breasts. There are some people, however, whose scars thicken and harden and become rubbery, red and itchy (hypertrophic scars) and these are very embarrassing, uncomfortable and a considerable nuisance. Hypertrophic scarring can sometimes be suppressed by the use of special silicone gel or silicone oil. It is sometimes helpful for people to anticipate this and use sheets of silicone on the scar. One example is Cicacare, which can be bought from Boots pharmacies. It is also important to realise that scars usually go on improving for up to two years after the operation. There are, therefore, stages in the scar formation which are important to recognise. In the first week or two the scar often looks very neat, particularly if there are no stitches showing. It then goes into a red phase lasting for a month or two and then, if the person is lucky, it starts to fade and the fading continues for a year or more. If, however, the person is unlucky and tends to make hypertrophic scars the scar will go on from being red into a raised, thick and unsightly mark. It will then take anything up to 2-3 years to finally settle down. If you happen to know that you make hypertrophic scars

then you must be prepared to have hypertrophic scars on your breasts. If, however, you have scars on other parts of the body which have not shown any hypertrophy there is a very good chance that you won't have this problem on the breasts

If you have the even worse problem of keloid scar formation then you must think very seriously indeed as to whether or not it would be sensible for you to have a mastopexy operation because keloid scarring on the breasts is very difficult to manage.

AUTHORSHIP

This information sheet was written by Mr Hugh Henderson, Consultant Plastic Surgeon at Leicester Royal Infirmary, BUPA Hospital Leicester and Nuffield Hospital Leicester in August 1999. It is meant to be an introduction to some of the important points about mastopexy-type surgery. It is not fully comprehensive but please read it more than once and make notes about the things you remain unsure about and please suggest extra information that should be included in any revised version.

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