# Management of the High-Riding Nipple After Breast Reduction

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**KEYWORDS**

• Management • High-riding nipple • Breast reduction

**KEY POINTS**

- Preventing excessive nipple elevation following reduction mammaplasty is far easier and more successful than correcting the problem.
- The key to avoiding overelevation of the nipple is to allow sufficient skin from the upper breast border to the top of the planned new areola window, a minimum of 8 cm and frequently 10 cm in larger breasts.
- Favor the superior, medial, or superomedial pedicles with vertical closure of glandular flaps to improve breast coning and projection, which likely reduces the risk of the reduced breast bottoming out. When bottoming out has occurred, correction can include a lower pole reduction including a transverse excision as a crescent or inverted T but avoiding further elevation of the nipple.
- In patients with apparent nipple malposition accentuated by upper pole deficiency, an augmentation with an implant or fat grafting can improve superior pole projection and indirectly lower or seem to lower the nipple-areolar position on the breast.
- In those patients whereby the nipple to sternal notch or nipple to upper breast border has been seriously shortened, it may be necessary to directly move the nipple-areolar complex by transposition, V-Y inferior advancement, or reciprocal skin grafting in addition to other steps, such as upper pole volume enhancement.

## INTRODUCTION

The high-riding nipple-areolar complex (NAC) is a potential complication of cosmetic or reconstructive breast procedures. In its milder forms, it is very common and results in an upward-facing nipple sitting above the breast equator and above the point of maximal projection. This milder form often goes unnoticed. In its more severe presentations, it can be very disfiguring and embarrassing.

Breast reduction and mastopexy, in particular, are routinely designed to elevate the NAC but often may result in an NAC that appears elevated more than ideal or anticipated in the preoperative plan. The site for proper nipple position during a reduction mammaplasty should be carefully selected in order to ensure the NAC ultimately is positioned at or near the most projected area of the breast, regardless of the dermo-glandular pedicle chosen or skin pattern selected. With a real potential for NAC displacement, some surgeons endorse marking the new nipple position 1.5 to 1.75 cm below the most projected area of the breast intraoperatively.[1] Ahmad and Lista[2] followed 46 consecutive women following vertical

No funding was used in the preparation of this article. Dr S.L. Spear is a paid consultant to Lifecell Corporation and to Allergan Corporation. Dr F.P. Albino does not have any affiliations to declare.
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Clin Plastic Surg 43 (2016) 395–401
http://dx.doi.org/10.1016/j.cps.2015.12.008
0094-1298/16/$ – see front matter © 2016 Elsevier Inc. All rights reserved.

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scar reduction mammaplasty and found that the nipple-areola complex 4 years after surgery was located on average 1 cm higher compared with the planned position by preoperative skin markings. Similarly, Keck and colleagues[3] note that a planned notch-to-nipple distance of 22 to 24 cm resulted in an immediate postoperative notch-to-nipple distance of 18 to 20 cm (*P* value .01). Furthermore, over the next 3 months, the nipple-to-notch distance continued to change by an additional 17%.

The importance of achieving a suitable NAC position following reduction mammaplasty develops from the real potential for a high-riding outcome and the difficulty in addressing this complication. The challenge in developing an operative plan to adequately address the high-riding NAC to the satisfaction of the surgeon and patients is based on the nature and degree of displacement and cannot be overstated. Part of this difficulty stems from the desire to avoid leaving scars that lie above the superior edge of the NAC and the limited amount of skin available between the nipple and the clavicle. Several strategies have been described to address these issues, including elevating the inframammary fold (IMF) and the breast parenchyma, expanding the skin superior to the NAC, and directly repositioning the nipple by excising it and grafting it in a more appropriate location.[4–7] The high-riding nipple presents a complicated reconstructive challenge. Appreciating its cause and the available corrective surgical options may help surgeons, on the one hand, minimize the likelihood of creating malpositioned nipples and may, on the other hand, help select an appropriate intervention to correct the problem when it occurs.

## SUMMARY/DISCUSSION

Nipple position and the overall appearance of the breast can be quite variable among those deemed high. Evaluating the breast aesthetically does not necessarily necessitate more than a basic appreciation for the overall breast shape and proportion. Nipple position and symmetry are critical elements to consider in the evaluation of breast appearance before or following surgery. **Fig. 1** demonstrates bilateral high-riding NACs for this 58-year-old patient, 6 years following Wise pattern reduction mammaplasty using an inferior pedicle. Unhappy with the current positioning of her nipples, she presented to the authors' office seeking revision. Note the short distance from the superior border of the breast to the top of the areola leading to a displeasing overall breast contour and a nipple malpositioned to the extent that it might become exposed inadvertently.

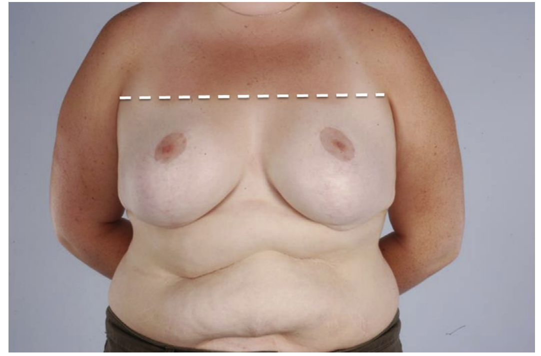

**Fig. 1.** A 58-year-old woman presents 6 years following reduction mammaplasty seeking improvement in her current nipple position. Note the short distance from the superior boarder of the breast to the top of the areola leading to a displeasing overall NAC position (*white dotted line* defines the approximate upper border of the breast silhouette).

Clearly a difficult problem to address, it is best to avoid the creation of a high-riding nipple following reduction mammaplasty all together. The most important lesson for treatment of the superiorly displaced NAC following reduction mammaplasty is that prevention is far easier than the solution. Toward this goal, it is critical to sufficiently evaluate the preoperative breast when selecting and subsequently marking the new nipple position (**Figs. 2** and **3**). Moving the nipple cranially is often a desired effect of a breast reduction; however, selecting a new target position requires sophisticated planning. Transposition of the IMF continues to prove to be the most widely accepted approach for selecting new nipple position; however, this approach may be fraught with problems in the setting of a pendulant and ptotic breast, gigantomastia, or when the breast footprint begins low on the torso. Rather the IMF transposition at the level of the breast meridian should be used as a guide to mark the new nipple position. The authors think it is equally or more important to ensure there is sufficient skin from the upper breast border to the top of the planned new areola window, a minimum of 8 cm and frequently 10 cm in larger breasts. Increasing the breast projection will also aid in ensuring the nipple position does not further move cranially. A superior, medial or superomedial pedicle is preferred in order to allow for resection of inferior parenchyma, minimizing the risk of bottoming out, and allowing for closure of medial and lateral glandular flaps to improve breast coning and projection. These pedicles promote superior pole fullness and, thereby, safeguard against the development of a high-riding nipple.

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