

Transaxillary Subfascial Augmentation Mammoplasty with Anatomic Form-Stable Silicone Implants



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KEYWORDS

- Breast augmentation • Silicone implant • Form stable implant • Transaxillary approach • Subfascial
- Outcome • Complications • High cohesive implant

KEY POINTS

- The transaxillary approach to breast augmentation is a successful technique that not only provides an inconspicuous incision but also offers the advantages of adequate placement of the inframammary crease and subfascial dissection under direct visualization.
- In the upper breast pole, the pectoral fascia helps to decrease visualization of the edges of the implant and provides soft-tissue coverage over the anatomic implant. The technique avoids the negative aspects of the submuscular position and provides a more comfortable recovery than the total submuscular pocket.
- An important characteristic of anatomic cohesive gel implants is their form-stable nature and their ability to maintain shape in all positions without significant deformation. This form-stable characteristic results from a higher degree of cross-linking within the gel.
- Ideal primary candidates are those who have significant hypomastia/amastia, are thin without sufficient soft tissue to adequately cover the implant, and have an absent or high inframammary fold. Patients who require greater volume in the lower breast and want to avoid visible incision scars on their chests also benefit from the present technique.

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INTRODUCTION

Breast augmentation has become one of the most frequently performed aesthetic surgical procedures, with more than 290,000 of these surgeries performed in 2013.¹ Over time, improvements in surgical techniques and different implant designs have led to improvements in safety and esthetic outcomes. The introduction of the latest-generation form-stable silicone gel implants and new surgical approaches have improved outcomes and established a new era of breast augmentation.²⁻⁴

The transaxillary approach for breast augmentation (TBA) is a well-known procedure, and its main benefits are related to the absence of incisions on the breast and the ability to place the implant within the submuscular and subglandular plane (Solz H, personal communication, 2005).⁵⁻¹⁶ Described initially for a submuscular pocket with blunt dissection,⁵ the procedure is not without drawbacks, including implant displacement, muscular distortion, and postoperative pain.¹⁷⁻²¹ Although TBA has been available for many years, critics have emphasized its limits in attaining precise positioning of the anatomic implant in the lower pole of the breast. However, in the authors' experience, the major advantages have been the absence of scars in the breast region, avoidance of breast ductal transection, and low probability of sensory nerve injury. In addition, endoscopic assistance has enhanced TBA by allowing better placement of the silicone implant inferiorly and improved management of the inframammary crease.^{9,11,12,14}

An alternative implant pocket is gaining popularity because of the better postoperative recovery it provides compared with submuscular approaches and because it avoids distortion when the pectoral muscle is contracted.^{10,22-29} Introduced in the 1990s, the subfascial technique is helpful for creating a support structure for the upper pole of the implant, which avoids inferior displacement and palpation of the implant edges.^{12,22,23} In addition, with the advent of the subfascial technique, the potential benefits of TBA to patients, such as axillary incision and shorter recovery time, have become clearer. Consequently, because of the association of both procedures, subfascial TBA seems to have gained new popularity.¹²

Silicone breast implants have advanced in recent decades with the introduction of new textures and anatomically shaped implants.³⁰⁻³⁸ With advances in implant technology involving different types of textures and gel cohesion, more satisfactory outcomes with lower complication rates can be achieved. Usually, these implants are anatomically shaped with less fullness at the

upper pole compared with round implants. Because of their high cohesiveness, these latest-generation implants maintain their shape with less gel bleeding and decreased rippling and wrinkling.

This article provides an overview of the use of subfascial TBA in primary breast augmentation with form-stable implants. Although breast augmentation is a well-studied procedure, previous reports concerning the TBA subfascial technique are limited, especially those associated with the latest generation of form-stable breast implants.¹¹⁻¹³ In addition, there are few detailed clinical reports that specifically address the operative planning, outcomes, and complications following TBA using form-stable implants.¹¹ Therefore, a detailed description of the authors' technique, including preoperative evaluation and intraoperative care of patients undergoing primary breast augmentation, is provided herein.

AXILLARY APPROACH

Introduced in the 1970s, TBA has become a popular technique for breast augmentation because the scar is placed in a less visible position, hidden in an aesthetically acceptable area, and this technique permits an adequate positioning of the new inframammary crease (Solz H, personal communication, 2005)⁵⁻¹⁶ (Figs. 1 and 2). In patients with a small areola or a poorly defined inframammary fold, TBA may be particularly advantageous.¹⁰⁻¹²

Since the introduction of TBA techniques in clinical practice in 1973,⁵ they have undergone significant modifications. The submuscular position was first introduced to provide optimal implant coverage; however, the drawbacks were breast asymmetry, implant displacement, and pain.⁵⁻⁷ In this technique, one-third of the upper implant was placed under the pectoralis major and two-thirds of the implant was placed over the rectus sheath, serratus, and oblique muscle. However, in the early stages of TBA, technical limitations were related to aspects of the blind technique, including difficult hemostasis and traumatic dissection, and technical limitations in creating an adequate pocket.¹⁴

Subfascial TBA was first introduced by Wright and Bevin.⁶ They emphasized the importance of the junction of the pectoral fascia with the rectus abdominis and the external oblique fascia. However, at that time, one of the main concerns was the possibility of unfavorable outcomes in terms of implant edge visibility. This aspect was more evident in thin patients with less soft-tissue coverage, whereby a sharp transition could be seen in the upper pole.^{7,10} With the goal of improving aesthetic outcomes, alternative

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