



Dermal flaps in breast reduction: Prospective study in 100 breasts[☆]

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KEYWORDS

Dermal flaps;
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Summary The most common complication of breast reduction with inverted T-scar technique is wound dehiscence at the junction of the vertical and horizontal sutures. In this study, a technique involving three triangular dermal flaps is presented with the results for healing in the junctional T zone.

Fifty women were included in a comparative, single-center randomized double-blind prospective study to evaluate the efficiency of the three-triangular dermal-flap technique in healing in the junctional T zone. All patients were seen for follow-up at 7 days, 14 days, 21 days, 28 days, 35 days, 42 days, and 49 days after surgery to evaluate primary healing in the T zone.

Average healing time was 19.7 days in the triangular-skin-flap series and 25.48 days in the control series, with a statistically significant difference ($p < 0.01$). One patient in the triangular-skin-flap series experienced dehiscence in the T zone (2%) versus eight patients (16%) in the control series. A statistically significant difference was noted ($p = 0.012$).

This technique is based on the association of two principles. First, ischemia on the edges as well as skin necrosis is limited by suturing the two superior skin flaps rather than directly suturing the cutaneous angles. In addition, this technique brings an underlying dermal support. Second, the inferior flap width allows fixing two sutures laterally to limit the central tension. This easy technique does not lengthen total operative time and significantly improves healing time. It is applicable to all breast reductions with inverted T scars.

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Introduction

Breast reduction is a relatively common plastic surgery procedure. Although shorter scars can be achieved with vertical scar techniques,^{1,2} inverted T-scar techniques are useful for cases of severe ptosis.^{3,4}

The most common complication when breast reduction is treated with inverted T-scar techniques is the dehiscence at the T-junction.

In this study, we evaluated treatment outcomes for healing in the T zone with a triangular-dermal-flap technique. We believe that this technique improves healing time in the junctional T zone.

Material and methods

Between January 2009 and December 2010, 50 women were included in our comparative, single-center randomized double-blind prospective study.

Criteria for exclusion from the study included: smokers (cessation for >2 months), a body mass index over 30, diabetes or high blood pressure, long-term use of corticosteroids or anticoagulants, or postoperative complications other than delayed healing (hematoma, infection, cysteateatonecrosis).

The triangular-dermal-flap technique was used on one of the two breasts, alternatively, after obtaining patients' informed consent. The technique was used for the "triangle" group of breasts versus the "control" group of breasts, for which the technique was not used. The sequence of randomization was established prior to study by the department of the medical information. Ethics approval was not required for our institution.

All breast reductions were performed by a single surgeon using Wise pattern marking.

The horizontal incision line was marked on the submammary fold, gradually ascending toward the lateral pole of the breast. Three triangles were marked at the onset of the intervention as described in Figure 1. The two superior equilateral triangles measured 1.5 cm long and the inferior isosceles triangle had a 5-cm base and 4-cm-long sides. The triangular flaps were deepidermized eliminating all the subcutaneous fat, and one piece of the excess skin and adipose and glandular tissues of the lower pole, with a wedge-shaped prolongation toward the center of the breast, were resected (Figure 2).

We then tailored a pedicled superomedial dermoglandular flap for the transposition of the nipple areolar complex (NAC). The flap was thicker toward its base, ensuring good vascularization, as well as sufficient tissues in the superior mammary pole. The transposition of the superomedial dermoglandular flap was not difficult. It is important that the NAC be rotated easily without tension. Conifcation of the breast is accomplished by suturing the NAC with 3/0 absorbable suture. Then the three flaps were sutured. The two superior triangle flaps are superposed on the inferior triangle flap with absorbable 3/0 suture. After placement of this suture, two lateral superior sutures are placed 1 cm laterally to the lower triangular flap to decrease the tension on the T zone (Figure 3).

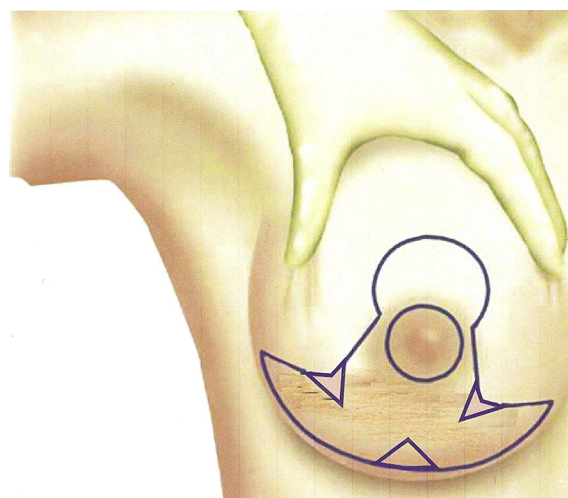


Figure 1 The horizontal incision line was marked on the submammary fold, gradually ascending toward the lateral pole of the breast. Three triangles were marked at the onset of the intervention. The two superior equilateral triangles measured 1.5 cm long and the inferior isosceles triangle had a 5-cm base and 4-cm-long sides.

The vertical and horizontal subcutaneous lines were sutured with absorbable 3/0 suture. Cutaneous suture is performed with two absorbable 3/0 monofilament intradermal continuous sutures horizontally and vertically with one intradermal continuous suture, avoiding the T zone, which was sutured with two absorbable 5/0.

In cases requiring additional reduction and remodeling after the breast is assembled, the base of the lateral glandular flap, with a volume usually greater in cases of severe hypertrophy, can be resected. No drains were used.

All patients were seen for follow-up at 7 days, 14 days, 21 days, 28 days, 35 days, 42 days, and 49 days after surgery

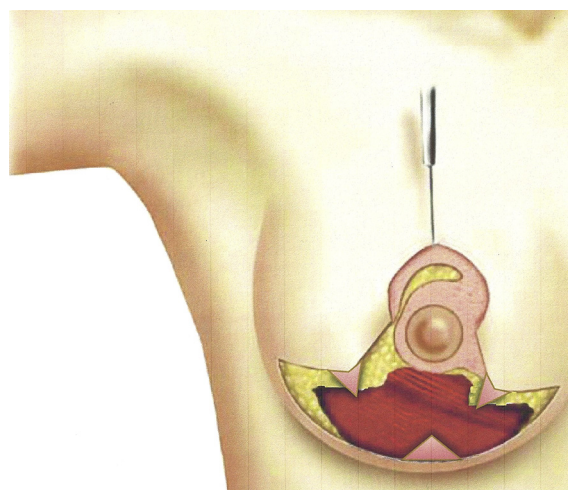


Figure 2 The triangular flaps were deepidermized eliminating all the subcutaneous fat, and one piece each of the excess skin and adipose and glandular tissues of the lower pole, with a wedge-shaped prolongation toward the center of the breast was resected.

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