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# Gynaecomastia surgery in The Netherlands: What, why, who, where...



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## KEYWORDS

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**Summary** Gynaecomastia, breast enlargement in men, is common in all age groups. It is operated on by plastic surgeons, general surgeons and paediatric surgeons. It is therefore possible that there is a difference in the populations treated, the indications for surgery and the management used by the different practitioners. We performed a survey in order to assess the approach to treatment of gynaecomastia by the different disciplines.

An electronic survey questionnaire was sent to members of the Dutch societies of surgery, paediatric surgery and plastic surgery. We received 105 responses from plastic surgeons, 95 from general surgeons and 15 from paediatric surgeons, representing respective response rates of 38.7%, 23.8% and 42.8%.

Plastic surgeons operated on gynaecomastia most frequently. The diagnostic criteria and workup were similar for all disciplines, although general surgeons used more imaging. There was a difference in the side operated on. General surgeons and paediatric surgeons operated mainly on unilateral cases (74% and 52%), while plastic surgeons operated mainly on bilateral cases (85%). Pharmaceutical treatment with Tamoxifen was reported only by general surgeons (13%). All disciplines used mainly the periareolar incision. Plastic surgeons reported more often the use of other surgical approaches as well as adjunctive liposuction and they did not always submit tissue for pathological examination. Perioperative antibiotics, drains and pressure garments were not always used. All disciplines agreed that the most common complication was bleeding, followed by seroma, infection, insufficient results, inverted nipple and nipple necrosis.

This survey highlights some differences in the practice of gynaecomastia surgery. The findings appear to point to the fact that the indications are different, being more aesthetic in the case of

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plastic surgeons. The results of this survey are important in establishing the standard of care and may be helpful for setting guidelines.

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Gynaecomastia (GM) is the term used to describe breast enlargement in men; it derives from the Greek words *γυνή* (*gyné*) meaning 'woman' and *μαστός* (*mastós*) meaning 'breast'. It is a ubiquitous finding seen in all age groups with peaks in prevalence postnatally, during puberty and in the elderly.<sup>1,2</sup> The reported prevalence between the ages of 10 and 16 is as high as 48.5%<sup>3</sup> with a peak incidence of 64.6% in boys between the ages of 14 and 14½.<sup>4</sup> GM has been observed in up to 72% of hospitalised patients.<sup>5</sup> An increase in subareolar fat without enlargement of the glandular tissue, which is clinically similar to GM, is described as pseudo-GM. Pseudo-GM is more common in overweight patients.

GM can be painful. In addition, it may have an impact on the patient's body image, leading to distress and embarrassment.

The development of GM is attributed to a hormonal imbalance. Pathological aetiologies are also possible and need to be ruled out; these include congenital and endocrine disorders, tumours and medications as well as recreational drugs. GM may be bilateral or unilateral. Nevertheless, most cases of GM are idiopathic.

The workup for patients with GM includes a thorough history and physical examination. Confirmation of adequate virilisation is essential. The medical literature is equivocal about the necessity for ancillary tests, such as blood tests and imaging.<sup>1,2,6–10</sup>

In most cases, GM does not require treatment. In cases of idiopathic pubertal GM, reassurance and an explanation about the natural course of GM are usually sufficient, as the GM is often transient.<sup>9</sup> If a specific cause of the GM is diagnosed and treatment is initiated during the initial phase, the breast hypertrophy may regress. It has also been suggested that GM may be treated using pharmacological agents. The use of agents such as androgens and Tamoxifen has been reported mainly in adults. Tamoxifen use has received the most attention in the medical literature and has also been reported for adolescents.<sup>11–14</sup>

If GM lasts for over a year, medical treatment will be unlikely to achieve regression, and surgery may be required to correct it.<sup>15,16</sup>

The traditional surgical treatment for GM is a sharp excision of the mammary gland through a semicircular incision on the caudal margin of the areola.<sup>17</sup> Cases with skin redundancy may be managed by various techniques: liposuction may be used as the only modality or be used as an adjunct to other surgical techniques.<sup>1,17</sup> Such operations can take place in different clinical settings. There are also different approaches to the post-operative management of GM.

Breast cancer in men is rare,<sup>18</sup> and tumours are rarely found in specimens from GM excisions.<sup>19</sup>

GM is operated on by different disciplines; it is therefore possible that there is a difference between the surgical specialisms in the populations treated, the indications for

surgery and the management used. To assess whether that is indeed the case, we performed a survey regarding the treatment of GM by the three disciplines that operate on it: plastic surgery (PLS), general surgery (GES) and paediatric surgery (PDS).

Knowledge of who operates for GM and the different pre-, peri- and post-operative strategies can be useful for determining what the present standard of care is and in the development of guidelines for the surgical management of GM, as well as planning the allocation of health-care resources.

## Material and methods

An electronic survey questionnaire was sent to members of the Dutch societies of Surgery, Pediatric surgery and Plastic surgery. The members received a link to the survey website using the Qualtrics survey software (Qualtrics Provo, UT, USA). It was not possible to identify the participating surgeons and it was not possible to send reminders in the case of non-response or incomplete response. Surgeons were offered the option to consent to being contacted for further information. If the surgeons stated that they did not perform GM surgery, they did not have to answer questions on their own management of GM and they were directed to the end of the survey and asked if they had ever witnessed a case of malignancy in a patient operated on for GM.

The survey was mailed to 400 general/oncological surgeons, 271 plastic surgeons and 35 paediatric surgeons.

An English translation of the survey appears in [Appendix 1](#).

We received 105 responses from PLS, 95 from GES and 15 from PDS, representing respective response rates of 38.7%, 23.8% and 42.8%.

## Results

Of the surgeons surveyed who responded, the majority operated on GM (PLS 93%, GES 85% PDS 54%). PLSs reported performing GM surgery more frequently than the surgeons from other disciplines (see [Figure 1](#)).

The respondents from all disciplines practised mainly in a university or teaching hospitals. Among the PLSs, there were more who worked in private clinics, but however only four worked exclusively in such a setting.

The preoperative workup was similar between the different disciplines. GESs were more inclined to use imaging and stated more often that they always used ultrasound and mammography (see [Figure 2](#)).

The use of pharmacological therapy was reported only by GESs, 13.2% of whom report prescribing Tamoxifen.

The criteria that surgeons consider as indications for surgery are presented in [Figure 3](#).

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