



MD AESTHETICS

Breast Asymmetry

What is Breast Asymmetry?

Breast asymmetry is very common and encompasses different sized and shaped breasts and/or nipple areolar complexes. The causes of the asymmetry are many, but most commonly include differential development of the two breasts during puberty and having had previous surgery on one of the breasts. Surgery to correct existing differences and to try to restore more symmetry between the two breasts is very dependent upon what asymmetry exists – it is not uncommon to require more than one operation in order to try to get the best results possible

Women that may benefit from Breast symmeterisation are those who:

1. have one breast larger than the other
2. different sized nipple-areolar complexes
3. have different shaped breasts
4. have had previous surgery on one breast (e.g. Lumpectomy)
5. have undergone breast reconstruction
6. wish to create a more proportionate figure
7. want to improve self-image and esteem

What size will my breasts be?

This depends very much on what it is you want as the end goal for your breasts. Some of the different goals include and are not limited to:

- both the breasts making smaller
- one breast made smaller and the other lifted
- both the breasts making larger
- one breast larger and one lifted
- one breast larger and one smaller

The aim for most people is to have more symmetrical breasts that are in proportion with their frame.

Breast Screening

When you are required to have a mammogram as part of the national breast cancer screening program, or for any other reason, please notify the radiographer that you have had breast surgery and what type you have undergone as implants and fat necrosis alter the findings on clinical examination as well as the technique and interpretation of scans.

How is the operation performed?

Whatever combination of procedures you require to symmetrise your breasts, the operation(s) is carried out under a General Anaesthetic (you are asleep) Duration of the surgery will depend upon what needs doing and can sometimes require more than one operation. The common operations include one or a combination of:

- differential Implant Augmentation – Implants of differing sizes are placed in to each breast
- Differential breast reduction – both breasts are made smaller – one more than the other
- Mastopexy (uplift)
- Fat grafting – often done in combination with one of the other procedures

The technique(s) employed to give you the best results will be discussed with you by Mr Davis in clinic.

It is not uncommon that you can go home the same day as the surgery, but occasionally a single night in hospital is advised depending upon multiple factors such as your overall medical health, distance to home from the hospital, who is at home with you etc. – this will again be discussed and agreed upon in clinic when you consult with Mr Davis.

What happens after surgery?

You will be required to wear a non-underwired support post-surgical bra (Mr Davis advocates LipoElastic® garments) for a period of six to twelve weeks. You will be encouraged to shower twenty-four to forty-eight hours after surgery, however you are to dab your breasts dry, let them dry naturally or to use your hairdryer on a cool setting to blow them dry – you are **NOT** to rub your breasts for one month after surgery.

After two weeks you will be asked to apply moisturiser over your scar on a daily basis for a period of three months.

You will come for a wound check one week after your surgery and routinely return to see Mr Davis in clinic between four and six weeks after surgery, and again after three months. Further follow-ups will be arranged as necessary.

Potential risks (see end of information sheet for explanations of each one)

- *Bleeding & Haematoma*

Bleeding can occur at any time in the first 10 days or so after the surgery so you should therefore avoid any trauma to your breast area and avoid strenuous exercise or anything that is causing your breasts to be moving vigorously in any direction. Where possible, arm movements should be limited in the first week.

Your breast will usually become swollen and tender with a bleed and may develop bruising – if this occurs you should return for review as you may require a return to the operating theatre to explore and stop any bleeding vessel(s) and remove any blood.

- *Seroma*

This is a collection of clear/pale yellow fluid that essentially leaks and collects from the tissues as part of the normal reaction to surgery/injury. This nearly always resorbs over a period of weeks, but is occasionally large enough to warrant it being aspirated with a needle and syringe in clinic.

- *Infection*

Whilst not common, should it occur your breasts may be swollen, red, warm/hot and tender – not to be confused with the inflammation of healing. You may also feel unwell in yourself. This is treated with a 5-to-7 day course of oral antibiotics. Very occasionally an infection can result in part(s) of the wound coming apart – this is managed by a regular change of dressings and showering, and will be allowed to heal by itself over the subsequent four-to-six weeks.

- *Swelling &/or bruising*

Swelling will almost certainly occur naturally and can take months to fully settle down. Bruising can be treated, unless contraindicated, with the use of Arnica or other such products should you wish.

- *DVT/P.E.*

Very occasionally a blood clot may form in one of the deep blood vessels in the leg (Deep Vein Thrombosis). Blood clots have the potential to break bits off that can travel up to the lungs resulting in a pulmonary embolus. As a way of reducing the risk you will be required to wear compression (TED) stockings on your legs from admission on the day of surgery until 2 weeks after surgery. You will also be encouraged to keep as mobile as is possible and to stay well hydrated.

- *Scars*

Scars are by definition permanent, so will always be there. Initially scars can be red and with time should fade through pink to ultimately be pale and flat. Occasionally scars can become hypertrophic or keloid whereby they are raised, red, lumpy, itchy and unsightly or can stretch to become wider.

- *Altered nipple sensation – numb or over-sensitive*
 The nerves supplying the nipple areolar complex can be damaged during the surgery resulting in your nipple(s) feeling numb after surgery. This usually recovers with time, however permanent loss of or reduced sensation can happen. Ever so occasionally the nipple can become oversensitive.
- *Inability to breast feed*
 It is not uncommon to be unable to breast feed after a breast uplift as the milk ducts and/or nerve supply to them is interfered with when relocating the breast tissue.
- *Altered breast sensation/numbness*
 As per the nipple, nerve damage can occur to the nerves supplying the skin over the breast. This is usually temporary but can occasionally be permanent, resulting in numb skin.
- *Nipple loss – full or partial*
 Just as the nerves to the nipple can be damaged, so can the blood vessels that supply and keep the nipple areolar complex alive. Damage to these can result in some (partial) or all (full) of the nipple and areolar being lost.
- *Asymmetry*
 No two breasts are ever completely symmetrical – they are “sisters not twins”. Despite best efforts to make the breasts as symmetrical as is possible, minor asymmetries will remain after surgery. Very occasionally a notable asymmetry can occur that requires further surgery to adjust volume, shape or nipple position.
- *Fat necrosis &/or lumpiness*
 When the breast tissue is mobilised its blood supply can become compromised, as per the nipple, resulting in some fat and breast tissue dying off (necrosing). This presents itself as a firm lump or lumpiness within the breast, and will usually settle by itself over the subsequent months. Very occasionally the old liquid fat can discharge itself through a hole in the scar/wound, requiring regular dressings until it settle and heals itself. Very occasionally the fat will calcify requiring further surgery to excise it.
- *Skin necrosis*
 Very rarely the blood supply to the skin of the breast can be compromised resulting in skin dying - this is most common at the T-junction where the vertical element of the scar meets the horizontal aspect of the scar in your breast crease. This is managed, should it occur, with dressings until healed. Very occasionally the scar requires revising.
- *Wound breakdown*
 Very occasionally some of the wound can come apart for a multitude of reasons. This is almost always small enough to manage conservatively with dressings, allowing nature time to heal the area. Should any scar that forms be unsightly or an issue then this can always be revised at a later date, often under a local anaesthetic such as those used by the Dentists if putting your teeth to sleep for a filling etc.

- *'Dog ears'*
These are little areas of skin and underlying fat/tissue that cause skin at the ends of your scars to sit a little proud. Often these settle with time and massage however occasionally they require removing under a local anaesthetic..
- *Implant displacement/rotation/extrusion*
Despite making a pocket to fit the implant you have chosen, with time the implants can move position, more commonly when under the muscle &/or with smooth implants, thereby changing the distribution of volume and shape of your breast(s). Rotation of the implant is not an issue with round implants however with anatomical (tear drop) implants if the implant should rotate then the volume of the implant will be in the wrong position and result in distortion of the shape and/or volume distribution of your breast(s). Implant extrusion can happen if your wounds come open during the healing phase and a part of the implant becomes exposed. Very rarely this can happen years down the line where the tissues stretch and become weaker, eventually opening up at the scar line. Should this occur you will require a return to theatre to wash the breast pocket and implant out before repairing the open wound.
- *Implant rippling, folds and palpable edges*
Implants are not completely filled with gel otherwise they would become too firm and unnatural. As a result of the slight under-filling the implant shell can form small folds or ripples that can be felt and sometimes seen through the skin and breast tissues. Placing the implants under the muscle can help to cover this, however with time as the breast soft-tissues stretch and become thinner and the muscle becomes thinner as the use of it is less once disturbed by an implant underneath it, this initial benefit becomes less and less. No matter whether you have an implant over or under the muscle, the implant edge +/- rippling is nearly always felt at the inferior margin where the breast crease is. Should palpable edges, rippling and folds in an implant be an issue then fat grafting over the top of the implant can often help cover this over.
- *Implant rupture*
Although manufacturers guarantee their implants for life against rupture, one must accept that just like anything else machine and man-made, a small percentage are going to fail and rupture. Rupture can be as a result of multiple factors. It usually presents with your breast swelling and enlarging and/or the shape of your breast changing. Following clinical examination, you will usually be sent for a scan and if rupture confirmed it is recommended that you have the implant(s) removed or exchanged.
- *Capsular contracture*
The body's immune system recognises that the implant does not belong to it, however it is too large to be able to destroy it so it does the next best thing and builds a wall around it, encapsulates it, in order to 'control & contain' any potential problems the implant could cause the body. We call this wall a 'Capsule'. For the most part you will not be aware that the capsule is there, however with time the capsule can become firm – this is not an indication to have anything done. The capsule can also start to contract, resulting in a change in shape of the implant and often the overlying breast.

It can also cause pain. If you have a change in shape and/or pain these are the indications to have your implant(s) exchanged or removed completely.

- *BIA-ALCL*

Breast Implant Associated – Anaplastic Large Cell Lymphoma is a rare blood type cancer that has become associated with having breast implants in. The theories of why it happens are to do with possible low grade infection and to do with the texturing of the implants – this will all be discussed with you in clinic, but data is always being updated as we learn more about this. Regular updates can be found on www.fda.gov and www.associationofbreastsurgery.org

BIA-ALCL most commonly presents between 8 & 10 years of having implants put in (reports are between 1 & 20 years) and is often represented by a spontaneous, painless swelling of the breast, although lumps, a rash and or pain can be presenting symptoms and signs. If the diagnosis is made, then the treatment is removal of the implant and surrounding capsule – this is often curative. Some patients have required chemotherapy and to date, 9 women have died from this condition.

The current lifetime risk ranges from 1:3000 to 1:30,000 depending upon the range of implants used.

- *Double-bubble deformity*

If you have heavy breasts or the bulk of your breast tissue is located lower down your chest wall, then when an implant is placed the breast tissue will invariably fall off the top of the implant creating a so-called “double-bubble” effect – you have the mound of the breast implant with the breast tissue sagging off the bottom. This more commonly happens when the implants are placed under the muscle, but can occur when placed on-top of the muscle.

- *Future ptosis & ‘Bottoming out’*

If you add weight to your breasts you are giving gravity more to work with so the resulting droop of your breasts will occur quicker than if you had no implants/extra volume and weight in place. The skin and soft tissues of your lower half of your breast can also stretch disproportionately resulting in implants dropping and too much volume being under your nipple-areolar complex – this is known as ‘bottoming out’. Similarly, just as the weight of your breasts combined with the help of gravity may have caused the skin and ligaments supporting your breasts to stretch and droop down or position themselves lower on your chest before a lift &/or reduction, these forces are still at work after your surgery with the remaining breast tissues.

The best way to combat this and prolong your results in all cases is to wear good, strong, well manufactured support bras as much as is possible. I advocate the use of LipoElastic® garments.

- *Visible veins/stretch marks*

Any veins or stretchmarks on your breast can be magnified and thus become more obvious when the breast is stretched over the underlying implant.

- *Further surgery in the future – this is likely to incur more costs*