College of Surgeons Academy of Medicine of Malaysia

Poster No. 317

"I lost weight, but I don't want big breasts…."
Combination of bilateral mastopexy and reverse abdominoplasty

Chai Siew Cheng[1], Wan Azman Wan Sulaiman[1], Arman Zaharil Mat Saad[1]

[1]Reconstructive Science Unit, Universiti Sains Malaysia, Kelantan, Malaysia

Reconstructive Sciences USM

INTRODUCTION

The World Health Organization (WHO) survey in 2010 ranked Malaysia as sixth in Asia with highest adult obesity rate. Campaign to lose weight for health concern is carried out to raise the awareness of community. Introduction of bariatric surgery beside dietary and lifestyle modification for morbidly obese patients lead to increase number of patients experienced body contour deformities secondary to massive weight loss. In male population, a common deformity is having female-like breasts due to redundant skin. Embarrassment and psychological distress are the main factors for patient to seek consultation from plastic surgeons.We are presenting a case of pseudogynecomastia post massive weight loss which treated with combination of bilateral mastopexy with inferior based pedicle and reverse abdominoplasty. Safety and outcome of the surgery will be discussed in comparison with other options.

CASE REPORT

"I lost weight, but I don't want big breasts…I look like a female!" was the chief complaint of a 20-year old gentleman after reducing his weight from 130kg to 82 kg (BMI 26.8) within 1 year with lifestyle modification. He was not confidence with his body figure especially bilateral female-like breasts due to excess and laxity of the skin over the chest. Clinically, he had bilateral grade 2 gynaecomastia according to classification proposed by Gusenoff, Jeffrey A. et al in 2007[1] with excess skin over the lateral chest and abdomen (Figure 1). Preoperative marking for bilateral mastopexy with inferior based pedicle and reverse abdominoplasty was done in standing position (Figure 2). Post operation day 4, patient was discharged well. Upon 2 months follow up, patient was evaluated for the satisfaction on surgical outcome (Figure 3). He was happy with his new chest contour and nipple areola complex. He had normal sensation and pigmentation over the nipple areola complex. He felt more confidence in social interaction.

DISCUSSION

Male patients who presented with breast enlargement often suffer from psychological stress and disturbance in their social interaction. Pseudogynecomastia involved increased subareolar fat without enlargement of glandular tissue without the presence of firm glandular tissue.[1]

Patients' concern of their body contour deformities, plateau of weight and cessation of smoking are the important factors before planning for surgery.[1,2] In selecting the surgical technique to achieve ideal chest wall, factors to be considered including 1) excess of skin, fat and glandular tissue of the chest wall, 2) nipple-areola complex position and size, 3) surrounding aesthetic unit including the upper abdomen and lateral chest, 4) patient's concern and preference and 5) surgeon's preference.

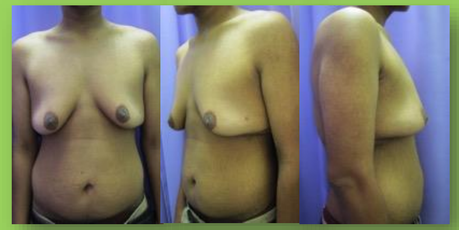

Fig.1: Anterior view – Grade 2 pseudogynecomastia with more ptotic right sided breast. Bilateral nipples are enlarged and medialized. Left oblique and right lateral views – Presence significant lateral chest roll.

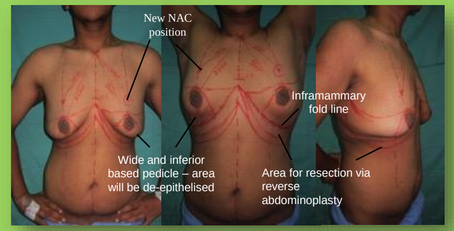

Fig. 2: Pre-operative planning for new nipple-areolar complex (NAC) and inferiorly based dermoglandular pedicle for mastopexy. Reverse abdominoplasty planned for correction of upper abdominal laxity.

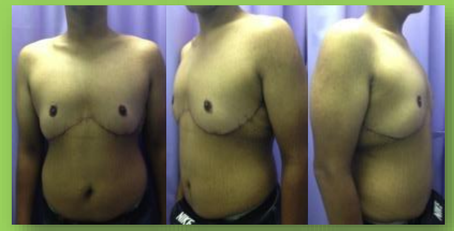

Fig. 3: Post- operation 3 months with flat anterior chest, sensate and normal pigmented symmetrical nipple areolar complexes.

In our case, patient was underwent bilateral mastopexy and reverse abdominoplasty in one setting. This combination of operations successfully improved the contour of anterior chest, lateral chest and upper abdomen. This operation showed no significant increased in post-operative complications as previous literatures.[3-4] New reconstructed nipple-areola complex was sensate and no pigmentation change. However, patient had to accept a relatively long scar which crossing the sternal region and extending bilaterally to lateral chest wall. Gusenoff JA et al.[1] reported that patients who had pedicled reconstruction may experience dysesthesia but not occurred in our patient.

In comparison with ultrasonic-liposunction and staged of excision of remaining redundant skin after several months as reported by Rohrich et al[5], the patients might experienced prolonged anxiety while waiting for skin retraction which might not occur. Liposuction technique and excision of excess skin may not be suitable for patients with more severe pseudogynecomastia to achieve optimal result due to the need to reposition the nipple-areola complex, therefore secondary operation may needed.[1] In 2007, Hamdy A. El-Khatib[14] reported to have satisfactory result by treating grade 3b and grade 4 pseudogynecomastia with single stage liposuction and dermopexy. The only drawback for his study was patients will had an inverted scar. Free-nipple graft operation can be relatively quicker surgery but increased the chances of nipple areola complex loss, decreased sensation, hypopigmentation of nipple-alreola complex and stuck on appearance.[1]

Many operative techniques had been described for treatment of male chest wall deformities, precise analysis of entire aesthetic unit of chest in continuity with the lateral chest and upper abdomen must be done to achieve ideal outcome.

CONCLUSION

Combination of bilateral mastopexy with inferior based dermoglandular pedicle technique and reverse abdominoplasty in treating pseudogynecomastia post massive weight loss is safe to achieve satisfactory result. Body-contouring surgery for chest wall deformities in massive weight loss patient need details pre-operative evaluation and planning.

References

1. Gusenoff, Jeffrey A., Coon, Devin B.A., and Rubin J Peter. Pseudogynaecosmatia after massive weight loss: Detectability of technique, Patient satisfaction, and Classification. *Plast Reconstc Surg* 2008;122(5);1301-1311
2. Simon, B. E., Hoffman, S., and Kahn, S. Classification of gynecomastia. *Plast. Reconstr. Surg.* 1973;51:48
3. CeCin DaouD YaCoub, RiCaRDo baRouDi, MaRiane beRnaRDes YaCoub. Extended reverse abdominoplasty. *Rev Bras Cir Plást.* 2012;27(2):328-32
4. Hamdy A. El-Khatib. A single stage liposuction and dermopexy for grade 3b and grade 4 pseudogynecomastia after massive weight loss: An observational study. *Int. Jof Surg* 2005;5:155-165
5. Rohrich, R., Ha, R., Kenkel, J., and Adams, W. P., Jr. Classifications and management of gynecomastia: Defining the role of ultrasound-assisted liposuction. *Plast. Reconstr. Surg.* 2003;111: 909