

Subareolar Mastopexy: Update

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Background: A preliminary report on a new technique for dermal overlap subareolar mastopexy appeared in 2001.

Objective: This paper reports on a series of 117 patients who underwent subareolar mastopexy and describes several modifications of the original technique.

Methods: Preoperative markings defined the upper edge of the new areola position, the circumferential outline, and the outer edge of the areola. The skin was deepithelialized, and the areolar flap was elevated to the level of the nipple pedicle. Dissection was performed in the subdermal plane to the inframammary fold, the breast tissue was elevated, and the medial and lateral flaps were overlapped for mastopexy. Depending on the procedure, a wedge of tissue was removed for breast reduction or a submuscular pocket was created for placement of an implant. Closure of the areola incision was carried out with the use of 2 or 3 purse-string sutures.

Results: Satisfactory results were achieved with few complications, including less areolar stretching and a higher degree of nipple-areolar projection compared with the results of conventional doughnut mastopexy.

Conclusions: This technique provides excellent results for those patients who are willing to accept partial improvement of ptosis in order to minimize the scar. The degree of ptosis correction is not as marked as that achieved with the vertical or anchor mastopexy. (*Aesthetic Surg J* 2003;23:357-363)

The incisions used for the correction of breast ptosis have diminished in size from the standard anchor incision to the vertical mastopexy and to the circumareolar mastopexy.¹⁻³ The major problems seen with the circumareolar technique are widening and flattening of the areola, together with hypertrophic scarring. A new technique of dermal-overlap subareolar mastopexy was originally described in September 2001.⁴ The technique involves advancing a dermal flap beneath the areola to reduce tension on the skin incision. Several nonabsorbable purse-string sutures are then placed on the advanced dermal flap to lend extra support to this area. The technique can be used for mild to moderate degrees of breast ptosis and mild degrees of mammomegaly. The technique has also been found to be beneficial in correcting tubular breast deformity. As experience has been gained, several modifications have been made. To date, 117 procedures have been performed, with a low rate of complications.

Methods

The degree of areola elevation was determined preoperatively by means of manual constriction of the skin. The upper edge of the new areola position was marked A (Figure 1). The circumferential outline was then marked around the areola, with marking A as the outer perimeter.

The outer edge of the areola was then outlined and marked B. Less areolar skin was to be resected than is removed in the standard circumareolar techniques. The skin between marking A and marking B was deepithelialized (Figure 2). The areolar flap was elevated as a myocutaneous flap up to the nipple pedicle (Figure 3). Dissection was in the relatively avascular intradermal plane, leaving dermis on the base as well as under the flap. If an internal mastopexy, reduction, or augmentation was performed, an incision was made through the dermis and dissection was performed in the subdermal plane to the inframammary fold (Figure 4). The breast tissue was elevated off the muscle and a vertical incision made to the nipple pedicle. The medial and lateral flaps were overlapped for mastopexy (Figure 5). A wedge of breast tissue was removed for breast reduction, or a subglandular or submuscular pocket was created for placement of a breast implant. A suction drain was inserted when a subglandular or submuscular pocket was created. Closure of the areolar incision was carried out with 2 or 3 3-0 Tycron purse-string sutures (Figure 6).⁴ In cases in which excess tension was present, a disc of Prolite Mesh (Atrium Medical Corp., Hudson, NH) was used successfully for added support (Figure 7).^{5,6} The areolar flap was then returned to the plicated dermal base (Figure 8). Absorbable subdermal sutures may be used for closure because there is no tension on the areolar edge (Figure 9).