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 Plastic and Reconstructive Surgery: Volume 123(3) March 2009 pp 115e-117e

New Inferomedial Based Mammoplasty with L-Scar [VIEWPOINTS]

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Figure. No caption available.

Sir:

More than ever before, the minimal scarring techniques used in mammoplasty have today become very popular.²⁻⁴ An alternative reduction mammoplasty technique is described by the authors that results in an L-shaped scar, with the nipple-areola complex based on an inferomedial pedicle flap.

Sixty-three patients were operated on using this method over the past 30 months. Twenty-three of them underwent reduction mammoplasty and 40 underwent mastopexy. The average patient age was 35.8 years. In the reduction cases, the maximum weight of the removed tissue was 940 g.

The incision lines were marked preoperatively, as usual, with the Wise pattern and the A, B, C, D, and E points. The new point (F) is determined on the bisector of the angle (C-E-D) by pinching the loose skin of the breast, between points B and E ([Fig. 1](#)).

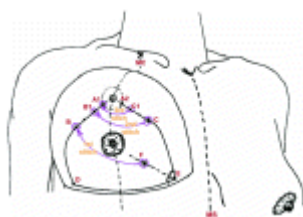


Fig. 1. The marking on the right breast, with the patient lying down. The new marking points F, B1, and C1 on the up-lifted breast. The E-F line is the bisector of the C-E-D angle. The corresponding suturing points are depicted (*purple*).

After these first markings, the corresponding points are sutured with temporary stay stitches, as follows: point F to B, point C to B1, and point C1 to A1. Then, the new areola margins are rearranged, because point A2 is now inside the new areola circle, and not in the new perimeter.

After the former, the new outer and inner contours of the new pattern are drawn, which comprises an L-curve that starts from point A1 (C1) and continues through points B1 (C) and B (F), and ends at point D of the Wise pattern. Next, the temporary stitches are removed, and the inferomedial pedicle for the nipple-areola complex is marked.

The skin is incised down to the muscle fascia, first in the inner pole and then in the outer one. In the inner pole, the incision is not as inferior toward the inframammary fold as in the outer one. It stops between points C and F. The two adipocutaneous flaps are unified by cutting through the mammary parenchyma just above the nipple, leaving an adequate amount of tissue on the upper pole ([Fig. 2](#)).

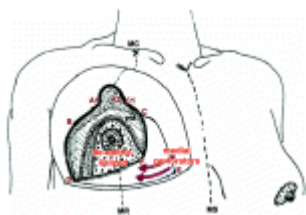


Fig. 2. Schematic depiction of the deepithelialized area to be removed and the extramedial perforators.

In cases of reduction mammoplasty, a horseshoe-shaped section of tissue (but with a shorter medial limb) is removed from around the nipple flap.²

The upper pole flap is undermined onto the pectoralis fascia, as far as the second rib, creating space for the top of the nipple flap to come in between. When the nipple-areola complex flap is too heavy, a suspension absorbable pexy stitch is used at this point.³ Wound closure is started, in the opposite way.

There were no major complications. Advantages of the method include the following: standardized easy marking; there is no medial scar; complications are rare and minor; immediate and early postoperative aesthetic results are very satisfactory; better shape and more complete projection of the breast than with inverted-T techniques because of a longer vertical scar; avoidance of the pleating of the vertical scar technique; and it has an easy learning curve for beginners. Disadvantages of the method include the distance from the areola to the submammary fold, which is longer than with other methods (7 to 13 cm).^{4,5}

With this new method, we have not so far experienced the relatively common complications of reduction mammoplasty, related to inadequate blood perfusion of the nipple-areola complex flap. We think that the key reason is the extramedial component of the base of the inferior flap.

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- * Figures/Tables-no more than two figures and/or one table

Authors will be listed in the order in which they appear in the submission. Viewpoints should be submitted electronically via PRS' en kwell, at www.editorialmanager.com/prs/. We strongly encourage authors to submit figures in color.

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