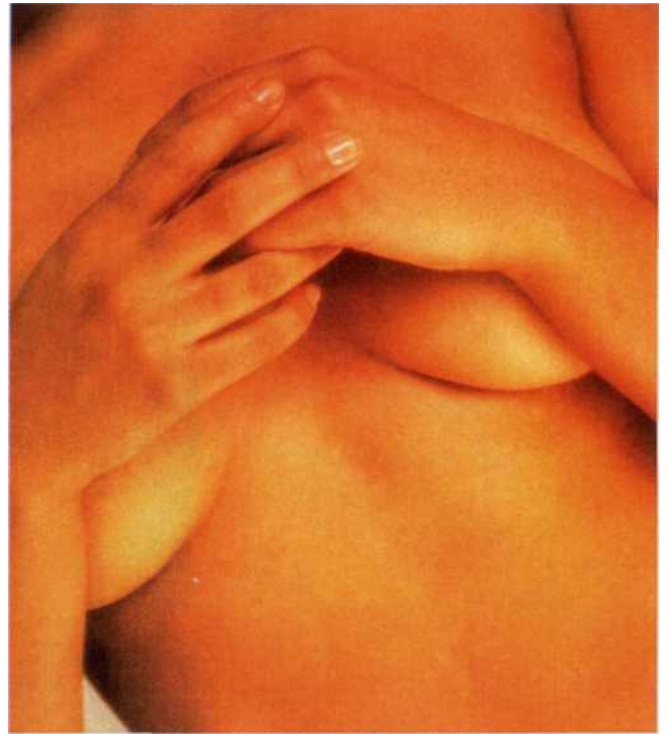


Vertically Speaking

by Boris M. Ackerman, MD



With decreased scarring and shortened operative time, the vertical breast reduction increases patient satisfaction

Successful breast reduction addresses both the functional and aesthetic aspect of the procedure. The plastic surgery community has been working along these lines for many decades. The typical breast reduction technique commonly utilizes the "Wise" pattern, which results in an upside-down T with scars around the areola vertical and transverse components in the inframammary fold.

The vertical breast reduction technique, however, leaves only circumareola and vertical scars, which run from the areola to the inframammary fold. This technique is gaining acceptance in the United States and can be performed in less time than the standard breast reduction. It also requires less anesthesia time, results in fewer scars, and allows for a shorter recovery period. In addition, the vertical breast reduction also produces shapely breasts with more projection. The late sequela of flattened and bot-tomed-out breasts seem to be significantly less.

Practicing Principles

The basic landmark for vertical breast reduction is the same as in the more conventional technique. Mainly, the inframammary fold, the level of nipple areola complex as it is transposed onto the anterior breast and midline of each breast, as well as the native inframammary fold are marked and compared for symmetry.

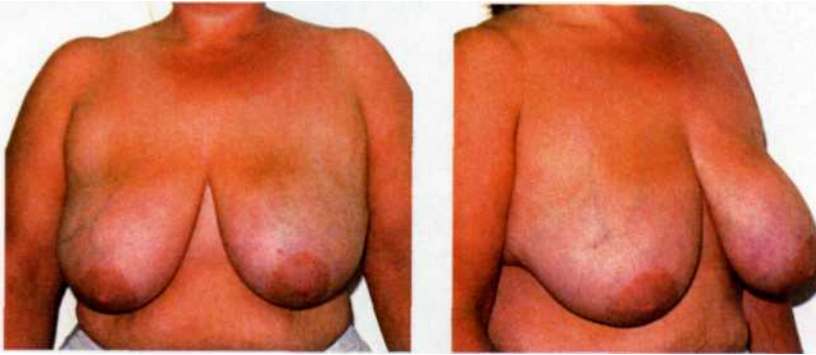
Other components of this technique are radically different from the more conventional reduction methods. In this technique, the new inframammary fold is created 2 cm to 5 cm higher than the native inframammary fold. This technique **requires** the creation of the medial and lateral pillars of the breast. These two pillars create the basis of the new breast shape and position on the chest wall. The entire procedure is dependent on glandular breast tissue for shaping as opposed to on the skin. The skin is simply redraped over the new breast mound.

The markings for this procedure are also quite different from the conventional breast reduction technique. The two cardinal landmarks in this technique are the vertical markings that demarcate the medial and the lateral pillars, as well as the so-called "mosque" pattern for the areola. Additionally, the new inframammary fold level is marked, approximately 2 cm to 5 cm higher than the native inframammary fold. The technical maneuvers do not lend themselves easily to a pattern type of reduction. They require a more intuitive approach, making it difficult to teach and learn this technique.

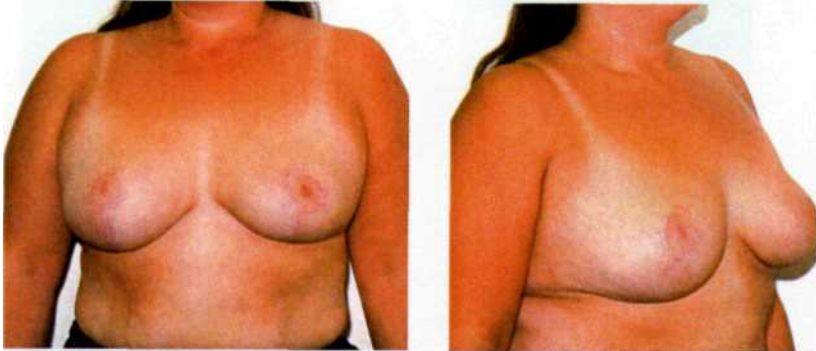
I became intrigued with vertical breast reduction techniques more than a decade ago when initial reports appeared in English language literature. While discussing this technique with my colleagues at the time, I could not locate anyone in the United States performing the vertical breast reduction technique who would welcome an observer. I was pleased when Madelaine Lejour, MD, PhD, of Belgium published her book with an accompanying video describing her technique of vertical mammoplasty.¹ This was the first English language reference source that was

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Preoperative: 27-year-old female showing typical signs and symptoms of macromastia.



Postoperative: One year after vertical breast reduction (900 g were removed from the left breast, and 840 g were removed from the right).

adjusted to various breast shapes and sizes.

Vertical breast reduction surgery has the same risk and complication profile as a conventional breast reduction. There does not seem to be any increase in incidents of nipple areola complex, vascular compromise, or wound healing difficulties. The main drawback to this procedure is that immediate postoperative appearance of the breast may have too much superior projection and takes longer for the breast to achieve its final shape. In my experience, this has not been a significant issue in regards to patient acceptance.

Patients are uniformly pleased with the results, despite an occasional need for revision surgery. The lack of the inframammary fold scar, as well as a pleasant breast shape that tends not to bottom out, contributes greatly to patient's satisfaction. Since breast contouring relies on shaping breast tissue and not on skin tension, scars tend to heal nicely. •

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Reference

1. Lejour M. *Vertical Mammoplasty and Liposuction*. St Louis: Quality Medical Publishing Inc; 1994.

helpful with various technical aspects of this procedure. After reading the book, as well as viewing the video multiple times, I identified a patient in my practice who I felt would be an ideal candidate to perform my first case. This patient did not have a significant degree of ptosis, nor did she require a significant amount of tissue removal.

After an extensive consultation with the patient, I performed my first vertical reduction mammoplasty. Both the patient and I were pleased with the results. I rapidly expanded indications for vertical breast reduction technique in my patients. In a short period of time, I was comfortable performing vertical breast reduction techniques in patients with larger breasts with greater ptosis. Over the past 5 to 6 years, I have been performing vertical breast reduction techniques exclusively, even with patients with large ptotic breasts.

In my early experience with this technique, I diligently followed Lejour's recommendation on the markings. The mosque pattern was more challenging, even with the vertical markings demarcating the medial and lateral pillars. I experimented with various areola patterns, including x-ray film and wire. Ultimately, I developed a wire pattern that could be easily

History Lessons

The history of breast reduction techniques evolved extensively from the late 19th century through today. Initially, breast reduction only reduced breast size, relieving patients of the physical disability with no consideration for nipple position or capacity for function. As techniques improved with time, progress was achieved with regard to contour and viability of the breast. However, the improvements came with extensive scarring with an inverted T closure, or the "Wise" incision.

In North America, various techniques were introduced in an effort to maintain good blood supply, areola sensation, and potential for lactation. Still, the trade-off of considerable scarring remained an undesirable result, particularly along the inframammary fold, below the areola, and in the lateral breast area. Some European and South American physicians were getting promising results with a number of vertical skin closure techniques.

The vertical breast reduction procedure was first introduced in 1964, but only received minimal attention until the late 1980s when Madelaine Lejour, MD, PhD. of Belgium, began utilizing and perfecting the technique. North American physicians have been resistant to the newer vertical breast reduction procedures.

One reason for this reluctance can be attributed to the fact that this technique relies less on pattern design and more on the freehand approach. This basic conceptual paradigm change makes it more difficult to teach and to learn. Nevertheless, it is worth the physician's time and effort to master this technique. There are now more courses available at national meetings teaching vertical breast reduction.