

# Drawback in Surgery as the Patients Perception of Postoperative Scar Quality

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## Description

The aesthetic appearance of female breasts is deemed displeasing when they become notably sizeable or ptotic and therefore symptomatic to the patient. These symptoms include backache, neck and shoulder pain and shoulder grooving resulting from the bra straps. In addition hand neuropathies, headaches, and chronic intertrigo rash of the inframammary fold are also troubling sequelae. Last but not least psychological manifestations such as poor body image, low self-esteem and sexual harassment are also attributed to macromastia. For all the previous reasons symptomatic macromastia is recognized as a medical condition for which surgical interference should be well advised. However there is still no single technique in the armamentarium of reduction mammoplasties that can be applied to all kinds of breasts efficient enough for providing an esthetically pleasing result.

## Breast Reduction

Nonetheless breast reduction still remains one of the most commonly performed plastic surgery procedures with several approaches described in literature. Studies show that with the inverted T-scar technique wound dehiscence mostly occurred at the junction of the vertical and horizontal sutures as this is a weak point due to the increased tension in this area and ischemia at the time of closure causing skin necrosis. This is a drawback in surgery as the patients' perception of postoperative scar quality directly influences patient approval of the procedure.

## Body Mass Index

Prospective review of thirty patients of Middle Eastern origin with a mean Body Mass Index (BMI) of 28.74. These 30 cases had a confirmed diagnosis of macromastia after physical examination. They were operated upon between the periods of January 2019 to January 2020 using the inferior pedicle inverted T breast reduction technique. Diabetic patients, smokers and patients with bleeding tendencies were excluded from the study. The patients were randomly divided into two equal groups of 15 patients each arranged by alternate sequential manner. In the first group (Group V) an inverted V flap was used in the IMF region at the point of junction between the vertical and

horizontal limbs of the inverted T. This is a flap shaped as an inverted V over the inframammary fold on the inferior pedicle that is not de-epithelialized. In the second group (Group Z) a non-invasive zip line suture device was placed at the junction between the vertical and horizontal limbs of the inverted T design after skin closure. The zip line device is an adhesive hydrocolloid formed of two strips attached in the center by polyurethane straps which are pulled on to support tautness in a fashion not unlike that of closing a zipper. Both techniques took approximately 3 hours intra-operatively. The operating surgeons have been using the V flap technique for several years, and due to wound dehiscence complications with the standard T technique it was not used as a control group.

Patient age and whether in the childbearing period or post-menopausal and parity were all documented. BMI was calculated. Examination of breast skin for signs of striae, intertrigo or maceration was undertaken. Breast examinations were performed while the patient was upright, sitting, leaning forward and lying supine for detection of any mass or breast abnormalities. The location and length of the potential scars of the inverted T technique were described to all patients. Routine investigations were undertaken including full blood picture, coagulation profile, liver and kidney function tests, and fasting blood sugar. A pre-operative mammogram was implemented for all patients. Three views of the breast documenting the appearance of the breast from the front and from each side were obtained to adequately serve to record the patients' pre-operative condition.

The patients were marked in the standing position. The midline was marked from the suprasternal notch (SSN) to the umbilicus. The breast meridian was then identified (from the midclavicular point to the midbreast bisecting the breast into two halves). The position of the infra-mammary fold (IMF) was identified and marked 2cm from the midline and 2cm from the anterior axillary line. Lastly the new nipple position was then marked; achieved by using a flexible ruler positioned under the breast to mark the anterior projection of the IMF. The point where this meets the breast meridian is the proposed nipple position.

All patients received an inferior pedicle inverted T reduction mammoplasty which was modified to include an 8cm wide inferior pedicle. A 4.5cm diameter circle was drawn within the areola using the cookie cutter. The new IMF was remarked when

the patient was in supine position and the final step prior to commencing was comparing measurements on both sides. One gram of broad spectrum antibiotics was given to the patient on induction of anesthesia after testing for allergy. The procedure for either group took approximately 3 hours.

The procedures were performed under general anesthesia. A local anesthetic mixture of 20ml of 1% lidocaine and 1:500000 adrenaline was then injected into each breast targeting the planes of incision of the skin and the breast tissue. Reduction mammoplasty was carried out in standard fashion. De-epithelialization was done around and below the areola to the inferior mammary line in group Z and around the inverted v flap

in group V. Suction drains were applied in all cases. Sterile adherent gauze pads were used over the vertical and horizontal limbs (including over the inverted V flap) at the end of the procedure.

Reduction mammoplasty was carried out in standard fashion and an inverted "V" flap centered on the breast meridian with its base situated on the IMF was included. The inverted V flap resembled an equilateral triangle with its limbs measuring approximately 4-5cm. The lateral limbs were incised full thickness down to the pectoralis major muscle fascia. De-epithelialization was done around and below the areola to the limbs of (and not including) the inverted V flap.