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Mastopexy Information Sheet

Mastopexy surgery, also known as “breast lift surgery”, is an operation that technically involves the repositioning of the nipple areolar complex and tightening of the sagging breast tissues. Basically, it is a procedure designed to make the female breast “perky” once again. Generally, it does not involve reduction of breast tissue or augmentation, just simply tightening up the breast so that it is perky and more youthful. Most women requesting a mastopexy procedure are those whose breasts have undergone significant changes post-partum. Children and nursing wreak havoc on most women’s breasts. However, there are some younger women who have not had children but still have glandular ptosis or sagginess of the breast that does need similar correction. Other individuals that have trouble with breast sagginess (also known as “ptosis”) are those who have had massive weight gain and loss or just have loose skin.



In any case, surgical treatment of glandular ptosis (breast sagginess) can be very challenging indeed. Basically, the degree of ptosis needs to be determined. The position of the nipple-areola complex in relation to the inframammary crease fold is evaluated, in addition to the degree to which the breast gland sits below the inframammary crease fold. If the volume of breast tissue is adequate but ptotic (saggy), then a straightforward mastopexy can be undertaken to restore the breast to its perky state. However, if the volume is inadequate and the breast is saggy, a combined augmentation with mastopexy will be required in order to optimize the breast.

There are a number of different mastopexy techniques that can be used to correct the ptosis. Again, this is determined by the degree of ptosis that is present. The mastopexy procedures available to us today include a crescent mastopexy (for minor ptosis), in which the NAC can be moved up 1-2 cm to get it to sit even with the opposite side. Other approaches are the doughnut or circum-areolar mastopexy, vertical mastopexy and a more extensive inverted-T (also known as an anchor) mastopexy. It is important to understand that the more significant the ptosis, the more aggressive the mastopexy procedure will be. Some minor forms of ptosis can be corrected with augmentation alone. However, it is not uncommon that a combined lift-augmentation mammoplasty be undertaken to optimize the result. It should be noted that the procedure of a combined lift-augmentation mammoplasty is a technically and conceptually challenging operation. This is because it requires the initial placement of a breast implant to get the correct volume & breast mound followed by a mastopexy that is done relative to the new breast mound. Where the implant ultimately ends up after healing is complete in relation to the mastopexy is not always a certain thing. Therefore it may require revision at a later date.



Oftentimes, women express their concerns about the scars associated with a mastopexy procedure. The minor mastopexies, such as a circumareolar crescent mastopexy leave incisions only around the NAC in the interface between the darker nipple tissue and the lighter breast skin. However, more extensive procedures such as a vertical mastopexy or an inverted-T lift will leave scars not only around the nipple but vertically below the nipple down to the breast fold and then, if necessary, on either side of the fold. The one that becomes most visible, that women comment on the most, is the vertical incision. It has been my experience that typically these incisions heal quite well and that the correction in ptosis, that is the restoration of a perky, beautiful breast, in the end is much more desirable to the patient than to avoid the vertical scars. This is not to minimize the reality of a scar, but rather to suggest that most patients are very happy to have a nice, perky breast, and that in the end the scars are not as big a concern as they seem to be in the beginning. Obviously, it would be nice if scarring could be avoided, but to date there is no good way to correct glandular ptosis (breast sagging) without placing scars on the breast.



Postoperatively, mastopexy patients are managed in similar fashion to breast reduction patients and augmentation patients, especially if a combined augmentation mastopexy has been done. If only a mastopexy is performed, the patient is placed in a brazier and kept quiet for the first week or two. Typically drains are not placed and therefore do not need to be removed postoperatively. Stitches are removed sometime between the first and second week after surgery. In my approach, the sutures are placed and then a layer of Dermabond glue is placed on the incisions to keep the wound clean and safe. The patients have been able to shower the day after surgery and to resume light activities at one week postoperatively and full athletic activities, except for contact sports at two weeks postoperatively. Three to four weeks postoperatively the patients are able to begin to resume their normal lifestyle without limitations barring any complications.

Initially, the Dermabond glue does a great job of improving the scarring as the wounds heal. Once the glue comes off at two to four weeks, then you will convert over to vitamin-E oil massage or to silicone sheet applications. Typically, the incisions heal nicely in time. It may take six months to a year-and-a-half for all of the redness to completely resolve in the incisions, but once it does the incisions are usually quite tolerable as is expressed by many my patients. But the incisions are real and will always be present.

If a combined augmentation mastopexy procedure is done, then the patient will usually not be kept in a bra but will be encouraged to do her implant displacement exercises, also known as breast implant massage exercises postoperatively, usually starting at one to three days postop. This requires displacement of the implants every couple of hours postoperatively for the first week, and then six to eight times a day for the following two months until the pocket is open and stabilized. This will optimize the result ultimately.

Some of the complications that can be seen after mastopexy are as follows:

- 1) **Hematoma** - This is perhaps the most common complication seen with mastopexy procedure, although it is still relatively uncommon. The percent of hematoma is somewhere around 5% or less. Because of this risk, it is requested of the patient that they remain quiet for that first week after surgery and preferably for two weeks. If a major hematoma does occur, it will require surgical evacuation and hemostasis by opening the wound back up, finding the bleeder, and cauterizing it.
- 2) **Fat Necrosis and Fatty Fibrosis** - Basically fat, or an area of fat of the breast that becomes ischemic. That is, the tissue does not receive adequate blood supply. Because of this, the fat becomes necrotic and eventually fibrotic. It becomes hard, tender, and bothersome to the patient. This will oftentimes be removed at a later date. It is possible for this to become infected, which will have to be treated in a different manner. Removal and revision would be delayed for four to six months postoperatively. Removal may leave that breast smaller than the other and requires a change of implant or increase in volume.

- 3) **Infection** - Fortunately, this is uncommon but it does occur. It occurs in 1-2% of the cases. The most common infection seen is a small stitch abscess, which can occur any time over the several months postop. If a small stitch abscess does occur, it is important to get it removed as soon as possible before it becomes more of a problem. This requires securing the small stitch and removing it. If it is a severe infection, it will require opening up the wound and treating it accordingly. An infected implant will need to be removed.
- 4) **Nipple and Skin Slough** - Skin slough usually occurs at the confluence of flaps, where there is the most tension. Typically, this can be debrided, and cleaned up so that it heals uneventfully. Occasionally, it requires some revision surgery to either close the wound or to remove the scar that develops. If the nipple sloughs or becomes necrotic, this is a more problematic complication. It is seen in less than 1% of mastopexy cases. There is a slightly higher incident of nipple death when mastopexy is combined with augmentation surgery. It basically means that the blood supply to the nipple itself is compromised and that the nipple can literally die. If this were the case, it would require excision of the necrotic tissue, wound management, closure, scar revision, and recreation of the nipple at a later date. It is very important postoperatively for the first four to five days that the patient keep a close eye on her nipples and the blood supply to them.
- 5) **Nipple Malposition** - As was mentioned previously, mastopexy or breast lifting procedures, especially when combined with augmentation, are very technically challenging. Every attempt is made to place the nipple at the correct position at its new nipple site, but oftentimes it does not correlate with how the tissues settle out over time. Therefore, it is not uncommon to have to go back and revise nipple malposition. The “high-riding nipple” is probably the most common complication seen after breast lift surgery. The larger the breast, that is the more weight that is present, the more likely the patient will get inferior descent of the breast, giving a “high-riding nipple” look. It is not uncommon to have to go back and correct this at a later date. It will continue to reoccur over the life of the patient.
- 6) **Scarring** - Although scarring is a real part of mastopexy procedures and a great concern to the patient, it is a reality of the procedure. There is no way to reposition the nipple and to tighten up the breast envelope without incisions. Still, in the end, patients are really quite happy with the perky, natural-appearing breast, despite the scars that are left. Most of these scars do soften out over time and obtain a color that is consistent with the skin around it. Of course, occasionally, hypertrophic or keloid scars will develop, which will need to be treated with an intralesional steroid injection. Other options are vitamin E oil massage or the application of silicone sheeting.
- 7) **Nipple Sensory Loss or Alteration** - This complication of the surgery is a real one. I have seen quoted anywhere from 5-15%. If this does occur, most sensation does return over time, but there is a small number of patients that will have permanent loss of nipple sensation or alteration, such as decreased sensitivity or even increased sensitivity.

It is very important to understand that in breast lifting procedures, whether it be a mastopexy, a combined mastopexy-augmentation procedure or breast reduction-type procedure that there is no guarantee as to the how the breasts will change over time. Whether an operation is done or not, the breasts will continue to change because of the effects of the continual downward pull of gravity. There are also the effects of just life itself, nursing and so forth. It is important that it is clearly understood that the breasts will continue to change despite procedures that have been done.

Consequently, the patient may have to go back and tighten up the breast envelope, reposition the nipple, revise the scars or adjust the placement of the implant

In conclusion, mastopexy is a very useful procedure. Although people have expressed concerns about scarring, most are extremely pleased to have a youthful, perky breast after the procedure. More often than not, a combined augmentation with mastopexy is the norm. Although there are a few people who are happy just to have a mastopexy, this is definitely the minority.