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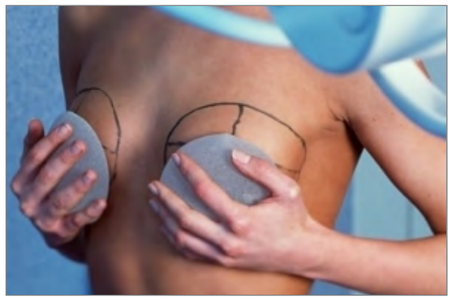
Breast Augmentation: Challenges and Complications

By Adam Schaffner, MD, FACS

Breast augmentation is the most popular cosmetic surgical procedure performed. While popular, it is also the cause of many problems which result in unhappy patients who undergo subsequent operative procedures to attempt to solve problems caused by the primary augmentation. Such problems include, but are not limited to, capsular contracture, implant malposition, fold malposition, double bubble deformity, symmastia, rippling, deflation of saline breast implants, ruptured implants, desire for a different implant size (larger or smaller) and the need for a breast lift.



Revision breast augmentation is more difficult, complex and less predictable than primary breast augmentation. Tissues may been thinned due to the weight of the breast implants, anatomic planes may have been violated, anatomic landmarks may be distorted, and scar tissue will make dissection more difficult. There may be more bleeding, especially if the scar tissue is extensive and if the capsule has to be removed due to capsular contracture.

All plastic surgeons aspire to have the lowest possible reoperation rate. Reoperation rates of approximately 20% in sequential post-market approval studies have remained relatively constant. Failure to improve this rate of reoperation should serve as a motivating factor for all plastic surgeons that perform breast augmentation to critically analyse their pre-operative decision-making process, their surgical technique, and the post-operative care they provide. In doing so, we can work together to reduce the rate of reoperation as much as possible.

There is a difference between reoperations and revisions. Reoperations include any event that transpires in the vicinity of the patient's breast augmentation. This may include breast biopsies and scar revisions. It may also include change of implant size and/or subsequent mastopexy. The reason for reoperation in these cases may be out of the control of the surgeon or patient. While it is important to reduce the rate of reoperation, it is of paramount importance to reduce the rate of revisions due to capsular contracture, implant or fold malposition, infection, extrusion, double bubble deformity, symmastia, or implant deflation or rupture.

As with all surgical procedures, the best results come from critical preoperative analysis. The patient's desires and preferences must be discussed and honoured to the extent they are realistic and reasonable. Unfortunately, some patients desire implants of a certain size which may not be in their best long-term interest. They may also desire more cleavage than is possible given their intermammary distance. It is incumbent upon the plastic surgeon to educate the patient about the risks and benefits of breast augmentation in order to set appropriate expectations and minimise the risk of complications. The optimal implant volume will fill the stretched envelope in addition to the existing breast parenchyma. The optimal implant dimensions for a given patient should be determined after assessing a patient's base width, anterior pull skin stretch, nipple to inframammary fold distance, sterna notch to nipple distance, and pinch thickness. While a patient may be a candidate for a range of implant sizes and styles, having an implant which is too large or too wide may cause problems which are difficult to correct and result in long-term dissatisfaction. It may also result in the need for revision surgery to correct rippling, atrophy, skin stretch and visible edges of the implant.

In short, plastic surgeons must recognise that implant volume is not the most important factor in implant selection. Breast implants should be selected based on proportions and dimensions. The final appearance of the augmented breast is related to the initial amount of breast tissue, its