Case 140: Congenital Synmastia 158

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158.1 Submitted by Higgs: March 15, 2012

This 21-year-old dental hygiene student came to see me recently about her cleavage.

On examination, she has a typical congenital synmastia (Americans call it symmastia). There is a bridge of tissue between both breasts that feels like subcutaneous fat and not breast tissue (Fig. 158.1). The deformity bothers her "all the time", when naked, in tank tops (singlets) or other clothes.

Does anyone have experience with treating similar cases?

There is little of use in the literature.

Hodgkinson: March 22, 2012
Yes – have lectured on this several times.

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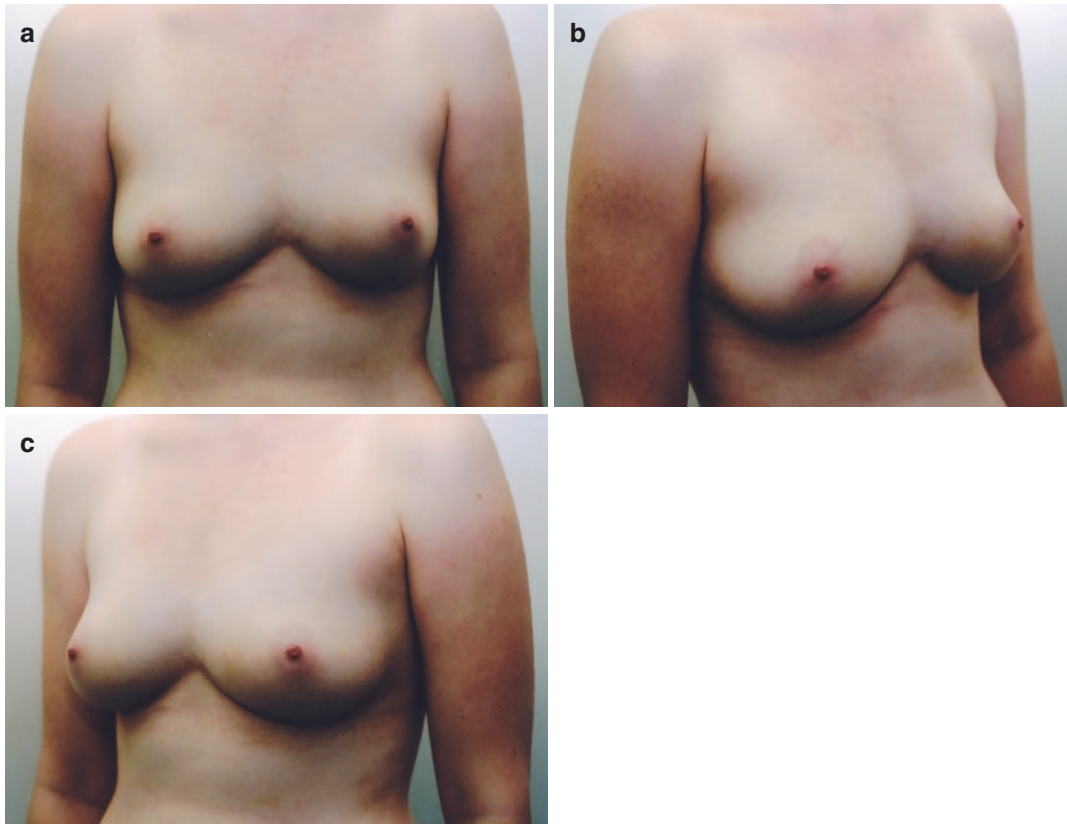

Fig. 158.1 (**a**–**c**) A 21-year-old girl is concerned by her cleavage

Fisher: April 19, 2012
While I have no experience in treating this, I think simple liposuction over the sternum extending a bit into parasternal breast areas with good compression over the sternum postoperatively should improve her cleavage without any major surgical intervention. This is what I would try first.

Mangubat
I would agree. In addition, I would consider additional liposuction to accentuate the inframammary folds (IMFs) and lateral breast borders, define the pectoralis major border better and fat grafting superiorly to round out the mound. I think you can get a good result.

Yoho
Use Design Veronique inframammary/sternal compression garment for 3 weeks after you do this to mould your result.

If this patient were older, it would be a certain thing that the breasts are largely fat, but in these younger patients, you never know until you try the liposuction. Having all breast glandular tissue and no fat is a rare thing however. Do not be afraid to use a 4 mm cannula (I always use a spiral one from Jeff Kolster, at KMI [1]) criss-cross, two incisions minimum, and use IMF so they do not show.

I think the idea of fat transfer to the breasts is a good idea if she wants a little more volume, and this will give her a result if your sternal thing does not work well. Use 150–200 mL of decanted unspun fat injected per breast from sterile suction container/sterile harvester tubes (just suck off the infranatant after waiting 10 min then pour into 50 mL syringes with screw on 3 or 4 mm transfer cannula about 6 in. long to streak through all layers of breast including muscle layers diffusely).

Prochazka: May 16, 2012
I have no direct experience with this presentation either.

But from first principles, it would make sense to do a slow, careful but nevertheless ultimately quite aggressive liposuction of the cleavage area with 2 mm cannulas, using small-access incisions in the inframammary fold (IMF) (as even a small midline incision could result in a keloid). I would plan the treatment area to be about 3–4 cm wide at the narrowest point, which should be roughly at the same vertical level as the nipples.

See how that goes. If skin-to-fascia adhesions do not result, perhaps some absorbable threads could later be inserted in a lattice pattern, taking care to vary the depth a little so that small bites of deep fascia are taken. The ultimate aim is to achieve some tethering of skin to fascia. The main risk would be irregularity/puckering.

Moore: May 24, 2012
My apologies for the delay in replying as I have been trying to restore some early photo files that have disappeared when I had my computer upgraded some weeks ago.

In early 2000, I had a patient, very similar to your lass, with congenital synmastia. She was in her early 20s, and like your patient was very distressed about her breasts. She came to me asking if breast augmentation could solve her problem. I advised her no but that breast augmentation combined with a direct attack on the synmastic area might well work.

In a nutshell, I approached her via inframammary crease (IMC) incisions, developed the implant pocket as per my usual practice and then directed my attention to the synmastia. Via the left IMC incision, I try to liposuction the synmastia removing as much fatty tissue in the midline as I could. Then under direct vision, I diathermied (in coagulation mode) the anterior tissues over the sternum in the midline to produce an inflammatory reaction that I hoped would stick the skin to the sternum.

Next, I inserted a Siltex spectrum contour profile adjustable implant (275 mL) into each pocket and filled each prosthesis with only 200 mL saline. I was able to close both pockets without any problem. I then used a rolled bolster (a 3 in. long half-used roll of Elastoplast) placed along the (now flat) synmastia groove and taped it in place with a criss-cross Elastoplast dressing.

The bolster remained in place for 10 weeks, the criss-cross tape required changing several times (about five times), but the compression bolster remained in place very well for the entire time.

The remote injection port of the implant I placed just below the IMC for easy access. At 3 months I added 25 mL of saline to each implant and over 3 months reached the maximum fill of 275 mL.

The result was very gratifying. Unfortunately, her photos are lost somewhere in my computer hard drive. I am therefore unable to show you her photos at this time.

I have had a number of secondary synmastias following breast augmentation (by other surgeons) and have treated them with a variant of the bolster technique. Usually, the synmastia in these cases is due to migration of only one (occasionally both) implant across the midline. These I have treated with an opposite relaxing capsulotomy. I treated the synmastia as in my first case and then used the bolster to push the offending implant into the relaxing capsulotomy. The results with these cases have also been gratifying. I now only leave the bolster in place for 6 weeks and do not use Elastoplast. I have not tried the purpose-designed breast vests that are now available on the market and would be interested in the experiences of those who have.

I hope this has been helpful.

Anderson
I would suggest liposuction with a 3 mm neck liposucker, which is shorter and has a flattened distal end and should give an excellent result as the "deformity" is due to excess subcutaneous fat anyway.

Hodgkinson
I have previously posted this case of congenital synmastia (Fig. 158.2).

Treatment; bilateral periareolar approach with glandular reshaping and mesh support.

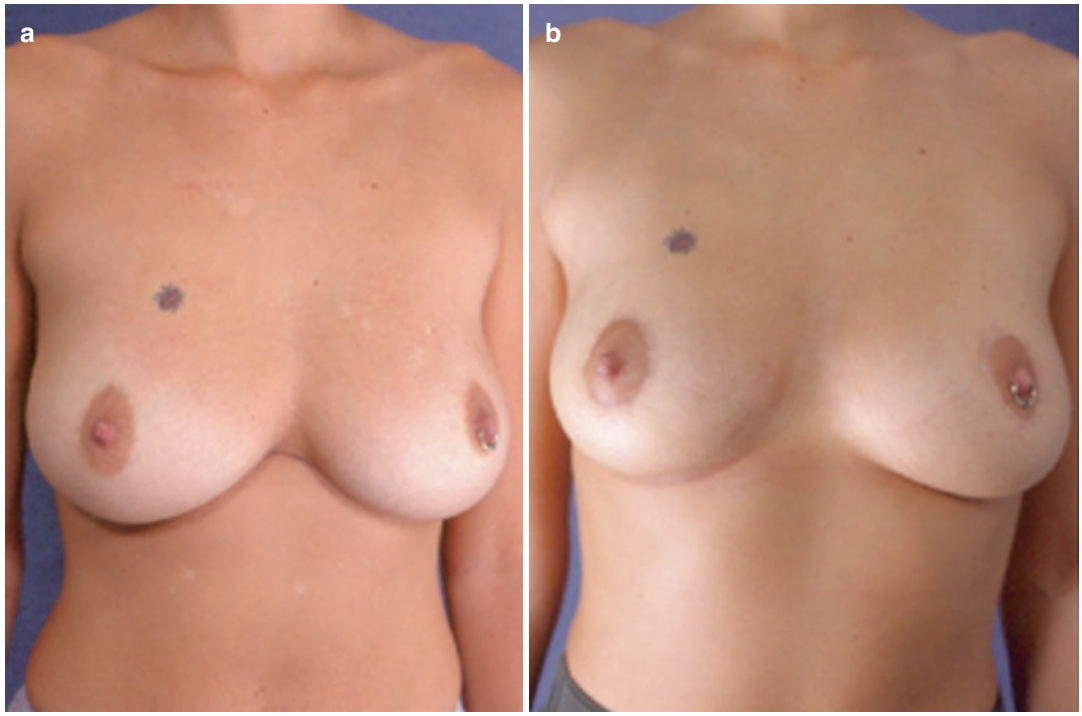

Fig. 158.2 A case of treated synmastia from Dr Hodgkinson. (**a**) Preoperative. (**b**) Postoperative

Followed by Reston chest plate worn for 6 weeks. Liposuction will not be successful and neither is internal or external suturing.

Shiffman: August 28, 2012

On the frontal view, it appears that the medial portions of both breasts are wider from the NAC than the lateral portions of the breast.

These cases are difficult to handle with liposuction alone unless there is a means of compressing the centre with a bra like Metcalf's (Oklahoma) that has a wide and longer compressive centre [2]. The compression should be at least 3 weeks. However, there is a risk of recurrence even then.

I would suggest liposuction between the breasts followed by sutures going through skin (using an opening made by an 18-gauge needle) and attaching to the underlying fascia or periosteum. It is then brought out to exit through the skin about 1–2 cm away from the starting opening. If the suture is then passed through the exit hole proceeding superficially to catch the subdermal layer and finally brought out the original opening when this is tied, the knot is pushed under the skin through the original opening. These should be *nonabsorbable* sutures. The suturing is done in a slightly curved fashion to conform to the shape of the medial breast. Again, a compressive dressing should be applied to the centre of the breasts over the sternum and kept on for at least 3 weeks.

Higgs: February 13, 2015

On September 19, 2012, under general and tumescent anaesthesia, liposuction was performed with a 3 mm flexible Mercedes cannula via the medial end of what would become the inframammary incisions. The aspirate was only 150 mL with about 20 mL supranatant fat. A routine subpectoral (not dual plane) dissection was performed with inferomedial origins of pectoralis major crushed and divided up to the sternum. Round, high-profile, intermediate texture, 325 mL, form-stable, silicone gel implants (Cereform RHMV325 plus) were used.

A special bra was used (sourced via the Internet) called a "Thongbra". This provided

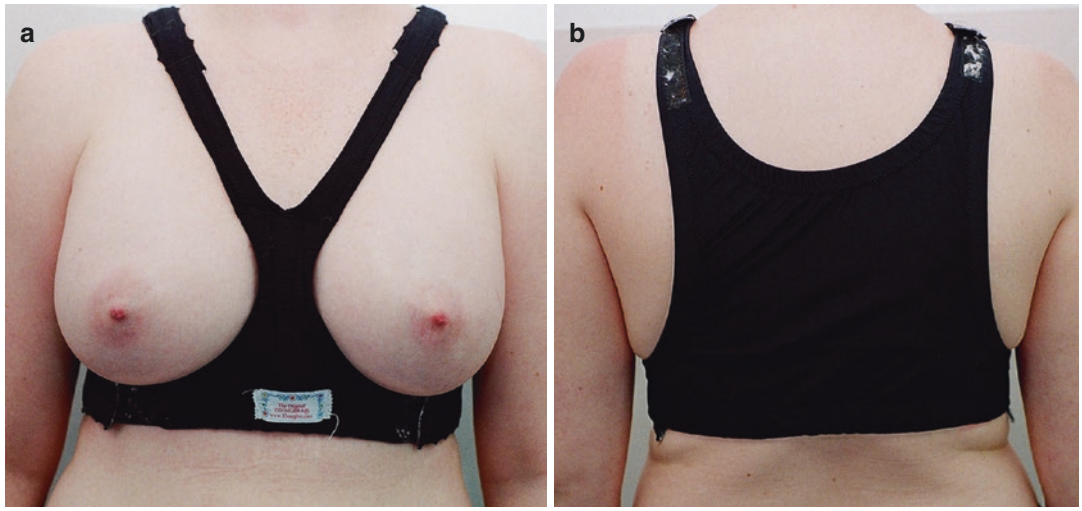

Fig. 158.3 (**a**, **b**) The Thongbra was worn for 4 weeks

gentle but firm pressure over the sternum and was described as uncomfortable but tolerable and acceptably comfortable after the first 2 weeks (Fig. 158.3). Extra padding was required under the breasts.

The results were satisfactory enough for the special bra to be ceased after 4 weeks. Unfortunately, the synmastia recurred gradually over months and was similar to the preoperative appearance when seen at 1 year.

When seen most recently on February 13, 2015, two and a half years had passed and there had been weight loss of 12 kg. The synmastia is now less obvious (Fig. 158.4).

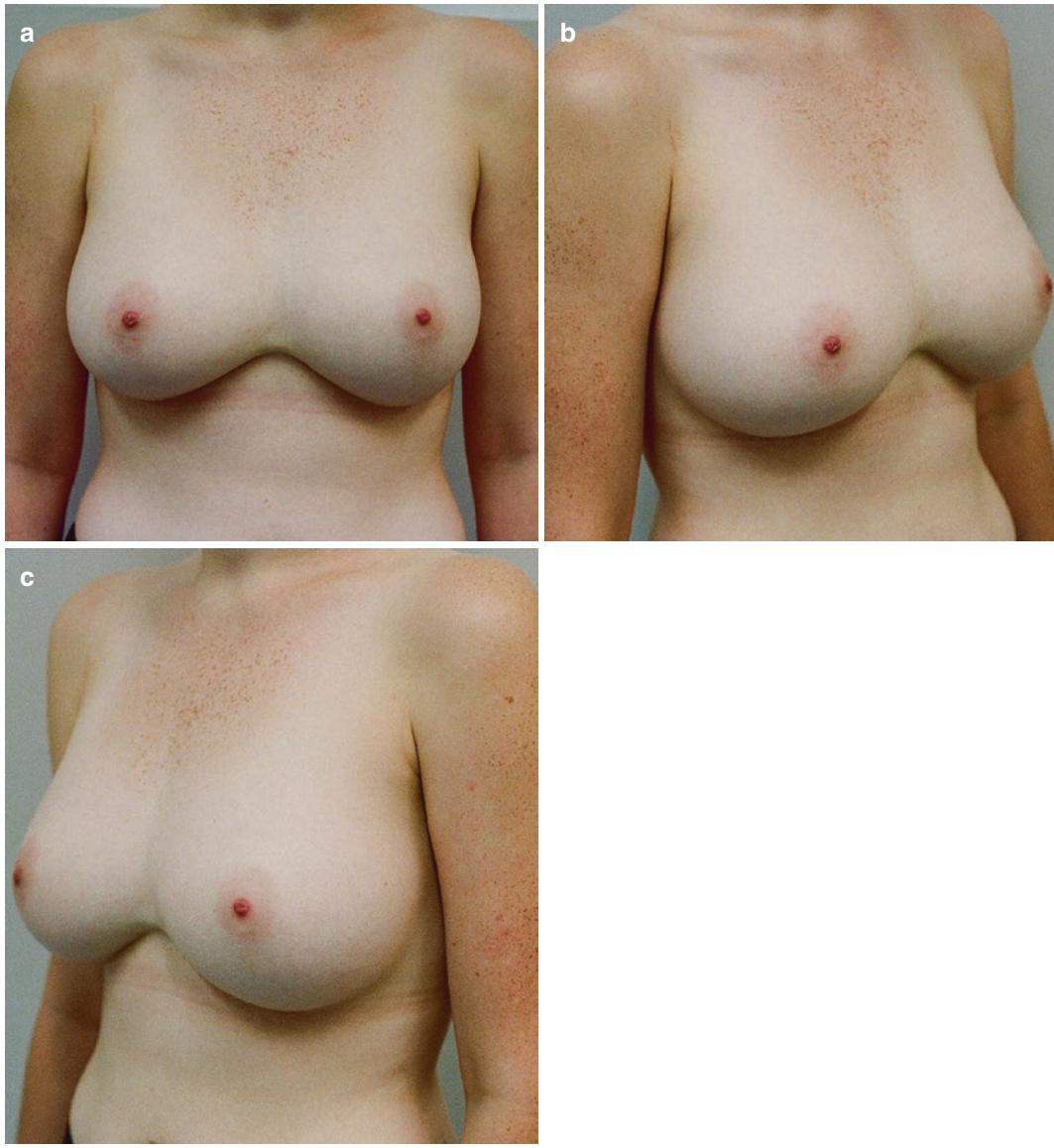

Fig. 158.4 (**a**–**c**) Appearance at two and a half years and following weight loss

References

1. KMI (Kolster Methods Incorporated) Innovative Med. Inc. 3185 Palisades Drive Corona, California, 92882, USA
2. Dan Metcalf M.D., 12400 St. Andrews Drive, Oklahoma City, Oklahoma 73120 USA