Aesth. Plast. Surg. 10:9–15, 1986

Aesthetic Plastic Surgery

An "All-Season" Mammoplasty

Claude Lassus, M.D.

Nice, France

Abstract. A reduction mammoplasty must produce a reduction in volume, a natural lasting shape, and minimal residual scarring. Many attempts to achieve this goal have been developed in recent years. The author described, in 1970, a vertical technique achieving an important reduction and a good shape but with the appearance of the end of the vertical scar below the brassiere line. In 1977, the author [3] modified the technique by the adjunction of a small horizontal scar to eliminate the inconvenience of the visible part of the vertical scar. In this article the author describes his technique which appears to be suitable for most types of breast deformities.

Key words: Breast reduction — Resection "en bloc" — Minimal scarring

The search for minimal scarring after mammoplasty is not recent. Hollander (Fig. 1) described in 1924 a technique of breast reduction resulting in a scar similar to that produced in the Elbaz technique. Later, Arie, in 1957, [1] proposed the vertical technique, a procedure that was mainly suitable for mildly hypertrophic and ptotic breasts. In 1970 [2], the author recommended a vertical technique for breast reduction based on Skoog's principles of (1) transposition of the areola by a bipedicle flap and (2) resection "en bloc" of skin, fat, and gland.

This technique enabled one to treat massive hypertrophic and ptotic breasts but the patient had to accept the appearance of the vertical scar 3 or 4 centimeters below the brassiere line (Fig. 2). This procedure was an important improvement because it gave a good breast shape, as well as minimal scarring, lasting over many years (Fig. 3), whereas the older techniques resulted in extensive scarring and a rapid deterioration of shape (Fig. 4).

Recently patients have become more critical of the results and are not looking just for reduction of their breast volume but expect minimal residual scarring and a natural lasting shape. For this reason the vertical technique has been modified by the addition of a short horizontal line [3, 4, 5].

Method

The midpoint between the acromion and the olecranion is marked on the arm and a further mark is made 2 centimeters distally. This latter point is joined to a similar one on the opposite arm and where it intersects with a vertical line from the center of each nipple is point "A'," the new nipple position (Fig. 5).

Point "B" is located where the vertical line from the nipple crosses the inframammary fold and was previously the end of the vertical scar. However, point "B'" is used now and is located 2, 3, or 5 centimeters higher depending on the degree of hypertrophy and ptosis (Figs. 6 and 7).

The amount of tissue to be resected is marked by joining A' to B' with an inner and an outer circular line. The outer circle is quite large. A superiorly placed areolar flap is fashioned 5 centimeters beyond the existing nipple to preserve the vascularization and innervation. Careful deepithelization of the nipple flap is carried out to keep satisfactory vascularization and innervation (Fig. 8). An "en bloc" resection of skin, fat and glandular tissue is removed between the inner and outer circular lines (Fig. 9).

A thin layer of glandular tissue is left underneath the areolar flap (Fig. 10). The resection is carried

Address reprint requests to Claude Lassus, M.D., Résidence Négresco, 1 Rue du Commandant Berretta, 06000 Nice, France

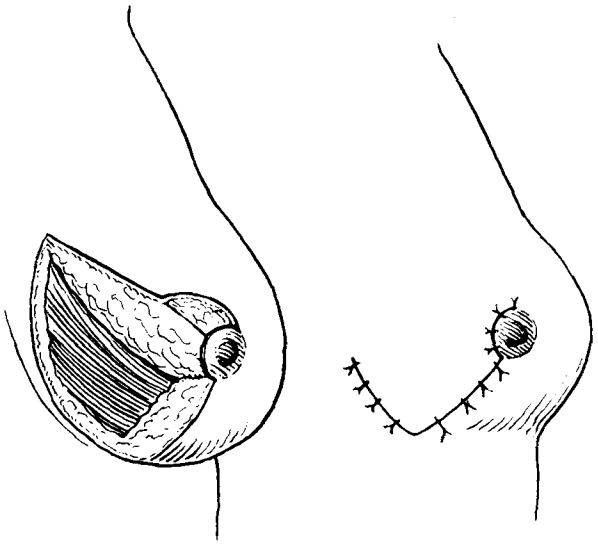
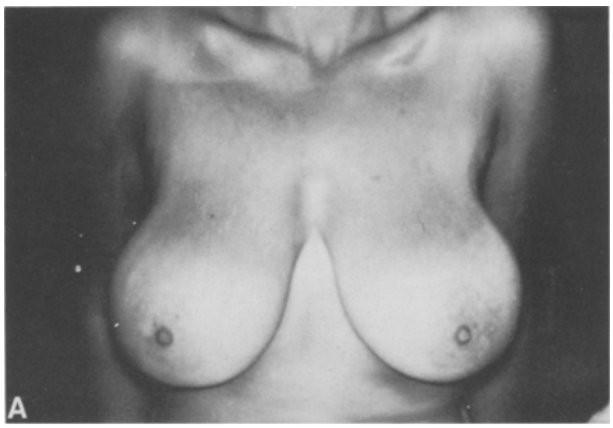


Fig. 1. Hollander's mammoplasty technique, 1924



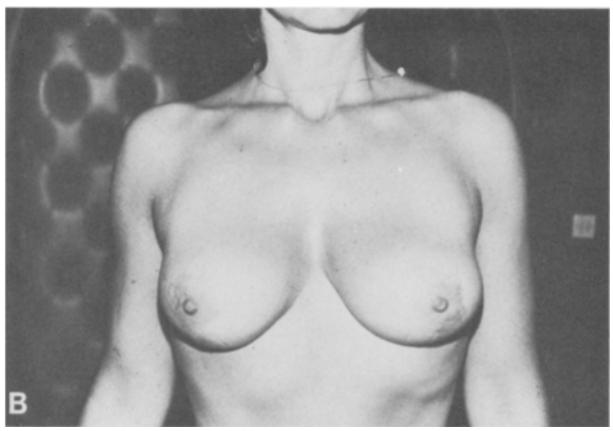
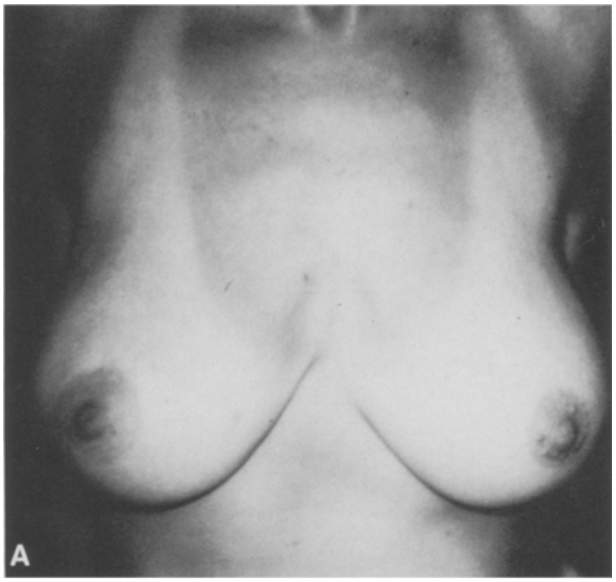


Fig. 2. **A.** Huge hypertrophic and ptotic breasts preoperatively. **B.** As a result of the Lassus vertical technique, the end of the vertical scar appears 3 cm beyond the brassiere line



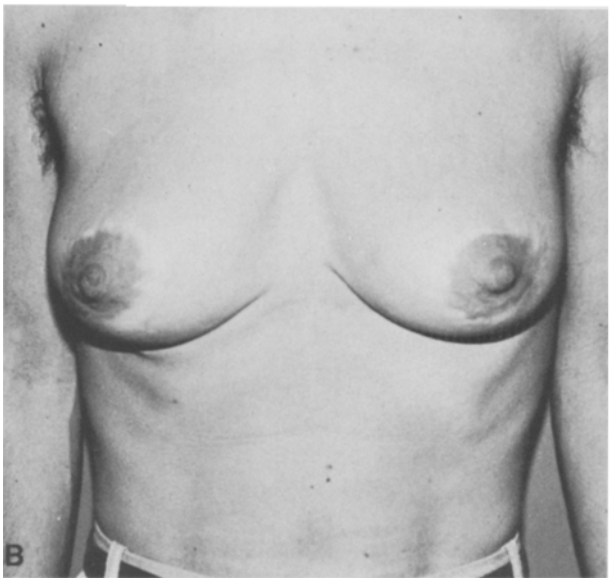


Fig. 3. **A.** Preoperative. **B.** Permanent good breast shape after Lassus vertical technique; 12 years postoperatively with a bad quality of the scars

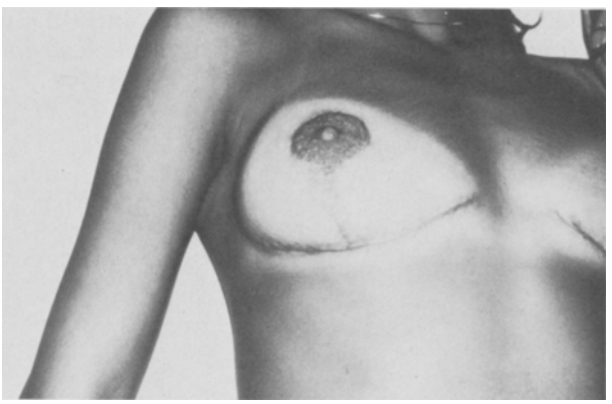


Fig. 4. Huge scarring and impairment of the shape of the breast after years using some other techniques

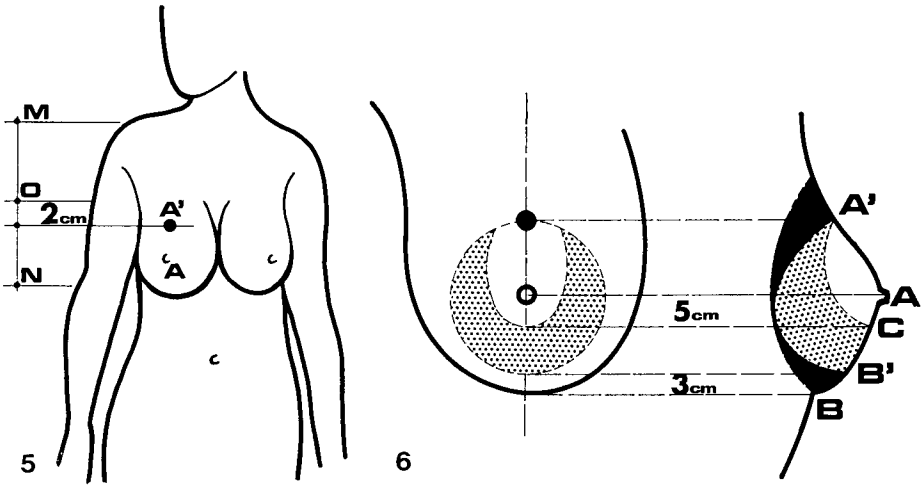
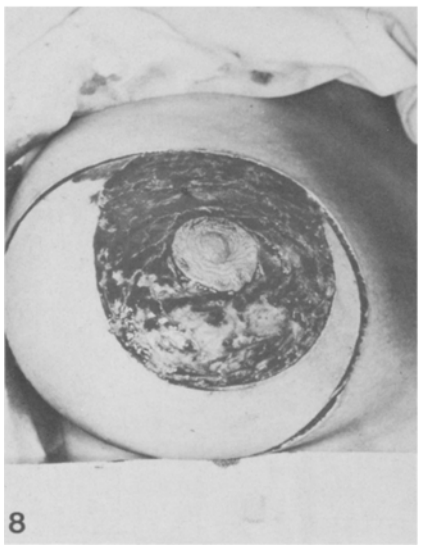


Fig. 5. Location of the new areola site in the actual Lassus mammoplasty. **Fig. 6.** Determination of a key point: B'. Drawing of the areolar flap. Drawing of the resection to be done. **Fig. 7.** Drawing on the patient. Details of the position of B'



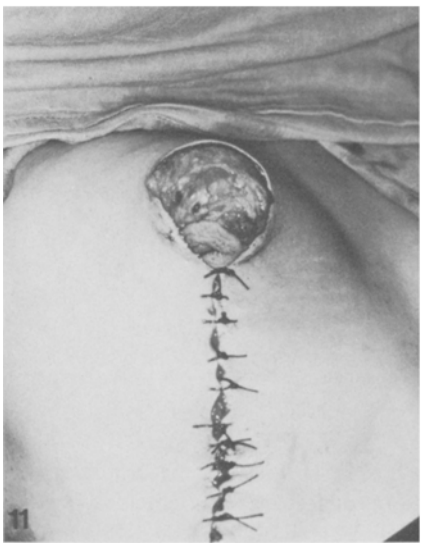


Fig. 8. Deepidermization of the nipple flap. **Fig. 9.** Resection "en bloc": skin, fat and gland. **Fig. 10.** Glandular lining underneath the flap. **Fig. 11.** The triangular skin resection to shorten the vetical scar. **Fig. 12.** The end of the operation

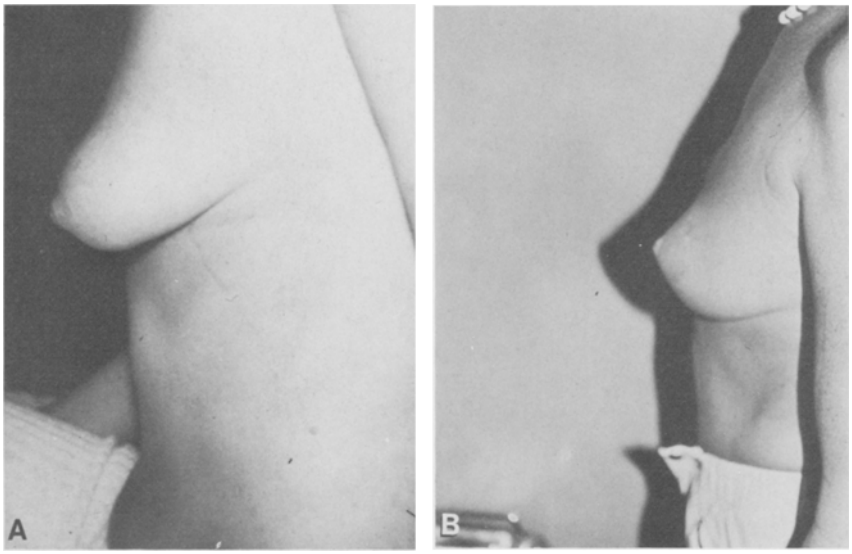


Fig. 13. (A) A single vertical scar for small ptotic breast (Class I) and (B) result 10 years after such a technique

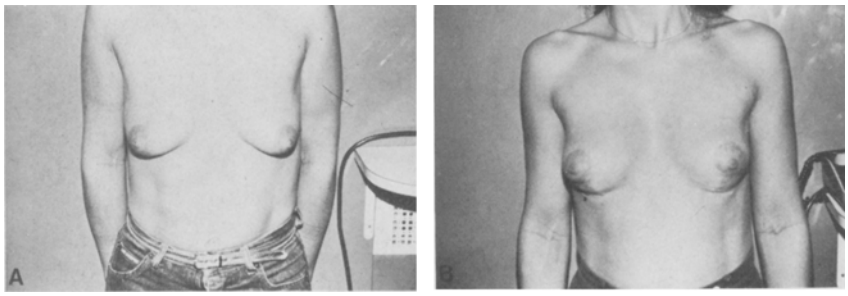


Fig. 14. Another result in a Class I

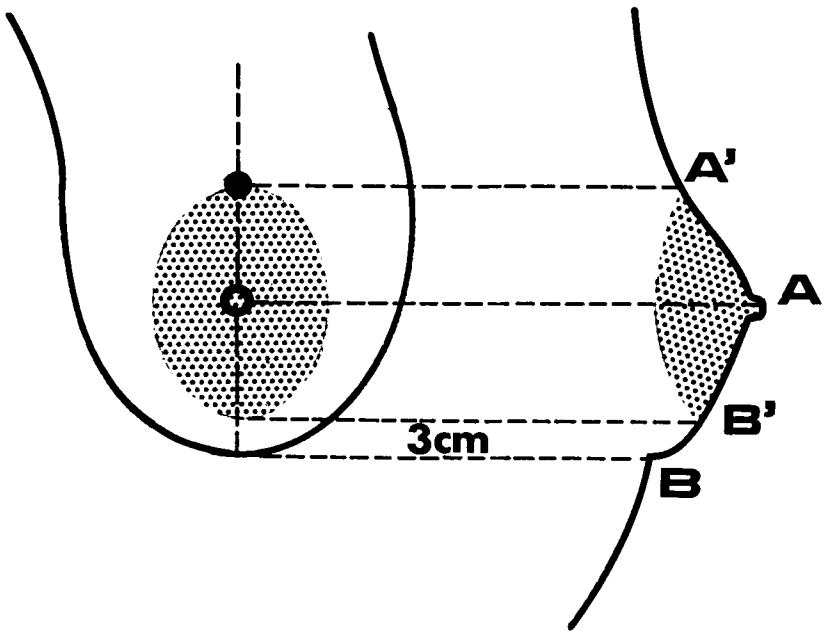


Fig. 15. Drawing of the technique for Class I breasts

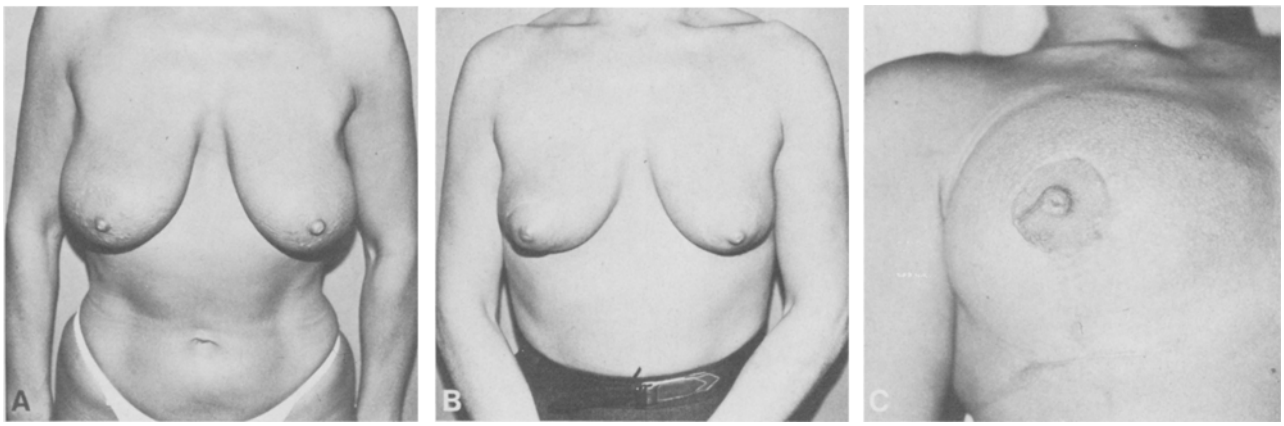


Fig. 16. Results in Class II breasts. (A) Before, (B, C) after

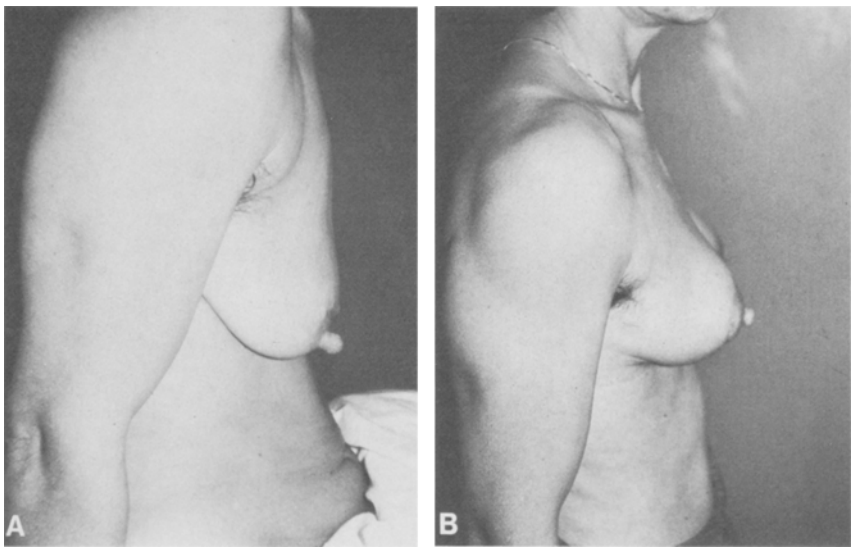


Fig. 17. Results in Class III breasts. (A) Before, (B) after

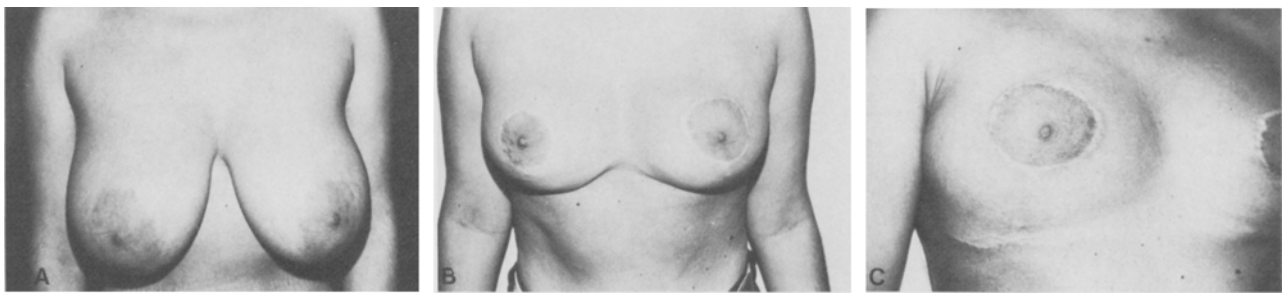


Fig. 18. Results in Class IV breasts. (A) Before, (B, C) after

out in an upward direction, sufficient to provide the desired final volume. Skin edges are approximated first by a few temporary interrupted sutures starting from B′ and working upward (Fig. 11). If the shape and size is satisfactory, the temporary sutures are removed and the skin edges approximated with buried inverting sutures of a nonabsorbable material.

To shorten the vertical scar and give a 5- or 6-centimeter length from the areola, a triangular skin excision is carried out at the lower end (Fig. 11).

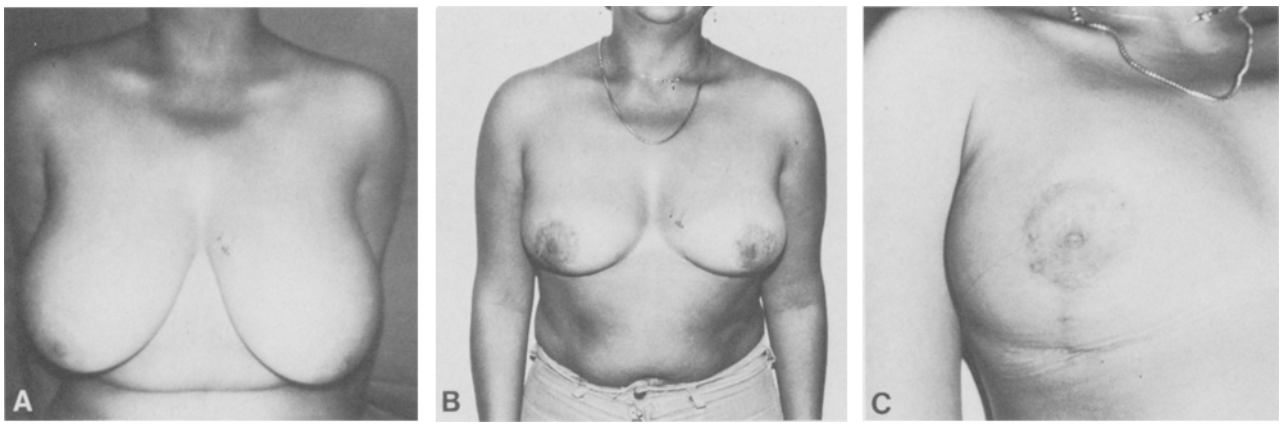


Fig. 19. Results in Class V breasts. (A) Before, (B, C) after

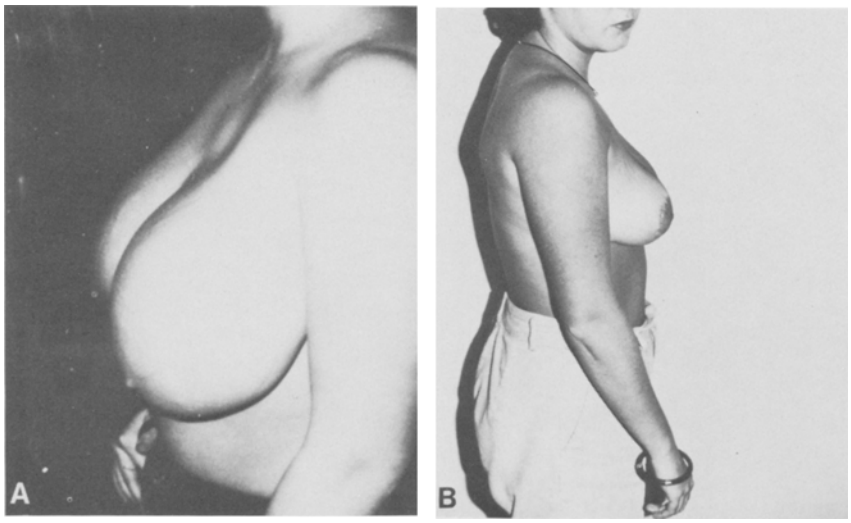


Fig. 20. Results in Class VI breasts. (A) Before, (B) after

The location of the new inframammary fold can be seen easily by pushing down with the hand on the superior part of the breast. This is better than measurement. The rest of the operation is routine. The wound is drained for 24 hours (Fig. 12).

Indications

This technique can solve the many different types of breast deformities. These different deformities can be classified as follows:

Class 1. Small breast plus mild degree of ptosis. Usually a single vertical scar, or at most a short horizontal one, is all that is left (Figs. 13, 14). In these cases there is no need to resect glandular tissue so the technique need not be modified. Points A′ and B′ are located as described except that B′ must be only a little above B, approximately 2 or 2.5 centimeters. The shape of the skin excision is more ellipsoid than circular (Fig. 15). When the deepithelization of the area has been carried out, the gland is undermined from the pectoral surface to allow it to be raised. The skin borders are then proximated as for a normal breast reduction.

Class 2. Normal volume plus moderate ptosis. A single vertical scar is all that is necessary but it may be easier to add a short horizontal scar (Fig. 16).

Class 3. Normal volume or moderate hypertrophy plus severe ptosis. Once again a vertical scar and a short horizontal one result from surgery but it is more difficult in these cases to keep the scarring above the brassiere line (Fig. 17).

Class 4. Average hypertrophy plus moderate ptosis. Once again the vertical scar and a short horizontal one are left (Fig. 18).

Class 5. Massive hypertrophy and severe ptosis. A vertical scar and a short horizontal scar result (Fig. 19).

Class 6. Gigantomasty. A vertical scar plus an acceptable horizontal one (Fig. 20).

Conclusion

In summary this technique is easy, safe, rapid, and can be used for all the different types of breast deformities. It requires a certain routine but does not need strict adherence to a fixed preoperative pattern and, much more important, is the aesthetic judgment and artistic feeling of the surgeon.

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