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Surgery for Gynecomastia

Bahman Teimourian, M.D. and Ronald Perlman, M.D.*

Washington, D.C.

Abstract. The surgical treatment for gynecomastia has had variations since 1538, when the first description of the surgical treatment was attributed to Paulus Aegineta. Since then, various incisions on and under the breast have been used. It has also been thought that when gynecomastia is severe, the excess skin should be removed along with the gland and fat. The technique for the correction of gynecomastia presented leaves minimal scar, allows access to the tumoral mass, and requires no skin excision.

Key words: Suction lipectomy — Large gynecomastia

Surgery for the correction of gynecomastia is indicated for patients who have an excessive preoccupation with their deformity, which is feminine in appearance. Gynecomastia is the most common breast disease in males, accounting for more than 65% of male breast tissue [6]. Other authors have reported even higher incidence, with the most common complaint being embarrassment, rather than pain and/or tenderness.

Review and General Considerations

In the past, surgical corrections of large gynecomastia have required the excision of both skin and glandular tissue [2, 7]. Many efforts used techniques originally designed for breast reduction on the female. The operative scar consisted of an inconspicuous periareolar portion, plus a more prominent lateral oblique or inverted T-component. Davidson has used the concentric circle approach to avoid the conspicuous scar [1]. This has also prevented the medial displacement of the nipple as seen with the lateral oblique approach.

Pitanguy described a transareolar incision with the formation of two small flaps of adipose or glandular tissue placed over one another during closure [5].

Letterman and Schurter described a superior semicircular, intra-areolar incision using a thick areolar flap. If epidermis were to be excised, it would be taken from the superior portion of the areolar in a semicircular fashion [3]. They later presented a technique for the correction of large gynecomastia which included an oblique incision with the nipple and areolar advanced upward and medially on a dermal pedicle, once again excising skin [4].

Simon et al. [6] felt that with large gynecomastia, unless an excision of skin was performed, the results were unsatisfactory. These authors agreed with Letterman and Schurter that if skin had to be removed, a superior crescent skin excision should be employed. Wray et al. [8] described a technique for the correction of gynecomastia utilizing a crescent transverse skin incision and free nipple transplantation. This procedure was used on patients in whom excess skin and subcutaneous tissue, in addition to breast tissue, had to be removed.

A new procedure for the correction of large gynecomastia has been devised incorporating the suction technique. As described above, the objectives are minimal scarring, good contour, flaps with adequate blood supply, and a nipple in the normal anatomical position.

Technique

Surgery is done under general anesthesia. Prior to the incision, 0.25% Marcaine with epinephrine is locally infiltrated in the subcutaneous plane throughout each breast. An intra-areolar incision is

Address reprint requests to Bahman Teimourian, M.D., 11125 Rockville Pike, Rockville, MD 20852
*Dr. Perlman is serving his residency.

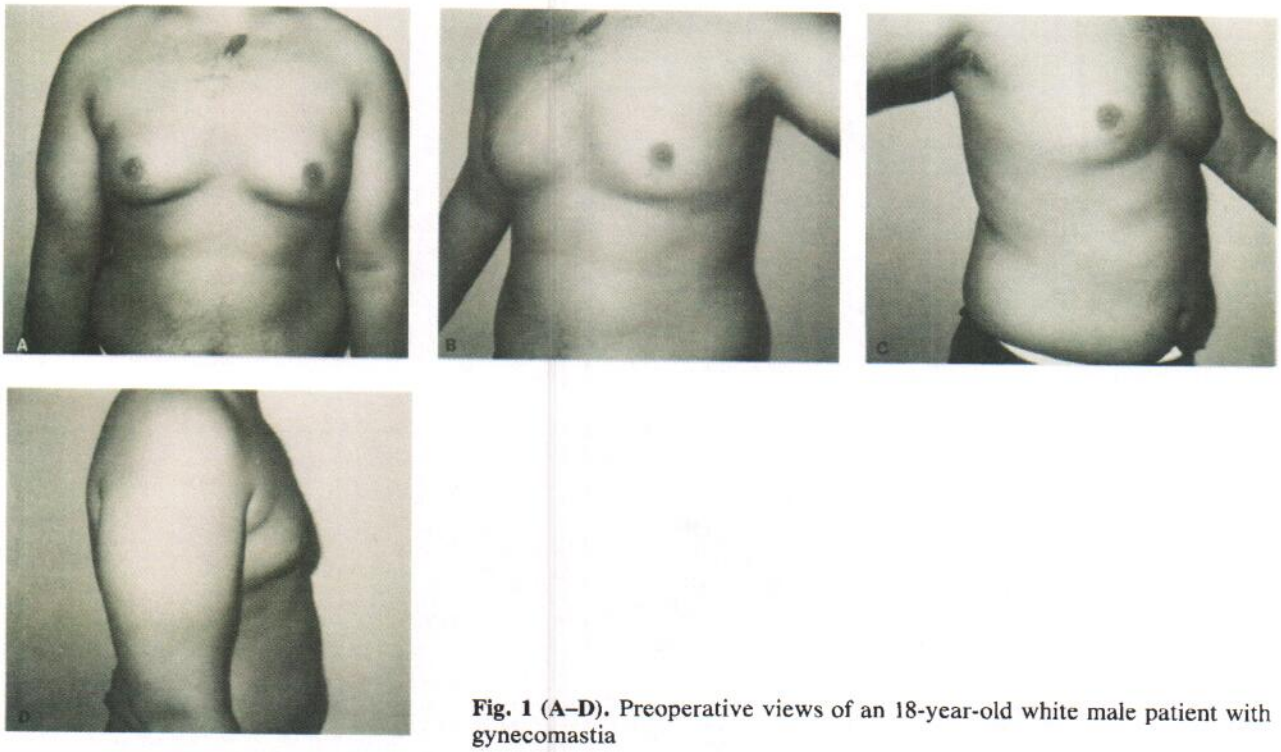

Fig. 1 (A–D). Preoperative views of an 18-year-old white male patient with gynecomastia

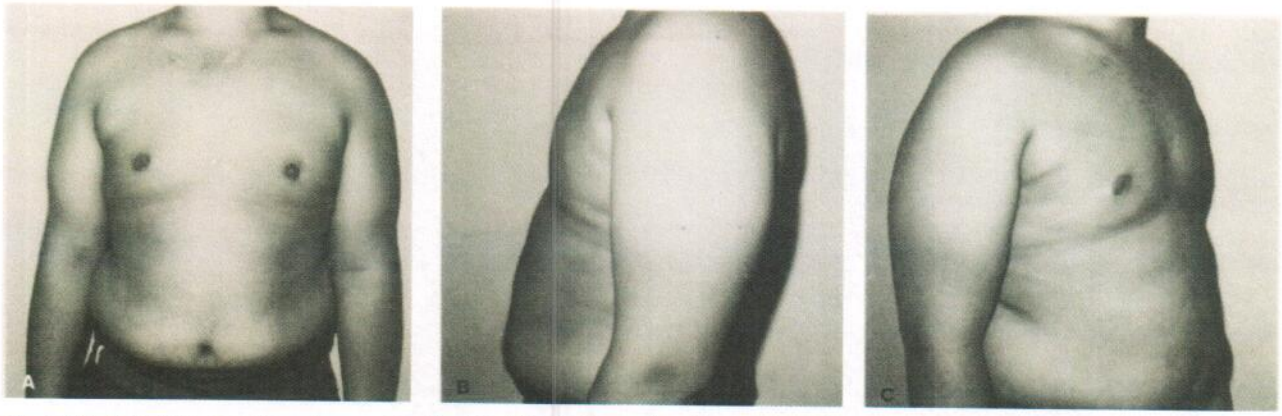

Fig. 2 (A–C). Postoperative views of patient in Fig. 1 6 months after undergoing surgical correction of gynecomastia

made in a crescent shape from the nipple to the 6 o'clock position through skin and dermis. A small skin flap is developed with sharp dissection. With a no. 8–mm plastic vacuum curette, the breast and surrounding fatty tissue are suctioned in a contouring fashion. Laterally, the catheter reaches over the serratus-pectoralis junction, superiorly to the clavicle, medially to the sternum overlying the rectus abdominus muscle, and inferiorly over the seventh rib.

Once this process is completed, the breast tissue beneath the nipple-areolar complex, including a 2–3-cm radius from the areolar, is removed by sharp dissection in a donut fashion. A small amount of fat is left beneath the areolar complex to prevent a depression. The wounds are all irrigated and a Jackson-Pratt drain is left in place. The wound is closed in 2 layers. Throughout the procedure, minimal bleeding is encountered.

Figure 1 shows an 18-year-old white male preoperatively who subsequently underwent reduction of the gynecomastia by the suction technique. Figure 2 shows several postoperative views at 6 months. No excision of skin was performed; 275 cc of fat were removed from each breast in addition to the donut excision of breast tissue.