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DISCLOSURE

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Gynecomastia: Tips and Tricks—Classification and Surgical Approach

Sir:

Gynecomastia continues to challenge plastic surgeons. Nahabedian reviews the breast deformities

to provide a better understanding of the current available data. The state of the art is centered on gland and fat removal by liposuction and its derivatives.^{1,2}

We suggest that it is important to keep in mind the reconstruction of an athletic appearance to obtain a virile chest, with the trapezoidal shape (larger side on the top), the nipple-areola complex adherent to the pectoral muscle, and downward orientation. We propose a new approach that classifies gynecomastia (Table 1) considering the volume excess but also the shape of the chest, and describe here how we treat gynecomastia, including our tips and tricks.

We evaluate the patient by pinching the fat on the breast with the patient in the standing position. Then, he contracts the muscles to enhance the sternal notch and the pectoral muscle borders that we have drawn. The new inframammary fold is designed close to the areola (0 to 3 mm).

We perform mastectomy through an areolar single-puncture incision at the 6-o'clock position, excising the

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Table 1. Classification of Gynecomastia

Classification	Clinical Features	Treatment Options
Grade I, minimal hypertrophy (<250 g)		
IA	Primarily fatty breast tissue	SAL/ML; SM by single puncture incision; nipple reorientation (downward) if IC; chest virilization (trapezoidal shape and sternal notch in evidence) if ID/IE
IB	Primarily fibrous breast tissue	
IC	Nipple malposition (upright)	
ID	Gynoid (rounded) shape of the chest	
IE	Absence of sternal notch	
Grade II, moderate hypertrophy (250–500 g)		
IIA	Primarily fatty breast tissue	SAL/ML; SM by single puncture incision; nipple reorientation (downward) if IIC; chest virilization if IID/IIIE
IIB	Primarily fibrous breast tissue with peripheral fat	
IIC	Nipple malposition (upright or upward)	
IID	Moderate gynoid shape of the chest	
IIIE	Absence of sternal notch	
Grade III, severe hypertrophy with grade I ptosis (>500 g)		
IIIA	Fatty and fibrous tissue with ptosis of grade I	SAL/ML; SM by single puncture incision; periareolar NAC transposition if required; nipple reorientation if IIIB; chest virilization if IIIC/IIID
IIIB	Nipple malposition (upright or upward)	
IIIC	Severe gynoid shape of the chest	
IIID	Absence of sternal notch	
Grade IV, severe hypertrophy with grade II or III ptosis (>500–700 g)		
IVA	Fatty and fibrous tissue with ptosis of grade II	SAL/ML; SM by periareolar incision with NAC transposition; chest virilization with nipple reorientation
IVB	Fatty and fibrous tissue with ptosis of grade III	
IVC	Nipple malposition (upright or upward)	
IVD	Severe gynoid shape of the chest	
IVE	Absence of sternal notch	

SAL, suction-assisted lipectomy; ML, manual liposuction; SM, subcutaneous mastectomy; NAC, nipple-areola complex.



Fig. 1. Preoperative (*left*) and postoperative (*right*) photographs showing (*above*) grade III and (*below*) grade IV gynecomastia. (*Above*) This patient underwent subcutaneous mastectomy by a single puncture incision and two-step liposuction with nipple reorientation (downward) and chest virilization (trapezoidal shape and sternal notch in evidence); contextually, he underwent delineation of the abdominal musculature. (*Below*) This patient underwent subcutaneous mastectomy by periareolar incision with nipple-areola complex transposition and two-step liposuction with nipple reorientation and chest virilization; contextually, he underwent abdominoplasty.

gland in strips, which leaves an imperceptible scar³ (grade I to III) (Fig. 1, *above*) or periareolar subcutaneous mastectomy in grade IV (Fig. 1, *below*). Any residual gland is removed, avoiding unaesthetic projection of the areola.

Liposuction is performed in two steps. First, careful liposuction removes the adipose tissue, ensuring skin adhesion to the muscular plane. Second, powerful liposuction is performed with basket/accelerator canulas at the pectoral borders, and at the sternal notch to emphasize the medial insertions. Residual adipose tissue homogenization by cannula avoids irregularity of the treated areas.

Twenty-four patients were recruited for this study. Seven were classified as type 1, 12 were classified as type 2, four were classified as type 3, and one was classified as type 4. Patients themselves evaluated the cosmetic appearance, based on a scale of 1 (excellent) to 4 (unsatisfactory). All patients achieved a major improvement (Fig. 1) and 91.6 percent of the patients evaluated their chest as excellent.

Traditional liposuction cannot accomplish the higher aesthetic goals imposed by modern standards of beauty, nor can it create a virile chest if one does not plan to correct the gynoid rounded shape, the



Video Available Online

Video. Supplemental Digital Content 1 shows an intraoperative view of selective liposuction, <http://links.lww.com/PRS/A722>.

nipple malposition and its forward projection, the gynoid inframammary fold, and the absence of mid-sternal insertions. We perform a liposuction procedure that closes the skin to the muscle and sculpts the borders of the pectoralis muscle, creating an obtuse angle (between the axilla pillar and the new inframammary fold) that emphasizes the trapezoidal shape (see **Video, Supplemental Digital Content 1**, which shows an intraoperative view of selective liposuction, <http://links.lww.com/PRS/A722>) and a new inframammary fold near the areola to redefine nipple downward oriented.

Mentz et al. first design the pectoral etching for the delineation of the thoracic musculature in men without gynecomastia that desire an athletic appearance or for body builders.⁴ These authors state that to augment muscle bulk appearance, fat over the pectoralis muscle may be two to three times thicker than the etched perimeters. We reduce fat over the muscle at the minimum closing the skin to the muscle and avoiding nipple and upper pole projection. We believe that a sculpted thorax should resemble not “a three-dimensional Roman breast-plate”⁴ but the “warrior who wore it” like the classical male breast sculptures.

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Tweeting All Surgeons: Update Your Facebook Status, Enhance Your Reputation, and “Pin” Your Practice on the Wild, Wild Web

Sir:

Businesses, professional organizations, researchers, and educators use social networking sites such as Facebook and Twitter to achieve their respective goals (Figs. 1 and 2). In addition, patients use social media to find medical information and search for health care providers. Using Facebook as an example, we outline how the individual plastic surgeon can use social media to enhance his or her practice in an efficient and unique manner.

Step 1: The potential uses for Facebook are endless. A social media campaign developed by the University of Wisconsin’s Division of Transplantation accumulated 5000 Facebook group members in 18 months, resulting in 9000 new registrations for organ donation—a 28 percent increase in the target age group.¹ A Taiwanese emergency medicine physician’s Facebook page acquired so many followers that the Taiwanese Minister of Health “vowed to spend more resources ... to improve emergency room overcrowding and quality of care.”² In March of 2012, this *Journal* featured an editorial emphasizing how social media allow *Plastic and Reconstructive Surgery* to engage with plastic surgeons, nurses, and the general public on a global scale.³ Facebook has also been used to increase participant retention in longitudinal research, by nongovernmental organizations to promote disease awareness, and for information exchange by residency programs and professional societies.^{4–6}

Step 2: Plastic surgeons should embrace social media as a form of personal branding that can establish their online identity. Facebook facilitates increased “face time” with patients, provides information about the surgeon’s breadth of services, and helps surgeons protect their reputations. In an age of consumer satisfaction and the inevitability of (at least a few) negative online reviews, “positive press” is essential.

Step 3: Use social strategies. Marketing principles used on standard informational Web sites, so-called digital strategies, are a one-way form of communication and generally are not successful on social networking sites. Piskorski studied over 60 companies