

Strattice for the repair of bottoming out and rippling

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Patient history

Patient is a 42-year old, 5-foot 6-inch, 120-pound, white female with no significant medical history. In 1996, she underwent bilateral augmentation mammoplasty with saline implants. The implants were placed subglandularly via an inframammary incision. A few years later, she experienced bilateral capsular contracture. In 2007, she consulted with another surgeon who replaced her saline implants with silicone implants (Allergan Style 15, 457 cc).

Presentation

In February 2008, patient presented at the author's practice for an initial consultation. Her complaints at presentation were breast droopiness, emptiness in the upper pole of the breast, and waviness of the implant. Breast examination revealed bilateral implant wrinkling/rippling at the superior pole and bilateral bottoming out due to inadequate inferior pole support (Figure 1).

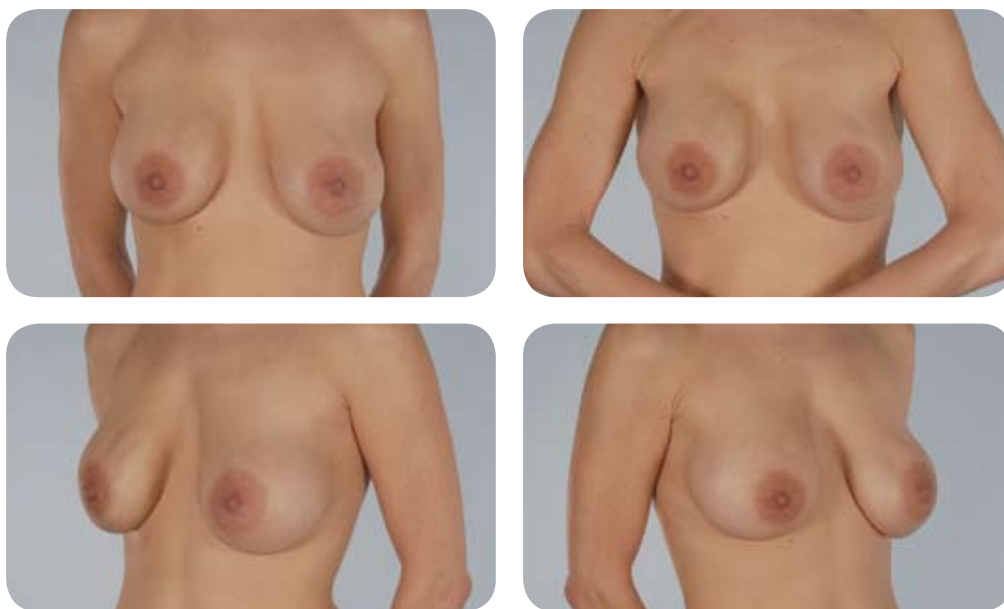


Fig 1 Preoperative stage. Note: Bilateral implant rippling/wrinkling at superior pole of breasts and bilateral bottoming out of breasts. Bottoming out of the left breast was more pronounced than that of the right breast.

Strattice® for the repair of bottoming out and rippling

Management plan

Bilateral mastopexy with conversion to a dual-plane placement of implants and the use of Strattice at the inferior pole for implant support were recommended for this patient. It was decided that the patient's current silicone implants were to be retained.

Repair

Preoperatively, the patient's midline, inframammary fold (IMF) and planned periareolar skin excision were marked. The desired nipple to fold distance was measured and marked (Figure 2).

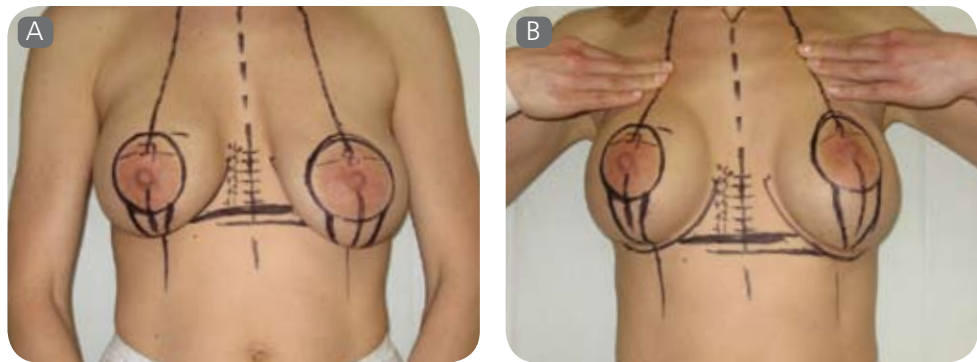


Fig 2 Preoperative markings. A: The incision site, desired nipple location, and current inframammary fold positions are marked. B: The desired inframammary fold position is shown in this view.

Intraoperatively, the marked periareolar skin was de-epithelialized. Next, an appropriately sized piece of Strattice was chosen, based on the inferolateral arc length of the breasts. In this case, an 8 x 16cm piece of Strattice was divided into two 4 x 16cm triangular pieces, one for each breast (Figure 3).

Fig 3 Preparation of Strattice for intraoperative use. An 8 x 16cm piece of Strattice was divided into two 4 x 16cm triangular pieces. Each triangular piece was to be used for inferolateral support of the implant.



An incision was made from the nipple to the fold and the implant was removed. (Figure 4A). The pectoralis major muscle (PMM) was released inferolaterally and elevated off the chest wall. A new implant pocket was also dissected between the capsule and the breast. The Strattice was placed at the IMF and its inferior border was sutured to the chest wall inferolaterally, using 3-0 running PDS sutures, to define the IMF and lateral border of the breast (Figure 4B). The implant was then reintroduced into the pocket. The inferior border of the PMM was brought over the implant and sutured to the superior border of the Strattice. A circumvertical mastopexy was then performed and the incision closed in anatomical layers (Figure 5A). The above procedure was repeated on the contralateral breast. A smooth 10FR BLAKE® drain was inserted into each breast (Figure 5B). The patient was discharged on the same day and was prescribed a 5-day course of DURICEF®.

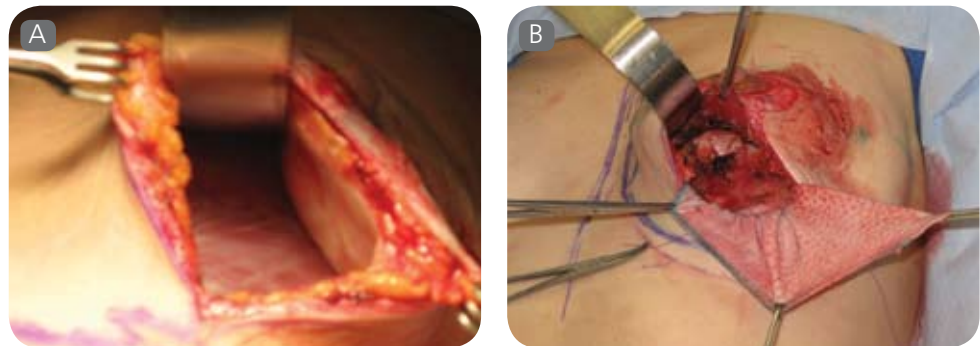


Fig 4 Intraoperative stage. A: Periareolar to fold incision. B: Strattice was sutured to the inframammary fold prior to implant reintroduction.

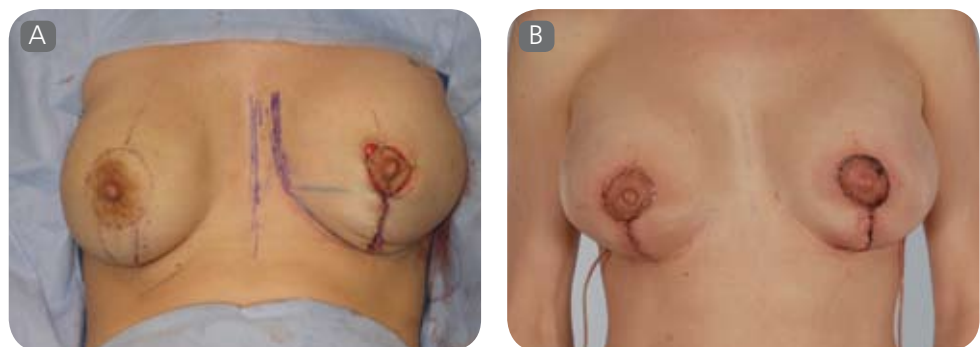


Fig 5 Immediate perioperative stage. A: Completion of repair of left breast. B: Postoperative Day 1.

Outcome

The patient experienced no perioperative or postoperative complications during a 3-month follow-up period. Both surgeon and patient were very pleased with the outcome (Figure 6). The patient continues to be followed.

Conclusion

The subpectoral placement of implants together with the use of Strattice at the inferolateral pole of the breasts provided the support needed to hold the implants in the pockets and correct bottoming out in this patient, with excellent results.

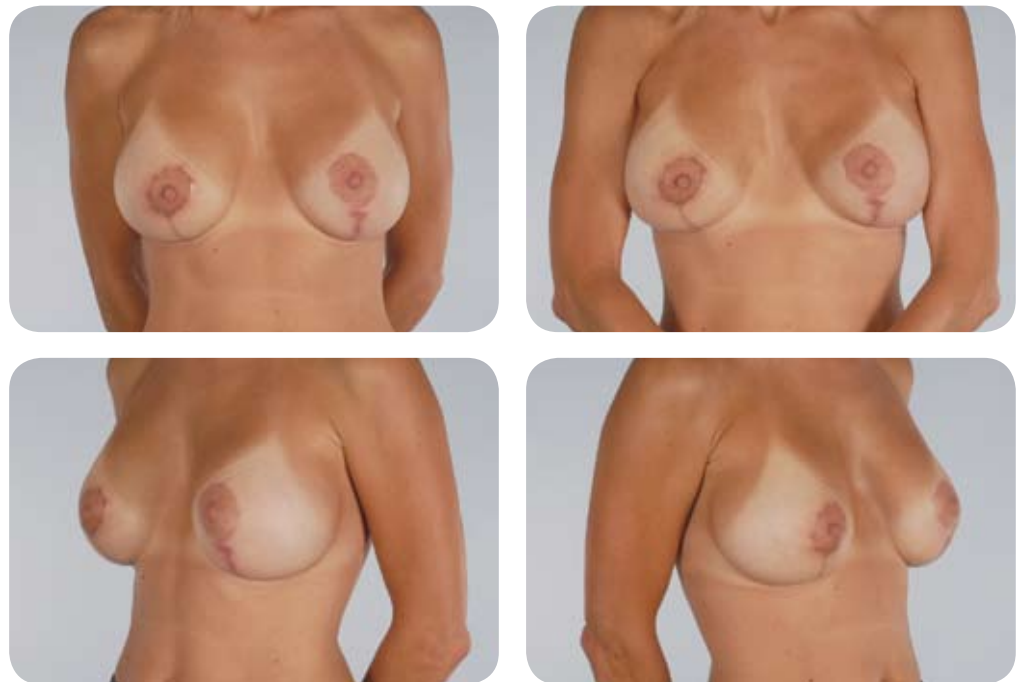


Fig 6 Postoperative stage at 3 months of follow-up. Note: Good symmetry between the breasts with nipples centered on the breasts and the absence of wrinkling/rippling on the superior poles.

Many variables including patient pathology, anatomy and surgical techniques may influence procedural outcomes. Before use, surgeons should review all risk information, which can be found in the "Instructions for Use" attached to the packaging of each LifeCell Tissue Matrix.

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