The Question: Liposuction excision of gynecomastia through an axillary liposuction opening: a novel technique: poor control of bleeding?

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Received 07 December 2015
Accepted 09 December 2015

The Egyptian Journal of Surgery
2016, 35:77–78

Egyptian J Surgery 35:77–78

1110-1121

We read the article 'Liposuction excision of gynecomastia through an axillary liposuction opening: a novel technique' [1] published in your reputed journal with interest. We must congratulate the author for a commendable and innovative approach. However, we have few reservations and comments to make with regard to the approach.

First, the author excludes Simon's [2] grade III from this approach and he does not mention its management. Moreover, he does not justify the exclusion, which becomes a major limitation of the technique. How were the patients with grade III gynecomastia managed? Second, the author's apprehension about the chances of hematoma and the need for a direct approach (periareolar incision) for hemostasis is evident at the level of obtaining patient's consent. Previously published data [3] suggest that routine closed-suction drainage after gynecomastia surgery is unnecessary, and it may be appropriate to omit drains after gynecomastia surgery; however, the author uses 16- or 18-Fr drain routinely, which suggests that the control of bleeding in this indirect excision technique is poor. Third, the author waits for natural hemostasis to occur when operating on the opposite breast, but does not have any means of controlling active bleeding. Hematoma ranging from 50 to 180 ml in four patients despite the use of large suction drains (16–18 Fr) clearly suggests poor control of bleeding. Finally, as this technique is blind, indirect, and utilizes a distant approach from the operative site, there is definite chance of residual gland being left in the cavity, resulting in contour abnormality; this is evident in the postoperative picture (i.e. Fig. 1).

References

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The Answer from Dr. Hady Abou Ashour:

Dear Sir, thank you for your interest in the article; I graciously accept your congratulation. It gives me immense pleasure to interpret your queries. Although most of them were clearly covered throughout the paper discussion, I would like to quote from the text in the article (in italic) to answer some questions and write answers for the rest of your queries.

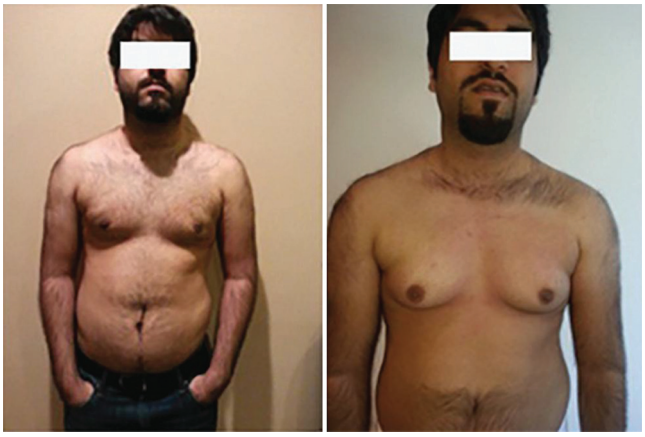
The first query: the exclusion of Simon's grade III in the study.

Patient and methods: All grades of gynecomastia were included in this study except those of Simon's grade III.

Simon's grade III of course has a separate entity of treatment due to the redundancy, which does not yield to the normal skin recoil after breast stroma excision. This means that reduction mammoplasty techniques are required to remove concomitant skin excess (look references below).

 DOI: 10.4103/1110-1121.176832

Figure 1



Preoperative and postoperative photo.

One more benefit of our single far approach is that some enlarged male breasts could not be accurately judged clinically to be either true or pseudogynecomastia. This situation was encountered in about 24 patients (16.78%). Therefore, liposuction only was sufficient for such cases, with no further need for any other incisions. This means that incision at the periareolar region is of no benefit in case of pseudogynecomastia and can cost the patient another unwanted scar with potential unexpected wound complications.

The second and third question: Most of the patients do not bleed after proper liposuction; we also excised the connecting terminal trabecula and unnamed vessels, which collapsed due to excess liposuction, and managed bleeding with the use of epinephrine with subsequent bandage. Inserting of drains is a conservative mean to drain acceptable amount of blood.

(Paper text) Together with application of tight elastic bandage, the use of epinephrine-containing tumescent fluid minimized the operative and postoperative bleeding.

The fourth question: Any irregularity in Simon's grade I and II is temporary and the skin recoils over time. By proper palpation of the breast, one can pick and excise any glandular remnant using both liposuction and scissors. The healing and recoil correct the contour over time.

NB: The following authors did not use direct hemostasis during their excision techniques; some of them used two openings unlike us, we used single opening. This means that gynecomastia bleeding is lesser in correct excision plane (look at the paper text).

(Introduction) Lista and Ahmad (19) (2008) referred to the use of the pull-through technique in association with PAL.

(Introduction) In 2010, Petty *et al*. (35) reported their experience with UAL and the arthroscopic shaver to resect the subareolar fibrous component.

(Introduction) In 2010, O Qutob (20) reported a case series of 36 patients undergoing vacuum mammotome resection of gynecomastia through one opening and liposuction through the other opening.

(Introduction) Paolo Morselli *et al*. (2012) (36) reported their 15 years of experience in the pull-through technique, with satisfying results, but again they used two incisions – one in the inframammary fold and the other one behind the anterior axillary line.

19. Lista and Ahmad [2008] referred to the use pullthrough technique in association with power-assisted liposuction (PAL) Plast Reconstr Surg 2008; 121:740–747.
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Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

References for surgery to Simons type III:

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