

Tubular Breast Deformity



Mr Roy Ng is a consultant plastic surgeon at Guy's and St Thomas' Hospitals NHS Trust, and at London Bridge Hospital. He has extensive experience in reconstructive and aesthetic surgery of the breast, including postmastectomy, developmental and postpregnancy deformities. He has a particular interest in the developmental problem of Tubular Breasts. Here, he describes the condition and approaches to its management.

The diagnosis of Tubular Breast Deformity can go unrecognised by patients and some doctors, with the condition simply assumed to be 'small' breasts. However, it is a specific developmental abnormality that can cause great distress to the individual and impact greatly on their psychosocial functioning.

The characteristic features of this deformity are a narrow breast base associated with a large and herniated nipple-areola complex. As a consequence, the shape of the breast resembles more a 'tube' than a mound. Other terms that have been applied to this condition include 'tuberous breast', 'constricted breast' and even 'Snoopy breast deformity'. There is a spectrum of severity, and one proposed classification by Heimburg et al¹ is illustrated in Figure 1.

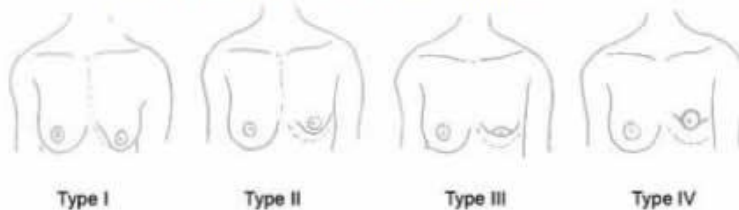


Figure 1. Classification of Tuberous Breast Deformity

Counselling and Treatment

Patients with Tubular Breast Deformity are often extremely self-conscious at the time of examination, and must be handled with great sensitivity and patience. They are often relieved when informed that there is a specific diagnosis, and overjoyed when informed that effective treatment is possible.

The deformity is readily corrected surgically. By means of a periareolar incision, the breast base is widened, volume is increased by insertion of a breast implant, and the nipple-areola herniation is corrected by a 'doughnut' mastopexy. The scars are confined to the areolar border and therefore quite inconspicuous (Figure 2).



Figure 2. Preoperative and postoperative photographs of a patient with Bilateral Tubular Breast Deformity, left more severe than the right.

References

¹Heimburg v.D., Exner K., Kruft S. and Lemperle G. The Tuberous Breast Deformity: Classification and Treatment. *British Journal of Plastic Surgery*. (1996), 49, 339-345.

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New technique for operation of Cholecystectomy

Mr Marshall, a laparoscopic and Upper GI surgeon, who has been with Newham University Hospital NHS Trust for three years, has pioneered a new technique for Cholecystectomy operations over the last 18 months. An honorary Consultant Surgeon with Bart's and London Trust, and Honorary Senior Lecturer at the Institute of Cancer at Charterhouse Square, Mr Marshall has recently joined the London Bridge Hospital and will be offering this procedure to patients who require a Cholecystectomy.



The technique employs an ultrasonic dissector (or Harmonic scalpel) as the sole instrument for dissection and sealing of the cystic artery and duct. The operation is performed in a retrograde, or fundus first, manner which enhances the display of the anatomy and allows the surgeon to see the operative field more clearly. The use of the Harmonic scalpel eliminates the need for electrocautery in this operation; which is a further benefit to the patient because of the concerns regarding inadvertent injury to abdominal structures and 'smoke' production. The technique enables more than 90% of patients who have undergone this type of Cholecystectomy, to go home the same day as their surgery. As a result of this rapid recovery, the technique has been selected for presentation at three International meetings over the last 12 months. This unique operative technique has

significantly improved the recovery period and improved the patients' experiences during this historically unpleasant procedure. Mr Marshall is an experienced laparoscopic surgeon; using this dynamic technique for hernia repairs, both inguinal and incisional, surgery for reflux disease, bowel surgery and obesity treatment.

The Department of Health has picked up on this technique and is looking to use it as the standard for 'best practice' for Cholecystectomy surgery.

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Mr Marshall