



GUIDELINES

Letters to the Editor, discussing material recently published in the *Journal*, are welcome. They will have the best chance of acceptance if they are received within 8 weeks of an article's publication. Letters to the Editor may be published with a response from the authors of the article being discussed.

Discussions beyond the initial letter and response will not be published. Letters submitted pertaining to published Discussions of articles will not be printed. Letters to the Editor are not usually peer reviewed, but the *Journal* may invite replies from the authors of the original publication. All Letters are published at the discretion of the Editor.

Letters submitted should pose a specific question that clarifies a point that either was not made in the article or was unclear, and therefore a response from the corresponding author of the article is requested.

Authors will be listed in the order in which they appear in the submission. Letters should be submitted electronically via PRS' *en*kwel, at www.editorialmanager.com/prs/.

We reserve the right to edit Letters to meet requirements of space and format. Any financial interests relevant to the content of the correspondence must be disclosed. Submission of a Letter constitutes permission for the American Society of Plastic Surgeons and its licensees and assignees to publish it in the *Journal* and in any other form or medium.

The views, opinions, and conclusions expressed in the Letters to the Editor represent the personal opinions of the individual writers and not those of the publisher, the Editorial Board, or the sponsors of the *Journal*. Any stated views, opinions, and conclusions do not reflect the policy of any of the sponsoring organizations or of the institutions with which the writer is affiliated, and the publisher, the Editorial Board, and the sponsoring organizations assume no responsibility for the content of such correspondence.

The *Journal* requests that individuals submit no more than five (5) letters to *Plastic and Reconstructive Surgery* in a calendar year.

Letters

Prophylactic Nipple-Sparing Mastectomy and Direct-to-Implant Reconstruction of the Large and Ptotic Breast: Is Preshaping of the Challenging Breast a Key to Success?

Sir:

We had the great pleasure of reading the interesting article by Gunnarsson et al. entitled "Prophylactic Nipple-Sparing Mastectomy and Direct-to-Implant Reconstruction of the Large and Ptotic Breast: Is Preshaping of the Challenging Breast a Key to Success?"¹ and we congratulate the authors on their method of dealing with risk-reducing mastectomy and immediate implant-based breast reconstruction in large and ptotic breasts. Reconstructive procedures are extremely challenging and require great ability to handle volume and symmetry, especially in large



Fig. 1. Preoperative markings for a 39-year-old patient who underwent prophylactic skin-reducing mastectomy and direct-to-implant breast reconstruction with full-projected implants.



Fig. 2. Postoperative photograph 12 months after surgery.

and ptotic breasts. This technique could be an alternative method for patients requiring prophylactic mastectomy, even if patients have to undergo double surgery.

We would like to know whether patients mind undergoing first mastopexy or reduction mammoplasty to reach a successful direct-to-implant breast reconstruction after nipple-sparing mastectomy. We have to consider that these patients are healthy, without cancer, and faced with a double operation to have a satisfactory result. We also have to take into account the cost of this dual procedure and the psychological stress to which we subject these patients.

Copyright © 2018 by the American Society of Plastic Surgeons

This procedure seems to be without significant complications and patients are selected carefully. In fact, no major risk factors are present, and smokers are required to quit smoking 6 weeks before and after surgery to reduce the complication rate. We would like to know whether the authors experienced any case of nipple malposition after nipple-sparing mastectomy and what percentage. Choi et al.² recently published their study concerning nipple-areola complex malposition following nipple-sparing mastectomy and reported that 7.4 percent of patients had undergone nipple-areola complex repositioning and only 6.5 percent of nipple-sparing mastectomies had been undergone before breast reduction or mastopexy. Nearly 8 percent of the nipple-areola complex repositioning group had a remote prior breast reduction or mastopexy procedure.

In our unit, we are accustomed to performing skin-reducing mastectomy³ and immediate implant-based breast reconstruction in women with large and ptotic breasts. The skin-reducing mastectomy follows the mastopexy/reduction pattern with an inverted-T scar. When the nipple-areola complex has to be lifted up less than 3 cm, a superior dermal pedicle flap is planned. A bipedicle dermal flap supplying the nipple-areola complex or nipple graft is preferred if the nipple-areola complex lift is greater than 3 cm. This reliable one-stage direct-to-implant breast reconstruction technique is suitable not only for prophylactic but also for therapeutic mastectomies and is associated with good cosmetic outcomes and high patient satisfaction in only a single operation (Figs. 1 and 2). The authors are to be commended for describing a further method that enlarges the number of reconstructive strategies for large/ptotic-breasted patients requiring prophylactic mastectomy and implant-based breast reconstruction.

DOI: 10.1097/PRS.0000000000004381.

Stefano Bonomi, M.D.

Laura Sala, M.D.

Umberto Cortinovis, M.D.

Department of Plastic Reconstructive Surgery
Fondazione IRCCS Istituto Nazionale dei Tumori
Milano, Italy

Correspondence to Dr. Bonomi
Department of Plastic Reconstructive Surgery
Fondazione IRCCS Istituto Nazionale dei Tumori
Via G. Venezian 1
20133 Milano, Italy
stefano.bonomi@istitutotumori.mi.it

DISCLOSURE

The authors have no financial interest to declare in relation to the content of their communication.

REFERENCES

1. Gunnarsson GL, Bille C, Reitsma LC, Wamberg P, Thomsen JB. Prophylactic nipple-sparing mastectomy and direct-

to-implant reconstruction of the large and ptotic breast: Is preshaping of the challenging breast a key to success? *Plast Reconstr Surg*. 2017;140:449–454.

2. Choi M, Frey JD, Salibian AA, Karp NS. Nipple-areola complex malposition in nipple-sparing mastectomy: A review of risk factors and corrective techniques from greater than 1000 reconstructions. *Plast Reconstr Surg*. 2017;140:247e–257e.
3. Nava MB, Cortinovis U, Querci della Rovere G, et al. Skin-reducing mastectomy. *Plast Reconstr Surg*. 2006; 118: 603–610; discussion 611–613.

Reply: Prophylactic Nipple-Sparing Mastectomy and Direct-to-Implant Reconstruction of the Large and Ptotic Breast: Is Preshaping of the Challenging Breast a Key to Success?

Sir:

We thank Dr. Bonomi et al. for their kind comments regarding our article.¹ To answer their first question in brief, our patients do not mind the two separate procedures. They are well informed that the aim of the two-stage procedure is to reduce and remodel the size and shape of their breasts and relocate the nipple-areola complex in the context of the footprint. It is our experience that the two-stage procedure is safer in terms of risks of complications such as skin and nipple necrosis. We believe one of the reasons is that the subsequent mastectomy is technically easier to perform and flap vascularity is primed following the preshaping of the breast.

In Scandinavia, we are fortunate to have a public health care system, which allows us to perform a two-stage approach without any additional patient costs, if it is considered to be beneficial in terms of safety and surgical outcome. We presume that it facilitates the patient's willingness to have a preshaping procedure before complete nipple-sparing mastectomy and direct-to-implant reconstruction.

We have experience using a Wise pattern skin design and a one-stage reconstruction with a deepithelialized inferior flap with somewhat promising results. However, oncoplastic collaboration at our institutes means that mastectomy and reconstruction are provided by different consultants and variations in skin flap quality. We were unhappy with the lack of consistency in the one-stage approach, especially in terms of nipple-sparing mastectomy survival; the only parameter that we could affect was making the breast more optimal for the inevitable mastectomy. A two-stage procedure enabled us to shape the breast (facilitating the subsequent mastectomy) and to achieve more reliable overall results.

Perhaps the most important message of our article is not the method but the finding—from what appears clear from our point of view—that previous scar in a nonirradiated breast does not compromise skin flap vascularity during mastectomy, and that preshaping appears to prime the flaps for the subsequent change in blood supply. This means that we do not have greater concerns with offering nipple-sparing mastectomy to