A technique for minimising the redundant skin of a mastectomy scar and improving cosmesis for delayed reconstruction

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BACKGROUND

Redundant skin at both ends of the scar is a recurring problem with mastectomies ('dog ear' deformity). We describe an incision that helps minimise this unsightly excess skin and provides a better skin flap for any potential delayed breast reconstruction. This technique is indicated for any mastectomy where a reconstruction is likely or the dog-ear deformity is anticipated (eg large, pendulous breasts or a high body mass index). Superior tumours close to the skin are a contraindication.

TECHNIQUE

The landmarks of the scar comprise the midline, the inframammary fold and the posterior axillary line. Start and end points for both curves are marked on the medial corner of the breast, as is the point where the infra-mammary fold line crosses the posterior axillary line. Two

Figure 2 Anterolateral view of scar markings showing direction change in the lateral aspect allowing for elimination of excess skin

Figure 1 Anterior view of scar markings showing the curve lines and skin island

Figure 3 A patient with a delayed right deep inferior epigastric perforator flap reconstruction after a long superior flap mastectomy and contralateral breast reduction showing the final result

downward pointing curved lines are drawn, with the superior curve crossing the breast just above the areola and the inferior line on the inframammary fold (Figs 1 and 2). The area between the curves will form a crescent containing the nipple–areola complex, with both tips pointing upwards. The mastectomy can be performed through this area. The shape of the scar with the direction change results in elimination of the excess skin.

DISCUSSION

Several techniques have been described to avoid dog ears, such as the ‘fish-tail’,¹ the ‘tear-drop’² and lateral-superior extension.³ These techniques are successful but produce unhelpful scars in immediate or delayed reconstruction (Fig 3). The curved long superior flap technique keeps the scar as low as possible while simultaneously removing excess skin. Although not novel, we believe that this technique is superior in terms of scar placement, reconstruction suitability and cosmesis.

References

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An alternative technique for optimal exposure of the pericardium in cardiac surgery

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Cardiac exposure with multiple heavy silk sutures passed through the edges of the opened pericardium can be cumbersome and time consuming, and sutures may cut through fragile pericardium. We apply Roberts forceps to four corners of the opened pericardium (Fig 1), remove the sternal retractor, and then retract the Roberts forceps upwards and outwards over the chest wall under tension. The sternal retractor is reinserted with the Roberts forceps still in situ and is progressively opened, ‘sandwiching’ the pericardium between the sternal edge and the retractor (Fig 2). The Roberts forceps are then removed. This provides excellent visualisation of the intrapericardial structures and is particularly suitable for trainees.

Figure 1 Roberts forceps (arrows) are applied to four corners of the pericardium.

Figure 2 The pericardial edges are elevated and ‘sandwiched’ between the sternal edge and retractor.