PREOPERATIVE DIAGNOSIS,Bilateral macromastia.,POSTOPERATIVE DIAGNOSIS,Bilateral macromastia.,OPERATION,Bilateral reduction mammoplasty.,ANESTHESIA,General.,FINDINGS,The patient had large ptotic breasts bilaterally and had had chronic difficulty with pain in the back and shoulder. Right breast was slightly larger than the left this was repaired with a basic wise pattern reduction mammoplasty with anterior pedicle.,PROCEDURE,With the patient under satisfactory general endotracheal anesthesia, the entire chest was prepped and draped in usual sterile fashion. A previously placed mark to identify the neo-nipple site was re-identified and carefully measured for asymmetry and appeared to be satisfactory. A keyhole wire ring was then used to outline the basic wise pattern with 6-cm lamps inferiorly. This was then carefully checked for symmetry and appeared to be satisfactory. All marks were then completed and lightly incised on both breasts. The right breast was approached first. The neo-nipple site was de-epithelialized superiorly and then the inferior pedicle was de-epithelialized using cutting cautery. After this had been completed, cutting cautery was used to carry down an incision along the inferior aspect of the periosteum starting immediately. This was taken down to the prepectoral fashion dissected for short distance superiorly, and then blunt dissection was used to mobilize under the superior portion of the breast tissues to the lateral edge of the pectoral muscle. There was very little bleeding with this procedure. After this had been completed, attention was

directed to the lateral side, and the inferior incision was made and taken down to the serratus. Cautery dissection was then used to carry this up superiorly over the lateral edge of the pectoral muscle to communicate with the previous pocket. After this had been completed, cutting cautery was used to cut around the inferior pedicle completely freeing the superior breast from the inferior breast. Hemostasis was obtained with electrocautery. After this had been completed, cutting cautery was used to cut along the superior edge of the redundant tissue and this was tapered under the superior flaps. On the right side, there was a small palpable lobule, which had shown up on mammogram, but nothing except some fat density was identified. This site had been previously marked carefully, and there were no unusual findings and the superior tissue was then sent out separately for pathology. After this had been completed, final hemostasis obtained, and the wound was irrigated and a tagging suture placed to approximate the tissues. The breast cleared and the nipple appeared good.,Attention was then directed to the left breast, which was completed in the similar manner. After this had been completed, the patient was placed in a near upright position, and symmetry appeared good, but it was a bit poor on the lateral aspect of the right side, which was little larger and some suction lipectomy was carried out in this area. After completion of this, 1860 grams had been removed from the right and 1505 grams was removed from the left. Through separate stab wounds on the lateral aspect, 10-mm flat Blake drains were brought out and sutures were then placed ****

and irrigated. The wounds were then closed with interrupted 4-0 Monocryl on the deep dermis and running intradermal 4-0 Monocryl on the skin, packing sutures and staples were removed as they were approached. The nipple was sutured with running intradermal 4-0 Monocryl. Vascularity appeared good throughout. After this had been completed, all wounds were cleaned and Steri-Stripped. The patient tolerated the procedure well. All counts were correct. Estimated blood loss was less than 150 mL, and she was sent to recovery room in good condition.