PREOPERATIVE DIAGNOSES:, Bilateral mammary hypertrophy with breast asymmetry, right breast larger than left.,POSTOPERATIVE DIAGNOSES:, Bilateral mammary hypertrophy with breast asymmetry, right breast larger than left.,OPERATION:, Bilateral reduction mammoplasty with superior and inferiorly based dermal parenchymal pedicle with transposition of the nipple-areolar complex with resection of 947 g in the larger right breast and 758 g in the smaller left breast.,ANESTHESIA: ,General endotracheal anesthesia.,PROCEDURE IN DETAIL: ,The patient was placed in the supine position under the effects of general endotracheal anesthesia. The breasts were prepped and draped with DuraPrep and iodine solution and then draped in appropriate sterile fashion. Markings were then made in the standing position preoperatively. The nipple areolar complex was drawn at the level of the anterior projection of the inframammary fold along the central margin of the breast. A McKissock ring was utilized as a pattern. It was centered over the new nipple position and the medial and lateral flaps were drawn tangential to the pigmented areola at a 40-degree angle. Medial and lateral flaps were drawn 8 cm in length. At the most medial and lateral extremity inframammary folds, a line was drawn to the lower level at the medial and lateral flaps. On the left side, the epithelialization was performed about the 45-mm nipple-areolar complex within the confines of the superior-medially based dermal parenchymal pedicle. Resection of the skin, subcutaneous tissue, and glandular tissue was performed along the inframammary fold, and then

cut was made medially and laterally. The resection medially was perpendicular to the chest wall down to the areolar tissue overlying the pectoralis major muscle, and laterally, the resection was performed tangential to the chest wall, skin, subcutaneous tissue, and glandular tissue towards the axillary tail. The pedicle was thinned as well, so it was 2-cm thick beneath the nipple-areolar complex and they were medially 4-cm thick at its base. On the right side, 947 g of breast tissue was removed. Hemostasis was achieved with electrocautery. Identical procedure was performed on the opposite left side, again with a superiorly and inferiorly based dermal parenchymal pedicle with deepithelialization about the 45-mm diameter nipple-areolar complex. Resection of the skin, subcutaneous tissue, and glandular tissue was performed medially down to the chest overlying the pectoralis major muscle and laterally tangential to the chest wall towards the axillary tail setting the pedicle as well beneath the nipple areolar complex. Hemostasis was achieved with electrocautery. With pedicle on the left, the breast issue on the left side was weighed at 758 g. Hemostasis was achieved with cautery. The patient was placed in the sitting position with wound partially closed and there appeared to be excellent symmetry between the right and left sides. The nipple-areolar complex was transposed within the position and the medial and lateral flaps were brought together beneath the transposed nipple-areolar complex. Closure was performed with interrupted 3-0 PDS suture for deep subcutaneous tissue and dermis. Skin was closed with running subcuticular 4-0

Monocryl suture. A Jackson-Pratt drain had been placed prior to final closure and secured with a 4-0 silk suture. The wound had been irrigated prior to final closure as well with bacitracin irrigation solution prior to final cauterization. Closure was performed with an anchor-shaped closure around the nipple-areolar complex, vertically of inframammary folds and across the inframammary folds. Dressing was applied. The suture line was treated with Dermabond. The patient returned to the recovery room with 2 Jackson-Pratt drains, 1 on each side and IV Foley catheter with instructions to be seen in my office in 2 days. The patient tolerated the procedure well and returned to the recovery room in satisfactory condition.