Discussion: Prospective Prospective Outcome Study of 225 Cases of Breast Augmentation

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Breast augmentation is in a virtual tie as the most commonly performed aesthetic surgical procedure today.[1] Although conceptually simple, there is much diversity in technical approach and aesthetic theory. Achieving consistent results is challenging and the reoperation rate is high, yet somehow the majority of patients are satisfied and it continues to grow in popularity.[1]

Prospective studies that include a control group and adequate follow-up are rare in breast augmentation. The topic historically has been a soft science shaped largely by expert opinion. A key contributory problem is gathering complete data. Breast augmentation patients are geographically mobile, reluctant academic participants, and sometimes quick to jump ship when dissatisfied. These issues are illustrated in this study where 20 percent of patients were unavailable for a 1-month interview, and most (195 of 225) were lost to follow-up less than 6 months after surgery. Minimizing the importance of the follow-up interval because longer intervals impair the inclusion rate and allow selection bias does not justify this result. Very limited follow-up also prevents the study of long-term problems, a lost opportunity here in view of the high ratio of postpartum patients and smokers in the study population.

A comment on the institutional review board process is in order. Institutional review board review is standard today to approve study design. However, the terms "institutional" and "board" imply a group of individuals at an academic center. Although institutional review board approval from one's own facility may meet the letter of the law, this does not represent the same standard.

The conclusions of this study are limited by the almost exclusive use of saline implants and a single-incision approach, and by not using any preoperative sizing methodology. However, there are interesting findings. First, the "back-to-normal" period of 25 days is a refreshingly honest assessment compared with the dubious notion that this can reliably occur within 24 hours.[2] Second, the mean pain rating of 5.9 of 10 is a realistic finding, at least early on. Third, the incidence of initial nipple numbness (39.1 percent) and its eventual resolution in all but 2.3 percent better defines this issue, although no attempt was made to correlate this problem with implant size or other factors. Finally, the numerous tables paint a rich portrait of the recovery period experience.

This study corroborates the findings of numerous others that breast augmentation produces a high degree of satisfaction, decreased breast self-consciousness, improved self-esteem, and improved quality of life. More elaborate instruments such as the BREAST-Q are expected to elaborate in greater detail on these various facets of patient satisfaction.

The finding of improved nipple sensation in roughly one-fourth of patients appears to be distinct from the transient hypersensitivity that likely results from overstretching the sensory nerve during pocket dissection. It is hard to imagine an anatomical basis for increasing sensuous feeling, though. If true, it would be interesting to know whether this is a transient or permanent phenomenon.

No preoperative sizing methodology was used in this study, and 2.2 percent of patients subsequently underwent size change surgery. Sizing methods today include both a physician-centric method based on tissue measurements, and a more subjective but physician–patient collaborative approach based on sizing with implants.[3,4] The latter, although admittedly somewhat crude and time consuming, has proven very effective. Although size equivocation after surgery still exists, the process has been shown to prevent size change surgery.[4]

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The data on patient satisfaction with breast firmness are not particularly relevant because of the almost exclusive use of saline implants and because no objective data such as the Baker classification system were correlated with subjective patient evaluation. Contrary to the statement that the feel characteristics of breast implants are a major concern, most patients do not dwell on consistency in the absence of specific problems such as capsular contracture, knuckles, ripples, or lower pole palpability through thin soft tissues.

The concept of reporting complications from the patient's perspective is novel and should probably be more widespread in practice. That patients underreport capsular contractures, rippling, and hypertrophic scars as complications is indeed fortunate but certainly does not justify less objective scrutiny.

The author favors an average implant size of 390 cc for the following reasons: most dissatisfied patients would rather be larger than smaller; implant manufacturers report that the average size used, 350 cc, is too conservative an upper limit on implant size; and patients prefer convexity. The author does not take into account regional or international differences in implant size preference that clearly exist. Furthermore, contrary to the author's experience, most patients seek to avoid obvious convexity, a telltale sign of surgery much like the too-tight appearance that prospective rhytidectomy patients dislike. I could not agree more that plastic surgeons should not be paternalistic in telling patients what implant size is best for them. Curiously, though, the author does just this by setting an average implant size requirement and by not using any preoperative sizing methodology.

Breast augmentation studies are by nature challenging to design and execute to a rigorous scientific standard. Although this study has imperfections readily acknowledged by the author, it nevertheless adds useful information to the body of work on the topic.

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