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**Breast Uplift (Mastopexy)**

**Mastopexy - General Information.**

In certain people the breasts become droopy. This may be aggravated by breast feeding or fluctuations in weight. In the breast uplift (mastopexy) operation the aim is to give the breast a more youthful and pert appearance, usually elevating the nipple to a more ideal position (it should normally sit at the midpoint of the upper arm bone – or 19-22 cm from the collar bone). The scars are placed in inconspicuous positions designed to be hidden when wearing a bra’ or bikini. The nipple is left attached to breast tissue to preserve its blood supply, and retain its natural appearance. If the areola is too large this will be reduced at surgery.

There are several types of uplift operation which can leave scars limited to around the areola, to more extensive scars around the areola and down from the areola to the breast crease and also on occasions along the breast crease underneath the breast. In some people breast augmentation may additionally by required, in others breast augmentation alone may produce the desired result. This will be discussed at the initial consultation.

**What types of breast uplifts are available?**

There have been many types of breast uplift procedures described over the years. There are three mane types, which each leave different scars.

In the peri-areolar mastopexy the scar is situated around the areolae. An ellipse of skin is excised around the areolae and the breast skin tightened. The advantage of this technique are very limited scars however the degree of uplift is limited, and the scars will inevitably stretch to an extent – this being more marked the larger the uplift and the larger the degree of areolae size reduction. This is a technique only applicable when the degree of droop is mild.

In the short scar mastopexy the scar is limited to around the areolae and to a scar that extends from the areolae to the crease under the breast. There may be a small horizontal scar in the crease. In this technique a glandulopasty (breast reshaping) procedure is usually performed. The advantage of this technique are shorter scars, a reduced likelihood of recurrent droop and less likelihood of a stretched areola scar. The disadvantage is that nipple sensation is more likely to be lost than in the other two techniques and the up/down scar may be quite wrinkled and irregular at in its lower portion. Additionally, this is a technique only suitable where the degree of droop is moderate.

 

Pre and 5 months following a short scar breast uplift

In larger droops or where the skin is very lax or when a patient desires the most significant uplift and is unconcerned regarding the scar in the crease under the breast a Wise pattern of scarring is used with a posterior mound technique. The scars that result are around the areole, a long scar in, or close to, the crease where the breast meets the chest wall and an up/down scar between the areolae and the crease under the breast. This technique is applicable to all degrees of droop.

 

Pre and 5 months following a Wise pattern posterior mound breast uplift

**Pre-operative advice.**

In order to optimize the result and minimize the risks a number of factors should be considered. Smokers have a much higher risk of developing complications. It is therefore advised that they should refrain from smoking for ideally four weeks prior to, and four weeks following surgery. Aspirin and related anti-inflammatories (other than those prescribed during the admission) should be avoided for one week before and 48 hours after surgery as these can significantly increase the risk of bleeding. Many supplements (gingko, ginger, turmeric, garlic) have anti-coagulant effects and therefore can increase the risk of bleeding and bruising and should be discontinued for a similar time period. The use of arnica is debatable with no clear evidence to support either its use or its avoidance.

It is recommended that patients on the combined oral contraceptive, and hormone replacement therapy, should stop these for four weeks prior to, and four weeks after surgery, as they may be associated with an increased risk of deep vein thrombosis (DVT). For patients on the pill alternative forms of contraception should be used.

Patients who are overweight also have a higher risk of complications. If patients are dieting, they should aim to get to their desired weight pre-operatively. Mr Cadier and his team have the policy that such surgery will only be offered to patients with a Body Mass Index (BMI) of less than 36. The BMI is calculated from the weight and height, and there are many simple tools available on the internet to help perform this calculation. Patients with a BMI of 36 or over have much higher risks both from the surgery and the anaesthetic and the risks therefore potentially outweigh the benefits.

**What happens before the operation?**

At the initial consultation with Mr Cadier after discussing regarding the specific concerns a full medical and surgical history will be obtained. As part of the consultation a psychological assessment is made to ensure that it is appropriate to undertake the surgery, and on occasions the completion of a psychological questionnaire may be required. In all cases Mr Cadier will write to the GP to request a past medical history. Patients may refuse this but need to be aware they are exposing themselves to more risks should they omit or forget some relevant past medical history. Also, in the post-operative period should there be any problems it is important that the GP is aware what has been undertaken in order to be able to offer effective help and advice. At the consultation details regarding the operation, the aims, the limitations, the recovery and the risks will be discussed. Before the operation you will usually attend for a pre-operative nurse led assessment. You may require a blood test. Any significant health problems not previously identified may be discussed with Mr Cadier or the anaesthetist, and a further assessment may be required to determine suitability for the procedure. At admission you will again be assessed by the nurses and you will be measured for a pair of compression stockings. These are worn to reduce the risk of thrombosis formation and should be worn for a minimum two weeks post-operatively. You will be seen by the anaesthetist prior to surgery and be able to discuss issues pertaining to the anaesthetic and also pain relief in the immediate post-operative period. You will also see Mr Cadier who may make some pre-operative markings and will take photographs for the medical records.

**Operative procedure.**

The breast uplift procedure takes between one and a half and two hours and is undertaken under general anaesthetic. Before starting the operation when the patient is asleep the breasts are infiltrated with a dilute solution of local anaesthetic and adrenalin, not only to provide postoperative pain relief but also to reduce bleeding. At operation skin is removed as well as breast tissue. The nipple is elevated to a more ideal position. The locations of the incisions will have been discussed and marked preoperatively. In some patients liposuction is also undertaken especially to the armpit region to reduce any bulging. The wounds are all sutured with self-dissolving stitches and dressings applied. Drains are inserted into each breast. The tissue that is removed is routinely sent for histological analysis.

**What to expect immediately after the operation**

On return to the ward patients will have an intravenous drip to provide fluids for the 24 hours following surgery. Drains are placed into each breast to allow any oozing or bleeding to accumulate into either a small bottle or bag by the side of the bed. These are usually removed at 48 hours prior to discharge. If any pain or discomfort is experienced following surgery, painkillers are given either by injection or as tablets. Pain is not a significant feature in breast reduction surgery. The patients will note dressings over all of the wounds with small windows over the nipples allowing these to be inspected on the night following surgery.

**What to expect after discharge.**

Your length of stay in hospital is variable and depends on many factors but is usually 2 days. Following the breast uplift procedure dressings are applied in the operating theatre as follows: butterfly tapes are applied directly to the wound and then an absorbent dressing is placed over this. These dressings are usually left intact for one week following surgery unless they become messy, in which case they are changed prior to discharge. Patients are invited to re-attend 7 and 14 days post discharge for a wound check by the nursing staff and a change of dressings. Dressings are required for a total of about two to three weeks following surgery. The tapes that are applied directly to the wound should be left longer if possible. From two to four weeks postoperatively (once the tapes have dropped off) the wound should be massaged once or twice a day with Vitamin E containing cream or lotion. Waterproof dressings are employed so that patients can shower after 48 hours being careful to interfere with the dressings. After 14 days the patients can get the wound wet provided there are no significant wound problems. Prolonged soaking in a bath should be avoided for three weeks postoperatively.

The breasts will feel tight and firm for two to three weeks and then gradually soften. Some bruising may occur especially if liposuction has been undertaken. Some lumpiness within the breast is common, most will soften with time, but the breasts will have a new pattern of lumpiness that should be learnt for breast self-examination purposes. Some numbness around the breast is inevitable and will gradually resolve over many months. Nipple sensation may be altered either down or up – this may be permanent. Hypersensitivity of the nipple may on occasions occur. If this does happen the nipple/areola complex should be massaged and desensitized by gentle tapping. At discharge a letter will normally be sent from the ward to your General Practitioner informing them of your admission and of the procedure undertaken. Patients are encouraged to keep their GPs informed however should they wish the admission to remain confidential please inform the ward staff and no communications will be sent.

**The breast appearance.**

Initially the breasts will not look correct. The mound of the breast will be too high and rounded, and the lower half of the breast will seem flattened and will appear to be squeezing the breast. Some bulging into the armpit is also very common, and the breast may have a boxy appearance. With short scar techniques there may be some wrinkling of the skin under the breast. All of this is normal. Over the first few weeks following surgery the up-down scar under the breast will stretch and the breasts will start to assume a more natural shape. However, it will take up to six to nine months to fully normalize.

**Bra’/clothing.**

A support or sports bra’ that gives firm all round support should be worn as much as possible day and night for six weeks following surgery. After this period normal bra’s including underwired varieties can be worn. It is probably prudent however to wait for a total of three months before assessing the new bra’ size and getting a new wardrobe. If undertaking vigorous sporting activities, a sports bra’ is advised.

**Scar maturation.**

The scars will inevitably go red, become lumpy and may widen. After two to four weeks when healed, massaging two times a day with Vitamin E containing ointment is advised. This should be continued for at least 2 months following surgery, and longer if the scars are not settling. Full scar maturation may take 6 – 24 months. Ultimately the scars will usually become pale and flat, however if this process is delayed other treatments including silicone therapy, steroid injections and laser treatment may be required. In rare cases a scar revisional procedure may be beneficial, though this will set the clock back in terms of scar maturation. Keloid scarring occurs when the scar starts growing beyond the boundaries of the wound. Why this occurs is largely unknown, but it appears to be associated with various skin types and is more common in a younger patient. Keloid scarring may be very disfiguring and necessitate prolonged treatments with silicone dressings, laser treatment and steroid injections. These treatments will incur costs.

**What restrictions are there following surgery?**

For the first one to two weeks following surgery patients should rest and convalesce. They should refrain from driving or from undertaking any light housework. After this period light housework and gentle activities can be undertaken, gradually building up to normal over a six to eight week period. Gentle gym activities and jogging can be resumed at 3-4 weeks however heavy lifting or any vigorous sporting activities (aerobics, tennis, and badminton) should be avoided for two to three months following surgery. Most patients refrain from work for 1-2 weeks, however in those with physical jobs or whom recovery is delayed an additional 1-2 weeks may be required. Sexual activities can resume when patients feel comfortable but usually no earlier than two weeks following surgery.

**What about pain relief?**

Despite the extent of the surgery breast uplifts are not usually associated with much pain. However regular pain relief is advised for the minimum of at least one week following surgery (usually a combination of anti-inflammatory medication and Paracetamol or Paracetamol / Codeine mixes). These should be prescribed prior to discharge from the hospital. Following the initial week pain relief should be taken as required.

**Follow up.**

After discharge patients require a wound check at 7 and 14 days post discharge. This can either be by the nursing staff in the outpatients where the surgery was undertaken or by the General Practitioner (their agreement would need to be sought). Dressings are required for two to three weeks postoperatively. Appointments for the initial dressing change are made prior to discharge.

You will also be reviewed by Mr Cadier at one and five months postoperatively. These appointments will be sent in the post.

 **Realistic expectations.**

No one is perfectly symmetric and in any individual their breasts will frequently have slight differences in size, shape and nipple position. Additionally, there may be slight differences in the chest wall muscles and in rib cage shape on either side. These differences will usually be identified at the initial consultation and the effect on the result discussed. All attempts are made to make the breasts the same in terms of size, shape and nipple position however some differences are inevitable. The areolae will be round and very similar at the end of surgery however, they seldom stay totally round and differences in the shape and size are common. In most cases revisional surgery will not convey much benefit and patients need to be realistic about the outcomes of surgery. If differences are marked, then occasionally revisional surgery may be appropriate though this is usually deferred for several months as some differences may reduce as the swelling settles.

To start off with the breast mound is placed too high and the scar length from the nipple to the infra-mammary crease is too short. This is on purpose as some bottoming out and recurrent sag of the breast is inevitable. Most changes occur in the first few months and by 4-6 months the shape will be stable. In the normal breast the upper pole is flat and not rounded. With breast uplift surgery the ultimate shape will be as per a normal breast. Patients seeking to have a round and full upper pole should consider the insertion of an implant. This however, significantly increases the complexity and cost of the operation.

**Histological examination and breast cancer.**

In all cases the tissue that has been removed will be sent for routine histological examination. The results usually come back within a fortnight and patients receive a letter confirming the results. Very rarely something untoward is detected and patients will be recalled back for urgent review. If a cancer is detected it is highly likely that the treatment that will be required will involve a mastectomy as it is impossible to locate the exact site of the tumour within the breast. Obviously on the positive side the cancer will have been picked up at an early stage. Patients over the age of 45 who have not had a mammogram within a year of surgery should consider whether it would be appropriate to have one pre-operatively. The scarring in the breast may be visible on routine mammography but will not affect the interpretation of the investigation. Breast cancers are not triggered by surgery to the breast.

**What are the risks?**

The risks are as follows:

* Bleeding (hematoma)
* Fluid accumulation
* Unfavourable scarring including hypertrophic and keloid scarring (discussed above)
* Infection
* Poor wound healing
* Potential loss of skin/tissue of breast where incisions meet each other
* Fatty tissue deep in the skin could die (fat necrosis) leading to lumpiness
* Skin discoloration, permanent pigmentation changes, swelling and bruising
* Changes in nipple or breast sensation, which may be temporary or permanent
* Breast contour and shape irregularities
* Breast asymmetry
* Potential, partial or total loss of nipple and areola
* Pain, which may persist
* Allergies to tape, suture materials and glues, blood products, topical preparations or injectable agents
* Potential inability to breastfeed
* Recurrent droop
* Possibility of revisional surgery
* Deep vein thrombosis and life-threatening pulmonary embolism
* Anaesthetic complications – these will be discussed with you by the anaesthetist before surgery.
* Death

In the first few hours on returning to the ward bleeding may occur and this can accumulate resulting in a haematoma. The breast swells massively, and patients need to return to the operating theatre for evacuation of the haematoma. This occurs in about 1:100 cases. There are usually no long-term sequelea. Small haematomas may go unnoticed and present with a firm swelling on outpatient review. The blood clot will have become liquid and is treated by simple aspiration in clinic.

The commonest complication is wound infection. Occasionally antibiotics are required, and dressing may be required for a longer period. In severe infections wounds can breakdown, usually at the bottom of the up/down scar at the T-junction. This is a relatively unusual complication in non-smokers, and patients of normal body weight. Patients who do smoke should refrain for 4 weeks before and at least 4 weeks after surgery. Usually the wounds will heal with simple dressings alone, though occasionally secondary surgery may be required. In very severe infections the tissues can be damaged and skin loss can occur. Secondary surgery will almost certainly be required; very rarely this involves the use of skin grafts.

Some patients develop painful lumps in the breast. These are usually due to small areas of fat necrosis, and they will usually settle down over 2-3 months. Occasionally they are permanent, and patients need to be aware of the new pattern of lumpiness. No treatment is required as attempts to remove surgically have the potential of damaging the shape of the breast. Sensory disturbance to the breast skin and nipple is described above. Some pain and discomfort will occur but usually resolves after a week or two. Some patients do experience a mastitis-like pain for a longer period and occasionally a course of medication is required. Skin discolouration and redness may be seen in the breast skin in some patients. There is usually no specific cause and no treatment is required as it settles by itself.

The most serious complication following breast uplift surgery is nipple loss. Fortunately, this is extremely rare. Should this occur the nipple and areola die, and a scab is formed which will eventually heal up leaving a scarred area. A new nipple can be reconstructed at a later date however these are poor imitations.

Following any surgery there is a risk in developing a deep vein thrombosis (DVT). This is a clot in the calf vein of the leg. In itself it may result in pain and swelling. The risk is that should the clot separate from the vein it can move to the lungs resulting in a pulmonary embolism. This is a potentially life-threatening situation. All attempts are made to reduce the risk using compression stockings during and for two weeks after surgery, using pneumatic compression devices on the legs at surgery and in the immediate post-operative period, by encouraging early mobilization, advising patients to stop the combined oral contraceptive pill or Hormone Replacement Therapy (HRT) four weeks prior to surgery, and where it is felt appropriate using injections of blood thinning agents.

All surgical and anaesthetic procedures have risks, and some are life threatening, these include pulmonary embolism, anaphylaxis (severe allergic response to a medication) and adverse drug reactions. Death however remains an extremely rare complication.

Risks and complications will be discussed, and all efforts made to minimize any risks. Patient safety is always our first concern. When complications do occur, all attempts are made not only to remedy the problem in as speedy a manner as possible but also to optimise the final result. As with all cosmetic surgical procedures undertaken by Mr Cadier, there is a fixed fee policy, which means that no further charges are incurred for the treatment of complications that are identified within 6 months following the initial surgery. Revisional policies for aesthetic concerns have changed and, in most cases, additional fees will be incurred. Patients need to be aware regarding the limitations of surgery and have very realistic expectations about outcomes.

Most patients are delighted with the result of surgery and the new shape of their breasts. Self-esteem is increased and patients become less self-conscious about their breast appearance.

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**About your Surgeon:**

Michael Cadier was educated at the French Lycée in London, studied at Oxford University and undertook Medicine at St Thomas’ Hospital, London. After training in London, Salisbury and Bristol he became an NHS Consultant in the Supra-regional Plastic Surgery Unit in Salisbury in 1996, becoming Head of this Service in 1999. In his NHS practice he developed a breast reconstruction service in Portsmouth, and in 2000 was appointed as cleft surgeon to the newly established Spires Cleft Centre, for which he also became the first Clinical Director in 2002. He undertook yearly cleft lip and palate Charity missions in rural Pakistan from 1996 to 2009. He has a busy aesthetic surgery private practice along the South Coast, undertaking the full range of aesthetic surgery procedures. He has performed over a thousand facelifts, and over 1500 breast augmentations, with similar numbers for all of the more common aesthetic procedures. In 2015 he became fully private, concentrating solely on aesthetic surgical practice.

He is widely published and lectures and teaches on aesthetic surgery both nationally and internationally. In 2006 he was invited to become an examiner for the FRCS (Plast). He is the Program Director for the South Coast Reconstructive Cosmetic Surgery Fellowship, was part of the first UK delegation in the CEN in cosmetic surgery (European regulation) and chaired the CSIC Royal College committee on Clinical Quality and Outcomes in Cosmetic Surgery.

The British Association of Aesthetic Surgeons (BAAPS) is the leading organization for aesthetic surgery in the UK. He was elected to BAAPS Council in 2006 and was President of BAAPS from 2014 to 2016. One of his key objectives is to ensure that UK plastic surgeons of the future will practice aesthetic surgery to the highest possible standard and with that aim he has helped establish a comprehensive national training program in aesthetic surgery.