Composite

BREAST AUGMENTATION TECHNIQUE

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The philosophy behind

COMPOSITE AUGMENTATION

The concept underlying the composite breast augmentation technique is simple: to combine the breast volume augmentation capacities of implants with the remodelling capacities of fat injections. It provides an extremely natural result, even in very thin patients. A reconstructed breast is very similar to a natural breast as the implant is placed in a pre-muscular pocket, in place of the normal mammary gland. Axillary access is also natural because there is no scar on the breast.

Breast implant

+

Lipofilling

for a natural result

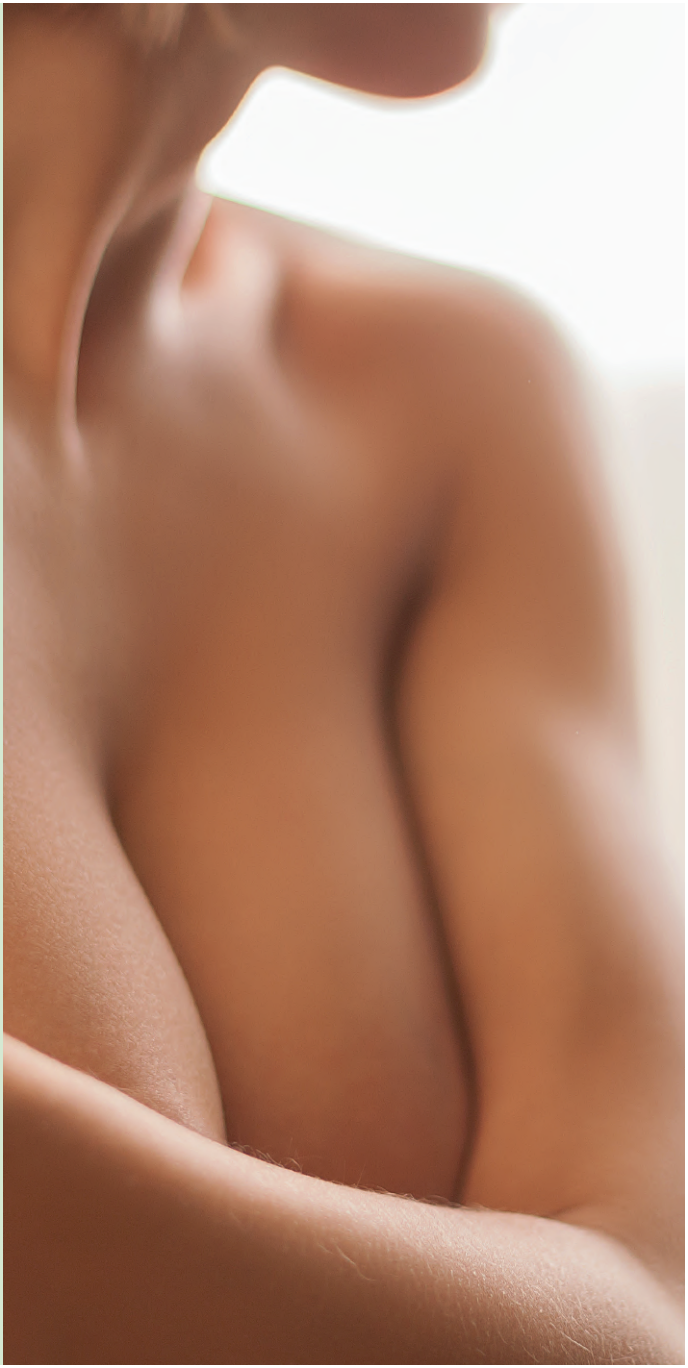
The birth

OF COMPOSITE AUGMENTATION

The first procedure combining breast implants and a subcutaneous fat grafting injection was towards the end of 2006 in a very thin patient with premuscular implants visible around the neckline. At the time, the recommended technique involved replacing implants in a new retromuscular pocket at the expense of a quite serious and painful procedure.

As Dr Delay [1, 2] and Dr Coleman [3] had just published very promising results for the correction of the after-effects of breast preservation treatment by breast lipomodelling and remodelling, we therefore took the decision to apply the same principles to camouflaging breast implants.

After a few months of use in secondary cases, which enabled us to validate the technique, we decided to apply lipomodelling at the same time as primo-implantation, thereby leading to the birth of the composite breast augmentation technique (CBA) [4, 5] which has since been the subject of numerous publications [6,7,8,10].



The surgical technique

OF COMPOSITE AUGMENTATION

1

PATIENT SELECTION

The technique is particularly suited to thin patients, for whom the thickness of the Pinch test around the neckline area is less than 2 cm.

2

FAT PREPARATION

This starts with liposuction performed using a tumescent technique and a multi-perforated 3mm cannula. Fat is collected in a Fat Washer where it is decanted prior to being retrieved in 10mL syringes for re-injection.

3

IMPLANTATION

With a pre-axillary access route through an L-shaped incision at the top of the retrofascial, the outer edge of the pectoralis major muscle is reached. Then retrofascial dissection of the implantation pocket is started, guided by the view made possible through the use of specific instruments described later. The purpose of this dissection is to obtain a bloodless, symmetric pocket with the exact dimensions of the implant to be fitted.

The surgical technique

OF COMPOSITE AUGMENTATION (CONT'D)

4

LIPOMODELLING

Once the implant has been fitted, further lipofilling is performed to cover the edges of the implant in areas where it can be noticed, particularly in thin patients. The injection is given using an olive tip cannula to reduce the risk of perforating the implant. It is 15 cm long and 1.2 mm wide. The injection is given from an incision made in the areola, the fat is injected into the subcutaneous space through the Cooper ligaments, close to the subcutaneous vascular network.

5

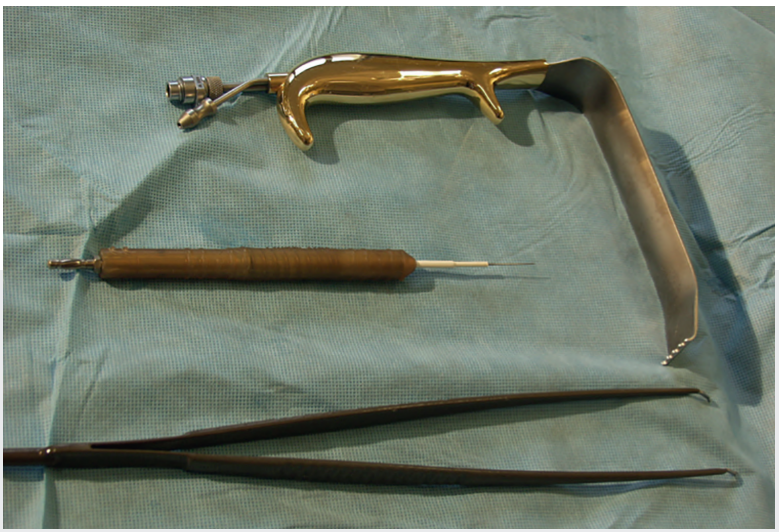
POSTOPERATIVE CARE

A sticky bandage is placed on the lipofilling areas at the end of the procedure to facilitate grafting; a medical bra is worn for 3 weeks to maintain the position of the implants.

Ancillary equipment

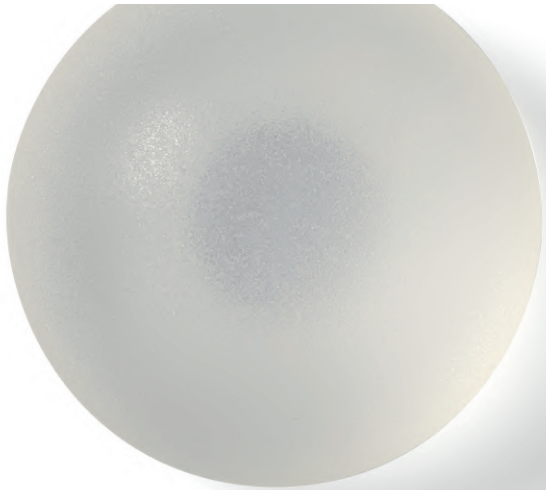
ADAPTED

In order to perform dissection of the prosthetic pocket properly and to control haemostasis, appropriate equipment should be used, and it should be sufficiently long to reach all the corners of the pocket.



This is composed of:

- Monopolar 35 cm long haemostatic forceps with a curved extremity.
- L-shaped spreader equipped with cold light lamp and suction. To ensure proper efficacy the blade must be 20 cm long and 3 cm wide.
- A 15 cm long coagulation tip.



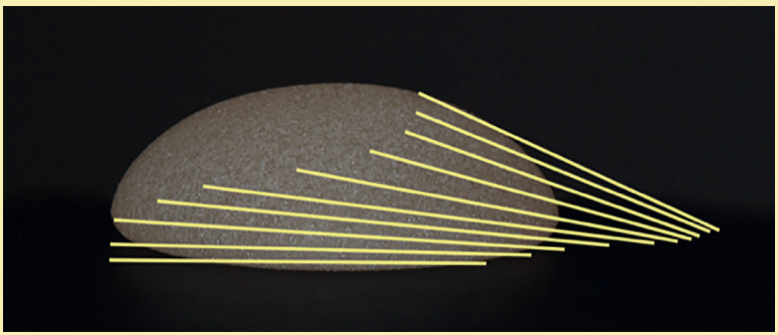
IMPLANT

Which one?

The choice

OF IMPLANTS

We only use round implants because adding fat above the upper edge of the implant provides a very natural shape, comparable to that obtained with an anatomical implant, ‘anatomization’ of the round implant is referred to, without having the risk of rotation which remains one of the drawbacks of anatomical implants.



The round implant is selected based on 2 criteria:

- The diameter of the implantation base of the breast which must be more or less respected,
- The projection which will define the size of the cup that is obtained.

Initial results

Several studies were published from our clinical series: the first publication in 2013[5] reported the results of 197 cases, this will be replicated in 2015[6] focusing on primary cases. The results of these 2 studies are very encouraging, including capsular contracture less than 1%. In 2014, Prof. Cunningham's team published an article[9] on the results of mammograms performed in 52 of our patients which reported that all the examinations are classified BI-RADS 1 or 2 and that none of the images analysed required further examination or biopsy.

CAPSULAR CONTRACTURE

For further details

SEE THE BIBLIOGRAPHY

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