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# INVERTED NIPPLES—A CASE REPORT

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## SUMMARY

*A simple and less time consuming technique was tried in a case and is being described in which the underlying pathology was directly approached. The nipple was released in vertical and horizontal directions. Nipple pedicle was stabilized by nonabsorbable purse-string sutures. Limited horizontal undermining beneath the areola was done sufficient enough to cover the nipple pedicle in order to maintain the sensations and vascularity of the areola.*

(*Key Words* : Inversion, nipple, areola, pendulous, purse-string suture, lactiferous ducts)

Inversion of the nipple, unilateral or bilateral could be congenital and can be caused by trauma or inflammatory diseases. The inverted nipple is situated on a plane lower than the areola. The inverted nipple presents the following problems :

1. Functional
2. Aesthetic
3. Emotional and psychological
4. Repeated irritation and infection

## Observations

The procedure which we have used for correcting the congenital inverted nipple was found to have the following advantages :

1. It avoids injury to lactiferous ducts and there is no loss of function.
2. As we have done limited radial undermining beneath the areola, just sufficient to cover the nipple pedicle, the sensation and blood supply of areola is preserved.
3. It avoids unnecessary excision of areola and thereby provides natural looking nipple areola complex.
4. Minimum scar
5. Painless erection of the nipple

A female patient aged 20 years with history of retracted nipple since puberty was operated upon by Daniel Mahler's technique (1983) which was modified as follows :

The nipple was pulled out by traction sutures (Fig. 1). A circular incision was made around the nipple (Fig. 2) and undermining was carried out backwards towards the mammary gland (Fig. 3) and radially beneath the areola to a limited extent (Fig. 4). All the tight bands of tissues were divided allowing the nipple to be free and 1-2 cms pedicle was created below the nipple (Fig. 5). A 5-0 nylon purse-string suture was tied around the pedicle base just tight enough so that it may not interfere with the blood supply of the nipple (Fig. 6). The nipple areola wound was closed by 5-0 nylon sutures. The excess of areolar tissue was not sacrificed but it was pulled outwards and the wound was closed with small dog ears, to be absorbed spontaneously (Fig. 7 and 8). A doughnut type of dressing was applied.

## Discussion

The inverted nipple as compared with the normal nipple, is associated with less dense fibrous tissue. The protusion of the normal nipple is due to greater bulk of dense connective tissue located beneath the nipple (Daniel, 1983). The inverted nipple is further retracted by the surrounding tissue of the areola.

Numerous procedures have been described for correction of inverted nipple starting from excision of entire areola (Keher, 1880)

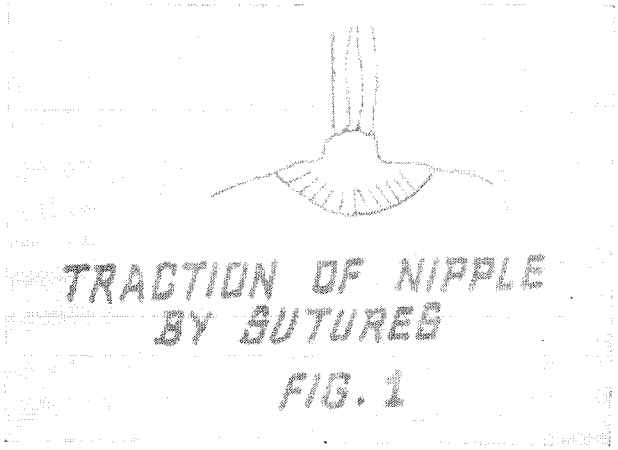


Fig. 1. Traction of nipple by sutures.

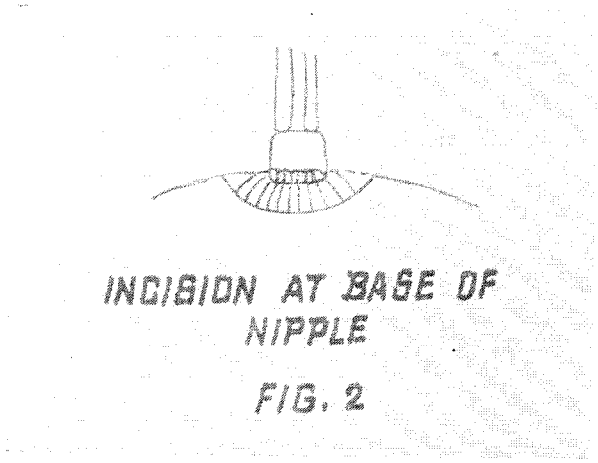


Fig. 2. Incision at base of nipple.

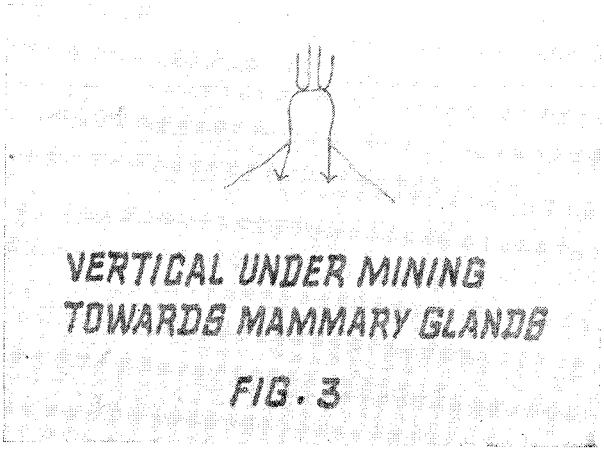


Fig. 3. Vertical undermining towards mammary glands.

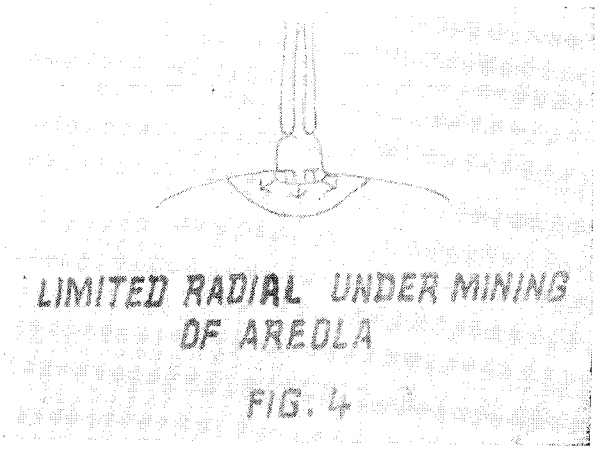


Fig. 4. Limited radial undermining of areola.

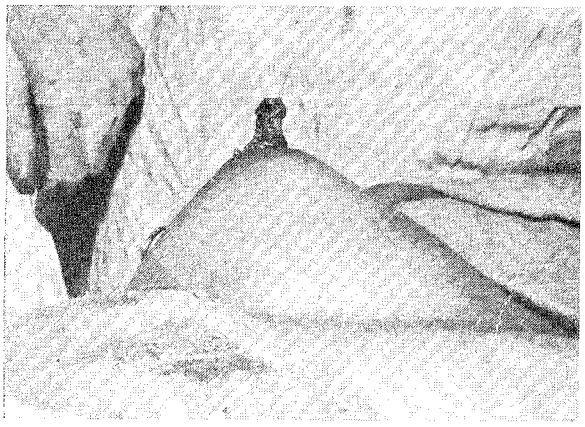

Fig. 5. Freed nipple with 1-2 cms of pedicle.

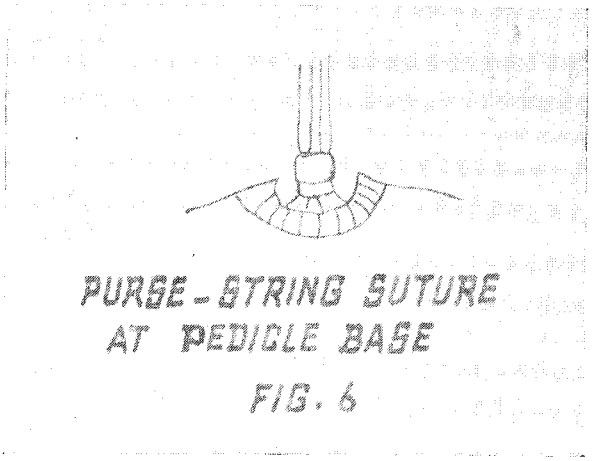


Fig. 6. Purse-string suture at pedicle base.

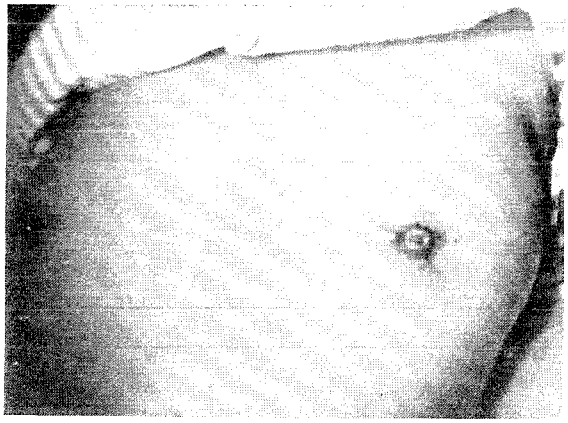

Fig. 7. Immediate post-operative result (right breast).

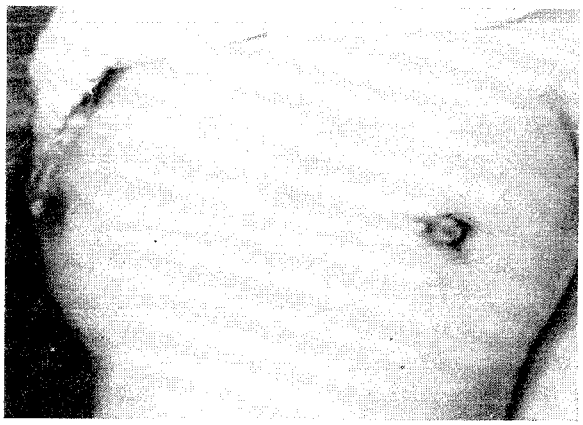

Fig. 8. Immediate post-operative result (left breast).

division of fibrous bands and lactiferous ducts (Schwager 1974 and Teimorian, 1980) and purse-string suture of mid areola.

The present technique is simple, less time consuming because it maintains sensation and vascularity of the areola.

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