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Gynaecomastia – Does Surgical removal justify the end results ?

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GYNAECOMASTIA or enlargement of the male breast is one of the few conditions in which amelioration by surgical excision is but a simple procedure and gives the patient much satisfaction. Though there have been other forms of treatment like endocrine therapy, the simplest and the quickest way to get rid of this condition is by surgical excision. This simple procedure must, however, be carried out in a cosmetic manner. With this in view, the old sub-mammary curvilinear incision (first introduced 13 centuries ago by Paulus Aegineta) has been replaced by the less visible perioareolar (demi circumareolar or intra-areolar) incision (first introduced by Dufourmentel in 1928) and later called the Webster's incision (Webster 1946). Pitanguy (1966) preferred a transareolar incision, transversely bisecting the areola and the nipple. Though most cases of gynaecomastia are amenable to excision with this limited exposure, for more massive ones resembling the female breast, Letterman and Schurter (1972) have advised larger oblique resection and transposition of the areola up and medially, as in the reduction mammaplasty of Dufourmentel and Mouly.

Whatever the incision, another factor that is equally important, is the leaving of adequate tissue behind the areola to resemble the normal male contour, (Fig. 1) (and also to prevent adhesion of the areola with the chest wall.

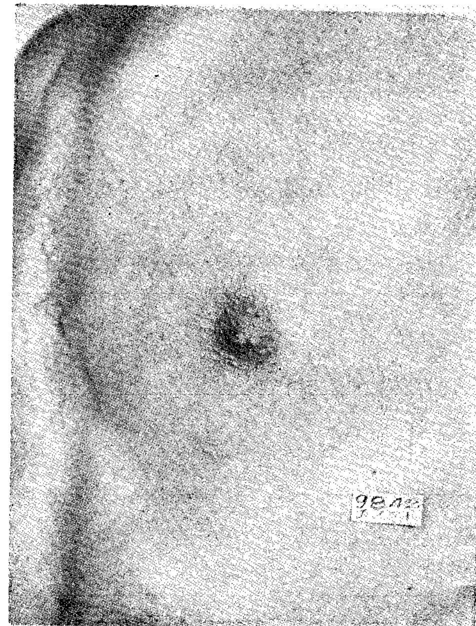

Fig. 1—Normal male breast and areola

The main indication for the surgical removal of an enlarged breast in the male is to rid the patient totally and forever of the associated psychological stigmata and not so

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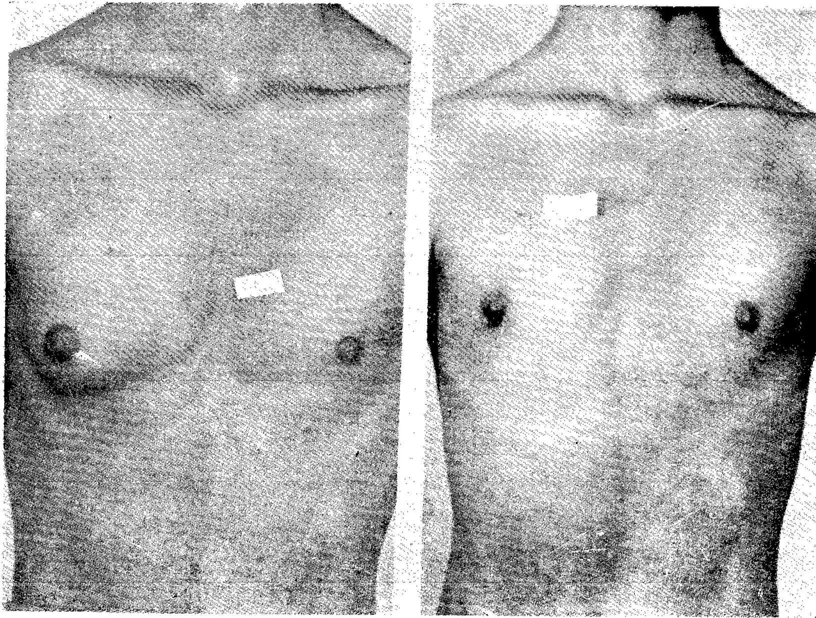

Fig. 2—Pre and postoperative unilateral gynaecomastia

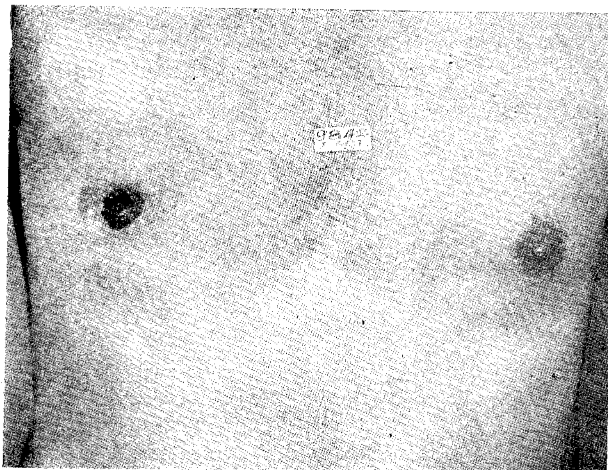

Fig. 3—Unsightly depression of the pectoral region following the resection.

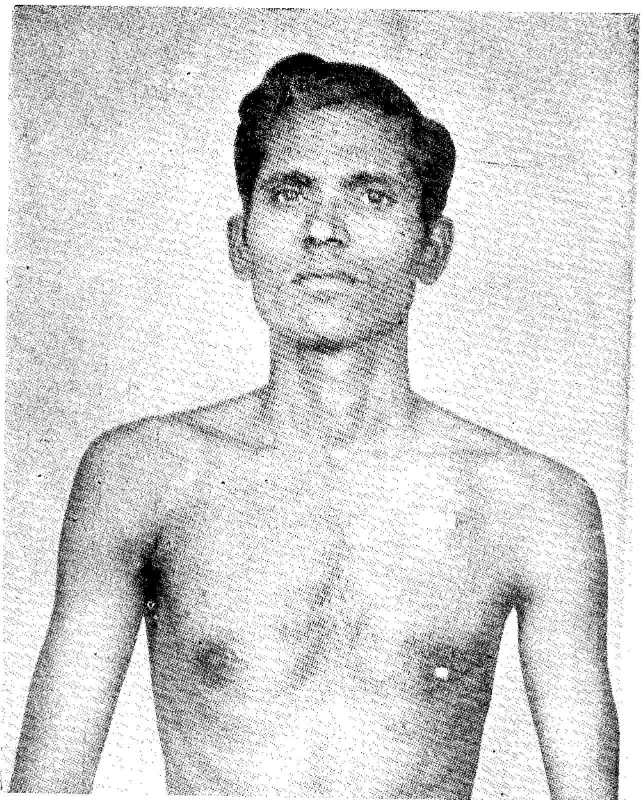

Fig. 4—Necrosis of nipple following circumareolar incision

much as the removal of an abnormal lump. To achieve this, surgery should be accurately cosmetic and should leave no telltale evidence to remind the patient of his previous physical condition and more important to have its repercussions on his psychological make up. A patient previously operated for gynaecomastia should feel no hesitation in exposing his chest when required. Does present day surgery for gynaecomastia achieve this ? (Fig. 2). It is the intention of this paper to emphasise certain details of technique by which the surgery for gynaecomastia justifies this end.

Analysis of data and results :

During the past five years (1968—1972) sixteen patients underwent surgery for gynaecomastia in the Christian Medical College & Hospital, Vellore. All were cases of idiopathic gynaecomastia with no other anomalies. Only one case had previous endocrine therapy with no obvious diminution in the breast size. The commonest age of onset was around puberty. In seven cases the complaint started between 10 and 15 years of age; in 2 cases between 15 and 20 years; and in 4 cases between 20 and 30 years of age. The youngest age of onset was 6 years and the oldest 39 years. The duration of the complaint varied from one to twenty years and 10 of the 16 cases presented within 5 years of the onset of the swelling. 6 cases had bilateral gynaecomastia and the rest had enlargment of one breast only. 6 patients with unilateral gynaecomastia had left sided enlargement and 4 on the right side. The size of the breast varied from 3 cms. to 10 cms. in diameter. The weight of the resected specimens varied from 30 gms. to 138 gms.

The incision :

In fourteen of the cases resection was possible through the limited exposure provided by a Webster's circumareolar incision. In 2 cases a submammary incision had been employed. because of poor cosmetic results, this incision is no longer be employed. Even the largest of gynaecomastia in our series (specimen weight 138 gms , size 10 cms.) was resected comfortably through a periareolar incision.

Extent of resection :

It is very important to leave behind the areola a disc of tissue to conform to the normal male contour (Fig. 1). An omission of this detail leads to an unsightly depression in the pectoral region (Fig. 3) and also causes adhesion of the nipple to the chest wall.

Post-operative care and complications :

Suction drainage and Elastoplast compression were used routinely in the postoperative period. One patient developed a haematoma which is one of the main comlications of the Webster's resection. The single case which had to be reoperated for evacuation of the haematoma and ligation of the bleeding vessel had been operated through a submammary incision. Necrosis of the nipple has been quoted as another complication of the peri-areolar incision (Fig. 4).

Conclusion :

1. Gynaecomastia, whatever the size, can be adequately excised through a circumareolar incision. Submammary incision has no place in present day cosmetic approach to gynaecomastia.

2. It is important to leave behind, the areola and nipple, adequate tissue to avoid an ugly depression in this region post-operatively, and also to prevent fixity of the nipple to the chest wall.

3. With proper post-operative care the complications following mastectomy through the periareolar incision can be eliminated.

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