COMMENTARY

Gynaecomastia Surgery: Should it be Individualised?

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Gynaecomastia is enlargement of male breast, and is the most common breast problem affecting men. It occurs in about 30% of middle-aged males and increases with old age due to decline in testosterone level. The first description of surgical treatment for gynaecomastia was made by Paulus Aegineta (635-690 AD), who used a semi-lunar infra mammary incision for excision of the breast tissue. Several treatments regarding gynecomastia have been described in literature, the most commonly performed procedure for Simon IIb and III stages is the combined liposuction and excision techniques.[1,2]

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In the present article the authors described a combined technique of liposuction and excess skin removal through the mammoplasty technique of depithelialisation of the skin and later suturing the skin edges to minimise scarring but they did not add any new option to the current practice of gynecomastia treatment modalities.[3]

They should have compared their technique with other more traditional excisional procedures. In my own experience a periaeriolar small incision exactly on the

margin between the skin and the areola is done and all breast tissue is excised with an excellent aesthetic scar, without requiring second stage excision of excess skin.

No postoperative complications like hematoma or infection were reported by the authors in all the 10 cases. The need for reoperation was not mentioned, although literature review revealed a reoperation rate of 4-8% of gynecomastia cases for hematoma evacuation and revision.[4,5]

The most common early complication after gynecomastia surgery is hematoma, which should be evacuated if possible. This prevents excessive scarring and distortion of the remaining breast. In liposuction cases, evacuation may not be possible. Under-resection of tissue is the most common long-term complication of gynecomastia surgery particularly in liposuction cases, when a residual mass of tissue is not removed. This can be avoided by using the pull through technique. Under-resection at the periphery of the breast can result from poor tapering and causes a noticeable deformity. Over resection in the nipple areola area can result in a saucer-type deformity that is difficult to correct. Loose skin is usually not considered a complication if it is part of the operative plan. Occasionally, loose skin occurs in an unexpected manner, and surgical excision is required.[6-8]

Surgical treatment of gynecomastia should ensure minimal scarring while respecting the aesthetic unit. The selection of the appropriate surgical method depends on the severity grade, the presence of skin redundancy and the volume of the male breast glandular tissue.

CONCLUSION

Surgery is the mainstay of treatment for gynecomastia. Although a wide range of surgical techniques have been described, the treatment of gynecomastia requires an individualised approach. Surgeons often find it difficult to choose the technique that will achieve the best results for a given patient.

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