Indications for Extra Full Projection Anatomical Cohesive Silicone Gel Implants in Cosmetic and Reconstructive Breast...
Indications for Extra Full Projection Anatomical Cohesive Silicone Gel Implants in Cosmetic and Reconstructive Breast Surgery

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Abstract: In 2003, a new extra full projection (EFP) anatomic cohesive silicone gel breast implant was introduced onto the European market. This review presents the early experience of a single surgeon with this new implant over a 29-month period. Between 2003 and 2006, the McGhan Style 410 EFP breast implants were inserted for highly selected indications. Twenty-eight patients received a total of 47 EFP implants. Their age range was 23 to 66 years (mean: 46 years). The implant was used in 6 primary and 7 revisional cosmetic breast augmentation patients. The series included 9 postmastectomy breast reconstructions. In further, 6 patients the implant was used to revise existing breast reconstructions. After a mean follow-up period of 31 months, there were no infections, malrotations, or significant capsular contractures and no patients have required revisional implant surgery. The novel implant was successfully used to address specific challenges in cosmetic and reconstructive breast surgery. These included large skin envelopes in breast augmentation patients declining mastopexy, complicated implant exchanges, and suboptimal prosthetic breast reconstructions. This prosthesis may prove a useful addition to the range of breast implants available, especially when there is an overlap of challenging aesthetic problems.

Key Words: breast reconstruction, cosmetic breast augmentation, silicone gel implants, extra full projection, breast implants, implant rupture, revision

Breast implants in the 21st century are technically reliable and provide a safe method for both cosmetic augmentation and postmastectomy breast reconstruction. After a period of uncertainty about their possible risks,1–4 there has been a constant search for new and safer implants.5 The main developments have been a renewed interest in saline-filled implants6,7 and a general move from “liquid” to cohesive silicone gel breast implants.8–13 In addition to assuring constancy of form,14 higher cohesivity gels theoretically eliminated the risk of gel leakage in the event of rupture.15,16 Since the year 2000, anatomically shaped implants have become popular17 especially those composed of cohesive gel.10,12

Shape and projection are the most visible, objective parameters of an implant-augmented breast. Anatomic implants closely imitate the natural breast shape, with a low profile, superiorly, and increasing projection towards the lower pole. Ranges of differently projecting implants are available today. The implants discussed in this article address specifically the issue of projection.

Although excellent cosmetic results can be achieved with round or anatomic implants in most breast augmentation patients, frequently the surgeon is faced with patients with atrophic and ptotic breasts, with large empty skin envelopes refusing the scars, which would result from mastopexy. Another challenging group of patients are those undergoing capsulectomy many years after cosmetic augmentation, who often possess large breast pockets in the presence of ptotic breasts. Anatomic implants with extra full projection (EFP) could conceptually fulfill the aesthetic needs of these patients. One of the challenges of prosthetic breast reconstruction is poor projection, especially in the nipple areolar area, often in association with excessive upper pole fullness. It is frequently difficult to achieve sufficient projection of the nipple areolar area to match the contralateral breast.18 Theoretically, this deficiency could be addressed by the use of anatomic implants with increased lower pole projection.

This article reviews a single surgeon’s experience with EFP anatomic cohesive silicone gel breast implants, highlighting the potential indications identified for this novel implant.
PATIENTS AND METHODS

All patients who received a McGhan 410 EFP cohesive gel implant (Inamed Esthetics, County Wicklow, Ireland) for either cosmetic or reconstructive breast surgery by the senior author (C.M.M.) between November 2003 and April 2006 were included in this study. All implants were placed in the subpectoral position for the primary cosmetic augmentation group and in the same pocket after capsulectomy. For breast reconstruction, the implant was sandwiched between the pectoralis major and latissimus dorsi muscles.

Case notes were reviewed and the patients were assessed in outpatient follow-up clinics. Preoperative and postoperative appearances were documented using standard medical photography. Four years after the first use of EFP implants, a final follow-up assessment questionnaire was sent to all patients to record their postoperative satisfaction. Parameters including shape and consistency were assessed using linear analogue scales, each with a maximum score of 10. All patients who underwent implant exchange were additionally asked to score the improvement in breast shape and overall outcome.

RESULTS

Over the 29-month period, 28 patients received a total of 47 EFP implants. Their age range was 23 to 66 years with a mean of 46 years. The patient clinic follow-up period averaged 31 months (range, 18–45 months). The EFP implant was used in 13 patients for cosmetic augmentation (26 breasts) and in 15 patients for postmastectomy breast reconstruction (21 breasts) (Table 1). The volumes of the implants used ranged from 370 g to 620 g, with 495 g and 520 g being the most frequently used sizes overall (Fig. 1). Most of the implants used were from the medium height category, and no low height prostheses were required (Table 2).

In the cosmetic augmentation group, 6 patients underwent primary augmentation and 7 underwent revisional implant exchange. In the primary cosmetic augmentation group, the indications for using EFP implants were a large skin envelope and patients with ptotic or atrophic breasts refusing to undergo skin reduction surgery (Fig. 2). The indications for revisional cosmetic surgery included visible wrinkling or ridging, excessive upper pole fullness, severe capsular contraction (Fig. 3), and implant rupture.

There was one immediate breast reconstruction with an EFP implant, although 8 patients underwent delayed or

| Table 1. Indications for Extra Full Projection Implants |
|---------------|----------------|---------------|
| Indication                      | Patients | Breasts |
| Cosmetic augmentation           | 13       | 26          |
| Primary surgery                 | 6        | 12          |
| Revisioanl surgery              | 7        | 14          |
| Breast reconstruction            | 15       | 21          |
| Immediate                       | 1        | 1           |
| Delayed/planned 2nd stage       | 8        | 11          |
| Revision of existing reconstruction | 6   | 9           |
| Total                           | 28       | 47          |

FIGURE 1. Frequency of EFP implant sizes used in cosmetic and reconstructive breast surgery.

FIGURE 2. Preoperative (A, B) and postoperative (C, D) views of a 23-year-old cosmetic augmentation patient with glandular ptosis who declined mastopexy, instead opting for EFP implants (615 g FX).
planned second stage reconstructive procedures (11 breasts). Selected indications in this group included a large skin envelope and the need for projection to match the contralateral breast. Nine existing breast reconstructions in 6 patients were revised using the new implant (Table 1). The implant was used in 2 breasts within this group to augment a latissimus dorsi flap, and in 7 breasts for implant exchange. The indications for revision were suboptimal pre-existing reconstructions with significant capsular contractures (Fig. 4), poor projection of the nipple areolar area and implant displacement (Fig. 5).

Postoperative problems (Table 3) were mainly identified in the patients undergoing revisional surgery. Two patients reported paraesthesia (affecting 3 breasts) and 1 patient complained of nipple hypersensitivity. In the revisional reconstructive group, one patient was treated empirically with antibiotics after developing a pyrexia of unknown origin. Another complained postoperatively of tightness of the pectoralis major muscle and difficulties in shoulder abduction, which resolved with massage and anti-inflammatories. In the follow-up period there were no hematomas, infections, implant malpositions, malrotations, or significant capsular contractures (Baker grade III or IV). No patients have required revisional implant surgery to date.

The final assessment questionnaire was returned by 21 out of 28 patients (75%) after 2 mailings. Ninety percent of the respondents (19/21) were satisfied with the overall outcome (Fig. 6) of their surgery (mean satisfaction score = 8.9 of 10). Only 2 patients scored their satisfaction below 6. The first of these 2 patients deemed the initial result as excellent, but felt the reconstructed breast had reduced in size over time in relationship to the simultaneously augmented contralateral breast.

FIGURE 3. Preoperative (A, B) views of a 47-year-old with severe capsular contractures 25 years after breast augmentation. Appearances (C, D) after bilateral capsulectomies and implant exchange to 520 g MX implants.

FIGURE 4. This 46-year-old patient had severe grade IV contractures 20 years after bilateral subcutaneous mastectomies and implant reconstruction 20 years ago (A, B). Postoperative views (C, D) after total capsulectomies and insertion of 450 g FX implants.
healthy breast. The second patient fell into the cosmetic primary augmentation group. She presented with postlactational atrophic breast tissue and underwent subpectoral placement of 495 g EFP implants, as per her request for maximal augmentation. Postoperatively she complained of descent of glandular tissue given her a pseudo “double-bubble” appearance. Both patients have been recalled for further consultation. In the 14 patients who underwent implant exchange to EFP prostheses, all scored their overall satisfaction with revision equal or above 6, with an average score of 8.4 (Fig. 7). Additionally, these women all rated the improvement of their breast shape as greater or equal to 6, with an average score of 8.3 (Fig. 8).

<table>
<thead>
<tr>
<th>Complication</th>
<th>Patients</th>
<th>Breasts</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nipple hypersensitivity</td>
<td>1</td>
<td>2</td>
<td>Not troublesome</td>
</tr>
<tr>
<td>Breast paraesthesia</td>
<td>2</td>
<td>3</td>
<td>Resolved in 2/3 breasts</td>
</tr>
<tr>
<td>Tightness of pectoralis muscle</td>
<td>1</td>
<td>1</td>
<td>Settled with massage</td>
</tr>
<tr>
<td>Pyrexia of unknown origin</td>
<td>1</td>
<td>N/A</td>
<td>Resolved</td>
</tr>
</tbody>
</table>

FIGURE 5. Preoperative (A) and postoperative (B) views of a 37-year-old patient who underwent revision of a delayed expander/implant reconstruction by exchange to a 410 g EFP implant. Note the correction of the low infra-mammary fold and improvement in lower pole projection.
In prosthetic breast reconstruction, the degree of projection of the contralateral breast must be considered when selecting the appropriate implant, as this will need to be matched to optimize esthetic outcome. After mastectomy, the inability to achieve natural-looking projection is one of the well-known shortcomings of implant reconstruction. Many in this group of patients have ptotic or atrophic breasts, posing a further challenge to the surgeon attempting to achieve symmetry without the need for contralateral surgery. The EFP implant can help to achieve the highly desirable projection of the nipple areolar area required to match the contour of the opposite breast (Figs. 4, 5).

Many patients who receive breast implants, eventually develop breast ptosis and a descent of the inframammary fold, requiring either exchange for a larger implant, mastopexy, augmentation mastopexy, or the more recently described “power lift,” ie, suturing of the posterior leaf of the capsule to the pectoralis major muscle. The surgeon must accept that despite assisting the correction of ptosis in a previously augmented breast, the EFP implant in revisional surgery will be subject to the same the effects of gravity and, thus, result in further breast ptosis over time. By the very nature of their challenging indications, these implants are used at the larger end of the volume spectrum (in our study between 370 g and 620 g). Therefore, they may be more likely to stretch the soft tissues of the breasts in the long-term. This has, however, yet to be established as EFP implants have only been available for 5 years in Europe.

The novel EFP implant has helped to address specific challenges in cosmetic and reconstructive breast surgery. This preliminary study suggests that this implant may have a role to play in carefully selected cases, and opens a new window of opportunity to primary cosmetic augmentation patients with large skin envelopes who decline skin reduction surgery. In revisional cosmetic surgery, it may be used to salvage intractable complications in long-standing implants, notably severe capsular contractures and implant rupture. The EFP prosthesis also demonstrates its potential in selected breast reconstruction patients, by improving projection in the nipple areola region and, thus, symmetry with the contralat-
eral breast. Our early experience with this implant within these specific niche indications is encouraging.

In conclusion, extra full projection anatomic cohesive gel implants were useful in complex primary and revisional breast surgery, especially where there was overlap of different challenging esthetic problems. These prostheses were used safely without undue complications.

REFERENCES

AUTHOR QUERIES

AUTHOR PLEASE ANSWER ALL QUERIES

AQ1—Kindly check whether the short title is OK as given at the top of every third page.

AQ5—Please define “FX”, “MX”, and “LX”.

AQ2—Please note that Ref. [23] is not cited anywhere in the text. Kindly insert its citation at an appropriate place or delete it from the reference list (you do not need to renumber any references).

AQ3—Please note that the text in Ref 24, “Frequency of EFP…,” was deleted because it did not appear to be part of that reference. Kindly check.

AQ4—Please note that the references 24, 25 and 26 have been renumbered as they were not in sequence.