

# A Short Note on- Breast Augmentation

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## Introduction

The aesthetics of the female breast have drawn a lot of attention because the organ has traditionally been linked to femininity. Depending on a person's physical makeup and cultural traits, there are several ideal sizes and shapes. Sometimes breast growth doesn't go exactly as it should. Because of this, women with smaller-than-average breasts feel their figures are out of proportion and seek surgical reshaping. It is crucial that the surgeon takes the patient's preferences into account when arranging an augmentation operation. Enhancing one's breast size can significantly improve one's self-image. Many women seek breast augmentation to treat hypo plastic breasts. Those who have experienced significant postpartum involution may also opt for augmentation to improve their appearance. These women have experienced fullness and want it back. Some women choose surgery to correct asymmetry.

Breast augmentation has become the most common cosmetic surgery procedure since the introduction of silicone gel prostheses in 1962. In 1895, Czerny attempted the first augmentation mammoplasty, transferring a lipoma to the breast. In 1950, Longacre performed autogenous flap augmentation. Since the 1950s, numerous injectable materials have been tested. In 1961, Uchida reported the use of injectable silicone. Cronin and Gerow's 1962 introduction of the silicone gel breast implant ushered in the modern era of breast augmentation.

During World War II, silicone development advanced to meet the needs of the aircraft-engineering industry. Because it was soft and inert, it piqued the interest of medical professionals as well. The first generation implants (1962-1970) had thick shells, thick gel, and a Dacron patch in the back. It was shaped like a tear drop. Second generation implants had thin shells, thin gel, and a round shape (1970-1982). Third generation implants (available beginning in 1982) had thicker shells, thicker gel, and a round shape. Fourth generation implants (from 1986 onwards) resembled third generation implants except for the textured surface. They come in both round and anatomical shapes. Implants in the fifth generation (from 1993 onwards) have a more cohesive silicone gel and a textured silicone surface.

Arion first reported the inflatable saline-filled implant in France in 1965. The main advantage of using an inflatable implant was that the implant could be inserted through a small incision. The possibility of gel bleed was also eliminated. This also reduced the rate of capsular contracture. Inflatable implant problems include deflation, visible surface wrinkles, and a knuckle-like feel in volumetrically under-filled devices. If the device is overinflated, it may have the feel of a firm ball. Because of the implant's weight, more tissue thinning may occur, resulting in downward displacement of the implant over time.

The female breast's roughly circular body rests on a bed that extends transversely from the sternum's lateral border to the mid axillary line and vertically from the 2nd through 6th ribs. The pectoral fascia overlying the pectoralis major forms two-thirds of the breast bed, with the remaining third formed by the fascia covering the serratus anterior. The retro mammary space is a loose connective tissue plane or potential space located between the breast and the pectoral fascia (bursa). This plane, which contains a small amount of fat, allows the breast to move on the pectoral fascia. A small portion of the mammary gland may extend along the inferolateral edge of the pec major toward the axilla (armpit), forming an anastomosis.

The medial mammary branches of perforating branches and anterior intercostal branches of the internal thoracic artery, which originates in the subclavian artery, supply the arterial supply of the breast. Lateral thoracic and thoracoacromial arteries, axillary artery branches posterior intercostal arteries are thoracic aortic branches located in the 2nd, 3rd, and 4th intercostal spaces. The axillary vein receives the majority of the venous drainage from the breast, but the internal thoracic vein also receives some.

The anterior and lateral cutaneous branches of the 4th to 6th intercostal nerves give rise to the breast nerves. Because they run within the intercostal spaces, the anterior primary rami of T1 to T11 are known as intercostal nerves. Each anterior ramus is linked to a sympathetic trunk by rami communicants. Intercostal nerve branches travel through the deep fascia covering the pectoralis major to reach the skin, including the breast, in the subcutaneous tissue that lies beneath this muscle. Intercostal nerve branches thus carry sensory fibres to the breast skin and sympathetic fibers to the blood vessels in the breasts and smooth muscle in the overlying skin and nipple.

## Indications for mammoplasty augmentation

Prior to the operation, a thorough physical examination should be performed. Each breast's bone and muscle structural foundation must be evaluated. Take note of the thorax shape. Take note of whether the patient has a "long" or "short" chest. The suprasternal notch to nipple distance, nipple to inframammary fold distance, base width or diameter, and breast height are all important measurements. Identify skin elasticity by looking for signs of poor compliance, such as stretch marks or a thin non elastic dermis. It is also necessary to define the breast parenchyma. The quantity, quality, and distribution of parenchyma may influence surgical techniques.

Breast augmentation uses four different types of incisions-Transaxillary, Inframammary, Periareolar, Transumbilical. Following implant selection, the patient and surgeon should decide on the type of incision to be used after thoroughly explaining the options, risks, and benefits of each. The inframammary incision allows for complete visualization of the pre pectoral or sub glandular pockets, as well as precise placement of almost all implants. The procedure does result in a visible scar within the inframammary fold.

The Trans axillary incision can be made either bluntly or using an endoscope. This method prevents scarring on the breast mound. It can be used in a sub pectoral or sub glandular pocket with both saline and gel filled implants. The disadvantages of this approach are the difficulty with parenchymal alterations and the possibility of requiring a second incision in the breast mound for secondary correction surgeries. It may be difficult to position the implant correctly. Tran's umbilical breast augmentation has the distinct advantage of requiring only a single, well-hidden, remote incision. In this method, only saline implants can be used. Obtaining hemostasis from this remote access port is difficult.