AUGMENTATION MAMMOPLASTY FOR THE MALE TRANSSEXUAL

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SYNOPSIS

Augmentation mammoplasty was performed on 16 out of 116 transsexuals at the time of genital surgery. The subareolar, infra-mammary and trans axillary approach was used. The trans axillary approach appears to be the most aesthetic technique with least complications.

INTRODUCTION

Transsexualism is a phenomenon of cross gender identification. The transsexual seeks to live the life style of the gender opposite to the anatomic sex, and often seeks medical help to change the somatic sex to fit the psychic sex. The male-female transsexual seeks cosmetic surgery for eyelids, nose, chin, thyroid cartilage, breast and genital change. This paper will describe the mammary aspects of these patients.

MATERIAL

Between January 1971 and June 1980, there were 116 male to female transsexuals who had passed the psychiatric screening and had genital surgery. Most of the patients had been on estrogen therapy for 6-24 months before attending our clinic. Ten of the patients had had augmentation mammoplasty prior to attending our clinic and 7 had had silicone injections.

The breast size of the remaining was assessed as follows: Male breast 36, minute or small breast 30, moderate 23, well developed 10. A total of 16 persons had augmentation mammoplasty performed at the time of genital surgery. A further 9 had augmentation mammoplasty done subsequent to genital surgery.

The volume and shape used for each patient was chosen after describing the various options. The round and hanging tear drop were equally popular. The range of volume used was 180-300, with 225 being the most popular size. Silicone prosthesis (Dow Corning or Surgitek) were used for most of the cases but for the last 2 cases the saline filled silicone bag (Heyer-Schulte) was used.

RESULTS

The technique of insertion evolved through the subaerolar incision followed by the inframammary incision and then the axillary approach.

The subaerolar incision was used for 2 cases. The incision was carried from 3 o'clock to 9 o'clock on the aerola and extended down along the anterior surface of the breast tissue to the inferior border of the breast to reach the retromammary space.

A silicone gel bag was inserted, subcutaneous fat coapted with catgut and silk used for the skin.

The inframammary incision provided adequate access to the retromammary space for the larger than average prosthesis that the transsexuals required and was used in 11 cases. While the non transsexual female often only needs 125-175 ml to augment her breasts, the male-female transsexual often begins with flat chest and has a need to project herself and thus requests for volumes of 250-275 are not uncommon.

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A 4 cm incision is made along the lower border of the proposed breast pocket and extended inwardly towards the retromammary space- a silicone gel bag is milked into the cavity which is then closed off with catgut, and silk to the skin.

The axillary approach gives a good access to the pectoral fascia and retromammary space and is what we now feel should be the incision of choice and have used for the last 3 cases. Hoehler 1973 (1) describes in detail his axillary approach, and Wright and Bevin 1976 (2) performed the procedure on an outpatient basis. The axillae are shaved on the preceeding evening. General anaesthesia is used for the genital surgery and continued for the mammoplasty. The patient remains in the lithotomy position and an assistant closes the labial stitches. The arms are abducted 80° to the chest. The outline of the retromammary pocket is marked on the skin, extending around the 6-7th rib below, the sternal border medially, the 2nd rib above, and the anterior axillary line laterally (Fig. 1) The arm, axilla, neck and chest are swabbed with cevalon. A 4 cm transverse incision is made across the axilla along the most proximal skin crease (Fig. 2). The incision is deepened by scissors towards the lateral border of the pectoralis fascia. The fascia is split parallel to the lateral border of the pectoralis muscle for at least 5 cm. A retromammary space is created in this plane by blunt dissection using a Rampell sponge forceps with the tip well padded by a raytex swab. With sweeping movements the pocket is extended to follow the prepared outline (Fig. 3). It is important to create a pocket of adequate size. Too small a pocket will make the prosthesis feel hard. We do not instil steroids or antibiotics into the wound. Insertion of the inflatable prosthesis is simple and the correct volume of saline instilled and the stylette removed. If a silicone gel prosthesis is used, gentle milking of the prosthesis into the wound is required to avoid bag rupture. The prosthesis is massaged into place. The fat is closed with interrupted chromic catgut and skin with silk, to be removed on the 4th post-operative day. A micropore tape is applied to the wound (Fig. 4).

A light plaster is applied and changed for an elastic brassier on the 1st post-operative day. The patient is instructed to massage the breasts 3 times a day for 2 weeks to minimize capsule formation.

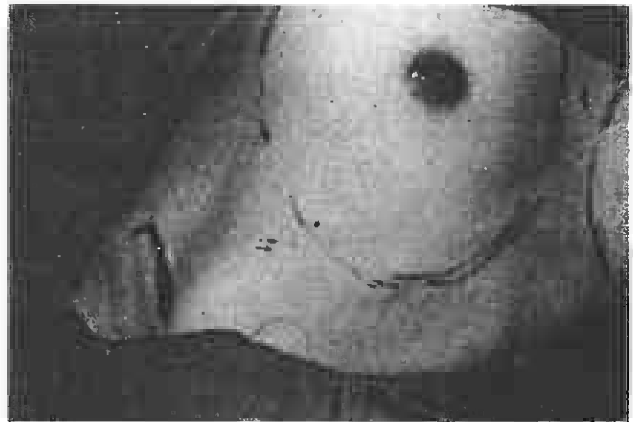

Fig. 2: A 4 cm transverse incision is made across the axilla.

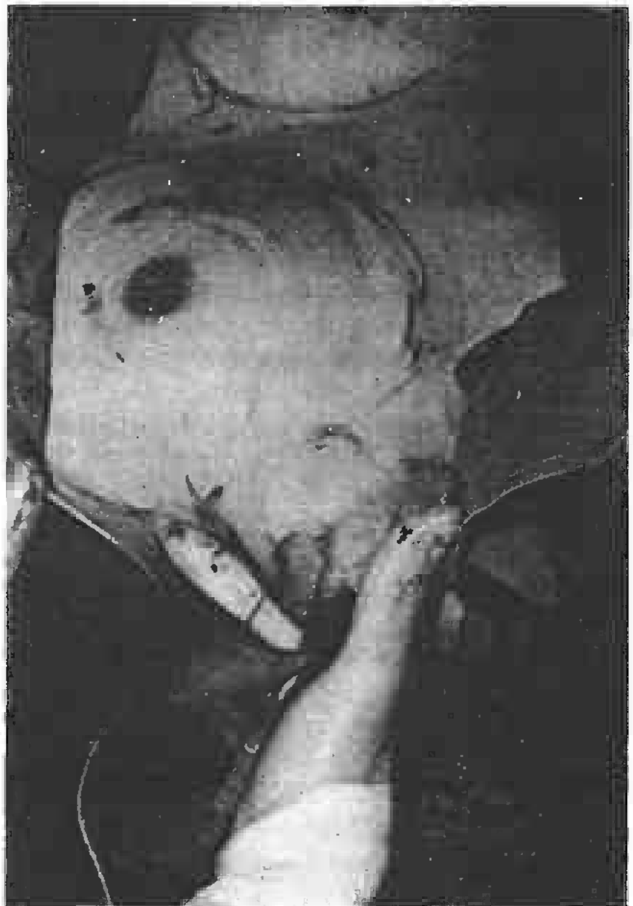

Fig. 3: Creation of a retromammary space.

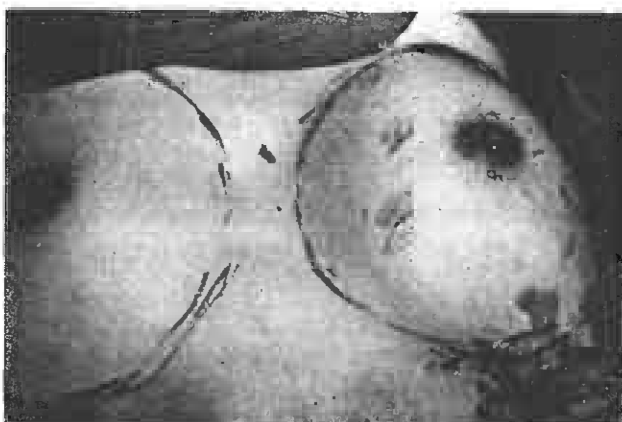

Fig. 1: Outline of retromammary pocket marked on the skin.

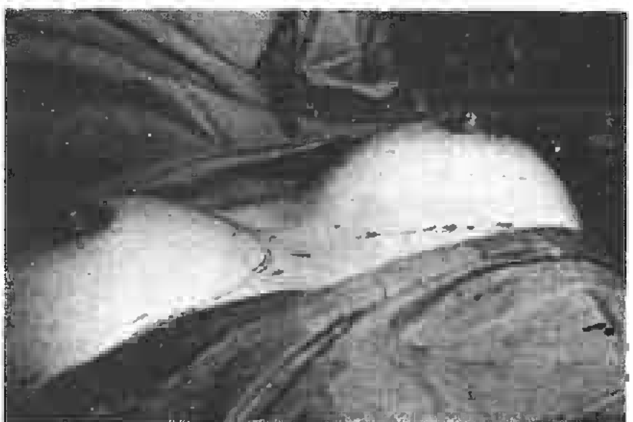

Fig. 4: The final result

COMPLICATIONS

There have been 3 cases of wound dehiscence, one of these having a haematoma, each with the infra-mammary approach. Secondary suture was successful in 2 cases and had to be repeated in 1 patient. Despite regular massaging of the breasts, capsule formation occured in 2 patients who had the prosthesis inserted by the inframammary route.

CONCLUSIONS

Consecutive experience with the subaerolar, infra-mammary and axillary approach has shown us that the axillary approach is the most aesthetic technique for augmentation mammoplasty, and is now our approach of choice. The desired shape and size of the cavity for the prosthesis can be planned precisely. It prevents lateral or downward displacement of the prosthesis. Augmentation mammoplasty by the trans axillary approach contributes favourably towards the surgical management of the transsexual.

REFERENCES

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