

Thank-you for contacting Dr. Medalie through the internet.

Dr. Medalie adheres to the same guidelines and principles of the Harry Benjamin International Gender Dysphoria Association. Prior to any surgical procedure, the prospective patients must fulfill the criteria established by the Benjamin Society and have letters of referral from a therapist (psychiatrist, psychologist or psychiatric social worker) who has had a long-term relationship with the patient. Your therapist should have a copy of these standards..

### **Chest Reduction Surgery**

The procedure is based on the following:

- Size and shape of breast
- Elasticity of skin
- Patient's needs and preferences

In general, patients who have smaller breasts can have the entire surgery performed in a keyhole pattern or in an incision around the areola-("peri-areolar or "puse-string" mastopexy). If the patient is willing to return for an additional procedure if necessary (revision of irregular scars-which are common), this is a very reasonable approach. In those patients with a large amount of breast tissue with excessive skin of poor quality and droop, it is usually recommend to remove the excess skin and breast tissue in the crease of the pectoralis muscles (elliptical or double skin excision mastectomy) and put the nipples back on as grafts. This surgery has the advantage of immediate and predictable results. I can contour the skin flaps and place the nipples where I want to. It has the disadvantage of permanently altering the sensation and erectile capacity of the nipples, and it leaves larger scars on the chest. Over time they fade and flatten out. Any of these operations can permanently affect sensation to the chest wall and nipple area.

Below is a patient who underwent peri-areolar surgery. The surgery starts with a cookie cutter around the nipple/areolar complex to make it smaller. The surrounding skin is then de-epithelialized, and then a subcutaneous mastectomy is performed. Once the breast tissue is gone, a drain is placed and the incision for the mastectomy is closed. The surrounding skin is then closed down to the smaller areolar with a purse-string suture (like a bag of marbles). This results in scalloping and bunching of the skin, but tightens the surrounding chest skin and elevates the nipples some. Because of the motion of the arms and the underlying pectoralis muscle after surgery, these scars invariably widen and develop an irregular appearance (as in the final post-op picture). I find that my peri-areolar patients ask for more revisions than my double incision patients. I can prevent this by extending the incision to create a true "keyhole" this results in a scar like a lollipop (i.e. a circle around the nipple and a decending vertical line). The advantage of this is more precise control of nipple/areolar position and size, and less irregularity of the scar. The disadvantage is the longer scar.



Pre-op peri-areolar



Areola resized and surrounding skin removed



Subcutaneous mastectomy performed



Breast tissue now gone



Purse string closure of skin to smaller nipple



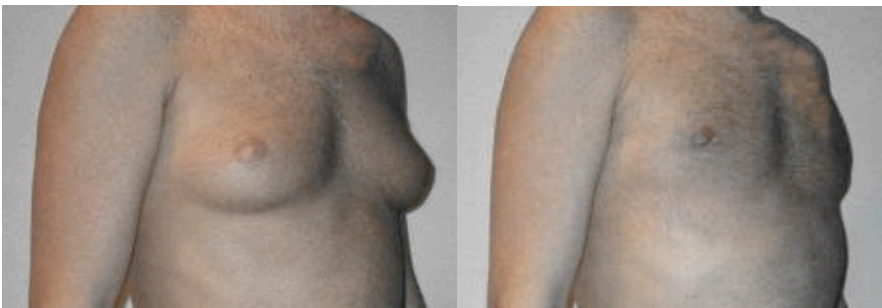
3 months post-op

Some small breasted patients have a strong preference for liposuction alone in order to preserve sensation or to stretch out the costs. You can have the liposuction done first, and if necessary, the residual breast tissue can be removed in a second operation. Having this done in two stages probably doesn't alter the final result, but does increase the number of operations required and time off work. In a majority of patients who have liposuction alone, I am certain that I could improve the result with surgical excision of the remainder of the breast tissue. The example below is ultrasonic liposuction in combination with subcutaneous mastectomy via a peri-areolar incision from the 4-8 o'clock position around the nipple



Before

After



Before

After

Chest surgery is routinely done as an outpatient. Depending on the extent of the surgery, silicone drains may be placed that will have to be removed in five to seven days. These drains help keep the tissues approximated and remove excess fluid. Removal is quite simple and can be done by any health care provider. If the elliptical (double incision) mastectomy is performed then the dressing holding the nipples in place needs to be removed at five to seven days. Below are two examples of elliptical mastectomy with nipple grafting. The first is at 3 months and the second at one year. Note that the red scars take up to a year to fade.



Before



After



Before



After

### Risks and complications

Obviously, procedures such as this are not without risks or complications and I want to review these with you.

- **Bleeding:** Bleeding is a risk of any operation, but the need for transfusion is very unlikely. More likely is the unwanted collection of blood beneath the skin. This may require simple monitoring or possibly another procedure to drain the excess blood. Blood that is left sitting under the skin can result in unwanted asymmetry or even infection.
- **Infection:** Infections are rare complications and usually treated with a course of oral antibiotics.
- **Nipple complications:** The nature of mastectomy is to remove tissue and by necessity small nerves. While there is some regeneration, sensation changes such as hypersensitivity or partial numbness can occur. When the nipples are used as grafts there will be a loss of sensation and erectile capacity. The blood supply of the nipple might be damaged with the more extensive surgery, and the nipple could die (particularly in smokers). If the nipples are used as grafts, then it is also possible that they might not survive (full loss is very unlikely, but partial loss can happen). These complications are rare in my experience.
- **Scarring:** The scars of the areola grafts usually heal very well, but the scars of the peri-areolar mastopexy can be bunched and pleated. Over time they will flatten out, but it is quite possible that they will need to be revised at a later date. The scars below the pectoral muscles (present in removal of large breasts) will take longer to fade out and will widen as mentioned above; however, a raised or excessively wide scar is possible and might need further treatment. It is possible that there may be residual tissue left, which appears as a contour deformity. This would need to be removed at a second stage.
- **Other risks:** Depression of the skin where the breast tissue was removed is a risk and possible complication. The possibility of this complication can be reduced or avoided by leaving some breast tissue on the skin. Since not all the breast tissue is removed, you are still at risk for

developing breast cancer, and therefore, you should still be vigilant in routine self-exam and screening for breast cancer.

- **\*\*Smoking is the number one reason that patients have peri-operative complications (loss or death of tissue). If you smoke you must quit completely (no nicotine patch etc.) for one month prior to the procedure.\*\***

## **SCHEDULING SURGERY IF YOU LIVE OUT OF TOWN**

I frequently perform operations on patients who live out of town and are unable to easily to see me in consultation prior to the procedure. I have several requirements for these patients: I must see pictures of them prior to scheduling surgery. They need to contact my office and have my secretary fax or e-mail them a history and physical form to be filled out and sent back. I must have a therapist letter. Typically the patient will come in to town 1-2 days prior to the procedure, and I will see them in my clinic (alternatively I will perform a phone consultation). I will then perform the operation and see them back in my clinic in 5-7 days to remove drains and change the dressing. This means that the patient will spend around 1 week in the Cleveland area. Patients who live far away, but can drive to Cleveland (2-6 hrs.), can go home the next day and drive back to see me for their first post-operative appointment. I will then follow the progress of the patient via e-mailed pictures on a weekly basis. Sometimes patients are unable to stay in town for the week. I have allowed them to go home with the drains and dressings in place. Their primary care provider can remove the drains and perform the first dressing change. I will follow the results via e-mail and sent digital pictures. My secretary has information about hotels in the area as well as financing.

## **FEES**

Please contact our office for current fees at 216-778-4450. Typical operation times run from 2-3 hours and would cost roughly \$1750-2250 for the anesthesia and facility fee as well as \$3000-4000 for the surgery fee depending on the procedure performed. The average patient spends around \$5500-6000 for a procedure (this includes all fees).

## **CONTACT**

I would be more than happy to discuss any of these procedures in more depth either by e-mail or in my clinic. If a patient lives far away, then pictures e-mailed or sent to me can help me determine what the best operative course might be.

For all non medical logistical questions please contact me secretary, Valerie at [yrowan@metrohealth.org](mailto:yrowan@metrohealth.org). You can also call 216-778-4450. My nurse, Andrea ([agallup@metrohealth.org](mailto:agallup@metrohealth.org)) understands the surgery very well and can answer most minor medical questions.

Thanks, and I hope to see you soon.

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