Letter to the Editor

Periareolar zigzag incision as an approach for gynecomastia

Incisão periareolar em zigue-zague como abordagem cirúrgica para o tratamento da ginecomastia

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Dear Sir,

We read with great interest the article titled, "Periareolar zigzag incision as treatment for gynecomastia"[1], under the Ideas and Innovations section in your reputed journal. We must congratulate the authors for their innovative idea of incorporating the basic principle of avoiding a long straight line by breaking the line as in W-plasty[2], Z-plasty, or geometric broken line closure.

A similar incision was described by Tu et al[3]. Of the various approaches described, including periareolar, transareolar, circumareolar, inframammary, and axillary, the periareolar seems to be one of the most commonly used approaches. The periareolar approach (superior, inferior, or medial) gives direct access to all the segments. Glandular excision can be performed under direct vision and promotes good hemostasis. However, the NAC aesthetic unit scar, which is sometimes hypopigmented and can be adherent, are the drawbacks of this approach.

Although the authors presented excellent aesthetic postoperative results, we find that the incision from the 3 o'clock to the 9 o'clock direction to be excessively longer than the 6- to 8-mm incision that we described earlier[4]. The innovative and novel idea of breaking the straight line by a zigzag incision is commendable, but we feel that it takes longer time to mark and execute the symmetrical incision. The three-layer closure seems to be tedious and consumes additional time and cost of operation theater charges and sutures; it also entails additional visits and procedures for suture removal. In our experience, a smaller incision left open seems to save time and cost, and to help prevent seromas while providing better aesthetic results.

The authors leave approximately 1 cm of the glandular tissue beneath the NAC, whereas we leave only approximately 0.5 cm of the gland. We strongly believe that pressure garments for longer periods provide better contouring; thus, we suggest using them continuously for 10 days and intermittently for 3 months. We feel that the use of a scar assessment scale and including a larger number of patients with longer follow-up would make the assessment more objective and allow for analysis of long-term results of this innovative approach.

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Answer

ANDRÉ LUIZ BILIERI PAZIO [1]

Dear Sir,

Thank you for your comments and interest in reading our article.

The aim of the zigzag incision for gynecomastia treatment is to camouflage the scar in the transition between normal skin and the areola-papillary complex. It is well known that techniques that break up or make the scar line more irregular provide greater camouflage and cosmetic acceptability[1].

Regarding the length of the incision, in our experience, extending the incision from the 3 o´clock to the 9 o’ clock points makes it easier to resect the glandular tissue that is underneath the areola-papillary complex and allows stopping of the bleeding securely and safely.

In our opinion, the three-layer closure is important to obtain a smooth aspect while avoiding a secondary deformity after resection of the glandular tissue (dinner-plate deformity). In addition, closing the incision in layers decreases the tension in the suture of the skin, which helps avoid complications such as hypertrophic scar and skin necrosis.

Once again, thank for your comments, and congratulations on your previous paper.

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