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A clinical case of secondary breast augmentation after previous implants removal

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The patient underwent primary breast augmentation at a different clinic. Two years later, the implants were replaced with larger breast implants (500 ml each). Three months after the procedure, inflammation of the right and left mammary glands occurred, which led to the removal of both implants. The patient was 24 years old when the surgery took place. She underwent a preoperative examination in accordance with the standards set by the Ministry of Health of Ukraine. The patient came to us for breast augmentation, correction of mammary gland contour imperfections, and management of postoperative scars. Round-shaped and moderate-profile implants were selected. Implant parameters: width 13 cm, projection 4.4 cm, implant texture — microtexture, volume 400 ml. We placed the implants in the retropectoral space, and used the dual-plane method for cavity formation. The surgical procedure lasted for a total of 140 minutes. The duration of the patient's hospitalisation was one day. No drains were used. The scars on the abdomen were also corrected and fixed in the projection of the inframammary fold. No complications occurred in the postoperative period. The patient received antibiotic therapy and took nonsteroidal anti-inflammatory drugs. Postoperative wound management was carried out. We prescribed compression underwear for the patient to wear for two months after surgery.

Mammoplasty is a commonly performed procedure in plastic surgery. It aims to produce predictable and agreed-upon aesthetic outcomes for the patient while maintaining a low rate of complications by adhering to modern surgical standards. The patient experienced complications that led to a significant scarring process. The pectoralis major muscle had a significant deformity, and the tissue showed scarring. The lack of muscle elasticity complicated the implant placement, leading to specific challenges throughout the operation. The occurence of complications following mammoplasty invariably has a lasting impact on the capsule's formation and increases the risk of developing both early and late postoperative issues.

Keywords
mammoplasty, breast augmentation, implant replacement.

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Breast augmentation surgery is one of the most common surgeries, with 1,892,777 surgeries performed worldwide in 2023. Two major aspects contributed to this scenario: the large number of plastic surgeons and the availability of various implant manufacturers [19, 11].

Numerous studies have been conducted on the adverse effects of silicone implants on breast tissue and approaches to addressing these problems [11]. Various indicators and methods can be used to select the ideal implant in terms of design, shape, and volume, including operative accesses, breast shape and contour, and nipple-areolar complex (NAP) position [12, 14].

Infectious complications after augmentation mammoplasty are rare, estimated to occur at a rate of 2—3 % [23].

About two-thirds of infectious complications emerge in the early postoperative period, while occasional cases of remote infectious complications developing years or even decades after surgery have been reported [25].

Infectious complications are more common after breast reconstructive surgery with implants compared to primary breast augmentation [3, 4, 21].

The major risk factors for infectious complications associated with breast implant placement

have not been thoroughly evaluated in prospective studies with long-term follow-up. The most significant determining factors have been identified as the surgical technique, the patient's general condition and the type of surgical intervention. Breast reconstruction after mastectomy and radiation therapy for breast cancer are particularly associated with an increased risk of infectious complications [7, 20].

The cause of infection in women with implants is difficult to determine, but potential sources include a contaminated implant, contaminated saline, the patient's skin, or milk ducts, as described in many studies where cultures were taken at the time of implant placement [27].

Late infection usually results from secondary bacteremia or an invasive procedure performed elsewhere in the body. Diagnostic and treatment strategies are provided and the importance of perioperative surgical prevention of remote infectious complications is discussed. The modern hypothesis about the possible role of normal microflora or subclinical infection in the occurrence of capsular contracture is also considered [9, 15—17, 24].

Anamnesis

Patient V., was born in 1999, was 24 years old at the time of surgery, and weighed 63 kg. She underwent primary augmentation mammoplasty in 2018 at the age of 19. Alergan implants in a round shape with a volume of 375 ml were placed.

Four years later (2023), the patient wanted to replace the implants with larger breast implants. She felt pain, discomfort, and changes in the aesthetic appearance of the mammary glands.

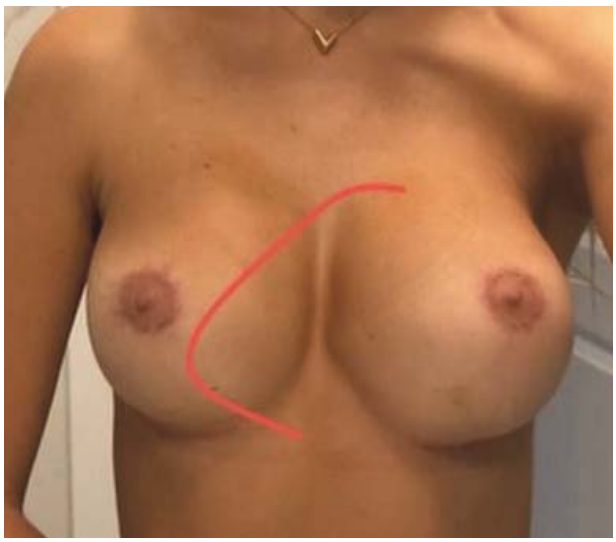

Figure 1. **Deformation of mammary gland contours after placement of 500 ml implants**

On March 30, 2023, she underwent placement of Mentor implants in a round shape with a volume of 500 ml. Fig. 1 presents the deformation of the mammary gland contours.

Three months after surgery, the patient reported a seroma on the right side and partially on the left side, along with pain and severe discomfort in the mammary glands. She had an elevated body temperature, and her chest became hot to the touch. The clinical signs progressed, and, in August 2023, a breast implant replacement surgery was conducted. The procedure included the removal of implants and the insertion of drains. According to the patient, the intraoperative visualisation of an intramuscular hematoma in the pectoralis major muscle and an inflammatory process supported the surgeon's decision.

Within two months after the operation, there was an inflammatory process in the suture area, followed by suppuration and long-term, considerable discharge from the drains.

In November 2023, hypertrophied scars appeared on the skin of the anterior abdominal wall, lower than the inframammary fold.

In 2024, the patient contacted us to discuss the possibility of correcting these complications. An operation was planned and carried out to reconstruct the pocket cavity for implants, increase the volume of mammary glands, manage scars, and relocate them to the projection of the inframammary fold.

At the preoperative examination and after agreeing on the desired volume of the mammary glands with the patient, it was decided to place round-shaped and moderate-profile breast implants. The implants had a width of 13 cm, which was determined by anthropometric tests, a projection of 4.4 cm, and Mesmo microtexture implant coating by Polytech Health and Aesthetics GmbH.

Before the operation, the patient had thickened scars around the areolas, their contours were unclear, and they were 4 to 7 mm wide. The scars from the previous surgical intervention were noted in the area of the abdomen, receding (at the most distant point) from the true inframammary fold by 5 cm to the right and 4 cm to the left. They were atrophic, measuring 4 to 8 mm wide, and tightly soldered to the body.

The contour of the mammary glands was clear, with a pronounced inframammary fold; the medial part was narrowed and deformed. The cleavage area at the level of the nipples was 8 cm, and at the level of the inframammary fold, it was 11.5 cm, as seen in Fig. 2*A*. When the pectoralis major muscles were contracted, the deformation of the contours of the mammary glands and their displacement laterally were noted, as seen in Fig. 2*B*, where white arrows

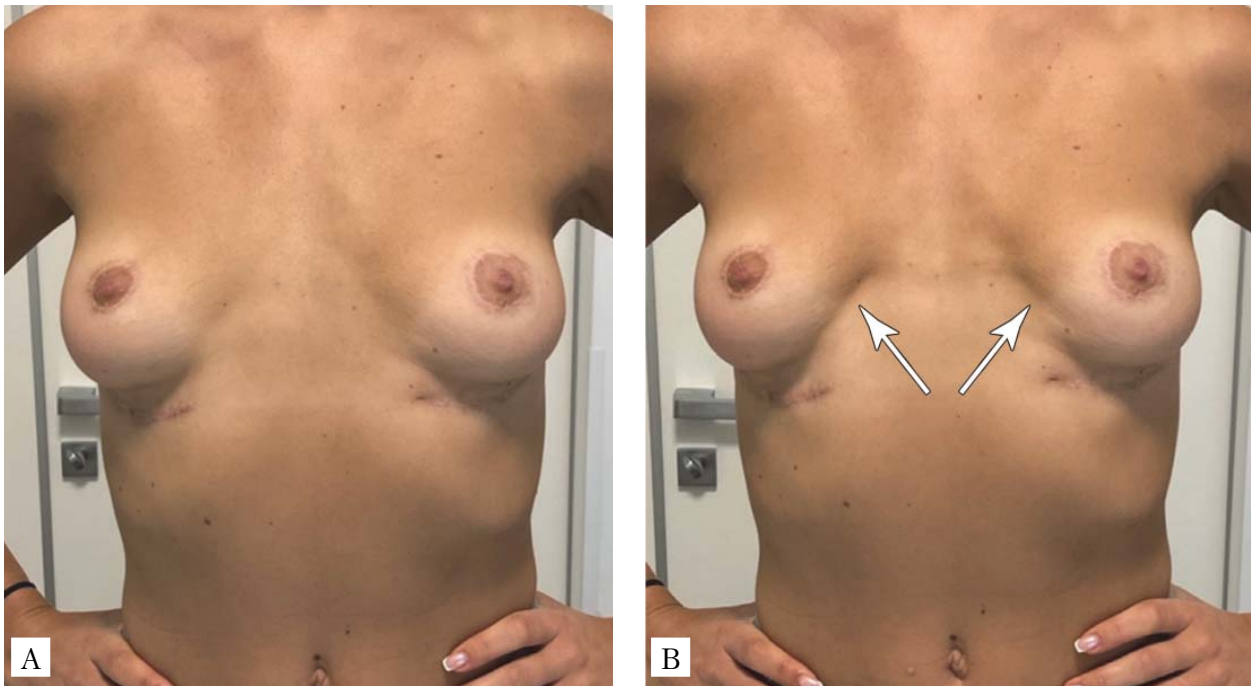

Figure 2. **The patient's condition before the reconstruction: without contraction of the pectoralis major muscles (A) with contraction of the pectoralis major muscles, which causes retraction and deformation of the internal contour of the mammary glands (B)**

mark the area of animation due to the pectoralis major muscles being strained.

The operation was performed under general anesthesia using local anesthesia (physiological solution 200 ml + lidocaine 10 % 4 ml + Bupivacaine 20 ml). The surgical procedure lasted for a total of 140 minutes. The duration of the patient's hospitalisation was one day. The preoperative marking of the patient is shown in Fig. 3.

After hydropreparation, the scars located on the anterior abdominal wall were excised. The dissection was conducted towards the inframammary fold. A planar dissection was performed, carefully selecting folds to ensure the proper contour of the mammary glands in the future. Further dissection was carried out in the retromammary space. The hard scars from the previous surgical procedure were dissected in the retromammary space up to the level of the nipples.

The pronounced scar process posed technical difficulties during the isolation of the pectoralis major muscle's edge. The muscle exhibited scarring, had a fibrous structure, and lacked elasticity. We formed a cavity to place the breast implants in the retropectoral space, then made vertical incisions in the scarred muscle due to its unelastic caudal part. The cavity was tamponed with Ceftriaxone antibiotic solutions. On both sides, the dissection and breast implant placement planes were symmetrical. On the left side, within the retropectoral space, there were remaining fragments of the previous implant capsule located in the central part of the retropectoral space. The capsule had dimensions of 5 × 4 cm, no additional inclusions, and a thickness of approximately 2 mm. We successfully removed it. After removing tamponing napkins, repeated hemostasis was performed. In such cases, we wash the implant cavity

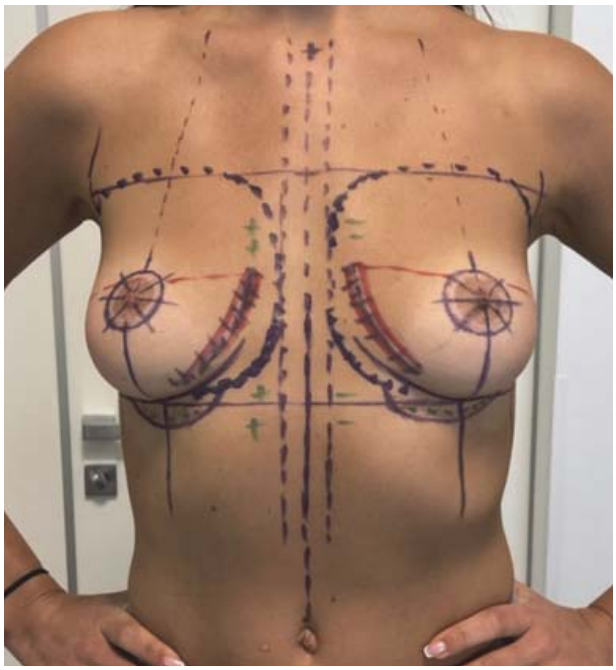

Figure 3. **Preoperative marking of the patient**

with a solution of Tranexamic acid at a concentration of 100 mg/ml. We used a Keller Funnel 2 to insert the implants in the prepared cavity.

No drains were used. The true inframammary fold was fixed in the correct position. The inframammary fold's fixation point was cranial to the lower part of the incision, as shown in Fig. 4.

A decision was made to extend the incision in order to align it with the inframammary fold in order to excise excess skin in the medial and lateral parts of the incision. The caudal part of the incision was not extended to the level of the inframammary fold. Instead, a dissection of the caudal part was carried out in a plane deeper than the superficial fascia. In the central part, the dissection was 10 cm long, which was enough to reposition the caudal part of the scar to the desired level of the inframammary fold. Since the caudal part of the incision was 25 cm and the cranial part of it measured 13 cm, the wound was sutured by absorbable suture poleglactine 3-0.

Figure 4. **The position of the caudal part of the postoperative scar in relation to the inframammary fold**

The correction of the scars around the areolas was not carried out due to a pronounced tension in this area, which could cause the development of non-cosmetic scars in the future. The patient was prescribed compression underwear.

The surgery lasted for a total of 140 minutes. The patient was hospitalised for a duration of one day and thereafter discharged for outpatient treatment. Prior to discharge, an ultrasound examination was performed, which revealed the absence of any fluid accumulation in the implant cavity.

In the future, examinations were conducted at intervals of 3—4 days. Pronounced postoperative swelling was noted for a period of 9—15 days. Immediately after the operation, a photo fixation of the obtained result was carried out. Fig. 5 shows the patient in a lateral projection immediately after the surgical procedure.

On the 5th day, up to 5 ml of fluid was detected around the implant on the right side, along with a localised hematoma measuring 4 ml in volume in the medial part of the mammary gland on the right side, namely in the retromammary space. Eight days after conservative treatment, a repeated ultrasound

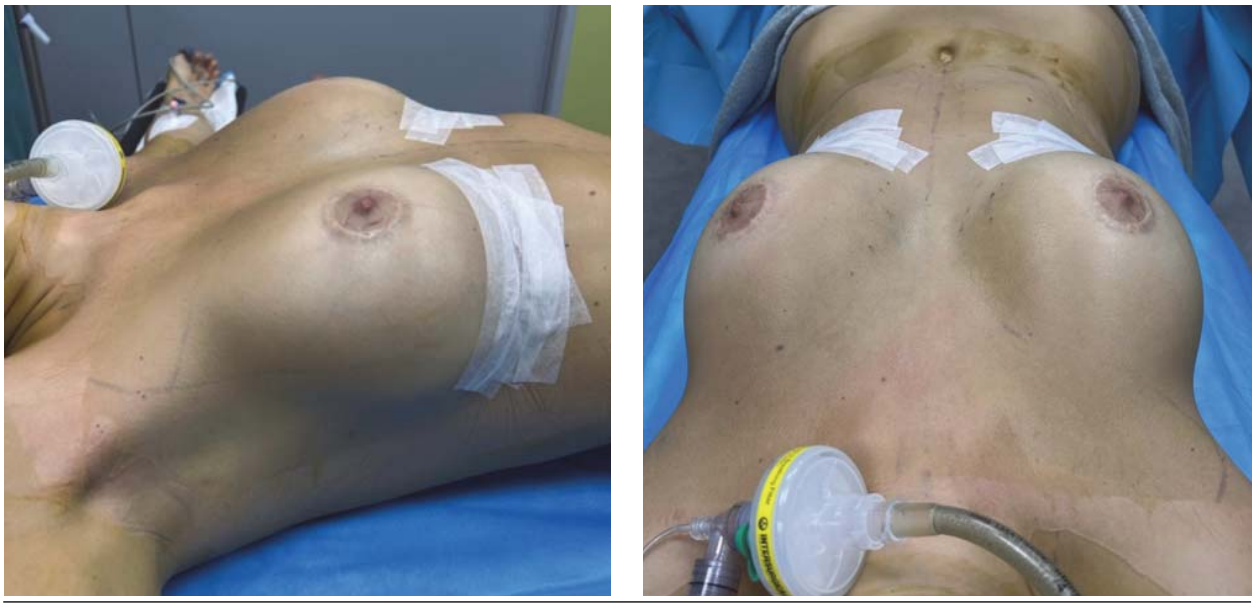

Figure 5. **The patient's condition immediately after the operation**

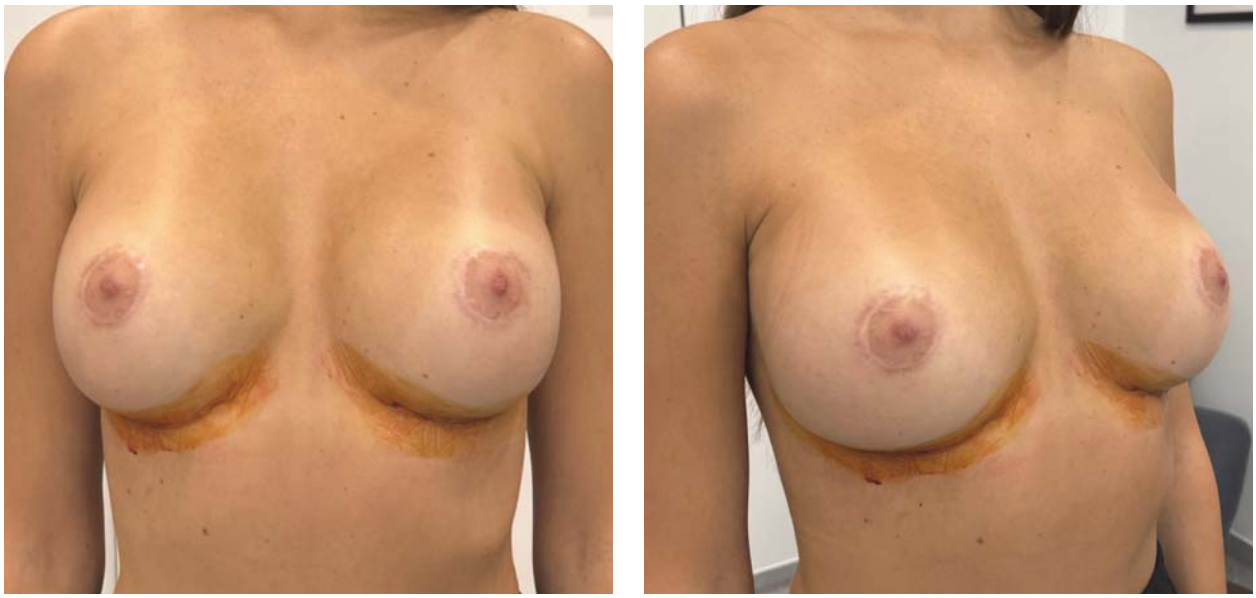

Figure 6. **The patient's condition on the 8th day after surgery**

examination did not reveal any free fluid in the area of surgical treatment. Fig. 6 shows the patient's condition on the 8th day after surgery.

The sutures were removed on the 14th day after surgery. An ultrasound study was conducted after 14 days to assess for any abnormalities, but no pathology was detected. The follow-up examination was made one month later. The implants were positioned symmetrically, and the neckline exhibited a symmetrical, clear contour without any deformities. The shape of the mammary glands was symmetrical, correct, and non-deformed. The implants showed minimal animation due to slight lateral displacement, which did not cause any changes in the mammary gland contour. The inframammary folds aligned with the location of postoperative scars. There was no skin deformation on the abdomen.

The main complication in the early postoperative period was impaired skin sensitivity in the area between the areola and the inframammary fold. However, this condition improved and returned to normal over a span of 2 months. The hematoma in the retromammary space, with a volume of 4 ml, cleared without complications and did not change the contour. No further accumulation of fluid around the implants occurred. No signs of purulent

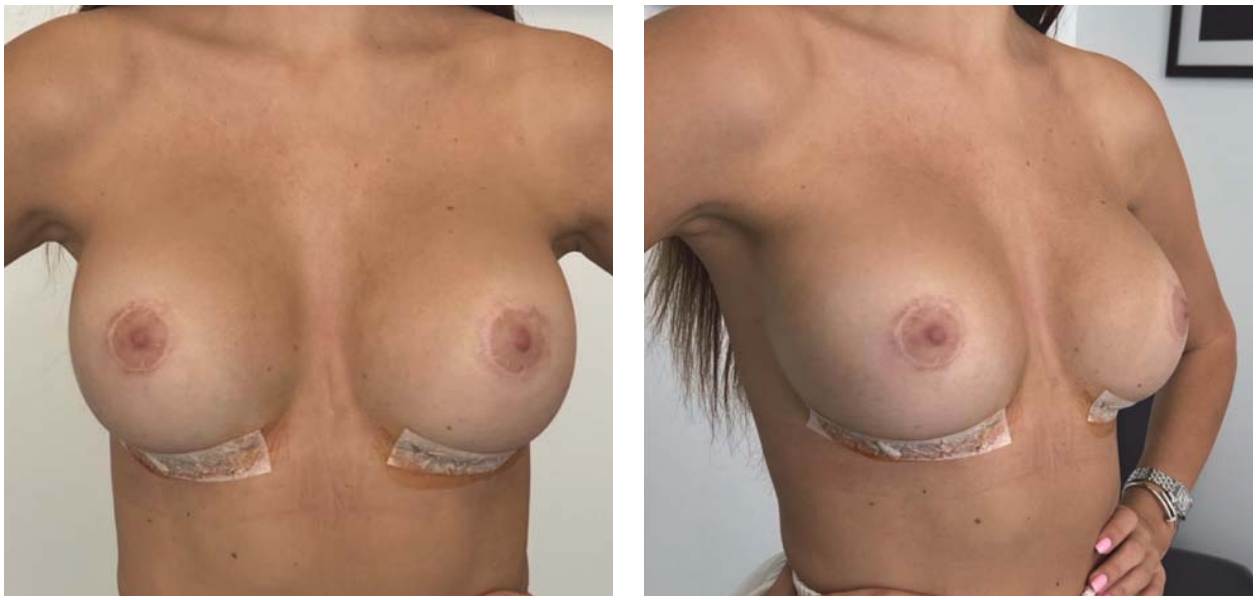

Figure 7. **The patient's condition one month after surgery**

Figure 8. **The patient's condition three months after surgery**

inflammation were observed in the incision area (0 %). Fig. 7 shows the patient's condition one month after surgery.

Three months after surgery, the patient reported complete satisfaction with the outcome. The breasts exhibited optimal symmetry, with the folds aligning with the position of the scars. The scars healed without any signs of inflammation. Fig. 8 shows the patient's condition three months after surgery.

Discussion

Augmentation mammoplasty is one of the most common cosmetic surgeries, and the most common method of breast reconstruction after mastectomy is tissue expansion followed by implant implantation. Despite this, reoperation rates of up to 15 % and approximately 21 % for implant-based reconstructions have been documented. Therefore, strategies to reduce early postoperative and long-term complications are extremely important. In particular, the important prevention of contamination and the formation of further biofilms that cause the formation of capsular contracture are critically important [8, 22, 26].

Certain methods are employed to prevent bacterial contamination of the implant and biofilm formation. These include administering antibiotic prophylactic doses, avoiding periareolar incisions, selecting appropriate implant coverage, performing surgery in the double or subpectoral plane, sealing nipple films, irrigating implant cavities with a triple antibiotic solution, or PVP-I, and using plastic medical sleeves for implant placement [1, 2, 18, 28, 29].

Prior to any invasive percutaneous procedure, it is standard practice to decontaminate the skin using antiseptics. While there is ongoing debate about the most effective preoperative skin antiseptic to reduce the risk of surgical site infections (SSI), surgeons worldwide have traditionally used PVP-I as the most commonly used antiseptic.

PVP-I, commonly known as «betadine», is a water-soluble compound obtained from the combination of polyvinylpyrrolidone and molecular iodine. PVP-I preparations, which are most often used in surgery, are a scrub and an aqueous solution and are one of the best methods of skin treatment during aesthetic breast surgery, as proven by a number of studies [5, 6].

Although strict adherence to rigorous aseptic and antiseptic protocols is maintained, there is still a possibility of contamination of the implants or the created cavity by S epidermidis located at the wound edges during the placement of the implant [10].

Conclusions

Mammoplasty is one of the most common operations in plastic surgery. It aims to produce predictable and mutually agreed-upon aesthetic outcomes with the patient. When performed in accordance with established surgical standards, this procedure has a low incidence of complications.

The operation requires adherence to stringent aseptic and antiseptic protocols. The presence of infectious complications suggests a violation of these norms.

Correcting postoperative complications necessitates a proficient and highly qualified surgical team with superior technical skills. During the postoperative period, it is extremely important for the patient to follow all recommendations in order to minimise the occurrence of any complications.

Declaration of interests

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Ethics approval and written informed consent statements

Both oral and written informed consent was obtained from the patient to publish the patient-related data in anonymized form.

Authors contributions

O. Panchuk: concept and design of the study, material processing; I. Donets: material collection and processing; K. Galperin: writing the manuscript, material processing.

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Клінічний випадок вторинної аугментаційної мамопластики після видалення попереднього імплантату

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Пацієнтка була первинно прооперована в іншій клініці. Було проведено первинну аугментаційну мамопластику. Через 2 роки імплантати замінили на більший об'єм, він склав по 500 мл. Через 3 міс після заміни імплантатів виникло запалення правої та лівої молочної залози, що призвело до видалення обох імплантатів. На момент нашої операції пацієнтці було 24 роки. Обстежена в передопераційному періоді за стандартами МОЗ України. До нас звернулася з бажанням збільшити об'єм грудей, скоригувати деформацію контуру молочних залоз, виправити післяопераційні рубці. Було підібрано круглі імпланти, середньої проєкції. Параметри імплантатів: ширина 13 см, проєкція 4.4 см, текстура імплантату — мікротекстура, об'єм 400 мл. Імплантати встановлювалися в ретропекторальний простір, застосовувалася техніка формування порожнини для імплантів по методу Dual-plane. Операція тривала 140 хв. Пацієнтка перебувала у стаціонарі одну добу. Дренажі в порожнину імплантів не встановлювалися. Одночасно було проведено корекцію рубців на животі та фіксація їх в проєкцію інфрамаммарної складки. Післяопераційний період проходив без ускладнень. Пацієнтка отримувала антибіотикотерапію та приймала нестероїдні протизапальні препарати. Проводилися перев'язки післяопераційних ран. Компресійну білизну пацієнтка носила 2 міс після операції.

Мамопластика — одна з найпоширеніших операцій в пластичній хірургії, яка дає змогу досягти передбачуваних і узгоджених з пацієнтом естетичних результатів, а також при дотриманні всіх норм сучасного виконання операції має низький рівень розвитку ускладнень. Ускладнення, що виникли у пацієнтки та зумовили необхідність видалення імплантатів, спричинили виражений рубцевий процес. Великий грудний м'яз був деформований, тканина його рубцево змінена. Це не давало йому змоги розтягуватися для встановлення імплантату, що створювало певні труднощі на операції. Ускладнення, які виникають після мамопластики, завжди мають віддалений вплив на формування капсули та підвищують ризик розвитку ранніх та віддалених післяопераційних ускладнень.

Ключові слова: мамопластика, збільшення молочних залоз, заміна імплантатів молочних залоз.

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