The authors describe their experience with therapeutic reduction mammoplasty in large-breasted women with breast cancer using superior and superomedial pedicles. The study involved 50 women with breast cancer and large breasts who underwent simultaneous bilateral reduction mammoplasty. The weight of the tissue removed ranged from 550 g to 1050 g and the tumor-free safety margins by frozen section were in the range of 4 cm to 12 cm. The age of the patients ranged from 36 to 58 (median 43) years and tumor size ranged from 1 cm to 4 cm. The cosmetic outcomes were excellent in 32 patients (64%), good in 15 (30%) patients, and fair in three patients (6%). The follow-up period was 8–36 (mean 20) months, with no local recurrence or systemic metastasis. The authors conclude that therapeutic reduction mammoplasty using superior and superomedial pedicles was shown to be oncologically safer than traditional conservative surgery. This oncoplastic procedure yields a satisfactory esthetic outcome with lower morbidity in large-breasted women with breast cancer.
for bilateral mammoplastic reduction techniques in patients with large breasts using medial and superomedial pedicles.

**Materials and methods**

Fifty large-breasted women with early breast cancer were enrolled in this study. Standard criteria for breast conservation therapy were maintained in all selected patients with a single tumor confirmed by preoperative mammography. Oncologic exclusion criteria were inability to obtain tumor-free safety margins after reasonable attempts, multicentric carcinoma, inflammatory breast cancer, contraindication to radiotherapy, and infiltrating lobular carcinoma due to a high incidence of multicentricity, and the need for preoperative magnetic resonance imaging which was not feasible. Nononcologic exclusion criteria were small breast size, centrally located tumors, comorbidity, and the patient’s own treatment preference (Table 1).

Preoperative marking was performed according to the site of the tumor. The superior pedicle was used for tumors located in the lower inner quadrant (Figure 1), while the superomedial pedicle was used mainly for tumors in the upper outer and lower outer regions. The same marking was performed for the other breast simultaneously (Figure 2).

De-epithelialization of skin in the medial parts of the designed flap was done (Figure 3). After tumor excision with a good safety margin (4–12 cm, Figure 4), the specimen was examined by frozen section in order to evaluate the safety margins.

In our series, we started first with the diseased breast, and after assessment of adequate tumor free safety margins, the same procedure in the contralateral breast was done to assure symmetry (Figure 5). All patients were referred to the Clinical Oncology and Nuclear Medicine Department where they received radiotherapy and adjuvant chemotherapy according to the stage and type of tumor. Follow-up after stitch removal was weekly for one month, monthly for 6 months, every 3 months for one year, every 6 months for 2 years, and then yearly. All patients were evaluated for postoperative complications, and esthetic and oncologic outcomes. The esthetic outcomes were evaluated after 6 months and

**Table 1** Patients and tumor characteristics

<table>
<thead>
<tr>
<th>Patients age (y)</th>
<th>36–58</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>43</td>
</tr>
<tr>
<td>Tumor pathology</td>
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<tr>
<td>DCIS</td>
<td>3</td>
</tr>
<tr>
<td>Invasive ductal carcinoma</td>
<td>44</td>
</tr>
<tr>
<td>Medullary carcinoma</td>
<td>3</td>
</tr>
<tr>
<td>Tumor stage</td>
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<td>pT1</td>
<td>10</td>
</tr>
<tr>
<td>pT2</td>
<td>40</td>
</tr>
<tr>
<td>pN0</td>
<td>14</td>
</tr>
<tr>
<td>pN1</td>
<td>36</td>
</tr>
<tr>
<td>Grading</td>
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<td>G1</td>
<td>9</td>
</tr>
<tr>
<td>G2</td>
<td>32</td>
</tr>
<tr>
<td>G3</td>
<td>9</td>
</tr>
<tr>
<td>Tumor location</td>
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<tr>
<td>Upper outer quadrant</td>
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</tr>
<tr>
<td>Lower outer quadrant</td>
<td>18</td>
</tr>
<tr>
<td>Lower inner quadrant</td>
<td>4</td>
</tr>
</tbody>
</table>

In our series, we started first with the diseased breast, and after assessment of adequate tumor free safety margins, the same procedure in the contralateral breast was done to assure symmetry (Figure 5). All patients were referred to the Clinical Oncology and Nuclear Medicine Department where they received radiotherapy and adjuvant chemotherapy according to the stage and type of tumor. Follow-up after stitch removal was weekly for one month, monthly for 6 months, every 3 months for one year, every 6 months for 2 years, and then yearly. All patients were evaluated for postoperative complications, and esthetic and oncologic outcomes. The esthetic outcomes were evaluated after 6 months and
Results

The age of the patients ranged from 36 to 58 (median 43) years. Twenty-eight patients had tumors at the upper outer quadrant, 18 patients at the lower outer quadrant, and four patients at the lower inner quadrant. The size of the tumor ranged from 1 cm to 4 cm. Most of the patients were diagnosed as having infiltrating ductal carcinoma (44 patients, 88%). The weight of tissue removed ranged from 550 g to 1050 g. The tumor-free safety margins ranged from 4 cm to 12 cm.

Wound dehiscence was the commonest postoperative complication. It occurred in four patients, which was minor and affecting less than half of the longitudinal scar in three patients, and was managed conservatively. The fourth patient had secondary infection with dehiscence affecting more than half of the longitudinal scar and was managed by secondary suturing after infection control.

Moreover, two patients developed partial necrosis of the areola; these were small areas and were managed by debridement of the edges and secondary suturing. Another two patients developed a small firm area along the suture line 9 months postoperatively and were investigated by son mammography and Tru-cut biopsy, revealing traumatic fat necrosis that was surgically excised.

Six months postoperatively, the cosmetic outcome was judged by 32 women (64%) as excellent (Figures 6 and 7), 15 women (30%) patients showed good results (Figure 8), and the other three patients (6%) rated the outcome as fair.
Local control could be a determinant of survival in a percentage of affected women, and large free margins of resection are recommended by the pioneers of breast conservative treatment.

Denewer used the pectoralis major myomammary flap in large-breasted women as a method of reconstruction. Reported advantages were that the donor side is reduced, with reconstruction of the other breast resulting in adjustment of the volume of both breasts in the same sitting, there is no loss of pectoralis major function because only a part of the muscle is used with easy transference, the nipple/areola complex is reconstructed during the same surgery, and four-quadrant biopsies can be taken from the healthy breast to be used in follow-up.

The main disadvantage of this procedure is symmastia. With the introduction of skin-sparing and nipple-sparing mastectomies as reliable and safe surgical procedures that facilitate immediate breast reconstruction, the challenge of the large breast persists. Denewer et al developed a new modification for the extended latissimus dorsi flap using the visualized fat overlying the serratus anterior muscle with its own blood supply driven directly from the thoracic branch of the thoracodorsal artery. This richly vascularized fat adds significant bulk with a decreased incidence of fat necrosis, enabling the surgeon to reconstruct a larger breast size without a contralateral reduction operation or an implant, with a low flap complication rate.

In this study, reduction therapeutic mammoplasty was used for the management of early breast cancer in large-breasted women, and we consider it to be a more conservative and less radical procedure.
Caruso et al evaluated the outcomes in 61 cases treated using reduction mammoplasty and reported five cases of skin complications and one case of partial nipple necrosis.\(^8\) In the present study, four patients (8%) developed wound dehiscence and two cases of partial areolar necrosis. However, Munhoz et al reported an immediate complication rate of 17.6%, comprising skin necrosis (8.1%), infection (2.7%), partial necrosis of the nipple-areola complex (2.7%), dehiscence (1.35%), and total necrosis of the nipple-areola complex (1.35%).\(^9\) Skin necrosis and wound dehiscence are the most often reported complications after therapeutic reduction mammoplasty.\(^10\) Obese patients, smokers, and diabetics carry an increased risk of developing local complications.\(^11\)

In our study, there was no conversion to mastectomy due to the easy attainment of tumor-free safety margins in all cases, as a result of wider excision being possible in large breasts. McCulley and MacMillan reported a series of 50 breast cancer patients treated with therapeutic mammoplasty, in which four patients (8%) required reoperation due to surgical margin involvement.\(^21\) Chang et al evaluated the degree of patient satisfaction and cosmetic results, and 20/37 women (54%) and 14/20 women (70%) reported excellent results.\(^7\) We now report similar results from our study. Caruso et al reported one case (1.6%) of local recurrence with a follow-up period of 68 months,\(^8\) and Chang et al showed a zero recurrence rate.\(^7\) No local recurrence was observed in our short-term study, but a further long-term study is needed to assess the long-term outcome of this surgical procedure in Egyptian women as regards the risk of local recurrence.

**Conclusion**

Therapeutic reduction mammoplasty for early breast cancer in large-breasted women is a surgically and oncologically safe procedure that yields satisfactory esthetic results with lower morbidity.

**Acknowledgment**

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**Disclosure**

The authors report no conflicts of interest in this work.

**References**
