Aesth Plast Surg (2019) 43:1437–1438
https://doi.org/10.1007/s00266-019-01491-6

EDITOR'S INVITED COMMENTARY

Invited Discussion on: Is There a Breast Augmentation Outcome Difference Between Subfascial and Subglandular Implant Placement? A Prospective Randomized Double-Blind Study

Elizabeth J. Hall-Findlay[1]

Received: 3 August 2019 / Accepted: 27 August 2019 / Published online: 6 September 2019

Level of Evidence V This journal requires that authors assign a level of evidence to each article. For a full description of these Evidence-Based Medicine ratings, please refer to the Table of Contents or the online Instructions to Authors www.springer.com/00266.

The authors are to be congratulated on an interesting way to "double blind" the results of breast augmentation using either a subglandular or a subfascial approach. The claim that subfascial augmentation is superior to subglandular augmentation has been controversial and, as with many aspects of aesthetic surgery, it is subject to personal opinion without good scientific evidence. This paper attempts to add more objective evidence both from a clinical and a radiological perspective. The results show that there really is not much difference.

The idea of having one surgeon perform all the subfascial augmentations and the other surgeon perform all the subglandular augmentations could have introduced bias because each surgeon could use different techniques that were independent of the plane.

I am surprised that the Baker III breast firmness was over 25% in each plane at one year. That is quite high—which also reflects how subjective the evaluation is for capsular contracture. These were all Silimed implants which are firmer than the softer smooth silicone gel implants.

I used the subfascial plane several years ago in 69 patients (I perform about 15% of my implants in the subpectoral plane). There is an initial learning curve, there is a bit more bleeding, and the procedure takes about 10 min longer (total). I used both textured (Biocell) and smooth implants. I reverted back to the subglandular plane because I did not see any significant difference for the extra time involved. Admittedly, my assessment was not evidence based, and it was just easier for me to go back to my original techniques.

It is unlikely that the thin fascia actually provides any more thickness to camouflage the implant edges. The reason that I tried was because Graf [1, 2] had convincing intraoperative video which showed that the fascia would pull on the muscle superiorly which would then better cover the implant edge. The difference was slight, and I felt it was better to use the subpectoral plane when faced with a very thin patient with minimal breast cover.

I would like to see the authors perform the same study using smooth implants. One aspect of the subfascial plane that might be valuable would be to help lateral slide of the implant if the surgeon could keep the fascia intact laterally during the dissection. The aggressively textured implants used in this study, by virtue of their adherence, could prevent the lateral slide that plagues smooth implants. Patients would need to be evaluated in the supine position both clinically and photographically.

One thing that I did try was to fold down the fascia as a sling to help hold up the implant in a mastopexy augmentation but, in spite of suturing up the fascia, this was not successful. This inferior fascia was quite thick and failed to hold the (smooth) implant superiorly; perhaps the lateral (thinner) fascia would also fail to hold the implant medially.

✉ Elizabeth J. Hall-Findlay
ehallfindlay@banffplasticsurgery.ca

[1] 106-75 Dyrgas Gate, Banff Plastic Surgery, Canmore, AB T1W 06, Canada

We need more evidence-based studies like this. For too long, we have been subject to expert opinion which is often clouded by a conflict of interest.

Compliance with Ethical Standards

Conflict of interest The author declares no conflict of interest.

Ethical Approval This article does not contain any studies with human participants or animals performed by any of the authors.

Informed Consent For this type of study, informed consent is not required.

References

1. Graf RM et al (2000) Subfascial endoscopic transaxillary augmentation mammaplasty. Aesthetic Plast Surg 24:216
2. Graf RM, Bernardes A, Rippel R, Araujo LRR, Damasio RCC, Auersvald A (2003) Subfascial breast implant: a new procedure. Plast Reconstr Surg 111:904–908