



Donut Mastopexy Lumpectomy

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Abstract

Advancements in oncoplastic techniques have enhanced commitment to restore shape and, hence, has improved cosmetic outcomes. Donut mastopexy lumpectomy is one such technique and is best utilized in a setting of a malignancy not extending to the skin or the nipple-areolar complex. As a potential alternative to standard lumpectomy, it has many advantages including restriction of scar to the periareolar region, ease and rapidity of surgery, retention of nipple-areolar sensation, and the possibility of performing augmentation mammoplasty. A mini breast lift is also provided without ugly and visible scars. This report provides an insight into the technical details and utility of donut mastopexy lumpectomy (DML) in breast oncoplasty.

Keywords Oncoplasty · Breast · Donut mastopexy lumpectomy

The whole world of a woman comes down on being diagnosed with breast cancer threatening her physical, emotional, and sexual aspects. The multidisciplinary approach to diagnosis and advancements in breast oncoplastic techniques including donut mastopexy lumpectomy (DML) enhance the commitment to restore the shape and hence cosmesis. DML is a potential alternative to standard lumpectomy in terms of accurate breast tissue resection and final cosmetic results. [1]

An access to most of the tumor locations in the breast is provided with DML while confining the incision to the areolar margins only. Similar to the nipple-areolar sparing mastectomy, this is best utilized in setting of a malignancy that does not extend to skin or nipple-areolar complex. It utilizes a pair of concentric circumareolar skin incisions; first placed at areolar margin and a second whose radius is no less than 1 cm longer. The intervening ring of skin is deepithelialized and wide skin flaps are developed over

the index and flanking quadrants to enable wide local excision of malignancy. Reconstruction of the gland is undertaken by undermining, advancing, and performing a layered closure of the flanking glandular breast tissue using absorbable sutures. Closure of skin uses an absorbable purse-string suture placed in the outer skin margin to reduce its diameter to that of normal areola and then completed with suturing of these two skin margins together, forming the new areolar margin. [2]

The present case was a 25-year-old unmarried female who presented with a left-sided breast lump in the upper inner quadrant, cT2N0. Trucut biopsy revealed an infiltrating ductal carcinoma. Metastatic work up was negative. She underwent a DML with sentinel lymph node biopsy, Figs. 1 and 2. The advantages of DML are multiple as of restriction of the scar to the periareolar region only, ease and rapidity of surgery, retention of nipple-areolar sensation, and possibility of performing augmentation mammoplasty. Mini breast lift is also provided without the ugly and visible scars as in other mammoplastic techniques. The principle technical disadvantages of this approach are areolar spreading, globular shaped breast, and hypertrophic scarring. DML may not be appropriate for lower pole lesions and very ptotic breasts. Final histopathology revealed a triple negative pT2N0 infiltrating ductal carcinoma breast. She is doing fine till 6 months of follow-up.

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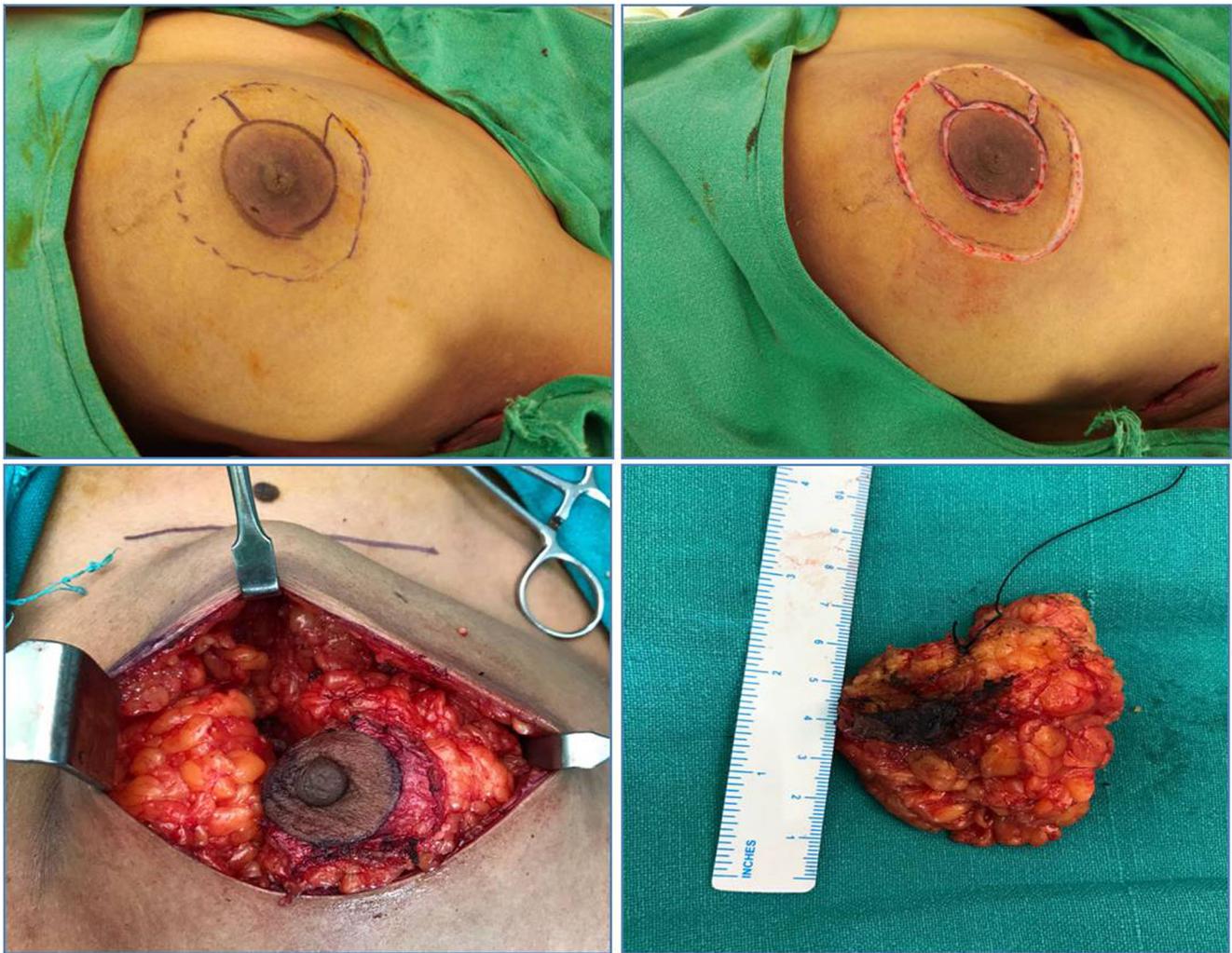


Fig. 1 Marking of incision for a lump in the left upper inner quadrant



Fig. 2 Postoperative picture showing scar restricted to the periareolar area

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