

Opinions on the “Trick” Technique to Reposition the NAC in Female-to-Male Transsexuals

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Dear editor,

We have read with great interest the article entitled “Shape, Position and Dimension of the Nipple Areola Complex in the Ideal Male Chest: A Quick and Simple Operating Room Technique” by Sara Tanini et al. [1] in *Aesthetic Plastic Surgery*. In this article, the authors presented their “trick” technique to reposition the NAC based on their anatomical study and statistical analysis. Good shape and position of the NAC were achieved in female-to-male transsexual patients with this technique. In their article, a consistent relationship between the position and shape of the NAC and the borders of the pectoral muscle was verified. Inspired by the authors, we would like to express our considerations on this technique.

First, although the pectoralis major muscle is an accessible landmark in different genders and body types, a mere measurement of the distance between the NAC and the borders of the pectoral muscle, which varies from patients with diverse statures and dimension of pectoralis major muscle, is not sufficient to locate the NAC concisely. In

this article, the average height of the reference group is 176 cm, which is not matched with the average height of a female. Moreover, although the reference group is the teenage male with a non-hypertrophic pectoralis major muscle, there are still obvious differences in the volume and dimension of the pectoralis major muscle between males and females. So an additional measurement of the ratio of vertical position and the longitudinal diameter of the pectoralis major muscle may further perfect the “trick” technique. Besides, when repositioning the NAC, the surgeon should take the patients’ postoperative workout plan into consideration as many transsexuals choose high-intensity exercise postoperatively to build up a typical male chest configuration which will hypertrophy the pectoralis major muscle and generate a more lateral projection of the NAC.

Second, in this article, all patients underwent mastectomy and free NAC grafting with an obvious and elongated incision placed along the inframammary fold. But as Cori et al. indicated in their research, this incision can be applied only in cases with very large breasts (> D Cup), mastoptosis grade III and poor skin elasticity. For patients with relatively small volume breasts, less severe mastoptosis or better skin elasticity, diverse approaches like liposuction and subcutaneous mastectomy through a semicircular incision, concentric circumareolar approach or inferior pedaled mammaplasty can be performed to avoid the elongated scar with high patient satisfaction with the aesthetic result [2]. But what cannot be denied is the application of free NAC grafting achieves good areola and nipple reshaping and repositioning as well as flattened male chest contouring without an inferior NAC pedicle, which can potentially generate higher breast projection in the lower breast pole.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflicts of interest to disclose.

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