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ORIGINAL ARTICLE BREAST SURGERY

Breast Asymmetry, Classification, and Algorithm of Treatment: Our Experience

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Abstract

Background In the literature, several classifications of breast asymmetries and treatment protocols have been proposed over time, which are mainly based on etiological or morphological characteristics of the deformity. The aim of this study was to present our new classification, based on patient's self-consciousness of breast asymmetry, a simple and reliable treatment algorithm is also presented.

Methods The case series included 343 patients treated between January 2006 and January 2015. Only patients presenting with developmental breast asymmetries were included in the study. All patients underwent prior classification in three groups based on the patient's degree of awareness of their asymmetry. A specific treatment algorithm was associated with each group according to breast size, grade of ptosis, and patient's desire. At the 48-month follow-up appointment, patients completed an anonymous questionnaire that addressed satisfaction with breast shape, size, and symmetry, scar appearance, body perception, self-esteem, perceived attractiveness, intimate life, and overall feelings about their breasts.

Results Mean patient age was 24.6 years (range 18–57 years). Mean follow-up was 54.4 months (6 months to 9 years). At the 48-month follow-up, 66.7% of the patients completed a visual analog scale (VAS) satisfaction questionnaire. An overall satisfaction rate of 77.0% was reported, and a statistically significant difference in the distribution of the overall satisfaction between groups was found. No patient expressed complete dissatisfaction.

Conclusions The proposed classification and the surgical algorithm is a simple, applicable, and reliable method to assess and treat breast asymmetries with a high satisfaction rate as confirmed from our results.

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Keywords Breast asymmetry · Classification · Treatment algorithm · Outcomes

Introduction

Nowadays, breast symmetry is considered an essential trait of female beauty [1]. Any deviation from canons of size and shape can cause some degree of dissatisfaction for a woman. Minor differences in shape, volume, or position of nipple–areola complex (NAC)/inframammary folds (IMF) between the two breasts are common. However, for some women, breast size discrepancy can be a disturbing cosmetic problem with an adverse impact on their quality of life [2–4]. In the literature, several classifications and treatment protocols have been proposed over time, which are mainly based on etiological or morphological characteristics of deformity [5]. The aim of this study was to present our experience on aesthetic surgery concerning breast asymmetry. We propose our classification based on patient's self-consciousness of breast asymmetry and a simple, applicable, and reliable algorithm to decide the

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surgical strategy to obtain the highest possible patient satisfaction rate.

Materials and Methods

Patients and Study Design

A retrospective study included a total of 343 women who underwent surgery for aesthetic breast asymmetry from January 2006 to January 2015. The study enrolled exclusively patients with developmental breast asymmetries, whereas cases of Poland's syndrome, acquired asymmetries, and tuberous breast were excluded. A preoperative interview was administered to all patients, who provided written informed consent for surgical treatment. Patients were classified into three groups based on the patient's degree of awareness of her asymmetry, as described below. Patients underwent follow-ups at 6-month intervals for 48 months postoperatively. At the 48-month follow-up appointment, patients completed an anonymous questionnaire that addressed satisfaction with breast shape, size, and symmetry, scar appearance, body perception, self-esteem, perceived attractiveness, intimate life, and overall feelings about their breasts. Each metric was scored on a visual analog scale (VAS) from 0 to 10 (0 or 1, worst possible outcome; 2, 3 or 4, fair; 5 or 6, good; 7 or 8, very good; 9 or 10, best possible outcome), on which scores of 6 or more were considered indicative of "very satisfied patients."

Classification

At the first consultation, the aim was to assess the patient's self-consciousness of breast asymmetry. The assessment consists in questioning the patient about her: (a) awareness of the asymmetry, (b) feelings about her physical appearance, and (c) need for special padding to conceal the asymmetry.

We classified breast asymmetries into three groups based on the patient's awareness: groups I, II, or III:

- *Group I* No preoperative awareness of breast asymmetry. Asymmetry was assessed only by surgeon's clinical examination. The patient presented to office to have breast surgery for aesthetic reasons, in terms of augmentation, mastopexy, or reduction mammoplasty

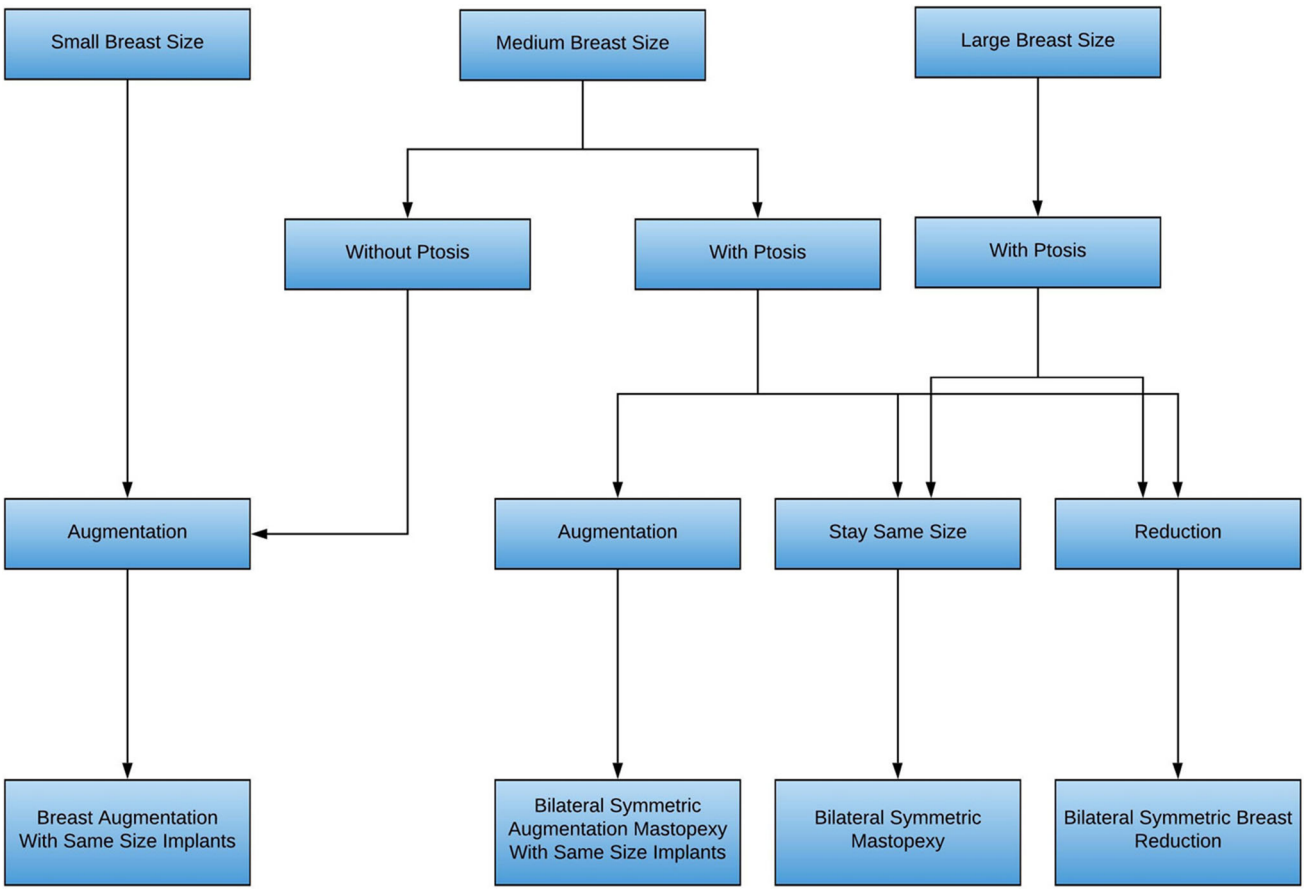

Fig. 1 Algorithm for Group I breast asymmetry treatment

with the same procedure on both sides and was informed about asymmetry for the first time during the interview with the surgeon.

- *Group II* Preoperative awareness of breast asymmetry. The patient does not use any external device to conceal it but wishes to correct it.
- *Group III* Preoperative awareness of breast asymmetry. The patient reports the breast asymmetry and suffers difficulty in dressing, needing special bra padding to improve her quality of life and self-esteem. She is very keen to have surgery to correct it.

Treatment Algorithm

The treatment algorithm is the result of combining the degree of awareness of breast asymmetry (our classification groups I–II or III) and patient's wishes in relation to the volume she desires. Achieving symmetry could be possible with unilateral or bilateral procedures, with or without implants. We schematized our planning methods in an easy-to-use flow diagram (Figs. 1, 2 and 3) referring to: breast volume (small $\leq$ 250 ml, medium 250–500 ml and large $\geq$ 1000 ml breasts) [6], breast ptosis referring to Regnault's [7] classification, and patient's desires such as augmentation, reduction, or mastopexy. In our surgical algorithm, we have included a series of common and well-known techniques of cosmetic breast surgery: breast augmentation with implant, hybrid augmentation (implant plus fat grafting), mastopexy with circumareolar, vertical, or inverted "T" approach with or without implant and breast reduction.

Statistical Analysis

Statistical analysis was done using STATA SE14 software. Continuous variables are expressed as means $\pm$ standard deviations (SD), range, median, and interquartile range (IQR). Categorical variables are expressed as proportions and confidence intervals (95% CI). For continuous variables a normal distribution was checked, and when not normally distributed, a normalization model was set, using a logarithmic function. Normally distributed continuous variables were compared with one-way ANOVA test with Bonferroni correction (parametric test), and non-normally

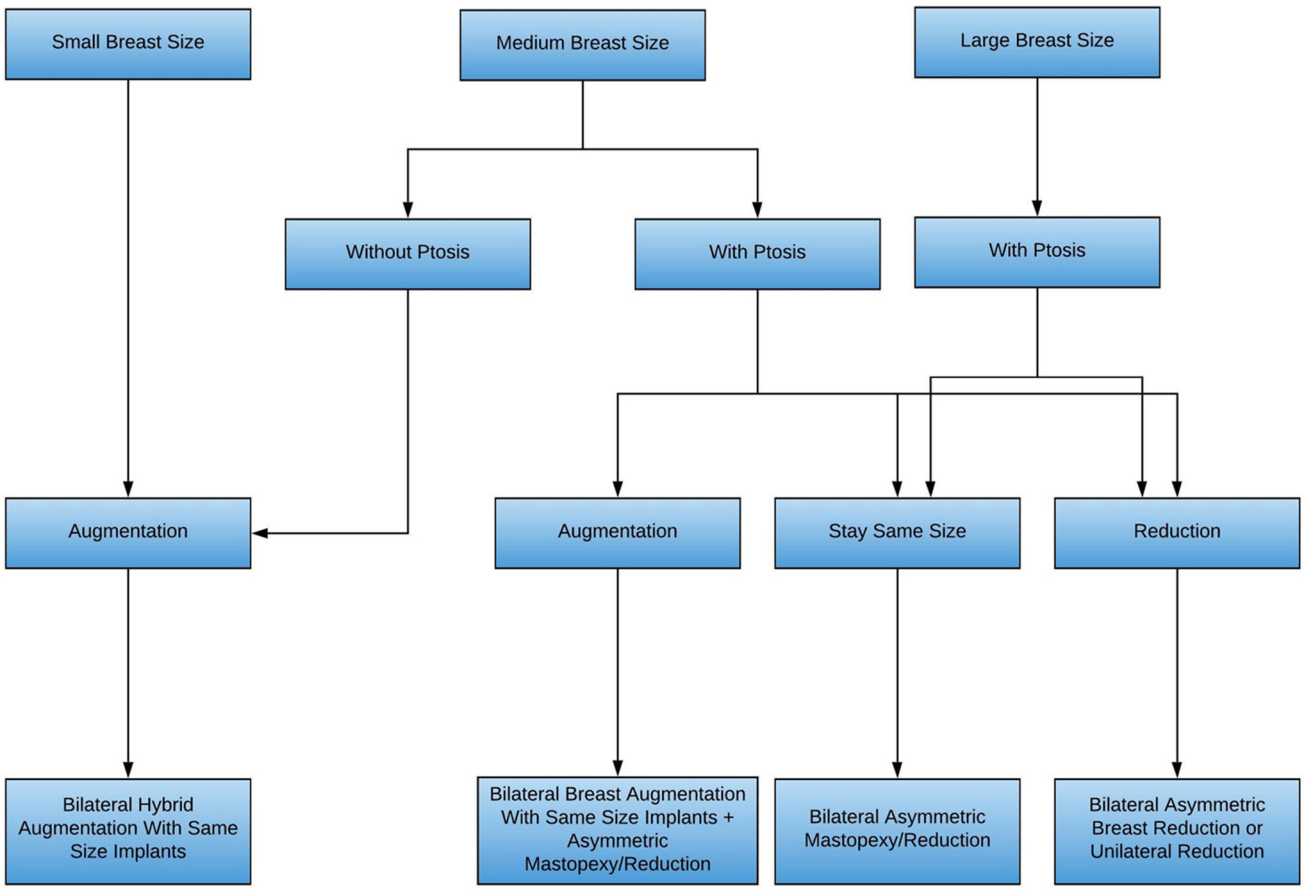

Fig. 2 Algorithm for Group II breast asymmetry treatment

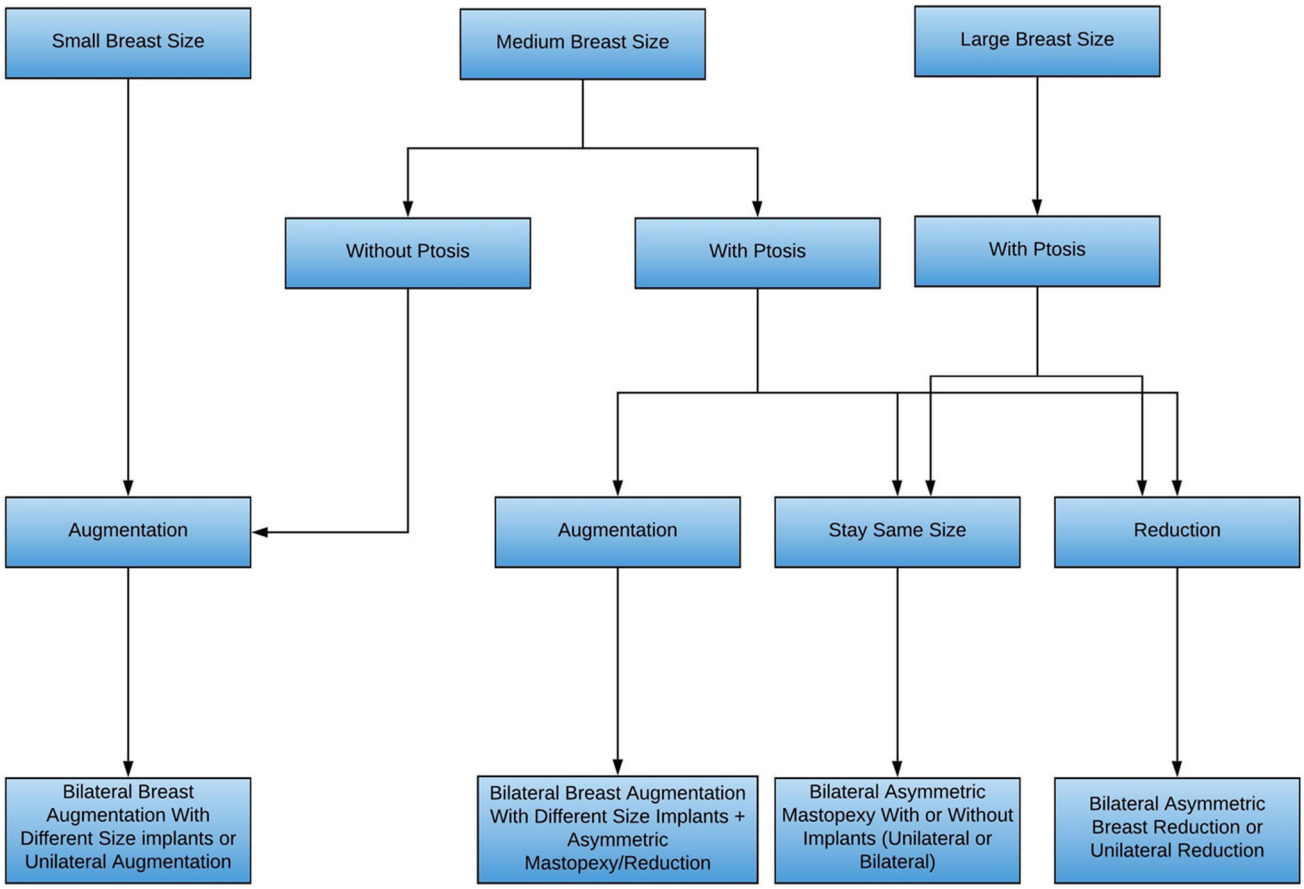

Fig. 3 Algorithm for Group III breast asymmetry treatment

Table 1 Summary of surgical procedures performed

Group	Surgical procedures	No
I	Bilateral breast augmentation with same-size implant/dual-plane implant	27
	Bilateral breast augmentation with same-size implant/subglandular implant	64
	Bilateral breast symmetric augmentation mastopexy with same-size implant	18
	Bilateral symmetric mastopexy	39
	Bilateral symmetric breast reduction	34
II	Hybrid breast augmentation with same-size implants	63
	Bilateral breast augmentation with same-size implants with asymmetric mastopexy/reduction	37
	Bilateral asymmetric mastopexy/reduction	22
	Unilateral breast reduction	2
III	Bilateral breast augmentation with different-size implants	14
	Unilateral breast augmentation	1
	Bilateral breast augmentation with different-size implants with asymmetric mastopexy/reduction	6
	Unilateral breast augmentation + asymmetric mastopexy	3
	Unilateral breast augmentation + unilateral reduction	4
	Bilateral asymmetric reduction	4
	Unilateral breast mastopexy + unilateral reduction	2
	Unilateral breast reduction	2

Table 2 Minor complications not requiring revision surgery 48 months postoperatively

	Group I (n = 182)	Group II (n = 124)	Group III (n = 37)
Sterile seroma	1	0	0
Liponecrosis/oil cyst after lipofilling	–	10	–
Hypertrophic scarring	2	1	1
Partial NAC necrosis	0	0	0
Wound infection/dehiscence	0	0	0

Table 3 Major complications requiring revision surgery 48 months postoperatively

	Group I (n = 182)	Group II (n = 124)	Group III (n = 37)
Hematoma	2	1	0
Implant displacement	1	2	0
Baker III–IV capsular contracture	3	1	1
Implant infection/exposure	0	0	0
Implant malposition	0	0	0
Total NAC necrosis	0	0	0
Residual asymmetry after surgery (incongruous skin and/or glandular resection, incorrect implant volume choice)	0	4	2

Table 4 Mean ± standard deviation and range of VAS scores for individual items on the questionnaire for each group

Questionnaire item	Group I	Group II	Group III	Total	Test	p Value
Breast size	7.2 ± 1.4 (5.0–9.0)	6.1 ± 1.0 (4.0–8.0)	5.6 ± 1.2 (4.0–8.0)	6.6 ± 1.4 (4.0–9.0)	k = 40.1	0.000*
Breast shape	7.2 ± 1.3 (5.0–9.0)	6.2 ± 1.1 (4.0–8.0)	5.7 ± 1.0 (5.0–8.0)	6.9 ± 1.3 (4.0–9.0)	k = 45.6	0.000*
Breast symmetry	7.2 ± 1.3 (5.0–10.0)	6.2 ± 1.1 (4.0–8.0)	5.6 ± 1.3 (4.0–8.0)	6.7 ± 1.3 (4.0–10.0)	F = 27.3	0.000*
Scar appearance	7.3 ± 1.1 (5.0–9.0)	6.3 ± 1.2 (5.0–9.0)	5.8 ± 1.0 (4.0–7.0)	6.8 ± 1.2 (5.0–10.0)	k = 29.5	0.000*
Self-esteem	7.6 ± 1.1 (6.0–10.0)	7.0 ± 1.1 (5.0–9.0)	6.6 ± 0.7 (6.0–8.0)	7.3 ± 1.1 (5.0–10.0)	F = 12.9	0.000*
Body perception	7.7 ± 1.3 (6.0–10.0)	6.8 ± 1.1 (5.0–9.0)	6.6 ± 0.7 (6.0–8.0)	7.3 ± 1.3 (5.0–10.0)	k = 31.6	0.000*
Overall feelings about breast	7.8 ± 1.2 (6.0–10.0)	7.0 ± 1.1 (5.0–9.0)	6.4 ± 0.9 (5.0–8.0)	7.3 ± 1.2 (5.0–10.0)	F = 19.2	0.000*
Attraction ability and intimate life	7.4 ± 0.9 (6.0–9.0)	6.9 ± 0.9 (5.0–9.0)	6.5 ± 0.7 (5.0–8.0)	7.1 ± 1.0 (5.0–9.0)	k = 24.4	0.000*

*Statistically significant result ($p < 0.05$)

distributed continuous variables were analyzed with Kruskal–Wallis test and with Dunn's test for multiple comparisons (nonparametric tests). To compare the categorical variables between groups, the Chi-square test was used. Statistical significance was defined as p values < 0.05.

Results

Mean patient age was 24.6 years (range 18–62 years). According to our classification, 182 out of 343 women (53.1%) were included in Group I, 124 out of 343 (36.1%) in Group II, and 37 out of 343 (10.8%) in Group III of

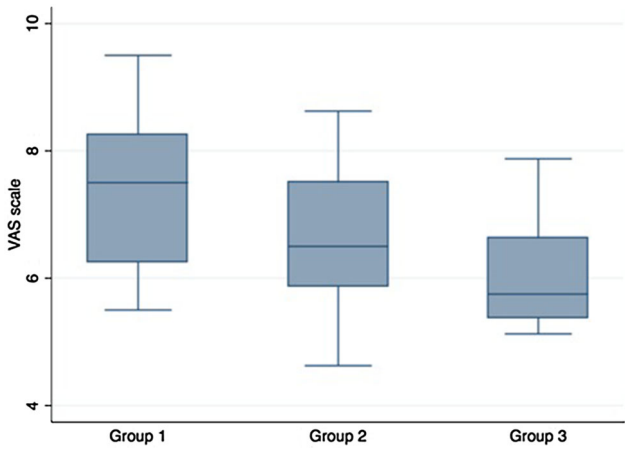

Fig. 4 Median, IQR and range of overall VAS scores for each group

breast asymmetry. Surgical procedures and minor and major complications are shown in Table 1, Table 2, and Table 3.

Mean volume of the additional fat injections in the hybrid breast augmentation technique was 50 cc per side (range 30–90 cc). Patients underwent from 1 to 3 sessions of lipofilling; 61% (39/63) of them required just one lipofilling procedure, 23% (15/63) required two procedures, and 16% (9/63) required three procedures. When more than one session was required, we waited over a 3-month interval at least. Mean implant volume was 295 cc (range 125–420 cc) for anatomical-shaped implants and 300 cc (range 125–350 cc) for round implants. All the implants used were from Mentor/Johnson & Johnson, Santa Barbara, CA. When breast reduction was performed, the mean resected volume was 300 g per side (range 60–950 g). Mean follow-up was 54.4 months (6 months to 9 years). At the 48-month follow-up, 66.7% (229/343) of the patients completed the visual analog scale (VAS) satisfaction questionnaire. Group I included 51.5% (118/229), Group II 38.4% (88/229), and Group III 10.1% (23/229) of the sample. A statistically significant difference was observed when comparing all the parameters analyzed between groups ($p < 0.0001$) (Table 4). Comparison of overall satisfaction between groups showed a statistically significant correlation ($k = 38.6$; $p = 0.000$;) (Fig. 4). Dunn's test showed a statistically significant correlation comparing continuous variables between Group I and Group II ($z = 5.0$; $p = 0.000$), between Group II and Group III ($z = 1.8$; $p = 0.033$), and between Group I and Group III ($z = 5.0$; $p = 0.000$) (Table 5). An overall satisfaction of 77% (95% CI = 71.8–82.8; $n = 178/229$) was observed, and a statistically significant difference in the distribution of the overall satisfaction between groups was found (Group I = 89.8%; 95% CI = 82.9–94.6; $n = 106/118$; Group II = 70.5%; 95% CI = 59.8–79.7; $n = 62/88$; Group III = 43.5%; 95% CI = 23.2–65.5; $n = 10/23$; $X^2 = 28.3$; $p = 0{,}000$). No patient expressed complete dissatisfaction. Lower levels of satisfaction were recorded in patients with Group III breast asymmetry, while patients with Group I showed the highest satisfaction. A representative case series is displayed in Figs. 5, 6, 7, 8 and 9.

Discussion

The aesthetic image of the female body relies greatly on the breasts [8]. Whereas in the past small variations were accepted, contemporary culture, new body images, and modern ideals of beauty have led people to believe that even small asymmetric variations in mammary border or shape are abnormal [9]. For these reasons, the asymmetric breast has become an aesthetic and social problem. Perfect symmetry may be disturbed by several intrinsic and extrinsic factors [10–12]. Breast asymmetry may result from growth disturbances or from a range of acquired

Table 5 Comparison of VAS scores for individual item of questionnaire between groups

Questionnaire item	Group I versus Group II		Group II versus Group III		Group I versus Group III	
	Test	*p* Value	Test	*p* Value	Test	*p* Value
Breast size	$z = 5.2$	0.000	$z = 1.7$	0.042*	$z = 5.0$	0.000*
Breast shape	$z = 5.6$	0.000	$z = 1.9$	0.029*	$z = 5.4$	0.000*
Breast symmetry	$t = 1.0$	0.000	$t = 0.6$	0.097	$t = 1.6$	0.000*
Scar appearance	$z = 6.2$	0.000	$z = 1.4$	0.082	$z = 5.3$	0.000*
Self-esteem	$t = 0.6$	0.000	$t = 0.4$	0.251	$t = 1.0$	0.000*
Body perception	$z = 5.1$	0.000	$z = 0.9$	0.196	$z = 4.0$	0.000*
Overall feelings about breast	$t = 0.1$	0.000	$t = 0.1$	0.087	$t = 0.2$	0.000*
Attraction ability and intimate life	$z = 3.7$	0.000	$z = 2.1$	0.000*	$z = 4.4$	0.020*

*Statistically significant result ($p < 0.05$)

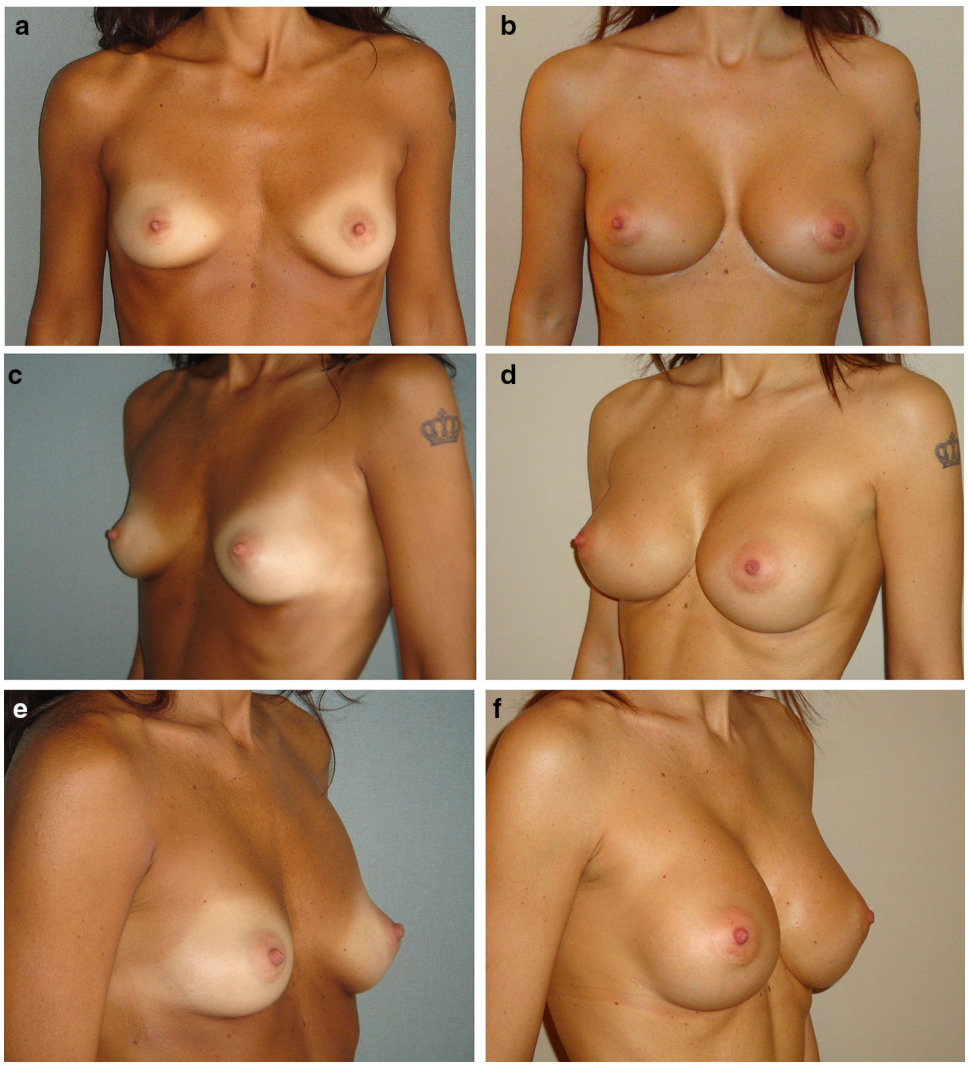

Fig. 5 a Case 1–Group I: a 29-year-old woman after 1 pregnancy without breastfeeding. Clinical case of Group I breast asymmetry. Preop frontal view. **b** Case 1–Group I: 12-month postop frontal view after bilaterally symmetrical breast augmentation using anatomical breast implant (CPG-323, 300 cc Mentor/Johnson & Johnson, Santa Barbara, CA). **c** Case 1–Group I: Preop left oblique view. **d** Case 1–Group I: 12-month postop left oblique view. **e** Case 1–Group I: Preop right oblique view. **f** Case 1–Group I: 12-month postop right oblique view

conditions [13]. In our study, we treated only patients with developmental asymmetry. Classifying this asymmetry as a growth and development disturbance is technically more precise than classifying it as congenital, since most of these conditions are not apparent at birth. These growth disturbances may be unilateral or bilateral and may involve the NAC positioning, the breast mound, or both. Errors in growth and development in terms of breast asymmetry include absence of structures, excess of structures, variations in size, and variations in shape. Currently, there is not a standard objective method to assess breast asymmetry [14–16]. Linear measurements, volume measurements using fluid displacement methods, or plaster of Paris molds have been proposed [17–19]. The advent of three-dimensional scanning techniques has enabled stereo inspection of the breast with the patient in the upright position, whereas conventional computer tomography and magnetic resonance imaging need to be done in supine or prone position, which is not the way plastic surgeons evaluate breast asymmetry [19–21]. According to the 3D scanning technique studies on breasts, it has been shown that no woman has a pair of absolutely symmetric breasts [21]. We present our experience of the assessment of breast asymmetry, focusing on the woman's self-consciousness of asymmetry. During the first preoperative interview, the senior author assessed the patient's self-consciousness of her breast asymmetry, assigning her to a group (groups I, II, or III of our classification) and investigating her desires. Then, the surgeon planned the surgical procedure referring to our treatment algorithm and so the patient became a central figure in the "decision-making process." Thus, it is reasonable to state that our algorithm is based on a combination of these two aspects: the detection of the asymmetry employing our classification and the patient's desires. In our experience, we noted that a lot of patients became critical of any imperfection, expecting perfectly balanced breasts after surgery. Tebbets affirms that the word "correction" should never be used in conjunction with breast

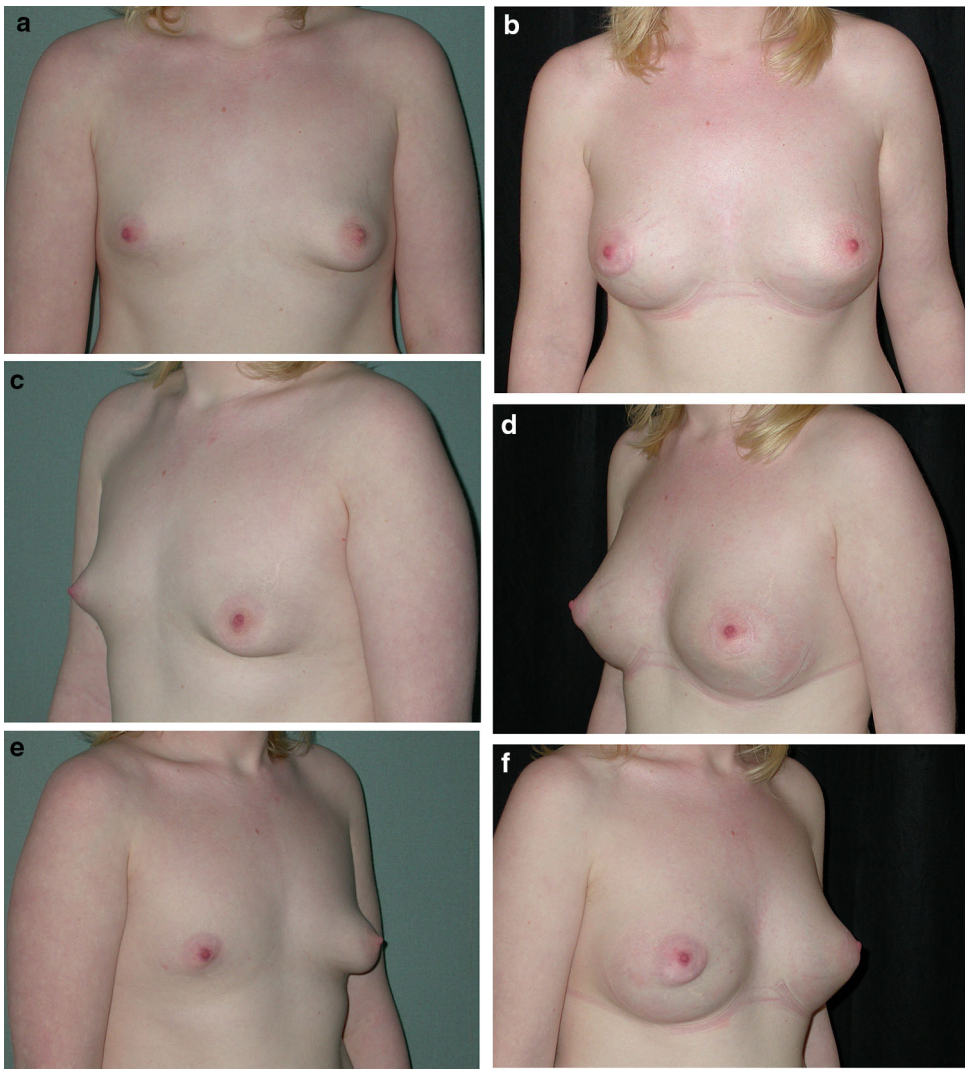

Fig. 6 **a** Case 2–Group II: a 19-year-old nulliparous woman. Clinical case of Group II breast asymmetry. Preop frontal view. **b** Case 2–Group II: 18-month postop frontal view after hybrid breast augmentation using bilaterally symmetrical anatomical breast implant (CPG-322, 290 cc Mentor/Johnson & Johnson, Santa Barbara, CA) and a unique session of additional 40-cc lipofilling in the right side. **c** Case 2–Group II: Preop left oblique view. **d** Case 2–Group II: 18-month postop left oblique view. **e** Case 2–Group II: Preop right oblique view. **f** Case 2–Group II: 18-month postop right oblique view

asymmetry: "correction implies a symmetry that is not achievable" [22]. In our opinion, the best any surgeon can deliver in breast asymmetry treatment is a different set of differences-improvement with the least possible residual postoperative asymmetry. A key point of our treatment algorithm to achieve the best postoperative satisfaction grade in grade I patients is correct and complete preoperative information about any residual asymmetry after surgery and the relative informed consent. We believe that a preoperative consultation in a comfortable setting in front of the mirror alongside the surgeon is critical to allow the patient to become aware of her condition [23] and understand the final aims of the surgery. We exhorted the patient to realize the slight preoperative asymmetry and accept this slight asymmetry as part of postoperative outcome. First group patients were treated according to breast size (small, medium, and large), presence and degree of ptosis, personal desires with breast augmentation with same-size implants, bilateral symmetric mastopexy with or without same-size implants, and bilateral symmetric breast reduction. Most frequently in Group I patients, the presented asymmetry consists only in small differences in breast and/or inframammary fold position or in the in nipple–areola complex position, as well as a different distribution of mammary volumes without volumetric discrepancies between the two breasts. In these cases, we carried out symmetrical procedures because we are convinced that obtaining greater symmetry would be impossible or at least an ambitious project that could generate frustration in the surgeon and paradoxically greater patient dissatisfaction. According to our results, informing the patient during the first visit about their preoperative breast asymmetry, otherwise not noticed, and the residual asymmetry that could persist after the procedure have produced a high satisfaction rate of 89.8% and no revision surgeries to correct residual asymmetries. The rate of secondary surgeries that we report in this group of patients can be attributed exclusively to immediate postsurgical hematoma

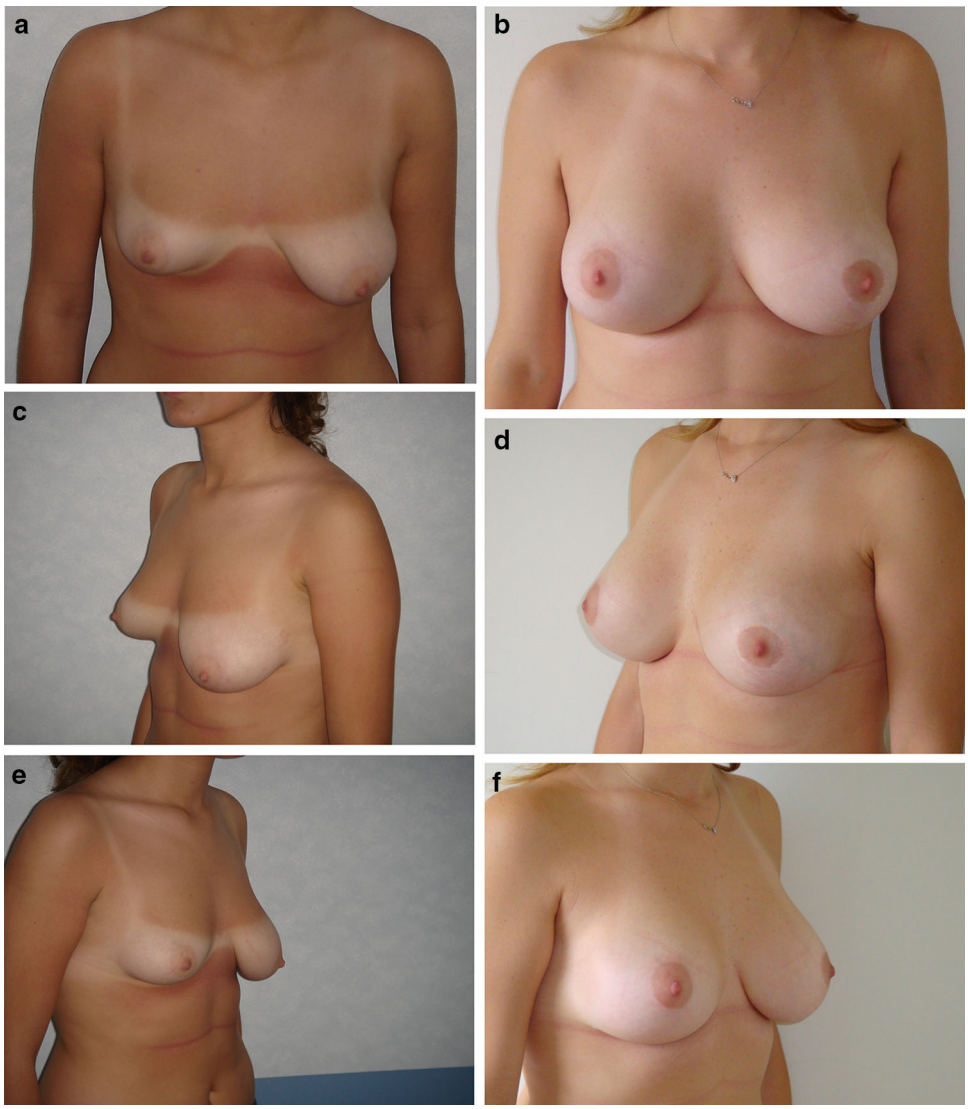

Fig. 7 **a** Case 3–Group II: a 27-year-old nulliparous woman. Clinical case of Group II breast asymmetry. Preop frontal view. **b** Case 3–Group II: 14-month postop frontal view after asymmetrical surgical procedure: breast augmentation on the right side and mastopexy/reduction plus implant on the left side using bilaterally symmetrical anatomical breast implant (CPG-323, 300 cc Mentor/Johnson & Johnson, Santa Barbara, CA). **c** Case 3–Group II: Preop left oblique view. **d** Case 3–Group II: 14-month postop left oblique view. **e** Case 3–Group II: Preop right oblique view. **f** Case 3–Group II: 14-month postop right oblique view

or to Baker III/IV capsular contracture treatment. In the second and third group of patients, breast asymmetry causes patient discomfort and impaired quality of life, and this is the reason they turn to the consultation of the plastic surgeon. The aim of treatment in these cases is focused on improving breast symmetry as far as possible, according to the patient's desires in terms of volume and shape to achieve the best possible outcome. Achieving symmetry in these cases can be possible with unilateral or bilateral procedures with or without implants. In case of breast augmentation, we treated Group II patients using a hybrid composite technique [24]: same-size implant plus monolateral subcutaneous fat grafting to achieve the symmetry. Fat transfer is becoming an increasingly common procedure for treating breast hypoplasia. It can be used in conjunction with the implant to provide additional soft-tissue coverage and contour improvement and to match breast discrepancies in volume and shape [25]. Patients with breast ptosis underwent mastopexy with or without implants, according to the Ragnault classification, using the round-block technique for Grade I, the inverted-teardrop or "J scar" technique for Grade II, and inverted T-scar technique or Balcony technique with implant for Grade II and III [26–28]. In all of these cases, when patients underwent augmentation mastopexy, same-size high-projection textured round implants were applied in a subglandular plane, and symmetry was achieved by asymmetrical skin/glandular resection. In patients with breast hypertrophy who desired breast reduction, we performed the inverted T-scar technique with asymmetrical skin/glandular resection. The treatment strategy in the third group was more articulated due to the relevance of breast asymmetry. Due to the high-volume discrepancy, in case of bilateral augmentation with or without mastopexy, we used implants of different sizes. Therefore, we used to verify or eventually change the preoperatively planned implants' size based on the

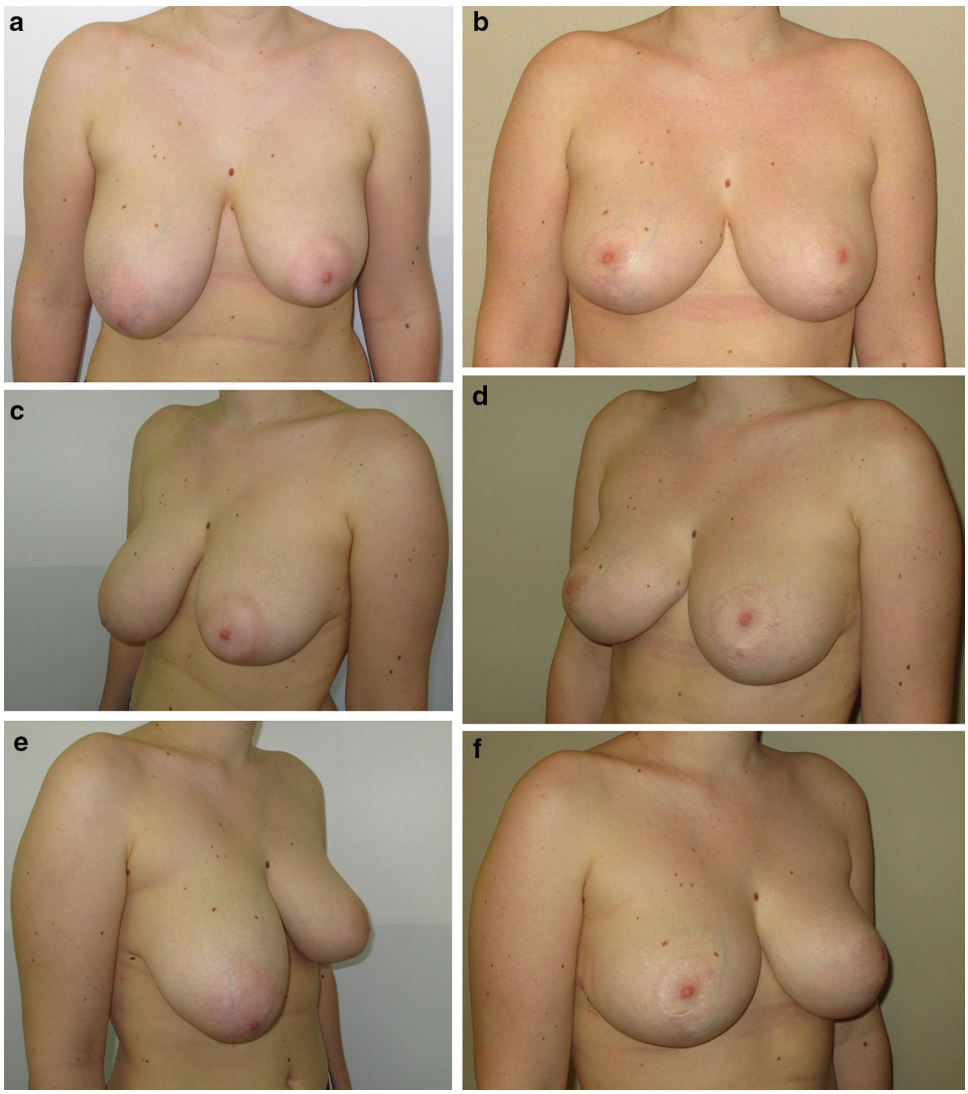

Fig. 8 **a** Case 4–Group III: a 24-year-old nulliparous woman. Clinical case of Degree III breast asymmetry. Preop frontal view. **b** Case 4–Group III: 24-month postop frontal view after asymmetrical breast surgical procedure: left-side inverted "T" mastopexy and right-side 450-cc breast reduction by using inverted "T" pattern. **c** Case 4–Group III: Preop left oblique view. **d** Case 4–Group III: 24-month postop left oblique view. **e** Case 4–Group III: Preop right oblique view. **f** Case 4–Group III: 24-month postop right oblique view

intraoperative aesthetic effects of breast implant sizers [29]. When possible, we preferred to use not particularly voluminous implants; we believe, as stated in the literature, that oversizing a breast implant to correct breast asymmetry would not produce a long-term stable outcome and could contribute to a higher revision rate [30]. In the third group, who more often underwent different surgical procedures on the two sides or unilateral surgery, we observed the lowest satisfaction rate of 43.5% and the highest revision surgery rate of 8%. However, in the postop period, none of Group III patients reported residual breast asymmetry. An overall patient satisfaction rate of 77% was achieved in the present series with dissatisfaction being primarily due to the different surgical procedures adopted in the third group. These data are superimposable to the Bostwick's thoughts, who claims that the worst results derive from different procedures on the two sides [31]. We believe that breasts treated with the same procedure behave similarly, since both breasts undergo similar changes through the years [32]. The advantage is linked to long-lasting results and lower rates of revision surgery dictated by discrepant surgical treatment on the two breasts (e.g., monolateral breast augmentation *vs* breast reduction), resulting in a different long-term appearance between the two breasts. Patients in the second and third groups were more often treated with unilateral or bilateral mastopexy or breast reduction. Performing these procedures on atrophied tissues is always a challenge for the surgeon in terms of results. Weakening and lengthening of the supporting structures of the breast can lead to an unsatisfactory long-term appearance. This could be the potential reason for lower satisfaction rates after 48months of follow-up. Although different-sized samples among groups, several surgical procedures compared, and the mean follow-up may be drawbacks of the study, our primary aim was to simplify the assessment and surgical management of

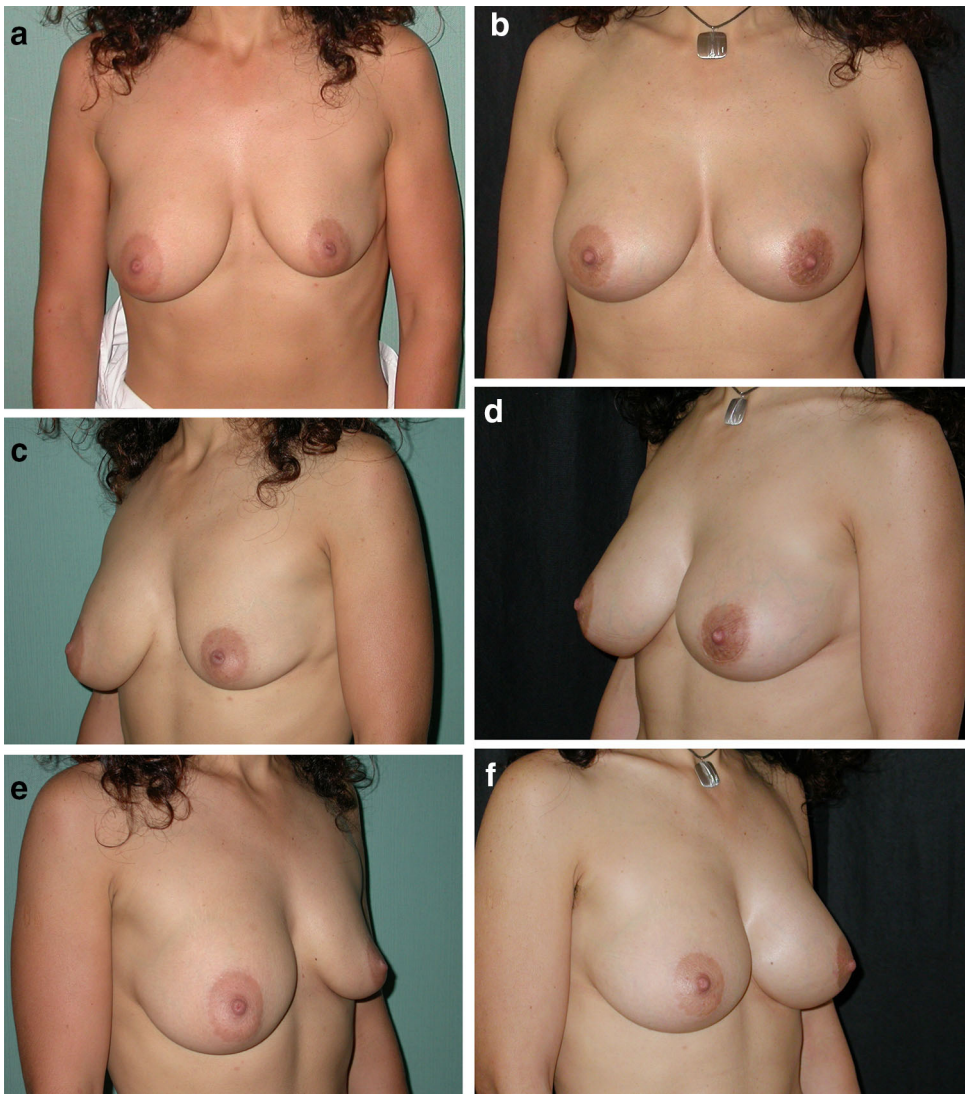

Fig. 9 **a** Case 5–Group III: a 30-year-old nulliparous woman. Clinical case of Degree III breast asymmetry. Preop frontal view. **b** Case 5–Group III: 16-month postop frontal view after asymmetrical breast surgical procedure: Monolateral left-side breast augmentation by using anatomical implant (CPG-322, 255 cc Mentor/Johnson & Johnson, Santa Barbara, CA). **c** Case 5–Group III: Preop left oblique view. **d** Case 5–Group III: 16-month postop left oblique view. **e** Case 5–Group III: Preop right oblique view. **f** Case 5–Group III: 16-month postop right oblique view

patients with breast asymmetry. To build our algorithm, we have used several known techniques of aesthetic breast surgery combined together to achieve the desired result of improving asymmetry in relation to the patient's wishes regarding volume. The resulting statistical analysis represented the feeling of each patient according to the result after the surgery. However, as a limit of our study, it did not represent the result of each technique separately. We believe that another limit of the current study is that it fails to consider the effect of demographic variables (e.g., age, education, employment, or relationship status). These factors could affect psychosocial adjustment and quality-of-life outcomes [33]. Nevertheless, in this study, all groups were matched according to demographic features to minimize the influence of these factors on the quality-of-life outcomes. We achieved a 66.7% response rate to the questionnaire. This high response rate could be attributable to our close follow-up and the trusting relationship that encouraged the patients to complete it. Moreover, a further limitation of this study lies in the fact that we did not consider in our study all patients with acquired causes of breast asymmetries such as previous breast surgery for both benign and malignant diseases or malformation such as tuberous breasts and Poland's syndrome.

Conclusions

Breast asymmetry causes distress due to the impaired body image and psychosocial impact that the defect has on patients' feelings about relationships. The solution requires enough experience to adapt eclectic skills to permit the patient to achieve one of the traits of beauty: breast symmetry. Aesthetic breast surgery has improved in the past 20 years thanks to the introduction of new and different

techniques. A good knowledge and application of these techniques in combination allows surgeons to achieve optimal functional and aesthetic results. Our patient-focused classification and the related surgical algorithm are a simple, applicable, and reliable method to assess and treat breast asymmetries with high satisfaction and low revision surgery rates.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

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

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