Tips for using shaped implants in breast augmentation
For your first cases

1. Select an ideal breast augmentation candidate.
   
   **NOTE:** An ideal candidate is a healthy patient with reasonable expectations who has a good skin envelope and tissue coverage without ptosis.

2. Avoid an excessively tight or loose envelope or an odd shape.

   **NOTE:** Shaped implants can work well for a constricted breast, but don’t attempt it until you have some experience using them in more ideal candidates.

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Manage Expectations

1. A patient who wants an obviously augmented-looking breast may be unhappy with a shaped device.

2. It is important that the patient understands the limitations of shaped implants as well as the benefits.

3. They may second-guess the size, but ensure them that you will select the appropriate size for their chest wall with the goal being a breast that looks good in the long term.
Preoperative Measurements

1. Examination should measure the base width (the most important measurement) and the sternal notch to nipple distance (SN:N).

2. Nipple position, asymmetry and chest wall asymmetry should be noted and pointed out to the patient.

   **NOTE:** Pointing out asymmetry ahead of time makes you a genius; pointing it out after the fact gives a patient the impression you are making excuses.

3. Measure nipple to inframammary fold (IMF) distance to determine constriction of the breast and the degree of ptosis.

   • As a general rule, a measurement less than 4cm means the breast is constricted, and a measurement greater than 9cm means enough ptosis exists to possibly qualify as a mastopexy candidate.

   • **NOTE:** Show photographs of patients (if available) with similar breast types with both round and shaped implants to see if the patient has a visual preference.
**Implant Selection**

1. The first step in consideration of appropriate implant selection is the patient’s base width.

2. The implant width should be within 1-1.5cm of the patient’s measured base width.

   **NOTE:** I use a moderate height implant if the SN:N distance is less than 20cm and a full height implant if the SN:N is greater than 20cm.

   **NOTE:** I select Moderate or High projection based on the laxity of the patient’s skin. There are a variety of subjective tests available in the literature that effectively describe skin laxity measurement techniques if desired.

   **NOTE:** I don’t make a big deal out of marking the patient. What you write on the chest wall doesn’t always translate to what you find on the inside. Nevertheless, if your preference is to mark the chest wall, below are some helpful tips:

**Patient Marking**

1. Mark the midline of the chest.

2. Mark the IMF.

3. The incision is usually marked 5.5-6.0cm from the lower edge of the areola with the skin on stretch, which usually represents where you want your IMF or just above it. On your first cases use a patient with a well-defined IMF that doesn’t need a lot of adjustment.

4. When marking, center the implant below the nipple and areola. All Sientra shaped implants feature a dot at the point of maximum projection to aid in positioning.

   **NOTE:** It is not necessary to mark the top of the dissection on the skin, but it can be done according to physician preference.
Pocket Dissection

1. Have the patient’s arms in the frogged position so as not to distort the nipple position with arms extended to the side.

2. Use general anesthetic with the muscle as relaxed as possible. It is important to have a good anesthetist/anesthesiologist who will completely relax the muscle.

   **NOTE:** With a flaccidly relaxed muscle, the dissection is very easy; there is less bleeding and the patient will have less pain postoperatively.

3. Make an incision along the marking.

4. All of the dissection should be done under direct vision.

5. Dissection is carried to the lateral margin of the pectoralis major muscle, which is elevated with a retractor placed underneath.

6. The lateral margin of dissection should be at the anterior axillary line, which should be the correct lateral dissection if you measured the base width correctly.

7. The dissection is then carried to the medial margin of the pectoralis insertion on the sternum.

8. NEVER detach the muscle from its sternal attachments.

9. Elevate the muscle superiorly to accommodate the height of the planned implant. This usually results in the muscle sweeping off the chest wall easily.

10. Sizers can be used if desired to check the pocket dissection.

   **NOTE:** Inflatable sizers filled with air can work for this purpose and do not take very long to use. The sizer should be 0.5-1 cm narrower than the planned implant to be used.

   **NOTE:** I do not tack the IMF unless there is a problem with it.

11. The wounds are irrigated and then inspected for hemostasis. Hemostasis is an important element for optimum outcomes.

12. The wounds are then irrigated with triple antibiotic saline (Ancef, Gent, Bacitracin, as long as the patient has no allergies) and 10cc of Marcaine is placed for early pain control.
Implant Insertion

1. Begin with the incision fully retracted.

2. For the left breast, introduce the implant in a sideways fashion to the incision, with the orientation line directed medially at roughly 10 o’clock position (it may be more like 9 o’clock for higher projecting implants). Reverse the orientation to 2 or 3 o’clock for the right breast.

3. As the implant is introduced into the pocket, manually rotate the implant up and into the pocket.

4. After implantation, use the orientation line and dot to ensure that the implant has achieved the optimal orientation for the patient.

5. The use of drains is not required but may be used depending upon surgeon preference and experience.

6. The wounds are then closed in 2 layers.

Postoperative Care

1. Consider putting the patient in a bra, mainly for comfort and so they can’t stare at themselves the first day.

2. Patients can take a shower the next day and are encouraged to perform arm movements the first night. Advise them to be active, walk, put their makeup on or fix their hair the next day. No push-ups, bench press, “fly” exercises or any other type of implant displacement exercises for 6 months to prevent lateral displacement of the implant. No implant displacement exercises!

3. A prescription should be considered to help relax the muscle.

NOTE: I usually send them home with Valium.
What I wish I knew when I first started using shaped cohesive implants

1. In my experience, shaped implants do not drop as much as smooth round (especially saline) implants, so put them where you want them. I don’t use a band to push them down; I put them where they should go.

2. It does take longer for these implants to “settle” so hold the patient’s hand and do not do a revision for at least 6 months and preferably a year. In 10 years, I have only had to lower 1 implant.

3. They may take longer to soften. Where a saline implant begins to soften within a couple of weeks, these may take months.

4. The only complaint I have had is that they look “too natural”, so screen your patients well and make sure they understand that they probably won’t get a “Baywatch” breast with a shaped implant.

5. This is not a “magic bullet.” You can’t universally make an ugly breast look good with shaped implants. It can be VERY useful in revision (especially in breast reconstruction) but make sure you have a lot of experience with shaped implants before you attempt it.