Commentary on: Asymmetry of Inframammary Folds in Patients Undergoing Augmentation Mammaplasty

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When patients present with reasonable symmetry in volume, base diameter, and inframammary fold position, breast augmentation can be a predictable, straightforward procedure. Unfortunately, this scenario is not the norm and dealing with preoperative asymmetries in all of these parameters can represent one of the biggest obstacles to providing outstanding results in breast augmentation. It is with this in mind that the findings of this paper prove noteworthy.1 Using computer evaluation software, and admittedly adhering to a strict standard for documenting symmetry, not a single patient in 111 consecutive women was found to be perfectly symmetric. In this patient cohort, differences noted from side to side were found in nipple position, volume, projection, base diameter, and most importantly the position of the inframammary fold. In this study, the right inframammary fold was found to be lower than the left in 60% of cases, the left fold lower than the right in 35% of cases, and equal fold levels were found in 5% of cases. When asymmetry was noted, the median difference between the folds was 4 mm. Additionally, while multiple combinations of asymmetries were noted, the data showed that if the right inframammary fold was lower than the left, the right nipple-areolar complex (NAC) also tended to be lower than the left as well. In other words, the position of the fold and the NAC tended to go together. Based on these findings a classification for fold position comparing one to the other is proposed.

These results have significant real world implications for the practicing breast augmentation surgeon. Generally speaking, the expectations of the average breast augmentation patient tend to be quite high. Any postoperative asymmetry that becomes evident has the potential to be a cause for patient dissatisfaction with the procedure, whether it is the fault of the surgeon or not. For this reason, identifying these asymmetries preoperatively becomes important in both helping to set realistic patient expectations and to develop a plan to deal with the asymmetry. Fortunately the data show that in 91% of the patients, the fold positions were within 1 cm of each other, and in 65% the folds were within 5 mm of each other. Such small differences can be effectively dealt with in most cases, and even if not perfectly matched postoperatively, any persistent difference in fold position is likely to be so small as to be of no consequence. However larger fold differences or the presence of other concomitant asymmetries can combine to make obtaining symmetry more challenging. Therefore, as pointed out by the authors, the first step is recognizing the various asymmetries and then developing a plan to deal with each one.

While several parameters that define symmetry were studied, I would reinforce the focus on the inframammary fold that is emphasized both in the title and the data. The inframammary fold represents the foundation of the breast, and any asymmetry in the level of the fold, or even any change in the position of the fold that may occur postoperatively will profoundly affect the overall appearance of the breast. For this reason, it is mandatory that position of the fold must be set accurately, symmetrically, and securely over time in order to create an aesthetic result in any type of breast procedure including breast augmentation, mastopexy, reduction, or reconstruction. Accomplishing this task begins with recognizing this important relationship right from the beginning and then developing a plan to set the foundation of the breast first. Once that is accomplished, the other elements of asymmetry can be dealt with as needed to provide an aesthetic result. The clinical data

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presented by the authors document all of these potentially important asymmetries, including most importantly the position of the inframammary fold. They are to be congratulated for presenting this data in such a clear and concise fashion.

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