Postoperative care following aesthetic breast surgery

– augmentation, reduction / mastopexy and augmentation mastopexy

The first aspect of postoperative care is to prevent or pre-empt potential problems; two main concerns are bleeding and infection. Towards the end of the procedure, I always undertake an antiseptic or saline washout before closing and check the blood pressure to contextualise the level of bleeding: a little ooze is safe if the pressure is high but not so if low. I have not used drains in breast surgery for over 15 years and I have not regretted that decision. Drains do not prevent bleeding or haematoma; they can be painful and could provide a portal for infection to get into the wound. The best way to avoid bleeding postoperatively is to stop it peroperatively. The three words I reiterate to myself at the end of the procedure are: "Haemostasis, Antisepsis and Analgaesia." For augmentation, I instil antibiotic into the wound as well as local anaesthesia; this is a boon for pain relief, especially if the implant is under the muscle. For all breast procedures a comfortable patient postoperatively is a haemodynamically stable patient who is then unlikely to bleed. I normally give an early intraoperative dose of antibiotics with dexamethasone plus tranexamic acid; I go on to give two more doses of antibiotics postoperatively. I think tranexamic acid helps to reduce blood loss and improve the operative field, while also helping to reduce postoperative bleeding, oedema and bruising; particularly if liposuction has been used as an adjunct to breast reduction surgery.

> *"The three words I reiterate to myself at the end of the procedure are:* ***Haemostasis, Antisepsis and Analgaesia"***

Next comes the dressing: should I have one? Over the years I find less is more as I have used dressings to give myself a (false) sense of security. Postoperatively, breasts need support but this is predicated on the age, the tissues and dissection. For breast reduction I have moved to adhesive paper strips for accurate final epithelial coaptation, this is then supported with tape such as Micropore – the adhesive side of freshly unrolled tape should be clean if not sterile – with a couple of layers over the wound. I might place something to bridge to a support bra, even if only for the first 24 hours; something absorbent in case there is oozing. If the tape is secure then a moisture gradient can be helpful to do just that – one layer of damp gauze (ideally aqueous antiseptic) then dry gauze is good to draw any blood away from the wound. After 24 to 48 hours the tape is all that is needed under the bra and is by then adherent enough to allow the patient to shower. If all goes well the tape can be peeled away at three weeks when the wound should be sealed and then only the support bra is required.

Once back on the ward, I used to tell patients not to move their arms much at all but I think recovery is better and quicker with regular, but gentle movement. There should not be any aggressive pectoral muscle flexion but very gently raising the arms from the side up towards the head stops stiffening up; I suggest once or twice an hour, on the hour if the patient remembers to do so but to stop if they feel any tightness, pull or pain. A little continued movement I think speeds recovery, much like continuous passive movement techniques used by our orthopaedic colleagues.

Postoperatively, activity should be limited and patients should avoid heavy lifting and excessive pectoral muscle use. This can be inadvertent, for example when sitting up using ones hands to push up, so patients need to be taught before going home how to get out of bed without chest muscle use by swinging the legs over the edge and ideally having some assistance. The patient needs to sleep on their back, never on the side or on their front; pillows can be used to facilitate this. Light exercise can be started from six weeks increasing gradually to full levels by 12 weeks. A support bra that is comfortable and does not cut in is used for six weeks.

"A comfortable patient postoperatively is a haemodynamically stable patient who is then unlikely to bleed"

AUTHOR

Tariq Ahmad,

Consultant Plastic Surgeon, Cambridge, UK.

Declaration of competing interests: None declared.

SECTION EDITOR

Dalvi Humzah,

Consultant Plastic, Reconstructive and Aesthetic Surgeon based in the West Midlands, England. He is an examiner and regional advisor for the Royal College of Physicians and Surgeons of Glasgow, Chairman of the Greater Midlands Skin Cancer NSSG and Co-Chairman of the UK Botulinum Toxin Group for Aesthetics (UKBTGA). He is a key opinion leader for the aesthetic industry and actively teaches and lectures internationally.