Reconciling Desires With Reality:

What Do I Want and What Will My Body Allow Me to Have?

"If you and your surgeon don't recognize and acknowledge what your body tissues will allow you to have now and for the future, one or both of you may pay a penalty you don't want to pay."

One of the first and most important steps on the staircase is understanding the importance of reconciling desires with reality—reconciling your wishes with your tissues. what you want with what your body will allow you to have. It's much easier to find a surgeon who will tell you he can produce what you want than to find a surgeon who knows and will tell you how what you want is likely to affect you now and in the future. The choices you make now may decisively influence your risks of having problems and reoperations in the future.

It is critically important that you understand not only what you want but also how what you want is likely to affect you and your breasts in the future. Wishes are fine, but good wishes come true only when you and your surgeon reconcile your wishes with what your tissues will realistically allow you to have.

Why Define What You Want, and How Definitive Should You Be?

Let's start by assuming that you would like to have breasts that are beautiful or, at the least, better than they are now. But what is a "beautiful" breast? What is "better than they are now?" You probably have some feelings about the answers to these questions, but the feelings may be general and not well defined. That's okay for starters. In fact, that's probably a good start. Think first in generalizations, then focus and define your desires more clearly as you learn more. You don't like what you have now, but how do you make a surgeon understand what you want?

The more clearly you define your expectations and the better you communicate your specific desires to your surgeon, the more likely you will achieve your goals.

Once You Have Defined It, Is It Achievable? at What Price?

Assume we have defined our goals and expectations in detail. Great! We know what we want, but getting it can be another matter. Reality sets in. Is it achievable? What are the costs? Will circumstances allow me to get what I want? These questions always require answers.

Let's assume you would like to have beautiful, full C cup or small D cup breasts with a naturally sloping upper breast (they look like breasts, not volleyballs), a nice hang to the lower breast without sagging, and nipples that point slightly upward that will maintain that look as you grow older. But, you are forty years old, have never had children, have virtually no breast tissue (your chest is absolutely flat); you are a workout fanatic with

almost no body fat; and you hate wearing bras. Can you get what you want? Will your body allow you to have what you want? Is it doable with current implant options and surgical techniques? No way, no how, not gonna happen. Your body is not going to allow you to have what you want, and if you push it, your body and you will pay the price! If you get implants large enough to produce the D cup you want, your tissues will change due to the weight, your already thin tissues will sag and thin more, and you are likely to see edges of the implant and see visible rippling as the implant pulls on the thin overlying tissues! Over time, excessively large implants or very highly projecting implants can cause your breast tissue to shrink away (atrophy) and can cause deformities of your ribs and chest wall beneath the implant.

In breast augmentation, one of the most difficult steps on the staircase is reconciling what bq. you want with what your body will allow you to have.

To make the right choices, you will need to understand more about your tissues.

Unfortunately, few surgeons and even fewer patients spend enough time with this step before doing an augmentation. A skilled, experienced surgeon can deliver almost anything you can dream up. With today's surgical techniques and implant options, you can create almost any size breast. What can be unfortunate is the price you may pay, now or later.

You come with only one set of tissues, you can't change those tissues for the better, and you can't replace those tissues.

If you choose options that exceed what your tissues can tolerate, sooner or later you are likely to pay with visible edges, loss of breast tissue, visible rippling, or other uncorrectable deformities.

Many patients never know before their augmentation what price they may pay years later if they don't recognize and respect what their tissues will allow them to have.

A classic example? Too large an implant with thin overlying tissues, excess tissue stretch, excess tissue thinning, shrinkage of your breast tissue, further aging and thinning of tissues, visible implant edges, and visible rippling from implants pulling on thin overlying tissues. Maybe even operations to try to correct rippling or visible edges that usually can't be corrected because no surgeon can change the qualities of tissues that have been compromised by excessively large implants.

Another classic example? An excessively highly projecting implant that is trying to force tight tissues to create a more projecting breast. The price over time is loss of breast tissue (atrophy) and possible rib and chest wall deformities, both uncorrectable deformities.

Unless you like problems, more surgeries, more costs, and more disappointments, you don't want to ignore what your tissues will allow you to have.

Is there any excuse for not knowing and not respecting your tissues? Maybe not good excuses, but there may be some mitigating circumstances. Some surgeons, especially early in their careers, have not followed enough patients long enough to fully appreciate what happens to tissues over time and how implant options can affect the equation. Happy augmentation patients often do not return for long-term, follow-up appointments, so the surgeon can't learn from what the surgeon doesn't see. The last thing that many younger patients want to think about is getting older (to be honest, even I don't like thinking about it, and I am older). But you will get older. Your tissues will change and not for the better (visualize your grandmother's breasts). How your implant affects those tissues can change over time. If you make good team decisions now, you have a much better chance of having nice grandmother breasts in the future.

A concept and a mission... to avoid penalties in the future

One of the missions of this book is to raise the level of awareness of this important concept:

If you and your surgeon don't recognize and acknowledge what your body tissues will allow you to have now and for the future and try to match your implant choice to your tissue characteristics, one or both of you may pay a penalty you don't want to pay.

Any team decision that ignores this concept is a bad team decision. You can make it be a bad decision by asking for the wrong thing(s). Your surgeon can present or encourage choices that make a bad team decision. Or your surgeon can, with perfectly good intentions, try to deliver what you ordered without helping you understand the implications of your choices. Any one or combination of these can result in bad team decisions that penalize you and your surgeon in the future.

Where Do We Start? With What You Don't Like or With What You Want?

Both, actually. Start with what you don't like; then list what you want. To help, here's a list of steps:

Defining what you don't like and what you want—a list

1. List the things you dislike about your breasts.
2. List how those dislikes affect your feeling of being normal or how those dislikes affect your lifestyle.
3. List the basics of what you would like to have based on what you know now. # Read the rest of this chapter to help you understand what your body may allow you to have.
4. Refine your list of what you'd like to have based on your new knowledge.
5. Look at your list carefully, and ask yourself if you are willing to live with your choices long term.
6. Finalize your list of "wants" that you will discuss with surgeons you visit.

7. Don’t let window shopping (looking at pictures in magazines and surgeon’s “brag books”) fool you about reality and the future. Think about your own tissues.

Listing Your Dislikes

Make this easy. Pick simple things like these that we have heard from patients:

My breasts are too small for my figure.

I wish the top of me matched the bottom.

I look like a bowling pin.

I can’t fill up any bra.

I wish I could wear a T-shirt or blouse without a bra.

I’m tired of buying things to fit the bottom, then having to spend more money altering or filling the top.

Cleavage is not a word in my vocabulary.

If I could take what’s on my butt and put it in my breasts, I’d be deadly.

Every bathing suit I buy must contain helpful devices.

I’m sick of males asking me why I just don’t wear trunks instead of that girlish bathing suit.

I’m not careful, I’ll trip on them.

Hold a pencil underneath? Hell, I could hold a barbell!

My upper breasts look like ski slopes! No, they look worse than a ski slope.

I wish I had what I had before I was pregnant.

I liked what I had when I was pregnant (or nursing) a lot better than what I have now.

I’m sure there are more, but you get the idea.

Listing What You Want Based on What You Know Now

These are examples listed according to how often we hear them from patients:

Fuller upper breasts

More cleavage

X cup breast (Choose the cup size.)

Perkier breasts

Not huge, but proportionate to my figure

More fullness at the sides to balance my hips

A better shape to my breasts

Fix my weird nipples

Baywatch breasts—big and round

Now that we know what we don't like and what we would like to have, let's learn more about the implications of our wants.

How Not to Define Your Expectations

Although some methods of defining breast size are popular, they are not as accurate as we might like to believe. First, let's consider how not to define your desired breast.

Cup size—especially cup size alone

Cup size is not even a consistent fashion measurement, let alone a medical term that can accurately and consistently define breast size.

But it's probably the most common yardstick women use. Any woman who has ever shopped for bras knows that a B is not a B is not a B. Although the labels say the same size, when you put them on, some fit and some don't. For the same woman, some B cup bras fit better than her usual C cup and vice a versa. Some B cup bras fit better than other B cup bras. Check your own bra drawer! How many cup sizes do you have?

We frequently hear from patients, I'm sorta a B cup and I want to be a full C cup. Our response is simple. Tell me what a sorta B or a full C cup is! Can you go buy me a bra that is labeled sorta B or full C? If you can't define it and you can't buy a bra labeled it, how do you expect a surgeon to create it? And if a surgeon tells you he can create it, what should that tell you about the surgeon?

Cup size is extremely variable and inconsistent from one brand of bra to another.

If cup size is inconsistent and you know it from buying your own bras, why would you want to rely on cup size to specify what you want?

You can't define it because it isn't a consistent measurement from manufacturer to manufacturer, as much as they'd like you to think it is. If a surgeon guarantees you a cup size, that should tell you something about the surgeon. How can you deliver something that isn't consistently definable? What about the surgeon who doesn't even know that bra cup size is not consistent or definable?

How do we use cup size? We have no objection to using cup size as a general guideline, provided you recognize it is only a general guide that can't be ordered or delivered, and your surgeon doesn't talk to you about cup size only when defining your desired outcome.

We always ask our patients the following questions: What cup size were you before you were pregnant? Largest during pregnancy? What cup size after pregnancy and nursing if you nursed? What are you now? What would you like to be? If cup size is not a consistent measurement, why do we ask? The answers to these questions give us a clearer understanding of how our patient sees her breasts. During our exam, measurements will precisely define the size of the patient's skin envelope.

Knowing what a patient thinks she is (by asking the questions) and knowing what she really is (from our measurements) helps us better understand the patient's perspective and her wishes.

But we NEVER define the desired result by cup size alone.

Many women don't buy bras to fit their breasts... a personal revelation from Dr. Tebbetts

During my first several years in plastic surgery, I was baffled by the array of bra types and sizes that patients applied to breasts that all looked very similar and that measured similar in size on exam. One of the more enlightening milestones of my plastic surgery career was the day I realized that women don't buy bras to fit their breasts. Most women buy bras to push their breast tissue where they think it looks best. Women don't necessarily buy bras that fit their breasts. They buy bras that the breast will fill. What do I mean?

The width of a breast (from side-to-side, Figure 4-1) increases with increasing cup size. But I was amazed that women who had measurements indicating a D cup width were often telling me they were a B cup. What they really meant was that they were wearing a B cup bra. Then one day I asked a patient to please put her bra on as I observed. The B cup bra did not fit the fold beneath the breast. The breast was wide, more like a D cup width. The bra she had picked was much narrower than the width of the breast. When the patient put it on, she leaned forward and tucked the outside part of the wider breast inward to fill the cup of the smaller and narrower B cup bra. A light went on! Then I understood! She picked the smaller B cup bra because the amount of breast tissue that she had would fill it! When she pushed the outside portion of the breast inward into the bra, it not only filled the bra but bulged at the top of the breast and toward the middle. More

cleavage! From that day on, I have been able to put bra cup size in perspective and rely more on measurements to document the size of breasts.

Breast Width and Cup Size

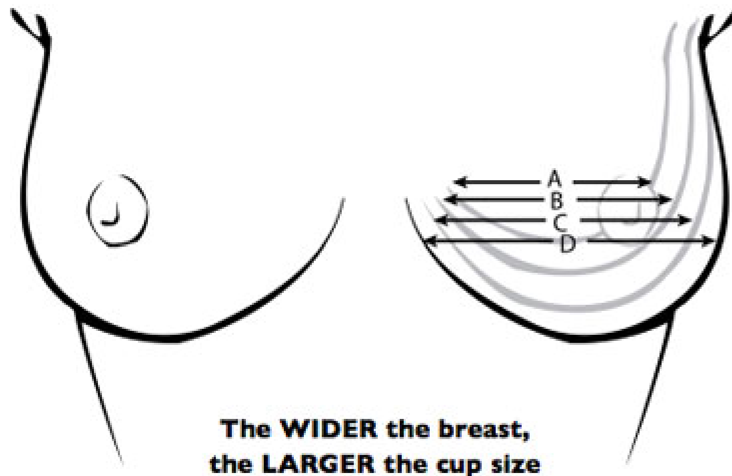


FIGURE 4-1

Women buy a bra that they can fill.

Women buy bras to push breast tissue where they want it to go to create a specific appearance.

Women don’t necessarily buy bras that fit their breasts!

Implant size in ccs

One measurement of the size of a breast implant is the volume (amount of filler) in the implant measured in cubic centimeters (ccs). Do you know how much a cc is? How much is 300 ccs? How many ccs are your breasts right now? How many ccs are in a B cup? How many ccs in a C cup? If you are thinking about trying to define what you want in terms of ccs, you should know the answers to all these questions. Fact is, some of these questions don’t have an answer, at least not one correct answer. The answer to some of the questions is “It depends.”

Join a conversation with a group of women discussing their breast implants, and you might hear, “I have 300 cc implants, and I’m a C cup.” Another woman responds, “How

can that be? I have 300 cc implants, and I'm a D cup." They could both be correct. The message? A certain implant size in ccs does not guarantee a certain cup size. Why?

When teaching courses to surgeons, I have frequently asked the question, how many ccs does it take to produce a C cup breast? Invariably, one or more surgeons will respond with a specific number of ccs that will predictably produce a certain cup size breast, usually a less experienced surgeon. Also invariably, another surgeon will answer correctly by pointing out the following:

An augmented breast consists of the skin envelope plus the implant plus whatever breast tissue the woman had
before the augmentation.

Expressed as a formula for surgeons: augmentation result = envelope + Parenchyma (breast tissue) + Implant

Now you can answer the question of how, if both women described above had 300 cc implants, one could have a C cup breast and the other a D cup breast. The woman who ended up having a D cup breast after augmentation had more breast tissue before her augmentation compared to the woman who ended up with a C cup breast.

A certain number of ccs in an implant does not make a certain cup size breast.

Be sure you understand this concept, and then ask yourself if your surgeon understands it, based on what the surgeon tells you.

The final size of the breast depends on the amount of breast tissue the woman had prior to surgery plus the size of the implant that was placed in the breast.

So a woman who has more breast tissue to begin with needs fewer ccs in an implant (smaller) to get to a C cup breast compared to another woman who had less breast tissue to begin with, and will need a larger implant to get to a C cup breast. If this concept is confusing, read it again until it makes sense.

Now you know why a certain size implant (in ccs) does not make a specific cup size breast!

The cup size an implant will make depends on how much breast tissue the woman had before her augmentation.

Now that we know how not to define our desired breast size, how do we define it? At this stage, it's fine for you to specify what you want with the simple "want list" you made. Don't worry too much about specifics until you understand more about how breast size affects your tissues. Later, you and your surgeon can make more realistic estimates of what is achievable (and the trade-offs) by thinking about your specific tissues. Do you have enough skin to create what you want? Do you have too much skin that will require

more than what you want to fill it optimally? And a whole series of additional questions that will help answer the question, Will your tissues allow you to have what you want? To what degree? And for how long?

Do you have what it takes (your tissues) to get what you want? and what do you have when you get it (the long-term result)?

How Much Is Enough?

How much breast is enough? In the first edition of this book, we stated that breast size should be in proportion to
body size or body shape. While that may be an ideal concept, it is not totally correct or realistic.

The amount of implant volume and the optimal size of the breast are defined only by the amount of skin available in
that breast—the width of the breast envelope and the stretch of the breast envelope. The smaller and narrower the
breast and breast envelope, the less fill or volume will fit into that envelope without causing tissue damage that
can produce the uncorrectable deformities we just mentioned. While we might like to produce large, wide breasts to
better balance large, wide hips, the amount of skin and breast fill that you come with may limit how much a surgeon
can safely put in your breast without causing permanent damage.

Remember these important principles (we will go over them more later):

- The wider a woman's breast before augmentation and the more the skin stretches (and we will measure both), the more volume is required to fill the patient's envelope to get an optimal result.
- If we don't put enough fill (implant size) in the breast, allowing for skin stretch, you won't have enough fill in the upper breast, and the upper breast will appear empty.
- If we put too much fill to match the width and stretch of your breast, you will have too much fill in the upper breast with excess upper bulging and a Baywatch looking breast. (Some women like this look, and we can produce it, but excess fill always comes with a price later—increased risk of sagging, excess tissue thinning, visible implant edges, and visible rippling from the implant pulling on thin overlying tissues.)

From a practical, common-sense perspective, a woman's breasts are "designed" to enlarge an amount that approximates the amount of enlargement that usually occurs with pregnancy. For most women, the breast usually enlarges an average of one to one and one-half cup sizes during pregnancy. Of course, the larger the breast before pregnancy, the greater the degree of enlargement during pregnancy. The larger the breast during pregnancy, the more the skin stretches to accommodate the enlarged breast tissue. After

pregnancy, the breast tissue shrinks and falls to the bottom of the larger, stretched skin envelope. The result is a more sagging breast that is emptier in the upper breast. Extreme enlargement with pregnancy usually results in a very sagging breast with thin skin and visible stretch marks.

If you have been pregnant and can remember the degree of fullness of your breasts at nine months (not necessarily the maximum fullness when your milk came in), the nine month amount of fill is approximately what is required to achieve an optimal amount of safe fill in your breast.

Similar changes occur following breast augmentation, and is the amount that the High FiveTM measuring system recommends. The larger the implant, the larger the resulting breast. The larger the implant, the more the breast skin stretches and thins and the more the breast will ultimately sag as a woman ages, losing upper fill.

An augmented breast may not sag quite as much as an unaugmented breast of the same size, but the larger the implant, the more the breast will sag in the future as you age.

If a surgeon tells you that an augmented breast won't sag or that excessively large implants (usually over 350 cc) can't possibly cause the problems listed previously, locate another surgeon who understands tissue dynamics.

The Funnel Analogy

What is ideal fill for each woman's skin envelope? If a woman has had previous pregnancies, her skin envelope is already stretched. Envision a funnel and pitcher pouring liquid into a breast envelope (Figure 4-2, A). If the envelope has already been stretched, the fluid will initially fill the lower breast. As more fluid is added, at some point, the breast appears full and natural with a natural appearing upper breast slope (Figure 4-2, B). If more fluid is added, the upper breast begins to bulge outwardly as the skin envelope is overfilled.

What Is Ideal Fill?

If you want a natural appearing breast, there is a correct amount of fill that is both the *least* and the *most* for an optimal result.

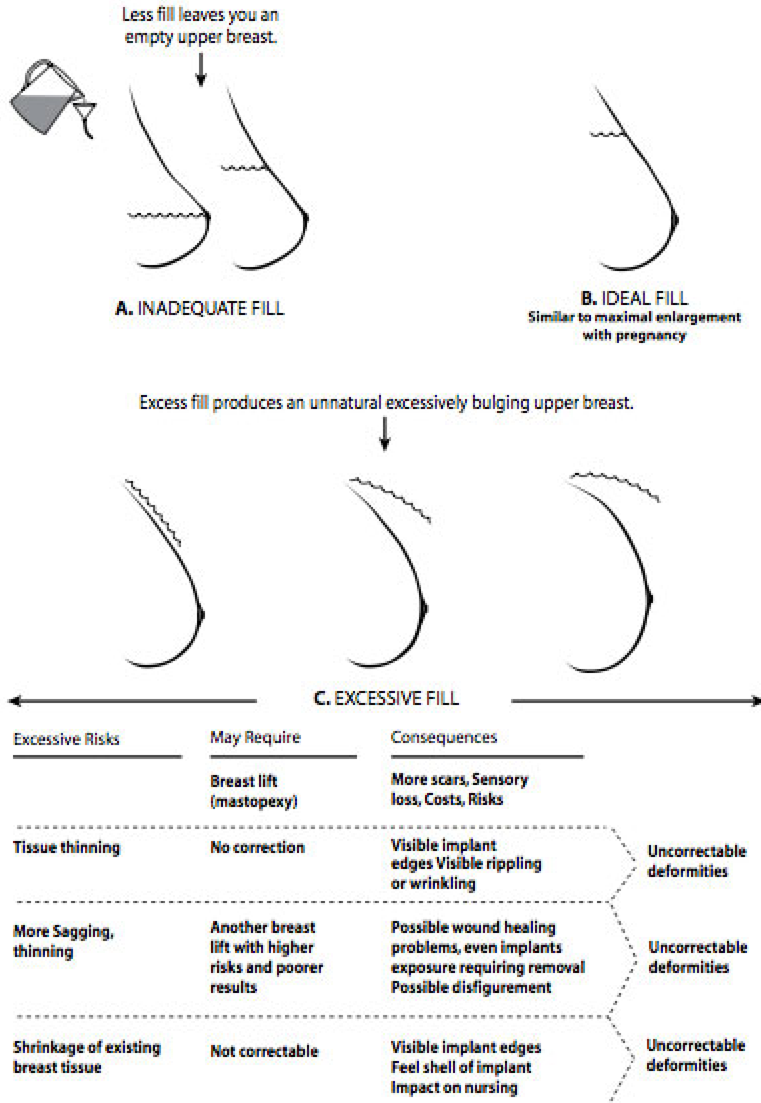


FIGURE 4-2

Exactly the same principles apply to breast augmentation. To achieve an optimal aesthetic result, enough filler must be added (the size of the implant) to adequately fill the envelope (Figure 4-2, B). If a woman wants a very bulging upper breast, more filler (a larger implant) is required. But the larger the implant, the more the stretch, the more the breast will sag in the future, and the greater the risk of tissue thinning with stretch, which allows the implant edges to become visible and visible rippling or wrinkling resulting

from the implants pulling on the thin overlying tissues. Visible implant edges and traction rippling are often uncorrectable by surgery.

How much is enough? If the best long-term result is the goal, the answer is to fill the existing envelope to ideal fill and a natural breast contour (Figure 4-2, B). Any overfill past this point virtually guarantees that the breast will sag more in the future, increasing risks of implant edge visibility and traction rippling, causing possible shrinkage (atrophy) of existing breast tissue, decreasing the quality of the result (Figure 4-2, C), and increasing risks of reoperations. For women who have never been pregnant, the surgeon must estimate a normal amount of stretch that would occur with pregnancy, given each woman's breast tissue characteristics.

Women who are very flat chested often ask surgeons to produce a breast that projects much more off their chest wall compared to what they have. Implants that have significantly more back to front thickness (projection) push the skin forward more and create more projection. These "high projection" and "extra high-projection" implants have become more and more popular recently for patients wanting a more projecting breast. Unfortunately, high-projection implants can cause significant and uncorrectable long-term tissue damage. The tighter a patient's skin and the more projecting (or large) the implant, the more pressure the implant exerts on the patient's breast tissue (parenchyma). This pressure, over time, causes the breast tissue to shrink or atrophy, decreasing soft-tissue coverage over the implant and possibly impairing a patient's ability to nurse or impairing sensation. Excessive implant projection and pressure can even cause rib-cage deformities. Highly projecting implants are sometimes needed in breast reconstruction, but are rarely indicated in primary breast augmentation.

A key concept is that a properly chosen breast implant does not force tissues to where they have never been or were never intended to go. An optimum implant either optimally fills the space present or stretches tissues no further than they are likely to stretch with a pregnancy.

When you choose an implant that is too large for your skin to support, the implant can cause tissue changes (listed in Figure 4-2, C) that cannot be reversed and that can result in unsatisfactory consequences and additional surgery. Remember that your choice of breast size has long-term consequences.

What Do You Have Now?

A surgeon can work only with the tissues that you bring to the surgeon.

Look at your breasts in the mirror. Do they look exactly like any other woman's breasts that you have ever seen? No. Do they match side to side? Never. And they will never exactly match following an augmentation! Do they look the same now as they looked five years ago? Probably not, if you look closely. No two women have exactly the same breast appearance because every woman's tissues and combination of tissues are different. The

two breasts never match exactly because the tissues are never exactly the same in both breasts.

No woman has two breasts that are the same, and no surgeon can create two breasts that are exactly the same.

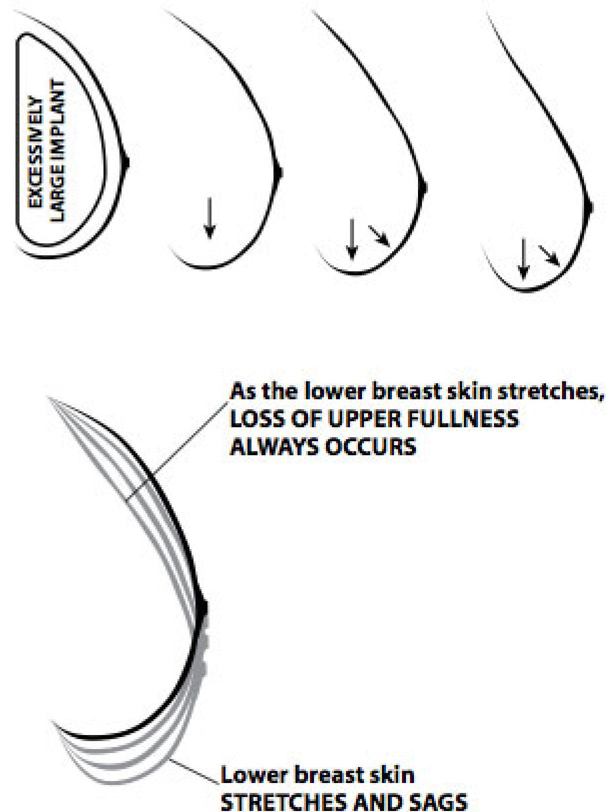
Your breasts don't look the same as they did five years ago because your tissues are five years older, and the characteristics of those tissues have changed. They will continue to change throughout your lifetime. I wish we could tell you they change for the better, but tissue quality predictably declines with aging.

Will what you have (your tissues) allow you to get what you want (your result)?

Since a surgeon can only work with what you bring, whether you can get what you want depends on what you bring the surgeon—your individual tissues—to work with. Will your tissues allow you to get what you want? Do you have the optimal amount and type of skin to accept the implant that will create the breast you are ordering? If your tissues will accept the implant, how will your choices affect your breasts in the future? These are complex questions that don't necessarily have a single correct answer. Begin by memorizing two inescapable truths, then tell every woman you know who is considering augmentation (and every surgeon you see who doesn't already know) the following:

The bigger the breast, the worse it will look over time— augmented or not! think about the woman you knew at a younger age with large breasts. How do they look now?

Aging in the Excessively Augmented



The larger the implant, the more your tissue will stretch.

The more your tissues stretch, the more the breast will sag.

Risks of visible rippling, visible edges, feeling the implant, and reoperations increase.

FIGURE 4-3

Your tissues won't get better as you age; they will get worse! think about your grandmother's breasts or any woman's breasts after age sixty.

We aren't dealing with magic here. A little logic and common sense goes a long way. The bigger the breast you request (all other factors being equal), the bigger and heavier the implant and the more that implant will stretch your tissues over time (Figure 4-3). Stretched breast skin sags and thins. All this happens as you and your tissues are getting older and more stretchy on their own. You can't do anything about what you come with

(genetics are inescapable) or how your breast envelope ages (aging is inescapable, too), but you certainly can affect how the implant may affect your tissues in the future by avoiding excessively large implants.

The bigger the breast you request, the worse it will look over time. Guaranteed.

Continue to remind yourself: the bigger the implant I request, the worse it will look over time, and the
greater my risk of reoperations and uncorrectable deformities.

Not only will it look worse, the bigger the implant you get now, the more likely you may pay in the future for additional operations and additional costs. You may, for example, require a breast lift (mastopexy) with additional scars, more risk of loss of sensation, and additional costs sooner if you select implants large enough to accelerate sagging. More about that later. For now, just recognize and acknowledge that: For the best long-term result, you might want to balance what you want with what your tissues will allow you to have. Your surgeon should help you understand the characteristics of your individual tissues and which options are realistic for you.

For the best long-term result, you might want to balance what you want with what your tissues can support over time. ask you surgeon specifically how the implants you select will affect your individual tissues over time, and take notes. this will make your surgeon aware that you are concerned about this and want the best result for the longest time with the least risk of reoperations and uncorrectable deformities.

The real truth is that different patients' tissues react differently to the same implant over time. No surgeon can tell you exactly how your tissues will age, how soon you will sag, or when you may need a breast lift. But you should remember this: if a surgeon doesn't bring up the subject of your tissue characteristics and how your choice of implant might affect your long-term result, stop and think. Just what are the chances that you will get the best long-term result from that surgeon?

Two Golden Rules for Good Results—Short Term and Long Term

For an optimal result, the surgeon must adequately fill the existing breast envelope.

Any fill more than that required for an optimal, aesthetic result will detract from the long-term result.

These principles will make more sense by applying them to two patient examples:

1. Sharon, a fictitious name but real patient, (patient number 1, Figure 4-4) had a C cup breast before pregnancy and enlarged to DD during pregnancy. After pregnancy, her envelope remained stretched (as usually occurs), but her breast tissue shrank and fell to the bottom of the envelope. She now has what appears to her a sagging breast, empty in the top and fuller and saggy at the bottom. Her

breasts won't look good unless the stretched envelope is adequately filled. Imagine a funnel in the top of the breast. If we poured in liquid, the bottom of the breast would fill first. Pour more into the funnel, and the middle will fill next. The top fills last. At some point, with the patient sitting, the breast would look optimal with adequate but not excessive upper fill. At that exact point, the amount of filler that we added to the breast is precisely the amount required to produce an optimal result. Exactly the same thing happens with breast implants. Too small, and you won't fill the top. Too large and the top will bulge, and the breast will sag more rapidly.

The size of implant that will be required to fill a larger, stretched envelope will be greater than the size required to fill a smaller, less-stretched envelope.

2. Consider a different patient we will call Janet (patient number 2, Figure 4-5). Younger, no children, with an A cup breast. The skin is tight, has never been stretched by pregnancy, and there is very little breast tissue (parenchyma). Janet's envelope is totally different than Sharon's envelope. It is tight, with less room for an implant. The larger the implant placed, the more the skin will push against the lower implant, and the more the upper breast will bulge. The bulging will decrease over time as the skin of the lower breast stretches, but if the implant is too large for the amount of stretch that can occur, the breast will have permanent, excessive upper bulging. If the implant is too large for the patient's skin characteristics, the lower breast skin will stretch excessively and the breast will appear saggy or have a "bottomed out" appearance—both are bad. The implant that will produce an optimal long-term result for Janet will be smaller than the ideal implant for Sharon. Janet has smaller breasts to begin with and skin that has never been stretched. To apply the principles, use enough implant to fill the envelope, allowing for stretch, but not so much implant that excessive stretch and sagging will occur with time.

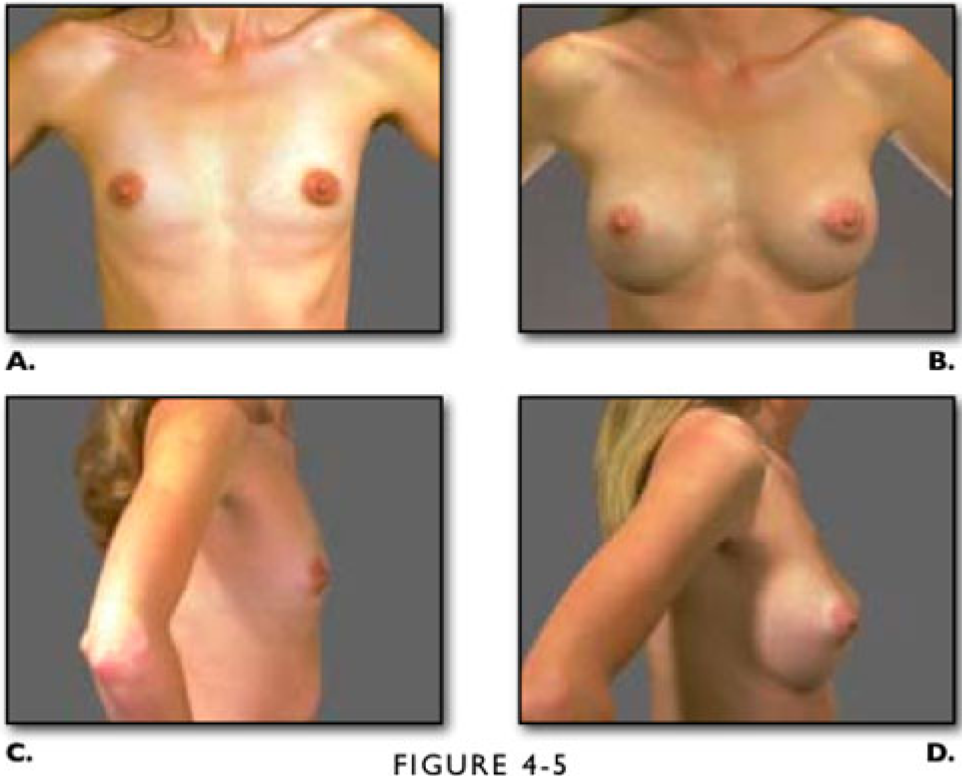


FIGURE 4-5

The smaller and tighter (unstretched by pregnancies) the envelope, the less implant the envelope can accept and give an aesthetically optimal result and a good long-term result without problems.

No surgeon can totally predict what a patient's tissues will do over time, but every surgeon and patient should consider these issues when making implant choices. Even if Sharon and Janet were the same height with the same torso proportions and both wanted the same, optimal result, the implant required to produce that result would be different in the two patients. Why? Because their tissues are different.

No implant will produce the same result in two different patients.

Just because your best friend had a round, smooth, saline-filled, 300 cc implant that produced a certain result, rest assured that the same implant will not produce the same result in your breast because your tissues are different.

Are You Willing to Live With What You Have Ordered?

Now, we get to balance what you want with the trade-offs of what you are willing to live with. What if you are Janet and you want Baywatch breasts? For those who were never treated to this prime example of video artistry, a Baywatch breast is very large, very round, and very bulging at the top, even without clothing. With your tight skin, can you get very large, round, bulging implants? You bet! If you can afford them and you can describe them, you can find a surgeon who will fill your order—guaranteed. I mean you

are guaranteed to be able find a surgeon who will fill the order, but the surgeon would have to be brain dead to guarantee the work.

Assume that now you have got them—the Baywatch breasts. Awesome! You love them, your significant other loves them, and most men must love them because they can't look in your eyes when they talk to you. You got'em—now what have you got? What will predictably happen to the extremely large breasts over time?

This really isn't a tough question; just think about what always happens to large breasts. The skin can't adequately support the weight of the breast tissue over time, so the breast sags. It's a little different with implants: they usually don't sag quite as much over time as an unaugmented breast the same size, but they nevertheless sag. The weight of the implant stretches and thins the skin. The thinner the skin, the more the breast sags. The weight of the implant pulls on the skin enough to create visible ripples around the edges of the breasts or in the upper part of the breast. Whatever breast tissue you may have had before augmentation may shrink significantly. If you need a reoperation for sagging or rippling, now what does the surgeon have to work with? Thinner, stretched skin. Poorer quality tissues. Less breast tissue to cover your implants. Tissues that have been compromised or damaged by excessively large implants, tissue changes that can never be corrected. Operating on thinner or poorer quality tissues often brings poorer results and more potential problems. You ordered them. Now you have them. What have you got?

Does this mean that no woman should have larger breast implants? Not necessarily. Sometimes, larger implants are required to adequately fill a woman's existing breast envelope. Some women simply want to have larger breasts and implants, and they certainly have the right to have what they want. But they also should understand what will likely happen over time.

What's important is, regardless of personal choices and choices dictated by your tissue characteristics, you should be informed and aware of the potential long-term implications of those choices before surgery.

It's your job to see that this happens.

Realism and the Perfect Breast

Regardless of how much homework you do, how well informed you become, and which choices you make, another inescapable truth is:

Perfection is not an option. surgeons can only produce improvement.

We hope that you will view the improvement as perfection compared to what you had before, but perfection doesn't exist in plastic surgery. Your breasts won't exactly match, you likely won't get every single thing you want, and even if you select a perfectionist surgeon, I guarantee you the surgeon won't be able to achieve perfection. Your tissues

aren't perfect. Time isn't kind to tissues, and neither you nor your surgeon can stop the clock

Go in with your eyes wide open. Do everything you can right, but be realistic about your expectations. Pin your surgeon down with questions that help you be realistic. Hopefully, your surgeon will do all this automatically, but ultimately, it's your job to pick the surgeon who best meets these goals.

What a Breast Augmentation Does and Does Not Do

A breast augmentation predictably does only one thing—enlarges your breasts. To avoid misconceptions, you should understand each of the following things that breast augmentation does not do predictably:

- In every woman, one breast is larger than the other. Breasts never match, and no surgeon can make breasts match. Putting a larger implant into the smaller breast will not make the breasts match and may create shape differences that are more apparent than a size difference.
- Breasts are never located at exactly the same level on the torso. One breast is always higher than the other, and one nipple is higher than the other. Breast augmentation does not move the breasts around on the torso and does not routinely relocate the nipple-areola, so these discrepancies will remain after a breast augmentation.
- Breast augmentation cannot predictably compensate for how you stand, for chest wall deformities you may have, or for spinal curvature deformities you may have. Breast augmentation only enlarges the breasts.
- In the gap between your breasts, only skin and a thin fat layer cover the underlying sternum. If you and your surgeon choose to move the edges of your implants into this area to narrow your cleavage, you are choosing to put your implants under inadequate tissue coverage. Over time, you are likey to experience visible implant edges and visible traction rippling that are largely uncorrectable.
- Regardless of the thickness of tissues overlying her implant, every augmentation patient should be aware that at some point in her life, she may be able to feel portions of her breast implant.
- A breast augmentation never produces a "natural" breast, because no natural breast contains a breast implant. The degree of naturalness of any type of implant is highly subjective and varies among patients and surgeons.
- Breast augmentation cannot make your breasts look like any picture or like any other person's breasts. Even though pictures might appear similar, vast differences can exist between the tissues in those pictures. Only tissue measurements tell the true story.

The Pleasures and Perils of Window Shopping for Breasts

Although I'm risking putting myself in a position I might not want to be in (and I should know better by now), I have observed that most women like to shop! If you needed a new

dress, chances are you would shop for it. If you were ordering a dress, you would want to see a picture before placing the order. Deep down, you know that shopping for a dress isn't the same as shopping for a breast, but instinctively, you are likely to apply some of the same principles. As an informed consumer, you would like to know what's available. You would really like to know what your breasts are going to look like before you proceed with your augmentation. Pictures and images are common ways to address these issues. Three commonly used media are magazine pictures, pictures from a surgeon's before-and-after ("brag") book, and pictures on a computer imager.

Before looking at pictures, remember these principles.

Three of the most important aspects of a woman's breast that determine breast size and the amount of implant required for optimal fill are the following:

1. BREAST WIDTH—the width of the breast prior to augmentation
2. SKIN STRETCH—how much the skin stretches prior to augmentation
3. AMOUNT OF BREAST TISSUE BEFORE AUGMENTATION

It is categorically impossible to accurately determine breast width, skin stretch, or amount of existing breast width, skin stretch, or amount of existing breast tissue from any picture.

Any decisions you make based on looking at pictures are inherently flawed and not based on your individual tissue characteristics.

Magazine Pictures

The only picture that truly represents breast characteristics is one totally without clothing, standing or lying down.

Most pictures in magazines don't meet these criteria. If nude, the model is almost always posed in a position that best complements her positives. Often the positioning interferes with (or contributes to) the appearance of the breast. At any rate, it doesn't allow an objective appraisal. If the model is wearing any clothing that touches the breasts (much less pushes the breasts to make them or the clothing look more appealing), you can't make objective judgements about the breast.

If you see breasts that you like, it's fine to take the pictures with you when you visit a surgeon. Pictures may help a surgeon understand what you like, and pictures may help you judge the surgeon:

If a surgeon looks at a picture and says, "sure, we can make that breast! No problem!" RUN THE OTHER WAY!

There could be a real problem if your tissues don't match the tissues of the person in the picture, and they never do. either the surgeon may not know, or the surgeon may not care.

exception: the picture is a picture of a woman standing, nude, with tissues exactly the same as yours. Does she exist?

On the other hand, if the surgeon replies, “Let’s look at your tissues and compare you as best we can to the person in the picture,” better!

Problem, still, is that the surgeon can’t evaluate the tissues of the woman in the picture.

If the surgeon replies, “I’ll use the pictures to help me understand what you’d like, and then I’ll try to help you understand our best options and trade-offs, given your tissues,” Great!

Surgeon “Before-and-After” Brag Books

We will cover this subject later when we discuss surgeon consultations. Some basic rules that we will mention again are:

If you can find a patient in the book who looks almost exactly like you BEFORE her augmentation, it’s possible that you MIGHT be able to look SOMEWHAT like her result AFTER your operation.

Unfortunately, you can’t accurately know the width of the breast and the degree of skin stretch of the skin in the picture, and these two measurements are the most critical in determining optimal fill for your breast.

If you can’t find someone who looks like you before her surgery, it’s still fun to look.

The best lessons you can learn from any before-and-after book are:

If the surgeon doesn’t have pictures to show you, consult other surgeons.

If every result looks good, consult other surgeons.

If the book does not contain a wide variety of breasts with some results better than others, consult other surgeons.

A surgeon’s habits are reflected in the quality of the pictures as well as the quality of the results. Look at the quality of the pictures! are they standardized? Good quality? Is the background consistent in all the pictures?

If the surgeon or his personnel can’t fully explain any question you ask about the pictures, consult other surgeons.

Computer Imagers and Images

Again, we will cover this topic more later, but keep in mind for now that anyone, even a technician, can produce changes on a computer that no surgeon can produce with living tissue.

If the surgeon uses the imager to help you understand some points, fine.

If a technician or the surgeon uses the imager to sell you something that doesn't make sense or to sell you other non-breast-related operations, BEWARE.

If the surgeon morphs (changes the appearance of) your breasts on the computer and prints you a simulated before-and-after picture, don't look at it too much, and try not to fix the image in your mind. Your result definitely won't match the image exactly.

We are all human. Once we have seen a simulated result, we tend to expect that result, even if the computer screen is covered with disclaimers informing us that this is only a simulation.

The computer can be a wonderful tool when used as a constructive tool to discuss options with you or provide you useful information. We use it a lot. When it's used primarily as a marketing tool to sell you an operation, you are likely not getting all that's best for you. To date, no one can precisely represent your tissue characteristics on a computer.

When it comes to images, shop all you want, but don't buy. Use pictures constructively, but base your buying on information and an evaluation of your tissues.

Internet- or Computer-Based "Modeling" Gimmicks

Almost every patient would like to know how their breasts might look following augmentation, with different sizes or types of implants. This natural human tendency makes patients easy prey for marketing gimmicks, such as computer- or Internet-based programs that show a model or mannequin and allow a patient to select implant sizes or types and see changes occur in the breasts. Virtually all of these marketing gimmicks are accompanied by long, detailed disclaimers stating that the images do not reflect actual results. Although the disclaimers may (and I emphasize "may") protect the marketers legally, prospective patients who use these gimmicks may make poor decisions if they don't carefully read all disclaimers. Despite any disclaimers, when most patients see an image based on a theoretical implant type and size that has nothing to do with their own personal tissue characteristics, the patient forms opinions. These opinions are often severely flawed, and in the best-case scenario, a very knowledgeable surgeon will need to spend considerable time reeducating the patient to reconcile the patient's desires with tissue realities. Worst-case scenario, a surgeon simply attempts to produce what the images showed without consideration of the patient's tissues (avoiding the additional time necessary to alternatively reeducate the patient). In the worst case scenario, problems may occur later as the result of poor decisions. Either surgeon scenario is not a good one for the patient (more time spent undoing bad ideas or ignoring tissue priorities or agreeing with poor decisions and suffering consequences later). Patients should

recognize these types of marketing hype that may have little to no relationship to reality and avoid them.