Commentary

Aesthetic Surgery Journal
2018, Vol 38(1) 58–59

DOI: 10.1093/asj/sjx132
www.aestheticsurgeryjournal.com

OXFORD
UNIVERSITY PRESS

Commentary on: Female-to-Male Gender Affirming Top Surgery: A Single Surgeon's 15-Year Retrospective Review and Treatment Algorithm

Stan J. Monstrey, MD, PhD

Editorial Decision date: June 26, 2017; online publish-ahead-of-print September 9, 2017.

In "Female-to-Male Gender Affirming Top Surgery: A Single Surgeon's 15-Year Retrospective Review and Treatment Algorithm," the authors report on a retrospective study of 1358 subcutaneous mastectomies performed in 679 female-to-male (FTM) transgender patients.[1] The objective of this study was to determine the safety profile and aesthetic outcome of two different operative techniques that were utilized for male chest contouring. The first technique, the so-called "keyhole" technique, was performed in 104 patients (15.3%), whereas 575 patients (84.7%) underwent the second technique, the "double incision free nipple graft (DIFNG)" technique. The keyhole technique is the operative procedure that is routinely utilized for gynecomastia resection through a semicircular (semi-areolar) incision as described in 1946 by Webster.[2] The DIFNG technique also is a classical surgical procedure, first described by Thorek more than 50 years ago, involving an elliptical mastectomy excision with a free full-thickness skin graft to reconstruct the nipple-areola complex (NAC).[3]

The authors should be complimented for this well-written and clear article of what definitely is the largest top surgery series to date, including 679 FTM patients. The authors conclude that with both techniques, safe and aesthetically pleasing results can be achieved. Indeed their results are good compared to the literature, achieving high aesthetic scores, low complication rates, and a low overall number of reoperations. Additionally, several interesting tricks and refinements are provided for both surgical procedures, including a very useful and simple NAC position chart for the DIFNG technique (the authors' Table 1).

I fully agree with the authors, who mention that top surgery in FTM individuals is a specialized surgical procedure that requires extensive experience to master and that, if surgeons do not perform this surgery regularly, complications may be more likely to occur earlier on the learning curve.

Although the authors mention that the growing demand for top surgery performed by the senior surgeon demonstrates the FTM community's positive response to their results, it should be added that this might also be related to the substantial increase in the number of transgender patients worldwide seeking surgical therapy for their gender dysphoria as well as to the improved reimbursement for gender confirming surgery.

The limitations of this study include that it is a retrospective review, that most patients were lost to follow-up beyond the first few initial appointments, and that almost no information is provided on how and by whom the (small number of) aesthetic scores were obtained. It is also unclear to what degree the low number of reoperations is a result of

Dr Monstrey is a Professor and Chairman, Burn Center, Department of Plastic Surgery, University Hospital Gent, Gent, Belgium.

Corresponding Author:
Dr Stan J. Monstrey, De Pintelaan 185, 2K12C, B-9000 Gent, Belgium.
E-mail: stan.monstrey@ugent.be

the actual (good) postoperative result or to what degree it also might be related to the financial burden for the patient having to pay for the correction himself. Nowadays, a subcutaneous mastectomy in a FTM transgender patient is more often considered a "reconstructive" procedure with better reimbursement possibilities compared to what the authors here refer to as "a cosmetic practice" surgical procedure.

However, in my opinion, the main drawback of this article is that only two (admittedly classic) techniques are reported here. Both procedures were first described in the 1940s and really withstood the test of time, as demonstrated by the fact that they are mentioned in every published article on subcutaneous mastectomy. Still, one can question the added value of this (very) large retrospective series. Actually, in all of the many other articles on top surgery, neither the safety of these two procedures nor the fact that aesthetically pleasing results can be achieved, have ever been questioned. Most surgeons familiar with this operation will agree that both techniques are still ideal but are mainly for patients presenting at both "ends" of the subcutaneous mastectomy spectrum: the semi-areolar technique is perfect for the small breasts with elastic skin, and the excision-free-nipple-graft technique is the best choice for the larger ptotic breasts.[4–6]

However, most surgeon who performing top surgery on a regular basis will agree that quite often there is a wide variety in the clinical presentation of FTM transgender patients requesting a subcutaneous mastectomy.[4–6] Various degrees and combinations of skin excess, breast volume, NAC dimensions, skin elasticity, and personal preference of the patients result in a such a diverse spectrum of clinical presentations and indications that it is very difficult (if not impossible) to split in only two surgical options. When looking at the numbers, it seems, for example, that more than 200 patients with no ptosis at all still underwent an elliptical excision, which according to their description always extends from the inframammary fold to above the position of the NAC. Did all 200 patients really need that much of a skin excision? A substantial number of FTM transgender patients also present with an areola that is too wide and a nipple that is too large, sometimes in combination with minimal or no skin excess, making them a poor candidate for either of the two techniques. Why do the authors perform a reduction-revision of the areola as a secondary procedure instead of simply adding a third technique to their armamentarium, the often described circumareolar technique?[4–6] Apart from the required areola reduction, the circumareolar technique can also provide a small correction of the position of the areola if needed, such as in patients presenting with some sagging of the NAC. In contrast to the authors' concern mentioned in the article, there is no risk to the vascularity of the NAC in the case of a shorter dermal pedicle.[4–6]

A final aspect that is not really addressed in this article is the sensation of the nipple. It has been reported that for patients with a moderate degree of ptosis who fall in between the two techniques described, the so-called "inferior pedicle technique" might be a better alternative with a more natural-looking NAC and an increased chance of retaining sensation.[4–6]

In conclusion, this is a very well-written article of the largest series to date of subcutaneous mastectomies in FTM transgender patients, confirming the value of the two most reliable and frequently utilized techniques for top surgery. Despite the fact that the authors consider previous FTM algorithms to be "overly complex with unnecessary techniques to account for intermediate grades of ptosis and skin elasticity," it might be considered somewhat of an "oversimplification" to limit the subcutaneous mastectomy to only two possible surgical techniques. The wide diversity in clinical presentation of FTM transgender individuals requesting top surgery might require a more individually tailored or custom-made surgical approach for this operation.

Disclosures

The author declared no potential conflicts of interest with respect to the research, authorship, and publication of this article.

Funding

The author received no financial support for the research, authorship, and publication of this article.

REFERENCES

1. McEvenue G, Xu FZ, Cai R, McLean H. Female-to-male gender affirming top surgery: a single surgeon's 15-year retrospective review and treatment algorithm. *Aesthet Surg J*. 2018;38(1):49–57.
2. Webster JP. Mastectomy for gynecomastia through a semicircular intra-areolar incision. *Ann Surg*. 1946;124: 557-575.
3. Thorek M. Plastic reconstruction of the breast and free transplantation of the nipple. *J Int Coll Surg*. 1946;9:194-224.
4. Cregten-Escobar P, Bouman MB, Buncamper ME, Mullender MG. Subcutaneous mastectomy in female-to-male transsexuals: a retrospective cohort-analysis of 202 patients. *J Sex Med*. 2012;9(12):3148-3153.
5. Monstrey S, Selvaggi G, Ceulemans P, et al. Chest-wall contouring surgery in female-to-male transsexuals: a new algorithm. *Plast Reconstr Surg*. 2008;121(3):849-859.
6. Wolter A, Diedrichson J, Scholz T, Arens-Landwehr A, Liebau J. Sexual reassignment surgery in female-to-male transsexuals: an algorithm for subcutaneous mastectomy. *J Plast Reconstr Aesthet Surg*. 2015;68(2):184-191.