Tuberous Breasts:

A COMPLEX UNDERRECOGNISED PROBLEM

Tuberous Breast Deformity was first described in 1976 by Rees and Aston[1]. Since then, it has been given many different names such as tubular breast, snoopy breast, herniated areolar complex, constricted breast, doughnut breast, nipple breast, breast with narrow base, and dome nipple.

"Tuberous" means protuberance, because the deformed breast resembles the shape of a tuberous root plant. As is common with other conditions, which have multiple names, it comes from the lack of understanding of the anatomical/ histopathological abnormality underlying the deformity.

WHAT IS IT?

It is a condition, which may include all or some of the following findings[2]:

(1) hypertrophy of the nipple–areola complex;
(2) pseudoherniation of the breast content into the areola, producing the very typical Snoopy-dog-nose deformity;
(3) hypoplasia with commonly related asymmetry with the contralateral side;
(4) vertical constriction with the reduced superior inferior diameter; and
(5) constricted transverse base.

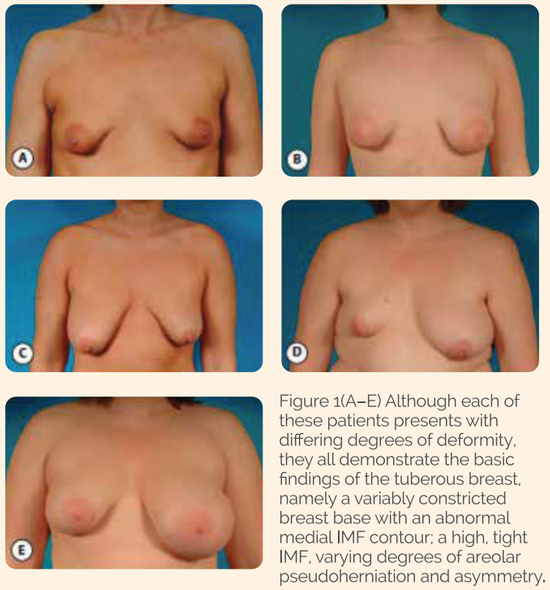

Figure 1(A–E) Although each of these patients presents with differing degrees of deformity, they all demonstrate the basic findings of the tuberous breast, namely a variably constricted breast base with an abnormal medial IMF contour; a high, tight IMF, varying degrees of areolar pseudoherniation and asymmetry.

It is classified by Grolleau's classification[3], which includes three main types and is based on the defect of the mammary base:
Type I, only the lower medial quadrant is deficient;
Type II, both lower quadrants are deficient; and
Type III, all four quadrants are deficient resulting in a greatly restricted mammary footprint.

Often this accompanied by significant asymmetry between breasts, in combination with significant breast ptosis on top of the tuberous deformity. It makes for one very complex issue and one of the most challenging corrective procedures in breast surgery.

HOW COMMON IS IT?

The truth is nobody really knows. This is mainly because the mild form of the condition is likely to be quite common but is seldom reported by the patients who accept it as a variation of normal breast. The more severe forms are actually reasonably uncommon, but are highly psychologically distressing to the patients that bear them.
One retrospective study found that 57.1 percent of all reduction mammaplasties (n = 92) and 83 2.percent of all augmentation mammaplasties (n = 178) had asymmetry with tuberous deformity in its 10-year self-selected consecutive patient cohort[4].
In today's image and body conscious society these kinds of problems have become a common source of referrals to the breast surgeon.

WHAT CAN WE DO ABOUT IT?

Despite being a complex problem, it is important to reassure patients that it can be corrected, but this may require complex or staged surgery depending on the severity of the findings. The most important factor in dealing with it is having an experienced breast surgeon who is experienced and appropriately trained to manage such a disfiguring condition. The second important part of management is its recognition and appropriate pre-operative planning. As I've mentioned above, it can certainly be subtle at times, but may become more prominent following breast surgery for other reasons, leading to dissatisfied patients.

The surgical options are varied depending on the severity of the condition, but may include a combination of any of these approaches:
1) Breast augmentation,
2) Round block mammaplasty,
3) Breast reduction/lift mammaplasty,
4) Variety of local flaps,
5) Breast expanders and
6) Myocutaneous flap breast reconstructions.

There is no one size fits all approach for this problem. A variety of techniques above may be suitable and each breast needs to be considered on its own merits.
A successful outcome requires a great deal of consideration, recognition and pre-operative planning, as well as psychological support to patients on this transformative journey.

At the end of the day, these patients are some of the most grateful and happy patients that we can treat, as any improvement in some of the more severe cases in particular can lead to a major change to their self-image, psychological wellbeing and ability to participate in the society without the self imposed restrictions.

If you'd like to learn more about this or discuss a patient that you are concerned about please contact us on:
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1. Rees TD, Aston SJ (1976) The tuberous breast. Clin Plast Surg 3:339–347
2. Liacyr Ribeiro, Affonso Accorsi and Roberto Rocha, Inferior Flaps for Tuberous Breasts, Aesthetic and Reconstructive Surgery of the breast, CHAPTER 37, 571-582
3. Grolleau JL, Lanfrey E, Lavigne B, Chavoin JP, Costagliola M (1999) Breast base anomalies. Treatment strategy for tuberous breasts, minor deformities and asymmetry. Plast Reconstr Surg 104:2040–2048
4. DeLuca-Pytell DM1, Piazza RC, Holding JC, Snyder N, Hunsicker LM, Phillips LG.

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Dr Michael Yunaev is an Oncoplastic Breast, General and Cosmetic Surgeon. After completing a Fellowship in General Surgery at Westmead Hospital, Dr Yunaev undertook a further 2 years of post fellowship training in Oncoplastic Breast Surgery and a further 2 year training fellowship in aesthetic Breast and Body Surgery. During this time, he also completed his Masters Degree in Breast Surgery at The University of Sydney.

Areas of interest include:

- Breast Cancer Surgery, including Oncoplastic Surgery
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- Liposuction/Fat Grafting
- General Surgery (Hernia/Gall Bladder/Skin Cancer)

Dr Yunaev is an active member of the Breast Surgeons Australia and New Zealand Society, Australasian Society for Breast Disease, General Surgeons Australia and Royal Australasian College of Surgeons. He is involved in training of a younger generation of surgeons through the Royal College of Surgeons and is active in research in his chosen field.

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