Surgical treatment of gynecomastia

Gynecomastia is a benign disorder, but one with profound psychological effects, even if the thoracic deformity is not very severe, which are in themselves an indication for surgical intervention as the only effective solution for idiopathic gynecomastia resistant to 3-6 months of medical treatment; in any case, the latter seems to have an effect only on gynecomastia of recent appearance and moderate degree.

It may be isolated or form part of an adipogynecomastia in an obese patient, the distinction being made by mammography.

Before deciding on operation, it is essential to exclude:

- temporary gynecomastia, essentially limited to a retroareolar prominence appearing in the pubertal period and disappearing in a few months in the majority of cases. Operation is indicated only if the phenomenon persists and resists medical management;
- an endocrine, tumoral or drug origin, the primary treatment of which is that of the relevant cause or medication.

A complete investigation must be carried out, directed to the detection of:

- an endocrine syndrome;
- hypogonadism, either isolated or part of a malformational syndrome such as that of Klinefelter;
- a testicular or adrenocortical tumor;
- the ingestion of certain drugs: estrogens, antiandrogens (for treatment of prostatic carcinoma in men), spironolactone, cimetidine, digitoxin, isoniazid, certain forms of chemotherapy inhibiting the synthesis of testosterone (bisulfan, vincristine, nitrosurea), certain psychotropic agents (tricyclic antidepressants, phenothiazines, amphetamines, diazepam, reserpine, metoclopramide, and certain drugs of abuse: hashish, cannabis).

If the disorder is iatrogenic, stopping the medication leads to regression of the gynecomastia. If a hormonal or drug cause has already been dealt with, the only effective treatment of a persistent gynecomastia is surgical, and the essential aim is to correct the dysmorphism leaving an unobtrusive defect which does not indicate that a breast operation has been performed.
Usual technique

The patient is positioned in dorsal decubitus or half-seated, the outlines of the gynecomastia having been carefully depicted in ink.

The classical incision, adequate with an areola of normal size, is an inferior or inferolateral hemiareolar incision (fig. 41). If this exceeds half the areola, there is a risk of contractile scarring which may lead to deformity of projection of the nipple. Through this incision the subcutaneous plane is reached and scissor dissection is begun superficially, from the entire periphery of the areola to the boundaries of the gland. It passes, as usual, at the level of the ridges of Duret, so as to respect the immediately subcutaneous tissue and not to damage the blood-supply.

When the entire surface of the gland has been freed to its periphery, having respected the areola, retroareolar glandular resection is performed with the scal-