

CASE REPORT

MANAGEMENT OF CONGENITAL SYMMASTIA WITH Z PLASTY: A CASE REPORT

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HOW TO CITE THIS ARTICLE:

Biswajit Mishra, Annada Prasad Pattnaik. "Management of Congenital Symmastia with Z Plasty: A Case Report". Journal of Evidence based Medicine and Healthcare; Volume 2, Issue 13, March 30, 2015; Page: 2126-2128.

ABSTRACT: BACKGROUND: Symmastia is defined as medial confluence of the breast. The term 'symmastia' is modified from Greek (sym meaning 'together', and mastos meaning 'breast') and was first presented by Spence et al. in 1983. Two forms of symmastia exist: congenital and acquired form. Congenital symmastia is a rare condition in which web-like soft tissue traverses the sternum to connect the breasts medially. There is few publication of this condition. Treatment options for this condition are also few. **MATERIAL AND METHOD:** Though Periareolar approach, and vertical reduction mammoplasty has been described as a method to reduce the size of the breast as well as correct symmastia. We used z plasty in our case because the patient was not willing for reduction of the size of the breast. **RESULT:** The patient had well defined midline groove, symmetric breast on each side. **CONCLUSION:** Z plasty can be an innovative method for creation of midline groove in congenital symmastia in patients of low socioeconomic status as an alternative to reduction mammoplasty and liposuction.

KEYWORDS: Symmastia, Z plasty, reduction mammoplasty.

INTRODUCTION: Accessory breast tissue, supernumerary nipple are common congenital anomalies of breast tissue. But symmastia is a very rare condition. Literature also does not reveal much regarding this condition. Treatment option for this condition is also very few. We are presenting a case of symmastia which was treated by z plasty.

MATERIAL AND METHOD: Our patient was a 24 year old unmarried female from low socioeconomic status who presented with chief complain of absence of a groove in the midline of breast. (Fig. 1). On examination it was found that breast tissue of both sides had merged with each other in the midline up to the lower boarder. The size of the breast was acceptable to the patient. Examination of the breast revealed no other abnormality. The patient was operated under general anesthesia. Skin marking was given as shown in the picture. Incision was given and deepened up to pectoralis fascia. After raising all the flap excess breast tissue was removed. Only the skin and underlying subcutaneous fat was preserved. Tacking suture was given with 3-0 monocryl starting from lower boarder of remaining breast tissue to upper boarder of opposite breast tissue. There are two advantage of giving this suture. First it will lift the breast tissue, so that the skin will drape over the underlying breast tissue. Secondly all the tension will be carried by deeper structures so that there will be minimal tension on the skin, thus preventing skin necrosis. Suction drain was given. Skin was closed with 5-0 prolene. Post-operative was uneventful. At the end of 10th post-operative day size of both the breast were equal with no necrosis of the skin flap. There was no hematoma, no seroma. Since the scar was in the midline

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we advised the patient to use silicone gel sheet and pressure garment to prevent hypertrophy scar formation.

DISCUSSION: Symmastia means medial confluence of breast. Sym means together and mastos means breast.

This rare clinical anomaly represents webbing across the midline of the breast that are usually symmetric. More common, however is the presternal blending of breast tissue that is associated with macromastia.¹ It is an congenital anomaly of ectoemal origin.

Cases may range from an empty skin web to those with apparent confluence of major portion of symmetric breast tissue within midline. However, the common denominator is the need for resection of pre sternal skin. Treatment options for this rare condition are very few.

Spence, Feldman & Ryan recommend correction of web defect using 3 methods.²

The first method is elevation of an inferiorly based triangular based skin flap that is advanced superiorly in an inverted y v manner following division of excess medial soft tissue.

Second option superiorly based medial flap that contains both skin and soft tissue. Excess skin & soft tissue were excised and the remaining flap was tailored to fit into the v shaped defect in the inferior incision.

Third option consists of vertical division and superior rotation of excess S.C tissue flaps with elevation of superiorly based skin flap inserted to v shaped defect in the inferior division.

The use of liposuction is suggested by schonegg & associates.³ The amount of skin involved in the web medially and its resiliency will determine the applicability of liposuction.

Though only three methods have been described in the literature our method can be used for correction of such an anomaly.

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Date of Submission: 05/03/2015.
Date of Peer Review: 06/03/2015.
Date of Acceptance: 16/03/2015.
Date of Publishing: 30/03/2015.