

BREAST AUGMENTATION – PATIENT INFORMATION

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This information is designed to prepare you for your consultation and possible surgery. You can use it to explain to friends and family members what is involved in breast augmentation surgery. Please read it carefully and feel free to call our office if you have any questions.

Breast augmentation with implants can be used alone or in combination with a breast uplift (mastopexy). Most patients are concerned mainly with improving size but when we see a patient we are looking at many different aspects of the breast apart from size. These include shape, chest and breast dimensions, skin quality, nipple position, level of the underwire fold and the amount of padding that is present to cover an implant. Many of these variables will be reviewed in this document.

There are more choices in implants now and the implants are better made with a more reliable envelope and better filler materials. Silicone gel implants are now allowed back on the market after a very frustrating period in the 1990's where we were restricted to saline filled implants. It has been shown that silicone does not cause disease but there is no question that there are still some mechanical problems that can occur.

Implants can be inserted through different incisions and either above or below the muscle. The various reasons for the different choices will be outlined. The limits of size choices – at either end of the scale – will also be reviewed.

PROBLEMS WITH BREAST IMPLANTS:

Dr. Hall-Findlay has been in practice since 1983 and has seen many changes in the quality and type of breast implants available. We are now very pleased with the newer silicone gel implants because the gel is more cohesive and the envelope is sturdier. We have found that these implants have a lower rate of capsular contracture (capsular contracture can result in hardening and distortion) and the implants feel more natural with fewer palpable (and sometimes visible) ripples.

A. Health concerns:

1. Diseases: Silicone gel breast implants were taken off the market both in Canada and the United States in 1992 because there were concerns that silicone caused

disease. Some patients felt that they developed rheumatologic diseases such as arthritis and lupus because they had breast implants. Numerous studies have been performed and finally the Institutes of Medicine reviewed all the information and made a definitive statement that there is no evidence that silicone causes any disease – either a known disease or one which had not been previously described. The studies were clear and both the FDA in the United States and the Health Protection Branch in Canada are convinced that silicone gel implants are safe and we are now allowed again to use them.

2. Cancer: There has never been a concern that implants are related to the development of breast cancer. Although there are some studies that show that there are fewer breast cancers in women with breast implants, the accepted position is that there is no relation between the presence of breast implants and the development of breast cancer. There is, however, no question that the presence of breast implants can make mammograms somewhat more difficult to perform and interpret. Because the implant sits behind breast tissue or behind breast tissue and muscle, the performance of breast self-examination is not impaired.

B. Mechanical problems:

1. Longevity: Breast implants are not natural. They are man-made and will not last a lifetime. How long they will last is not known but it is clear that the newer implants last longer. Patients are sometimes mistakenly under the impression that they need to be changed every 10 years but this is not true. We do know that the silicone gel implants used in the 1980's often did rupture by 10 years and the advice for those implants is to at least have them re-evaluated. Even when the implant envelope has torn (usually just through wear and tear) the implant is still usually contained within the breast capsule that every patient forms. Unfortunately both mammograms and MRI's are not good at diagnosing a ruptured implant.

2. Rippling: All breast implants have ripples and folds that can sometimes be both felt and seen. The ripples are more common in thin patients with minimal natural breast tissue. They are also more common with saline implants. The newer silicone gel implants have fewer problems with rippling and are more natural feeling.

3. Capsular contracture: Capsular contracture is both unpredictable and not preventable. All patients form a capsule from their own cells around every foreign body – from a sliver to a pacemaker. The capsule will form a complete covering around the implant but sometimes it will contract and tighten around the implant making it feel hard. This tends to make the breast appear rounder and sometimes distorts the breast shape. This capsular contracture occurs far less frequently with the newer silicone gel implants and far less frequently – in our experience – than with saline implants. Capsules can be surgically released but improvement only occurs about half the time.

4. Leaking: When saline implants develop a leak the implant will empty quite quickly and the breast will get smaller within hours to days. When one of the older gel

implants develop a leak, the gel oozes out but it usually stays within the capsule. Occasionally the leaking gel can be forced out into the surrounding tissues. Silicone does not leak “all over the body” but it is quickly contained and forms what we call silicone granulomas or palpable lumps around the implant. The newer cohesive gel (or “gummy bear”) implants do not leak out in the same way. The gel is more solid and stays intact – much as a cut gummy bear or ju-jube candy.

TYPES OF IMPLANTS AVAILABLE:

A. Saline implants:

We rarely now use saline implants for several reasons. They feel less natural because the saline moves around and because the implants are more prone to rippling. We believe that they can be more prone to problems in some patients because of the “water hammer” effect of the saline putting pressure on the walls of the implant with movement. There is no confusion, however, about knowing when a leak has occurred. Loss of saline and reduction in breast size is quite rapid and can sometimes only take a few hours for complete “deflation”.

B. Silicone gel implants:

1. Cohesive: All silicone gel implants now are “cohesive” to varying degrees. Some are very cohesive but the implants can also feel too firm. Implants that resemble a soft gummy bear are probably the best. The gel in these implants stays in place when the implant is cut with scissors or a knife.

2. Textured versus Smooth envelopes: Some implants have a textured surface and some have a smooth surface. When we started using the newer cohesive gel implants we thought that it was the textured surface that was giving a lower capsular contracture rate. We have now used both the textured and smooth surface implants with equally good results.

3. Profile: Some implants have a low profile and some have a higher profile. Patients cannot tell the difference (and neither can surgeons when reviewing patient photos). The choice of profile gives the surgeon some more flexibility in size choices when trying to fit the ideal base diameter to a particular patient. We fit the shape, profile and size to the desires of the patient but the actual choice of type of implant is something that the patient needs to leave to the surgeon.

4. Shape: Some implants are round and some have a tear drop type of shape. Although a tear drop shape may initially sound ideal, it is not appropriate to most patients. Again it is a choice that we need to make depending on a review of an individual patient’s shape, size and desires.

BREAST “FOOTPRINT” ANALYSIS

There are many different aspects of a patient’s breasts that are important for us to consider. The position of the breasts on the chest wall (the “footprint”) needs to be analyzed. Most patients are not aware of these variables and are not aware of what can and cannot be changed. We will review each of these in turn.

A. Underwire level:

Some patients are “high breasted” and some are “low breasted”. The position of the breasts on the chest wall can be quite different from patient to patient. When a patient’s breasts are low on the chest wall they can be disappointed with the result. The underwire level of the breast will not change – and in some cases it is purposely lowered. Lowering is considered only in some types of breasts and ideally only in those patients where the breasts sit high on the chest wall.

B. Distance from the collarbone:

Just as important as the underwire level is the level of the upper breast border. Patients will often push their breasts up to show how they want them changed. An implant can raise the upper breast border – and shorten the distance from the collarbone only a couple of centimeters. A breast uplift alone without an implant cannot change this position at all.

C. Cleavage:

The distance between the breasts on the chest wall can only be changed slightly. Some patients are quite wide and they often hope that we can narrow this distance. Although we can be successful in some cases, improvement is unpredictable. Some patients will actually get wider. This is one reason why it is important for us to assess the desired size but to tailor the actual implant size to the desired breast base dimensions.

D. Chest wall:

The implant base diameter needs to fit the chest wall horizontally – both to fit (or improve) cleavage, but also to fit (or improve) how the breast meets the sides of the chest wall. In some patients the breasts are not only small in size but also too small to properly fit the horizontal dimensions of the chest wall. This may mean that a patient needs to choose an implant which is somewhat larger than they initially thought. On the other hand, an overly large implant will hang over the sides of the chest wall and get in the way with arm movement.

Most patients have some asymmetry in both breast size but also in breast shape. In some patients we will try to keep the same implant size but in some patients we will purposely choose a different size so that we can match up the desired base diameters so that the

patient looks more symmetrical after surgery. Patients are aware of a significant difference in implant sizes but the ultimate goal is to make them look as even as possible. Many of these choices cannot be made by the patient and are best left to their surgeon. We see things that patients are often not aware of and it is important that patients trust our experience to give them the best result possible.

BREAST ANALYSIS

The position of the breast on the chest wall is an important consideration, but the actual breast itself needs to be analyzed.

A. Size and padding:

The main issue for us to assess is not just the size – and differences between the breasts – but also the amount of breast tissue and fat present for padding. It is important that there be enough tissue to pad the implant otherwise the implant edges will be visible. If there is not enough padding present the implant may be better placed under the muscle (see section on implant positioning). Even with good padding the implants can often be palpated underneath and on the outside of the breasts. It is important for the patients to have enough padding in the areas where patients expose their breasts in bras or bathing suits. Adequate padding is important in the upper part of the breast and around the cleavage area.

B. Sagging:

Patients often say that their breasts sag if they are “empty” especially after pregnancy. But plastic surgeons define sagging as the position of the nipple relative to the underwire fold. If the nipples are in a good position then an implant alone will give a good result. If the nipples are low then a breast uplift may be indicated. A breast uplift will have more scarring (around the nipple and down to the fold instead of just an incision in the fold itself). Although most patients recover normal to near-normal sensation breast augmentation alone is less likely to interfere with sensation than a breast uplift (mastopexy).

Some patients would prefer to accept some sagging and therefore avoid extra scarring. It is important for us to review with each patient what they would look like with augmentation alone. An implant alone will not raise the breast – in spite of some advertising to the contrary.

If a patient’s breasts are very saggy (ptotic) then an implant alone is not an option. There is a narrow group of patients where a choice of having or not having a breast uplift can be considered. If the nipples are positioned below the underwire level then an uplift must be considered – otherwise the breasts will have a “double bubble” appearance with the breasts dropping off the bulge of the implant.

We have less control over breast shape than patients think. The shape a patient presents with determines the shape that results after surgery. If a patient is a bit “saggy” before surgery then they will still be a bit “saggy” after surgery. If the patient has some “skin on skin” and can hold up a pencil with their breasts then that shape will remain after surgery. Patients often request a breast where the nipple is well above the underwire fold but they have to start that way – we cannot even achieve this ideal with a breast uplift (unfortunately).

An ideal breast has the nipple positioned about one-third to one-half up the breast mound. If the nipple is too low the breast shape is unattractive and the nipple needs to be elevated by performing a breast lift. In a “high breasted” patient with low nipples sometimes the underwire fold can be slightly lowered with a good result. These patients may be able to avoid having an uplift because the nipple appears to be in a better position on the breast itself.

C. Skin quality:

Some patients will have very tight skin with good elasticity. These patients sometimes are limited to smaller implants because the skin will not stretch. The good news is that the skin will also not sag very easily in these patients.

Some patients have very poor quality skin and even an uplift might result in repeat sagging. These patients may need an uplift as the years pass and in some patients it is difficult to achieve a good result. It may seem counterintuitive but in these difficult cases sometimes breast tissue needs to be removed from the lower part of the breast and a larger implant used to give a better shape.

D. Areola shape and size:

The areola may stretch with breast augmentation. The amount of stretching is not in the surgeon’s control. The areola size can be reduced when a breast uplift is performed but stretching can still occur when an implant is used at the same time as an uplift.

When there is significant asymmetry in nipple position or areolar size, we may suggest making an incision around the areola to change the size but also to reposition the nipple into a more symmetrical position. The usual incision for breast augmentation is in the underwire fold under the breast but occasionally we will suggest using an incision around the areola for asymmetry reasons.

E. Nipple shape and size:

Rarely will patients ask for the nipples to be reduced at the same time as the augmentation. This can be done but the risk of losing sensation is somewhat higher.

IMPLANT POSITION

Implants can be placed either above or below the pectoralis muscle. They are always placed completely behind breast tissue so that breast examination can be properly performed. We sometimes recommend that the implant be placed above the muscle and sometimes we recommend that the implant be placed below the muscle. There are different reasons for different advice in different patients. Patients will often come in to the consultation convinced that they want one or the other position based on what their friends have said. We recommend that patients ignore this “street advice”.

A. Below the muscle:

The main reason for placing implants below the muscle is for padding. It is important that the edges of the implant not be visible – and sometimes in the very thin patient even placing the implant below the muscle is not adequate. We will assess the amount of padding in each patient and make our recommendation.

The other reason for placing implants below the muscle is for mammography. The presence of implants in either position can make mammograms harder to perform and harder to interpret. As long as the implant stays soft mammograms can be done with the implant either above or below the muscle. However, when capsular contracture occurs with hardening of the breast, mammograms are easier to perform when the implant is below the muscle.

But there are problems with the implant when it is placed below the muscle. The cleavage is widened and there can be movement of the breasts with muscle movement. Patients cannot lift weights without the breasts moving. This can be very obvious to others but many patients learn how to keep from contracting the muscle. This muscle movement is often called the “dancing breast syndrome”.

Implants can also tend to stay in too high a position on the chest wall when they are placed under the muscle. This is because the muscle goes into some spasm after the surgery and the muscle spasm can distort the surgically created pocket for the implant. If the implant heals in this position it may need to be corrected. Some people think that the muscle “holds” the implant higher than when it is placed above the muscle but this is false. The implant only stays high when it has healed in an incorrect position.

B. Above the muscle

When a patient has enough padding, the implant placed above the muscle can result in the most natural breast appearance. There is no point in placing an implant below the muscle in a patient with adequate padding. Placing the implant below the muscle will only widen the cleavage and result in muscle movement with exercise.

INCISION PLACEMENT

A. Inframammary incision:

Incisions are usually placed in the underwire fold under the breast. The incision needs to be about 2 inches long (5 centimeters) with the cohesive or “gummy bear” implants so that the gel is not fractured on insertion (think of squishing a gummy bear with your thumb). The incision with saline implants could be shorter because the implant was filled after the envelope was put in place.

B. Periareolar incision:

Occasionally a patient will request an incision around the areola but this can only be considered in patients with relatively large areolas. The scars around the areola can be better than the scars under the breast but they are more visible because of their location. The incisions around the areola are also more likely to interfere with nipple sensation.

C. Armpit (axillary) incision:

We used to use the axillary incision in some patients for saline implants in the 1990’s. It is harder to get a good pocket shape and any revision meant a second scar in the fold under the breast because access to correct capsules etc was not adequate through the armpit. We don’t use the axillary incision for the cohesive gel implants because the incision needs to be larger and there is more risk of implant displacement.

IMPLANT SIZE

The choice of implant size is more complicated than just the size alone. As outlined above, we need to take the breast and chest wall dimensions into account as well as skin quality and elasticity. We also need to look at nipple position and breast asymmetry.

A. Bra size:

Bra sizes are confusing and it depends on which clip setting is used and what style and brand of bra a patient likes. It is important to understand that cup sizes are different with different band sizes. A 34D has the same cup size as a 36C which has the same cup size as a 38B. A discussion with the patient about cup size is only the beginning.

B. Rice test:

It is difficult to place an implant in a bra because it doesn't sit properly. We suggest to patients to try the "rice test". This involves trying on a bra (without padding) that has the correct band size and placing rice loosely inside a soft plastic bag or an old nylon stocking. A bra cup is about 150 to 180 cc and a kitchen cup is about 250cc. Most implant choices will start about 200 cc (a minimum to fit the breast dimensions) and go up to about 400cc. Beyond that (for most average sized patients) the implant will be too big for the skin envelope and will stretch the skin and cause sagging and the breast will extend out under the armpit. What we recommend for a patient who is 5'1" will be quite different for a patient who is 5'10" tall.

C. Photos:

We find that a review of photos gives us the best idea of what to aim for. These can be either photos of other patients or photos from magazines. We can talk about breast shape but we have little control over shape. The shape that a person has initially will determine the shape they have after surgery (eg cleavage, sagging etc). But a review of photos gives us the best idea of what size to aim for. We often refuse to focus on actual implant size because patients are often misled by photos from the internet. The actual implant size will depend on how tall the patient is, how wide their chest wall is, and how much breast tissue they started with.

We will do our best to give a patient a size that is close to what they request. Patients need to remember that size is not the only variable and the goal is to give each patient the best result possible – not an exact size.

PREPARATION FOR SURGERY

A. Size:

It is important for patients to have as good an idea as possible of what size they would like. In spite of the limitations listed above, it is important for patients to look for photographs on the internet (lookingyourbest.com and breastimplantinfo.com) are good sites. We think it is important to review photos with the patients' existing size and shape in mind. Having the patients try the rice test at home is also a useful guideline (but not exact).

B. Mammograms:

For patients who are over 40 years old, we will ask to see a copy of a mammogram performed within the last year. Patients should always try to go to the same place so that mammograms can be compared to previous ones. The best time to go is after your period when the pressure of the exam will be less uncomfortable.

C. Instructions:

Make sure that you read through your instructions. It is important to read the section on medications to avoid. We want you to get the best result possible and it is important that we reduce all tendencies to bleed excessively. Although aspirin and anti-inflammatories, such as ibuprofen, are great drugs we don't want you to take them (or any herbals) for two weeks before surgery because they can cause you to bleed too much during and after surgery. Tylenol and codeine are both fine, but even one aspirin ten days before surgery can cause excessive bleeding.

RECOVERY:

There is usually very little pain with the surgery. When the implant is placed under the muscle it can be a bit more uncomfortable. Most patients describe the discomfort as being similar to the pressure that results when the milk comes in after giving birth.

There are very few restrictions after surgery. It is important to avoid excessive exercise for a few weeks such as swimming or weight lifting. Jogging may be uncomfortable without a very supportive sportsbra. Most patients can go back to work within a few days to a couple of weeks.

FOLLOW-UP:

We normally like to see patients a few weeks after surgery then a few months later and at one year. We are also prepared to see patients on a regular basis every year or so to do an examination and make sure that there are no problems.

REVISION SURGERY:

Revision surgery is fortunately rare but occasionally necessary. If there are any complications such as capsular contracture it may be indicated to undergo another operation. Patients also need to realize that breast implants will not last a lifetime and any repeat surgery as the years pass is likely to involve costs.

If both the patient and the surgeon are not satisfied with the result, then we are prepared to do what we can to make improvements. Sometimes there is nothing that can be done. We need to remind patients that exact size determination is not possible – the size of implant that we choose will be what we feel fits best with the patient's desires and their breast shape, skin quality and breast dimensions. We rarely will agree to a size change.

The following photos will illustrate some of the points that are made in the text above. Most of the results shown are at least one year after surgery unless otherwise specified.



This patient shows the ideal breast shape for an augmentation. Her nipples sit high on the breast mound and well above the inframammary (underwire) fold. She has good cleavage which is not too wide. Initially her breasts did not reach the edge of her chest wall and after surgery they fit her body better. These are not large implants but are 225 cc each. These are saline implants placed above the muscle through an incision in the inframammary fold.



The saline implant on this patient's right breast leaked. It is important to note that on the implanted side the upper breast border is elevated only slightly. It is also important to note that the weight of the implant has also dropped the lower pole of the breast to some degree. These implants were 300 cc saline each placed above the muscle with an incision in the inframammary fold.



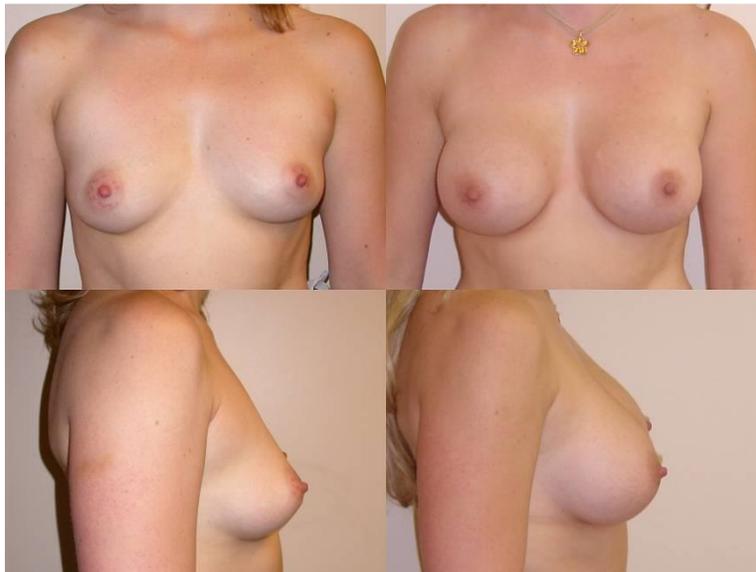
The shape that a patient starts with determines the shape that results after surgery. The cleavage stays the same. This patient had 371 cc cohesive gel implants placed above the muscle.



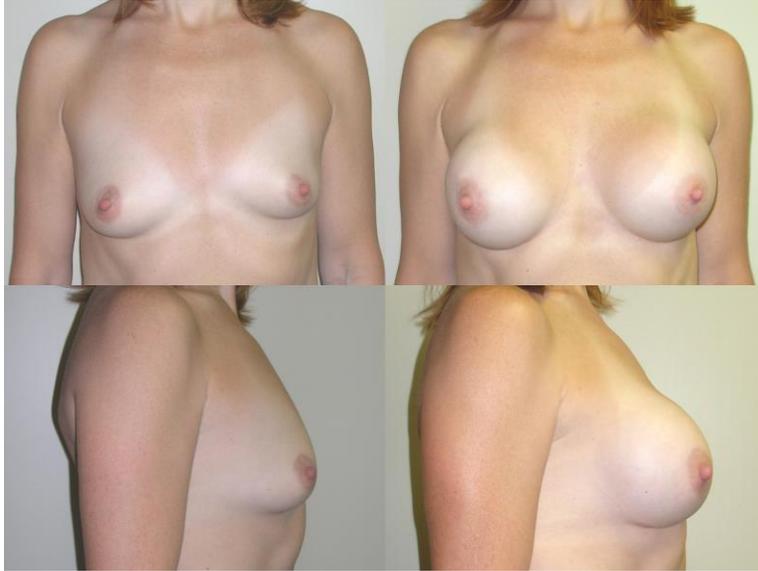
This patient has some “skin on skin” before surgery (she could hold a pencil under her breasts) and the same shape results after surgery. The implants were placed above the muscle and were 360 cc saline each through an inframammary incision.



This patient had 300 cc saline implants placed above the muscle through an inframammary incision.



This patient had some asymmetry with the left nipple higher and the underwire fold higher on the left side. The fold on the left was lowered and both implants were 390 cc saline and were placed above the muscle through an inframammary incision.



This patient also needed her left fold lowered. She had 310 cc cohesive gel implants placed above the muscle through an inframammary incision. There is still some asymmetry but it is mild.



This patient's breast shape was improved with 360 cc cohesive gel implants placed above the muscle. Note that her nipples were above the fold but that there was some dropping of the lower pole of the breast.



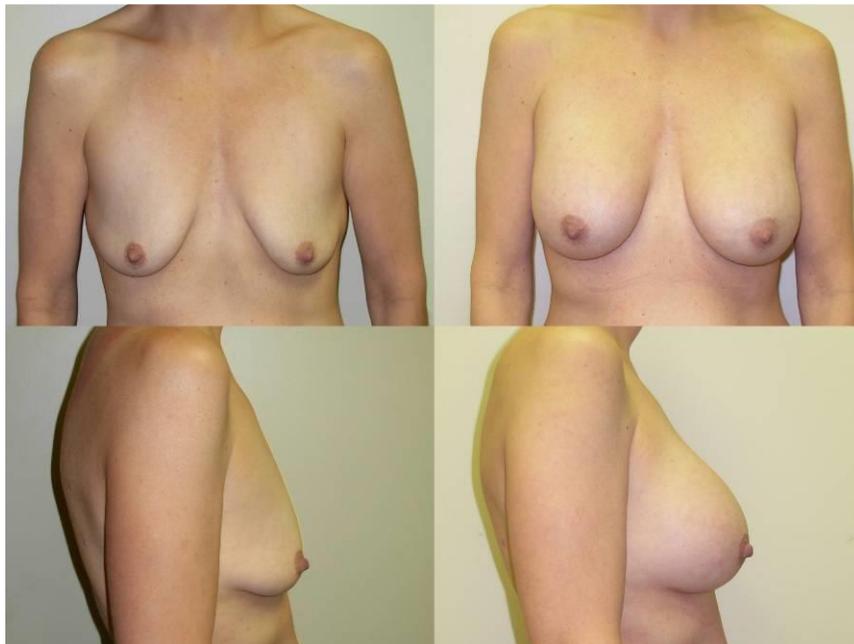
This patient's breast base diameter did not fit her chest wall dimensions. Her shape (and size) was improved with 250 cc saline implants placed above the muscle and both folds were slightly lowered.



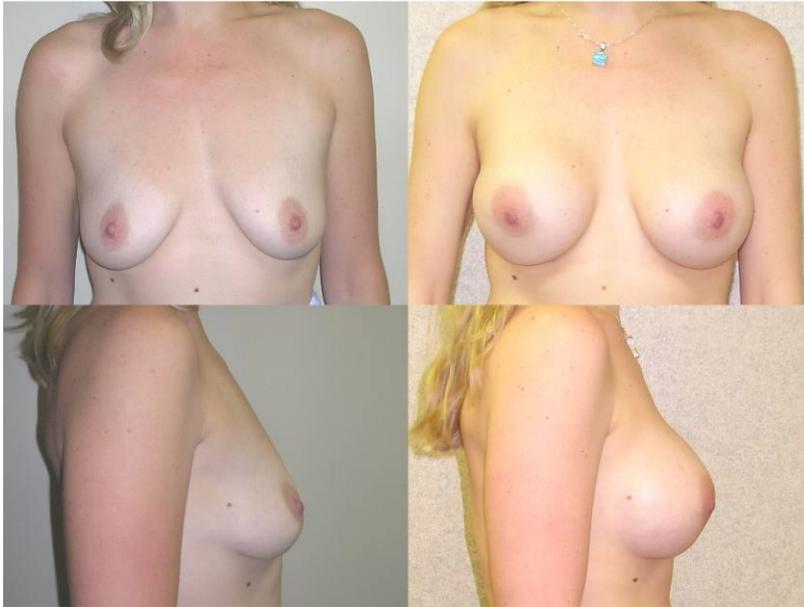
Both folds were slightly lowered in this patient as well. She had 325 cc cohesive gel implants placed above the muscle through an inframammary incision.



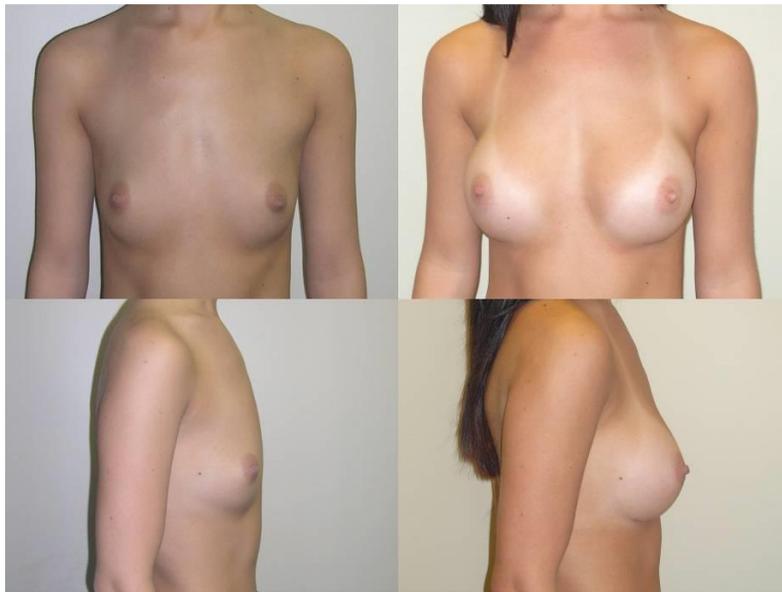
This patient's asymmetry was only partially corrected with breast augmentation.



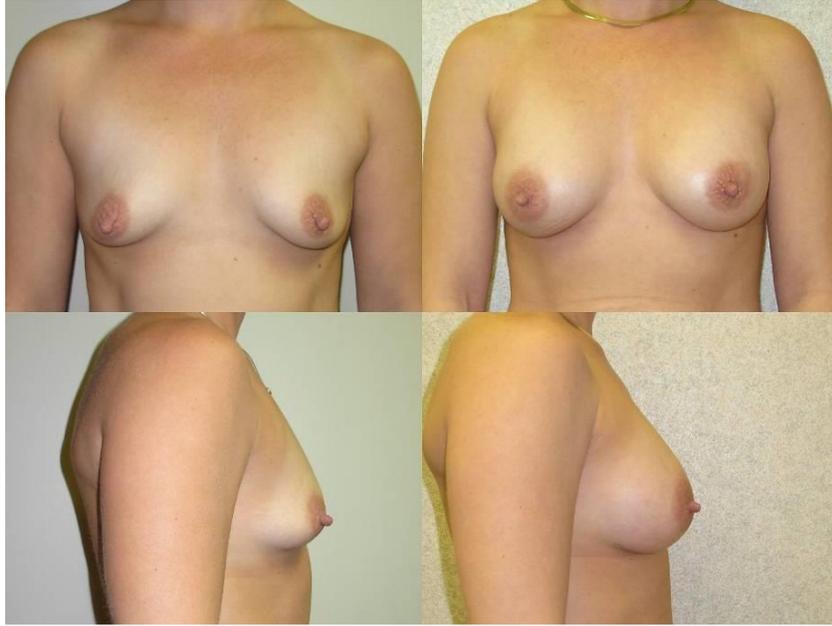
Note how low this patient's breasts are on the chest wall. The shape is better but is still low after breast augmentation. She has 325 cc cohesive gel implants placed above the muscle through an inframammary incision.



This patient is also “low breasted” and her implants were 410 cc cohesive gel placed below the muscle through an inframammary incision. This is a 2 ½ year follow-up.



This patient has breasts which are low with a wide cleavage. Her shape has been improved with 300 cc cohesive gel implants placed above the muscle.



This patient's cleavage was narrowed to some degree with 200 cc cohesive gel implants placed above the muscle. Note that the breasts still have a bit of a "saggy" appearance.



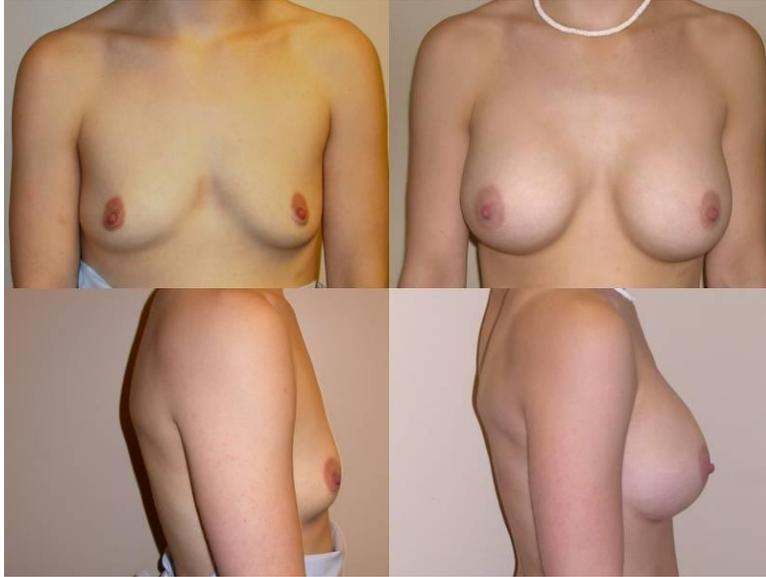
This patient's cleavage was also improved – note the dotted lines marked preoperatively. She had 325 cc implant placed on the right and a 275 cc implant placed on the left. A larger implant was used on the right to increase the volume but also to improve the base diameter to match the left.



This patient needed a fairly large (325 cc) implant to fill out the base diameter to improve the wide breast shape. These implants were placed above the muscle through an inframammary incision.



This patient also has wide breasts and the implants chosen had to be fairly large to try to fill out the cleavage and make the nipples look more centralized. A 375 cc cohesive gel implant was used on the right side and a 350 cc cohesive gel implant on the left side. They were placed above the muscle through an inframammary incision.



This patient also has wide breasts with nipples widely spaced. 375 cc cohesive gel implants were placed above the muscle through an inframammary incision.



Different size implants were used to improve the size asymmetry. 325 cc saline was used on the right and 300 cc saline used on the left. These implants were placed above the muscle.



230 cc cohesive gel implants were placed above the muscle through an inframammary incision.



If breasts tend to sag a bit before surgery then implants can make the sagging somewhat worse. This patient had 275 cc cohesive gel implants placed above the muscle.



This patient sagged before surgery and still sagged after surgery. The result is still good but she would have been disappointed if she was not prepared before surgery to still have some “skin-on-skin”. She has 300 cc saline implants placed above the muscle.



This patient is saggy both before and after surgery. She had 300 cc saline implants placed above the muscle.



This patient was also saggy before surgery. She had 350 cc saline implants placed below the muscle through a peri-areolar incision.



This patient had her implants placed below the muscle. Note that the muscle does not cover the outer aspect of the implant and some rippling of the implant can be seen through the skin. The implants were 300 cc saline on the right and 275 cc saline on the left. Saline implants tend to show rippling more than cohesive gel implants but all implants can ripple.



It is difficult to achieve a good result in body builders. This patient had her implants placed beneath the muscle. They were 270 cc saline implants.



This is an example of the “dancing breast syndrome” when the implants are placed under the muscle. The patient is standing normally on the left but the movement is shown when the muscle is contracted in the photos shown on the right. Note that the breasts move outward and the cleavage is widened when the muscle contracts. Her implants were 400cc saline each.



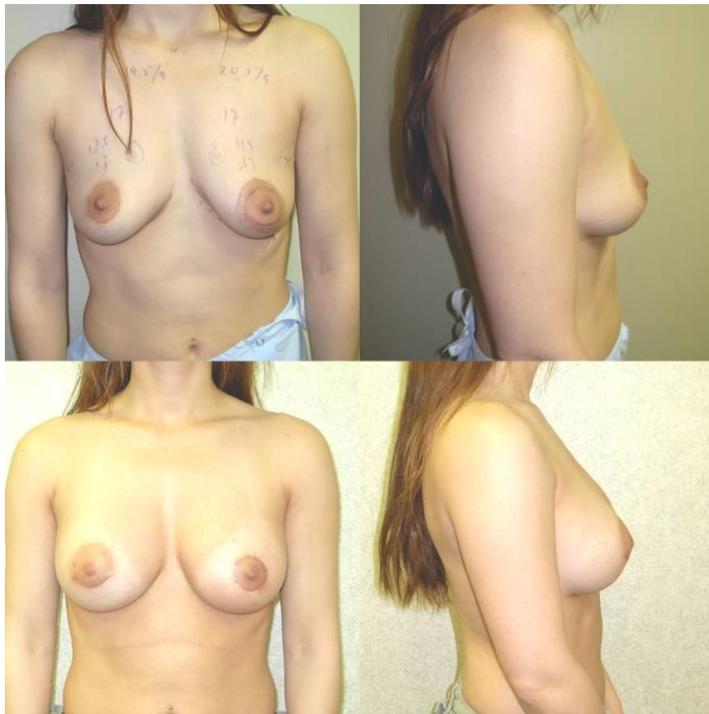
Incisions in the inframammary crease can be thick on occasion. The scars in the upper photos are at one year and the photos underneath are at two years. We say that scars can take a year to settle but sometimes they take longer.



This patient had her incisions placed under the areola. The implants were placed above the muscle with 230 cc on the right and 265 cc on the left. The incisions are not bad but can be seen to some degree.



This patient also had her incision placed under the areola. It can be seen. Note how the areola widened and became larger. The implants were saline with 330 cc on the right and 305 cc on the left.



This patient is shown early after surgery where the left areola was made smaller with an incision all the way around the left areola. The areola is over-corrected initially because it will stretch.



This is an example of capsular contracture where the capsule has tightened around the implant making the edges visible and giving a poor result. Capsular contracture can be better tolerated in patients with more padding.



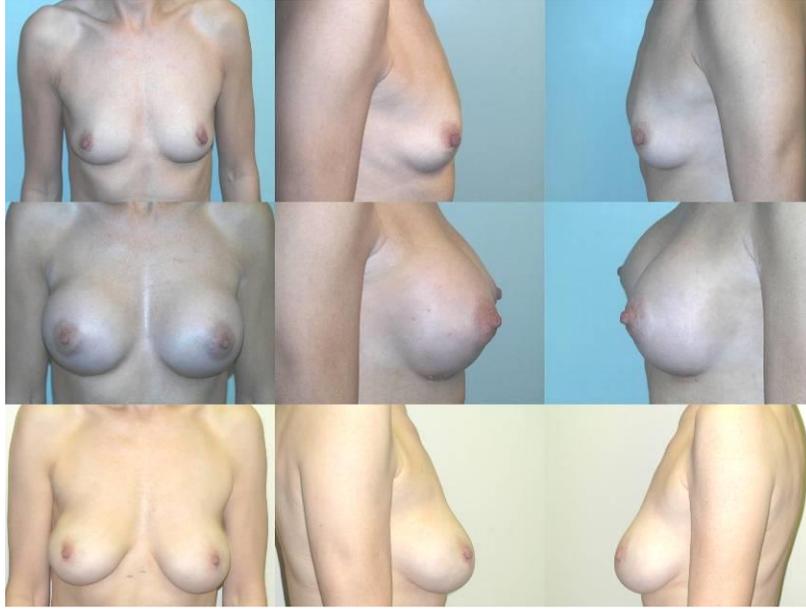
This is another example of capsular contracture with hardening and distortion shown in the upper photos. A successful correction was achieved with re-operation.



Note that with time the breasts can drop and look more saggy. Larger implants are likely to cause more sagging especially in patients with poor quality skin. This is a 5 year follow-up of 350 cc saline implants.



Note how initially the implants look a bit high and then how with time they dropped more than desired.



Note that this patient is very “low breasted”. Although the result initially improved the low appearance, the implants settled with time into the original position. Although patients with this result will often ask for a larger implant the result will not improve. The upper pole of the breast will not fill out but instead the bottom of the breast will drop even further. Larger implants do not solve the problem but instead they often make the breasts look worse. These implants are 325 cc saline implants.

We hope that this information booklet will give you a better idea of what is involved in breast augmentation. There is a separate information booklet on breast uplift (mastopexy) which should be read by those patients who may need an uplift with or without implants.

It is important to realize from these photos – and the information provided – that not all patients are the same. Often we are restricted in what we can achieve depending on the size and shape that a patient starts with. Poor skin elasticity and gravity are our enemies and time can result in less than desirable changes.