LETTERS

Adjustments to the round-the-clock technique for correction of gynecomastia

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Dear Editor,

We read with great interest about the new technique that Tarallo et al. [1] proposed for gynecomastia treatment using very small incisions. In our practice, we have also used a similar technique for treating gynecomastia of all grades. We have learned a few things over the course of our experience.

It is always advisable to perform liposuction first, before the glandular tissue is excised. Doing so has several advantages over performing excision first. The main advantages are better hemostasis, better creation of a surgical plane for dissection of the gland, and better assessment of the amount of glandular tissue that needs to be left behind in order to prevent contour deformities. We have found this technique to be particularly challenging in grade 3 gynecomastia, especially when the glandular tissue is large and widespread. An additional technique that we sometimes found useful was the use of small illuminated retractors. This improved our ability to create a plane between the gland and subcutaneous planes, especially in areas far away for the areola. We even tried using a naso-endoscope for better visualization, especially when dealing with perforators. However, the incisions needed to be extended by a few millimeters, which defeated the purpose of small-incision gynecomastia surgery.

While this technique is surely advantageous, especially in terms of scarring and faster recovery, it also has definite limitations in treating larger and firmer glands. In some cases, the benefit of small scars may be offset by the ability to better contour the whole chest in a more accurate manner.

Notes

Conflict of interest
No potential conflict of interest relevant to this article was reported.

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Reference

1. Tarallo M, Di Taranto G, Fallico N, et al. The round-the-clock technique for correction of gynecomastia. Arch Plast Surg 2019;46:221-7.

Response to Letter: Adjustments to the round-the-clock technique for correction of gynecomastia

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We would like to thank the authors (SH and NR) for appreciating our work and suggesting adjustments to improve our technique [1]. We warmly welcome experience-sharing and discussions of surgical practices.

We read with interest that the authors prefer to perform liposuction before mastectomy, conversely to what we described. As we treated patients with true gynecomastia, we used superficial liposuction in the final step of surgery, in order to smooth the contour and reduce any unpleasant remaining irregularity. We acknowledge that performing liposuction first can assist in haemostasis and enhance the dissection, but our main concern is overcorrection of the chest, especially in thin patients. We believe that in cases of true gynecomastia, only after complete resection of the glandular tissue can the