

# Medical aids and breast reduction: an oxymoron

DA Hudson,  B Lelala,  F Malherbe,  CN Hudson 

Division of Plastic Surgery, Faculty of Health Science, University of Cape Town, South Africa

Corresponding author, email: [donald.hudson@uct.ac.za](mailto:donald.hudson@uct.ac.za)

Of all the procedures performed by plastic surgeons, bilateral breast reduction (BBR) is the most misunderstood by both clinicians and medical aids. This problem is not unique to South Africa; even in the USA there is limited insight into this condition and what criteria should be met for the selection of appropriate cases.<sup>1-3</sup> Consequently, BBR is excluded as a benefit by many medical funders.<sup>1-3</sup> It is erroneously viewed as a cosmetic procedure performed by plastic surgeons to improve breast shape.

Many articles indicate that BBR is not a cosmetic operation, and that large breasts place stress on the upper spine,<sup>2,6,7</sup> leading to backache, shoulder pain, headaches as well as intertrigo.<sup>1-8</sup> There are three absolute sequelae of breast reductions – firstly, there is significant scarring, approximately 40–100 cm in length.<sup>5</sup> Secondly, it is highly likely that following the breast reduction, there will be long term reduced nipple sensation.<sup>5</sup> Thirdly, normal breastfeeding after a breast reduction only occurs in a third of patients.<sup>5</sup> In contrast, breast augmentation (which is usually cosmetic), a quicker and simpler procedure, results in much less scarring, seldom affects nipple sensation and has no impact on breastfeeding. Breast augmentation and reduction are poles apart. The plastic surgeon also endeavours to deliver a “cosmetic” component to the result of breast reduction.

The reason that plastic surgeons perform breast reductions is because most commonly the nipple is carried on a flap, and flap design and transposition is the ambit of a plastic surgeon.

Bilateral breast reduction is a functional operation.<sup>4-8</sup> It has been shown to improve degenerative spine disease.<sup>6,7</sup> Additional benefits include reduced depression, increased patient satisfaction and psychological and sexual well-being.<sup>6-8</sup> It has also been shown to alleviate occipitally based migraines and headaches.<sup>8</sup> However, this message is not understood by those making decisions in the medical aids.

A partial solution is better education of the younger generation of health care practitioners. However, this idea yields false hope. The burgeoning undergraduate curriculum means that plastic surgery has been drastically reduced in its exposure to undergraduates. Another aggravating factor is that not uncommonly, the medical adviser to the medical aid may not even be a surgeon. Colleagues have shared this frustration, noting that sometimes the clinical decision is made by a nurse or, it appears on occasion, by a non-clinician. Additionally, the rapid expansion of all branches of clinical medicine makes it difficult, if not impossible to remain up to date with the changes and advances that are occurring.

Another misunderstood aspect of breast reduction, and in fact of all plastic surgery, is the limited cost incurred.

There is no mesh/implant, etc., and the only disposable cost is that of sutures. At Groote Schuur Hospital (GSH), the division of Plastic Surgery uses less than 1% of the total surgical consumable budget, making it the “cheapest” surgical division by a long way. A patient having a “private/cosmetic” breast reduction at GSH would pay a total of R36 905.00. The same procedure at a private hospital would cost approximately R50 000.00, assuming a theatre fee of approximately R40 000.00, and the surgeon, assistant and anaesthetist being remunerated at medical aid rates.

Bilateral breast reduction is definitely one of the commonest procedures performed at GSH, as Africa is a continent of big breasted women. About 50 women per month request breast reduction. There is no cosmetic component and many indigent patients are overwhelmed by functional disability. Similarly, the procedure is carried out in public hospitals in Canada<sup>1</sup> and the UK.<sup>1</sup>

Even in the USA, the criteria for breast reduction remains unresolved. The majority of insurance carriers rely on a resection weight of 500 grams per breast; however, the body of literature shows that resection weight does not correlate with patient satisfaction.<sup>9</sup> Kerrigan et al.<sup>2</sup> suggest that it should be driven by patient symptomatology using a structured validated questionnaire. It is also well documented that some criteria still used by health insurers are totally obsolete.<sup>1-3</sup> There is now substantial research indicating that breast reduction not only alleviates the physical symptoms of macromastia (backache, shoulder pain, etc.), but also improves the patient’s quality of life irrespective of resection weight.<sup>1,7,9</sup> The American Society of Plastic Surgeons in 2017 had already set out recommendations for breast reeduction<sup>9</sup> but these go unheeded.

In essence, macromastia (enlarged breasts) is primarily a functional issue affecting the shoulders, neck and back, with an inadvertent cosmetic component. It is a common condition that is largely misunderstood.

## Conflict of interest


The authors declare no conflict of interest.


## Funding source


No funding was required.

## ORCID

DA Hudson  <https://orcid.org/0000-0002-1489-0087>

B Lelala  <https://orcid.org/0000-0001-7448-3314>

F Malherbe  <https://orcid.org/0000-0001-8910-6925>

CN Hudson  <https://orcid.org/0000-0001-3717-742X>

## REFERENCES

1. Rawes CMA, Ngaage LM, Borrelli MR, et al. Navigating the insurance landscape for coverage of reduction mammoplasty. *Plast Reconstr Surg.* 2020;146:539-47. <https://doi.org/10.1097/PRS.00000000000007241>.
2. Kerrigan CL, Collins D, Kim HM, et al. Reduction mammoplasty: defining medical necessity. *Med Decis Making.* 2002;22:208-17. <https://doi.org/10.1177/0272989X0202200309>.
3. Boukovalas S, Boson AL, Padilla PL, et al. Insurance denials in reduction mammoplasty - how can we serve our patients better? *Plast Reconstr Surg.* 2020;146:127-36. <https://doi.org/10.1097/PRS.00000000000006968>.
4. Yaacobi D, Olshinka A, Shachar T, et al. Is time a factor in quality-of-life improvement following breast reduction? *Aesth Surg J.* 2021;41:758-62. <https://doi.org/10.1093/asj/sjaa375>.
5. Hall-Findlay EJ, Shestak KC. Breast reduction. *Plast Reconstr Surg.* 2015;136:531e-44. <https://doi.org/10.1097/PRS.0000000000001622>.
6. Cabral IV, Garcia ED, Sobrinho RN, et al. Increased capacity for work and productivity after breast reduction. *Aesthet Surg J.* 2017;37:57-62. <https://doi.org/10.1093/asj/sjw175>.
7. Chao JD, Memmel HG, Redding JF, et al. Reduction mammoplasty is a functional operation improving quality of life in symptomatic women - a prospective single centre breast reduction outcome study. *Plast Reconstr Surg.* 2002;110(7):1653-4. <https://doi.org/10.1097/00006534-200212000-00004>.
8. Ducic I, Iorio ML, Al-Attar, Ali A. Chronic headaches/ Migraines: Extending indications for breast reduction. *Plast Reconstr Surg.* 2010;125:44-9. <https://doi.org/10.1097/PRS.0b013e3181c2a63f>.
9. Munger BN, Kalaria SS, Moliver CL. Commentary on: Reductio ad absurdum - examining the validity of the 500 g rule in reduction mammoplasty. *Aesth Surg J.* 2021;41(6):NP361-3. <https://doi.org/10.1093/asj/sjaa399>.