Correction of Inverted Nipples

Nipple inversion is usually secondary to shortening of breast ducts and the counteractive forces of the fibrous breast preventing full projection of the nipple.

Causes
It is present in 2% of women and will present for treatment if aesthetics or an inability to breast feed is a concern. In a significant number, inverted nipples are *hereditary* and are noticed during breast growth as a teenager. When the nipple inverts after it has been everted as an adult, it is advisable to see your GP and be assessed in a Breast Screening Unit to ensure that there is no underlying pathology such as *Paget's disease or Breast Cancer*.

Breastfeeding
Most women with inverted nipples who give birth are able to breastfeed without complication, but inexperienced mothers may experience higher than average pain and soreness when initially attempting to breastfeed. A baby that latches on well may be able to evert an inverted nipple. The use of suction devices such as Avent Niplette or a breast pump during breast feeding may help to draw out inverted nipples.

Severity of inversion
Dependant on the degree of nipple inversion and its ability to evert spontaneously or manually, inverted nipples have been classified by Han and Hong (1999) as follows:
Grade I The inversion is corrected simply by manipulation; the nipple protrusion is long-lasting. Milk ducts are usually not compromised and breast feeding is possible.
Grade II The inversion can be corrected by manipulation, but recurrence of the inversion is frequent. Grade II nipples have a moderate degree of fibrosis. The milk ducts are mildly retracted but do not need to be cut for the release of fibrosis.
Grade III The inversion cannot be corrected without a surgical procedure. Milk ducts are often constricted and breast feeding is impossible. Women with Grade III inverted nipples may also struggle with infections, rashes, or problems with nipple hygiene. The fibrosis is remarkable and milk ducts are short and severely retracted.

Surgical Treatment
Cases of Grades I and some grade II can be corrected by conventional simple procedures such as the use of niplette devices or breast pumps. But some cases of Grade II and almost all of Grade III cannot be corrected by conventional methods, in spite of the high frequency of relapse. Cutting of the

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lactiferous duct, such as the Pitanguy and Broadbent methods, can correct the very severely inverted nipple.

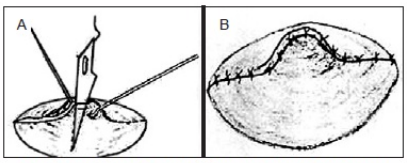

Figure 2 – In A, technique for transareolomammilary incision. In B, result after closure. (Reproduced from Pitanguy et al.[10])

Risks

Although surgery is normally performed as a *daycase* procedure and patients are able to go home after few hours following the surgery, some women may be asked to remain in the hospital overnight. However, the patients are advised to avoid driving immediately after the procedure because they will be still under the effect of anesthesia, therefore it is best to be driven home by a friend or relative. Miss Hazari uses the *Pitanguy technique* to correct the severely inverted nipple with good results. The **recurrence** rate is between 10-20% and very occasionally a re-operation may be required. To reduce recurrence especially as the scar contracts, you must massage the scar. A Niplette device in the first few weeks will also help to keep the nipple everted as the scar contracts and matures. **Nipple sensation** is altered in over 40% of women having this procedure and this may be permanent in approximately 20% of patients. The response of the nipple to cold or sexual stimulus may be reduced. Women who are keen to **breastfeed, should avoid this operation**, as she may not be able to breastfeed as some of the milk ducts are divided during surgery along with the fibrous bands. The main side effects of surgery are **pain**, **swelling** and sensitivity in the nipple area which can last for up to two weeks after the procedure has been performed. Other problems that can occur include **scars** within the nipple area which generally settle well over 12-18 months, **bleeding, haematoma** (collection of blood), bruising and occasionally **infection**.

Dressing

You will have a bulky dressing which will consist of a sponge around the nipple and a tie-over to keep the nipple everted. This will be covered with a waterproof cover. Prior to your discharge from hospital, an appointment will be made for you to be seen in the clinic 7-10 days after surgery. Miss Hazari will remove the dressings covering the area. Sutures do not have to be removed as these dissolve.

Recovery time is different with each patient. Patients can generally go back to work in a week after the surgery. Immediately after the procedure the nipples will more likely feel sore. The soreness should diminish over few weeks. Painkillers to help with the discomfort.