Editorial

The Greatest Myths in Breast Augmentation

John B. Tebbetts, M.D.

Dallas, Texas

1. Bigger is better.

   Without debating social implications and from the perspective of tissue effects over time, bigger breasts are not better. If breast envelopes consistently supported weight over time, mastopexy would not exist. If bras could circumvent genetics, gravity, pregnancy, and aging, the price for bigger might be less and the spectacularly beautiful 18-year-old D-cup breast would not be spectacularly saggy with an empty upper pole by age 30. The envelope of the average breast is designed to support a certain range of weight. When genetics, hormonal influences, weight gain, pregnancy, nursing, or breast implants exceed that range, negative effects predictably occur. Consequences of excessively large breast implants include ptosis, tissue stretching, tissue thinning, inadequate soft-tissue cover over an implant, visible implant edges, traction rippling, parenchymal and subcutaneous tissue atrophy, potential implant exposure or extrusion, and a high likelihood of needing further operations with additional costs and risks in the future. Virtually all of these problems are preventable prospectively by limiting implant size.

   What is "too big"? To some patients and surgeons, too big does not exist. There is always a rationalization that it is "what the patient wants," plus some level of psychological, physiological, or financial rationale as to why it is okay to do it. With luck, the patient may become a magazine centerfold or cover that the surgeon can frame as office-wall art for marketing. Never mind that over her lifetime the patient will likely experience substantial negative consequences and potential reoperations caused by excessively large implants.

   When implant volume exceeds 350 cc, even when that volume is required to adequately fill a previously stretched envelope, implant-soft tissue dynamics exert predictable negative consequences over time on the tissues of the breast. When patients request or require implants of 350 cc or greater, even for reconstruction, they should be educated thoroughly and acknowledge their acceptance of all of the risks listed previously in informed consent documents. Meeting a patient's short-term desires is not as important as minimizing potential negative consequences for her over her lifetime. Will she really want breasts that large if she honestly knows what she is eventually going to get? The rationale that she will go somewhere else and get them anyway clearly exposes the priorities of the surgeons that use it.

2. Patients do not deserve choices, because they do not know what is best. The surgeon knows what is best.

   Patient choices are limited only by a surgeon's commitment to skill development and patient education. In breast augmentation, no single "best" set of choices exists. Choices, each with unique benefits and tradeoffs, provide equally acceptable alternatives that can achieve similar excellent results. Informed consent law requires surgeons to educate patients about all available alternatives. If a surgeon's skills and mindset are limited to one set of choices, that set of choices is the best that surgeon can offer.

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3. There really is one best choice of incision location, implant, and pocket location.

This statement is true only if that set of choices is the only way that a surgeon knows to perform breast augmentation. If a "best" set of choices really existed, presumably we would all be doing it that way, although some might observe that plastic surgeons have a unique proclivity for arguing the obvious to preserve the status quo while neglecting the possible. What is best is obviously what a surgeon knows how to do. A surgeon's motivation to continually learn and progress is the only factor limiting his or her range of skills.

Incision location is inconsequential postoperatively if the surgeon delivers a beautiful breast. Each incision location has tradeoffs, but tradeoffs should not sell against one incision or another. Assuming that a surgeon has skills with more than one incision approach, selection should be based on the following criteria:

- Which incision allows the surgeon the best control for a specific breast and implant type?
- Which incision traverses and traumatizes the least amount of normal tissue for access?
- Which incision has the least risk to adjacent critical structures or neurovasculature?
- After applying the first three criteria, educating the patient, and assuming that the surgeon can deliver equal results through more than one approach, which incision does the educated patient prefer?

Choice of implant type and size is critical to optimal long-term results in augmentation, yet consultation discussions may consist of "here, stuff this rice bag, water bag, or test implant into your bra, and tell me which size you'd like," "bring me a picture of what you'd like to look like," or "what cup size would you like to be?" Although each of these methods may yield useful information, none addresses the most critical issues in augmentation:

- What are the characteristics of that specific patient's tissues (envelope size and compliance, measurements, parenchyma amount and distribution, percent fill of the maximally stretched envelope by the existing parenchyma)?
- Based on those tissue characteristics, how much volume is required to optimally fill the existing envelope?
- If the patient requests more than the amount required for an optimal result, is she fully aware of and willing to accept responsibility for the long-term consequences?
- Is the surgeon willing to commit adequate time resources to ensuring that the patient understands and accepts an inevitable set of tradeoffs, regardless of the type and size of implant chosen?

One of the most important things that a surgeon can do to prevent future complications and reoperations is to ensure adequate soft-tissue coverage for every breast implant over both the short and long term, selecting pocket location to provide coverage over the short term and making implant size decisions that are most likely to preserve coverage over the long term. Some exceedingly thin patients, regardless of their wishes and the surgeon's financial considerations, would probably be better served over the long term by not having a breast augmentation. Similar stringent criteria should apply to reoperations. Regardless of the etiology, if tissues become so thin postoperatively that no reasonable techniques can provide adequate soft-tissue coverage, implants should be removed to prevent medical or aesthetic consequences that far exceed the aesthetic compromise of removing the implants. Leaving implants under inadequate soft-tissue coverage, no matter how difficult the decisions, risks further tissue damage that can produce permanent, uncorrectable deformities.

How thin is thin, and when should that affect our decisions? Quantifiable (though still somewhat subjective) measurements are more accurate than totally subjective opinions. Any patient with less than a 2-cm pinch thickness (1 cm of skin and subcutaneous tissue) superior to the breast parenchyma should carefully consider subpectoral placement of the implant, regardless of the tradeoffs of a subpectoral placement. Medial origins of the pectoralis

major along the sternum should be preserved in most cases, even when the patient desires more narrowing of the intermammary distance, to avoid uncorrectable deformities, such as dimpling from readherence of cut muscle edges, implant edge visibility, and traction rippling from the implant pulling on a capsule that is attached to thin, overlying tissues. When pinch thickness at the inframammary fold is less than 0.4 cm, leaving pectoralis origins intact across the inframammary fold may be preferable to achieve more coverage, accepting slightly increased risks of upward implant displacement and a less predictable and accurate inframammary fold. To minimize complications, in most cases the base width of the implant should not exceed the base width of the patient's existing breast parenchyma.

4. It is best for a surgeon to choose a technique and an implant, then do them all that way.

   This myth is as logical as the assumption that all patients are the same with respect to their tissue characteristics and their desires. Unfortunately, the myth becomes true if a surgeon's skills are limited to one technique and one implant. Patient breast tissue, envelope, and parenchyma are widely variable. Optimal results in a wide range of breast types cannot be predictably achieved using any single combination of implant, incision approach, and pocket location.

   Surgeon obstinacy and lack of motivation to learn and change can limit technique and implant options for augmentation patients. Criticizing any technique or implant alternative is easier than admitting no experience. Expressing opinions not based on experience is easier than focusing resources to expand skills and gain experience. Most informed surgeons acknowledge that the glandular ptotic breast and the constricted lower pole breast require individualized techniques and implant selections to optimize results. In these types of breasts, tissue characteristics of the envelope and parenchyma dictate that surgeons recognize and address the tissue components—or the results will be disastrous. In fact, similar tissue characteristics and implant-soft tissue relationships exist in every primary breast augmentation case that, if addressed, could improve long-term results. The question is whether surgeons choose to insist on a more sophisticated approach to augmentation that addresses those factors. The "it does not matter" attitude, even in the most routine primary breast augmentation, rarely produces optimal results and never produces advancements.

5. Artistry is what distinguishes the better augmentation surgeon.

   Believe it or not, artistry in augmentation is more than a popular buzzword for magazine quotes and television interviews. Artistry is predictable execution of an augmentation that results from precise patient evaluation, thorough surgical planning, and selection of alternatives based on a diverse surgical skill set and experience. Artistry in breast augmentation is not only the visual result; it is also how thoroughly the patient was educated, the range of options she had available to her, how quickly and uneventfully she recovered, the number of operations she will require in the future, and the effects of the implants on her tissues over time. The ability to sketch a beautiful breast or display potential results to the media or to a patient on an imager screen does not necessarily ensure consistently optimal augmentation results or consistently deliver an easier, quicker recovery to the patient with a more uneventful long-term outcome. Artists, though creative, are not always disciplined or motivated to expand their horizons. Any surgeon who is open-minded, committed to learning, and exercises incessant self-criticism can become an artistic augmentation surgeon.

6. Over the past 20 years, we've really advanced the state of the art in augmentation.

   It sounds nice, but in truth, it is a myth. We have endoscopes. We can insert implants through the umbilicus. We have a few more choices of implant types than we had 20 years ago. But if we had really advanced the state of the art, why do many patients spend 2 or more hours in the operating room for a breast augmentation? Why are the majority of surgeons in the United States using what we

were using 20 years ago—round, smooth, underfilled breast implants and blunt pocket dissection? Why is the Food and Drug Administration (FDA) allowing surgeons and manufacturers that work under a study to implant silicone gel implant devices that are essentially the same devices that caused a ban of breast implants in 1992? Why do many patients still require 1 to 2 weeks to return to normal activity? Why do patients require drains postoperatively? Why are patients sometimes required to wear bandages, straps, and other devices for days or weeks following their augmentation? Most embarrassingly, how can large numbers of patients in two large premarket approval studies submitted to the FDA by a large number of plastic surgeons experience reoperation rates of 28 to 44 percent in the first 3 years after their augmentations?[1,2] And we wonder why the public and the FDA are skeptical?

The answers are somewhat disturbing. Perhaps we are not doing as good a job as we could and should be doing in breast augmentation. Although we continue to debate and defend the status quo, we fail to allocate adequate time in our educational forums to address in-depth details of more advanced techniques and options. Program committees continue to schedule 7-minute presentations and 30 to 40 minute panels that at best may entertain, but rarely provide enough in-depth information to realistically affect patient outcomes. Conflict and disagreement often seem more important than practical substance. Politics, ego, jealousy, and organizational financial requirements limit productive information exchange. If organizations continue to prioritize the number of surgeons on the program over the amount of practical, useful information conveyed, meetings will remain more socially entertaining than educational. If surgeons do not demand more in-depth treatment of pertinent subjects, then they are unlikely to get it.

Advancements rarely evolve from espousing and protecting the status quo. Just because something "works" and has worked for the past 20 years does not imply that it is optimal. If we invested a fraction of the effort advancing the art that we invest in protecting the status quo in breast augmentation, we likely would not be using largely the same implants and techniques that we were using 20 years ago. Implant manufacturers predictably produce what surgeons request. If a majority of surgeons request and use 20-year-old commodity products, implant manufacturers will reallocate company resources to the bottom line and to stockholders, improving stock prices and dividends at the expense of research and development. Price wars between implant companies for commodity products (none are really much different from the other—round and smooth is round and smooth) further decrease operating margins for the companies and decrease funds available for future research and development of new products. The annual reports, Securities and Exchange Commission filings, and sales data of the two breast implant manufacturers remaining in the United States evidence this historical progression and list the percentage of net profits that are allocated to research and development of new products. Surgeons are left with no implant products that are new and better to offer patients. Most compelling, there is not a single new implant device even in the pipeline that can reach the market in less than 7 to 10 years. Try to name a single technology-oriented business that has survived for two decades by preserving the status quo. And even if the status quo survives, what is the rationale that explains how no new or better products for a decade is good for patients or surgeons?

It is difficult to deal with the FDA. When we lack the organizational resources, clout, and response time to effectively offset poorly conceived and scientifically unsupported FDA rulings, it potentially hurts our patients and us. Instead of laying blame, it is past time to assume responsibility, learn from history, and improve.

7. Implant shape does not matter.

Many discussions of implant shape distract from the infinitely more important issues of how to do every augmentation better, of guaranteeing every patient a

faster and more uneventful recovery, and of making decisions and performing surgery that minimizes the risks of complications and reoperations to the patient in the long term. Shape issues could probably be readily resolved by applying the following standards:

- If you do not like it, do not use it.
- If you are not committed to learning how to use it optimally, do not use it.
- Hold the status quo sacrosanct if you're happy and do not want new techniques and products developed.
- Even if you have limited or no clinical experience with any product or technique in primary augmentation, freedom of speech nevertheless guarantees the right to verbalize unsubstantiated opinions.

Any skilled surgeon can produce virtually any desired breast shape (natural or "Baywatch") using a properly selected round or shaped implant. The issue is not whether a shaped implant can produce a more natural result, because it is clearly possible to achieve perfectly natural appearing results with round implants. For 10 years, I used exclusively round implants and published series with natural results.[3,4] My interest in anatomic or shaped implants totally evolved from an interest in preventing implant shell collapse and folding while preserving optimal aesthetics. The most important questions are whether shaped implants may allow more optimal implant fill volumes to increase shell longevity, and whether they offer additional options to surgeons and patients.[5]

Implant shape is not a very important issue to surgeons who have little concern about implant-soft tissue dynamics over time, who are not very concerned about implant shell longevity and the potential effects of shell-fold fatigue, who are unwilling to educate patients about fill issues or who believe that patients are not sophisticated enough to understand and make informed choices, or who have little or no personal experience using shaped implants in primary augmentations. More than 50 soft-tissue and surgeon factors affect final breast shape. When a surgeon does not understand and address these factors in professional presentations or publications, the surgeon is unlikely to understand the complex implant-soft tissue dynamics and fill issues that are distinctly different between round and shaped implants in different breast types. Absent significant clinical experience with any type of implant or technique in primary augmentation, the validity of a surgeon's opinion approximates that of a dimpled ballot.

If we are to believe that implant shape does not matter, we need to reconcile that theory with the fact that surgeons worldwide have used over 500,000 shaped implants and continue to use them in large numbers. Implant shape, even subtleties in the shape of round implants, may hold very important keys to prolonging implant shell life with more types of filler materials. We have not even begun to integrate state-of-the-art engineering technologies into the design of breast implant shapes. No accurate, valid models exist to test shell-fold fatigue in a wide range of implant shapes. We know that implant shell folding is probably a major cause of premature shell failure, yet we do not definitively understand how shell shape and fill volume affect the risks of shell folding.

For the record, as most readers of this journal are aware, I have developed anatomic breast implant designs and received financial compensation for some of those designs. What most readers are not aware of is that I have also developed round implant designs and that I use in my practice both round and anatomic-shaped implants for breast augmentation, based entirely on patient preference and tissue considerations after thoroughly educating each patient about all options. My concerns are not whether an implant is round, anatomic, shaped, or some other design, provided it is safe and delivers optimal long-term results. Do I believe that round or anatomic implants can produce good aesthetic results? Without question. Do I have biases? Absolutely. But my biases are not what many might think. The four things about implants, either round or anatomic, that concern me most are as follows:

- Is the implant adequately tested and

predictably medically safe?
- To what degree does the design of the device allow me to control the shape of the patient's breast in the long term?
- What are the likely effects of the device on the patient's tissues in the long term?
- What is the longevity of the device that will determine the number of reoperations for the patient?
- Does the design of the device offer me additional alternatives compared with other devices?

Unquestionably, based on my 21-year experience in breast augmentation, anatomic and shaped implants provide an entire range of options in a wide range of breast types that I cannot address optimally with round implants. Can a patient always see the difference? I do not know. Can all surgeons see the difference? Again, I do not know. But I can see the difference in most cases, and, more importantly, I know that I am expanding my skills, improving my results, and maximizing the options available to me and to my patients. Most importantly, while optimizing aesthetics, I am also making every effort to maximize the shell life of the implants I provide to patients.

Neither round nor anatomic-shaped implants are necessarily better in every primary augmentation. Each type has unique, positive attributes and unique tradeoffs. Informed consent law requires that patients be informed of both options; although this law does not require surgeons to divulge their experience with each implant type to patients, ethically they should.

With respect to implant selection, a few commonsense thoughts:
- If a surgeon has committed to a learning curve and a meaningful number of cases (at least 10) and cannot deliver optimal results with any type of implant or technique, the surgeon should probably not use that implant or technique. If the surgeon is not willing to commit to the learning curve, patients (who unfortunately do not know) might reconsider their choice of surgeon.
- Consistent, safe, predictable results are most important. If a surgeon and his or her patients are happy with the results, that is one level of good. If the same surgeon can expand skills to offer patients more options and deliver the same results, that is another level.
- If a surgeon prefers the status quo for any reason, that is the surgeon's prerogative, but hopefully he or she will honestly state the clinical experience on which an opinion is based and respect those who want to advance the state of the art in augmentation.

8. A surgeon really does not need any surgical experience to determine and definitively state which techniques or implants are bad, which techniques work or do not, or what is possible or not.

This myth is like asking a bus driver to describe techniques for flying the space shuttle, then believing what you hear. In professional presentations, journal publications, and media to the public, surgeon ethics rules should require that whenever a surgeon speaks positively or negatively about any surgical technique, treatment modality, or breast implant product, the surgeon is required to state honestly, accurately, and verifiably his or her personal experience with that technique or product. We are ethically bound to disclose financial relationships, so why not require disclosure of surgical experience? In scientific discussions, differing opinions based on logic, a constructed rationale, or even personal preferences have a place. Each, however, should be identified for what it really is.

When a surgeon makes pronouncements about what is possible and what is not—or what is necessary and what is not—the validity of the pronouncements frequently relates to his or her level of clinical experience. For example, in a recent scientific publication, one surgeon suggested that an endoscope is not really necessary or desirable to perform axillary breast augmentation, whereas another surgeon suggested that it is difficult or impossible to place anatomic breast implants accurately through an axillary incision, especially in a submammary pocket. In both cases, highly skilled and respected surgeons made inaccurate statements based on a lack of clinical experience with the subjects on which

they were commenting. We can all improve in this regard. I distinctly remember commenting negatively in print about umbilical breast augmentation when I had a total two-case experience. My theoretical concerns were appropriate. My failure to disclose my lack of experience was not. I would have been more credible had I admitted, "I do not know how."

Techniques or products considered "bad" seem to mysteriously change with time. In 1992, some surgeons rather pointedly denounced the failure rates and visible rippling of underfilled, silicone gel filled implants. Even manufacturers muttered privately about shell failure rates with gel implants. But when the FDA inexplicably decided to allow the old, underfilled gel implants—which were essentially the same designs that existed at the time of the 1992 ban—to be "restudied" in premarket approval submissions, some of the same surgeons who complained about the devices suddenly enlisted in the studies and signed up patients while manufacturers happily reviewed the profits that resulted from selling the products once again. Are saline implants better than silicone? It depends on which tradeoffs you want to accept. But we cannot have it both ways. We cannot credibly criticize failure rates, then change our story about the same devices when it is convenient or profitable.

9. Most patient morbidity, complications, and reoperations are caused by the breast implant and are beyond the surgeon's control.

Breast implants have likely been blamed for more complications than all surgeon-induced problems combined. No breast implant design can compensate for suboptimal evaluation of a patient's tissues, operative planning, or execution of surgical techniques. No breast implant solves clinical problems by virtue of its design alone. Surgeons produce some unavoidable morbidity simply by performing augmentations, but the degree of morbidity and the rate of complications usually reflect the quality of the operation. Even capsular contracture, a biologic response to the implant that is not a complication, relates directly to multiple surgeon-related factors, including dissection technique, tissue trauma, bleeding, and pocket contamination.

Surgeons determine opportunities for improvement, opportunities that often lie in the most basic functions that he or she performs with every augmentation patient. For example, can any surgeon assess the compliance of the breast envelope simply by looking at it? How much accuracy is achievable without objective measurements and is the extra 3 minutes required to perform them worthwhile? What we fail to notice can produce suboptimal decisions. A similar-sized implant (300 cc, for example) can have dramatically different long-term effects when placed in similar-sized breasts with similar dimensions and amounts of parenchyma, but with distinctly different envelope characteristics. Failure to accurately assess and quantitate breast envelope characteristics can deprive a surgeon of the opportunity to make optimal decisions that affect the long-term result. Countless other opportunities for improvement exist, but surgeons must pursue them instead of justifying the status quo.

The surgeon controls what occurs intraoperatively, and his or her choice of techniques can have profound effects on a patient's outcome. Are 30-year-old blunt dissection techniques really still acceptable? Ask the opinions of two patients, one who experienced a 2-day return to normal activity and the other who had a 2-week return to normal activity, with the difference attributable to the degree of tissue trauma and inflammation that resulted from surgical trauma and blood absorbed into tissues. Yet blunt dissection remains staunchly defended by many surgeons. Does surgical instrumentation matter? Do minute details of surgical technique matter? All of these factors matter and all deserve attention and improvement, based on the number of complications and reoperations that patients are experiencing.[1,2]

Can surgeons affect the necessity of adjunctive measures postoperatively by the techniques they use intraoperatively? Is

general endotracheal anesthesia worth the costs and effort? Can appropriate use of muscle relaxants reduce trauma to the pectoralis during dissection of a subpectoral pocket? Are intercostal blocks really necessary for patient comfort, or could we remove the time, cost, and risk of those blocks by improving surgical technique, reducing bleeding, and eliminating blunt dissection and trauma to the periosteum or perichondrium, all of which cause pain? Over an entire practice career, consider the continuing unnecessary and unproductive investment of time, cost, and risk of performing intercostal blocks (or any other unnecessary procedure) on every augmentation patient compared with the constant yield of improving surgical technique to avoid the necessity of an adjunctive procedure—a one-time investment in improving skills that would eliminate risk and waste and improve every patient's recovery. What about drains? If bleeding or excessive trauma does not occur, are drains really necessary? What about postoperative bras and devices used to position the implant? Are there documented methods that ensure predictable implant position, without resorting to devices that require patient compliance, that inconvenience patients, and that compromise the results if improperly used by the patient? If there are better alternatives that require fewer adjunctive measures, why do not we use them? If drains, binders, special bras, straps, massage, and countless other adjuncts are really necessary, how can some surgeons get predictably excellent results without using any of them? There are countless other examples that raise the questions, "Why will we not change? Why do we continue to embrace two-decade-old technology and techniques?" Pertinent questions with difficult answers.

In this information age, patients are rapidly learning that "it does not have to be that way." Breast augmentation can be more predictable, with fewer problems and a faster recovery with less risk of reoperation. If a surgeon acknowledges his or her role as the primary determinant of outcome, that the details matter, and that advancement requires motivation and effort, patients will benefit.

10. When a surgeon establishes a set of preferences of technique and implant, by definition that is the best option, and the surgeon should rigidly defend that choice over an entire practice career.

Rational surgeons would agree that we should do what we know how to do, that we should offer patients tested, reliable techniques and implants that are most likely to deliver predictable results with minimal complications. The next higher perspective recognizes that good can always be better, that patients deserve better, and that surgeon commitment to expanding skills is a major factor affecting patient outcomes. Fortunately, we have voices that espouse both perspectives, and there is probably some merit to defending the status quo, at least until it is clear even to the janitor in the operating room that there is a better way.

Recall the previously mentioned surgeon who theorized that an endoscope is unnecessary for axillary augmentation. Perhaps we could theoretically perform augmentations with a claw hammer, but today we have scalpels and blunt dissectors. Today we even have sophisticated electrocautery instruments and endoscopes! How many technically critical functions are better performed blunt and "blind" when more accurate and less traumatic techniques are available? Perhaps it is simply a matter of surgeon perspective. To definitively resolve the question, why not operate patients side by side, with one patient's pocket dissected with a blunt dissector and the other patient's entire pocket dissected using optimal electrocautery instrumentation and techniques with endoscopic assistance? Then observe which patient experiences less morbidity and returns to normal activities most rapidly. Rather than looking at selected cases in a 7-minute presentation, let us compare actual patients in the real world. Who does better—and why? Answer questions for the patient's benefit, not for the surgeon's ego. Our patients could benefit if we recognize and resist the imprint from the surgeon genome that says, "I've never done it, but I know it is bad. I get great results doing what I'm doing, so why change? Why even think about

changing? I know best. After all, I am the surgeon."

11. Whatever is easiest is best.

    Rarely is what is easiest what is best, and, on the uphill slope of the learning curve, it is never true in breast augmentation in my experience. This myth may attain a degree of truth only after significant investment of time and effort produces a high level of proficiency based on substantial experience. It is rarely true when derived from a limited experience in a narrow perspective that explored few alternatives.

    Progress in breast augmentation is impeded by patient satisfaction with the operation. Many patients are happy with less-than-average results. Positive effects on their sense of confidence and well-being sometimes encourage patients to continue undergoing reoperation for problems such as capsular contracture or infection when implant removal without replacement is far more logical medically. It is not easy to more thoroughly address patient education, evaluation of each patient's tissues, preoperative decision-making processes, progressively increasing surgical skills, minimizing morbidity, and speeding recovery. But from a patient's perspective, it is best. Surgeons must insist on outcomes that far exceed patient expectations, helping patients make better choices that reduce risk of reoperation and adverse tissue consequences while improving implant longevity.

    Financial considerations sometimes interfere with delivering what is best, especially if best costs more, the patient does not have the money, and the surgeon had a slow previous month. From a surgeon's economic perspective, dealing with a single complication resulting from suboptimal decisions or perceived financial need can result in a net loss of revenue that approaches the revenue from three primary breast augmentations. If litigation occurs, losses to the patient and the surgeon are substantially greater. Patients sometimes think they know what they want until they realize what they got, and even then sometimes do not acknowledge that easiest is not always best.

THE TRUTH

Now that we've explored some myths, the truth. In breast augmentation, which is one of the most rewarding procedures in plastic surgery for both patient and surgeon, we can do better, we should do better, and we must do better. It is time to move forward.

John B. Tebbetts, M.D.
Suite 300
2801 Lemmon Avenue, West
Dallas, Texas 75204

REFERENCES

1. Mentor Corporation. *Saline-Filled Breast Implant Surgery: Making an Informed Decision.* Santa Barbara: Mentor Corporation, 2000. Pp. 11–17.
2. McGhan Medical Corporation. *Saline-Filled Breast Implant Surgery: Making an Informed Decision.* Santa Barbara: McGhan Medical Corporation, May 2000. Pp. 10–17.
3. Tebbetts, J. B. Transaxillary subpectoral augmentation mammaplasty: Long-term follow-up and refinement. *Plast. Reconstr. Surg.* 74: 636, 1984.
4. Tebbetts, J. B. Transaxillary subpectoral augmentation mammaplasty: A nine-year experience. *Clin. Plast. Surg.* 15: 557, 1988.
5. Tebbetts, J. B. Patient acceptance of adequately filled breast implants. *Plast. Reconstr. Surg.* 106: 139, 2000.