Response to: Commentary on “*Surgical treatment of gynaecomastia: a standard of care in plastic surgery*” by Alessandro Innocenti, Serena Ghezzi & Dario Melita.

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We appreciate the recent comments and acceptance of our offered algorithm in the treatment of gynaecomastia by Innocenti et al.. The author of the letter has impressive experience in reshaping of the male chest and shared multiple valuable data in the past. Among our own results, we discussed the published recommendations, which are comparable with the standard of care in our department [1–3].

A couple of questions came up which we want to answer. We completely agree that even in high-grade gynaecomastia, a scar sparing approach should be the first choice without extra areolar scars [4]. Whenever reasonable, we offer the subcutaneous mastectomy through a periareolar incision combining with liposuction. Since ultrasound-assisted liposuction offers the option to perform conventional liposuction in addition with thermal energy, we would like to enforce to use this modality. For single reduction of fatty tissue, the standard tumescence liposuction is effective and is performed most of the time. In our patients, we recognized a positive shrinking effect by applying subdermal thermal energy using the ultrasound mode. Moreover, bleedings can be reduced by tumescence in combination with ultrasound by thermal coagulation.

For postoperative care, we routinely use suction drains, leave skin tapes for 2 weeks, and recommend a compressive dressing or custom-made jersey for 6 weeks. Therefore, we are in line with Innocenti et al. that these additives reduce complications and help reshaping. Quilting sutures are an evidence-based method to reduce postoperative seroma, as already proven in abdominoplasties. [5]. However, we did not consider this technique in the past, due to the moderate

rate of complication. A ratio between postoperative complications and extra time in the OR, potential stitch marks on the skin, and fascial tension has to be made.

Talking about scar sparing techniques and planning of submammary incisions always need to be discussed critically. As mentioned before, the periareolar approach is the preferred technique. Since 3rd degree gynaecomastia or large pseudogynaecomastia after massive weight loss usually shows excessive redundant skin with derangement of the nipple areolar complex (NAC) and distinct skin folds, even an effective skin retraction would not lead to satisfying results. Moreover, the skin quality after massive weight loss or in 3rd degree ptosis is often reduced with higher laxity compared with young, adipose or pre-adipose patients with dominating lipomastia and moderate skin excess. Referring to our results, we offer both, the minimal, periareolar incision, or the initially prominent scars in the submammary fold. This decision is made stage-adopted depending on clinical findings and patient's preference. Additionally dislocated NACs often need a new inset to gain a physiological appearance, if skin retraction is likely to be insufficient [6].

These scars might mimic the lower border of the pectoralis major muscle and offer immediate results, which may influence a distinct patient-based decision for one or the other technique.

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Compliance with ethical standards

Conflict of interest Tobias R. Mett and Peter M. Vogt declare that they have no conflict of interest.

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