

Fig. 1. Measures taken for this study. The red line represents the initial philtral insertion. The blue line represents the theoretical upper lip level after a theoretical upper lip lift and thus the new philtral crest insertion. In this patient, the upper lip lift at this level would have displaced more than 1.72 times the initial value, which means more than three-fourths of the philtrum width (yellow line).

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this communication.

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Combined Base Imbrication and Top Hat Nipple Reduction

Sir:

The nipple-areola complex holds an important psychological place, as it is the center focus of the breast mound. Just as the absence of the nipple is debilitating, so too is the presence of hypertrophic and/or inverted nipples. The nipple is composed internally of a series of lactiferous ducts that are responsible for connecting the mammary gland and supplying milk during lactation.¹ Nipple sensation is derived from the anterior and the third, fourth, and fifth lateral cutaneous intercostal nerves.² Blood supply to the nipple is predominantly from a plexus of vessels branching from the internal thoracic artery.³



Video. Supplemental Digital Content 1 demonstrates a technique for nipple reduction, <http://links.lww.com/PRS/B165>.

Vecchione used a split-thickness skin graft after direct tip amputation.⁴ This method, however, cuts through the nipple core housing the lactiferous ducts, most likely creating a functional disruption of breast feeding. Circumcision techniques around the nipple base have been used to decrease height and diameter without compromising lactation.^{5,6} As such, wedge resections of the nipple should be placed vertically to maximize nipple sensation.⁷

The “average” nipple is generally agreed to be 1 cm in diameter and 1 cm in anterior projection,⁶ with a ratio of 1:3.6 (or 28 percent) nipple-to-areola diameter.⁸ Elongated nipples are more common in postpartum women⁹ and also occur more frequently among Asian women than among Caucasian women.¹⁰

We present a video for documentation of a technique for nipple reduction. (See **Video, Supplemental Digital Content 1**, which demonstrates a technique for nipple reduction, <http://links.lww.com/PRS/B165>.) It is a modification of the Cheng top hat technique. The wedge excision is greater in width and then imbricated as a burrow triangle to further decrease nipple height and maximize blood supply and sensation. The inferior excision can be further extended as a circumferential strip removal as advocated by Jin to maximize dimensional decrease (Fig. 1).

We present this technique to maximize reduction of length predominantly. The Jin technique increases the volume of nipple within the skin with two wedges to compensate. This technique places the wedge at the 6-o’clock position only, avoiding a scar the patient can see from above, or at the 12-o’clock

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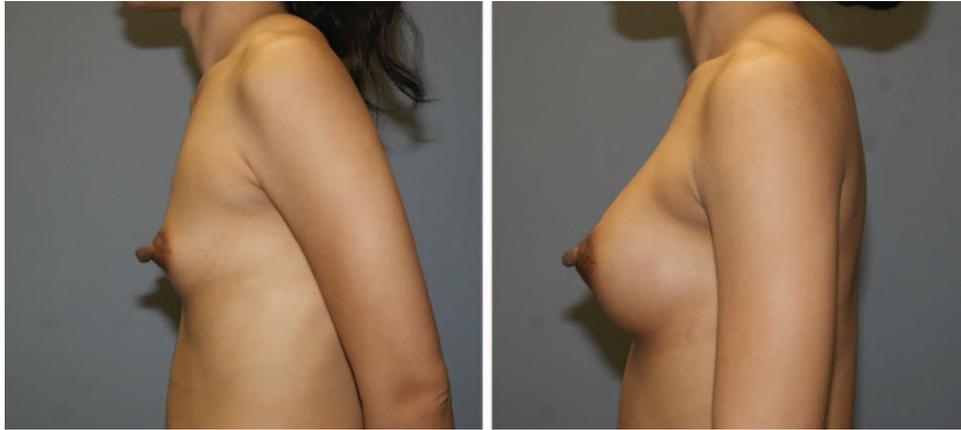


Fig. 1. A 28-year-old woman who underwent breast augmentation surgery with nipple reduction shown (left) preoperatively and (right) 2 months postoperatively.

position. The imbrication of the base widens the relative base, which can help change the mushroom-on-a-stalk appearance that commonly occurs during the postnatal period. The modified top hat component of Cheng allows more control of the height. The wedge and top hat nipple reduction technique with imbrication of the base allows control of height, width, and shape of the new nipple.

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Orchialgia after Orchiectomy

Sir:

Orchiectomy is an accepted treatment for testicular pain.^{1–5} In one study, 73 percent of patients who underwent inguinal orchiectomy had complete pain relief; the remainder reported at least partial relief.¹ Using a scrotal orchiectomy approach, these authors reported 55 percent relief of testicular pain. A laparoscopic approach for testicular pain has been described in which the genitofemoral nerve is resected.^{6,7} A different approach to testicular pain is to denervate the testicle instead of performing orchiectomy: this open approach, termed “microsurgical denervation,” has been reported for treatment of orchialgia, with success rates approaching 85 to 100 percent.^{8–11} This requires microdissection of cord structures, preserving the testicular artery and vas deferens in patients who have not had an orchiectomy, but the genital branch of the genitofemoral nerve is not specifically identified. The purpose of the present report is to describe an extension of our treatment of groin pain of neural origin after hernia surgery^{12–14} to patients with persistent orchialgia after orchiectomy, focusing on identifying the genital branch of the genitofemoral nerve at the external