DOI -10.37951/CEREM.2022.V2I6.33-35

REVIEW ARTICLE

SURGICAL TREATMENT OF GYNECOMASTIA

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ABSTRACT

Gynecomastia is the growth of the male mammary gland resulting from secondary branching of the ducts and proliferation of the fibroelastic stroma, usually resulting from an imbalance between the estrogenic stimulating action and the androgenic inhibitory effects. Differential diagnosis should be made with breast carcinoma, dermoid cyst, hematoma, lipoma, lymphangioma and neurofibroma. The treatment of choice is surgical since drugs such as clomiphene, tamoxifen, danazol and testolactone have low efficacy. Reducing adenomastectomy with an inferior periareolar incision is the technique of choice. Liposuction should be considered in cases of severe lipomastia.

KEYWORDS: BREAST; GYNECOMASTIA; SURGERY

INTRODUCTION

Gynecomastia is the growth of the male mammary gland due to secondary branching of the ducts and proliferation of the fibroelastic stroma. In most cases, it seems to result from an imbalance between estrogenic stimulating action and androgenic inhibitory effects[1].

The imbalance between estrogen and androgen, pituitary gonadotropins, corticosteroids, prolactin, thyroid and growth hormones may play a role in the origin of gynecomastia[1].

It predominates at puberty and after 65 years of age, especially in overweight or obese people.

LITERATURE REVISION

The macroscopic appearance of glandular tissue in gynecomastia is similar to that of the female breast. It must be distinguished from the increase in volume caused by the accumulation of fat called lipomastia[2].

In the hypertrophic breast, dense, hyaline, periductal and collagenous connective tissue is observed, in addition to hyperplasia of the lining of the ducts and plasma cell infiltrate[3].

A ginecomastia pode ser classificada em:

Gynecomastia can be classified into:

Physiological: when it appears in the neonatal period, puberty, adolescence and senility.

Primary hormonal alterations: Klinefelter syndrome, in which there is a chromosomal alteration (47, XXY). Familial prepubertal gynecomastia which is a rare autosomal dominant disorder due to increased aromatase activity.

Sexual development alterations: Male pseudohermaphroditism, which is characterized by individuals with hypospadias, post-pubertal atrophy of the seminiferous tubules, azoospermia, infertility and gynecomastia.

Non-hormonal clinical conditions: Liver cirrhosis, hyperthyroidism, malnutrition, trauma, tumors, liver and kidney failure.

Induced by drugs and psychoactive substances: Anabolic steroids, estrogens, digitalis, spironolactone, cimetidine, ketoconazole, amphetamine, antihypertensives, antidepressants, cytotoxic agents, alcoholic beverages and illicit drugs (heroin and marijuana).

Diagnosis is based on clinical data, supplemented by mammography and ultrasound. It rarely requires punctures and percutaneous biopsy[4].

Withdrawal of the drug causing gynecomastia or correction of the underlying condition that altered the balance of estrogens and androgens causes regression of gynecomastia, particularly if breast growth is of recent onset.

Therapeutic management is usually expectant in adolescents who have physiological gynecomastia, as many cases regress spontaneously. The parenchyma/fat ratio and breast consistency will help determine the most effective treatment modality. Treatment with antiestrogenic drugs has no scientific evidence[5].

When gynecomastia persists in adults, causing psychological disorders due to aesthetics, surgical treatment with subcutaneous adenomastectomy, with or without liposuction, is the most used method.

Subcutaneous adenomastectomy: The procedure is

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performed in the operating room under local anesthesia with lidocaine without vasoconstrictor, associated with anesthetic sedation. An inferior periareolar incision is made, the subcutaneous flap is made with a scalpel or scissors up to the plane of the pectoralis major muscle, removing the entire mammary gland, preserving the areola and nipple[6].

Figure 1: Gynecomastia in a 14-year-old adolescent.

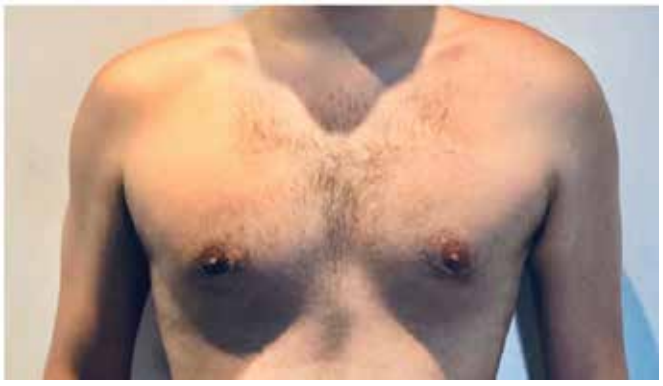

Figure 2: Result after 2 years of surgical treatment of gynecomastia with an inferior periareolar incision.

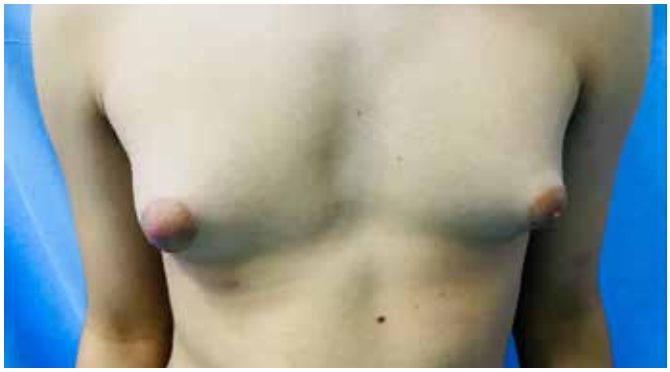

Photo 3: Gynecomastia in a 15-year-old adolescent.

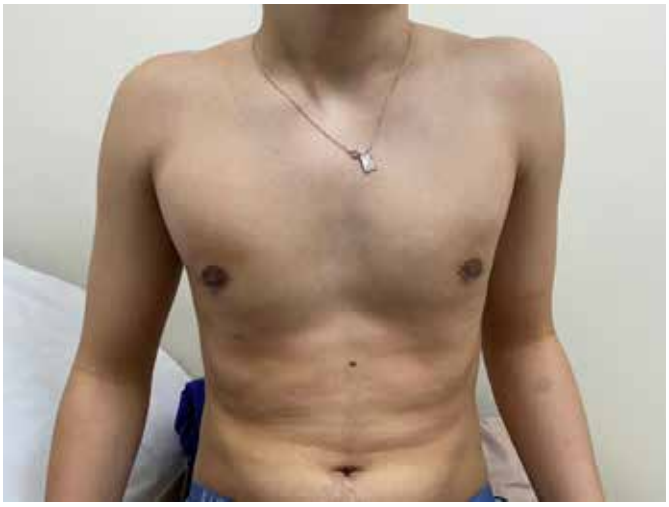

Photo 4: Result after 15 days of surgical treatment with bilateral adenomastectomy with inferior periareolar incision.

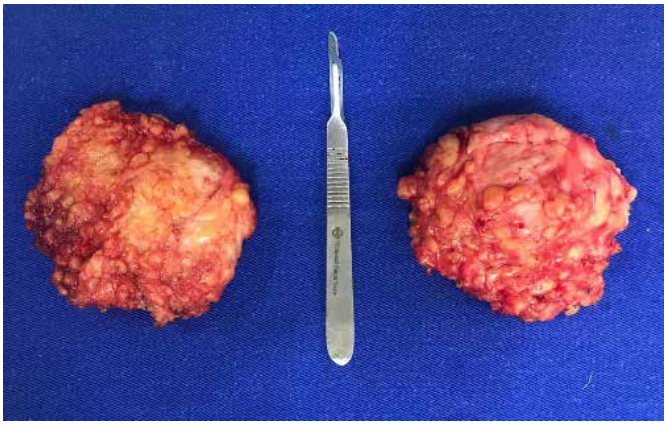

Photo 5: Macroscopic appearance of the surgical specimen of bilateral adenomastectomy for gynecomastia.

CONCLUSION

Healthy men with palpable breast tissue is not uncommon. Thus, these asymptomatic patients should not receive a diagnostic investigation, let alone be treated. Treatment of gynecomastia depends on the underlying cause. Physiological pubertal gynecomastia usually does not require treatment and resolves spontaneously within 3 years in approximately 90% of patients. When gynecomastia is drug-induced, it may regress after drug withdrawal. Surgical treatment with the subcutaneous adenomastectomy technique, using the inferior periareolar incision, is the technique of choice in most cases when gynecomastia persists in adults[5].

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