Symmastia (Greek: syn, meaning “together” and mastos, meaning “breast”) is defined as a medial confluence of the breasts. Congenital symmastia is a rare clinical anomaly, which represents webbing across the midline of the breasts that are usually symmetric. Like many anomalies of ectodermal origin, a broad spectrum of defects may be observed varying from an empty skin web to an apparent confluence of breast tissue across the midline. Few cases of symmastia were reported in the literature, with different techniques used for its correction, but there is no standard treatment for this condition.

**CASE REPORT**

An 18-year-old girl was referred with the complaint of lack of cleavage between her breasts (Fig. 1). She had no family history of similar condition or of any other breast abnormality. She had not undergone any breast operation. Physical examination revealed a medial confluence of the 2 breasts with a web of skin and fat connecting them and the absence of intermammary sulcus. The patient was satisfied with her breast size, but she wished to have the normal cleavage between the breasts.

Preoperative marking was done for the midline, the inframammary fold, and the lateral sternal border. The inframammary fold incision was marked 3 cm in length with its medial end lying 3 cm lateral to the midline.

The patient was given general anesthesia with oral intubation. Liposuction was performed in the presternal area and the web between the breasts but was not extended beyond the lateral border of the sternum. No liposuction was performed in the breast tissue. Approximately 200 mL of liposapirate was obtained. The inframammary fold incision was made, and dissection was performed, through this incision, toward the midline. Then, 3 quilting sutures were inserted in the intermammary area on each side of the midline between the dermis of the presternal skin and the periosteum at the lateral sternal border. Postoperatively, a compression bolster was applied to the intermammary sulcus for 2 months, 24 hours a day.

**RESULTS**

Postoperative cleavage between the breasts was achieved, and the patient was satisfied with the result (Fig. 2). Dimpling was observed at the site of quilting sutures, but it resolved after 1 month of the operation (Fig. 3). There were no postoperative complications.

**DISCUSSION**

Congenital symmastia was reported for the first time by Spence et al in 2 cases with successful treatment. Piza-Katzer et al reported 2 cases of congenital symmastia in a mother and a daughter, and they found the abnormal arrangement of collagen fibers in the breast tissue (including Cooper’s ligament) in both cases, and so, they assumed that this condition may have a familial cause.

There is a broad spectrum of congenital symmastia varying from an empty skin web to an apparent confluence of breast tissue across the midline. So, if the deformity is minimal, the patient should be informed about the complications that could result from the operation to be weighed against the benefit that she can get from the operation. These complications include asymmetry, contour irregularities, and scarring.

Because the midline confluence of the breasts could contain fatty and glandular tissue, the degree of congenital symmastia could be affected by the fluctuations in

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body weight and by the breast maturity. So, the operation should be performed after breast maturity is complete, and the patient’s weight is stable.

The ideal technique for congenital symmastia correction should include 3 steps. First is the removal of the excess tissue between the 2 breasts. This is achieved either with surgical resection or with liposuction as in the case presented in this study. The use of liposuction only was reported to give successful result by 1 study, but in another study, the correction was insufficient, and a second procedure was performed with resection of the glandular-fatty tissue in the cleavage and suturing the skin to the chest wall.

Second is to fix the skin of the intermammary sulcus to the underlying periosteum with sutures either at the midline or at the lateral sternal border as in our case presented here.

These sutures can be inserted through small inframammary fold incision, as in our presented case, periareolar incision, or vertical scar mammoplasty incision. However, the inframammary incision gives superior cosmetic result as it is less visible. These sutures cause some dimpling, but it resolves with time as observed in this study (Fig. 3) and other study.

The third step is the application of postoperative compression to the intermammary sulcus to facilitate the healing between the skin and the chest wall either with a bolster or a sternal shaping bra.

CONCLUSION

Congenital symmastia can be successfully treated by following the 3-step approach described in this article with combination of liposuction, skin fixation to sternum, and postoperative intermammary compression.

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