

LETTERS**Adjustments to the round-the-clock technique for correction of gynecomastia**

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Dear Editor,

We read with great interest about the new technique that Tarallo et al. [1] proposed for gynecomastia treatment using very small incisions. In our practice, we have also used a similar technique for treating gynecomastia of all grades. We have learned a few things over the course of our experience.

It is always advisable to perform liposuction first, before the glandular tissue is excised. Doing so has several advantages over performing excision first. The main advantages are better hemostasis, better creation of a surgical plane for dissection of the gland, and better assessment of the amount of glandular tissue that needs to be left behind in order to prevent contour deformities. We have found this technique to be particularly challenging in grade 3 gynecomastia, especially when the glandular tissue is large and widespread. An additional technique that we sometimes found useful was the use of small illuminated retractors. This improved our ability to create a plane between the gland and subcutaneous planes, especially in areas far away for the areola. We even tried using a naso-endoscope for better visualization, especially when dealing with perforators. However, the incisions needed to be extended by a few millimeters, which defeated the purpose of small-incision gynecomastia surgery.

While this technique is surely advantageous, especially in terms of scarring and faster recovery, it also has definite limitations in treating larger and firmer glands. In some cases, the benefit of small scars may be offset by the ability to better contour the whole chest in a more accurate manner.

Notes**Conflict of interest**

No potential conflict of interest relevant to this article was reported.

ORCIDSreekar Harinatha <https://orcid.org/0000-0001-5364-1475>Nithya Raghunath <https://orcid.org/0000-0003-2939-5280>**Reference**

1. Tarallo M, Di Taranto G, Fallico N, et al. The round-the-clock technique for correction of gynecomastia. Arch Plast Surg 2019;46:221-7.

Response to Letter: Adjustments to the round-the-clock technique for correction of gynecomastia

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We would like to thank the authors (SH and NR) for appreciating our work and suggesting adjustments to improve our technique [1]. We warmly welcome experience-sharing and discussions of surgical practices.

We read with interest that the authors prefer to perform liposuction before mastectomy, conversely to what we described. As we treated patients with true gynecomastia, we used superficial liposuction in the final step of surgery, in order to smooth the contour and reduce any unpleasant remaining irregularity. We acknowledge that performing liposuction first can assist in haemostasis and enhance the dissection, but our main concern is overcorrection of the chest, especially in thin patients. We believe that in cases of true gynecomastia, only after complete resection of the glandular tissue can the

surgeon properly assess the residual adipose tissue to be removed and carefully reshape the final appearance. Nonetheless, patients with pseudogynecomastia can benefit from traditional liposuction, which can also be performed at the beginning of the procedure.

Furthermore, the authors reported their experience with a similar technique for grade 3 gynecomastia [1]. They stated that the treatment of patients with large and widely spread-out glands is challenging through a small incision. In our experience, we use the round-the-clock technique only for the correction of grade I–II gynecomastia. In patients with more severe conditions, we prefer to apply a hemiperiareolar incision at the inferior half of the areola. This has a 2-fold purpose: it provides wider access to the glandular tissue, and also accommodates the subsequent skin resection, which is usually mandatory in the treatment of grade III gynecomastia. One appealing trick suggested by the authors is the use of small illuminated retractors. We agree that using such retractors can notably expedite the procedure, helping to better visualize the plane between the gland and the subcutaneous layer, especially in areas difficult to access [1]. We look forward to applying this manoeuvre to our next challenging cases. However, an endoscope can be too bulky for this procedure, hindering a minimal-incision approach for the correction of gynecomastia.

Again, we would like to express our appreciation to the authors for their suggestions and pertinent comments on our article. We all agree that both our reports will help stimulate interest in developing new techniques with minimal incisions, aiming to reduce the complication rate and morbidity in patients undergoing surgical correction of gynecomastia.

Notes

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Reference

1. Tarallo M, Di Taranto G, Fallico N, et al. The round-the-clock technique for correction of gynecomastia. *Arch Plast Surg* 2019;46:221-7.