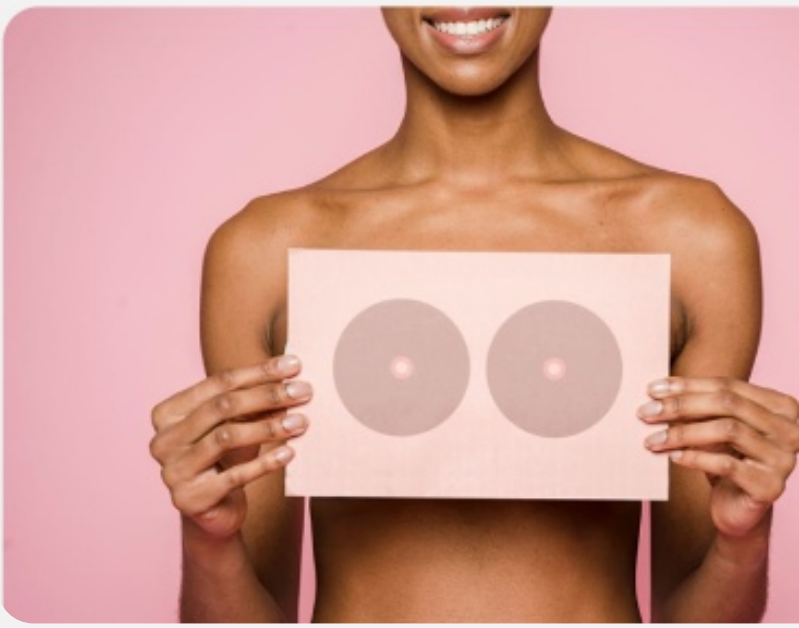
Philip Turton

Information Sheet for

Patients Undergoing Bilateral Breast Augmentation (BBA)



Mr E. P. L. Turton MBChB FRCSEd FRCS (Gen Surg) MD (Hons)
Consultant Specialist Breast Surgeon — Specialising in Oncoplastic and Cosmetic Breast Surgery
cosmeticbreastsurgeon.co.uk

Introduction

The size and shape of the breasts can have an important influence on how a woman feels about her body, her femininity and her overall confidence. Some women have always felt that their breasts are too small or out of proportion with the rest of their figure. Others become unhappy with changes that develop following pregnancy, breastfeeding, weight loss or ageing. Although clothing and padded bras can create the appearance of greater breast volume, they cannot alter the natural appearance of the breasts when undressed.

Breast augmentation, also known as augmentation mammoplasty or breast enlargement, is an established surgical procedure that increases or restores breast volume using implants. For appropriately selected women with realistic expectations, it can improve body confidence and satisfaction with breast appearance. However, the decision to have surgery is highly personal, and the potential benefits must always be considered alongside the limitations, recovery, long-term implications and possible complications.

Who chooses to have breast augmentation?

Women seek breast augmentation for a variety of reasons. Some have naturally small or underdeveloped breasts and feel that their breast size is out of proportion with their frame. They may wish to achieve a fuller shape, improve balance with the rest of their body or feel more confident in and out of clothing. Other women were previously satisfied with their breast volume but have noticed a loss of fullness following pregnancy, breastfeeding, weight loss or ageing. The breasts may appear smaller or deflated, particularly in the upper part, and the skin may have become looser. In some women, the lower breast may begin to overhang the natural crease beneath it.

Breast augmentation can restore volume and improve breast shape, but it cannot reliably correct significant drooping or substantially raise a low nipple position. Where loose skin or breast droop is more pronounced, a breast uplift (mastopexy) may need to be considered. This may be performed instead of an augmentation, combined with an augmentation in a single operation (mastopexy-augmentation), or undertaken as the first part of a planned two-stage procedure. With the two-stage approach, the breast uplift is performed first and the augmentation approximately six months later, once the breasts have healed and settled. The most appropriate approach will depend on the woman's anatomy, skin and breast-tissue quality, and desired outcome. The procedures and associated costs differ and will be explained during the consultation.

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How do I go about finding more information on breast augmentation?

Unfortunately, unless there is a significant underlying medical condition which has led to a deformity of the breast or a post-operative deformity that requires correction it is not possible to obtain augmentation mammoplasty on the NHS except in the most exceptional circumstances. There are numerous sources of information about breast augmentation, including Mr Turton's website, implant manufacturers' information, books, magazines and material published online. The quality of these sources varies, and they should be complemented by a detailed consultation with the specialist experienced breast surgeon who will perform your operation.

It is possible for women to approach their surgeon directly through the local private hospitals. Please note that it is considered good medical practice for the surgeon to keep the patient's general practitioner informed of any consultations and medical interventions that subsequently occur, and we will routinely write to your GP. Mr Turton has prepared this information sheet to support your consultations, help you understand the proposed surgery and contribute to the informed-consent process. It should be read carefully alongside the related information on his website. It is not intended to describe every possible outcome or complication and does not replace the individual discussion with Mr Turton. You will have the opportunity to ask questions before deciding whether to proceed.

How do I select a surgeon?

Choosing the right surgeon is one of the most important decisions you will make. Breast augmentation should be performed by a surgeon who is on the General Medical Council's Specialist Register, has completed recognised specialist surgical training and has substantial, continuing experience in cosmetic breast surgery. You should establish how frequently the surgeon performs breast augmentation and whether breast surgery forms a major part of their clinical practice, rather than being one of many unrelated cosmetic procedures they undertake.

Relevant professional memberships may include the Association of Breast Surgery (ABS) or the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS). Royal College of Surgeons of England Cosmetic Surgery Board Certification provides additional evidence that a surgeon has met recognised professional standards in a specified area of cosmetic surgery.

You may also wish to consider the surgeon's NHS background, breadth and length of experience, and independently submitted patient reviews. Reviews can provide useful insight into other patients' experiences but should be considered alongside formal qualifications,

specialist registration and relevant surgical experience. The hospital or clinic should be registered with the Care Quality Commission. You should also establish who will perform your operation, who will provide your follow-up care and how you can obtain advice if a concern arises after surgery.

There are practical advantages to choosing an established local specialist, particularly for continuity of care, postoperative review and access to advice. Mr Turton personally undertakes his patients' consultations, surgery and follow-up care.

Mr Turton completed his specialist training in general surgery before undertaking advanced subspecialist training in breast, oncoplastic breast and aesthetic breast surgery. He was continuously employed as a consultant specialist reconstructive and oncoplastic breast surgeon at Leeds Teaching Hospitals NHS Trust from 2004 to 2024. His NHS work included breast augmentation, breast reduction and mastopexy for congenital and developmental breast conditions, breast reconstruction and procedures to correct breast asymmetry.

He has also practised privately in cosmetic breast surgery since 2004. His private practice encompasses breast augmentation, breast reduction, mastopexy, correction of breast asymmetry, tuberous breast deformity and nipple inversion, breast reconstruction, breast liposuction and revision breast surgery. Over more than two decades of consultant practice devoted to breast surgery, he has performed many thousands of breast operations.

Mr Turton is a full member of the Association of Breast Surgery and has served on its Clinical Practice and Standards Committee and Aesthetic Surgery Committee. He was the first UK breast surgeon to obtain Royal College of Surgeons of England Cosmetic Surgery Board Certification in cosmetic breast surgery. This combination of specialist qualifications, extensive breast-specific experience and long-established local practice enables him to offer carefully considered advice, surgery tailored to each patient's anatomy and objectives, and personal continuity of care throughout treatment.

Further information about Mr Turton's experience and patient feedback is available on his website and at iWantGreatCare (www.iwantgreatcare.org/doctors/mr-philip-turton).

Pre-operative evaluation

Your reasons for considering surgery:

During your consultation, Mr Turton will ask why you are considering breast augmentation, how long you have been thinking about it and what you hope the operation will achieve. Many women wish to feel better proportioned, improve how their clothes fit or restore breast volume lost following pregnancy, breastfeeding or weight loss.

You will be asked about the breast size and shape you would prefer and, where relevant, how your breasts changed during pregnancy. Bra cup sizes are not standardised between manufacturers, so it is not possible to guarantee a particular cup size after surgery. However, Mr Turton will discuss the likely range of outcomes and help you select an implant that is appropriate for your anatomy and objectives.

The aim is to balance your preferred appearance with what can be achieved safely and realistically. The dimensions of your chest, the amount and quality of your breast tissue, skin elasticity, nipple position and existing breast shape all influence the implants that are suitable and the result that can be achieved. If you have previously found larger breasts uncomfortable—for example, during pregnancy—it is important to mention this when considering whether augmentation and the proposed implant size will be right for you.

Your health and medical history:

Please provide full and accurate details of your physical and mental health, previous operations, and any medical conditions or symptoms that have not yet been diagnosed. This should include any previous or current mental health condition, psychological treatment or related medication. Please also tell us about any previous or current use of medicines for weight loss or diabetes, including tablets or injections, when you last used them and the dose taken.

We need to know about all prescribed and non-prescribed medicines, vitamins, supplements and herbal preparations, as some may need to be adjusted before or around the time of surgery. Please tell us about any allergies or previous reactions to medicines, dressings, adhesives, latex or food.

It is particularly important to disclose any personal or family history of autoimmune or inflammatory disorders. These may include rheumatoid arthritis, thyroid disease, type 1 diabetes, coeliac disease, vitiligo, Sjögren's syndrome, fibromyalgia, chronic fatigue syndrome, polymyalgia and inflammatory bowel disease. Relevant conditions may require further assessment or discussion before surgery.

You must tell us if you currently smoke or have smoked previously, including the use of e-cigarettes, vaping products, nicotine-replacement products or any other source of nicotine. Please also provide details of any significant family history of cancer, particularly breast or ovarian cancer, including which relatives were affected and their approximate ages at diagnosis.

Breast examination and measurements:

Mr Turton will perform a full examination after discussing your reasons for surgery and the appearance you hope to achieve. This will include checking for any palpable breast lumps or other findings that may require further investigation. Detailed measurements will be taken to

assess your chest dimensions, breast volume, skin and tissue quality, nipple position, breast crease and the relationship between the two breasts.

Natural breast asymmetry:

No woman's breasts are exact mirror images. Some degree of asymmetry is normal and is present in almost everyone, although many women do not notice it until their breasts are examined closely or viewed in clinical photographs.

Before surgery, one breast may be larger, smaller, wider, narrower, fuller or more drooped than the other. The nipples may differ in height, direction, size or shape and may not sit exactly level. One breast may lie higher or lower on the chest, and the inframammary fold - the natural crease beneath the breast – is commonly higher on one side. Differences in the chest wall, ribs, shoulders, spine or posture can also affect how the breasts sit and appear.

Breast augmentation does not remove these natural differences. Pre-existing asymmetries will usually remain after surgery and can sometimes become more noticeable when the breasts are enlarged. For example, nipples that are at different heights before surgery will not automatically become level, and breasts with different shapes will not become perfect mirror images. Differences in the position of the inframammary folds may also remain.

A straightforward breast augmentation can sometimes reduce the appearance of a difference in breast volume, for example by using implants of different sizes, but it cannot reliably correct every difference in breast shape, nipple position, chest-wall anatomy or breast-crease level. Attempting to improve a more marked asymmetry may require different implants, adjustment of the breast pockets, fat transfer, an uplift or another procedure. Even with additional surgery, perfect symmetry cannot be achieved and should not be expected.

Mr Turton will identify and discuss any significant asymmetry during your consultation and, where helpful, demonstrate it using a mirror or clinical photographs. It is important that you understand your starting anatomy and have realistic expectations of what surgery can achieve. Many women prefer to accept a degree of natural asymmetry rather than undergo more extensive surgery, additional scarring and greater expense.

If asymmetry is a particular concern for you, please raise it during your consultation. Mr Turton can explain whether any improvement is realistically possible, what additional procedures might be required and what limitations would remain. Breast augmentation can improve volume and proportion, but it will not create perfectly identical breasts, perfectly level nipples or a particular cleavage unless the underlying anatomy already permits this.

Specific considerations

Ptosis – ptosis (sagging) is the medical term for drooping of the breast. It occurs when the breast tissue and nipple descend on the chest, particularly when the nipple lies at or below the inframammary fold - the natural crease beneath the breast. The degree of ptosis varies considerably. In more marked cases, the nipples may point downwards.

Breast implants add volume but do not lift the breast or reliably raise the nipple. Augmentation alone may improve the appearance of very mild drooping or upper-breast emptiness, but it cannot correct more significant ptosis. Attempting to fill substantially loose or drooping breasts with larger implants can produce an unnatural or excessively heavy appearance and may contribute to further stretching over time.

If you wish to raise the nipples or remove loose skin, a breast uplift (mastopexy) may be required. In selected women, an uplift and augmentation can be performed during the same operation. However, the combined procedure is more complex, costs more and carries additional potential complications, including problems with healing, scarring, nipple position, breast shape and implant position. For some women, it is preferable to perform the uplift first and consider augmentation approximately six months later, once the breasts have healed and settled.

A limited uplift using an incision around the areola may provide approximately 1–2 cm of nipple elevation in carefully selected patients. Greater degrees of ptosis usually require additional incisions and therefore additional scars. Depending on the technique required, these may extend vertically down from the areola towards the breast crease and sometimes full length along the crease itself. Examples of mastopexy and breast-reduction scars can be seen on Mr Turton's website.

Some women prefer to accept a degree of looseness or drooping and proceed with augmentation alone to restore breast volume. This can provide good fullness and projection in a bra, while the breasts and nipples may retain a more downward position when the bra is removed. This can be an entirely reasonable choice, provided that the likely appearance and limitations are understood. The objective is to achieve an outcome that suits the individual woman - not to impose a preconceived ideal of breast shape.

Even if you do not have ptosis before augmentation, breast droop can develop later. It may affect both breasts differently and can therefore cause or increase asymmetry. A pre-existing difference in nipple height or direction may also become more noticeable with time. Pregnancy, breastfeeding, weight changes, hormonal changes, ageing, thinning or stretching of the breast tissues, capsular contracture and the weight of the implants can all influence how the breasts change.

These natural changes also occur in women without implants, but they may be more apparent following augmentation. Future treatment may involve removing or replacing the

implants, performing a mastopexy, or combining these procedures. In some circumstances, it may be preferable to remove the implants and perform an uplift without replacing them. Alternatively, new implants may be considered after the breasts have healed, usually following an interval of approximately six months. Permanent removal of the implants may therefore be the most appropriate option for some women in the future.

Implant size

Your preferred breast size and shape are central to the consultation. Looking at before-and-after photographs on Mr Turton's website and Instagram (@turtonphilip) can help you identify outcomes that appeal to you. You may wish to save or print a small selection of photographs to discuss with him. These images are useful for communicating your preferences, although another patient's result cannot be reproduced exactly because every woman's starting anatomy and tissues are different.

Implant volume is measured in millilitres (ml), but the volume alone does not reliably predict the final bra cup size. A commonly quoted estimate is that approximately 125–150 ml produces an increase of around one cup size, but this relationship is too imprecise to guide implant selection. Bra sizing varies considerably between manufacturers, and the effect of a particular implant depends on the woman's chest dimensions, existing breast volume and tissue characteristics. A particular cup size therefore cannot be guaranteed.

Mr Turton uses a biodimensional assessment to identify implants that fit your body and are in proportion with your frame. This involves assessing and measuring:

the width, shape and symmetry of your chest wall;

the dimensions and existing volume of your breasts;

the thickness and coverage of your breast tissue;

the elasticity and quality of your skin and breast tissue;

any looseness or stretching of the breast skin;

changes caused by pregnancy, breastfeeding or weight loss; and

your overall starting breast shape and nipple position.

These findings are considered alongside the appearance you hope to achieve. They help determine the appropriate implant width, volume, projection and shape, as well as whether the implant is best placed above, partly beneath or beneath the pectoral muscle. Selecting an implant that is too wide, heavy or large for the available tissues can produce an unnatural

appearance and increase the likelihood of stretching, implant visibility, rippling, displacement and further breast droop.

Implants are available in different widths and profiles. The profile describes how far an implant projects forwards in relation to its width. Moderate- and full-profile round implants can produce a natural appearance when they are correctly matched to the patient's chest and tissues. Higher-profile implants provide greater forward projection for a given width, while extra-high-profile implants can create a more prominent or deliberately augmented appearance when this is desired and anatomically suitable. The final upper-breast fullness is influenced not only by implant profile, but also by implant volume, placement and the amount and distribution of the patient's existing breast tissue.

Anatomically shaped implants have a tapered contour, with less fullness at the top and more volume in the lower part. They can be helpful in selected women, including some who are very slim or have little existing breast tissue, but they are not suitable or necessary for everyone. For some women they are too flat at the top or the risk or rotation is a factor to avoid them. Mr Turton will explain the relevant advantages, limitations and potential complications of the implant options appropriate for you.

Crisalix three-dimensional imaging may be used after the biodimensional assessment and initial implant options have been identified. It can simulate how different implant sizes and profiles might look on a three-dimensional image of your body and can be helpful when discussing your preferences. The simulation is a visual guide rather than a prediction or guarantee of the final result. Healing, tissue behaviour, implant settling and natural differences between the breasts will all influence the actual postoperative appearance.

Implant type

Breast implants have an outer shell made from silicone elastomer. Most implants used for cosmetic breast augmentation in the UK are filled with cohesive silicone gel. Saline-filled implants are also available, but they tend to feel less natural and may be more prone to visible rippling or folding. Mr Turton generally prefers modern implants containing highly cohesive silicone gel because they retain their shape while providing a natural appearance and feel when appropriately selected and positioned. Implants are available in both round and anatomically shaped - or teardrop - designs. Round implants are available in a very wide range of widths, projections and gel characteristics and can produce either a very natural or a more noticeably augmented appearance. Anatomical implants place proportionately more volume in the lower part of the breast and may be useful for particular breast shapes or in women with very little existing breast tissue. However, they can appear too flat in the upper breast for some women and may produce a visible change in shape if they rotate.

The outer surface of an implant may be smooth, textured or coated with micropolyurethane foam. The surface can influence how the implant interacts with the surrounding tissues, its

stability within the breast pocket and the likelihood of particular complications. Micropolyurethane foam-coated implants are designed to encourage close adherence between the implant and surrounding tissues. They can be particularly helpful when implant stability is important, including in selected revision procedures or when reducing the likelihood of anatomical implant rotation. They have also been associated with a lower incidence of capsular contracture in some clinical settings. However, they require specific surgical experience and have their own limitations and safety considerations.

Mr Turton has extensive experience with implants from different manufacturers and with the full range of round and anatomically shaped devices. He is also experienced in selecting the most appropriate implant surface and positioning the implant correctly for the individual patient.

There is no single implant that is best for every woman. The choice will depend on your chest and breast dimensions, existing breast tissue, skin quality, desired appearance, implant position and the relative advantages and potential complications of each device. Mr Turton will explain the options that are appropriate for your circumstances, including the reasons for his recommendation, before an implant is selected. Relevant implant-safety issues, including those associated with different implant surfaces, are explained later in this information sheet and will also be discussed during your consultations.

Positioning of the implant

Breast implants may be placed above the pectoral muscle or partly beneath it. The most appropriate position depends on the thickness and quality of your breast tissues, your existing breast shape, the implant selected and the appearance you wish to achieve.

Tissue-preserving augmentation:

Where a woman has adequate natural breast-tissue coverage, wishes to have a relatively modest implant and is suitable for placement above the muscle, Mr Turton may recommend a tissue-preserving augmentation. This is not a particular implant, branded system or single fixed technique. It is a surgical approach based on careful patient selection, appropriate implant choice and precise surgery, with the aim of preserving normal anatomy wherever possible. The implant is placed in a carefully created pocket above the pectoral muscle, directly beneath the breast tissue (subglandular). The pectoral muscle is left undisturbed and the stronger peripheral attachments that define the natural breast footprint are preserved wherever possible. This approach reflects a simple principle: Preserve what does not need to be disturbed. Change only what needs to be changed. Placement above the muscle can allow the implant to move naturally with the breast, avoid implant movement caused by contraction of the pectoral muscle and provide a less painful, more straightforward recovery. It may also fill a mildly loose breast envelope more effectively and can help maintain cleavage where the patient's natural anatomy permits it.

However, adequate breast-tissue thickness is essential. In a woman with thin tissues, an implant placed above the muscle may be easier to see or feel, particularly around its upper edge, and rippling may become visible when leaning forwards. The likelihood of capsular contracture may also be influenced by the implant surface and its position. Tissue-preserving augmentation is therefore suitable only when the patient's anatomy, implant dimensions and desired result allow it.

Dual-plane or subpectoral placement: When there is insufficient breast tissue to provide reliable upper implant coverage, Mr Turton will usually recommend placing the upper part of the implant beneath the pectoral muscle. This is commonly called a dual-plane or partial subpectoral augmentation. The muscle provides additional coverage over the upper part of the implant, softening the transition from the upper chest to the breast and making the implant edge and rippling less visible. Subpectoral placement may also reduce the likelihood of capsular contracture in some circumstances and is generally Mr Turton's preferred position when a smooth-surfaced implant is selected for a woman with limited tissue coverage. The disadvantages are that the operation is usually more uncomfortable initially and recovery may take longer. The muscle can flatten or displace the implant temporarily when it is contracted forcefully, particularly during weight training or exercises involving the chest. This implant movement on muscle contraction is a normal consequence of dual-plane placement, but it can sometimes be noticeable. Subpectoral placement may also flatten the upper breast, limit cleavage or fill a loose breast envelope less effectively in some women.

Implant position and breast screening:

Breast implants obscure some breast tissue during mammography, regardless of whether they are positioned above or beneath the muscle. Subpectoral placement may make it easier to displace the implant during specialised mammographic views, allowing more of the breast tissue to be examined. Mammography can nevertheless be less sensitive in women with implants. You should always tell the radiographer that you have breast implants so that the appropriate implant-displacement views can be performed.

Implant surface and position:

Macrotextured implants were widely used in the UK for many years because tissue adherence helped limit implant movement and rotation and could reduce capsular contracture in certain positions. Their use has declined following recognition of the uncommon association between textured implant surfaces - particularly more heavily textured devices - and breast implant-associated anaplastic large-cell lymphoma (BIA-ALCL).

Smooth, microtextured and micropolyurethane foam-coated implants each have different characteristics. Smooth implants do not adhere to the tissues in the same way and can move more freely within the pocket. Microtextured and micropolyurethane foam-coated implants may provide greater stability and may be advantageous when placing an implant above the muscle or when controlling rotation is particularly important. However, implant-surface

selection must also take account of the differing safety considerations, including BIA-ALCL, which is discussed fully later in this information sheet. No single implant position or surface is best for every woman. Mr Turton will assess your tissue thickness, breast and chest dimensions, skin quality, degree of looseness and desired appearance before recommending the most appropriate combination. He will explain the particular advantages, limitations and potential cosmetic issues of the options suitable for you.

The operation

Smoking, vaping and nicotine: You must not smoke, vape or use nicotine-containing products for at least six weeks before and six weeks after surgery. Nicotine reduces blood flow to healing tissues and smoking or vaping increases the likelihood of wound-healing problems, infection and poor scarring. Stopping permanently will provide the greatest benefit to both your surgical recovery and your general health.

Anaesthetic and surgical approach:

Breast augmentation is performed under a general anaesthetic. In Mr Turton's practice, the anaesthetic is always administered by an experienced consultant anaesthetist.

There are several possible incisions through which a breast implant can be inserted. Mr Turton usually places the incision within or immediately next to the inframammary fold - the natural crease beneath the breast. This approach provides direct access to the implant pocket, allows precise control of the breast crease and avoids making an incision through the nipple or armpit. The resulting scar is normally concealed beneath the breast. If a different approach is appropriate for you, Mr Turton will explain the reasons for this before surgery. Mr Turton uses a meticulous surgical technique refined through many years of specialist breast practice. Careful dissection, strict sterile precautions, precise implant-pocket creation and minimal handling of the implant are used to optimise the cosmetic result and reduce the likelihood of complications. The incision is closed using three internal layers of dissolvable sutures, so there are normally no external stitches to remove. The deepest layer provides prolonged support and is designed to dissolve gradually over approximately 12 months. A fine cosmetic suture is placed immediately beneath the skin surface to help the scar heal as neatly as possible.

Dressings and initial support:

At the end of the operation, the incision will be covered with white adhesive strips called steri-strips and a water-resistant dressing. The dressing protects the wound but is not completely waterproof. Mr Turton therefore recommends shallow baths rather than showers for the first one to two weeks, keeping the dressings dry. A soft elasticated support called Tubigrip will be placed over the breasts at the end of the operation. This means that a sports bra is not usually required during the first week and avoids discomfort or pressure from an

incorrectly fitting bra. A stabilising band may also be applied when additional control of the implant position is required. The Tubigrip and any stabilising band should remain in place, including during a shallow bath, and must be kept dry. They should feel supportive but not excessively tight. The Tubigrip is often applied as a double layer for the first night. It is usually reduced to a single layer the following morning, and its lower edge may be trimmed to make it more comfortable.

After the operation:

An overnight hospital stay is normally recommended. Mr Turton considers this the safest and most reassuring approach, as it allows you to recover from the anaesthetic with appropriate nursing observation and support. Antibiotics are given at the time of surgery and are normally continued for three days afterwards. After the first postoperative week, the hospital will usually provide an appropriate post-surgical support bra. Please ask the breast care nurse about its fitting and use.

Returning home

Pain relief and early movement: You will normally need regular pain relief for approximately the first four days after breast augmentation. A commonly used combination is paracetamol and ibuprofen, taken together at breakfast, lunchtime and evening, before reducing them as your discomfort improves. You must follow the doses and instructions provided by the hospital, and you should only take ibuprofen if it is suitable for you.

For the first seven days, avoid stretching your arms and try to keep your elbows reasonably close to your sides. Do not repeatedly raise your arms above shoulder height or undertake repetitive household tasks such as vacuuming, unloading the dishwasher or making beds. Regular gentle walking is strongly encouraged during the first two weeks, with the distance increased gradually as you become more comfortable. Some patients can return to driving before the end of the first two weeks, but only when it is entirely comfortable and safe to do so. You must be able to wear a seat belt, control the vehicle normally, look over both shoulders and perform an emergency stop without pain or hesitation. You must not drive while taking medication that could impair your reactions, and you should comply with any requirements imposed by your motor insurer.

Follow-up appointments and support bras:

You will normally be reviewed in the dressing clinic approximately one week after surgery. At this stage, you can usually begin wearing a post-surgical or supportive sports bra. The breast care nurse can advise you about suitable garments, and will usually provide one. We recommend using the Lipoelastic “PI Super” and “PI Elite” bras. These are available online, and the discount code TURTON will usually provide a 10% reduction when purchasing any from the manufacturer.

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A second review will usually take place in the outpatient department approximately two weeks after surgery. If healing is progressing normally, you can generally begin wearing an underwired bra at around six to eight weeks. You may choose to continue wearing a supportive sports bra at night, particularly if your breasts are heavier, as regular support may help limit stretching and breast droop over time.

Returning to exercise and other activities:

If your recovery is uncomplicated, most normal activities and light exercise can usually be resumed gradually from around six weeks. Strenuous exercise, heavy lifting and repeated forceful use of the chest muscles should be reintroduced progressively. A somewhat longer period of restriction is usually advised when anatomically shaped implants have been used, to reduce the possibility of implant rotation while the tissues are healing around the implant. Mr Turton and the breast care team will advise you when it is appropriate to resume particular forms of exercise. Any sexual or other physical contact involving the breasts should be avoided during the early healing period and should remain gentle when resumed. Forceful pressure or manipulation may cause pain and could interfere with healing or implant position.

Swelling and implant settling:

Most obvious swelling settles within approximately three weeks. However, it can take six to eight weeks - and occasionally longer - for swelling to resolve after subpectoral or dual-plane placement and for the implants to begin settling into their final position. The two breasts may settle at different rates, so some temporary difference between them is common during the early stages of recovery.

Caring for your scars:

Do not poke, pick or scratch the scars, and do not attempt to pull out any visible suture material. Interfering with the healing incision can cause inflammation, encourage a dissolvable suture end to protrude and introduce infection. A serious infection extending to the implant could require its removal. If a suture end becomes visible, or a scar becomes increasingly red, tender, swollen or discharges fluid, please contact the breast care team so that it can be assessed. Once the wounds are fully closed and healed - usually from approximately two weeks - silicone scar gel may be helpful, particularly if you have a tendency to develop thickened or raised scars. A product such as Lipoelastic scar gel can be applied twice daily and continued for up to 12 months to support optimal scar maturation.

Exposure of a new scar to excessive sunlight or ultraviolet light increases the likelihood of lasting pigmentation. Avoid tanning beds and keep the scars covered from direct sunlight until they have matured and faded to a pale colour. This commonly takes 6–12 months but can occasionally take up to two years. Once the wounds have healed, use a high-factor broad-spectrum sunscreen whenever the scars may be exposed.

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Implant massage:

Routine implant massage is neither required nor recommended in Mr Turton's practice. Massage was previously advised for some smooth-shelled saline implants, but it is not appropriate for the implants and surgical techniques currently used and may disturb the healing implant pocket. Do not massage or deliberately manipulate your implants unless Mr Turton has specifically advised you to do so.

Special considerations and possible complications

Pregnancy should preferably be avoided for at least six months after breast augmentation. This allows the breasts, scars and implant pockets time to heal and settle. Pregnancy and breastfeeding can subsequently alter breast volume, skin elasticity and breast shape and may change the cosmetic result of the augmentation.

Most women remain physically able to produce milk after breast augmentation, and many breastfeed successfully following a subsequent pregnancy. However, a small proportion may be unable to breastfeed fully or may produce a reduced volume of milk. It is important to recognise that some of these women would have experienced difficulty breastfeeding even if they had not undergone breast surgery.

Some antibiotics, or vomiting or diarrhoea associated with illness or medication, may reduce the reliability of oral contraception. If unsure, you should ask your doctor for contraceptive advice and use additional barrier contraception until advised. Where additional precautions are required, these should be continued until you have restarted and completed the advised period of uninterrupted pill-taking.

Blood clots:

Deep-vein thrombosis (DVT) is a blood clot, usually occurring in a leg. A clot can occasionally travel to the lungs, where it is known as a pulmonary embolism (PE). These complications are very uncommon following breast augmentation, particularly in otherwise healthy, mobile women without a personal or close family history of blood clots. Your individual risk will be estimated before surgery. Please disclose any previous DVT or PE, known clotting disorder, close family history of blood clots, recent prolonged immobility or other relevant medical condition. Preventive measures include intermittent pneumatic compression devices around the legs while you are under anaesthetic, anti-embolism stockings - usually worn for two weeks - and early, regular walking after surgery.

Haematoma:

A haematoma is a collection of blood within the breast pocket and is different from the more superficial bruising that commonly follows surgery. It can occur after any operation but affects fewer than 1% of patients undergoing breast augmentation under Mr Turton's care. A haematoma would usually manifest during the first 24 hours, most often within the first few hours after surgery. The affected breast may enlarge suddenly, become noticeably tighter and more uncomfortable than the other side, and be associated with light-headedness or feeling unwell. A very small haematoma can sometimes be observed and allowed to settle naturally. A larger haematoma will usually require a return to theatre, often on the same day, so that the collection can be removed and the implant pocket carefully checked.

During the early recovery period, follow the nursing team's instructions and keep your movements calm and gentle. Avoid unnecessary exertion, sudden forceful arm movements or repeatedly pushing yourself up from a chair or bed with your arms.

Infection:

Deep infection involving a breast implant is uncommon. A rate of approximately 2% has been quoted in national information, although reported figures vary according to the type of surgery and the patients included. In more than 2,000 implants placed for primary breast augmentation during over 22 years of consultant practice, Mr Turton has not had a deep infection resulting in implant loss.

Minor wound-healing problems are more common than deep implant infection, although they remain very uncommon in Mr Turton's primary augmentation practice. Redness, tenderness or discharge around the suture line may be treated as a possible superficial infection, even when there are no other symptoms. Mr Turton's estimated incidence of this is below 1%.

An infection involving the implant would usually cause increasing breast swelling, pain, redness or heat and may be associated with fever, shivering or feeling generally unwell. This requires urgent assessment and treatment. Antibiotics may be sufficient for a superficial infection, but an established deep infection around an implant usually requires the implant to be removed to allow the infection to settle. If one implant had to be removed, there would be a noticeable temporary asymmetry between the breasts. A replacement implant can usually be considered after the infection has fully resolved and the tissues have healed, but the implant may need to remain out for several months. A subsequent operation carries a greater possibility of recurrent infection than the original uncomplicated augmentation. Infection can also occur later, although this is extremely rare. Any significant infection elsewhere in the body should be treated appropriately. Avoiding smoking, vaping and nicotine is particularly important because these impair tissue healing and increase susceptibility to wound complications.

Breast implant-associated cancers

Breast implant-associated anaplastic large-cell lymphoma (BIA-ALCL): BIA-ALCL stands for breast implant-associated anaplastic large-cell lymphoma. It is an uncommon cancer of the immune system that develops in the fluid or scar-tissue capsule surrounding a breast implant. It is not breast cancer and does not arise within the breast tissue itself. The association between breast implants and this rare lymphoma was first identified by the US Food and Drug Administration (FDA) in 2011. Since then, regulatory agencies and specialist organisations throughout the world have collected and reviewed reported cases. The number of recorded cases has increased as awareness, recognition and reporting have improved, but BIA-ALCL remains uncommon.

According to the latest published MHRA figures, as of 31 December 2024 there had been 114 confirmed reports of BIA-ALCL following implant surgery undertaken in the UK and six reports following surgery outside the UK. The MHRA calculated a UK reporting rate of approximately 1 case for every 12,187 breast implants and tissue expanders sold.

This figure should not be interpreted as an individual woman's precise lifetime risk. It is calculated from confirmed reports and the number of devices sold rather than the number of women implanted, and not every device sold will necessarily have been used. The figures will continue to change as further implants are inserted, patients are followed for longer and additional cases are investigated or reported.

For context, approximately 1 in 7 women in the UK will develop conventional breast cancer during their lifetime. The MHRA BIA-ALCL figure is approximately 1 reported case per 12,000 implants or tissue expanders sold. These figures measure different things and cannot be compared directly, but they help illustrate that BIA-ALCL is rare.

Implant surface and BIA-ALCL:

BIA-ALCL has been associated predominantly with implants that have a textured surface. International evidence suggests that it occurs more frequently with more heavily textured - or macrotextured - devices than with less textured implants. Certain macrotextured implants were withdrawn from use after being associated with a disproportionately high number of cases.

Cases reported in women who had a smooth implant at the time of diagnosis have often involved incomplete implant records or previous exposure to a textured implant. Current evidence indicates that this (still rare) association is much stronger with textured than with smooth implants, but it is not possible to assign every woman or implant a precise individual risk.

Microtextured and micropolyurethane foam-coated implants have different surface characteristics from macrotextured devices, but they are still considered when discussing

implant-surface-related safety. The MHRA continues to monitor reports across implant manufacturers and surface types. Each surface has potential advantages and disadvantages, and these must be balanced against the possibility of other complications such as capsular contracture, implant movement, malposition, bottoming out or rotation.

The cause of BIA-ALCL has not been established. One previous theory was that bacterial biofilm on an implant surface or particulate irritation from the implant surface may cause prolonged inflammation, stimulating immune-system T-cells in a small number of susceptible patients. Implant texture, genetic susceptibility and an individual patient's immune response may all be relevant, but no single theory has yet been proven.

How BIA-ALCL presents:

BIA-ALCL most commonly presents as a new collection of fluid around an implant several years after surgery. This may produce a relatively rapid and usually painless enlargement of one breast. Less commonly, it may present as a lump in the breast or armpit, increasing firmness, pain or a change in breast shape.

Most late breast swelling and other changes in women with implants are caused by conditions other than BIA-ALCL, including capsular contracture, implant rupture, trauma, benign fluid collections or, very rarely, infection. Nevertheless, a new or unexplained change should be assessed rather than ignored. If you develop late swelling, a new breast or armpit lump, increasing firmness, persistent pain or an unexplained change in breast shape, you should contact your GP in the first instance. Your GP can arrange referral to an NHS breast clinic if investigation is required. Alternatively, you may arrange a private consultation with Mr Turton or another appropriately qualified breast specialist.

The UK diagnostic and treatment guidelines available on-line should be followed. Investigation may include an ultrasound scan and removal of some of the fluid surrounding the implant. The fluid must be sent for specific laboratory tests if BIA-ALCL is suspected; it cannot be diagnosed from the appearance of the fluid alone.

Treatment and outlook: In the UK, most cases are diagnosed at an early stage and are treated successfully by removing the implant and the complete surrounding capsule. Further treatment is often unnecessary when the disease is confined to the fluid or capsule surrounding the implant and has been completely removed. More advanced disease can form a mass or spread beyond the capsule and may require additional treatment from the specialist multidisciplinary cancer team. BIA-ALCL can be fatal, but this is rare, particularly when it is recognised and treated at an early stage. Awareness of the possible symptoms allows appropriate investigation without suggesting that every late breast change is likely to be lymphoma.

Other extremely rare cancers reported around breast implants:

The MHRA is also monitoring an extremely small number of reports of other cancers arising in the capsule around breast implants. These include breast implant capsule-associated squamous-cell carcinoma (BIA-SCC) and lymphomas other than BIA-ALCL. The FDA has additionally received reports of other very rare tumours, including sarcomas, in women with breast implants. These reports are much rarer than BIA-ALCL. At present, there is insufficient information to calculate their incidence, identify particular risk factors or determine whether one implant filling, surface or manufacturer carries a greater risk. Cases have been reported around both silicone- and saline-filled implants and around smooth and textured devices.

Possible presenting features overlap with those of BIA-ALCL and more common implant complications. They may include late swelling, a fluid collection, a new lump, pain, hardening or a change in breast shape. These symptoms do not usually indicate cancer, but they should be assessed appropriately. The MHRA does not recommend removing breast implants in patients without symptoms solely because of concern about these rare capsule-associated cancers.

Breast implants and conventional breast cancer:

Breast implants have not been shown to increase the incidence of conventional breast cancer. Women with implants should remain breast-aware, report new breast symptoms to their GP and attend routine NHS breast screening when invited. You must tell the breast-screening service that you have implants so that the appropriate mammographic technique can be used.

Because information and reporting figures continue to develop, the latest MHRA information should be consulted for updates:

MHRA information about BIA-ALCL and current UK figures:

https://www.gov.uk/guidance/breast-implants-and-anaplastic-large-cell-lymphoma-alcl

MHRA information about squamous-cell carcinoma and other lymphomas occurring in the breast-implant capsule:

https://www.gov.uk/government/publications/squamous-cell-carcinoma-scc-and-different-types-of-lymphomas-occurring-in-the-capsule-around-breast-implants

The safety of breast implants:

Many medical devices are implanted into the body, including artificial joints, heart valves, pacemakers, surgical meshes and breast implants. Most patients do not develop a generalised adverse reaction to the materials used in these devices. However, no implanted

medical device is entirely without risk, and some individuals may develop local or systemic symptoms following implantation.

Silicone breast implants have been used since the 1960s and have been implanted in millions of women worldwide. They are among the most extensively studied medical devices. Large scientific reviews, including the UK Independent Review Group report in 1998 and the US Institute of Medicine report in 1999, found no evidence that silicone breast implants caused breast cancer or a defined autoimmune or connective-tissue disease. Those reviews concluded that the principal established safety concerns were local complications such as capsular contracture, rupture, pain, infection, changes in appearance and the need for further surgery.

These reports remain historically important but do not represent the end of scientific investigation. They predated recognition of BIA-ALCL and other subsequently reported implant-associated conditions. Regulators, manufacturers and researchers continue to monitor breast-implant safety, and information may change as further evidence becomes available. Breast implants are not lifetime devices. Although many remain satisfactory for a considerable number of years, their lifespan cannot be predicted for an individual patient. The likelihood of rupture, capsular contracture, displacement, changes in breast appearance and further surgery generally increases with time. Anyone choosing breast implants should accept that additional assessment or expensive surgery may be required in the future.

Symptoms sometimes referred to as breast implant illness

Some women with breast implants report a collection of general symptoms that they believe may be related to their implants. “Breast implant illness” (BII) is a patient-led, non-medical umbrella term that has become widely used in the media and on social media; it is not currently recognised as a single formal medical diagnosis. Reported symptoms include persistent fatigue, difficulty with memory or concentration (“brain fog”), joint or muscle pain, muscle weakness, headaches, disturbed sleep, skin rashes, hair loss, anxiety, low mood, weight changes and a general deterioration in wellbeing.

These symptoms have been reported following both cosmetic augmentation and breast reconstruction, with silicone- and saline-filled implants, smooth and textured surfaces, and devices from different manufacturers. They may begin soon after implantation or many years later. The same symptoms are also commonly experienced by women who have never had breast implants, although the available evidence does not establish whether they occur with the same frequency. They may have a wide range of medical, hormonal, psychological or lifestyle causes. There is currently no agreed diagnostic test, set of diagnostic criteria or proven biological mechanism that establishes BII as a single medical condition or confirms that breast implants are the cause of an individual patient’s symptoms.

Mr E. P. L. Turton MBChB FRCSEd FRCS (Gen Surg) MD (Hons)
Consultant Specialist Breast Surgeon — Specialising in Oncoplastic and Cosmetic Breast Surgery
cosmeticbreastsurgeon.co.uk

Current evidence has not established that breast implants cause a specific autoimmune or connective-tissue disease. However, it cannot exclude the possibility that implants may contribute to systemic symptoms or an immune or inflammatory response in a susceptible minority of patients. The MHRA and FDA continue to collect reports and review emerging evidence. Furthermore, some women report improvement after their implants are removed, while others experience partial improvement, no change or worsening symptoms. It is not currently possible to predict who will benefit, and improvement cannot be guaranteed. Removal of the surrounding capsule is a more extensive operation with additional potential complications and is not automatically required because systemic symptoms have been reported.

Mr Turton has not personally encountered this pattern of unexplained systemic symptoms among his personal augmentation or reconstruction patient cohort during more than 22 years of consultant practice. Nevertheless, any patient reporting such symptoms would be taken seriously and should undergo appropriate medical assessment to investigate other possible causes. If symptoms remained troublesome, implant removal could be considered after discussing the uncertainties, surgical risks and likely cosmetic consequences.

Allergic and inflammatory reactions

A true allergic reaction to the materials within a breast implant is exceptionally rare and has not occurred in Mr Turton's practice. Please nevertheless disclose any known allergy or previous reaction to an implanted medical device, medicine, dressing, adhesive or latex.

Keeping the information in perspective

Most women undergoing breast augmentation do not develop systemic illness and report high levels of satisfaction with their breast appearance. Nevertheless, established local complications, rare implant-associated cancers, reported systemic symptoms and the possibility of currently unknown long-term effects must all form part of the decision to proceed.

No information sheet can guarantee that every future complication or newly recognised association is already known. Implant-safety evidence continues to evolve, and patients should consider the most recent information available at the time of their consultations and surgery.

Further information and future updates are available from the following regulatory sources:

MHRA information about symptoms sometimes referred to as breast implant illness:

https://www.gov.uk/guidance/symptoms-sometimes-referred-to-as-breast-implant-illness

Mr E. P. L. Turton MBChB FRCSEd FRCS (Gen Surg) MD (Hons)
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MHRA Cosmetic Breast Augmentation Risk Awareness Tool:

https://www.gov.uk/guidance/cosmetic-breast-augmentation-risk-awareness-tool

MHRA information about BIA-ALCL and current UK figures:

https://www.gov.uk/guidance/breast-implants-and-anaplastic-large-cell-lymphoma-alcl

US Food and Drug Administration information about breast-implant risks and complications:

https://www.fda.gov/medical-devices/breast-implants/risks-and-complications-breast-implants

Nipple and breast sensation

Changes in sensation can affect the nipple, the areola - the darker skin surrounding the nipple - or the skin of the breast, most commonly across its lower part. Sensation may be reduced, absent, increased or occasionally unpleasant. Some changes improve as the nerves recover, but Mr Turton estimates from his clinical experience that approximately 15% of patients undergoing primary breast augmentation will have some permanent alteration in sensation affecting one or both breasts. A sensory change is generally considered permanent if it has not recovered within approximately 12 months. Removing the implant at a later date would not normally restore sensation if the change resulted from permanent alteration or injury to a nerve. Nipple sensation can be important to sexual arousal and enjoyment. If this is particularly important to you, you should take the possibility of permanent reduction or loss of sensation into account when deciding whether breast augmentation is right for you.

Rippling

Breast implants are soft, flexible devices rather than solid structures. Their shells can therefore develop gentle waves or folds as the implant responds to gravity, pressure and the support provided by the surrounding tissues. If the covering of breast tissue, fat and skin is too thin to conceal these folds, rippling may become visible through the skin. Rippling is most commonly seen or felt along the inner or outer parts of the breast or across its lower part. It may be more noticeable when sitting upright, leaning forwards or bending down without a bra. Thin tissues, loose skin, loss of weight, larger implants and placement above the muscle can make it more apparent. With some textured implants, adherence between the implant and surrounding tissues may also contribute to visible surface irregularity.

Placement beneath the pectoral muscle provides additional coverage over the upper and inner parts of the implant and reduces the likelihood of visible rippling in these areas.

However, the muscle does not cover the whole implant, so rippling may still occur around its lower or outer portions. It is not always possible to prevent rippling completely, particularly in very slim women or when the natural tissues become thinner with age.

During your assessment, Mr Turton will measure your tissue thickness using callipers and a skin-and-tissue pinch test. This helps determine whether placement above the muscle will provide adequate implant coverage or whether dual-plane placement would be more appropriate.

Palpable implants (edges, knuckling, folds, kinks)

Even when an implant is not visible, part of its edge or shell may sometimes be felt beneath the breast tissues. This may feel like a definite step, ridge, fold, small knuckle or kink. Palpability is more likely in women with very little natural breast tissue, following weight loss or tissue thinning, and when an implant is placed above the muscle. It does not necessarily mean that the implant is damaged or ruptured.

Dual-plane or subpectoral placement can reduce the likelihood of feeling the upper and inner implant edges by providing additional muscle coverage. However, in athletic women, contraction of the pectoral muscle can cause temporary flattening or movement of the implant and breast.

Implant selection can also influence palpability and rippling. More highly filled round implants, including textured Silimed, GCA and some Mentor implants, and some more form-stable anatomical implants, may wrinkle or collapse a little less than softer gel implants. The trade-off is that a more highly filled or cohesive implant may feel firmer. Anatomically shaped implants have a gentler transition - or “take-off” - at their upper edge and can produce a subtle contour in a very slim or flat-chested woman. However, they generally provide less upper-breast and inner-cleavage fullness and carry the additional possibility of a visible shape change if the implant rotates.

These options may be particularly relevant when the tissue thickness measured by the pinch test is approximately 20 mm or less. Where relevant, Mr Turton will discuss the balance between softness, implant visibility, palpability, rippling, projection and the desired breast shape when recommending an implant.

Folds, knuckling or kinks can also develop or become more noticeable over time as the tissues thin, weight changes, the implant settles or capsular contracture develops. Complete prevention cannot be guaranteed. If a fold becomes prominent, painful or associated with a change in breast shape, it should be assessed to exclude implant damage or another complication.

Capsular contracture and removal of implants

The body naturally forms a layer of scar tissue, called a capsule, around every breast implant. A normal capsule is thin, soft and usually neither visible nor noticeable. Capsular contracture occurs when the capsule thickens or tightens (or both) around the implant. This can make the breast feel firmer and may alter its shape or position. The severity of capsular contracture is classified using the Baker grading system. Grade I describes a normally soft breast with a natural appearance and is not considered abnormal. Grade II describes a breast that feels slightly firm but still looks normal. In Grade III, the breast is firm and appears abnormal or distorted. In Grade IV, it is hard, distorted and painful. A mild degree of firmness may cause little concern and require no treatment. More advanced contracture can make the breast feel very hard, move the implant upwards, distort the breast and cause discomfort or pain.

Published rates vary considerably according to the length of follow-up, implant surface, implant position, surgical technique and whether mild or only clinically significant contracture is counted. Long-term implant studies commonly report capsular contracture in approximately 10–20% of women over 10 years, although the rate for an individual patient or implant cannot be predicted precisely. The likelihood continues to increase with time, and contracture can occur in one or both breasts. No medicine, supplement, massage programme or surgical technique can guarantee prevention. Treatments such as vitamin E and other antioxidants have been proposed, but there is insufficient reliable evidence that they prevent or reverse an established contracture. Do not take supplements for this purpose without Mr Turton's approval, as some can increase bleeding or interact with medicines.

Treatment of capsular contracture:

Treatment depends on the severity of the contracture, the symptoms, the appearance of the breast and the patient's wishes. A mild, comfortable contracture can often be observed without treatment. A significant, painful or cosmetically troublesome contracture usually requires further surgery, which is generally more complex and can be more expensive than the original augmentation. Surgery may involve removing part or all of the capsule, removing or replacing the implant, altering the implant pocket, or changing the implant type or position. Complete capsule removal is not automatically necessary or appropriate in every patient; the safest and most effective approach depends on the capsule's thickness and position and its relationship to the surrounding breast tissue, muscle and chest wall.

Capsular contracture can recur after revision surgery, even when the capsule has been removed and the implant replaced. If a significant contracture develops for a second time, Mr Turton will generally advise the patient to consider permanent removal rather than repeated implant replacement. This reflects the possibility that further revision surgery may again be

Mr E. P. L. Turton MBChB FRCSEd FRCS (Gen Surg) MD (Hons)
Consultant Specialist Breast Surgeon — Specialising in Oncoplastic and Cosmetic Breast Surgery
cosmeticbreastsurgeon.co.uk

followed by contracture and that implants may ultimately prove unsuitable for that individual patient.

After capsulectomy and implant replacement, the breast will not necessarily return to its original augmented appearance. Removal of the tight capsule creates a more spacious breast pocket, and the breast or replacement implant may appear softer, lower or less full, with more edge palpability. Further changes in shape, implant position or asymmetry are possible and reoccurrence is more common.

Permanent implant removal:

If breast implants are removed and not replaced, the breasts will lose the volume provided by the implants. They may appear flatter, emptier or more drooped than before the original augmentation. This is influenced by the size and weight of the implants, the duration of implantation, pregnancy, weight changes, ageing and the degree to which the skin and breast tissue have stretched or thinned.

When capsular contracture is accompanied by loose skin or breast droop, Mr Turton may recommend removing the implant and capsule and performing a mastopexy at the same operation. In other circumstances, it may be safer or more predictable to remove the implant first and allow the tissues to heal and settle before considering an uplift or another implant. If replacement remains appropriate, it can be reconsidered after approximately six months. Some patients will be best advised not to have another implant.

Micropolyurethane foam-coated implants:

Micropolyurethane foam-coated silicone implants have been associated with relatively low rates of capsular contracture in a number of clinical studies. Their surface encourages close adherence to the surrounding tissues, which can also reduce implant movement and rotation. They can therefore be useful in selected primary augmentations as well as complex revision procedures, particularly where implant stability or recurrent contracture is a concern. These implants require specific surgical experience. They adhere more firmly to the surrounding tissues, can be more difficult to insert or remove, and may require a longer incision. Revision surgery can consequently be more technically demanding.

Micropolyurethane foam is also considered a textured implant surface when assessing implant-associated safety. BIA-ALCL has been reported with polyurethane-coated implants, although it remains rare. Estimates from other countries cannot be applied directly to an individual UK patient because implant use, manufacturers, reporting systems and lengths of follow-up differ. The current MHRA data and the particular advantages and limitations of the proposed implant should therefore be considered when deciding whether its use is justified.

Mr Turton will only recommend a micropolyurethane foam-coated implant when he considers that its potential benefits in the particular circumstances outweigh its disadvantages. The alternative implant surfaces and positions will also be discussed.

Current UK BIA-ALCL figures, including the MHRA breakdown by implant surface, are available at:

https://www.gov.uk/guidance/breast-implants-and-anaplastic-large-cell-lymphoma-alcl

Rupture / Deflation / Replacement:

Breast implants are not lifetime devices, and no woman should assume that her first augmentation will last for the remainder of her life. In a 10-year study of Mentor silicone-gel implants used for primary breast augmentation, approximately 1 in 4 women underwent at least one further breast operation, and approximately 1 in 9 had an implant removed, with or without replacement. Further operations included patient-requested changes as well as treatment of complications. These figures relate to particular implants and patients within that study and cannot predict an individual woman's outcome, but they illustrate the importance of anticipating the possibility and future cost of additional surgery.

Saline implants and tissue expanders:

Saline-filled implants are rarely used by Mr Turton for cosmetic breast augmentation, although saline-filled tissue expanders may be used during some stages of breast reconstruction. If the shell of a saline implant or expander fails, the saline is harmlessly absorbed by the body. The breast may deflate gradually or, less commonly, lose its volume quite suddenly, making the problem readily apparent.

Silicone implant rupture:

The commonest cause of silicone implant rupture is gradual weakening of the elastomer shell as the implant ages. In FDA studies of several modern silicone-gel implants, approximately 7–12% had ruptured by 10 years - broadly around 1 in 10. The reported rate varies according to the implant model, whether it is calculated per patient or per implant, the proportion of women completing follow-up and the use of MRI to detect silent rupture. This figure therefore provides a general guide rather than a precise prediction for an individual patient or implant.

Rupture can also result from trauma, damage during surgery or another procedure, severe capsular contracture, repeated folding of the implant shell or, occasionally, no identifiable cause. Modern implants are more durable than many earlier designs, but no manufacturer can guarantee how long an individual implant will remain intact.

Modern implants contain highly cohesive silicone gel with a consistency more like a set jelly than a liquid. When the shell first develops a tear, the majority of the silicone will usually

remain contained within the scar-tissue capsule surrounding the implant. This is called an intracapsular rupture. Most ruptures remain intracapsular for a considerable time and may produce no change in the appearance or feel of the breast; they are therefore often described as “silent.”

A rupture may sometimes cause a change in breast size or shape, increasing firmness, a lump, swelling, aching, burning or discomfort. It may also contribute to capsular contracture or a collection of fluid around the implant. Any new fluid collection requires appropriate investigation because several implant-related conditions can produce a similar presentation.

If a rupture remains undetected or untreated for a prolonged period, silicone can pass into the surrounding capsule and tissues. It may then travel to lymph nodes, most commonly in the armpit, where it can produce enlargement or a lump. Complete removal of silicone that has migrated into surrounding tissues or lymph nodes may not be possible. This is why identifying and managing a rupture before extensive silicone migration occurs is preferable.

Gel bleed:

Gel bleed is different from rupture. It describes the passage of minute amounts of low-molecular-weight silicone through an intact implant shell. Modern implant shells are designed to minimise this, but they cannot prevent it completely. Silicone may gradually be taken up within the surrounding capsule and can contribute to local inflammation or capsular contracture in some patients.

Likelihood of rupture:

The likelihood of rupture increases as an implant ages. Revision surgery is generally more straightforward when an implant remains intact and there is no extensive capsular contracture or silicone migration. Nevertheless, replacing an intact implant is still an operation with its own recovery, costs and potential complications

Monitoring your implants:

Mr Turton recommends arranging a self-funded consultation and silicone-sequence MRI between eight and ten years after augmentation, even if the implants are causing no apparent problems. If the implants are retained, he recommends further review and imaging approximately every two years. Elective implant replacement may also be considered at or after this stage, depending on the imaging findings, implant age, breast appearance, symptoms and the patient’s preference.

This is Mr Turton’s clinical recommendation for monitoring the implants he places. Routine imaging of asymptomatic implants is not currently mandated as a national UK screening programme or guideline. Implant assessment and imaging are normally provided privately and must be funded by the patient. Costs vary between providers and will change over time.

Ultrasound can identify many implant ruptures and is often a useful initial investigation. A dedicated, non-contrast silicone-sequence MRI is more sensitive for detecting silent intracapsular rupture and is particularly helpful when an ultrasound result is uncertain. No imaging test is completely accurate: false-positive and false-negative results can occur, and the findings must be interpreted alongside the clinical assessment.

Changes in the natural breasts:

Breast implants do not prevent the natural breasts from changing. Pregnancy, breastfeeding, weight gain or loss, hormonal changes and ageing can cause loss of breast volume, thinning or stretching of the tissues and increasing breast droop. These changes can occur whether or not the implants remain intact and may eventually lead a patient to consider implant replacement, removal, an uplift or a combination of more costly procedures.

If you develop a new breast lump, unexplained swelling, pain, hardening or a change in breast shape, you should contact your GP for assessment and referral to the NHS rapid access breast clinic where appropriate. These symptoms may have causes unrelated to the implant and should not be assumed to represent rupture. A private consultation with Mr Turton or another appropriately qualified breast specialist can also be arranged.

Scarring and persistent pain:

Every operation produces a permanent scar. Following breast augmentation, the scar is usually positioned within or close to the natural crease beneath the breast, where it is normally well concealed. Scars are often pink, firm or slightly raised during the early stages of healing and then gradually soften and fade. Full scar maturation commonly takes 12 months and can occasionally take longer. A hypertrophic scar occurs when the scar becomes thicker, wider, redder or more raised than expected but remains within the boundaries of the original incision. This is different from overgranulation, which is an excessive growth of healing tissue within an incompletely healed wound. Both can usually be managed with appropriate wound or scar treatment. A keloid scar extends beyond the boundaries of the original incision and can become prominent, itchy or uncomfortable. Keloid formation following an incision beneath the breast is extremely rare, and Mr Turton has not encountered it in more than 22 years of performing breast augmentation. In his experience, more than 99% of augmentation scars become fine and fade very well, although no surgeon can guarantee the final appearance of an individual scar.

Temporary tightness, discomfort and altered sensation are expected during the early recovery period. Most patients find that their implants begin to feel like a natural part of their body by approximately six weeks, although complete settling and adaptation can take longer.

In Mr Turton’s experience, fewer than 1% of his primary breast-augmentation patients develop persistent, troublesome breast pain. Possible causes include deep scar tissue, capsular contracture, stretching or irritation of a sensory nerve, implant position or pressure

from the implant. Persistent or increasing pain should be assessed to identify its cause and whether any treatment is required. During more than 22 years of consultant practice, Mr Turton has not needed to remove implants following primary breast augmentation solely because of otherwise unexplained persistent pain.

Double bubble:

A double-bubble appearance is an uncommon cosmetic problem in which two visible curves or creases develop across the lower part of the breast. One is formed by the implant in its new position and the other by the breast's original inframammary fold. This can create a step, indentation or second bulge near the crease beneath the breast. It is more likely when there is pre-existing breast droop, a constricted or tuberous breast, a particularly strong or high inframammary fold, or a significant difference between the natural breast shape and the selected implant. In these circumstances, the dense tissue forming the original breast crease may fail to stretch and blend smoothly over the lower part of the implant. Mr Turton also considers the problem more likely in some predisposed breasts when an anatomically shaped implant is placed beneath the muscle.

A mild double-bubble appearance may improve as the tissues stretch and the implant settles over several months. If it remains noticeable or troublesome, revision surgery may be required. This can involve adjusting the implant pocket or breast crease, changing the implant or performing fat transfer, an uplift or another corrective procedure. Revision treatment is normally self-funded, may cost more than the original augmentation and cannot guarantee complete correction or prevent recurrence.

Granulomas:

A granuloma is a local inflammatory reaction in which the body forms a small area of firm tissue around foreign material. Silicone granulomas are uncommon but can occur following gel bleed, implant rupture or silicone migration. They may develop within the implant capsule, breast tissue or nearby lymph nodes and can sometimes be felt as a lump. Most breast lumps in women with implants are not caused by silicone and are unrelated to the augmentation. Nevertheless, any new or unexplained breast or armpit lump should be assessed promptly rather than assumed to be an implant problem. Your GP should normally be the first point of contact and can arrange an urgent referral to an NHS breast clinic when clinically appropriate. Further assessment may include examination, ultrasound, mammography, MRI or biopsy, depending on the findings.

Implant malposition and bottoming out:

Implant malposition means that an implant has moved away from its intended position. It may move too far towards the armpit (lateral and superior malposition), towards the centre of the chest (medial malposition), upwards or downwards. An anatomically shaped implant can rotate within the pocket, producing a visible change in breast shape.

An implant can also flip from front to back, known as anterior–posterior flipping. This can occur with either round or anatomically shaped implants and may make the breast appear flatter, unusually prominent or distorted because the back of the implant is facing forwards. Flipping is more likely when the implant is relatively mobile within an oversized or stretched pocket and can become more apparent as the surrounding tissues loosen over time. A flipped implant may sometimes be repositioned by manipulation, but recurrent or persistent flipping may require revision surgery.

Inferior malposition occurs when the implant descends below the intended inframammary fold - the natural crease beneath the breast. This is commonly called “bottoming out.” The lower part of the breast may appear excessively full, the nipple may appear unusually high on the breast, and the scar can move upwards onto the lower breast rather than remaining within the crease.

Malposition can occur when the breast tissues are naturally thin, loose or unable to provide sufficient long-term support. Previous pregnancy, weight loss, ageing, a weak or poorly defined breast crease, and stretching caused by the size or weight of the implant can all contribute. Selecting an implant that is too large, wide or heavy for the patient’s tissues increases the likelihood of displacement and bottoming out.

Implant surface may also influence stability. Smooth and some minimally textured or “nanotextured” implants do not adhere to the surrounding tissues in the same way as more textured or micropolyurethane foam-coated implants. They can therefore remain more mobile within the pocket and, in women with particularly loose or weak tissues, may be more likely to descend or move sideways. This does not mean that smooth or nanotextured implants will routinely bottom out: implant dimensions, tissue quality, pocket position, surgical technique and postoperative support are all important.

Accurate pocket creation and control of the inframammary fold reduce the likelihood of early malposition but cannot eliminate it. This is one reason why Mr Turton normally uses an incision in the crease beneath the breast, which provides direct access and allows precise assessment of the implant pocket and breast fold. Malposition can nevertheless develop gradually as gravity, implant weight and natural tissue ageing stretch the breast over time.

Micropolyurethane foam-coated implants encourage close adherence to the surrounding tissues and may provide greater stability in selected patients, including some complex revision cases or when rotation of an anatomical implant is a particular concern. However, they are more difficult to insert through a small incision, can be more difficult to remove or reposition, and have specific implant-surface safety considerations, including BIA-ALCL. These are discussed in the relevant section of this information sheet.

A minor difference in implant position may be accepted without treatment. More noticeable malposition may require revision surgery to adjust or reinforce the implant pocket, reposition or replace the implant, change the implant plane, use a smaller implant, or combine these

measures with an uplift or fat transfer. Revision surgery is usually more complex and can be more expensive than the original augmentation. Correction cannot be guaranteed, particularly when the underlying tissues are thin or weak, and malposition can recur.

Subsequent breast investigations:

Women with breast implants can still undergo breast examination, mammography, ultrasound, MRI and breast biopsy. The doctor, radiographer or other healthcare professional must be told that implants are present so that the investigation can be planned and performed appropriately. Biopsies should be undertaken by an experienced clinician using suitable image guidance where required, to minimise the possibility of damaging the implant.

Breast implants obscure some breast tissue on a mammogram because X-rays cannot pass through the implant. Mammography can therefore be less sensitive for detecting small breast cancers that cannot yet be felt. Additional implant-displacement views - often called Eklund views - are used to ease the natural breast tissue forwards and improve visualisation. These views can usually be performed with implants above or beneath the muscle, although displacement and imaging may be easier when the implant is subpectoral. Mammography examines the breast tissue and should never be relied upon to assess whether an implant is intact.

Having breast implants does not alter your eligibility for routine NHS breast screening. In England, women are normally invited for mammography every three years from the age of 50 until their 71st birthday; women aged 71 or over can contact their local screening service to request continued screening. Always tell the screening service that you have breast implants when arranging and attending an appointment.

Before augmentation, breast imaging may be recommended according to your age, breast symptoms, examination findings and personal or family history of breast cancer. Mr Turton can usually arrange a private screening mammogram for an asymptomatic woman over 40 who has not had recent appropriate breast imaging (please ask). Women with a significant family history or an identified genetic risk may require assessment through a specialist breast-risk or screening service.

Breast screening is intended for women without symptoms. If you develop a new lump, nipple change, unexplained swelling, persistent focal pain or another new breast symptom, do not wait for a routine screening appointment. Contact your GP, who can arrange assessment and referral to an NHS breast clinic where appropriate.

Current NHS information for women with breast implants is available at:

https://www.gov.uk/government/publications/breast-screening-breast-implant-guidelines/breast-implants-and-breast-screening

In conclusion

Breast augmentation is an established operation with high levels of patient satisfaction when it is performed for appropriate reasons, carefully planned and supported by realistic expectations. However, breast implants are Class III implantable medical devices, and augmentation surgery has limitations, possible complications and long-term financial implications.

Conventional breast cancer:

Current evidence does not show that breast implants increase the incidence of conventional breast cancer. Rare cancers arising in the capsule around an implant, including BIA-ALCL, BIA-SCC and other lymphomas, are separate conditions and have been explained earlier in this information sheet.

Implant lifespan:

Breast implants are not lifetime devices. FDA studies of several modern silicone-gel implants report rupture rates of approximately 7-12% by 10 years - broadly around 1 in 10 - although rates vary between implant models and studies. Published capsular contracture rates also vary, but figures of approximately 10 - 20% over 10 years are commonly reported.

Further surgery:

In one 10-year study of Mentor silicone-gel implants used for primary augmentation, approximately 1 in 4 women underwent at least one further breast operation and approximately 1 in 9 had an implant removed, with or without replacement. Further operations included patient-requested changes as well as treatment of complications. You should anticipate the possibility and future cost of implant investigation, revision, replacement or permanent removal.

BIA-ALCL:

BIA-ALCL is an uncommon lymphoma associated predominantly with textured implant surfaces. The latest published MHRA data, to 31 December 2024, give an overall UK reporting rate of approximately 1 case per 12,187 breast implants and tissue expanders sold. This is a reporting rate per device sold rather than an individual woman's lifetime risk, and the rate varies according to implant surface and other factors.

Systemic symptoms:

"Breast implant illness" (BII) is a non-medical, patient-led umbrella term for a variety of non-specific symptoms that some women attribute to their breast implants. It is not a recognised medical diagnosis, and there is no diagnostic test, agreed set of criteria or proven biological

mechanism. Current evidence has not established that breast implants cause these symptoms, which are also common in women without implants and may have many other explanations. Although some women report improvement after implant removal, this does not prove that the implants caused their symptoms, and removal cannot be expected or guaranteed to resolve them.

Changes with time:

The breasts and the cosmetic result will change with ageing, pregnancy, breastfeeding, hormonal change and fluctuations in weight. Implants can also stretch or thin the tissues. Further surgery may eventually be desired or required, but it is not possible to predict when this will be necessary for an individual patient.

Limits of current evidence: Clinical studies cannot identify every extremely rare complication or exclude conditions that have not yet been recognised. Information about breast implants continues to develop, and this sheet should be considered alongside the latest MHRA information and your individual discussions with Mr Turton.

Breast augmentation remains a suitable and worthwhile procedure for many appropriately selected women. The decision should be based on a clear understanding of the likely benefits, limitations, alternatives, recovery, possible complications and future costs. Please discuss any remaining questions or concerns with Mr Turton before deciding whether to proceed.

Important points to remember:

If you can easily feel your ribs beneath or beside your breasts, you are also likely to be able to feel part of an implant. Women who are slim or have little natural breast tissue are more likely to feel the implant edges or develop visible rippling. Dual-plane placement can provide additional coverage but cannot eliminate this possibility completely.

If the possibility of feeling an implant edge would be unacceptable to you, breast augmentation may not be the right operation for you.

Larger implants place greater weight and pressure on the breast tissues. An implant that is too large or heavy for your anatomy is more likely to cause tissue stretching, thinning, rippling, malposition and breast droop over time. A smaller, appropriately proportioned implant is generally kinder to the tissues.

An augmented breast may look and feel very natural, but an implant cannot reproduce every characteristic of a natural breast. Pre-existing differences in breast size, shape, nipple height, nipple direction and breast-crease position will usually remain and may become more noticeable after augmentation.

It is essential to develop a realistic understanding of what surgery can achieve for your individual anatomy. Photographs and three-dimensional simulation can assist the discussion but cannot guarantee the final result.

Tell Mr Turton and the pre-assessment team about every prescribed and non-prescribed medicine you take, including weight-loss or diabetes injections, anticoagulants, antidepressants, steroids, hormonal treatments, vitamins, herbal remedies and other supplements. Some may need to be adjusted before surgery. Do not stop any prescribed medicine unless specifically advised to do so, and do not take supplements without prior approval because some can increase bleeding or interact with medicines.

If you have been diagnosed with body dysmorphic disorder, or have persistent and distressing concerns about a perceived defect in your appearance, please tell Mr Turton. Cosmetic surgery may not provide the improvement in wellbeing that you hope for and may need to be deferred or considered only after appropriate assessment and support.

Please read this information sheet carefully alongside the related information on Mr Turton's website and the relevant implant manufacturer's patient information. Raise any questions or matters that are particularly important to you during your consultations.

This information sheet has been prepared by Mr Turton to support your consultations and help you make an informed decision. It describes the principal issues relevant to breast augmentation but cannot cover every possible outcome or complication. It does not replace the individual discussion with Mr Turton, during which you will have the opportunity to ask questions before deciding whether to proceed.

Further information

MHRA Cosmetic Breast Augmentation Risk Awareness Tool:

https://www.gov.uk/guidance/cosmetic-breast-augmentation-risk-awareness-tool

MHRA information about BIA-ALCL and current UK figures:

https://www.gov.uk/guidance/breast-implants-and-anaplastic-large-cell-lymphoma-alcl

MHRA information about symptoms sometimes referred to as breast implant illness:

https://www.gov.uk/guidance/symptoms-sometimes-referred-to-as-breast-implant-illness

MHRA information about other rare cancers reported in the breast-implant capsule:

https://www.gov.uk/government/publications/squamous-cell-carcinoma-scc-and-different-types-of-lymphomas-occurring-in-the-capsule-around-breast-implants

Mr E. P. L. Turton MBChB FRCSEd FRCS (Gen Surg) MD (Hons)
Consultant Specialist Breast Surgeon — Specialising in Oncoplastic and Cosmetic Breast Surgery
cosmeticbreastsurgeon.co.uk

NHS information about breast implants and breast screening:

https://www.gov.uk/government/publications/breast-screening-breast-implant-guidelines/breast-implants-and-breast-screening

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