Philip Turton

Information Sheet for

Patients Considering Bilateral Breast Reduction

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Introduction

Breast reduction, also called reduction mammoplasty, reduces the weight and volume of the breasts and reshapes them into a smaller, more lifted form. For many women, the benefits extend beyond appearance: lighter breasts can make exercise, everyday activities and finding comfortable clothing easier, and can improve confidence and comfort. The operation can be helpful even when breasts are not exceptionally large, particularly as it involves an uplift approach at the same time, provided that the proposed change is appropriate for the woman's anatomy and wishes.

Mr Turton's aim is to achieve a worthwhile reduction and a well-proportioned breast shape while protecting the blood supply to the remaining breast tissue, skin and nipples. A particular bra cup size cannot be guaranteed, and the breasts and areolae will not become exact mirror images. Breast reduction also does not routinely remove separate folds of skin and fat beneath the arms or extending around the sides and back. These limitations are explained below because they should form part of your decision before surgery.

This sheet is provided before or after your consultation to help you understand the operation, its recovery and possible complications. Please read it carefully and raise anything that is especially important to you during your discussions with Mr Turton. It supports your individual consultation and the separate consent process; it is not itself a consent form.

Why women choose breast reduction

Women seek breast reduction for different reasons. Some find that heavy breasts interfere with running, swimming, other exercise or work. Others experience discomfort in the neck, back or shoulders, deep marks beneath their bra straps, or recurrent soreness and irritation in the crease beneath the breasts. Difficulty finding supportive bras, swimwear and clothing can be a substantial practical problem.

Large or drooping breasts may also affect body confidence, intimacy and the way a woman feels about her proportions. Unwanted attention or comments can contribute to this. Some women simply prefer smaller breasts; others want to improve a marked difference between the two sides. The reasons are personal, and there is no single breast size at which surgery becomes appropriate.

A reduction normally includes an uplift and reshaping of the breast. Where only a modest reduction is wanted, the main benefit may come from lifting and reshaping rather than from removing a large amount of tissue. Mr Turton will discuss whether reduction, mastopexy or another approach best matches your priorities.

What breast reduction can and cannot achieve

Breast size and the limits of reduction

Please explain whether you want a substantial reduction in size, a more moderate change, or mainly an uplift with a small reduction. Before-and-after photographs on Mr Turton's website and Instagram page, @turtonphilip, can help you describe the appearance you prefer. Another woman's result cannot be reproduced exactly because her starting anatomy and tissues differ from yours.

Bra cup sizes are not standard surgical measurements. They depend on the band size, bra design and manufacturer, as well as breast volume and shape. Neither the weight of tissue removed nor the measurements taken before surgery can reliably predict a final cup size. Mr Turton will aim for the outcome discussed with you, but cannot promise a particular cup size or an exact reduction by a specified number of cup sizes.

There is a limit to how much tissue can safely be removed. This depends on your breast dimensions, nipple position, skin quality and the amount of tissue that must remain to maintain circulation and create a satisfactory shape. In a conventional reduction, the nipple and areola remain attached to a bridge of living tissue called a pedicle, which carries their blood supply and some nerve and milk-duct connections. Preserving this tissue may limit how small the breast can safely be made. A long pedicle is present when the breasts are very elongated to start with, so the pedicle will 'occupy a reasonable volume of the remaining breast'.

Some women may therefore feel that their breasts remain larger than they had hoped, despite a substantial reduction of the tissue around the pedicle. Further reduction may not be advisable or technically possible without additional risks. For selected very large breasts, a free-nipple graft may allow a greater reduction, but it has important trade-offs, explained later. Your preferred size must be balanced against tissue safety and the likely shape and healing of the breast.

Breast symmetry and shape

Natural breasts are rarely exact mirror images. Before surgery, they may differ in volume, width, shape, firmness, degree of droop and position on the chest. The nipples may sit at different heights, and differences in the ribs, chest wall, shoulders or posture can also affect breast appearance. Breast reduction can improve a substantial imbalance but cannot eliminate every difference.

The natural crease beneath each breast, called the inframammary fold, commonly sits at a slightly different height on each side and may differ in curvature, including where it

approaches the breastbone. These pre-existing differences may be concealed by larger, drooping breasts and become more noticeable after reduction. Breast reduction does not correct pre-existing differences in the height or curvature of these folds.

Mr Turton adjusts the amount of tissue removed and the reshaping of each breast to your starting anatomy, aiming to achieve the best possible balance while protecting the blood supply to the remaining tissues and nipples. Removing an identical weight from each side would not necessarily produce equal breasts, and removing different amounts does not guarantee identical results. Some residual difference in size, contour, projection, nipple position or scar length should be expected, even after careful planning and surgery. Swelling and settling may also progress at different rates on the two sides, so symmetry should not be judged in the early stages of recovery.

The width and position of the natural breast footprint (the area where the breast sits on the chest) also influence the final shape. A broad breast cannot always be made narrow, and a particular cleavage or degree of upper-breast fullness cannot be guaranteed. These anatomical limitations also influence how the breasts look without a bra. The aim is an improved, well-proportioned result, rather than two perfectly identical breasts.

Areolar size and roundness

The areola is the pigmented skin surrounding the nipple. The two areolae often differ before surgery in size, shape, colour and the definition of their outer edges. Pigmentation may fade gradually at the border rather than form a sharply defined circle. Mr Turton aims to create appropriately sized, well-positioned areolae with as much symmetry as the tissues allow, but perfectly round, identical areolae cannot be guaranteed.

During reduction, the skin is brought together around the reshaped breast and the nipple-bearing pedicle. Differences between the breasts, the length and position of the pedicles, skin elasticity and the direction of tension during closure and healing can influence the final outline. One areola may therefore be slightly more oval, larger, less evenly rounded or positioned somewhat differently from the other. Its outline can also change as swelling subsides and the scars mature.

Small differences can remain despite careful planning and surgery. The nipple and areola are living tissues whose blood supply must be protected; they cannot be repeatedly trimmed or moved solely to pursue a geometrically exact match. A minor difference does not in itself mean that something has gone wrong. If a difference remains a concern after healing, Mr Turton can assess it, but further surgery is not automatically advisable and may create additional scars, alter sensation or affect circulation without achieving perfect symmetry.

Fullness and folds beneath the arms and around the back

Many women have a fold of loose skin and fatty tissue beside the breast, beneath the arm or along the side of the chest. In some it is small and barely noticeable; in others it forms a substantial roll that continues around towards the back. These tissues may blend into the outer breast but extend beyond the area treated by a standard breast reduction.

Unless a separate procedure has specifically been discussed and included in your surgical plan, you should expect these underarm, lateral chest-wall and back folds to remain after breast reduction. They may appear more noticeable alongside the smaller breast, even though the fold itself has not increased. Breast reduction is not a general tightening operation for the side of the chest, upper arms or back.

If these areas concern you, please point them out at your consultation. Treatment depends on whether the fullness is mainly fat, loose skin or a combination. Liposuction may help selected fatty areas but cannot reliably remove a substantial loose skin fold. More extensive skin excess may require a separate excision, a lateral chest lift or a back lift, with a longer scar extending around the side and sometimes across part of the back. Extensive treatment can involve a general anaesthetic and changes of position during surgery. The extent of excision and scar depends on the individual fold; it does not invariably extend to the small of the back.

Treatment of a pre-existing fold outside the agreed breast-reduction area is a separate procedure with its own assessment, recovery, possible complications and cost. It should not be assumed to be included in the breast-reduction fee or in any later revision. A small prominence at the end of the breast scar, sometimes called a dog ear, is assessed separately from a broader pre-existing underarm or back roll.

Symptoms and general wellbeing

Breast reduction often improves symptoms associated with breast weight, but cannot guarantee relief of breast, neck, back or shoulder pain. Breast tissue can remain sensitive to hormonal changes, and pain may also come from joints, muscles or other causes. Established changes in posture may not fully correct; physiotherapy may be helpful.

Surgery can improve satisfaction with breast appearance, but will not necessarily resolve wider difficulties with mood, relationships or body image. Please tell Mr Turton about any mental health condition or persistent distress about your appearance. If body dysmorphic disorder is suspected, further assessment and support may be appropriate before deciding whether surgery would help.

Alternatives and timing

Alternatives include having no surgery, a professionally fitted supportive bra, physiotherapy, appropriate treatment for pain or skin irritation, and weight management where relevant.

Weight loss may reduce breast volume in some women but is less effective for others and may leave looser skin. These options do not reproduce all the changes achieved by reduction surgery. An uplift may be more appropriate where droop, rather than excessive breast volume, is the main concern.

Ideally, your weight should be reasonably stable before surgery. Future pregnancy, breastfeeding, hormonal changes, weight gain or weight loss can alter the result. Breast reduction can reduce or permanently prevent breastfeeding, even where the nipple remains attached to a pedicle. If breastfeeding is a priority, consider whether to defer surgery until your family is complete. A free-nipple graft disconnects the nipple from the milk ducts, so breastfeeding from that breast will not be possible.

Arranging a consultation

Most patients contact Mr Turton's secretary, victoria.Short@Nuffieldhealth.com, or use the enquiry form at www.cosmeticbreastsurgeon.co.uk. Breast reduction is usually bilateral, meaning both sides, although a one-sided reduction may be appropriate for a substantial asymmetry, including after previous breast treatment.

Mr Turton is a consultant specialist breast surgeon whose consultant practice has been devoted to breast surgery. He completed specialist training in general surgery before undertaking advanced subspecialist training in breast, oncoplastic breast and aesthetic breast surgery. He has practised privately in cosmetic breast surgery since 2004 and was a consultant specialist reconstructive and oncoplastic breast surgeon at Leeds Teaching Hospitals NHS Trust from 2004 to 2024. Mr Turton is Board Certified in Cosmetic Breast Surgery and has performed many thousands of breast operations. He personally undertakes his patients' consultations, surgery and follow-up.

We normally write to your GP about your consultation and treatment. Please raise any concern about this with Mr Turton at the consultation so that it can be discussed in the context of your care.

Pre-operative assessment

Please provide full details of your physical and mental health, previous operations, breast symptoms and any previous breast surgery or radiotherapy. Tell us about diabetes, bleeding or clotting disorders, problems with healing or scars, previous anaesthetic difficulties and any personal or close family history of blood clots. A family history of breast or ovarian cancer should include which relatives were affected and their approximate ages at diagnosis.

We need to know about all prescribed and non-prescribed medicines, vitamins, herbal preparations and supplements, and all allergies or reactions to medicines, dressings, adhesives, latex or food. Include previous or current use of weight-loss or diabetes

medicines, whether tablets or injections, with the dose and when you last took them. Ask about any changes to medication during your consultation and hospital pre-assessment. Do not stop prescribed medicines or start supplements without appropriate advice.

Mr Turton will examine your breasts and assess their dimensions, tissue quality, nipple position, asymmetry and the surrounding chest-wall folds. Any lump or unexplained finding may need investigation before surgery. Mammography or other imaging may be recommended according to your age, symptoms, examination and personal or family history. Clinical photographs may be taken with your verbal consent to support planning and follow-up. Keeping your face out of a photograph reduces identification but does not make the image completely anonymous; any use beyond your care requires appropriate consent.

You will have time to consider the information, likely outcome, costs and recovery. Mr Turton's practice allows a reflection period of at least two weeks, with a further consultation to address remaining questions. You may change your mind about proceeding. Please mention if an exact size, areolar appearance or correction of the underarm folds is essential to your decision, so the limitations can be explored before booking surgery.

Preparing for surgery

Smoking and nicotine

Mr Turton asks patients to avoid smoking, vaping and all nicotine-containing products for at least six weeks before surgery and for at least six weeks afterwards, continuing until the wounds have healed. Nicotine can reduce blood flow to healing tissues; smoking increases the possibility of wound problems, infection and tissue loss. Tell Mr Turton about any current or previous use, including nicotine replacement, so that preparation for surgery can be planned appropriately. Stopping permanently benefits your general health as well as recovery.

Hospital admission and fasting

Surgery is undertaken at Leeds Nuffield or Spire Leeds hospital, with the arrangements confirmed when your operation is booked. An overnight stay is normally recommended so that you can recover with nursing care and observation. The hospital and level of care should suit your medical needs. You will have a hospital pre-assessment and normally be admitted on the day of surgery.

Follow the fasting instructions in your hospital admission letter. The permitted times for food and drink are important for anaesthetic safety. If the operation is delayed after admission, the team may give you revised instructions about water. Do not decide to extend drinking times yourself. The pre-assessment and anaesthetic teams will advise about your usual medication.

You may bathe or shower before attending, but do not apply moisturiser to the breasts on the day before or the day of surgery because it can interfere with the surgical markings. Mr Turton will see you, confirm the agreed operation and mark the breasts. An experienced consultant anaesthetist will discuss the anaesthetic and assess you before surgery. If you are particularly anxious, please tell the team; additional support or medication may be appropriate.

The operation

Breast reduction is performed under general anaesthesia and usually takes several hours. Mr Turton removes breast tissue and excess skin, reshapes the remaining breast and raises the nipple and areola. The usual skin pattern produces an anchor-shaped scar: around the areola, vertically down to the breast crease and along the crease beneath the breast. This is also called a Wise-pattern or inverted-T reduction. The scar may extend towards the side to accommodate the amount of skin removed. Alternative scar patterns may be suitable for selected smaller reductions.

The skin pattern and the internal pedicle are different parts of the operation. The pedicle is planned to maintain a reliable blood supply to the nipple and areola while allowing the breast to be reduced and reshaped. The choice depends on your anatomy, previous treatment and the reduction required. A free-nipple graft may be recommended in selected circumstances, as described below.

Antibiotics are given at the time of surgery, so please make any allergies clear. Local anaesthetic may be used to improve early comfort. Mr Turton normally closes the skin using interrupted PDS stitches in the deeper skin layer and a fine continuous PDS stitch just beneath the surface. These stitches are absorbable and generally do not need routine removal. A drain is usually placed in each breast and normally remains overnight. The wounds are covered with dressings, and an elasticated Tubigrip support is applied.

Breast tissue removed during reduction is normally sent for laboratory examination. Occasionally an unexpected abnormality is found, which may require further investigation or treatment. Mr Turton will explain any finding relevant to you.

After the operation and returning home

You will initially recover under nursing observation and may have a drip until you are drinking normally. Tenderness, tightness, swelling and bruising are expected, although the amount varies. Pain relief will be provided and adjusted to keep you comfortable. At home, paracetamol and ibuprofen are commonly used if suitable for you; follow the doses and instructions given at discharge.

Wear the Tubigrip as instructed during the first week, then use the appropriately fitted postoperative supportive surgical bra that is provided to you by the hospital at the end of the first week, at your dressing change appointment. The breast care nurse will advise on fit. Support is normally worn day and night for at least six weeks, except for washing as advised. It should feel supportive without excessive pressure on the wounds or nipples. An underwired bra should wait until the scars have healed and it is comfortable and appropriate to wear one.

Activity and practical help

Gentle walking should begin early and continue regularly at home. During the daytime, aim to get up and walk for a few minutes each hour while awake, according to your comfort and ability. Avoid prolonged bed rest. Move your hands, elbows and shoulders gently to limit stiffness, while avoiding forceful pushing, pulling, repeated overhead reaching and stretching across the healing wounds during the first few weeks.

Arrange help with bags, shopping, childcare and household tasks. In the early recovery period, avoid heavy lifting, vacuuming, making beds and other tasks that strain the chest or arms. Take particular care when getting in and out of bed or a car. Movement should be calm and comfortable; a complication can still occur even when all postoperative advice has been followed.

The timing of return to work depends on your job and recovery. Light duties may be possible sooner than physical work. Exercise and heavier activity are usually reintroduced gradually from around six weeks if healing is satisfactory, with individual advice from the team. Resume driving only when you can wear a seat belt, turn to look safely, control the vehicle and perform an emergency stop without pain or hesitation. Do not drive while affected by sedating medicines, and follow your insurer’s requirements. Breast contact should be gentle when resumed and should not put pressure on healing wounds.

Dressings and appointments

Dressings are normally reviewed at approximately one and two weeks, and Mr Turton will usually review you at around three weeks. Some wounds need dressings for longer. Small dried marks from blood or clear yellow fluid can occur on a dressing. Contact the team if a dressing becomes wet, loose, saturated, increasingly stained or associated with an unpleasant smell, increasing pain or redness. A dressing provides protection but does not guarantee that the wound beneath it remains sterile.

Keep the Tubigrip and dressings dry. Shallow baths are usually the simplest option while they remain in place. Normal bathing or showering can resume when the team confirms that the wounds have healed sufficiently, often around three weeks. Free-nipple grafts need specific dressings and care; follow the individual instructions given.

Some swelling may last six weeks or longer. Early differences between the breasts can reflect uneven swelling and settling, and the final shape should not be judged immediately. The breasts soften and settle over several months, while scars may continue changing for 12–18 months or longer. Sudden or increasing one-sided swelling should be assessed rather than assumed to be normal settling.

Possible complications and side effects

Careful planning, surgical technique and postoperative care reduce the likelihood of problems, but cannot remove every risk. The following explains the principal recognised complications and their possible consequences. The likelihood varies with the extent of reduction, technique, previous surgery, body weight, diabetes, smoking and individual healing. Some problems need additional appointments, dressings, investigations or further surgery.

Blood clots and general anaesthetic risks

Deep-vein thrombosis (DVT) is a blood clot, usually in a leg. A clot can travel to the lungs, causing a pulmonary embolism (PE). These are uncommon but potentially serious complications. Tell the team about previous clots, clotting disorders, a close family history of clots, prolonged immobility and hormonal medication. Your individual clotting and bleeding risks will be assessed before surgery.

Preventive measures include pneumatic compression around the legs during surgery, anti-embolism stockings, normally worn for two weeks, and early regular walking. Low-molecular-weight heparin injections may be prescribed when the expected benefit outweighs the bleeding risk. General anaesthesia can cause nausea, sore throat or other temporary effects; allergic reactions and serious heart, lung or other complications are uncommon but possible. The anaesthetist will discuss risks relevant to you.

Bruising and haematoma

Bruising can spread below the breasts towards the abdomen and usually fades over a few weeks. A haematoma is a collection of blood within the operated breast and is different from ordinary superficial bruising. It usually develops in the first 24 hours, although later bleeding can occur. One breast may become noticeably larger, tighter or more painful, sometimes with light-headedness or feeling unwell.

A small collection may settle with observation. A larger haematoma may require a return to theatre to remove the blood collection and address its source. Blood transfusion is rarely required. Contact the hospital team promptly for sudden breast swelling, increasing tightness or bleeding through the dressings.

Seroma

A seroma is a collection of fluid in the operated area. It may cause swelling, a sense of fluid movement or discomfort. A small seroma can settle naturally, but a larger or persistent collection may need drainage, sometimes more than once. If the fluid becomes infected, antibiotics and further treatment may be required.

Infection

In Mr Turton's experience, infections after breast reduction are usually localised and may occur around a stitch or a small area of delayed healing. Increasing redness, heat, tenderness, discharge, fever or feeling unwell should be reported to the hospital or breast care team. Antibiotics may be prescribed when infection is suspected.

More extensive skin infection is called cellulitis. An infected collection beneath the skin is an abscess and may require drainage as well as antibiotics; admission or further surgery is occasionally necessary. Infection can occur despite antibiotics given during the operation and may delay healing or affect the final scar and breast shape.

Delayed wound healing and skin loss

Small areas of delayed healing or wound separation can occur, particularly at the T-junction where the vertical scar meets the scar beneath the breast. This is distinct from extensive skin loss. Small superficial areas usually heal with appropriate dressings, but can take several weeks and leave a wider scar.

If part of the skin has an inadequate blood supply, it can become non-viable, called skin necrosis. More extensive areas may require removal of damaged tissue and prolonged wound care, sometimes for months. Further surgery may be needed. Smoking, diabetes, previous radiotherapy, tissue tension and other factors can increase the risk. A substantial change in nipple or skin colour should be assessed promptly.

Nipple and areolar blood supply

In a conventional reduction, the nipple and areola are moved on their tissue pedicle. Despite precautions, circulation can become inadequate and cause partial or, less commonly, complete tissue loss. The risk depends on the anatomy, extent of surgery, previous treatment and patient factors, and may be greater in very large or complex reductions.

The Association of Breast Surgery's patient guide quotes approximately 1 in 100 cases for nipple loss, which may be partial or complete. This is a general estimate rather than Mr Turton's personal complication rate; individual risk varies with the extent of reduction, technique and patient factors.

A superficial problem may cause blistering or loss of the outer skin layer. It is generally easier to manage than deep tissue loss and may heal with dressings, although pigmentation, texture or scarring can change. Partial or full-thickness nipple–areola loss is more significant. Damaged tissue may need removal, and healing can leave a flatter nipple, reduced pigmentation, altered sensation and a different appearance from the other side.

Rarely, tissue loss extends into the underlying pedicle and central breast. This can leave a substantial defect requiring repeated dressings, debridement or further procedures. Healing and subsequent reconstruction may take many months and, in severe cases, around a year or longer. Loss of tissue can leave a permanent contour difference. This is a possible course of a severe complication, rather than the expected healing time for every nipple problem.

Free-nipple grafting for selected large reductions

When preserving a long or bulky nipple-bearing pedicle would limit the reduction or create concern about circulation, Mr Turton may recommend a free-nipple graft. The nipple and areola are detached and placed onto the reshaped breast as a skin graft. This can permit a greater reduction and avoids relying on the original long pedicle to supply the nipple. It may also be considered during surgery if the nipple's circulation is unsatisfactory, where this possibility has been discussed and consented to beforehand.

A free-nipple graft can be an appropriate option for selected very large breasts, but is not required for every large reduction and does not eliminate all healing risks. Suitable pedicle techniques can preserve the nipple successfully in many large reductions. The choice balances your anatomy, preferred size and safety with the consequences for appearance, sensation and function.

The graft is initially numb because its original nerves have been divided, and permanent loss of normal nipple and sexual sensation should be expected. Some protective sensation may return, but it is unpredictable. The nipple is often flatter and its projection and response can change. The areola may lose pigment, become paler or develop patchy or uneven colour. The graft may partly or completely fail to take, leaving an area requiring dressings and sometimes further treatment. Breastfeeding from that breast will not be possible.

Once healing and scars have settled, medical nipple–areola tattooing can improve the appearance of lost or uneven pigmentation or create the visual impression of an areola where tissue has been lost. It does not restore sensation, breastfeeding or a projecting nipple. Tattooing may need more than one session or later refreshing and is a separate treatment with its own costs.

Fat necrosis

Fat necrosis occurs when a portion of breast fat loses its blood supply. A small area may feel like a firm lump or broader rubbery patch, sometimes with tenderness. It is a benign process

and does not turn into cancer. It can soften over time or leave a persistent lump, scar tissue, an oil cyst or calcification visible on imaging.

Small localised fat necrosis is different from extensive loss of tissue. A larger affected area may cause inflammation, oily discharge, wound breakdown, infection or a contour defect and may need drainage, removal of non-viable tissue or further surgery. The serious form associated with loss of the nipple-bearing pedicle is described above. A new or changing lump must be assessed and should not automatically be assumed to be fat necrosis.

Nipple and breast sensation and persistent pain

Sensation may be reduced, lost, increased or simply different in the nipple, areola or breast skin. The two sides may be affected differently. Following large-volume breast reduction, approximately 50% of patients might be expected to experience some loss of nipple sensation, ranging from partially reduced sensitivity to complete numbness. Approximately 10% of patients overall might be expected to have complete permanent nipple numbness, meaning that sensation does not return. Published rates vary considerably.

Numbness and altered sensitivity may improve over several months, sometimes over a year or longer. Some patients recover only partial sensation or find that it remains different from before surgery. Altered nipple sensation may affect sexual pleasure, so please consider its importance to you before deciding on surgery. The consequences of free-nipple grafting are described separately above.

Brief shooting sensations, tingling and sensitivity can occur during healing. Persistent troublesome pain is less common and may relate to nerve irritation, scarring, fat necrosis or another cause. Pain that is increasing, persistent or associated with a new finding should be assessed so that treatment can be directed to its cause.

Scarring and stitch reactions

Breast reduction leaves permanent scars. Initially these may be pink or darker than the surrounding skin, firm, raised, itchy or slightly uneven. They generally soften and fade over 12–18 months, sometimes longer, but their final appearance cannot be guaranteed. Infection, delayed healing and tension can widen a scar or make it more noticeable. The scars on each breast may differ in length, position and appearance.

A hypertrophic scar becomes unusually thick or raised within the original incision. A keloid grows beyond the original wound edges and is a different type of scar response. Please tell Mr Turton if you have previously developed either. Treatment may improve troublesome scars, but no cream or dressing guarantees a fine scar.

Mr Turton uses individual PDS stitches in the deeper skin layer and a continuous fine PDS stitch just beneath the surface. PDS gradually loses strength and is absorbed over several months; absorption is generally substantially complete at twelve months. Scar maturation

continues beyond this. Small firm bumps along the scar may be felt while knots and healing tissue settle and are often part of normal recovery.

Occasionally a stitch end works through the skin, causing a small spot, irritation or discharge. Do not pull it out, pick at it or try to cut it yourself. The breast care nurse or Mr Turton can trim or remove exposed material where appropriate. A small stitch abscess may need local treatment and, where infection is suspected, antibiotics. Increasing redness, pain, swelling or discharge should be assessed rather than dismissed as an ordinary stitch reaction.

Once the wound is completely closed and healed, often from around three weeks, silicone scar gel may help, particularly for raised scars. The team will advise when to start; Mr Turton normally recommends use twice daily for six to twelve months where appropriate. Do not apply it to an open or weeping area. Protect healing scars from direct sun and ultraviolet exposure; use clothing and, on healed skin, high-factor sunscreen. New scars can develop persistent colour changes after sun exposure.

Dog ears and residual contour differences

A small fold or prominence can remain at the end of a scar, known as a dog ear. There may also be puckering, a slight indentation or unevenness where tissues meet. Some changes improve as swelling settles and the scars soften; others remain. A dog ear differs from the wider pre-existing skin-and-fat fold beneath the arm or around the back, although both can be present together.

Further correction, if appropriate, may require extending the scar, removing more tissue or another procedure. Complete correction cannot be guaranteed, and further surgery can itself produce a raised or thickened scar. Minor differences may be best accepted if further surgery is likely to create greater scarring or other problems. Any further treatment and its costs depend on the findings and the agreed aftercare arrangements.

Additional contouring and later surgery

Removal of pre-existing underarm, lateral chest-wall or back folds is not included in a standard breast reduction unless specifically agreed and included in the quotation. A separate body-contouring operation, or later elective surgery to change size, shape or minor asymmetry, may involve additional surgeon, anaesthetic and hospital fees. Necessary treatment of a complication is considered according to the clinical circumstances and agreed aftercare terms. This information does not remove your statutory rights.

Changes over time and further surgery

Reduced breasts continue to change with age, gravity, pregnancy, hormonal changes and weight fluctuations. They can enlarge again or become looser, and the lower part of a breast may stretch or settle, sometimes called bottoming out. These changes may be different on

each side. Maintaining a stable weight helps preserve the result but cannot prevent all natural changes.

Further reduction or an uplift may be possible, but repeat surgery can be more complex and carries additional risks to circulation, healing and sensation. The details of the original operation are important for planning another procedure. A later wish for a different size or shape does not mean that a further reduction is necessarily safe or advisable.

Breast health and future investigations

Breast reduction does not remove the risk of breast cancer or replace routine breast awareness and screening. Your personal risk depends on several factors; it is not the same for every woman. Attend screening when invited or as advised for your individual risk. Tell the radiographer or breast clinician that you have had a reduction because internal scarring and fat necrosis can alter imaging appearances.

A new breast or armpit lump, persistent focal pain, nipple discharge or an unexplained change in shape or skin should be assessed. After discharge from postoperative care, your GP is normally the first point of contact and can arrange referral to a breast clinic where appropriate. An early postoperative concern should instead be raised promptly with the hospital or Mr Turton's team.

When to seek advice during recovery

Contact the hospital ward or breast care team promptly for sudden or increasing breast swelling, bleeding through the dressings, increasing pain, spreading redness, discharge, fever, wound opening or a significant change in the colour of a nipple or the breast skin. Use the contact details provided at discharge, including the out-of-hours route.

New calf swelling or pain, unexplained breathlessness or chest pain needs urgent medical assessment. For severe breathing difficulty, collapse or severe chest pain, call 999. These events are uncommon, but knowing when and how to seek help is part of preparing for surgery.

Costs and what the operation includes

Mr Turton's fee reflects his extensive expertise in breast reduction, more than two decades of consultant practice devoted exclusively to breast surgery, and his personal involvement in consultation, surgery and follow-up. Patient safety is central to Mr Turton's approach. Surgery takes place at Nuffield Health Leeds Hospital or Spire Leeds Hospital - two of Yorkshire's largest private hospitals - with dedicated operating theatres, recovery facilities and inpatient nursing care. This hospital-based setting provides overnight support and

observation during the important early recovery period. Formal pathological examination of the removed breast tissue is included in the hospital package.

At the time of publication, the total cost is usually £12,000–£13,000. Hospital charges are reviewed periodically, so this guide range may change. General hospital website prices may not reflect your individual treatment. Following assessment, you will receive a fixed-price hospital quotation confirming the cost, inclusions and applicable terms for aftercare and additional treatment.

Before deciding

Breast reduction can offer substantial improvements in comfort, proportion and confidence. Your decision should reflect both the changes you hope for and the limits imposed by your anatomy and the need to protect living tissue. A particular cup size, exact symmetry, perfectly round matching areolae or removal of adjacent underarm and back folds should not be assumed.

Please discuss any remaining questions with Mr Turton before proceeding. This information sheet describes the principal issues relevant to breast reduction but cannot cover every possible outcome or complication. It should be considered alongside your individual consultations and the agreed surgical plan.

Further information

Mr Turton's website: www.cosmeticbreastsurgeon.co.uk

Association of Breast Surgery patient information: https://associationofbreastsurgery.org.uk/patients/cosmetic-surgery

NHS information about breast reduction: https://www.nhs.uk/tests-and-treatments/cosmetic-procedures/cosmetic-surgery/breast-reduction-female/

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