Philip Turton

Information Sheet for

Patients Considering Bilateral Mastopexy

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Introduction

A breast uplift, also called mastopexy, reshapes the breasts, removes excess skin and raises the nipples to improve the position and contour of breasts that have become loose or drooping. It can help women feel more comfortable with their appearance and proportions, particularly after pregnancy, breastfeeding, weight loss or changes with age. The aim is to make the best use of your own breast tissue, with an approach suited to your anatomy and the appearance you would like to achieve.

Mr Turton plans the reshaping carefully while protecting the blood supply to the breast tissue, skin and nipples. An uplift can produce a substantial improvement, but it leaves permanent scars (albeit carefully placed), and cannot promise a particular bra cup size, identical breasts or perfectly matching areolae. It does not replace volume that has been lost, and the breasts will continue to change over time. 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 mastopexy, recovery and possible complications. It covers an uplift alone and the additional considerations when implants are inserted, exchanged or removed. Please read it carefully and raise anything that is especially important to you with Mr Turton. It supports your individual consultation and the separate consent process; it is not itself a consent form. If implants are involved, please also read Mr Turton's Breast Augmentation Patient Information Sheet and the relevant implant information.

Why breasts become loose or drooping

Breast shape changes with genetic factors, skin elasticity, the weight and distribution of breast tissue, pregnancy, hormonal changes, weight fluctuations and ageing. Some women develop droop without having had children; others notice an empty or deflated appearance after pregnancy or weight loss. Breast implants can also stretch the tissues over time. The two sides may change differently, making a pre-existing asymmetry more noticeable.

The medical term for breast droop is ptosis. Assessment considers both the position of the nipple in relation to the natural crease beneath the breast and the amount of tissue hanging below that crease. A breast can have loose, low-hanging tissue even when the nipple remains above the fold. Mr Turton will assess the whole breast rather than base the recommendation on a single measurement or a home test.

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What an uplift can and cannot achieve

Breast size and upper breast fullness

Please explain whether you mainly want the breasts lifted and re-shaped, would also prefer them smaller, or want additional volume. 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.

Mastopexy mainly changes shape rather than adding volume. The breasts often look and feel more compact and may fit a smaller bra even when little breast tissue is removed. If a substantial reduction in weight or volume is wanted, a breast reduction may be more appropriate. Conversely, if there is too little breast tissue to create your preferred fullness, an implant or, in selected circumstances, fat transfer may be considered, but not necessarily at the same operation.

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. Mr Turton will aim for the outcome discussed with you, but cannot promise a particular cup size, an exact change in cup size or that your existing bras will fit afterwards.

An uplift reshapes your existing tissue but cannot reliably create or maintain the rounded upper-breast fullness associated with an implant. The upper breast may initially look fuller because of swelling and the tightness of the newly reshaped tissues. Some of this fullness reduces as the breasts soften and settle. A particular cleavage, projection or appearance without a bra cannot be guaranteed.

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. Mastopexy 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 drooping breasts and become more noticeable after an uplift. Mastopexy alone does not correct pre-existing differences in the height or curvature of these folds.

Mr Turton adjusts the skin removal and reshaping of each breast to your starting anatomy, aiming to achieve the best possible balance while protecting the blood supply to the tissues

and nipples. Removing identical amounts of skin or tissue 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.

The width and position of the natural breast footprint, meaning the area where the breast sits on the chest, influence the final shape. A broad breast cannot always be made narrow, and nipples that naturally point slightly outwards may retain some outward orientation. Small residual differences can become more noticeable when the breasts are examined closely after surgery. 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 mastopexy, the skin is brought together around the reshaped breast and the nipple-bearing tissue. Differences between the breasts, the length and position of the supporting tissue, skin elasticity and the direction of tension during closure and healing 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 mastopexy.

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 an

uplift. They may appear more noticeable alongside the reshaped breast, even though the fold itself has not increased. Mastopexy 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 mastopexy area is a separate procedure with its own assessment, recovery, possible complications and cost. It should not be assumed to be included in the mastopexy 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.

Choosing the most appropriate operation

Mastopexy without implants

If you are broadly happy with the volume of your breasts in a supportive bra but dislike their droop without one, an uplift and reshaping alone may offer the change you want. Mr Turton often favours this approach when there is enough natural breast tissue to achieve a satisfactory shape. It avoids introducing an implant and its long-term maintenance needs.

The operation can raise the nipple, reduce an enlarged areola, remove loose skin and redistribute the existing breast tissue back above the crease line to form a more aesthetically pleasing breast appearance. How much reshaping is possible depends on the amount and quality of that tissue and the need to preserve its circulation. Breasts that are particularly heavy or have very stretched skin may loosen again more readily. An uplift with some reduction may be preferable where breast weight is likely to compromise the result.

Mastopexy with breast augmentation in one operation

An uplift with implants, called augmentation-mastopexy or mastopexy-augmentation, may be considered when both lifting and additional volume are wanted. An implant can provide more fullness, particularly in the upper breast, but does not remove excess skin or reliably raise a significantly low nipple by itself. Choosing a large implant simply to avoid an uplift can leave a larger, heavier breast with persistent droop, a much harder and riskier breast to correct again in the future, and an unsatisfactory nipple position.

Combining an uplift and augmentation is significantly more complex than either procedure alone. The skin is tightened, while conversely the implant adds volume and pressure beneath it, expanding it. Implant size, the extent of lifting, skin quality, previous surgery and blood supply must be balanced carefully. Inevitably less tightening is possible when the procedure is combined. Wound separation, poor scarring, nipple or skin circulation problems, including necrosis (loss of the nipple and areola) and implant exposure or infection are important additional considerations. A serious wound or implant problem may require implant removal and a period without it. Combining the procedures does not guarantee that only one operation will be needed.

Mr Turton will advise whether a single operation is appropriate for your anatomy and desired outcome. The implant may need to be smaller than you initially hoped in order to allow safe closure and healing. Implants do not prevent future sagging, and their weight can contribute to further stretching of the tissues.

Mastopexy followed by augmentation in two stages

For women with significant breast droop, particularly grade 3 ptosis, Mr Turton strongly recommends an uplift first, with implants considered later only if additional volume is still wanted. This is his preferred approach when substantial lifting and skin tightening are required, especially where tissues are thin or stretched or previous surgery raises concerns about blood supply. Based on more than two decades of specialist breast surgery, he considers staging to offer greater control over reshaping and a more predictable cosmetic result in these circumstances.

An uplift tightens the skin and reshapes the breast, whereas an implant expands the tissues from within. Performing the uplift first allows more complete removal of excess skin and careful reshaping without having to accommodate the volume and pressure of an implant at the same time. This gives Mr Turton greater freedom to achieve an effective uplift while protecting the blood supply to the skin and nipples. It also allows the mastopexy wounds to heal before an implant is introduced. This is an important consideration because wound breakdown over an implant can lead to exposure or infection, sometimes requiring implant removal and further treatment.

Mr Turton normally allows at least six months between operations, and longer if healing or settling requires it. By then, you can assess the shape and size of your lifted breasts before deciding whether you still want implants. Any implant can then be selected to suit the settled breast shape and the additional fullness you wish to achieve. In Mr Turton’s experience, many women are satisfied with the uplift alone and decide not to proceed with augmentation.

If you choose both stages, the total cost is higher than a combined operation, and each stage involves its own anaesthetic, recovery and surgical risks. You do not pay for the second operation as part of the initial uplift; it is booked separately and charged at the

hospital's prevailing fixed-price package rate. For women requiring a substantial uplift, Mr Turton considers the additional time and potential cost worthwhile for the greater control over reshaping and healing, and the opportunity to make a more informed decision about implants. Staging does not guarantee a particular result or remove the risks of either operation.

Mastopexy with implant exchange

Women who have had implants for several years may develop loose breast tissue hanging in front of the implant, stretching of the lower breast, implant malposition or capsular contracture. Capsular contracture is tightening of the scar capsule around an implant, which can cause firmness, distortion or discomfort. Simply exchanging the implants does not correct the skin excess, low nipple position or changes in the natural breast tissue.

An uplift may improve these problems, but previous incisions, thin tissues and any work needed on the implant pockets or capsules make planning more complex, risks of complications higher, and outcomes less predictable. The amount of skin tightening and nipple movement must be balanced against circulation and the size of the replacement implant. Revision surgery typically has a less predictable result and a higher risk of healing problems than a first uplift.

Where previous augmentation has left significant breast droop or a substantially distorted appearance, particularly alongside thin, stretched tissues, capsular contracture or implant rupture, Mr Turton recommends implant removal and mastopexy without immediate implant replacement. This includes a "waterfall" deformity, where the natural breast tissue hangs down over the implant. Removing the implants allows him to concentrate on reshaping the remaining breast tissue and removing excess skin, without the additional volume and pressure of new implants during healing.

This operation may be your definitive treatment if you wish to remain without implants. If you subsequently want additional fullness, new implants can be considered after the breasts have healed and settled, normally at least six months later and subject to reassessment. Further augmentation is entirely optional and would be a separate operation with its own recovery, risks and cost.

Mastopexy with implant removal

If you want your implants removed, an uplift commonly improves the remaining breast shape and nipple position. An uplift cannot replace the volume supplied by the implants. The breasts will likely be considerably smaller, softer and flatter, with less upper-breast fullness. The extent of these changes depends on the implant size removed and the amount and quality of your remaining breast tissue.

Previous stretching and thinning of the natural tissues can limit what is achievable. Some asymmetry or contour irregularity may remain despite reshaping.

An implant capsule may need to be released or partly or completely removed, depending on its condition and the reason for surgery. Complete capsule removal is not automatically necessary or the safest option in every patient. Although Mr Turton is an expert at removing capsule tissue, capsule surgery can add risks of bleeding, tissue injury, fluid collection and damage to the chest wall. Mr Turton will discuss the intended approach and any limits imposed by the surrounding tissues. If an implant has ruptured, silicone may have escaped into the surrounding tissues or lymph nodes. It is not always possible or appropriate to remove every trace of silicone, particularly where doing so would damage otherwise healthy tissue.

Combining implant removal with an uplift requires particular care over blood supply to the skin and nipples. In Mr Turton's staged approach, implant removal and the uplift are performed together in the first operation. If you subsequently wish to have new implants, breast augmentation can be considered as a separate second operation, normally at least six months later, once the breasts have healed and settled. There is no requirement to proceed with implants if you are satisfied with the uplift alone.

Fluid can collect in the space previously occupied by the implant; a small collection may settle, whereas a larger or persistent seroma may need drainage. Selected patients may consider later fat transfer, with the limitations explained below.

Alternatives and timing

Having no surgery is a reasonable option. A well-fitted supportive bra can improve comfort and appearance in clothing, although it cannot tighten previously stretched skin or change nipple position. Maintaining a stable weight helps avoid further fluctuations. If breast weight rather than droop is the main concern, reduction may be more appropriate. If loss of volume predominates with little or no droop, augmentation alone may be an option.

Fat transfer, also called lipofilling or lipomodelling, uses fat taken from another part of your body. It can provide subtle changes or fill selected small areas, but does not reproduce the shape and predictable added volume of an implant and is not a substitute for removing substantial loose skin. A variable proportion of the transferred fat is reabsorbed, so the final volume is less predictable and several procedures may be needed. It can be expensive and is limited in slim women by the amount of fat available. It has its own possible complications, including reabsorption, lumps, fat necrosis and changes on breast imaging.

Ideally, your weight should be reasonably stable before surgery, including after weight loss using medication. If you are planning a pregnancy or further substantial weight loss, consider whether to postpone an uplift. Ageing, pregnancy, breastfeeding and subsequent

changes in breast volume can stretch the skin again and alter the result. Surgery should always wait until breastfeeding has finished and breast size has settled.

Mastopexy can reduce milk production or make breastfeeding impossible, even when the nipple remains attached to the underlying breast tissue. Some women are able to breastfeed afterwards, but this cannot be guaranteed. If future breastfeeding or nipple sensation is particularly important to you, discuss this before deciding on surgery.

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.

Arranging a consultation

Most patients contact Mr Turton's secretary, Victoria.Short@Nuffieldhealth.com, or use the book a consultation form at www.cosmeticbreastsurgeon.co.uk/booking.

Mastopexy is usually bilateral, meaning both sides, although a one-sided procedure may be appropriate for a substantial asymmetry or following 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.

Preoperative 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.

Some weight-loss and diabetes medicines, including semaglutide and tirzepatide, slow stomach emptying and can affect preparation for anaesthesia even when you have followed normal fasting instructions. Make sure the pre-assessment and anaesthetic teams know about their use. They will advise on any changes needed; do not stop treatment 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.

If you have had breast surgery elsewhere, details of the previous operation and, where relevant, your implant records are helpful. Existing scars and previous changes to the breast blood supply can affect the choice of technique and the amount of further reshaping that is safe.

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, upper-breast fullness, 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 (especially nipple areola necrosis). 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.

Medicines and contraception

Some medicines and supplements increase bleeding, while others affect clotting risk, blood sugar or the response to anaesthesia. Advice must take account of why you use them. Ask Mr Turton and the hospital pre-assessment team about any changes needed, especially if you take aspirin, clopidogrel, anticoagulants, anti-inflammatory medicines, steroids, hormonal treatment or psychiatric medication. Do not independently stop prescribed treatment. Avoid starting supplements without Mr Turton's approval, as some can increase bleeding risk.

Tell the team which contraception you use and if pregnancy is possible. Certain medicines used around surgery can affect hormonal contraception; vomiting or severe diarrhoea can also reduce absorption of an oral contraceptive. Ask the anaesthetic or pharmacy team whether any treatment you receive requires additional precautions, and follow the advice for your particular contraceptive. Do not stop contraception without advice and an appropriate alternative.

Hospital admission and fasting

You will have a hospital pre-assessment and normally be admitted on the day of surgery. An overnight stay is normally recommended so that you can recover with nursing care and observation. Admission and discharge arrangements will be confirmed when your operation is booked. Arrange for a responsible adult to take you home and help during the early recovery period.

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.

Remove breast or nipple jewellery as advised by the hospital, and tell the team about any piercing-related irritation or discharge. An active infection or a significant change in your health may mean postponing surgery. Do not replace nipple jewellery across healing tissue unless the team advises that it is appropriate.

The operation

Mastopexy is performed under general anaesthesia. The length of surgery depends on the amount of reshaping and whether other procedures are involved. Mr Turton removes excess skin, reshapes the breast tissue and raises the nipple and areola while preserving their attachment to living tissue that carries the blood supply. This tissue support is often called a pedicle. The skin pattern and the internal reshaping are different parts of the operation and are planned together.

Incisions and scar patterns

A full uplift usually produces an anchor-shaped scar: around the areola, vertically down to the crease and along the crease beneath the breast. This is called a Wise-pattern or inverted-T mastopexy. It allows substantial reshaping and removal of loose skin. The scar beneath the breast may need to extend towards the side, and its length and position may differ between the breasts.

A vertical or lollipop pattern, with a scar around the areola and down to the crease, may suit selected breasts with minimal droop. A scar around the areola alone, sometimes called a periareolar or doughnut uplift, allows an even more limited adjustment. It cannot achieve the same tightening as a full uplift and can cause widening of the areola or surrounding scar, puckering or flattening of the breast. The shortest scar is not always the best option for the required change.

Mr Turton will explain the proposed pattern before surgery. The nipple is not normally detached and sewn back as a graft. If an unusually complex situation makes a free-nipple graft a possibility, this requires a separate discussion about permanent sensory loss, loss of breastfeeding, pigment change, flattening and the possibility of graft failure; it is not a routine part of mastopexy.

Closure and dressings

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. Drains may be used, particularly where more extensive reshaping or implant surgery is involved; the team will explain when they can be removed (usually the morning

after surgery). The wounds are covered with dressings, and an elasticated Tubigrip support is applied.

Where tissue is sent for laboratory examination, an unexpected abnormality can occasionally be found and 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, minor 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. Combined or revision implant surgery may require longer restrictions. Breast contact should be gentle when resumed and should not put pressure on healing wounds.

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. If stronger painkillers make you drowsy, do not drink alcohol, operate machinery or make important decisions while affected.

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. Do not remove dressings yourself unless specifically instructed, and avoid picking or scratching along the scars.

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 lifting and reshaping, technique, previous surgery, implants, body weight, diabetes, smoking and individual healing. Some problems need additional appointments, dressings, investigations or further surgery. A risk can be important to your decision even when it is uncommon.

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. Serious heart, lung or other complications are uncommon but possible and can occasionally be life-threatening. The anaesthetist will discuss risks relevant to you.

Bruising and haematoma

Bruising can very rarely 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 would require a return to theatre to remove the blood collection and address its source, and an additional night in hospital may be needed. A substantial collection can place pressure on healing tissues and affect nipple circulation. Blood transfusion is rarely required. Contact the hospital team promptly for sudden breast swelling, increasing tightness or bleeding through the dressings.

Later bleeding can occasionally occur after you have gone home. Avoid forceful reaching, stretching or straining during early healing, but continue gentle walking as advised. Medicines that affect bleeding need individual consideration before surgery. A haematoma can still occur despite careful surgery and following the postoperative instructions.

Seroma

A seroma is a collection of fluid in the operated area, including a space left after implant removal. 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. Drainage has a small risk of introducing infection, so an asymptomatic small collection may be observed. If fluid becomes infected, antibiotics and further treatment may be required.

Infection

Most infections after mastopexy are 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, and additional dressing visits may be needed.

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.

Where an implant is present, a deep infection involving it is a more significant problem and may require implant removal. Replacement may need to wait several months, commonly around six months, until the infection has resolved and the tissues have recovered. Removal on one side can leave a marked temporary difference between the breasts. Re-insertion is a further operation and is not always advisable.

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.

If an implant lies beneath a wound that breaks down, it may become exposed or infected. This can require implant removal as well as treatment of the wound. The possibility is particularly relevant when an uplift is combined with augmentation or revision implant surgery.

Nipple and areolar blood supply

The nipple and areola are normally moved with their blood supply attached. Despite precautions, circulation can become inadequate and cause partial or, less commonly, complete tissue loss, called necrosis. The risk is influenced by the distance the nipple needs to move, tissue quality, smoking, diabetes, pressure from an implant and any previous surgery or radiotherapy. Previous operations may have divided blood vessels that would otherwise help support the nipple.

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, poor circulation affects deeper breast tissue as well as the nipple and areola. A substantial defect may require removal of damaged tissue, prolonged dressings or further surgery, with healing and later correction taking many months. Permanent differences in contour, pigmentation, nipple projection or sensation can remain. Reconstruction or medical

tattooing may be considered after healing, but cannot restore all the original appearance or function.

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.

An ultrasound scan or biopsy may be needed to distinguish fat necrosis from other causes of a lump. Small localised areas often need no operation. More extensive fat necrosis can cause inflammation, oily discharge, wound breakdown, infection or a contour defect, and may require drainage or removal of non-viable tissue. 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, particularly near the scars. The two sides may be affected differently. Some women experience partial loss of sensitivity and others complete numbness. Changes may improve over several months, sometimes over a year or longer, but partial or complete loss can be permanent. Published rates vary with the operation performed and how sensation is assessed.

Altered nipple sensation may affect sexual pleasure, so please consider its importance to you before deciding on surgery. Recovery cannot be guaranteed, and later corrective surgery cannot reliably restore lost sensation. Be careful with hot-water bottles, heat pads and direct heat over numb skin, as reduced feeling can make a burn less noticeable.

Brief shooting sensations, tingling, itching, tenderness or sensitivity to temperature can occur during healing. These usually improve. 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

Mastopexy 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, including around the areola.

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 around 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.

Skin colour and contour changes

Bruising and swelling can temporarily change the colour and texture of the skin. Occasionally a patch remains lighter or darker after healing; pigment from a deep bruise can leave a longer-lasting mark. Areolar pigmentation may also look uneven, particularly where the original colour faded gradually at the edges or healing has been delayed.

Wrinkling, puckering, a small indentation, flattening or a palpable ridge can occur where tissues have been reshaped. Some improve as swelling settles and the scars soften; others persist, particularly with very thin or previously stretched skin. Further treatment may be considered after settling, but cannot guarantee a completely smooth contour.

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 mastopexy 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.

Allergic reactions and injury to deeper tissues

Dressings or adhesives can occasionally cause an itchy rash or skin irritation. Tell the team so that the cause can be assessed and the dressing changed if necessary. Reactions to medicines or other materials used during surgery are also possible; a severe allergic reaction, called anaphylaxis, is rare and requires urgent treatment. Please disclose previous reactions before surgery.

Injury to deeper nerves, blood vessels, muscle or the chest wall is very uncommon. Air entering the space around the lung, called a pneumothorax, is a rare potential complication, particularly when surgery involves an implant pocket or a capsule attached to the chest wall. It may require hospital treatment and a chest drain. The relevance of these risks depends on the operation being performed.

Additional considerations when implants are involved

Implants bring their own potential problems, including capsular contracture, rupture, gel bleed or silicone migration, rippling, palpable edges, movement out of position, rotation or front-to-back flipping. Under-muscle implants can move or temporarily distort the breast during forceful chest-muscle contraction. Implant position and the overlying breast tissue may change differently with time. These issues can require investigation, further surgery, replacement or permanent removal, with additional financial and cosmetic consequences. Breast implants are not lifetime devices.

Breast implant-associated anaplastic large cell lymphoma, or BIA-ALCL, is a rare lymphoma associated predominantly with textured implants. Other extremely rare cancers, including squamous cell carcinoma and other lymphomas, have been reported in implant capsules; their causes and frequency remain uncertain. Some women report general symptoms that they associate with their implants, often called breast implant illness or BII. This is not a

single established medical diagnosis, and a causal relationship has not been established. These matters, implant choice and longer-term monitoring are explained in Mr Turton's Breast Augmentation Patient Information Sheet and the relevant implant information.

These implant-specific issues should not be confused with the risks of an uplift in a woman who has never had implants. For someone who has previously had textured implants, removal cannot be assumed to eliminate the future risk of BIA-ALCL. New persistent swelling, a lump or an unexplained breast change should still be assessed. Current MHRA information is listed at the end of this sheet.

Changes over time and further surgery

The early result is not the final result. Tightness and swelling make the breasts look higher and firmer at first. As these reduce and the tissues relax, some settling of the lower breast and loss of upper fullness are expected. The amount and timing vary, and the two sides may settle differently. This does not automatically mean that the uplift has failed.

Breasts continue to change with age, gravity, pregnancy, hormonal changes and weight fluctuations. More substantial droop can recur, especially with heavy breasts, due to genetic variability, poor skin elasticity, previous major weight loss or implants. The lower part of the breast can stretch, sometimes called bottoming out. An implant does not prevent this process. Maintaining a stable weight helps preserve the result but cannot prevent all natural changes or guarantee how long the uplift will last.

Some women later wish to change the size or shape again. Repeat mastopexy, reduction, augmentation or another procedure may be considered, but further surgery can be more complex and carries additional risks to blood supply, healing and sensation. It cannot guarantee a particular result and may not be advisable for a minor difference. Previous operation details are important when planning any further surgery.

Breast health and future investigations

Mastopexy does not remove the risk of breast cancer or replace routine breast awareness and screening. Attend screening when invited or as advised for your individual risk. Tell the radiographer or breast clinician that you have had an uplift, because internal scarring, fat necrosis and calcification can alter imaging appearances and occasionally require additional tests.

If you also have implants, tell the screening service when booking. Implants can obscure some breast tissue on mammograms, and additional views are normally needed. Screening mammography is not a substitute for assessing a new symptom or for appropriate investigation of a possible implant problem.

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 cosmetic breast surgery, 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 his 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.

At the time of publication, mastopexy alone with Mr Turton usually costs around £12,000. Hospital charges are reviewed periodically, so this guide price may change. Your individual fixed-price hospital quotation will confirm the procedure, cost, inclusions and terms for aftercare and additional treatment. General website prices may not reflect your treatment. An uplift with implants or revision surgery has different costs; if surgery is staged, each operation has its own quotation.

Before deciding

Mastopexy can offer a worthwhile improvement in breast shape, proportion and confidence. Your decision should balance the changes you hope for against the limits of your anatomy, permanent scars and the possibility of further change or surgery. A particular cup size, lasting upper-breast fullness or exact symmetry cannot be guaranteed.

Please discuss any remaining questions with Mr Turton before proceeding. This sheet describes the principal issues but cannot cover every possible outcome or complication. Read it alongside the related website information, your individual consultations and agreed surgical plan, and the breast augmentation information if implants are involved.

Further information

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

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

Nuffield Health information about breast uplift: https://www.nuffieldhealth.com/treatments/breast-uplift-mastopexy

BAPRAS information about uplift and related surgery: https://www.bapras.org.uk/public/patient-information/surgery-guides/body-contouring/procedures

For patients with current or previous breast implants, MHRA information about BIA-ALCL: https://www.gov.uk/government/publications/information-about-bia-alcl-for-people-with-breast-implants

MHRA reported BIA-ALCL data and updates: https://www.gov.uk/guidance/breast-implants-and-anaplastic-large-cell-lymphoma-alcl

MHRA information about other cancers reported in implant capsules: https://www.gov.uk/government/publications/squamous-cell-carcinoma-scc-and-different-types-of-lymphomas-occurring-in-the-capsule-around-breast-implants

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