

Commentary on: Pain Control Following Breast Augmentation: A Qualitative Systematic Review

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A hallmark that distinguishes science from other intellectual endeavors is that it builds upon past accomplishments rather than beginning afresh. In their review article, Dr Stanley and her coauthors focused on the treatment of significant pain following breast augmentation after a decade-long era in which avoidance of such pain has become de rigueur for many surgeons and their patients. Preemption of pain is not simply the preferred method of our time; it is an ethical imperative. Recent evidence has also shown an increase in long-term opioid use, even in patients who received a single narcotic prescription following ambulatory surgery.¹

This article reviews various previously-published treatment strategies for breast augmentation, yet only gives perfunctory mention to a study that described in exquisite detail how postaugmentation pain can be reduced and subsequently managed by ibuprofen alone, with a return to full normal activities within 24 hours.^{2,3} This method has since been taught to hundreds of surgeons at the Maintenance of Certification–Plastic Surgery Breast Augmentation course at each annual meeting of the American Society for Aesthetic Plastic Surgery, as well as at innumerable other educational forums.

These authors dismiss that study with the assertion that this “may not be possible in all cases.” Yet the series results (which were reviewed by a contract research organization, or CRO) documented only a 4% failure, which indicates the need for these extreme methods is uncommon. And that was a decade ago. Have these authors personally implemented these processes? In what cases was it not possible? Emphasizing pain management adjuncts rather than contemporary surgical processes suggests to readers that severe pain is inevitable after breast augmentation. Using surgical technique as a metaphor, special postoperative straps are used to push an implant into an area of underdissection or away from an area of overdissection; however, both can be avoided if pocket dissection is precise. Similarly, postoperative narcotics should not be used to make up for suboptimal surgical techniques and processes.⁴

Another characteristic of science is the reproducibility of its findings. The processes described in that 2002 publication have been successfully adopted by many surgeons.

So why have not more plastic surgeons implemented these processes? Are plastic surgeons not reading their journals? Are they too complacent to improve? These are not rhetorical questions but matters that must be examined by plastic surgeons as individuals and as a specialty.

Instead of motivating improvement, this article offers refuge to surgeons who choose to remain static. This publication calls into question whether the emphasis plastic surgeons are placing on evidence-based medicine is sincere or merely lip service.

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