The breast became the focus of attention as an icon of beauty hundreds of years ago. The desire for larger breasts can be dated back as early as medieval times, when women started to wear corsets to optically increase the volume of their chest. Thus, breast augmentation continues to be the number one plastic surgical procedure for aesthetic purposes in the United States and throughout the world. The ongoing

Motiva Ergonomix Round SilkSurface Silicone Breast Implants: Outcome Analysis of 100 Primary Breast Augmentations over 3 Years and Technical Considerations

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Background: Macrotextured anatomical implants are frequently used in aesthetic breast surgery; however, several safety concerns linked to this implant type have been raised recently. In an attempt to address these shortcomings, Motiva Ergonomix implants have been introduced. Here, the authors describe the current world’s largest experience with these novel devices in aesthetic breast surgery and evaluate the postoperative outcome of 100 primary breast augmentations.

Methods: A retrospective assessment of 100 consecutive primary breast augmentation patients over a period of 3 years was conducted. Patients were followed for a minimum of 6 months postoperatively. Demographics, surgical data, and complications were recorded. In addition, a survey regarding the breast augmentation outcome was performed.

Results: The reasons for surgery were mainly hypoplasia (52 percent) and ptosis (28 percent). All implants were placed by means of an inframammary approach in a submuscular pocket, and the average implant volume was 370 cc (range, 150 to 700 cc) with mostly full projection (65 percent). The revision rate was 7 percent. The authors observed four cases of implant malpositioning, one implant rupture, one implant exchange for aesthetic reasons, and one hematoma evacuation. Nevertheless, the authors achieved a 100 percent satisfaction rate with the postsurgical outcome among both patients and surgeons.

Conclusions: Motiva Ergonomix implants provide reliable and satisfying results for both patients and surgeons. They can be used safely and effectively for aesthetic breast surgery. However, like all breast prostheses, Motiva Ergonomix implants are not completely free of complications and should be used only with advanced technique to achieve optimal results. (Plast. Reconstr. Surg. 141: 831e, 2018.)

CLINICAL QUESTION/LEVEL OF EVIDENCE: Therapeutic, IV.

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success story of breast augmentation was deeply shattered in the 1990s by the U.S. Food and Drug Administration ban of silicone gel implants. After numerous studies on their safety, the U.S. Food and Drug Administration reapproved silicone-filled implants for aesthetic purposes in 2004. Just recently, a possible new threat, breast implant–associated anaplastic large cell lymphoma, was brought to our attention. The possible implications for the whole industry are not to be foreseen. In particular, the implant shell surface is thought to be responsible for this new entity of malignancy, with rougher surfaces being more prone to trigger the disease. Thus, breast implants with less texturization are recently gaining popularity again.

Breast implants today come in various sizes, shapes, and projections. The balance of augmenting the breast and retaining a natural appearance is often desired by patients and represents a surgical challenge. Traditionally, round implants have been used to increase fullness of the breast’s upper pole, whereas anatomical or teardrop-shaped implants were designed to best mimic the natural breast shape, with more fullness in the lower pole. Although anatomical implants have generally proven to be a safe and effective alternative to classic round implants, the placement requires a more advanced technique and they harbor the additional risk of implant malrotation, which is described in up to 5.2 percent of cases.

In an attempt to mimic a natural appearing breast without the problems of rotation, Motiva Ergonomix implants were designed and introduced by Establishment Labs (Alajuela, Costa Rica) in 2013. According to the company’s description, Motiva Ergonomix are round, 100 percent filled implants that adapt shape after implantation to give a natural appearance and feel, without the risk of rotation deformity. Motiva Ergonomix implants are supposed to adjust with gravity to the patient’s position. The technology used is a combination of a specific elastomer shell and the special rheologic properties of newly developed silicone gel (Fig. 1).

In addition to special rheologic properties, Motiva Ergonomix breast implants stand out with a newly designed surface. Breast implant surfaces have conventionally been characterized as either smooth or textured. Textured surfaces can be induced by projecting salt, sugar, or other particles onto the implant shell. Lately, several studies have linked aggressive texturing with secondary adverse effects such as late seroma and double-capsule formation. Motiva Ergonomix implants are manufactured with a so-called SilkSurface, which is obtained without the use of foreign materials such as salt or sugar, for better biocompatibility (Fig. 2). According to the company’s claims, the nanosurface promotes a more natural interaction between the implant and the surrounding tissue, allowing the implant to better adapt to the movement of the breast.

The special surface and rheologic characteristics suggest that Ergonomix implants are a useful addition to the techniques available to the aesthetic and reconstructive breast surgeon. However, currently no independent clinical data are available on these new prostheses proving them safe and effective. In general, a review of the breast

![Fig. 1. Motiva SilkSurface concept. Motiva Ergonomix implants adjust with gravity to the patient’s position. With gravity, the maximum point of projection shifts to the lower pole when the patient is in standing position. When the patient lies flat, the implants will react in a similar way to a natural breast, and the maximum point of projection will move closer to the middle of the breast.](image-url)
implant device literature reveals that financial support from the industry is common and sometimes company employees are even listed as coauthors.\textsuperscript{9–11} Therefore, it can be hard to determine whether study results are reported in an unbiased fashion or whether the conclusions drawn should be considered skeptically. Thus, it is important to note that this project is entirely independent of any company’s support or input. Here, we present the outcome of the first 200 Motiva Ergonomix implants used at our institution in 100 consecutive patients over 3 years. We evaluate the performance of the devices and share technical insights on their optimal use.

PATIENTS AND METHODS

This study is a retrospective assessment of data collected over a period of 3 years. From 2014 until 2017, 100 consecutive patients underwent primary breast augmentation with Motiva Ergonomix round SilkSurface silicone breast implants. All patients were female, the mean age at surgery was 32.8 years (range, 18 to 60 years), and the average body mass index was 20.6 kg/m\textsuperscript{2} (range, 17 to 29 kg/m\textsuperscript{2}). A detailed history was taken and basic examinations were performed to ensure that all patients were in good overall health. The rate of smokers was 42 percent, and 4 percent of patients were treated for depression or anxiety. Screening for comorbidities such as high blood pressure and diabetes was performed (Table 1). Exclusion criteria included pregnancy or breast-feeding, a medical condition interfering with wound healing (e.g., active infectious collagen disease), active fever (temperature >38°C), severe lung disease such as chronic obstructive pulmonary disease or cystic fibrosis, active cutaneous or systemic infections, radiation therapy or chemotherapy, and alcohol or drug abuse within 6 months before surgery.

Surgical Procedure

All surgical procedures were carried out by the first author (G.M.H.) and one assistant, respecting the patient’s body type and aesthetic goals. Selection of implant size was facilitated by using external sizers and conducted with particular emphasis on the patient’s wishes and her idea of the ideal breast size and shape. Implant selection was always finalized in two separate appointments before the actual surgery. After sterile washing of the patient in general anesthesia and supine position, disposable drapes were applied. Nipple shields were used in all procedures.\textsuperscript{12} An inframammary approach was chosen in all patients and all implants were placed in a modified

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Table 1. Patient Demographics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value (%)</th>
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<tbody>
<tr>
<td>Patients</td>
<td>100 (100)</td>
</tr>
<tr>
<td>Female</td>
<td>100 (100)</td>
</tr>
<tr>
<td>Age, yr</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>32.8</td>
</tr>
<tr>
<td>Range</td>
<td>18–60</td>
</tr>
<tr>
<td>BMI, kg/m\textsuperscript{2}</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>20.6</td>
</tr>
<tr>
<td>Range</td>
<td>17–29</td>
</tr>
<tr>
<td>Smoking</td>
<td>42 (42)</td>
</tr>
<tr>
<td>Psychopharmacologic drugs</td>
<td>4 (4)</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0 (0)</td>
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</table>

BMI, body mass index.
submuscular position, similar to the dual-plane technique.\textsuperscript{13} Because of the superior elastic properties of the Ergonomix implant, a short incision of approximately 3 cm is sufficient for implant placement (Fig. 3). In our modified dual-plane pocket dissection (Fig. 4), we first dissect a subglandular pocket with a narrow part in continuity with the incision and a progressively wider part with an apex toward the axilla. Subsequently, the gland stays attached to the muscle in the inferior part but not in the two upper quadrants. (Right) The dissection of the submuscular plane is similar to the classic dual-plane technique except for the release of the inferior part of the muscle. Here, the pectoralis major muscle is separated from the sternal border from inside-out using electrocautery. Because of the modified subglandular dissection, the now-free muscle edge still is attached to the gland. This allows both sufficient draping of the gland and more stable positioning of the pectoralis major muscle, inhibiting it from sliding cranially (window-shading) during implant placement. We incise the inferior border of the pectoralis major muscle centrally to prevent breast animation deformity. To prevent dislocation of the Motiva Ergonomix implants, inframammary fold violation should be avoided whenever possible (danger zone marked in red). We generally recommend a fixation of the inframammary fold in all Motiva Ergonomix patients.
with an apex toward the axilla. Subsequently, the gland stays attached to the muscle in the inferior part but not in the two upper quadrants. This allows for improved draping of the breast after placement of the implant, resulting in an even more natural appearance. Next, the lateral edge of the muscle is lifted and the submuscular plane is developed. The dissection is similar to the classic dual-plane technique, except for release of the inferior part of the muscle. Here, the pectoral muscle is separated from the sternal border from inside-out using electrocautery. The sufficient dissection of the muscle can be easily palpated from inside the submuscular plane. Because of the modified subglandular dissection, the now-free muscle edge still is attached to the gland. We feel that this approach allows both sufficient draping of the gland and more stable positioning of the pectoralis major muscle, inhibiting it from sliding cranially (window-shading) during implant placement. Finally, we incise the inferior border of the pectoralis major muscle centrally to prevent breast animation deformity. For estimation of the size and shape of the dissected implant pocket, we use a simple technique of trapping air inside the pocket. This method allows us to elegantly assess pocket preparation and avoid boxiness and underdissection or overdissection.

A crucial component in breast augmentation with the Ergonomix implant is the management of the inframammary fold. Disruption of the ligamentary suspension of this important anatomical structure should be avoided (Fig. 4, right) but, if indicated, a thorough refixation should be ensured. Because of the Velcro effect, specific management of the lowered inframammary fold is rarely needed with macrotextured anatomical implants. What we have seen from our experience with the first Ergonomix patients is a tendency of caudal migration and mobilization of implants over time (see later under Results). Thus, we have implemented fixation of the inframammary fold in all our patients. This was performed even in cases with smaller implants and no violation of the inframammary fold. We reinforced the infra mammary fold in a multilayered closure technique similar to that published recently by Montemurro et al. Solid fixation of the inframammary fold to the chest wall by suturing the superficial fascia of the cranial wound edge to the deep fascia including the superficial fascial system of the caudal wound edge (three-point suture) with a running 0 braided nonabsorbable suture (Ti-Cron; Covidien, Mansfield, Mass.) has successfully eliminated implant dislocation in our study cohort. Wounds were further closed using 3-0 absorbable, interrupted, deep dermal sutures (Polysorb; Covidien) and a running 4-0 intradermal suture (Caprosyn; Covidien) and application of Leukostrips (Smith & Nephew, London, United Kingdom). All procedures were performed as outpatient surgery without the placement of drains. The standard postoperative regimen included checkups after 3 days, 7 days, 14 days, 3 months, and 1 year; antibiotic prophylaxis; nonsteroidal antirheumatic drugs for 7 days; and a surgical bra continuously for 8 weeks. Surgical data collected included implant volume and projection. All perioperative and postoperative complications including reoperations and reasons for revision were recorded in a prospective patient database. Patients were followed for at least 6 months postoperatively. The results were analyzed by means of descriptive statistics.

Survey

In addition to the analysis of our patient database, we performed a survey at the 1-year follow-up appointment. The surgeons and 71 patients, who reached the 1-year follow-up so far, were asked to answer a questionnaire. A six-item Likert scale was used to assess the breast augmentation outcome. The questionnaire results were analyzed by means of descriptive statistics.

RESULTS

Outcome Analysis

Between 2014 and 2017, 200 Motiva Ergonomix round SilkSurface silicone breast implants were used in 100 consecutive patients. The reasons for aesthetic breast surgery were mainly hypoplasia (52 percent) and ptosis (28 percent). In 8 percent of patients, combined hypoplasia with ptosis was corrected, and 12 percent of patients suffered from asymmetry (Table 2). The average implant volume was 370 cc (range, 150 to 700 cc), and most implants were chosen with full projection (65 percent), followed by Demi (34 percent) and Corsé (1 percent). All implants were placed by means of an inframammary approach

<table>
<thead>
<tr>
<th>Table 2. Reasons for Breast Augmentation</th>
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<tr>
<td>Reason</td>
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<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Hypoplasia</td>
</tr>
<tr>
<td>Hypoplasia with ptosis</td>
</tr>
<tr>
<td>Ptosis</td>
</tr>
<tr>
<td>Asymmetry</td>
</tr>
</tbody>
</table>
When a new breast prosthesis is introduced to the market, it is paramount to continuously evaluate its safety and rigorously record all short- and long-term complications. In this pilot study cohort, seven patients (7 percent) experienced a complication, with six of them potentially implant related (there was one postoperative hematoma that was evacuated 3 hours after surgery) (Table 4). We observed two implant dislocations beyond the inframammary fold approximately 6 and 12 months postoperatively. The problem was solved by a revision procedure to reposition the inframammary fold. During the reset of the fold, the implant pocket was examined and a ruptured implant was discovered in one of the cases. After capsulectomy, the implant was replaced with an Ergonomix prosthesis of the same size and sent to the manufacturer for evaluation. Two weeks of surgical tape fixation of the inframammary fold was carried out postoperatively in addition to the standard surgical bra in cases of dislocation. In two cases, the implants gained hypermobility within 6 months after augmentation to an extent not tolerable for the patients. In both cases, a surgical revision was necessary to perform a plication of the implant pocket.

One patient felt that the augmented breasts were too large with too much upper pole fullness and requested a revision for aesthetic reasons. During revision surgery, we encountered a preoperatively undetected capsular contracture on both sides. The capsules were removed completely and new prostheses were implanted. [See Figure, Supplemental Digital Content 1, which shows (left) a subclinical capsular fibrosis, encountered during an implant exchange for aesthetic reasons. A complete capsulectomy was performed. (Right) Fibrosis with a capsule greater than 2.5 mm thick was confirmed histologically, http://links.lww.com/PRS/C759.] Histologic evaluation after hematoxylin and eosin staining showed fibrous tissue with occasional vessel ingrowth and a thickness of the fibrous capsule between 1.93 and 2.55 mm on the right side and 1.2 and 2.57 mm on the left side. Notably, there were no additional complications such as wound dehiscence, infection, or seroma observed in the study cohort. No patient experienced life-threatening events, and no allergic reactions to any device or substance used were encountered.

Survey Analysis

To further assess postoperative results, a survey was carried out. The breast augmentation results were evaluated by three plastic surgeons and by the individual patient 1 year postoperatively using a six-item Likert scale questionnaire.17 Patients were further asked to answer questions regarding their recovery and quality of life after breast augmentation. Overall, patients and surgeons alike were satisfied with the result of the breast augmentation (Fig. 5). However, although 86 percent of patients strongly agreed that they were satisfied with their outcome (Fig. 5, above), surgeons felt that way in only 73 percent of cases (Fig. 5, below). The generally high rate of patient satisfaction corresponds well with the rest of the survey results. All patients were happy with the size of the breast (the one patient with an implant exchange 6 months after implantation for aesthetic reasons was happy at 1 year after revision surgery), had a fast recovery, experienced positive reactions from their environment, and would repeat the procedure any time (Fig. 6). Six percent of patients disagreed somewhat with the shape of their breasts and 4 percent described a remaining foreign body sensation. Only one patient had no improvement of self-esteem after the operation, and two patients

### Table 3. Surgical Procedural Parameters

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary augmentation</td>
<td>100 (100)</td>
</tr>
<tr>
<td>Inframammary approach</td>
<td>100 (100)</td>
</tr>
<tr>
<td>Volume, cc</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>368</td>
</tr>
<tr>
<td>Range</td>
<td>150–170</td>
</tr>
<tr>
<td>Projection</td>
<td></td>
</tr>
<tr>
<td>Full</td>
<td>65 (65)</td>
</tr>
<tr>
<td>Demi</td>
<td>34 (34)</td>
</tr>
<tr>
<td>Corsé</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Submuscular position</td>
<td>100 (100)</td>
</tr>
</tbody>
</table>

### Table 4. Complications and Revisions

<table>
<thead>
<tr>
<th>Complication</th>
<th>Prevalence (%)</th>
<th>Surgical Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant dislocation</td>
<td>2 (2)</td>
<td>Refixation of the inframammary fold</td>
</tr>
<tr>
<td>Implant mobility</td>
<td>2 (2)</td>
<td>Plication of implant pocket</td>
</tr>
<tr>
<td>Implant rupture</td>
<td>1 (1)</td>
<td>Capsulectomy and implant exchange</td>
</tr>
<tr>
<td>Implant exchange for aesthetic reasons</td>
<td>1 (1)</td>
<td>Capsulectomy and implant exchange</td>
</tr>
<tr>
<td>Postoperative hematoma</td>
<td>1 (1)</td>
<td>Evacuation</td>
</tr>
</tbody>
</table>
felt limited in sports to some degree. Although 93 percent of patients reported their life quality to have improved by the breast surgery, 7 percent disagreed with that statement (Fig. 6).

Considered together, our clinical and questionnaire data clearly demonstrate Motiva Ergonomix implants to be safe and effective in aesthetic breast surgery. The use of Motiva Ergonomix implants results in aesthetically pleasing results with a natural appearance and feel (Figs. 7 and 8). Applicable in a variety of indications, these novel devices enable the skilled surgeon to deliver very satisfying outcomes with an acceptable complication rate.

**DISCUSSION**

The market for breast prostheses is most dynamic, and today’s implants have come a long way since their first application in 1962 by Gerow, Cronin, and Biggs in Houston, Texas. More than 50 years after the first breast augmentation with a silicone implant, the so-called fifth-generation implants currently in use excel with a cohesive, more form-stable, silicone, and textured surface. However, setbacks such as the scandals around implants manufactured by Poly Implant Prothèse and the recently reported occurrence of anaplastic large cell lymphoma in patients with breast implants remind us to critically evaluate any innovation no matter how exciting. The implementation of an innovative device can pose a challenge to its users. To adequately apply Ergonomix implants, some changes in the standard breast augmentation technique are advisable. Here, we summarize the lessons we have learned and some innovative approaches we developed aiming to harness all the benefits and to avoid potential shortcomings of these novel prostheses.

The most common complication in our cohort was implant malpositioning (two cases of implant dislocation beyond the inframammary fold and two cases of hypermobility). Both cases of hypermobility occurred in patients with ptotic...
breasts and considerable skin excess. Based on this experience, we feel that smoother implants such as Ergonomix should be used with caution in this patient population, particularly when an additional mastopexy procedure might be indicated. Textured implants that promote early tissue ingrowth\textsuperscript{19} can potentially facilitate stabilization of the implants within the pocket. This feature could be especially advantageous in cases of patients with a less firm soft-tissue envelope more prone to dislocation.\textsuperscript{20}

In addition to facilitating placement, the shell structure of the Ergonomix implants excels with a truly innovative surface potentially affecting tissue reactions to the implant. The SilkSurface has 8000 contact points per square centimeter, with a roughness parameter of 2488. In contrast, a smooth surface implant is typically measured to have a roughness parameter less than 500. Each contact point has an average size of 16 µm, making the nomenclature “nanosurface” often used for the SilkSurface somewhat misleading. Nevertheless, the irregularities of the SilkSurface are at least 10 times smaller than the textures of competing manufacturers’ implants.\textsuperscript{21} Shell texturization is meant to decrease the risk of dislocation and capsular contracture but turns out more and more to be a double-edge sword. Although overaggressive, salt-based texturing was recently linked to secondary adverse events such as late seroma and double-capsule formation,\textsuperscript{7,8} a suspected decrease in pore size of Allergan’s Biocell (Allergan, Inc., Dublin, Ireland) surface over the past decade is speculated to correlate with increased implant nonadhesions and dislocations.\textsuperscript{21} However, cell adhesion and cellular ingrowth are not only related to the topology of the shell surface but are most certainly multifactorial.\textsuperscript{22–24} The same is true for capsular contracture, which is influenced by bacterial colonization, surgical approaches, biomechanical behavior of the capsule, and previous irradiation.\textsuperscript{25} Whether microtexturization like that

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**Fig. 6.** Patient survey. Breast augmentation with Motiva Ergonomix implants lead to overall positive effects on patients’ quality of life. All patients were happy with the size of the breast, had a fast recovery, experienced positive reactions from their environment, and would repeat the procedure any time. Six percent of patients disagreed somewhat with the shape of their breasts and 4 percent described a remaining foreign body sensation. Only one patient had no improvement of self-esteem, and two patients felt limited in sports to some degree. Ninety-three percent of patients reported overall improved quality of life after surgery. BA, breast augmentation.
used in Ergonomix implants is truly advantageous has not been thoroughly examined, and we have observed one case of capsular contracture formation in our cohort. Similarly, large-scale studies will be necessary to determine the actual rupture rate and place the single incident in our cohort over 3 years in context.

With this in mind, the surgeon should be aware of the somewhat different behavioral properties of the Ergonomix implant compared with the macrotextured or even polyurethane-coated implants when it comes to pocket preparation. An overly aggressive approach should be avoided because the so-called Velcro effect of rough implants cannot be expected with Ergonomix implants. Especially when it comes to manipulation of the inframammary fold, caution is mandatory. The usual approach in a breast augmentation with a larger implant in a breast that has a short nipple-to-fold distance is to lower the inframammary fold. It is not uncommon when using textured implants to subsequently not reconstruct the newly set fold in such cases because there is little tendency of the implant to drop significantly after the operation. We encountered four patients that experienced implant dislocation below the inframammary fold or expansion of the initial implant pocket with resulting implant hypermobility. This is especially

**Fig. 7.** Representative clinical case. This patient requested a somewhat significant breast augmentation of approximately 2 cup sizes. We placed 400-cc Motiva Ergonomix implants with full projection on both sides. The postoperative photographs were taken 1 year after surgery.
bothersome to the patient in the prone position, where the implant can migrate as far as the axilla. When we started to notice this tendency, we changed our management of the inframammary fold. Resetting of the fold was done less often and only when unavoidable. These were typically patients with a very tight skin envelope requesting larger augmentations. We started to reinforce the inframammary fold in every patient for additional security of this important anatomical structure. Furthermore, we were very cautious with lateral preparation of the implant pocket trying not to violate the deep fascial attachments lateral to the pectoralis major and minor muscles. With these modifications, we were able to eliminate dislocation problems in our patient cohort.

Nevertheless, patient satisfaction after breast augmentation is generally high despite relatively frequent complications and reoperations. It has been shown in a recently published nationwide study involving more than 15,000 U.S. patients that implants are effective in improving women’s

Fig. 8. Representative clinical case. This patient suffered from hypoplasia with asymmetry and constricted lower poles of both breasts. To correct size and shape, a 625-cc Motiva Ergonomix implant was placed on the right side and a 525-cc implant was used on the left side. The postoperative photographs were taken 1 year after surgery.
quality of life. The authors found significant and sustained improvements in satisfaction and psychosocial well-being. These findings are confirmed in our evaluation, clearly demonstrating that women undergoing breast augmentation with Ergonomix implants are generally happy with the results. This is complemented by high satisfaction with outcomes among the authors.

CONCLUSIONS

Currently, there are at least 11 companies in Europe, the Americas, and Asia that manufacture breast implants. After the fifth generation of breast prostheses was established some years ago and adapted by most companies, Motiva Ergonomix implants represent the most recent true innovative concept introduced to the market. Here, we describe the world’s current largest experience with these novel devices. We found in our study cohort of 100 patients over 3 years that Motiva Ergonomix implants provide reliable and satisfying results for both patients and surgeons. They can be used safely and effectively for aesthetic breast surgery. However, like all breast prostheses, Motiva Ergonomix implants are also not completely free of complications and should be used only with advanced technique to provide optimal results.

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