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Gigantomastia: A Case Series with Review of Literature

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Abstract

Background: Gigantomastia is a rare and potentially debilitating disorder characterized by excessive and disproportionate enlargement of the breasts. There is no universally accepted definition, although many published series use a postoperative reduction weight of more than 1.5 kg per breast as a descriptive criterion. The condition may be associated with pregnancy, puberty, medications, systemic disease, or may occur without an identifiable precipitating factor. Severe enlargement can result in musculoskeletal pain, functional limitation, skin changes, psychological distress and significant impairment of quality of life. [1,2]

Methods: We present a case series of four women with clinically significant bilateral gigantomastia managed in our institution. Clinical presentation, associated factors, investigations, operative management, histopathology and postoperative outcomes were reviewed. A review of relevant literature was undertaken to contextualize the clinical spectrum and management of gigantomastia.

Results: Four patients aged 25–40 years presented with progressive bilateral breast enlargement. All patients had massive symmetrical hypertrophy with Grade III ptosis, striae and dilated superficial veins. Common symptoms included neck and back pain, shoulder grooving, difficulty walking and sleeping, and psychological distress. Two patients had pregnancy-related or postgestational associations, while one developed progressive enlargement following infertility treatment. Hormonal and systemic evaluations were normal in all four patients, and ultrasonography demonstrated diffuse glandular hypertrophy without focal lesions. All patients underwent bilateral reduction mammoplasty. The total amount of breast tissue removed was 20.7 kg, ranging

from 4.2 to 5.6 kg per patient. Histopathology demonstrated lobular and ductal hyperplasia with stromal fibrosis, without atypia or malignancy. At 6 months, all patients had resolution of pain with improvement in mobility, posture, sleep and quality of life, with satisfactory functional and cosmetic outcomes.

Conclusion: Gigantomastia is a rare condition with substantial physical and psychosocial morbidity. Thorough evaluation to exclude secondary causes and malignancy, followed by individualized surgical planning, is essential. In patients with established symptomatic disease, reduction mammoplasty can provide substantial functional and quality-of-life improvement.

Keywords: Gigantomastia, Macromastia, Breast Hypertrophy, Postgestational Gigantomastia, Reduction Mammoplasty, Breast Reduction, Plastic Surgery.

Introduction

Gigantomastia, also termed massive breast hypertrophy, is an uncommon disorder characterized by excessive and disproportionate enlargement of the breasts. Despite numerous publications, there remains no universally accepted clinical or quantitative definition. Dancey et al. reviewed 115 patients and noted that the frequently cited criterion of more than 1.5 kg of tissue reduction per breast represents a postoperative rather than a practical preoperative definition. They proposed classification according to etiology, management and prognosis.[1]

The etiology of gigantomastia is heterogeneous. Described categories include gestational, juvenile or pubertal, drug-induced and idiopathic forms. The underlying pathophysiology remains incompletely understood. Proposed mechanisms include hypersensitivity of breast tissue to normal circulating concentrations of estrogen and progesterone, altered prolactin responsiveness and increased sensitivity of local hormonal receptors. [1,2]

Gestational gigantomastia is a particularly uncommon form characterized by rapid and excessive breast enlargement during pregnancy. A systematic review of 50 reported cases highlighted the considerable clinical morbidity associated with the condition and the need for multidisciplinary management.[2] A subsequent systematic review of cases reported during the 21st century further demonstrated the wide clinical spectrum and variability in medical and surgical management. [3]

The clinical consequences of severe breast enlargement extend beyond breast-related symptoms. Patients may develop neck, shoulder and back pain, shoulder grooving, difficulty walking and sleeping, skin stretching, ulceration, infection, venous congestion and considerable psychological distress. [1,3]

We present a series of four patients with gigantomastia who underwent bilateral reduction mammoplasty and achieved satisfactory functional and cosmetic outcomes. The purpose of this case series is to describe the clinical spectrum encountered in our patients and discuss the current literature regarding pathogenesis, evaluation and management.

Materials and Methods

A retrospective case series of four patients with clinically significant bilateral gigantomastia treated in the Department of Plastic Surgery at AIIMS Bibinagar was reviewed.

The following parameters were assessed:

- Age and body mass index
- Obstetric history
- Possible precipitating factors
- Duration of breast enlargement
- Symptoms and functional impairment
- Clinical breast findings

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- Hormonal and systemic investigations
- Ultrasonographic findings
- Conservative treatment
- Surgical technique
- Amount of tissue excised
- Histopathological findings
- Postoperative outcome and follow-up

All four patients underwent bilateral reduction mammoplasty. The available follow-up was 6 months.

Case Presentations

Case 1:

A 25-year-old unmarried woman with a BMI of 30 kg/m² presented with progressive bilateral breast enlargement for 2 years. She complained of neck and back pain, shoulder grooving, difficulty walking and sleeping, and significant psychological distress.

Clinical examination revealed massive symmetrical breast hypertrophy with Grade III ptosis, prominent striae and dilated superficial veins.

Hormonal and systemic investigations were within normal limits. Ultrasonography demonstrated diffuse glandular hypertrophy without a focal lesion. Conservative treatment was attempted but was unsuccessful.

The patient underwent bilateral reduction mammoplasty using a superomedial pedicle. A total of 4.2 kg of breast tissue was removed, comprising 2.0 kg from the right breast and 2.2 kg from the left breast.

Histopathological examination demonstrated lobular and ductal hyperplasia with stromal fibrosis, without atypia or malignancy.

At 6 months follow-up, the patient reported complete resolution of pain with improvement in mobility, posture and sleep. There was significant improvement in quality of life, with a good functional and cosmetic outcome.

Case 2: Postgestational Gigantomastia

A 29-year-old G2P2 woman with a BMI of 33.7 kg/m² presented with progressive bilateral breast enlargement persisting for 4 years postpartum. The breasts had failed to regress following cessation of breastfeeding.

She complained of neck and back pain, shoulder grooving and difficulty walking and sleeping. Examination revealed massive symmetrical hypertrophy with Grade III ptosis, striae and dilated superficial veins.

Hormonal and systemic investigations were normal. Ultrasonography showed diffuse glandular hypertrophy without a focal lesion. Conservative treatment was unsuccessful.

The patient underwent bilateral reduction mammoplasty, with removal of 5.4 kg of tissue—2.8 kg from the right breast and 2.6 kg from the left breast.

Histopathology showed lobular and ductal hyperplasia with stromal fibrosis, without atypia or malignancy.

The final diagnosis was postgestational gigantomastia. At 6 months follow-up, there was complete resolution of pain, improvement in mobility and posture, and improved sleep and quality of life. The patient had a good functional and cosmetic outcome.

Case 3: Gigantomastia in a Middle-Aged Woman

A 40-year-old G2P2 woman with a BMI of 34 kg/m² presented with a 10-year history of progressive bilateral breast enlargement.

She reported neck and back pain, shoulder grooving, difficulty walking and sleeping, and psychological distress. Examination demonstrated massive symmetrical breast hypertrophy with Grade III ptosis, striae and dilated superficial veins.

Hormonal and systemic investigations were normal. Ultrasonography demonstrated diffuse glandular hypertrophy without a focal lesion. The patient did not opt for conservative treatment.

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She underwent bilateral reduction mammoplasty using a superomedial pedicle. A total of 5.6 kg of breast tissue was removed, with 2.8 kg removed from each breast.

Histopathology showed lobular and ductal hyperplasia with stromal fibrosis, without atypia or malignancy.

At 6 months follow-up, the patient had complete resolution of pain and improvement in mobility, posture and sleep, with significant improvement in quality of life and a good functional and cosmetic result.

Case 4: Gigantomastia Following Infertility Treatment

A 30-year-old G1P0A1 woman with a BMI of 30 kg/m² presented with progressive bilateral breast enlargement developing over 2 years following infertility treatment. The enlargement failed to regress after discontinuation of treatment.

She experienced neck and back pain, shoulder grooving and difficulty walking and sleeping. Examination revealed massive symmetrical hypertrophy with Grade III ptosis, striae and dilated superficial veins.

Hormonal and systemic investigations were normal. Ultrasonography showed diffuse glandular hypertrophy without a focal lesion. Conservative treatment was not opted for.

The patient underwent bilateral reduction mammoplasty using a superomedial pedicle. A total of 5.5 kg of tissue was excised, comprising 2.8 kg from the right breast and 2.7 kg from the left breast.

Histopathological examination demonstrated lobular and ductal hyperplasia with stromal fibrosis, without atypia or malignancy.

At 6 months follow-up, the patient had resolution of pain and improvement in mobility, posture and sleep, together with improved quality of life and a good functional and cosmetic outcome.

Table 1: Clinical characteristics of the four patients

Variable	Case 1	Case 2	Case 3	Case 4
Age	25 years	29 years	40 years	30 years
BMI	30 kg/m²	33.7 kg/m²	34 kg/m²	30 kg/m²
Obstetric status	Unmarried	G2P2	G2P2	G1P0A1
Duration	2 years	4 years postpartum	10 years	2 years
Associated factor	None documented	Postgestational	None documented	Following infertility treatment
Neck/back pain	Present	Present	Present	Present
Shoulder grooving	Present	Present	Present	Present
Difficulty walking	Present	Present	Present	Present
Difficulty sleeping	Present	Present	Present	Present
Psychological distress	Present	Not specifically documented	Present	Not specifically documented
Ptosis	Grade III	Grade III	Grade III	Grade III
Striae	Present	Present	Present	Present
Dilated veins	Present	Present	Present	Present

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Variable	Case 1	Case 2	Case 3	Case 4
USG	Diffuse glandular hypertrophy	Diffuse glandular hypertrophy	Diffuse glandular hypertrophy	Diffuse glandular hypertrophy
Focal lesion	Absent	Absent	Absent	Absent
Hormonal/systemic work-up	Normal	Normal	Normal	Normal
Surgery	Reduction mammoplasty	Reduction mammoplasty	Reduction mammoplasty	Reduction mammoplasty

Table 2: Operative and histopathological findings

Parameter	Case 1	Case 2	Case 3	Case 4
Pedicle	Superomedial	Superomedial	Superomedial	Superomedial
Right specimen	2.0 kg	2.8 kg	2.8 kg	2.8 kg
Left specimen	2.2 kg	2.6 kg	2.8 kg	2.7 kg
Total specimen	4.2 kg	5.4 kg	5.6 kg	5.5 kg
Histopathology	Lobular/ductal hyperplasia + stromal fibrosis	Same	Same	Same
Atypia	Absent	Absent	Absent	Absent
Malignancy	Absent	Absent	Absent	Absent
Follow-up	6 months	6 months	6 months	6 months
Outcome	Good	Good	Good	Good

The combined tissue excision across the four patients was 20.7 kg, averaging approximately 5.18 kg per patient.

Discussion

Gigantomastia is an uncommon disorder that can cause substantial physical and psychosocial morbidity. The absence of a universally accepted definition has resulted in considerable heterogeneity among published studies. Dancey et al. reviewed 115 patients and noted that the commonly used threshold of 1.5 kg of tissue per breast is essentially a postoperative definition and does not adequately assist preoperative clinical decision-making. 1 In our series, all four patients had tissue excision exceeding 2 kg per breast in at least one breast, with total excision ranging from 4.2 to 5.6 kg per patient. Thus, all four cases represent marked gigantomastia by commonly used postoperative criteria.

A. Etiology and Pathogenesis

Gigantomastia may be categorized as gestational, juvenile, drug-induced or idiopathic. [1] Although the exact pathogenesis remains uncertain, hormonal hypersensitivity has been proposed as an important mechanism. Increased sensitivity of breast tissue to normal levels of estrogen, progesterone or prolactin may result in disproportionate glandular and stromal proliferation.

Our series demonstrates the heterogeneous nature of the condition. One patient had clear postgestational gigantomastia, with persistent enlargement for four years after her second pregnancy and failure of regression after breastfeeding. Another developed progressive breast

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enlargement following infertility treatment. The remaining two patients had no specific precipitating factor documented in the case records.

Importantly, hormonal and systemic investigations were normal in all four patients, supporting the possibility that abnormal breast tissue responsiveness rather than elevated circulating hormone levels may contribute to the condition.

B. Clinical Presentation

The patients in our series had remarkably similar physical findings. All four demonstrated:

- Massive symmetrical breast enlargement
- Grade III ptosis
- Striae
- Dilated superficial veins
- Neck and back pain
- Shoulder grooving
- Difficulty walking
- Difficulty sleeping

Psychological distress was specifically documented in Cases 1 and 3.

These findings are consistent with the clinical morbidity described in previous reports. Gigantomastia can cause mechanical loading of the cervical and thoracic spine, shoulder-girdle symptoms and functional limitation. [1,3]

C. Role of Imaging and Histopathology

Ultrasonography in all four patients demonstrated diffuse glandular hypertrophy without a focal lesion. Histopathology consistently showed lobular and ductal hyperplasia with stromal fibrosis, without atypia or malignancy.

Although gigantomastia is primarily a clinical diagnosis, imaging is useful when focal lesions or malignancy need to be excluded. Histopathological assessment is particularly relevant when surgery is undertaken, both for confirmation of benign pathology and exclusion of occult malignant disease.

D. Management

Management of gigantomastia should be individualized according to the cause, severity, rate of progression, associated complications, response to conservative measures and reproductive plans.

E. Medical Treatment

Several medical therapies have been described, particularly for gestational gigantomastia, including bromocriptine, cabergoline, tamoxifen and other hormonal agents. Evidence, however, remains predominantly based on case reports and small case series rather than high-level comparative studies. [2,3]

In our series, conservative treatment was unsuccessful in Case 1 and Case 2. Cases 3 and 4 did not opt for conservative management. All four patients therefore underwent definitive surgical treatment.

F. Surgical Management

Reduction mammoplasty is an established treatment for severe symptomatic breast hypertrophy and gigantomastia. The objectives are removal of excessive breast tissue, relief of symptoms, restoration of breast proportions and preservation of nipple-areolar viability whenever possible.

Our patients underwent bilateral reduction mammoplasty, with a superomedial pedicle documented in Cases 1, 3 and 4. The second patient's operative record in the supplied case series does not specify the pedicle. The tissue excision was substantial, ranging from 4.2 to 5.6 kg.

Recent literature has challenged the historical assumption that free nipple grafting is mandatory for all patients with gigantomastia. A 2024 systematic review and meta-analysis evaluated whether free nipple grafting is necessary in gigantomastia and supports consideration of

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nipple-sparing approaches in appropriately selected patients.[7] Similarly, a systematic review of nipple-sparing gigantomastia reductions has evaluated the safety of maintaining a vascularized nipple-areolar complex in large, ptotic breasts. [6]

A 2025 systematic review and meta-analysis of nipple-areola-complex-carrying pedicles found a low pooled rate of postoperative sensory loss, although patient selection and surgical technique remain important.[8]

Therefore, the choice of pedicle should be individualized according to breast size, degree of ptosis, nipple-to-inframammary-fold distance, vascular anatomy, surgeon experience and anticipated pedicle length.

G. Gestational and Postgestational Gigantomastia

Gestational gigantomastia is characterized by excessive breast enlargement occurring during pregnancy. The 2017 systematic review by Mangla and Singla analyzed 50 case reports and highlighted the rarity and significant morbidity of the condition. [2]

A subsequent systematic review of gestational gigantomastia in the 21st century identified 66 cases and further emphasized the variability in presentation and treatment.[3]

The distinction between gestational gigantomastia and postgestational gigantomastia is clinically relevant. Gestational disease occurs during pregnancy, whereas persistent breast enlargement after delivery may be termed postgestational gigantomastia. In our series, Case 2 clearly demonstrated a postgestational pattern because the enlargement persisted for four years after delivery and failed to regress following breastfeeding.

Recent literature also continues to document severe gestational cases with complications such as ulceration, infection, hemorrhage and cardiopulmonary compromise, reinforcing the importance of early recognition and multidisciplinary management. [4]

H. Multidisciplinary Management

Severe gigantomastia can involve multiple organ systems and may require multidisciplinary care. Depending on the clinical setting, management may involve:

- Plastic surgery
- Breast surgery
- Obstetrics and gynecology
- Endocrinology
- Radiology
- Anesthesiology
- Wound-care services
- Infectious disease specialists
- Psychological support

This is particularly important in gestational disease, where maternal and fetal considerations may influence timing and choice of treatment. [2–4]

I. Outcomes

All four patients in our series demonstrated a favorable outcome after reduction mammoplasty. At 6 months:

- Pain had resolved.
- Mobility had improved.
- Posture had improved.
- Sleep had improved.
- Quality of life had improved.
- Functional and cosmetic outcomes were reported as good.
- No atypia or malignancy was identified in any patient.

The consistent symptomatic improvement in our four patients illustrates the functional benefit that can be achieved through definitive reduction surgery in severe gigantomastia.

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Table 3: Comparison with selected literature

Study	Main contribution
Dancey et al., 2008 [1]	Reviewed 115 patients; emphasized absence of a universal definition and proposed classification
Mangla & Singla, 2017 [2]	Systematic review of 50 gestational gigantomastia case reports
Alhindi et al., 2023 [3]	Systematic review of 66 cases of gestational gigantomastia in the 21st century
Zelko et al., 2023 [6]	Systematic review of nipple-sparing approaches in gigantomastia reduction
Bonomi et al., 2024 [7]	Systematic review/meta-analysis evaluating whether free nipple grafting is necessary
Fofung et al., 2025 [4]	Contemporary review of 76 gestational gigantomastia episodes and management outcomes
Current series	Four patients; 20.7 kg total tissue excision; reduction mammoplasty with good 6-month outcomes

Limitations

This study has the limitations inherent to a small retrospective case series. The sample size was limited to four patients, and follow-up was restricted to 6 months. Long-term recurrence, particularly after subsequent pregnancy, could therefore not be assessed. Furthermore, not all patients had identical treatment pathways, and detailed reproductive and medication histories were not available for every patient.

The study nevertheless provides clinically relevant observations regarding the presentation and surgical management of severe gigantomastia and demonstrates consistent symptomatic and functional improvement following reduction mammoplasty.

Conclusion

Gigantomastia is a rare but potentially debilitating disorder associated with considerable physical, functional and psychological morbidity. The four patients in this series demonstrated marked bilateral breast enlargement, Grade III ptosis and significant mechanical symptoms. Hormonal and systemic investigations were normal, while imaging showed diffuse glandular hypertrophy without focal lesions.

All four patients underwent bilateral reduction mammoplasty, with a combined 20.7 kg of breast tissue excised, and all demonstrated substantial improvement in pain, mobility, posture, sleep and quality of life at 6 months.

Early recognition, appropriate exclusion of secondary causes and malignancy, individualized surgical planning and multidisciplinary management are essential in the treatment of gigantomastia. Reduction mammoplasty provides effective definitive treatment for appropriately selected patients with established symptomatic disease.

Take-home Message

Gigantomastia is not merely excessive breast size; it is a potentially disabling condition. Early evaluation and multidisciplinary management followed by appropriately planned reduction mammoplasty can provide substantial functional and quality-of-life benefits.

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Case 1:

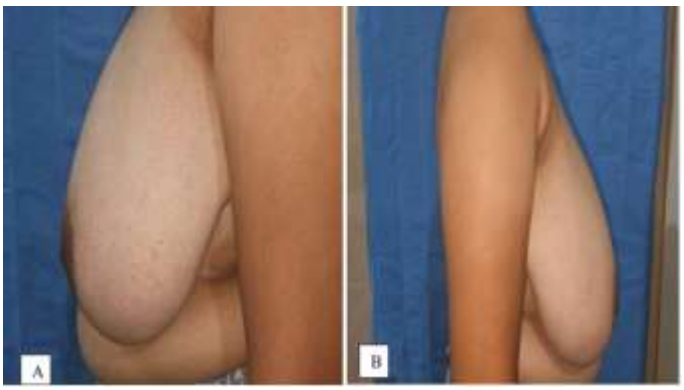


Figure 1: Preoperative clinical photographs demonstrating massive bilateral breast enlargement with marked ptosis. (A) right lateral/oblique view; (B) left lateral/oblique view.



Figure 2: Preoperative surgical markings demonstrating the planned reduction mammoplasty pattern and relevant measurement. (A) Anterior view;



Figure 3: Clinical photographs at 1 month after surgery demonstrating healing of the surgical wounds and improved breast contour following reduction mammoplasty(A) Anterior view; (B) right lateral view;

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Case 2:



Figure 1: Preoperative clinical photographs demonstrating massive bilateral breast enlargement with marked ptosis. (A) Anterior view; (B) right lateral/oblique view; (C) left lateral/oblique view.



Figure 2: Preoperative surgical markings demonstrating the planned reduction mammoplasty pattern and relevant measurement. (A) Anterior view; (B) right oblique view; (C) left oblique view



Figure 3: Clinical photographs at 1 week after surgery demonstrating the early Postoperative appearance following reduction mammoplasty.



Figure 4: Clinical photographs at 1 month after surgery demonstrating healing of the surgical wounds and improved breast contour following reduction mammoplasty (A) Anterior view; (B) right lateral view; (C) left lateral view.

Case 3:



Figure 1: Preoperative clinical photographs demonstrating massive bilateral breast enlargement with marked ptosis. (A) Anterior view; (B) right lateral/oblique view;

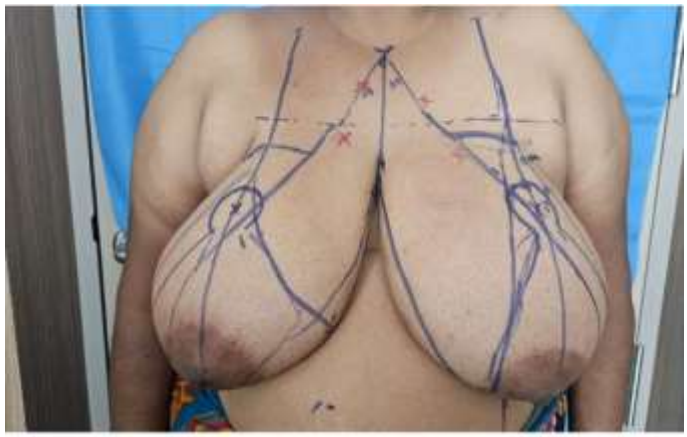


Figure 2: Preoperative surgical markings demonstrating the planned reduction mammoplasty pattern and relevant measurements. (A) Anterior view;

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Figure 3: Clinical photographs at 1 month after surgery demonstrating healing of the surgical wounds and improved breast contour following reduction mammoplasty. (A) Anterior view; (B) Right lateral view;

Case 4:



Figure 1: Preoperative clinical photographs demonstrating massive bilateral breast enlargement with marked ptosis. (A) Anterior view; (B) Left lateral/oblique view;

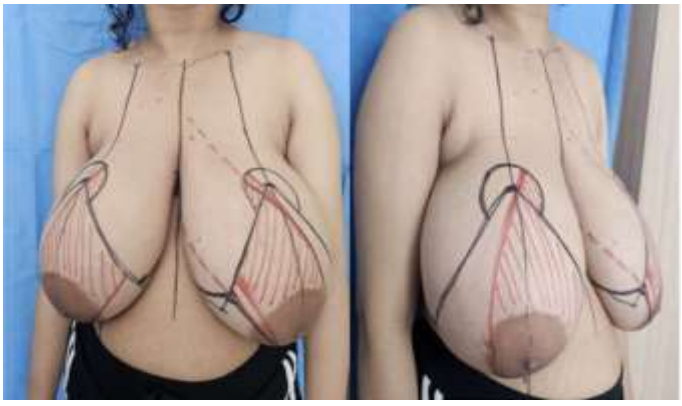


Figure 2: Preoperative surgical markings demonstrating the planned reduction mammoplasty pattern and relevant measurements. (A) Anterior view; (B) Right lateral view;



Figure 3: Clinical photographs at 1 week after surgery demonstrating healing of the surgical wounds and improved breast contour following reduction mammoplasty. (A) Anterior view; (B) Right lateral view;

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