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Implant Shape in Breast Augmentation: Aesthetic Outcomes and the Ability to Distinguish Between Shapes

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What is already known on this topic?

- **Implant shape choice is a major challenge:** *Choosing between round and anatomical implants is a central challenge in breast augmentation, with each offering specific benefits and limitations.*
- **Anatomical implants aim for natural results:** *The anatomical implants were designed to mimic the teardrop form of the natural breast and are often chosen for patients seeking subtle results, but they carry the risk of rotation and higher cost.*
- **Round implants provide upper pole fullness but may look artificial:** *The round implants enhance cleavage and projection, which some patients desire, but excessive upper pole fullness can create a less natural or "operated" appearance.*
- **The true effect of implant shape on outcomes remains debated:** *It is already known that research has produced conflicting findings, with some studies suggesting surgeons and observers cannot reliably distinguish implant types, while others report subtle but noticeable differences.*

Abstract

Objective: This study aimed to evaluate the impact of implant shape—round vs. anatomical—on long-term aesthetic outcomes in breast augmentation and to determine whether observers could reliably distinguish between implant types.

Methods: Thirty female patients who underwent subpectoral augmentation with silicone gel implants (15 round, 15 anatomical) were included. All surgeries were performed by a single senior surgeon. Standardized preoperative and 1-year postoperative photographs were evaluated by 10 plastic surgeons and 10 surgical nurses. Observers identified implant type and, separately, surgical nurses assessed naturalness using a 4-point Likert scale. Statistical analyses included chi-square tests, independent samples *t*-tests, and Fleiss' Kappa coefficients to evaluate inter-rater agreement.

Results: Observers demonstrated limited ability to correctly identify implant type. Among surgeons, correct classification rates were 27.0% for anatomical implants and 26.3% for round implants, with an overall Fleiss' Kappa of 0.110, indicating slight agreement. Nurses achieved similar results, with correct classification rates of 27.3% and 22.7% for anatomical and round implants, respectively (Fleiss' Kappa = 0.126). Combined analysis of all observers yielded a total Kappa value of 0.040, suggesting classifications were largely random. Mean naturalness scores did not differ significantly between implant groups (2.68 ± 0.17 vs. 2.68 ± 0.15; $P = .909$). Factors most frequently cited for "artificial" appearance included low nipple position, excessive upper pole fullness, and overall large breast size.

Conclusion: Implant shape had no significant impact on long-term natural appearance or observer identification accuracy. These findings highlight that both round and anatomical implants can achieve comparable aesthetic results, with patient-specific anatomy and preferences remaining central to implant selection.

Keywords: Breast implants, mammaplasty, observer variation, patient satisfaction, treatment outcome

Introduction

Breast augmentation is one of the most commonly performed aesthetic surgical procedures worldwide.[1] Implant shape, primarily round vs. anatomically (teardrop), is a critical factor that influences postoperative breast appearance, patient satisfaction, and complication profiles.[2] Anatomical implants are designed to mimic the teardrop contour of the natural breast, with maximal projection at the lower pole and lower volume at the upper pole. This gradual upper pole slope and greater volume in the lower pole can provide a subtle, natural appearance, particularly in thin patients. Therefore, they are often associated with high patient satisfaction, particularly among those seeking natural-appearing results. Conversely, round implants have symmetrical height and width with maximal central projection, which can enhance upper pole fullness and cleavage. A more prominent upper pole appearance is associated with high satisfaction rates among patients who desire a fuller aesthetic appearance.[2,3]

Despite theoretical advantages for each implant shape, round implants may appear less natural in patients with thin soft tissue coverage and can result in an "augmented" rather than natural breast contour if upper pole fullness is excessive.[3] However, the risk of implant rotation, which can cause visible contour irregularities and limited upper pole fullness, and may not meet all patient expectations, is a major drawback of anatomical implants.[4]

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What this study adds on this topic?

- **Implant shape could not be reliably identified long-term:** *Both surgeons and nurses classified implant type at chance-level accuracy after a mean follow-up of 16.6 months.*
- **Naturalness did not differ between implant types:** *No significant difference in perceived naturalness was observed between anatomical and round implants.*
- **Artificial results were linked to other factors, not shape:** *The nipple malposition, excessive upper pole fullness, and large breast size were the main reasons for an artificial look, rather than the choice of implant shape.*
- **Methodological control strengthened reliability:** *This study demonstrated that by standardizing implant variables, using a single senior surgeon, and employing blinded evaluations from both surgeons and nurses, the results provide strong and objective evidence to inform the ongoing debate.*

Although implant shape significantly influences breast appearance and patient satisfaction, the actual visual impact of shape selection on outcomes remains debated.[5,6] Rubi et al[7] found that in a blinded photo-based survey, even experienced surgeons could not reliably differentiate between anatomical and round implants in patients with sufficient soft tissue coverage. Conversely, a controlled study of 14 patients who underwent sequential exchanges of round and anatomical implants of the same size and projection found that blinded observers correctly identified implant shape in 100% of cases.[8] However, controlled and comparative studies on this topic are limited.

Considering that surgical outcomes are also influenced by patient anatomy, tissue characteristics, aesthetic preference, and patient expectations, this study aimed to investigate the effect of implant shape on aesthetic results and whether implant shape can be distinguished after long-term follow-up.

Methods

A total of 30 female patients who underwent breast augmentation surgery were included in this study. All patients underwent subpectoral breast augmentation with silicone gel implants performed by a senior author. Implant-related variables, such as implant brand and profile (high profile), were the same in all patients. Fifteen patients had a round shape, while 15 had an anatomical (teardrop) implant shape. Patients who underwent surgery in 2024 were enrolled in this study. Breast implant sizes ranged from 300 to 450 cc for all patients. Patient follow-up duration, breast base width, and age were recorded.

The inclusion criteria for the study were determined as follows: (i) having a follow-up period of 1 year or more, (ii) having pre- and post-operative photographs, including front, side, and cross views, (iii) no complications during follow-up, and (iv) no obvious asymmetry in the breast or chest wall.

The patients were divided into 2 groups: (i) 15 patients with round implants and (ii) 15 patients with anatomical implants. Preoperative and 1 year postoperative photographs, including front, side, and cross views, were obtained for evaluation (Figure 1). For the evaluation, 10 plastic, reconstructive, and aesthetic surgeons and 10 surgical nurses who assisted in breast aesthetic surgeries were regularly included to identify the implant shape. The observers were asked to evaluate the preoperative and postoperative photographs of 30 patients, present them in a mixed order, and predict which implant type was used. No time limit was set for evaluation.

Photographs were evaluated by 20 female surgical nurses to investigate the natural appearance of the breast using a 4-point modified Likert scale: 1-point, highly artificial appearance; 2-point, artificial appearance; 3-point, natural appearance; and 4-point, highly natural appearance. The following criteria were used to select photographs as artificial or highly artificial: i) low nipple position, ii) excessive upper fullness, and iii) overall large breast appearance.

This study was approved by the Ethics Committee of Medipol University (Approval No.: E-10840098-202.3.02-4922, Date: July 30, 2025) and conducted according to the Declaration of Helsinki. Written informed consent was obtained from all participants.

Statistical Analyses

All statistical analyses were performed using IBM SPSS Statistics (version 26.0; IBM Corp., Armonk, NY). Descriptive statistics were calculated and are reported as frequencies, percentages, means, and standard deviations. Differences in correct and incorrect implant shape classifications between the evaluator groups (plastic surgeons and surgical nurses) were assessed using the chi-square test, with statistical significance set at $P < .05$. Perceived naturalness scores according to the implant type (anatomical vs. round) were compared using an independent sample *t*-test. Inter-rater agreement among evaluators was examined using the Fleiss' kappa coefficient, with values ranging from 0 to 1 interpreted to determine the degree of concordance. All analyses were conducted using 95% CIs.

Results

The mean age of the patients participating in the study was 29.25 years (20-44) in the anatomical implant group and 28.6 years (22-42 years) in the round implant group. The mean preoperative breast base dimension of round and anatomical implant groups was 11.6 cm (11-13 cm) and 11.8 cm (11-13 cm), respectively. The average breast volumes in the anatomical and round implant groups were 370 cc (range, 300-440 cc) and 355 cc (range, 300-450 cc), respectively.

The mean follow-up duration was 16.2 months (range, 12-22 months) in the round implant group and 17.1 months (range, 14-21 months) in the anatomical implant group.

Implant Shape Identification

In the plastic surgeon group, the correct classification rate for anatomical implants was 27.0% and the incorrect classification rate was 23.0%, with a kappa value of 0.013. For round implants,

the correct classification rate was 26.3% and the incorrect classification rate was 23.7%, with a kappa value of 0.207. The overall agreement coefficient for the plastic surgeon group was calculated as Fleiss' kappa = 0.110, indicating only a "slight agreement" among the observers.

In the nurse group, the correct classification rate for anatomical implants was 27.3% and the incorrect rate was 22.7%, with a kappa value of 0.109. For round implants, the correct classification rate was 22.7% and the incorrect classification rate was 27.3%, yielding a kappa value of 0.127. The overall agreement coefficient for the nurse group was Fleiss' kappa = 0.126, again reflecting "slight agreement."

When all evaluators were considered together, the correct classification rate for anatomical implants was 27.2% and the incorrect rate was 22.8%, with a kappa value of 0.031 (Figure 2). For round implants, the correct classification rate was 24.5% and the incorrect rate was 25.5%, with a kappa value of 0.045. The overall Fleiss' Kappa value for the entire group was 0.040, confirming only "slight agreement" among the observers (Table 1).

These results indicate that both surgeons and nurses showed low agreement in distinguishing implant types, suggesting that the classifications were largely comparable to random selection. These findings support the view that anatomical and round implants cannot be visually distinguished over the long term based on their aesthetic appearance. In the plastic surgeon group, there were 160 (53.3%) correct classifications and 140 (46.7%) incorrect classifications. In the nursing group, there were 150 (50.0%) correct and incorrect classifications. A chi-square test comparing correct-incorrect distributions between groups yielded an X^2 value of 0.667, with a P value of .414 (Table 2).

Natural Appearance

Assessment of breast appearance by surgical nurses using a 4-point Likert scale revealed no significant difference in naturalness scores between the anatomical and round implant groups. The mean naturalness score was 2.68 ± 0.17 for anatomical implants and 2.68 ± 0.15 for round implants. An independent sample t-test analysis confirmed that this difference was not statistically significant (t = −0.115, P = .909). These findings indicate that, from the perspective of nursing evaluators, anatomical (teardrop) and round implants are indistinguishable in terms of long-term natural appearance (Table 3).

When the data regarding which features were most influential in cases rated as "artificial" or "highly artificial" were analyzed, the most frequently cited factor was a low nipple position (39.2%). This was followed by excessive upper pole fullness (31.7%) and an overall large breast appearance (29.1%). Among the 7 evaluations classified as "highly artificial," 3 were attributed to excessive upper pole fullness, 2 to a low nipple position, and 2 to an overall large breast.

Discussion

The impact of implant shape on aesthetic outcomes in breast augmentation has been the subject of considerable debate and investigation. Early assumptions favoring anatomical implants for more natural outcomes have been rigorously challenged by

Figure 1. Pre- and post-operative standardized patient photo with front, side, and cross angles for the blinded observer evaluation.

Figure 2. Pre and post-operative (17 months) patient photo with 345 cc, high profile, anatomical implants. Only 30% of the observers identified correctly.

randomized controlled trials, photographic assessments, and patient-reported outcomes.

In a randomized controlled trial by Hidalgo and Weinstein, 75 patients undergoing primary breast augmentation underwent a round implant placed in 1 breast and an anatomical implant of similar volume in the other, followed by an intraoperative photographic evaluation by 10 plastic surgeons. Aesthetic preference scores did not differ significantly between the 2 shapes ($P > .05$). The correct identification rate for implants was only 26.5%, suggesting that surgeons were unable to distinguish implant shape and its effect on aesthetic appearance.[9]

Al-Ajam et al[10] performed a double-blind assessment of 60 patients in whom both anatomical and round implants were evaluated postoperatively by 22 surgeons. The correct implant identification rate among observers was only 55.9% (62.7% round and 49.0% anatomical). Although anatomical implants scored slightly better in the upper pole contour, natural appearance, and overall aesthetic results, these differences were not statistically significant. In accordance with these data, Friedman et al[11] showed that surgeons correctly identified round implants in 63.89% of cases, but recognition accuracy dropped to 46.69% for shaped implants. Moreover, the authors concluded that round implants

Table 1. Kappa Values According to Implant Type and Observer Groups

Groups		Correct	False	Kappa (According to Implant Shape)	Kappa
Plastic surgeon	Anatomical	81 (27.0)	69 (23.0)	0.013	0.110*
	Round	79 (26.3)	71 (23.7)	0.207*	
Surgical nurse	Anatomical	82 (27.3)	68 (22.7)	0.109*	0.126*
	Round	68 (22.7)	82 (27.3)	0.127*	
Total	Anatomical	163 (27.2)	137 (22.8)	0.031	0.040*
	Round	147 (24.5)	153 (25.5)	0.045*	

Table 2. Comparison of Observer Groups Analysis with Chi-square test

Variables	Plastic Surgeon	Surgical Nurse	X^2	*P*
Correct	160 (53.3)	150 (50.0)	0.667	.414
False	140 (46.7)	150 (50.0)		

Table 3. Comparison of Mean Scores Regarding Implant Shape and Natural Appearance

Groups	n	Mean	SS	*t*	*P*
Anatomical	15	2.68	0.17	−0.115	.909
Round	15	2.68	0.15		

were consistently judged as more natural in appearance ($P < .001$) and provided more favorable upper pole fullness.

Rubi et al[7] investigated whether experts could distinguish between the outcomes of augmentations performed with anatomical vs. round implants. Thirty patients with subpectoral cohesive silicone implants of ≤340 cc were evaluated by 30 observers, including surgeons and nurses, who reviewed standardized pre- and postoperative photographs twice at a 12-week interval. Across 1800 assessments, the overall accuracy in identifying implant shape was 50.3% for anatomical and 49.7% for round implants. Considering the rotation risk and high cost, the aesthetic results of anatomical and round implants are visually indistinguishable when small- to medium-volume implants are placed in the subpectoral plane.

Similarly, in a study conducted by Bronz et al,[12] a photographic review showed that the 2 shapes were nearly indistinguishable, and their findings indicated that both implant types could provide durable and natural-appearing outcomes when carefully selected.

Consistent with previous studies, a live global ballot at the London Breast Meeting in 2016 tested the ability of clinicians to identify implant shapes in 50 augmentation cases. Delegates correctly classified implants only 58% of the time, with modestly higher accuracy for round (63%) than that with anatomical (54%) devices. Similar findings were reported at the 2014 American Society of Aesthetic Surgeons Meeting, where surgeons achieved only 46% accuracy. These results highlight that implant shape is difficult to discern postoperatively, even for experienced surgeons.[6] Moreover, Cheng et al[13] showed that surgeons correctly identified implant type in only 52% of patients.

In contrast to earlier studies reporting minimal or no visible distinction between implant shapes, Bletsis et al[5] demonstrated that both lay observers (100 students) and plastic surgeons could differentiate between anatomical and round implants with above-chance accuracy (74% and 67.3%, respectively). Within their cohort, anatomical implants were consistently rated as more natural and attractive, with participants expressing a clear preference for neutral or slightly negative upper pole contours and regarding excessive upper pole fullness as unnatural. These findings suggest that anatomical implants may provide a subtle aesthetic advantage in terms of perceived naturalness and attractiveness.

Montemurro et al[8] conducted a unique within-patient comparison to evaluate whether breast implant shape can be distinguished when all other variables are controlled. Fourteen women, who initially received either round or anatomical devices of a given size and projection, later underwent replacement with the opposite shape while maintaining the same implant dimensions. Standardized photographs captured at 12 months of age were blindly assessed by 10 surgeons and 10 nurses. Remarkably, all 20 observers correctly identified the implant shape in all cases (100%, $P < .0001$). The authors emphasized that prior studies often failed to control for inter-individual differences, which may explain the inconsistent findings in the literature. Their results clearly demonstrated that round and anatomical implants produce discernible differences in appearance, although both shapes are capable of achieving aesthetically favorable outcomes. Ultimately, the study reinforced the idea that implant choice should be individualized according to patient anatomy and goals.[8]

Together, these findings suggest that the aesthetic impact of implant shape may be perceptible in specific clinical scenarios. In a 15-year review of 932 augmentations, Cárdenas-Camarena and Encinas-Brambila reported satisfactory results for round and anatomical gel implants. The authors recommended anatomical implants for patients with minimal breast tissue, significant asymmetry, prominent thoracic features, or inferior pole deficiency, whereas round implants were better suited for patients with superior pole deficits, moderate pseudoptosis, or adequate soft tissue coverage. Importantly, patient preference for a fuller upper pole often guides the decision, underscoring the role of individualized implant selection.[2]

Implant shape is an important but not the only variable affecting aesthetic results. In an article published by Tebbet in 2002, 53 tissue- or surgeon-related variables that could affect breast augmentation surgery were highlighted.[14] Kovacs et al[15] also showed that the actual postoperative projection for both implant shapes was approximately 22%-25% less than that expected from manufacturer data, suggesting tissue and chest wall dynamics attenuate the theoretical implant effect. Additionally, Cheema et al[16] emphasized that the final breast appearance depends not only on implant geometry but also on tissue coverage and chest proportions. They concluded that implant choice should not be based solely on appearance but must be individualized according to patient anatomy and risk profile.

Examining the perception of beauty in breasts is important for improving results. In an observational analysis of 100 models of naturally attractive breasts, Malluci et al[17] identified 4 consistent aesthetic parameters: an upper-to-lower pole ratio of 45 : 55, upward nipple angulation averaging 20°, a straight or slightly concave upper pole slope, and a convex lower pole. They suggested that deviation from this template was associated with reduced attractiveness through excessive upper pole fullness, downward nipple orientation, or disproportionate lower pole length. This study emphasized that these proportions provide an objective reference for evaluating breast aesthetics and serve as a guide for implant selection and surgical planning, ensuring that the outcomes align with the principles of natural beauty. Consistent with these findings, in the study, when the reasons for artificial and highly artificial appearance were asked, the most common reason was low nipple position. In addition, the lower placement of the nipple indirectly caused the upper pole to appear fuller or the lower pole to appear shorter.

Although numerous studies have examined implant shapes, several methodological shortcomings limit the strength of the current evidence. Early randomized trials, such as those by Hidalgo and Weinstein, used intraoperative photographic evaluations that failed to reveal long-term outcomes and may limit clinical reality. Also, the fact that evaluations were made only by surgeons prevents the generalizability of the data.[9] Similarly, the study by Al-Ajam et al[10] was limited by a short follow-up period, included only surgeon observers, and omitted patient-reported outcomes. Additionally,

the use of implants with different profiles causes implant-related variables to affect the outcome. However, the selection of study populations with small implant volumes by Rubi et al[7] and Bronz et al[12] restricted generalizability. By contrast, Montemurro et al[8] reported a 100% correct identification rate of implant shape, but their study consisted exclusively of revision cases, where altered tissue elasticity, capsule formation, and prior scarring exaggerate shape differences. Moreover, the sample size was small. These factors likely explain their unusually high identification rate and limit generalizability to primary augmentations.

Considering these limitations, this study provides meaningful insight to support surgeons in making evidence-based implant selection decisions. The findings indicate that implant shape alone should not be the dominant factor in surgical planning, as both round and anatomical implants can achieve comparable long-term aesthetic outcomes when patient anatomy, soft-tissue characteristics, and implant dimensions are properly matched. However, understanding the subtle role of implant geometry remains valuable—particularly for patients with limited soft tissue coverage, thoracic asymmetry, or congenital deformities, where anatomical implants may offer more natural contouring. For the majority of primary augmentations, the study reinforces that individualized assessment and precise surgical execution outweigh the theoretical differences between shapes. This allows surgeons to approach implant selection with greater confidence, flexibility, and patient-specific focus, simplifying decision-making while maintaining high aesthetic predictability.

Despite the methodological strengths of this study, several limitations must be acknowledged in interpreting the findings. The relatively small cohort of 30 patients restricts the statistical power and external generalizability of the results. However, the study design intentionally prioritized methodological homogeneity and control—standardizing implant characteristics, surgical technique, and observer conditions—to minimize confounding variables. Although this approach improves internal validity, future multicenter studies with larger and more diverse populations are required to validate these outcomes with greater statistical strength.

Another limitation is the absence of patient-reported outcome measures (PROMs). The study relied on objective, blinded evaluations rather than subjective self-assessments to eliminate psychological and perceptual bias. Only patients who were satisfied and free from postoperative complications were included to ensure that the photographic analysis represented stable, unbiased aesthetic results. Nonetheless, future research incorporating validated PROM tools such as the *BREAST-Q* would provide a more comprehensive understanding of patient satisfaction in relation to objective outcomes.

The use of 2-dimensional standardized photography, while consistent with prior literature, represents another limitation. Although 2D images allow reproducible and comparable visual assessments, they cannot provide volumetric precision equivalent to 3-dimensional (3D) imaging systems. Furthermore, small positioning or calibration differences in 3D scans may also introduce measurement errors, potentially misrepresenting visual results. In this study, 2D photography was the most practical and reliable method available, given that 3D equipment was not accessible in the clinic. Moreover, 3D volumetric analysis could enhance measurement accuracy, particularly in evaluating preoperative breast volume and soft-tissue distribution.

The selected implant volume range (300-450 cc) also represents a controlled methodological decision to maintain group homogeneity. The number of patients with implant sizes below 300 cc was limited, and including them could have introduced bias due to uneven size distribution. Additionally, as smaller implants have less influence on visible contour differences, focusing on moderate volumes provided a more accurate evaluation of shape-related outcomes. In summary, future studies with larger sample sizes, multicenter collaboration, incorporation of PROMs, and 3D imaging will be instrumental in further defining the influence of implant shape on long-term aesthetic outcomes.

Cumulative evidence indicates that the breast implant shape, which is an important factor in breast augmentation surgery, is not an independent determinant of postoperative outcomes. Randomized trials, blinded photographic assessments, and meta-analyses have consistently suggested that the visual distinction between round and anatomical devices is limited in routine clinical practice. These findings reinforce the idea that both shapes are capable of producing natural and attractive outcomes, and optimal results are achieved through careful preoperative planning, respect for tissue dynamics, and tailoring implant selection to each patient's unique morphology and aesthetic goals.

Data Availability Statement: The data that support the findings of this study are available on request from the corresponding author.

Ethics Committee Approval: Ethical committee approval was received from the Ethics Committee of Medipol University (Approval no: E-10840098-202.3.02-4922; Date: July 30, 2025).

Informed Consent: Written informed consent was obtained from all patients who participated in this study.

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