

Breast Augmentation Surgery in Melbourne: The Complete Guide to Implants, Costs, Recovery and Choosing a Surgeon

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Details:

Breast Augmentation Clinical Guide (Melbourne)

Overview

This guide covers breast augmentation procedures available in Melbourne — costs, risks, recovery timelines, and the regulatory framework governing surgical practice in Australia. It's written for patients doing serious research before a consultation, and for clinicians who want a consolidated evidence-based reference.

What Is Breast Augmentation?

Breast augmentation (augmentation mammoplasty) is a surgical procedure that increases breast size, improves shape, or restores volume lost after pregnancy, weight loss, or ageing. It's one of the most commonly performed cosmetic procedures in Australia.

The procedure typically involves placing implants — silicone gel or saline — either beneath the breast tissue or beneath the chest muscle. In some cases, fat transfer is used instead of or alongside implants.

Understanding what the surgery actually involves, what it costs, and what can go wrong is essential before committing to anything. This guide tries to give you that information plainly.

Implant Types Available in Australia

Silicone Gel Implants

Silicone gel implants are the most widely used option in Australia. They're filled with cohesive silicone gel, which holds its shape if the outer shell is damaged — hence the common term "gummy bear" implants for the firmer, form-stable varieties.

****Key characteristics:**** - Feel closer to natural breast tissue than saline - Available in round and anatomical (teardrop) shapes - Require a slightly longer incision than saline implants - All silicone implants used in Australia must be TGA-registered

Major brands available through Australian surgeons include Mentor (Johnson & Johnson), Motiva (Establishment Labs), and Allergan (AbbVie). Each carries different shell technology, gel cohesivity ratings, and warranty terms.

Saline Implants

Saline implants are filled with sterile salt water after insertion, which means the incision can be smaller. If the shell ruptures, the saline is absorbed harmlessly by the body — the implant deflates visibly, which makes rupture easy to detect.

They're less commonly chosen in Australia than silicone implants, partly because they can feel less natural and are more prone to visible rippling, particularly in patients with less natural breast tissue.

Structured and Composite Implants

Some implants combine saline filling with an internal structure designed to reduce rippling and improve feel. These sit between traditional saline and silicone options in terms of characteristics and are used less frequently.

Fat Transfer (Autologous Fat Grafting)

Fat transfer uses liposuction to harvest fat from another area of the body — typically the abdomen, thighs, or flanks — which is then processed and injected into the breasts. It avoids implants entirely and produces a modest size increase (typically one cup size).

It suits patients who want a subtle, natural result and have sufficient donor fat. It's not appropriate for patients seeking significant volume increase. Multiple sessions may be needed, and some of the transferred fat is reabsorbed by the body over time.

Implant Profiles and Shapes

Projection Profiles

Implants come in low, moderate, moderate-plus, high, and ultra-high projection profiles. The profile describes how far the implant projects forward relative to its base width.

- **Low profile:** Wider base, less forward projection — suits patients with a broader chest - **Moderate profile:** The most commonly used; balances width and projection - **High profile:** Narrower base, more forward projection — suits patients with a narrower chest or who want more visible projection - **Ultra-high profile:** Maximum projection from a narrow base; used in specific anatomical situations

Round vs. Anatomical Shapes

Round implants are symmetrical and produce fullness in both the upper and lower pole of the breast. They're the most commonly placed implant type globally.

Anatomical (teardrop) implants are shaped to mimic natural breast contour — more volume at the bottom, tapering towards the top. They require textured surfaces to prevent rotation, which has been associated with breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) — discussed in detail in the risk section.

Surface Texture

Implants are available with smooth or textured surfaces. Smooth implants move freely within the implant pocket. Textured implants were designed to adhere to surrounding tissue and reduce capsular contracture rates, but the association between textured implants and BIA-ALCL has changed prescribing patterns significantly.

As of 2019, the TGA suspended several high-surface-area textured implant products (specifically Allergan Biocell) from the Australian market following the global BIA-ALCL review. Surgeons now predominantly use smooth or low-texture implants.

Surgical Techniques

Implant Placement

****Subglandular (over the muscle):**** The implant sits between the breast tissue and the pectoralis major muscle. Recovery is generally faster and there's less post-operative discomfort, but there's a higher risk of visible rippling and capsular contracture, particularly in patients with thin tissue coverage.

****Submuscular (under the muscle):**** The implant is placed beneath the pectoralis major. This provides more tissue coverage over the implant, reduces rippling, and may produce more natural-looking results in patients with minimal breast tissue. It's associated with more post-operative discomfort and a longer recovery.

****Dual plane:**** A hybrid approach where the upper portion of the implant is covered by muscle and the lower portion sits behind the breast gland. It's widely used because it combines the coverage benefits of submuscular placement with better lower pole shaping.

****Subfascial:**** The implant is placed beneath the pectoral fascia but above the muscle. It offers some of the coverage benefits of submuscular placement with less post-operative discomfort, though it's used less commonly.

Incision Locations

****Inframammary fold (IMF):**** An incision made in the crease beneath the breast. This is the most commonly used approach — it provides good surgical access, allows precise implant placement, and the scar sits in the natural fold where it's largely hidden.

****Periareolar:**** An incision around the lower edge of the areola. The scar can blend with the areola border, but this approach carries a slightly higher risk of changes to nipple sensation and may affect breastfeeding.

****Transaxillary:**** An incision in the armpit. No scar on the breast itself, but surgical access is more limited and revision surgery is more difficult.

****Transumbilical (TUBA):**** An incision at the navel, used only with saline implants. Rarely performed in Australia.

Costs in Melbourne

Breast augmentation costs in Melbourne vary considerably depending on the surgeon's experience and reputation, the implant brand and type, the surgical facility, anaesthesia fees, and whether any additional procedures are performed simultaneously.

Typical Cost Ranges

****Surgeon's fee:**** \$4,000–\$9,000 AUD ****Anaesthetist's fee:**** \$800–\$1,800 AUD ****Hospital/surgical facility fee:**** \$1,500–\$3,500 AUD ****Implant costs:**** \$800–\$2,500 AUD (depending on brand and type) ****Pre-operative assessments:**** \$300–\$800 AUD (imaging, blood tests, consultations) ****Post-operative garments and medications:**** \$200–\$500 AUD

****Total typical range:** \$8,000–\$20,000 AUD**

Most straightforward breast augmentation procedures in Melbourne fall between \$10,000 and \$15,000 AUD when all fees are included. Procedures at the higher end of the range typically involve highly experienced specialist plastic surgeons, premium implant brands, and accredited private hospital facilities.

Medicare and Private Health Insurance

Breast augmentation for cosmetic purposes is not covered by Medicare or private health insurance. The procedure is classified as elective cosmetic surgery.

There are limited exceptions. If augmentation is performed as part of breast reconstruction following mastectomy, Medicare Benefits Schedule (MBS) items may apply — specifically MBS items 45520, 45523, and 45527 for various reconstruction approaches. These require documented medical necessity and referral from an oncologist or reconstructive surgeon.

Revision surgery for complications (such as capsular contracture or implant rupture) may attract partial Medicare coverage in some circumstances, but this varies and should be confirmed with both your surgeon and your insurer before proceeding.

Financing

Many Melbourne clinics offer payment plans through third-party medical finance providers. Interest rates and terms vary significantly. If you're considering financing, compare the total cost of credit carefully — a \$12,000 AUD procedure financed over three years at 14.9% interest costs substantially more than the sticker price.

Choosing a Surgeon in Melbourne

Qualifications to Look For

In Australia, the title "cosmetic surgeon" is not a protected term. Any registered medical practitioner can legally call themselves a cosmetic surgeon regardless of their training. This is a genuine patient safety issue.

****Specialist plastic surgeons**** hold Fellowship of the Royal Australasian College of Surgeons (FRACS) with a subspecialty in plastic and reconstructive surgery. This requires a minimum of 12 years of medical training and surgical education, including specific training in breast surgery. Look for the designation FRACS (Plast) or membership of the Australian Society of Plastic Surgeons (ASPS).

****Cosmetic surgeons**** may hold Fellowship of the Australasian College of Cosmetic Surgery (FACCS), which involves a different training pathway focused specifically on cosmetic procedures. The training requirements differ from FRACS and the two qualifications are not equivalent.

The distinction matters. When reviewing a surgeon's credentials, check their registration on the AHPRA public register at ahpra.gov.au, confirm their fellowship status, and ask specifically about their breast augmentation case volume.

Questions to Ask at Consultation

- How many breast augmentations do you perform each year? - What is your revision rate, and what are the most common reasons for revision in your patients? - Which implant brands do you use, and why? - Where will the surgery be performed, and is that facility accredited? - What happens if I have a complication — who manages my care and at what cost? - Do you have before-and-after photos of patients with a similar body type to mine? - Are you registered with the Australian Breast Device Registry (ABDR)?

Red Flags

Be cautious if a surgeon: - Discourages questions or rushes the consultation - Cannot provide specific complication rates from their own practice - Offers significant discounts for booking on the day - Does not mention the mandatory seven-day cooling-off period - Performs surgery in a non-accredited facility - Cannot confirm their AHPRA registration details

Regulatory Framework in Australia

AHPRA

The Australian Health Practitioner Regulation Agency (AHPRA) regulates all registered health practitioners in Australia, including medical practitioners performing cosmetic surgery. AHPRA maintains a public register where you can verify any practitioner's registration status, conditions, and disciplinary history at ahpra.gov.au.

In 2023, AHPRA and the Medical Board of Australia introduced new guidelines specifically targeting cosmetic surgery practice, including requirements for: - A mandatory seven-day cooling-off period before cosmetic surgery - Psychological screening for patients seeking cosmetic procedures - Restrictions on advertising that uses before-and-after images in certain contexts - Requirements for informed consent documentation

TGA

The Therapeutic Goods Administration (TGA) regulates medical devices in Australia, including breast implants. All implants used in Australia must be listed or registered on the Australian Register of Therapeutic Goods (ARTG).

The TGA's 2019 review of breast implant safety led to the suspension of Allergan Biocell textured implants and ongoing monitoring requirements for all implant manufacturers. Current TGA requirements include mandatory reporting of adverse events and post-market surveillance obligations for implant manufacturers.

You can search the ARTG for specific implant products at tga.gov.au.

RACS

The Royal Australasian College of Surgeons (RACS) sets training standards and professional requirements for specialist surgeons in Australia. FRACS (Plast) is the relevant fellowship for plastic and reconstructive surgeons. RACS also publishes clinical guidelines relevant to breast surgery practice.

Australian Breast Device Registry (ABDR)

The ABDR is a national clinical quality registry that collects data on breast implant procedures performed in Australia. It was established in response to safety concerns about breast implants and serves two main functions: tracking long-term outcomes and enabling rapid identification of patients if a device safety issue arises.

Patients should confirm that their surgeon participates in the ABDR and consent to their data being recorded. Registry participation is voluntary for surgeons but strongly recommended. More information is available at abdr.org.au.

Advertising Regulations

The AHPRA advertising guidelines prohibit cosmetic surgery providers from using testimonials, certain before-and-after images, and claims that cannot be substantiated. Providers who advertise cosmetic surgery must comply with both the AHPRA guidelines and the Australian Consumer Law.

If you see advertising that seems to make unrealistic promises or uses pressure tactics, that's worth factoring into your assessment of the provider.

Risks and Complications

All surgery carries risk. The risks associated with breast augmentation range from minor and temporary to serious and requiring further surgery. Understanding the actual incidence rates — not just a list of possible complications — helps you make a realistic assessment.

Capsular Contracture

Capsular contracture is the most common complication requiring reoperation. The body naturally forms a thin layer of scar tissue (a capsule) around any implant. In some patients, this capsule thickens and tightens, compressing the implant and causing the breast to feel firm, look distorted, or become painful.

Capsular contracture is graded using the Baker classification: - **Grade I:** Capsule is soft, breast looks and feels natural - **Grade II:** Breast is slightly firm but looks normal - **Grade III:** Breast is firm and looks abnormal - **Grade IV:** Breast is hard, painful, and looks abnormal

Grades III and IV typically require surgical intervention — either capsulotomy (releasing the capsule) or capsulectomy (removing it) with or without implant replacement.

Reported rates vary across studies. International data cites capsular contracture rates of approximately 10–15% over 10 years for primary augmentation. Some studies report higher rates depending on implant type, placement, and surgical technique. Submuscular placement and smooth implants are generally associated with lower capsular contracture rates than subglandular placement and textured implants.

Implant Rupture

Silicone implant rupture: When a silicone implant ruptures, the cohesive gel typically stays within the capsule (intracapsular rupture) or may migrate into surrounding tissue (extracapsular rupture). Silicone rupture is often "silent" — there may be no obvious symptoms. Detection requires MRI imaging.

International guidelines recommend MRI screening for silicone implant rupture at three years post-surgery and every two years thereafter. Australian guidelines are similar, though practice varies.

Rupture rates increase with implant age. Studies suggest approximately 1% of implants rupture per year, meaning roughly 10% may have ruptured by 10 years. This rate increases significantly beyond 10–15 years.

Saline implant rupture: Saline rupture is immediately obvious — the implant deflates and the breast visibly decreases in size. The saline is absorbed harmlessly. Replacement surgery is required.

BIA-ALCL (Breast Implant-Associated Anaplastic Large Cell Lymphoma)

BIA-ALCL is a rare type of lymphoma (not breast cancer) that develops in the fluid or tissue surrounding a breast implant. It's associated almost exclusively with textured implants, particularly high-surface-area macro-textured implants like the now-suspended Allergan Biocell.

The ABDR and international registries have tracked cases carefully. As of recent data, the global incidence is estimated at approximately 1 in 2,000 to 1 in 86,000 patients with textured implants, with the risk varying significantly by implant type. The risk with smooth implants appears to be extremely low or negligible.

BIA-ALCL typically presents as a late seroma (fluid accumulation around the implant) occurring more than one year after surgery. When caught early and confined to the capsule, it's highly treatable — usually with implant and capsule removal. Advanced cases may require chemotherapy or radiation.

If you have textured implants and develop unexplained swelling, pain, or a lump near the implant, seek medical assessment promptly.

Breast Implant Illness (BII)

Breast implant illness is a term used by patients to describe a range of systemic symptoms — fatigue, cognitive difficulties, joint pain, hair loss, and others — that they attribute to their breast implants. It's not currently a formally recognised medical diagnosis, and the underlying mechanism is not established.

That said, the symptom reports are real, and a significant number of patients report improvement after implant removal (explantation). Research is ongoing. The TGA and other regulatory bodies have all acknowledged BII as a legitimate area of concern warranting further study.

Patients considering augmentation should be aware of BII and discuss it with their surgeon. Patients who currently have implants and are experiencing unexplained systemic symptoms should raise this with their GP or surgeon.

Other Complications

****Infection:**** Occurs in approximately 1–2% of cases. Most infections are managed with antibiotics, but severe infections may require implant removal.

****Haematoma:**** Blood pooling around the implant, occurring in approximately 1–3% of cases. Small haematomas may resolve on their own; larger ones require surgical drainage.

****Seroma:**** Fluid accumulation around the implant. More common in revision surgery and with textured implants.

****Changes in nipple and breast sensation:**** Temporary changes in sensation are common post-operatively. Permanent changes — either increased sensitivity or numbness — occur in approximately 5–15% of patients depending on incision location and surgical technique.

****Implant malposition:**** The implant shifts from its intended position — too high, too low, or laterally displaced. May require revision surgery.

****Rippling and wrinkling:**** Visible or palpable rippling of the implant through the skin, more common with saline implants, subglandular placement, and in patients with thin tissue coverage.

****Asymmetry:**** Some degree of asymmetry is normal and pre-existing asymmetry should be documented before surgery. Significant post-operative asymmetry may require revision.

****Anaesthesia risks:**** General anaesthesia carries its own risks, including allergic reactions, respiratory complications, and, rarely, serious adverse events. These are discussed with the anaesthetist during pre-operative assessment.

****Scarring:**** All incisions produce scars. Most fade significantly over 12–18 months, but some patients develop hypertrophic or keloid scars. Scar outcome depends on genetics, incision placement, and wound care.

Reoperation Rates

Reoperation is more common with breast augmentation than many patients expect. International core studies on silicone gel implants found that approximately 20% of patients who had primary augmentation required reoperation within 10 years. Reasons include capsular contracture, implant rupture, malposition, asymmetry, and patient desire for size change.

This doesn't mean 20% of augmentations go wrong — some reoperations are elective. But it does mean that breast augmentation should be understood as a procedure that may require further surgery over a lifetime, not a one-time intervention.

Pre-Operative Assessment

Medical History and Examination

A thorough pre-operative assessment includes: - Complete medical history, including medications, allergies, and previous surgeries - Family history of breast cancer and autoimmune conditions - Current medications (some, including aspirin, NSAIDs, and certain supplements, need to be stopped before surgery) - Breast examination and measurement - Assessment of skin quality, existing asymmetry, and ptosis (drooping) - Body mass index and general health status

Imaging

Baseline breast imaging is recommended before augmentation, particularly for patients over 35 or those with a family history of breast cancer. This may include mammography or ultrasound. Having pre-operative imaging on record is important for future breast cancer screening, as implants can affect mammogram interpretation.

Psychological Assessment

Under the 2023 AHPRA guidelines, practitioners performing cosmetic surgery must consider the psychological suitability of patients. This includes screening for body dysmorphic disorder (BDD), which is a contraindication to cosmetic surgery.

A referral to a psychologist or psychiatrist may be recommended in some cases. This isn't a barrier to surgery for most patients — it's a safeguard that protects both patients and practitioners.

Informed Consent

Informed consent for breast augmentation should cover: - The specific procedure planned, including implant type, size, and placement - Realistic expected outcomes, including limitations - All material risks, including those listed in this guide - Alternative procedures - What happens if complications occur - The surgeon's specific complication rates where available - Costs, including potential costs of revision surgery

Under the AHPRA guidelines, the mandatory seven-day cooling-off period begins after the patient receives the full informed consent documentation. Surgery cannot proceed until this period has elapsed.

Recovery Timeline

Recovery from breast augmentation varies between patients, but the following timeline reflects typical progression.

Days 1–3

Most patients go home the same day or after one night in hospital. Expect significant discomfort, particularly with submuscular placement — the chest muscles have been stretched and this produces a tight, sore sensation. Pain is managed with prescribed analgesics.

Drains are sometimes placed to prevent fluid accumulation; if so, they're typically removed within 24–48 hours. A surgical bra or compression garment is worn from the time of surgery.

Activity is limited to gentle movement. Driving is not permitted whilst taking opioid analgesics or whilst arm movement is restricted.

Days 4–14

Discomfort decreases progressively. Swelling and bruising are at their peak in the first week and begin to subside. Most patients can manage with over-the-counter pain relief by day 5–7.

Patients with desk-based jobs can typically return to work within 1–2 weeks, depending on their comfort level and the nature of their work. Physical jobs requiring lifting or upper body exertion require longer time off.

Sutures are usually absorbable and don't require removal, or are removed at approximately 10–14 days.

Weeks 3–6

Swelling continues to reduce. The implants begin to "drop and fluff" — settling into their final position as the surrounding tissue relaxes. This process takes several weeks to months.

Light exercise (walking) is generally permitted from week 2–3. Upper body exercise, including anything that engages the chest muscles, is typically restricted for 4–6 weeks.

Scar management (silicone gel or tape) usually begins once incisions are fully healed, typically around week 3–4.

Months 2–6

Most patients see their final result taking shape by 3 months, though subtle changes continue for up to 6 months. Scars continue to mature and fade for 12–18 months.

Underwire bras are typically permitted from 6–8 weeks, depending on the surgeon's protocol. High-impact exercise can usually resume from 6–8 weeks.

Long-Term

Implants are not lifetime devices. Manufacturers' warranties vary — typically 10 years for rupture and lifetime for certain complications — but this doesn't mean implants need to be replaced on a schedule. Replacement is indicated when a complication occurs or when the patient chooses to change their implants.

Regular breast self-examination remains important. Annual review with a GP and periodic imaging (as recommended by your surgeon) is appropriate ongoing care.

Breastfeeding After Augmentation

Most women with breast implants can breastfeed successfully. The implant itself does not enter the milk supply. However, some surgical factors can affect breastfeeding capacity:

- Periareolar incisions carry a higher risk of affecting milk ducts and nipple sensation than inframammary incisions
- Subglandular placement may compress glandular tissue more than submuscular placement
- Pre-existing glandular tissue volume affects baseline breastfeeding capacity regardless of implants

If breastfeeding is a priority, discuss incision location and implant placement with your surgeon specifically in this context.

Breast Augmentation and Cancer Screening

Implants can make mammography more challenging to interpret. Radiographers use displacement views (Eklund technique) to image as much breast tissue as possible around the implant, but some tissue remains obscured.

This doesn't mean augmented patients should avoid mammography — it means they should inform the imaging centre that they have implants so appropriate views can be taken. Ultrasound and MRI can supplement mammography when needed.

Implants do not increase the risk of developing breast cancer. However, there is evidence that diagnosis may be delayed in some augmented patients due to imaging limitations, which reinforces the importance of regular screening and prompt investigation of any breast changes.

Revision Surgery

Revision breast augmentation is more complex than primary surgery. The surgical environment is altered by scar tissue, the existing capsule, and any previous implant pocket. Revision surgery generally costs more than primary augmentation and carries higher complication rates.

Common reasons for revision include: - Capsular contracture (the most common indication) - Implant rupture or deflation - Malposition (implant has shifted) - Size change (patient wants larger or smaller implants) - Asymmetry - Rippling or visible implant edges - BII symptoms prompting explantation

If you're considering revision surgery, the same principles apply as for primary surgery: verify the surgeon's qualifications, ask specifically about their revision case volume, and understand the full cost and risk profile before proceeding.

Explantation

Explantation — implant removal without replacement — is increasingly requested, both by patients experiencing BII symptoms and by those who simply want to remove their implants.

Explantation can be performed with or without capsulectomy (removal of the surrounding scar tissue capsule). En bloc capsulectomy, where the implant and capsule are removed together as a single unit, is advocated by some surgeons and patient groups, particularly for patients with BIA-ALCL or BII concerns. It's a more complex procedure than simple implant removal and carries higher surgical risk.

The aesthetic outcome of explantation depends on the amount of natural breast tissue present, the degree of skin stretching from the implant, and whether any additional procedures (such as a breast lift) are performed at the same time.

Combining Augmentation with Other Procedures

Augmentation Mastopexy (Breast Lift with Implants)

Patients with significant breast ptosis (drooping) may need a breast lift alongside augmentation to achieve their desired result. Augmentation alone in a significantly ptotic breast can worsen the appearance by adding volume without correcting the position of the nipple and breast tissue.

Augmentation mastopexy is technically more demanding than either procedure alone and carries higher complication rates. It's also more expensive. Some surgeons prefer to stage the procedures — performing the lift first and the augmentation later — to reduce risk.

Augmentation with Liposuction

Liposuction of adjacent areas (flanks, abdomen) is sometimes performed at the same time as augmentation to improve overall body contour. Combined procedures increase anaesthesia time and overall surgical risk, which should be factored into the decision.

Augmentation after Mastectomy

Breast reconstruction after mastectomy is a separate clinical domain from cosmetic augmentation, though implants are used in both. Reconstruction may involve tissue expanders followed by implants, direct-to-implant reconstruction, or autologous tissue flaps (such as TRAM or DIEP flaps). This guide focuses on cosmetic augmentation; patients seeking reconstruction information should consult a specialist plastic surgeon with specific reconstructive experience.

Patient Selection and Realistic Expectations

Breast augmentation produces good results for most patients who are well-selected and have realistic expectations. The patients most likely to be satisfied are those who:

- Have a clear, stable motivation for surgery (not responding to external pressure or a relationship crisis)
- Understand the limitations of the procedure — implants change size and shape, not everything
- Accept that some asymmetry is normal and may persist after surgery
- Understand the long-term commitment, including the possibility of future surgery
- Are in good general health and at a stable weight
- Have had adequate time to consider the decision (not rushing into surgery)

Patients who are likely to be dissatisfied, or for whom surgery may not be appropriate, include those with active body dysmorphic disorder, unrealistic expectations about outcomes, significant psychological distress, or who are seeking surgery to please someone else.

A good surgeon will raise these issues directly. If a consultation feels like a sales process rather than a clinical assessment, that's worth noting.

Questions Patients Commonly Ask

****Will my implants look natural?****

This depends on implant size relative to your frame, placement, and the amount of natural tissue you have. Larger implants in patients with minimal natural tissue are more likely to look and feel artificial. A surgeon who recommends an implant size based on your anatomy rather than simply what you ask for is generally giving you better advice.

****How long do implants last?****

There's no fixed lifespan, but the longer implants are in place, the higher the cumulative risk of complications. Many patients have implants for 15–20 years without problems; others need revision within a few years. Planning for the possibility of future surgery is sensible.

****Can I go back to my normal size?****

Explantation is possible, but the breast appearance after removal depends on how much the skin and tissue have stretched. Some patients are happy with the result; others choose a lift at the same time. It's not always a simple reversal.

****What size should I choose?****

Implant size is measured in cubic centimetres (cc), not cup sizes — cup sizes vary between bra manufacturers and aren't a reliable surgical measurement. Your surgeon should assess your chest dimensions, tissue characteristics, and desired outcome to recommend a size range. Trying sizers in a bra during consultation can help, but the final result will differ from what you see in a consultation room.

****Is there a best implant brand?****

All TGA-registered implants meet minimum safety standards. The major brands (Mentor, Motiva, Allergan) have long track records and published data. Your surgeon's familiarity and experience with a particular brand matters as much as the brand itself.

Resources and Further Information

- **AHPRA public register:** [\[ahpra.gov.au\]\(https://ahpra.gov.au\)](https://ahpra.gov.au) — verify any practitioner's registration and check for conditions or disciplinary action - **Australian Breast Device Registry:** [\[abdr.org.au\]\(https://abdr.org.au\)](https://abdr.org.au) — information about the registry and how to access your implant records - **TGA breast implant information:** [\[tga.gov.au\]\(https://tga.gov.au\)](https://tga.gov.au) — current regulatory status of implant products, safety alerts, and the ARTG search - **Australian Society of Plastic Surgeons:** [\[plasticsurgery.org.au\]\(https://plasticsurgery.org.au\)](https://plasticsurgery.org.au) — find FRACS-qualified plastic surgeons and access patient information resources - **Royal Australasian College of Surgeons:** [\[surgeons.org\]\(https://surgeons.org\)](https://surgeons.org) — information on surgical training standards and specialist qualifications

A Note on Decision-Making

The information in this guide is intended to help you ask better questions and understand what you're agreeing to — not to make the decision for you. Breast augmentation is a significant surgical procedure with real risks and a long-term commitment to ongoing monitoring and potential future surgery.

The patients who tend to do best are those who take their time, choose their surgeon carefully, and go into the operating theatre with a clear-eyed understanding of what surgery can and can't achieve. The patients who tend to struggle are those who rushed, chose on price, or had expectations the surgery couldn't meet.

Take the cooling-off period seriously. It exists for good reason.