

Subfascial Gluteal Implant Augmentation



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KEYWORDS

• Buttock augmentation • Gluteal implants • Gluteal augmentation • Subfascial gluteal implants

KEY POINTS

- Preoperative planning and use of templates are crucial for determining implant volume and position.
- Preoperative markings are crucial in guiding the surgical procedure and should be performed with the patient in a standing position.
- The gluteal point of maximal projection should lie at the pubic bone level on a lateral view.
- Buttock implants should always be placed vertically, and orientation is aided with a white line across the implant equator.
- Buttock augmentation is major surgery; therefore, adequate precautions should be taken to avoid significant complications.

INTRODUCTION

The attractiveness of the buttocks is judged in proportion to the waist.¹ According to Singh,² there is 1 female body shape that men universally find most attractive (full buttocks, narrow waist). The ideal female proportions can be condensed into a waist-to-hip ratio of nearly 0.7 (measuring the waist at its narrowest and the buttock at the level of maximum circumference).

In addition to this overall proportional relationship, there are various characteristics associated with attractive youthful buttocks. These include (1) a marked lumbosacral lordosis with a downward pelvic tilt, (2) a very feminine cleavage as the buttocks separate superiorly, (3) inferior buttock separation creates a diamond shape together with the internal upper thighs, (4) maximum projection where the buttock

equator joins an imaginary vertical line between the medial and central one-third of the buttocks, (5) minimal infra-gluteal crease, and (6) no ptosis.^{3,4}

THE SUBFASCIAL PLANE

Because the subcutaneous, submuscular, and intramuscular techniques have inherent problems associated with the dissection plane, the subfascial plane can ideally accommodate a gluteal implant and overcome the shortcomings of other approaches (**Fig. 1**).^{1,5} This technique is based on extensive cadaver dissections and study of each distinct anatomic layer. The gluteal fascia is very strong at the origins and insertions. It covers the gluteus maximus muscle, the largest and most superficial muscle in the region, and is a significant contributor to the projection of the

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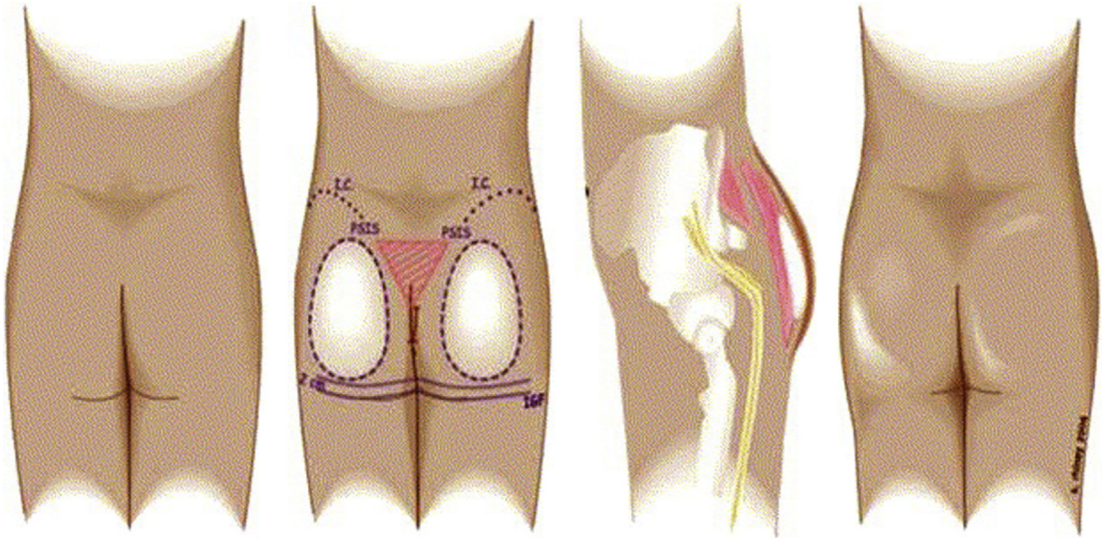


Fig. 1. Relevant anatomy and position of a subfascial implant, which must be centered in the buttock and completely covered by the fasciocutaneous flap. The sciatic nerve, visible on the lateral view, is a safe distance away from the implant pocket. (From de la Peña JA. Subfascial technique for gluteal augmentation. *Aesthet Surg J* 2004;24:265–73; with permission.)

buttocks. The anterior two-thirds of the gluteus medius muscle, also covered by the gluteal aponeurosis, provide bulk to the upper one-third of the buttocks. The gluteal aponeurosis' origin is on the posterior iliac bone, the sacrum, and the coccyx; laterally, it inserts on and envelops the greater trochanter and extends to the iliotibial line. This aponeurosis covers the entire gluteal region and is capable of holding gluteal implants in an adequate position because the fascia is stronger at the origin and insertion sites, and is compliant in the middle.⁶ Consequently, when an implant is placed in this space, an anatomic contour is created naturally.

The gluteal aponeurosis sends expansions to the skin, which insert into the deep dermis. They work as a system to adhere the skin and subcutaneous tissues in the gluteal region. Aponeurotic expansions are distributed in a transverse direction (**Fig. 2**), along the axis of the muscle fibers throughout the gluteal region.⁷ This system of fascial attachments should be maintained in any gluteal implant surgery. The aponeurotic expansions to the skin are preserved, and the subaponeurotic space allows proper positioning of an implant without risking injury to the deep neurovascular structures (**Fig. 3**).

TREATMENT GOALS

Patient treatment is focused on enhancing size, contour, and projection of the gluteal region

because of hypoplasia, hypotrophy, or aging. In other cases, where patients present with a mild lumbosacral lordosis, the volume gained by the implant creates the illusion of a more noticeable angle. To help create an adequate gluteal cleavage, liposuction of the waist is needed in some cases. The inferior buttock–inner thigh diamond can be created by liposuction of the inferior inner quadrant of the gluteus and the inner thigh. For most patients seeking gluteal augmentation,

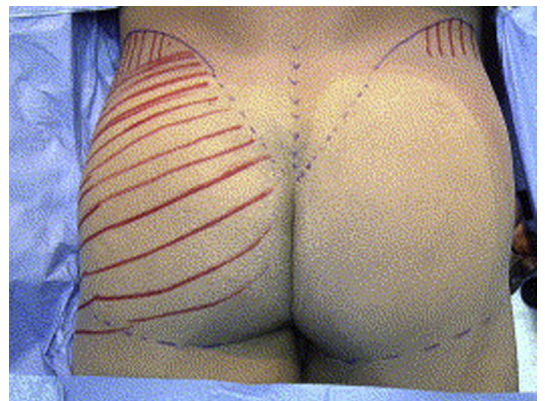


Fig. 2. The aponeurotic expansions run from the gluteal aponeurosis to the dermis in the direction of the red lines drawn on the skin. (From de la Peña JA, Rubio OV, Cano JP, et al. Subfascial gluteal augmentation. *Clin Plast Surg* 2006;33:408; with permission.)

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