

Gluteal Augmentation with Fat Grafting

The Brazilian Buttock Technique: 30 Years' Experience



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KEYWORDS

• Liposuction • Liposculpture • Fat grafting • Buttocks • Adipose tissue • Brazilian • Beauty

KEY POINTS

- This procedure is for increasing the projection of the gluteal region through the association of liposuction and fat grafting.
- There are 2 main body types: gynoid, with a concentration of fat below the waistline, and android, which concentrates fat above of the waistline.
- Both types can benefit from this type of surgery.
- The gynoid type in general needs liposuction of the hips, thighs, legs, and tummy and fat injection in the buttocks.
- The android type needs liposuction of the arms, axilla, back, hips, tummy, and breasts with fat injection of the buttocks and often the inner thighs as well.

HISTORY AND EVOLUTION OF FAT GRAFTING FOR BUTTOCK AUGMENTATION

Illouz¹ introduced liposuction in Brazil in November 1980, and Fournier² showed us liposculpture in 1983. We have been performing liposuction since 1982 and we learned from them that fat could be reinjected. In 1985, I started injecting large quantities of fat obtained from liposuction into different areas of the face and body. At the time other surgeons were injecting small quantities of fat on the face, 5 to 10 mL, into the malar areas and nasolabial folds or in the body to correct small liposuction sequelae. My work was the first to show the safety of injecting large quantities of fat in one surgical procedure. The area where the most quantity of fat was injected was the buttocks, up to 450 mL on each side.

At the time not many surgeons were using the liposculpture technique, and we had to find our

way slowly. Soon we started injecting larger amounts in different areas of the body, 500 mL into each buttock, 300 mL in each breast, 300 mL into each medial thigh, and so forth. Patients were happy with the results, and we realized that with careful planning we could totally reshape the face and body by aspirating and injecting fat. We showed our results and published an abstract of our 18-month experience in 218 patients at the International Society of Aesthetic Plastic Surgery (ISAPS) Congress in New York City in 1987. We experienced for the first time from our peers the rejection that the fat grafting technique would suffer in the years to come. Criticism was usually concentrated on 2 points: the safety of patients and the reabsorption of the injected fat. The article "Eighteen Month Experience with Injected Fat Grafting" was published in 1988.³

In 1988, the only accepted procedure for volume augmentation was the insertion of silicone implants.

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Fat grafting had been discredited as a viable option since the time of Peer.⁴ Peer had shown that fat grafts could have a survival rate of 50%. To some it was a failure. To others, like me, a 50% of survival of the graft was a success. I showed fat grafting could have major advantages with fewer complications.

By 1988 I had changed from the aspirator to syringes. I created the Brazilian Buttock technique, which consists of aspiration of fat from the flanks, abdomen, and thighs with injection into the buttocks and trochanter areas. Injected fat grafting undoubtedly constitutes a major step in repositioning the loss of soft tissue, which before was very difficult to correct.

In 1995, I performed surgical demonstrations of buttock augmentation at the University of Southern California (USC). The results were shown after 6 months in the United States at the Teleplast video-conference.⁵ In 1996, I reported 8-year results with syringe liposculpture, for the treatment of localized fat deposits, to reshape the body and the face using disposable syringes and fine tip cannulas. In some cases, I inject up to 500 mL of fat on each side of the buttocks, in the muscle, on the muscle, into the fatty tissue, and subcutaneously, when needed. In the inner thigh, I have injected from 100 to 300 mL and in the calf from 50 to 150 mL. Fat grafting was

performed in multiple tunnels in the deep and superficial planes. Fat absorption was estimated by clinical evaluation and measurements to be between 20% and 50% of the volume.⁶

Since then I have treated thousands of patients, performing facial and body augmentation. On the face, fat is injected to treat wrinkles and depressions, improve malars and zygomas, nasolabial and nasojugal folds, lips, and eyelids. In the body I perform buttock augmentation and reshaping, filling trochanteric depressions, breast augmentation, medial thighs augmentation, calf and ankle augmentation, treating liposuction sequelae, improving scar depressions, and hands and fingers. The technique of injection of liposuctioned fat, initially received with discredit, was accepted only after years of showing good results. Today it has become one of the hottest topics in most plastic surgery meetings.

AESTHETIC CONSIDERATIONS OF BUTTOCK AUGMENTATION

Normal buttocks should have a smooth round gluteal projection; a short intergluteal fold the infragluteal fold should reach the midthigh line. The waist-hip ratio (WHR) is a significant measure of female attractiveness (**Fig. 1**). Preferences may vary

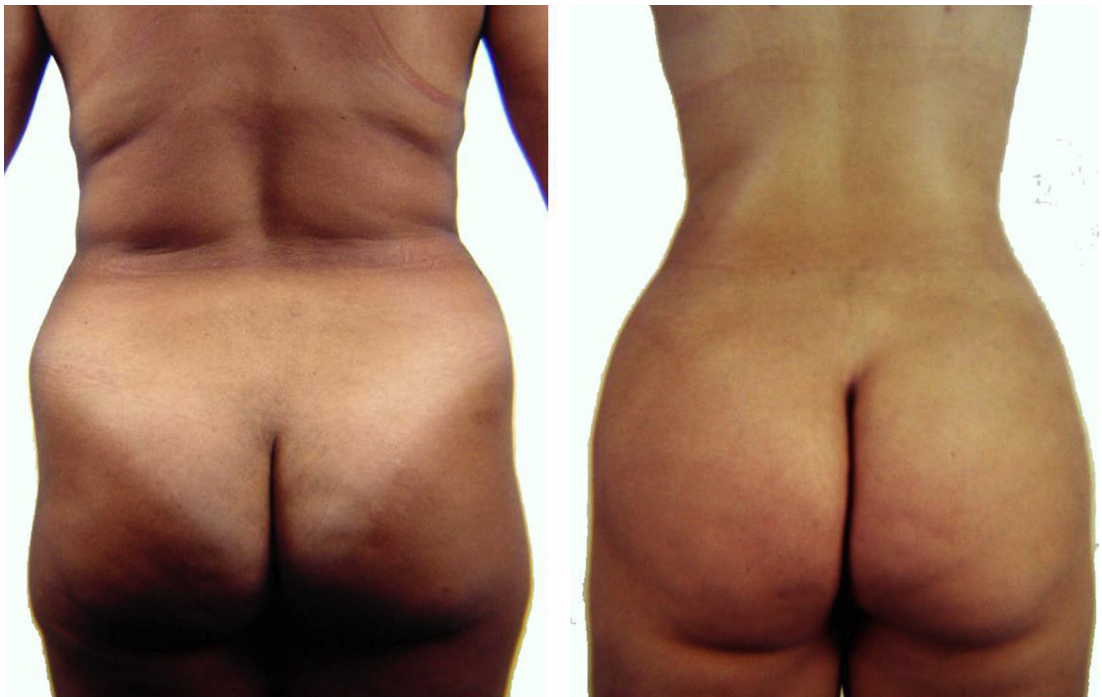


Fig. 1. The waist-hip ratio (WHR) is a significant measure of female attractiveness. The illustration shows two different patients. On the left a patient of the android type of body, with fat concentrated in the upper body. On the right a gynoid type patient, with fine waist and fat concentrated on the lower body. The lateral thighs should be in continuation with the shape of the buttock without excess fat. The back and flanks should not have excess fat and should have a smooth curve towards the buttocks.

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