Circumferential Body Contouring
The Lower Body Lift

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KEYWORDS

• Lower body lift • Two position circumferential procedure
• Circumferential lower truncal dermatolipectomy • Buttock reshaping • Massive weight loss
• Transposition-Gluteoplasty

KEY POINTS

- Lower body lift (circumferential lower truncal dermatolipectomy, CLTD): Modification of the lower body lift procedure as an alternative to the belt lipectomy.
- Perioperative optimization: Standardized perioperative requirements and settings are highlighted and described in detail.
- Technical details: The correct choice of technique is the key to a higher patient satisfaction. Massive-weight-loss patients are far more tolerant of longer scars, allowing a generally high acceptance of, for example, the fleur-de-lis excision pattern.
- Gluteal enhancement: The loss of gluteal volume is a frequent consequence of weight loss. For specific cases the transposition-gluteoplasty is incorporated, which allows a gluteal reshaping with autologous tissue.
- Procedure combination: The combination of liposuction and lower body lift can be performed for additional contouring of the abdomen, the flank, and gluteal region. For selected cases the harvested fat tissue may be transferred for additional improvement of gluteal volume and shape.

INTRODUCTION

The overweight and massively obese population is growing continuously every year. With the success and increasing number of bariatric procedures, the authors have registered a yearly increase of body contouring procedures. In addition, owing to the rising experience in this field of plastic surgery, these procedures have wider ranges of indications, including patients after massive weight loss, patients with primarily cosmetic indications (aging process), or patients who seek correction of contour deformities after previous liposuction. Coincidentally, the requirements and demands for such operations are continually increasing. In addition to the typical problem areas such as the abdomen, the mons pubis, and hip region, patients frequently present with growing attention to the aesthetic restoration of the gluteal area.

The variety of gluteal deformities after weight loss results in a wide range of patient complaints and discomfort. Some patients complain of an enlarged buttock, some of a deficient gluteal volume with gluteal flattening (platypygia), and yet others suffer from cellulite or a lengthening of the infragluteal fold. However, patients primarily seek an enhancement of the gluteal shape and projection.

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A well-shaped buttock is characterized by several factors: it is more rounded than angular, the intergluteal fold is short rather than long, and the feminine gluteal cleavage has a superior and inferior buttock separation. Dividing the buttocks into an upper, middle, and lower section, the ideal maximum projection lies between the upper and middle third. The infragluteal fold should run in a round rather than horizontal curve with a minimal crease, ideally without any droop. The side view should illustrate an S-shaped contour in relation to the back and thigh, as a smooth inward sweep of the inferior back and waist area.[1] To meet these ideal characteristics, several techniques are available to plastic surgeons. In the late 1960s surgeons performed gluteal augmentation with existing breast implants. Today various gluteal implants are accessible, which can be implanted epifascially, subfascially, or submuscularly. Nowadays gluteal contouring is most frequently performed through liposuction, particularly by sculpturing the adjoining regions such as the hips, flanks, and saddlebag deformities, achieving excellent results without any direct buttock approach.

During the past decade, buttock augmentation by autologous fat grafting has gained wider acceptance and success. Many different techniques such as macrografting or micrografting are available for contour improvement of the gluteal region, solely or in combination with liposculpturing.[2]

These techniques, however, are not suitable for patients after massive weight loss. These patients suffer from atonic skin quality with a high degree of laxity and, consequently, with the indisputable requirement of tissue resection. These severe deformities have caused a continuous development of various lifting procedures, such as the pioneering circumferential lower body lift described by Ted Lockwood in 1993.[3–6] Further developments of these procedures in combination with autologous tissue augmentation, such as the deepithelialized gluteal flaps for buttock reshaping, enable an improvement in the postoperative results. In 2005, Sozer and colleagues[7] reported of a series of 20 deepithelialized turnover dermal fat flaps for buttock augmentation in bariatric and aesthetic patients undergoing lower body lifts. After more than 200 cases, the technique has evolved to include a split portion of the gluteus maximus muscle, resulting in a better blood supply to the flap, more caudal reach, and a dramatic decrease in fatty necrosis.[8]

In this context, the authors have established a technique of gluteal fat tissue transpositioning (transposition-gluteoplasty) during modification of the lower body lift (circumferential lower trunk dermatolipectomy [CLTD]), which has been shown to be a reliable alternative for enhancement of the gluteal projection and shape.

PATIENT SELECTION AND SCREENING

A precise physical examination and assessment of patients' medical history during the first consultation is mandatory for every patient. The authors recommend a repeat of evaluation before surgery, if it is performed after a delay since the first consultation. The assessment of medical history includes: the current weight; initial and current body mass index or, in future, the A body mass index; the weight history with weight fluctuations and constancy periods; the frequency of exercises; former bariatric procedures; nutritional disorders; medication; the number of pregnancies and children; history of cesarean section, abdominal surgeries, and abdominal hernias; gastrointestinal, cardiac, and pulmonary history; and smoking history. Previous liposuction in the abdominal area has to be asked after from patients, because they might conceal this before treatment. Patients must present a stable weight for at least 6 to 12 months preoperatively; required weight loss should be completed before the surgery.

The clinical examination is the essential part of every medical history assessment. The examination of the lower trunk should include an accurate palpation of the abdominal, lateral thigh, and gluteal adipose tissue in patients while in upright, prone, supine, and lateral position. This approach enables the examiner to assess the tissue conditions in regard of volume and mobility by pinching and metrically measuring. It is crucial to consider the existent adipose tissue at the lateral and posterior lower gluteal and proximal thigh region. Unfortunately, untreated distinct masses of local adipose tissue in these regions will assuredly limit the gluteal improvement, because downward tractions will consequently displace gluteal tissue in the caudal direction. Skin quality with the presence of striae must be evaluated, explaining to the patient that supraumbilical striae will not be resected in abdominoplasty procedures (except for fleur-de-lis procedures). Furthermore, any existing lower and upper abdominal pannus has to be assessed and measured, documenting any existing eczema or consequent hyperpigmentation. Any preexisting scar (subcostal, midline, horizontal) in the abdominal and gluteal area must be documented in writing and photographically, as they can impair the blood supply of the tissue flap. The status of the abdominal muscles must be assessed and any existing rectus diastasis, incisional, epigastric, or umbilical hernia excluded, in specific cases, by supportive computed tomography or magnetic resonance

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