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A modified technique combining vertical and high lateral incisions for abdominal-to-hip contouring following massive weight loss in persistently obese patients

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KEYWORDS

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Summary Massive weight loss following bariatric surgery or diet and exercise can often result in significant improvements not only in health status but also in overall lifestyle. The resulting redundant skin, however, may itself present new and unanticipated problems, both physical and psychological, making surgical intervention a necessary option.

Various surgical techniques have been described regarding the management of body contour abnormalities associated with massive weight loss. Most of these techniques, though, seem best suited for those patients who are at or near ideal body weight, with more localised excess abdominal tissue. In order to produce a more streamlined overall anterior truncal contour, then, in those patients who remain in the 'obese' category (BMI > 30), we developed a modified approach to the vertical (fleur-de-lis) abdominoplasty in conjunction with high lateral incisions. This modification safely allows for maximal resection of both the excess horizontal and vertical tissues. Because there is no undermining required for closure, there is no increase in serious postoperative wound complications (i.e. tissue necrosis). In addition, lack of undermining allows for the use of extended high lateral incisions which, when coupled with deep hip adipose tissue and overlying skin removal, improves the waistline-to-hip contour. This technique resulted in high patient satisfaction with only minor complications.

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Approximately 5% of the US population now meets the criteria for morbid obesity, defined as being more than 100 lbs (46 kg) over ideal body weight or having a body mass index (BMI) greater than 40.¹ Those with a BMI < 40 but who are also considered overweight may be divided into the categories of 'obese' (BMI 30–34.9) and 'severely obese'

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Table 1 Results of 16 patients including the preoperative data, procedure details and postoperative complications

Patient	Age/sex	BMI	Surgery/diet	Duration (month)	Weight loss (lbs)	Smoking	Surgery	EBL (ml)	Complications
G.M	50F	30.75	RYGB	16	150	N	mVA-HCT + bilateral(B/L) BP	250	Seroma
S.T	51F	37.89	RYGB	20	90	N	mVA-HCT + B/L RM + VHR	350	None
L.S	45F	30.71	RYGB	16	100	N	mVA-HCT + VHR	250	None
L.S	51F	30.39	Diet/exercise	17	100	N	mVA-HCT + UHR	200	None
S.B	32F	35.43	Diet/exercise	24	80	1ppd × 12 yr	mVA-HCT	350	None
J.G	41F	35.07	Diet/exercise	16	100	N	mVA-HCT	200	None
C.C	42F	35.85	RYGB	30	160	N	mVA-HCT	300	Skin breakdown
J.S	35F	35.14	RYGB	21	135	N	mVA-HCT + BP	600	None
P.G	38F	33.58	RYGB	24	200	1ppd × 10 yr	mVA-HCT	300	None
R.R	37F	38.12	RYGB	15	140	N	mVA-HCT + UHR	600	None
R.F	50F	31.65	RYGB	19	120	N	mVA-HCT	200	None
M.J	36F	31.77	Diet/exercise	12	70	N	mVA-HCT + RM	500	None
B.A	38F	40.12	RYGB	36	100	N	mVA-HCT	200	None
S.W	45F	30.7	RYGB	18	90	N	mVA-HCT + VHR	300	None
S.K	35F	34.49	RYGB	19	135	1/2ppd × 1 yr	mVA-HCT	250	None
T.W	36F	37.77	RYGB	24	140	N	mVA-HCT + RM	750	None
	41.4 = 41	34.34	RYGB = 12	20.43 = 20	119.38 = 119	3			Seroma = 1 Skin breakdown = 1
		(>30–8 > 35–8)	Diet = 4						

EBL, estimated blood loss; RYGB, Roux-en-Y gastric bypass; mVA-HCT, modified vertical abdominal-to-hip contouring technique; BP, brachioplasty; RM, reduction mammoplasty; VHR, ventral hernia repair; UHR, umbilical hernia repair.

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