

Body Contouring Surgery in the Massive Weight Loss Patient



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KEYWORDS

- Body contouring surgery • Massive weight loss • Total body lift • Liposuction • VASER

KEY POINTS

- Body contouring surgery after bariatric surgery addresses the large quantities of inelastic skin after massive weight loss.
- The author puts forth 11 surgical principles to approach body contouring in the massive weight loss patient.
- Proper patient selection, unique preoperative preparation, intraoperative planning, and resource management improve results and reduce morbidity.
- Technical advances in women include improved management of adiposity with spiral flap augmentation/suspension of the breasts and concomitant ultrasonic-assisted lipoplasty and lipoaugmentation.
- Direct oblique excision of flank bulges extending posterior to the abdominoplasty instead of the traditional lower body lift is yielding better mid/lower torso contours.

INTRODUCTION

An estimated 36.7% of the adult population in the United States is obese.¹ Defined as a body mass index of greater than 30 kg/m², obesity is associated with comorbidities that double mortality from cancer, cardiovascular disease, and diabetes.² Predictions based on a linear time trend suggest that 51% of the US population will be obese, and 9% will be morbidly obese by 2030.³ Weight loss by dietary changes and exercise usually does not achieve the desired weight loss goals on an individual.⁴ As such, bariatric surgery has become the treatment of choice for obesity and morbid obesity.⁵ The Roux-En-Y gastric bypass procedure remains the gold standard surgical option for the

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obese patient with gastric sleeve gaining traction. In the course of achieving massive weight loss (MWL) and alleviation of comorbidities, bariatric surgery creates quality-of-life problems for the plastic surgeon.

Minimally invasive gastrointestinal bypass surgery for morbid obesity was successfully pioneered by Phillip Schauer at the University of Pittsburgh Medical Center.⁶ Despite their numerous health advantages, disgruntled patients soon complained of disturbing lax skin and subcutaneous tissue. Schauer asked the senior author to help. Addressing a hospital auditorium full of MWL patients, Hurwitz learned of the disheartening changes in body contour with repulsive hanging skin and bizarre rolls of skin and fat. They were embarrassed by flattened breasts, hanging pannus, ptotic mons pubis, and sagging inner thighs. Clothes fit poorly. Vigorous activity was difficult. Skin beneath folds becomes moist, malodorous, and inflamed.

In the late 1990s, plastic surgeons limited their treatment of skin redundancy of the torso and thigh by a circumferential abdominoplasty, a lower body lift, and a medial thighplasty.⁷⁻¹³ Sagging breast were treated independently. The results often fell below expectations. Delayed wound healing was common. There was scant precedent for successfully performing body contouring surgery after MWL. The bypass patients of the 1980s usually underwent the physiologically disruptive jejunal-ileal bypass and were poor candidates for prolonged body contouring surgery. Modern minimally invasive surgery with the Roux-en-Y gastrointestinal bypass delivered a much less traumatized and healthier patient. After 4 years of innovative effort, we introduced a comprehensive single stage solution called total body lift surgery.¹⁴

Body contouring after MWL is now embraced as a safe and reliable option to improve self-esteem, social life, work ability, physical activity, and sexual activity.¹⁵⁻²¹ Most often excisional, body contouring surgery can also use liopaspiration, dermal suspension techniques, and autologous fat grafting. It has been estimated that as many as one-third of MWL patients will require reconstructive surgery after their weight loss. Estimates as high as 80% purport that patients desire body contouring surgery after MWL; however, only 12% undergo the corrective surgery.

CURRENT APPROACH AND PRINCIPLES

Because of comorbidities and prolonged postoperative negative nitrogen balance (starvation), we avoid panniculectomy coincidental with gastric bypass. Moreover, the panniculectomy scar may preclude optimal subsequent surgical planning for definitive torso contour correction. After MWL, panniculectomy is simply the removal of hanging panniculus by a long anterior transverse excision of skin and fat between the umbilicus and pubis. There is no undermining of the superior flap or alteration or reconstruction of the umbilicus. Panniculectomy may be complemented with liposuction of surrounding, non-undermined bulging skin. It satisfies the medical indications by correcting the inflammatory sequelae of an overhanging pannus. This limited abdominoplasty is rarely aesthetically adequate.

Our innovative total body lift approach features comprehensive and coordinated planning in as few stages as possible.¹⁴ Loose skin is excised and gender-specific features sculpted. Female adipose-related features of the breasts, waist, hips, and buttocks are shaped.²² Men have restoration of upper body dominance and visibility of broad superficial muscles with aggressive treatment of gynecomastia and love handles.²² These are extensive and complex operations over large portions of the body, requiring a team of operators, working in consort from 3 to 6 hours with the patient under general anesthesia. Minor wound healing complications were common, but major morbidity is rare.²³ Before embarking on such lengthy procedures, the surgeon and

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