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Cosmetic Surgery Following Weight Loss Surgery

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KEYWORDS
• Body contouring • Massive weight loss • Postbariatric • Brachioplasty • Thighplasty • Mastopexy • Abdominoplasty

KEY POINTS
- Massive weight loss patients require comprehensive preoperative evaluation and management of expectations.
- Patients and surgeon must together develop a plan and schedule for the order and timing of each surgical procedure, based on the patients' priorities.
- Procedures are wide ranging and include contouring of the abdomen, inner and outer thighs, buttocks, back, breasts, arms, and face/neck.
- Staging procedures are often required to avoid simultaneous opposite directions of pull.
- Complications are common after cosmetic procedures for massive weight loss but are often minor in severity and easily managed in the office.

INTRODUCTION: NATURE OF THE PROBLEM

The obesity epidemic continues to increase worldwide, despite continuous efforts to battle weight gain (Figs. 1–9). Current treatment options include diet and exercise, medical weight loss, and bariatric procedures. As more patients turn to surgical management of obesity, an increasing number of patients present for body contouring procedures after massive weight loss (MWL), most of which are considered cosmetic procedures by insurance carriers. Although abdominoplasty and breast lift surgery are the most common, brachioplasty and thighplasty for excess extremity skin are gaining in popularity, as are lower body lift (LBL) procedures. Deformities after weight loss are often severe and unpredictable, sometimes causing significant functional impairment due to rashes or poor-fitting clothes. Attention to preoperative assessment, surgical planning, and postoperative management is critical to optimizing results for this complex patient population.

SURGICAL TECHNIQUE

Preoperative Planning

Careful assessment of any patient who presents for body contouring after MWL, defined as a loss of greater than 50% of excess weight more than the ideal body

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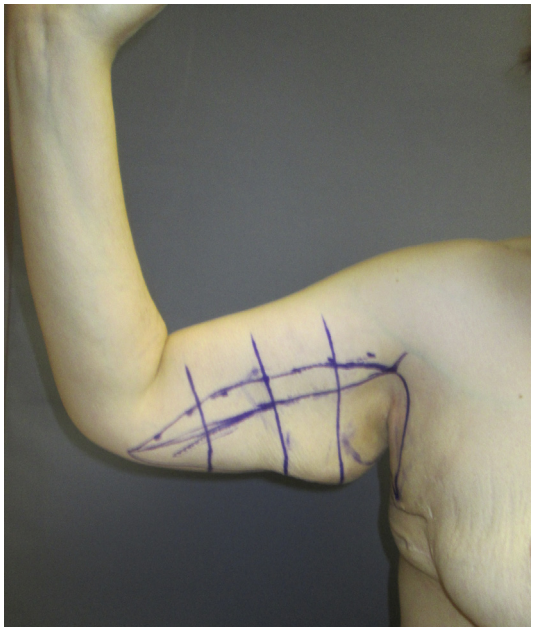

FIG. 1 Markings for a brachioplasty.

weight [1], is paramount to performing surgery safely and minimizing complications. It cannot be overstressed that a focused history and physical will keep a surgeon—and patients—out of trouble. The surgeon should understand the patients' reasons for pursuing surgery as well as their expectations for eventual results. The latter must be reasonable and aligned with what the surgeon can offer.

Given that these operations are superficial, involving mainly skin and subcutaneous structures, they are considered low risk by the American College of Cardiology and American Heart Association [2]. Suitability for general anesthesia should be obtained from a preanesthesia unit, if one is available, or from the patients' primary care physician or other medical specialist. For patients with a positive psychiatric history, or if there is a concern about psychiatric stability or body dysmorphic disorder, a referral to a mental health specialist is recommended. Patients on chronic pain medication should be sent back to the physician managing their pain medications, and a clear plan should be developed for postoperative pain control.

Modifiable risk factors include medical comorbidities, body mass index (BMI), tobacco use, and nutrition status; these should be optimized before agreeing to surgery. Management of medical comorbidities, such as hypertension and diabetes, should be left to a primary care physician or generalist. All patients should be evaluated equally, as BMI cutoffs may not consider significant deformities of certain areas. After weight loss, patients should have a stable weight for at least 3 months, within a 5-kg range [3]; this generally occurs approximately 15 months after bariatric surgery. Nutritional assessment should include, at a minimum, screening of albumin; vitamins A, B, D, E, and K; and iron levels, especially in patients who have had malabsorptive bariatric procedures, such as Roux-en-Y gastric bypass or biliopancreatic diversion. Studies have shown that, despite supplementation, up to 50% of patients who have had bariatric surgery have at least one elemental or nutritional deficiency [4,5]. A complete blood count should be obtained on all patients who have sustained MWL. A fast and easy set of questions that can be asked in the clinic is included in Box 1.

Although previous events in a patient's history, such as a cardiac or cerebral ischemic event, cannot be modified, perioperative risks can be reduced by following accepted guidelines [2]. Additionally, the surgeon must pay attention to previous scars in the same anatomic location as a planned surgery and be mindful of disrupted vascular connections that could lead to untoward outcomes.

Patients generally have many anatomic areas that require correction. Patients need to delineate the areas they would like addressed to the surgeon and together formulate a schedule. The authors' recommendation is to start with patients' highest priority and move down their list. Staging procedures may be required to minimize the operative time and avoid opposite vectors of tension. Some combinations of procedures can be performed safely and expeditiously, whereas other combinations are advised against. Procedures commonly combined include abdominoplasty with mastopexy, upper body surgery with lower extremity surgery, and lower body surgery with upper extremity surgery.

Markings

Patients should be marked preoperatively in the holding area, which is a good time to review with patients the location and length of the scars. Although all resection margins are marked preoperatively, the authors' recommendation is to commit to one line at the start of the procedure and dissect toward the other, only committing to the second margin after confirming that closure will be possible.