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# Thighplasty: improving aesthetics through revival of the medial, horizontal procedure: A safe and scar-saving option

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Postbariatric patients

**Summary** *Introduction:* Thighplasty is a common bodycontouring procedure, but also associated with a high complication rate. The purpose of this study was to access the outcome of the medial horizontal thigh lift as it is a common surgical technique regarding thigh deformity correction performed at the authors' department. Surgical keysteps, clinical applications, advantages and disadvantages of the procedure are shown. Postoperative evaluation took place with special focus on individual patient satisfaction.
*Methods:* Retrospective analysis of 25 bilateral thigh lifts with single medial horizontal incision line was performed. Evaluated data include patient age, sex, body mass index, combined procedures, additional liposuction, weight loss, former bariatric surgery, comorbidities, smoking status and surgical complications. Follow-up was performed with a standardized protocol and the scar was accessed according to the Vancouver-Scare-Scale. Additionally the patients were asked to complete a questionnaire divided into the sections 'scars', 'postoperative result' and 'sexuality'.
*Results:* Average patient-age was 43 years. Average follow-up was 2 years and 8 months. Average weight loss before surgery was 57 kg. 36% of all patients additionally received a liposuction of the medial thigh. In six cases (24%), we observed complications, which were designated as 'minor complications' in five times (conservative management without problems) and 'major complication' in one time (surgical revision). Postoperative patient-satisfaction was high.
*Discussion and Conclusion:* Compared to the horizontal and vertical combined thigh lift with the classic T-shaped incision lines we observed fewer complications and a reduction of postoperative morbidity. Additionally patient satisfaction was very high. We estimate that the main reason therefore is the avoidance of the vertical scar and its associated short- and longterm problems. The evaluated data confirm the medial horizontal thighplasty as a good and valuable

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surgical option for the management of thigh deformities with moderate skin and tissue excess, localized in the upper part of the thigh.


## Introduction

Thighplasty is a common body contouring procedure. In general, there are many surgical options to perform a thigh lift. The medial scar positioning (medial thigh lift) seems to be the standard and is a widely accepted procedure. Nevertheless, there are many subgroups of surgical options for the medial thigh lift, including vertical or horizontal procedures, the classic T-shaped thigh lift and additional procedures (e.g., additional liposuction). Overall, the complication rate reported is high, up to 70%.[1] In contrast, the postoperative result often is not satisfying. According to our literature analysis, we could not find any previous scientific evaluation, with special focus on exactly this technique of thighplasty. The purpose of this study was to access the outcome of the medial horizontal thigh lift as it is a common surgical technique for thigh deformity correction performed at the authors' department.

### Indication

To achieve a perfect postoperative result, the clinical application of the medial horizontal thigh lift should be limited to the following patient group of thigh deformities: The tissue and skin excess should be less to moderate, although this information is difficult to quantify. The resectable volume and tissue excess should be localized and distributed in the upper third/half of the medial thigh (Figure 1). Skin and tissue excess, localized mainly in the distal portion of the thigh, can hardly be treated with this technique. (Figure 5)

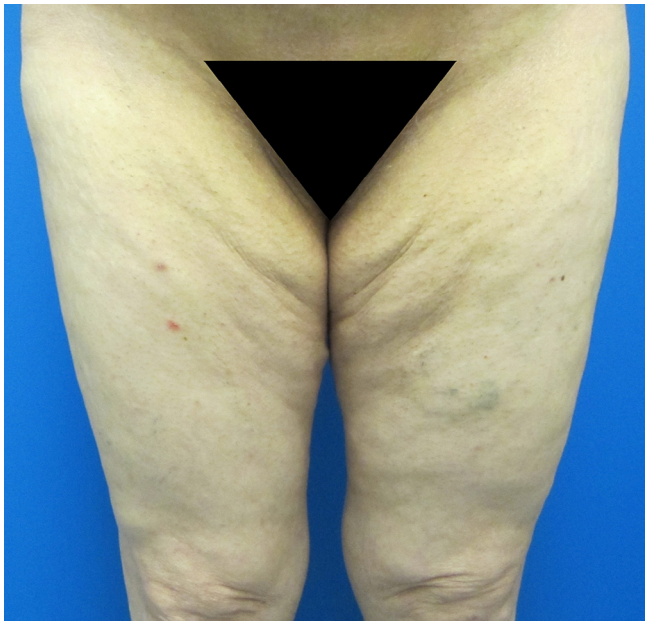

**Figure 1** Ideal indication for a medial horizontal thighplasty: Moderate volume and tissue excess localized in the upper third of the medial thigh.

### Surgical technique

Preoperative marking is essential and is done in standing position. The pinch test is used to determine the resectable tissue, which is markedly ellipse shaped. The former cranial incision and later the scar position are within the perineal fold and continues within the gluteal fold and should not extend beyond the posterior femoral midline. For surgery, the patient is placed either into supine position or into a modified lithotomy position at our department. Surgical intervention starts under general anesthesia with infiltration and liposuction if indicated. The area of liposuction should at least cover the resection area and can also include more distally placed portions of the medial thigh. Afterward, incisions are made along the markings, and the tissue is resected with monopolar diathermy. It is essential to stay superficial to the Colles fascia, preserving vital structures, and drainages should be used. Wound closure is performed using deep and subcutaneous Vicryl® (Polyglactin 910, polyfil) 2.0 and 3.0 sutures and intracutanous Monocryl® (Poliglecapron, monofil) 3.0 or 4.0 sutures. Several deep key stiches with inclusion of the Colles fascia and the adductor longus tendon are necessary for scar fixation, positioning within the perineal fold, and prevention of massive scar migration. Sterile wound dressing and complete bandaging of the lower extremity complete the surgery. Postoperative low-molecular-weight heparin (enoxaparin) therapy is necessary during the hospital stay. Mobilization starts on day 1 postoperatively. Drainage removal is done if the collected fluid is less than 20 ml/24 h. (Figure 2)

## Patients and methods

A retrospective analysis and a systematic follow-up with a standardized questionnaire of 25 bilateral medial horizontal thigh lifts have been performed at our department. The included surgical interventions were performed between June 2009 and February 2015. The following patient data were collected: patient age, sex, combined procedures, additional liposuction, comorbidities, smoking status, former bariatric surgery, weight loss, body mass index (BMI), and surgical complications. Major complications were designated as postoperative events requiring surgical revision and acute life-threating events. Minor complications were designated as postoperative events that could be managed conservatively without problems. During follow-up, information was collected with a standardized protocol regarding scar migration, labial fold distortion, change in urinary stream, patient satisfaction, change in sexuality, change in attractiveness, and postoperative weight change. The scar was evaluated according to the Vancouver Scar Scale (VSS)[2] by the surgeon (Figure 3). The