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# VIDEOS

- Video 2.1** Belt lipectomy markings: Description of deformity
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- Video 2.5** Belt lipectomy surgery: Planned incisions and elevation up to umbilicus
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- Video 2.16** Belt lipectomy surgery: Resection of posterior excess and discussion of transfusion
- Video 2.17** Belt lipectomy surgery: Closure and turn, placement of binder and foam
- Video 6.1** Upper body lift and brachioplasty: markings.  
(1) Description of upper body & arm deformities.  
(2) Marking ideal IMF & presenting IMF & lateral transition.  
(3) Marking the arms/Inner ellipse.  
(4) Marking the arms/Outer ellipse.  
(5) Lateral/upper back excess markings.

**Upper body lift and brachioplasty: arm component.**

- (1) Explanation of Surgical approach & intraop markings.
- (2) Tailor tacking the arm.
- (3) Tailor tacking the chest and lateral chest.
- (4) Removing arm staples and remarking.
- (5) Arms segmental resection closure tech 1st segment.
- (6) Arms segmental resection closure tech 2nd segment.
- (7) Arms segmental resection closure tech 3rd segment.

**Upper body lift and brachioplasty: chest component part 1:**

- (1) Removal of the tailor tack sutures from the chest.
- (2) Removing NA complex for FTSG.
- (3) Incising new IMF with angulation.
- (4) Determining the amount of tissue to resect.
- (5) The excess tissue is resected.

**Video 6.2 Upper body lift: chest component part 2.**

- (1) Explanation of the anatomy after chest resection.
- (2) Reapproximating the chest wound with staples.
- (3) Attaching infer. flap's Scarpa's fascia to inf border of Pec.
- (4) 2nd layer of chest closure.
- (5) Temp closure of lateral dogear to be removed from back.
- (6) The opposite side has the same performed Part I.

**Video 6.3 Upper body lift: chest component part 3.**

- (1) The opposite side has the same performed Part II.
- (2) Explanation of the chest closure.
- (3) Closure of the arm & Insorb staples.
- (4) Showing completed chest closure, chest meridian.
- (5) Determining new position of the NA complexes.
- (6) Depth NA complex bed & Place FTSG & Bolster.

**Video 6.4 Upper body lift: Upper back component.**

- (1) Explanation of the back excision in lateral decubitus.
- (2) Back dissection.
- (3) Final resection and temporary closure with staples.
- (4) Final closure and staples around the T.



**Fig. 3.11**

The hip pinch test helps document the extent of soft-tissue relaxation and also demonstrates to the patient improvements in cellulite and skin tone that may be possible with thigh/buttock lifting. Cellulite that is apparent when the patient is upright but disappears when the patient is supine is called *cellulite of laxity* or *gravitational cellulite*. It is successfully treated with body lifting.

While examining patients for laxity of the skin and subcutaneous tissue, we should not only observe the degree of actual laxity but also estimate the degree of potential laxity that would occur if liposuction alone were used to treat the aesthetic deformity. The extent of rectus muscle diastasis and of total musculofascial wall decompensation is determined. Hernia defects and abdominal scars should be documented.

Before being photographed, the patient is weighed without clothes for future reference. The patient should understand that if he or she gains weight after any body-contouring surgery, the contour results could change from the expected postoperative appearance. Patients are responsible for maintaining their body weight at an acceptable level.

## Goals

- Treat the trunk and the thighs as a single unit.
- Create abdominal contouring by using high lateral tension.
- Lift the anterior and lateral thighs.
- Lift the buttocks.
- Recreate normal lumbar lordosis.

## Operative Approach

### THIGH/BUTTOCK LIFT COMBINED WITH HIGH-LATERAL-TENSION ABDOMINOPLASTY—LOWER BODY LIFT

Key elements of the lower body lift include the following:

- Incisions placed within current high-cut bikini lines.
- Two-layer SFS suspension with permanent sutures.
- Discontinuous undermining through the SFS zone of adherence for more distal transmission of lifting forces.
- Liposuction of familial fat deposits of the circumferential trunk and thighs.

### Markings

Accurate and symmetrical preoperative markings are essential for the success of lower body lifts because each side of the thigh/buttock lift is performed when the surgeon is unable to see the opposite side. Markings are made with the patient in the standing position after high-cut bikini margins are outlined. The final incisional scar should always lie within bikini outlines.



Fig. 3.12

The superior anchor resection line is marked along the lateral body contour and continues posteriorly. The amount of vertical tissue redundancy superior to the planned line of closure is estimated with the patient's knees 6 to 10 inches apart. This is usually 5 to 6 cm of stretched skin, representing about one-fourth of the vertical excess along the lateral body.

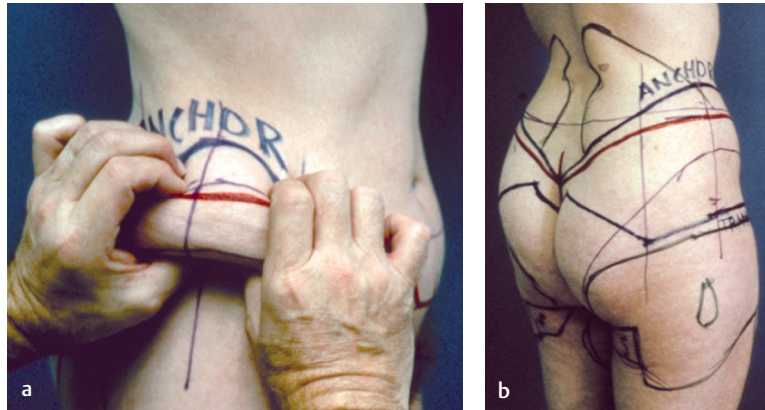


Fig. 3.13ab

Next, the redundant tissue inferior to the line of closure is estimated. This generally ranges from 10 to 20 cm vertically along the lateral contour, producing a total vertical resection of 15 to 26 cm of stretched skin. The amount of resection may be 30 to 40 cm or more in a patient who has lost a massive amount of weight. Although the actual extent of resection is determined at surgery, symmetrical estimated resection lines are used as a reference so that the final scar is symmetrical.

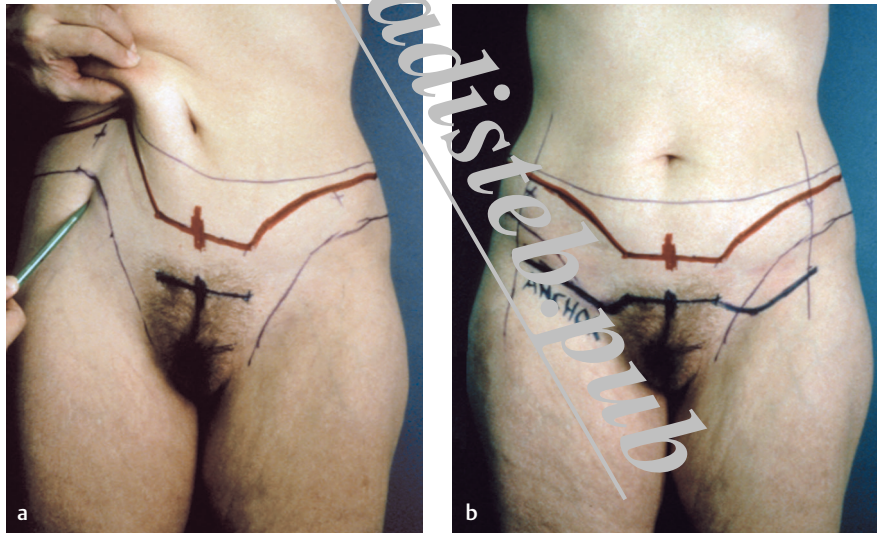


Fig. 3.14ab

Anteriorly, an inferior anchor resection line is marked to resect inguinal redundancy inferior to the final scar line. A superior reference line is marked across the abdomen at the umbilical level.

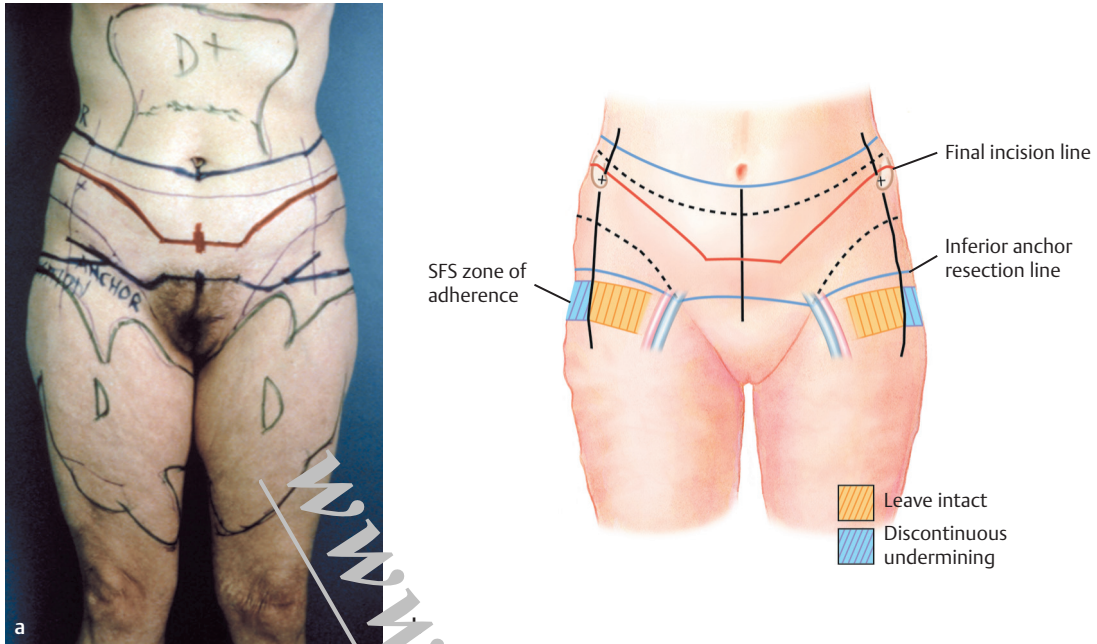


Fig. 3.15ab

The crosshatched areas are the zone of adherence. The medial (*yellow*) adherence should be left intact to anchor the abdominoplasty, and the lateral (*blue*) adherence should be released with the discontinuous undermining cannula to allow distal transmission of the lifting force. Direct undermining is usually not required.

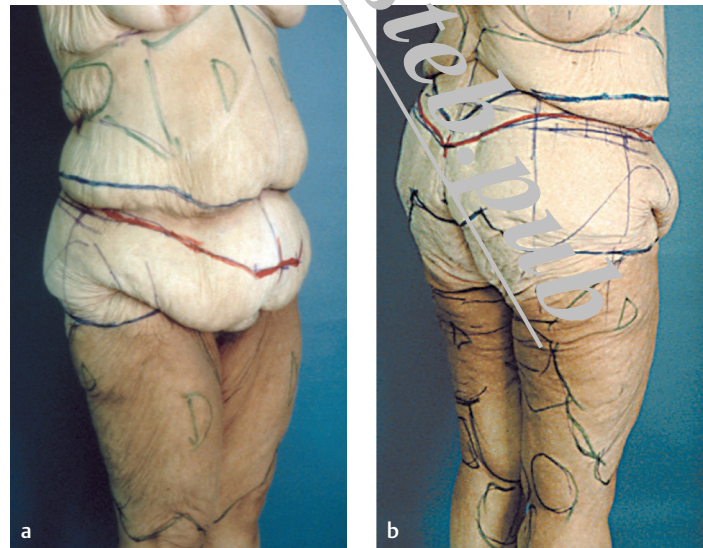


Fig. 3.16ab

It takes 45 to 60 minutes to make preoperative markings for the lower body lift and liposuction. Vertical lines are dropped in similar positions around the body and are measured at each location to help maintain symmetry.

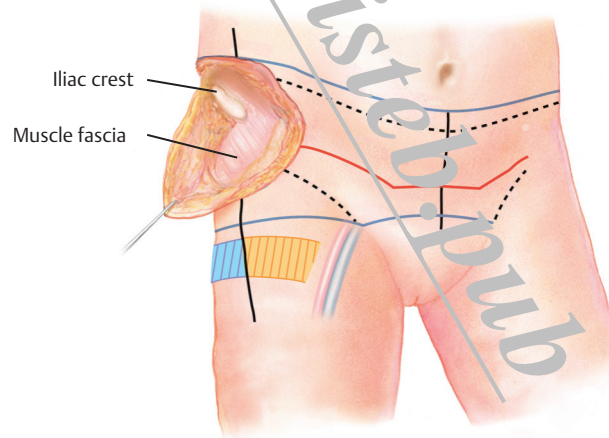


## Technique



**Fig. 3.17**

After general anesthesia is induced, the patient is placed in the lateral decubitus position on a vacuum beanbag positioner. Prone positioning is not as effective for obtaining optimal thigh lifting. The hips are flexed 45 degrees, and the thighs are abducted with foam blocks to keep the knees wide apart. Liposuction of the posterolateral trunk and circumferential thigh is performed if needed.



**Fig. 3.18**

An incision is made through the superior resection line. Undermining superficial to muscle fascia is begun along the lateral contour anterior to the iliac crest, staying lateral to the femoral triangle lymphatics.

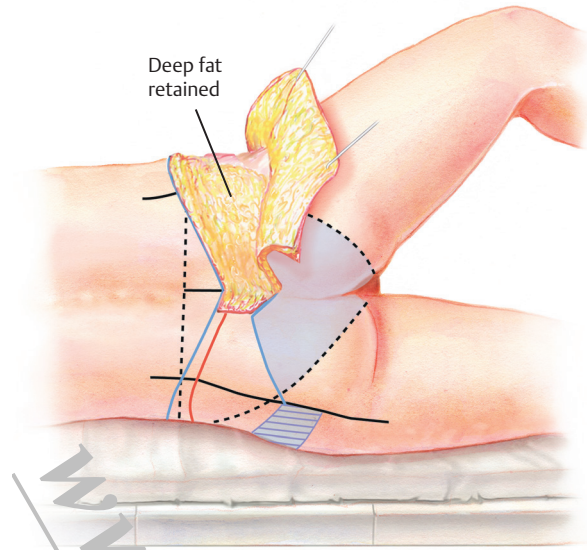


Fig. 3.19

The dissection then sweeps posteriorly in the same plane, leaving deep fat posterior to the iliac crest. Direct undermining should extend beneath the flap to be resected. Beyond this, no direct undermining is performed over the buttocks or into the thigh.

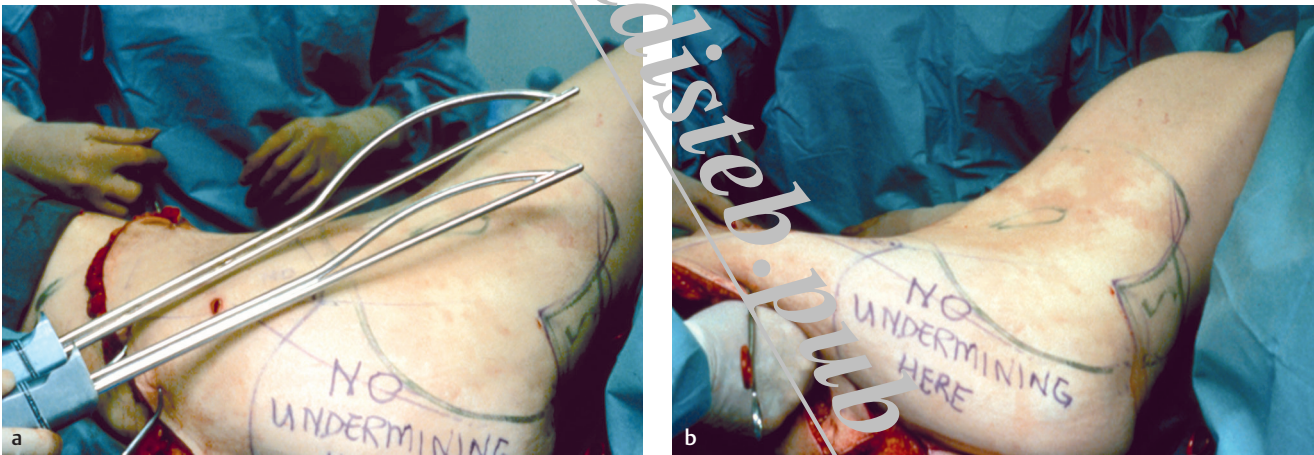
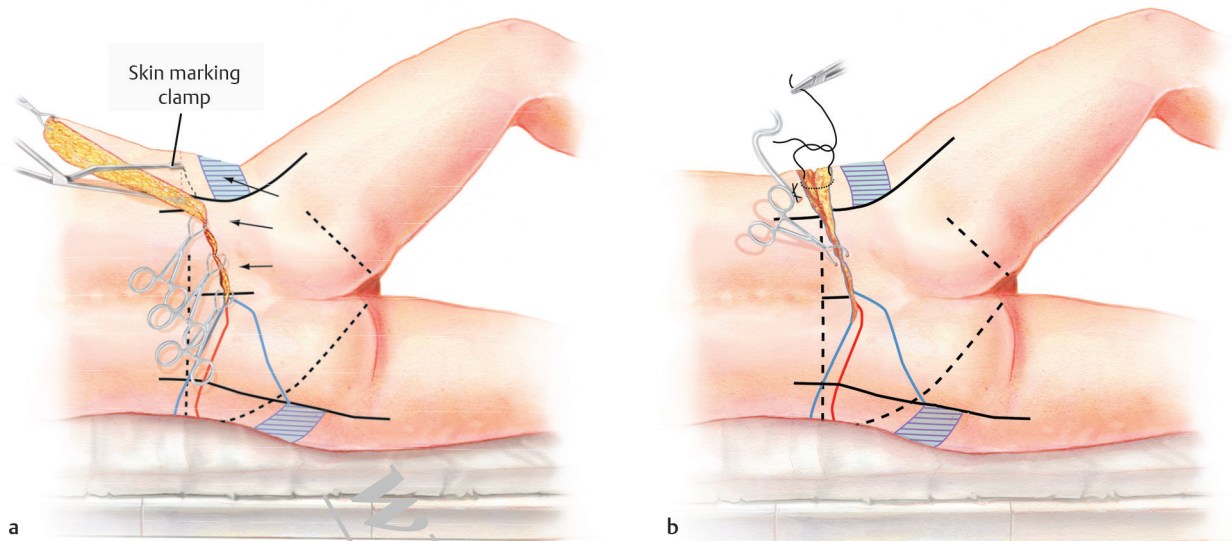


Fig. 3.20ab

The SFS fibrous adherence in the trochanteric region must be released with discontinuous cannula undermining (Byron Medical) to allow distal transmission of the lifting forces.



**Fig. 3.21ab**

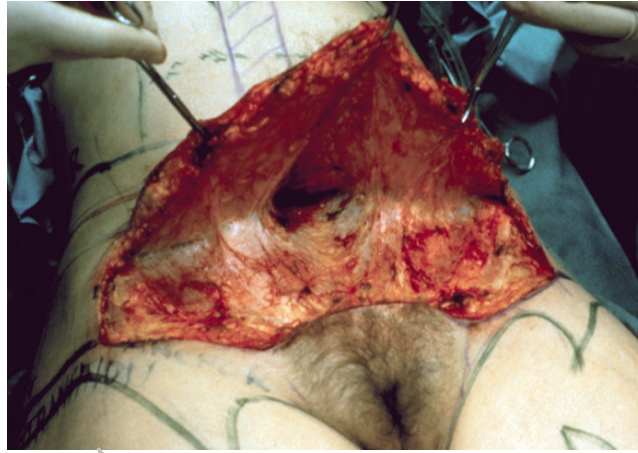
The redundant soft tissue is resected using flap-splitting techniques and a Lockwood marking clamp (Padgett Instruments, Kansas City, MO).

By resecting more SFS than skin, minimal-tension skin repair is possible after SFS anchoring sutures are placed (two-layer, no. 1 and 2-0 braided nylon dipped in polymyxin-bacitracin antibiotic solution, large-taper needles). Two 15- or 19-Fr fluted Blake silicone drains (Ethicon, Somerville, NJ) are inserted into each distal thigh, exiting the mons pubis anteriorly and near the incision posteriorly.



**Fig. 3.22**

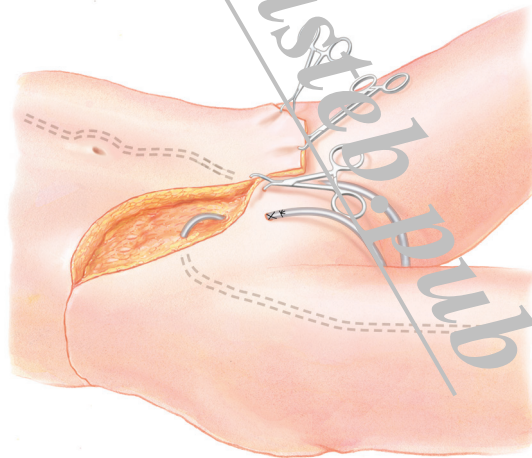
Stacked towels are temporarily laterally sutured to reduce pressure when surgery is performed on the opposite side.



**Fig. 3.23**

After the second thigh/buttock lift is completed, the patient is placed in the supine position for the final stage of the procedure. The hips stay flexed at an angle of 40 to 45 degrees, with the thighs widely abducted and the knees supported with blanket rolls. The high-lateral-tension abdominoplasty begins with an incision along the inferior anchor resection line. Direct undermining is limited to the tissue to be resected inferiorly and to the edges of the rectus diastasis centrally.

After diastasis repair, the tissue is resected, with the highest tension along the lateral third of the anterior incision.



**Fig. 3.24**

A final drain is placed into the epigastrium, exiting via the pubis. The SFS is repaired with 0 and 2-0 braided nylon, and the skin is repaired with running 3-0 polydioxanone deep dermal sutures and a running 3-0 polypropylene (Prolene) suture in the superficial dermis.

### Postoperative Course

Light dressings are applied and no compression garments are used. Postoperatively, the patient's hips are flexed and the thighs are abducted to reduce tension on the