

Discussion

Autoprosthesis Buttock Augmentation During Lower Body Lift

Postbariatric plastic surgery offers abundant technical challenges. Not only must excess skin over large areas be removed, but high-tension closures also are essential for reduction of postoperative sagging attributable to residual skin laxity. The high tension straightens silhouettes, muting gender-specific curves. Judicious use of unwanted adipose tissue about the buttock, hips, and breasts has great utility. Plastic surgeons must lead in addressing aesthetic issues and tissue transfer for the rehabilitation of this rapidly enlarging patient population.

Toward these ends, we have been offered a new technique and a retrospective clinical review of fat flap buttock augmentation. Physicians Ozan Sozer, Francisco J. Aguelo, and Coty Wolf of El Paso, Texas, direct our attention to an important facet of body contouring after massive weight loss. The more successful the weight loss, the more likely it is that there will be disturbingly flat buttocks. Moreover, as traditional lower body lifts raise ptotic buttocks, the flatness is accentuated. When the problem is not preemptively addressed, the well-intentioned plastic surgeon becomes the culprit for a flatter and elongated rear end.

This well-referenced report rightly recognizes the pioneering work conducted by Pascal and Le Louarn [5] of France. Their reliable and safe lower back and upper buttock sit-upon flap is very good, but may not adequately augment the buttocks. The flap does as well as it does because the useful adipose sags so much after the skin is removed. I can confirm that raising the buttock skin flap to receive the adipose flap does not compromise healing of the midback closure [1], although I do reduce the width of the beltlike low back excision to accommodate the added bulk and reduced skin flap blood supply.

Although I concur with the authors' concepts and am impressed with the striking buttock rounding and enlargement in three photographed cases, I differ with their technique, and I am troubled by their complications.

Instead of the lateral decubitus position, I favor the prone position. The prone position facilitates expo-

sure, team surgery, and symmetry [3,4]. No one chooses the lateral approach for breast augmentation or reconstruction. Why should this approach be chosen for buttock augmentation?

Despite the beautiful diagrams of the operation, the flap development and critical underlying blood supply remain unclear. Before a surgeon can adopt this operation, essential intraoperative photographs are necessary, which were not provided. Apparently the added fill is a lateral extension adipose flap elevated off the lumbar and tensor fascia lata fascias. This extension flap is turned or flipped 180° medially and inferiorly to be sewn to the inferior gluteal region. Because the base flap originates from gluteal perforators, there is no reason for tedious deepithelialization. Instead, overlying skin should be simply and rapidly removed.

With the reader's forbearance, I submit my own recent case of buttock augmentation with operative photographs, using a similar flap design for a 6-foot 5-inch man undergoing a total body lift [2] (Figs. 1 and 2).

I can confirm the authors experience that the adipose lateral extension is prone to fat necrosis. I suggest that the surgeon aggressively amputate suspect tissue extension rather than bury it. An ischemic flap was probably the authors' source of local transient buttock hardness. I would not categorize the use of a VAC for wound management and flap pressure necrosis as "minor complications." We appreciate the use of near full-length and comparable photographs, but in all cases, the hip donor-site contour was obscured by underwear. From these limited views, I fail to see the need for augmentation in case 3 (Fig. 4 in the article). I suspect excessive hip concavity, which leaves an accentuated hip–buttock contour. The concavity probably is attributable to transposition of the needed adipose and a depressed scar. Our evaluation would be aided by recorded pre- and post-treatment body mass indexes.

I agree that the perforator gluteal fat flap is an effective and aesthetic augments of the buttocks. I have learned, as have Sozer and colleagues, that the elevated portion is precarious.



Fig. 1. Posterior oblique view of a 23-year-old, 250-pound, 6-foot 5-inch man before and 12 days after an extended buttock flap augmentation similar to the method presented in the article with the key operative sequences in Fig. 2. The man weighed 460 pounds before his gastric bypass. He underwent a single-stage total body lift.

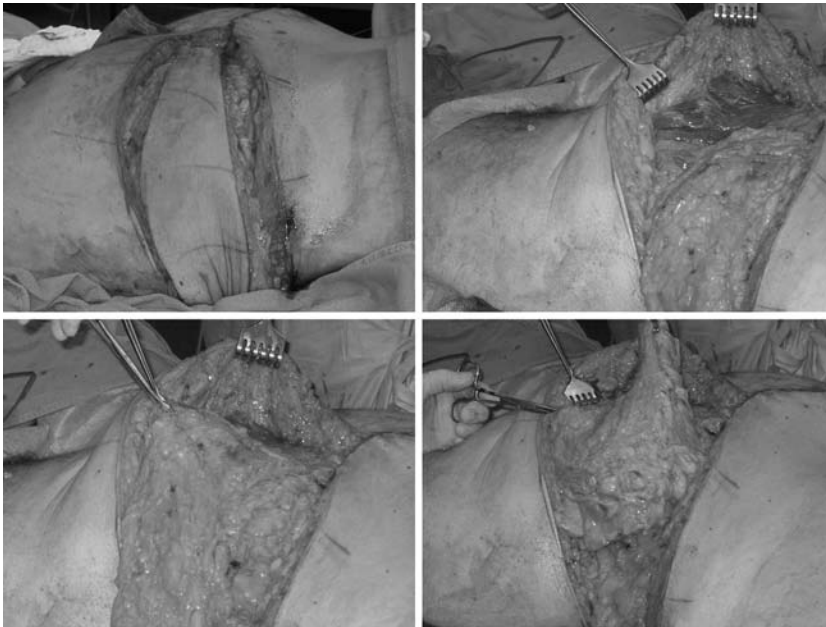


Fig. 2. Key operative sequences in gluteal adipofascial flap augmentation of the buttocks. Upper left: The 23-year-old patient is prone, and the anticipated excess left-side, lower-back, and upper-buttock skin is isolated in the form of an ellipse. Upper right: The skin has been removed, and a skin flap is elevated and held up by a rake over the gluteus musculature. Lower left: The adipofascial pad has been directly pulled inferiorly by a clamp to fill the supragluteal space. It will be sutured to the gluteal fascia with 0 braided absorbable sutures. Lower right: The lateral extension is turned over 180° on top of the advanced adipofascial flap for further augmentation. The buttock skin will then be advanced and sutured to the lower back incision.

References

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