ABDOMINOPLASTY: AVOIDING PITFALLS

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Pitfalls if not recognized and mitigated during planning and execution of abdominoplasty can mar the final aesthetic outcomes.

Most common is misjudging the extent of skin laxity. For instance, the earliest sign of supraumbilical laxity may be horizontal orientation of umbilicus and only later a concertina effect on the skin is apparent. In such situations, performing a mini-abdominoplasty instead of standard abdominoplasty would give suboptimal results. In Figure 1, the left side

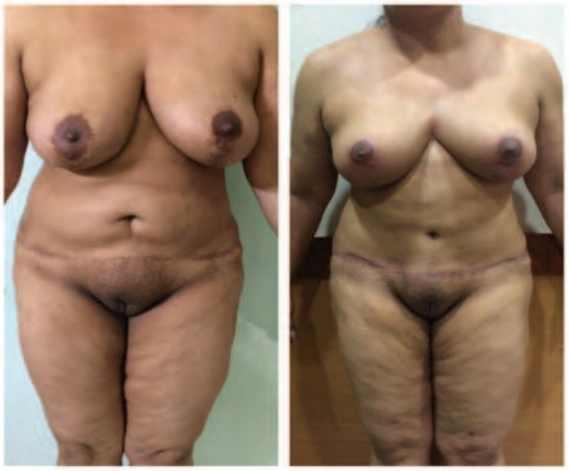

Figure 1 - Left side shows mini - abdominoplasty result. On the right after converting to standard abdominoplasty.

shows the result of mini-abdominoplasty performed in a patient with supra-umbilical laxity. Result after standard abdominoplasty is shown in Figure 1 on the right side. Similarly, performing standard abdominoplasty in patients with circumferential laxity would mar the aesthetic result, as evident in Figure 2 left side. Positive translation test (pinching the flanks corrects the lateral thigh laxity) and signs of buttock ptosis are tell-tale evidence of circumferential laxity. This patient finally underwent lower body lift resulting in dramatic improvement in the abdomen as well as thigh contour (Figure 2 right side).

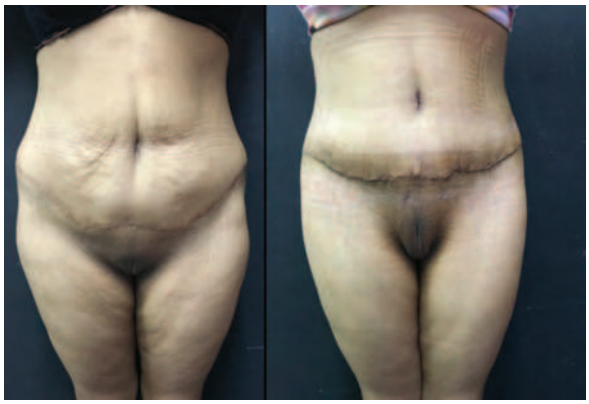

Figure 2 - Shows on the left side standard abdominoplasty. On right side after conversion to lower body lift.

Transverse laxity in the upper abdomen can be ascertained by pinching the skin in a horizontal fashion. Figure 3 shows a patient who refused to have the anchor abdominoplasty and only underwent lower body lift. He subsequently was distressed about the residual laxity in the midriff area

Male abdominoplasty patients often have a hidden penis due to overhanging pannus. If not recognized and corrected, this can lead to dissatisfaction. These patients require aggressive defatting and suspension of the mons to reveal the external genitalia - Figure 4. Often there is horizontal excess as well in the mons area. This needs to be shortened by removing vertical ellipse of skin on either side of mons as continuation of medial thighplasty.

The other pitfall is incorrectly "siting" the abdominal scar. Most common situation is either the whole scar is high - Figure 5 - or the lateral end of the scar is lower than the rest of the scar. Asymmetrical scar is also often seen. To prevent the high scar, one should mark the lower incision with the abdominal pannus pulled maximally in the cranial direction. At the level of the mons, it should be 5-7 cm from anterior vulvar commissure. In the inguinal region, it should be not more than 2-3 cm from the inguinal crease. The lateral end of the incision is marked without pulling the pannus in the cranial direction. This way the lateral end of the scar doesn't end up lower than the rest of the scar. Ideal scar location should have lowest point at the midline mons and the highest point at the lateral end. From the mons to the lateral point the scar should be inclined at a gentle 45 degrees.

The best way to mitigate an asymmetrical scar is symmetrical marking. All parts of the marking should be measured from fixed bony landmarks to ensure symmetry. Also, the upper marking is ascertained and confirmed by intraoperative tailor tacking. Once the final marking is made, one should not deviate from it while making the incisions.

Umbilicus re-siting can also be tricky. A common mistake is to ascertain the position of the umbilicus in the superior flap with the patient flexed in a beach chair position. This is more of a problem if the umbilicus has a long stalk. Then as the patient straightens out postoperatively, the umbilicus slowly migrates cranially and ends up as a high umbilicus.

A final pitfall is the development of a keloid scar at the site of umbilicoplasty. Periumbilical scar is the only visible scar in abdominoplasty. If this becomes keloidal, it can cause immense distress to the patient. Therefore, patients who have a keloid tendency (Fitzpatrick Type 4 and above) should have the option to choose scarless umbilicoplasty.[1]

Citation: 1. da Silva Júnior, V.V. & de Sousa, F.R.S. Aesth Plast Surg (2017) 41: 600.

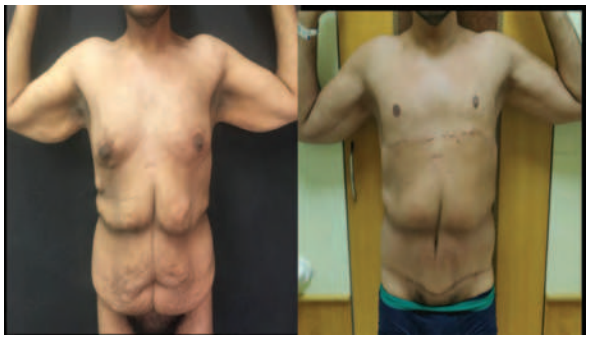

Figure 3 - Transverse laxity shown in the midriff area on the right image despite lower and upper body lift.

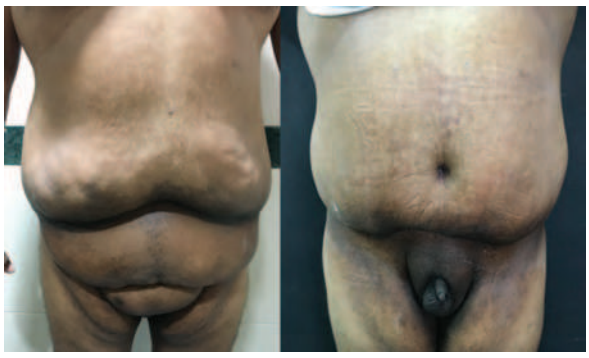

Figure 4 - Aggressive defatting and suspension of mons to reveal hidden penis.

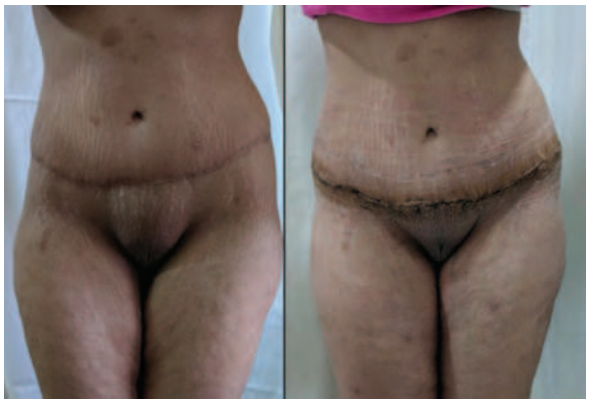

Figure 5 - High scar requiring revision abdominoplasty to lower the scar.