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THIS BOOKLET WAS WRITTEN TO FURTHER EDUCATE MY PATIENTS ON SOME OF THE PROCEDURES THAT I PERFORM.

CONTENT

I want to thank all of you for taking the time to read this booklet. The contents of this booklet are designed for both my pre-operative patients and those seeking more information about post massive weight loss surgery. The aim is to give you a better understanding of the procedures that you will or may undergo, as well as pre-operative, operative and post-operative descriptions. To those of you, who are already my patients and are scheduled for an upcoming surgery, I thank you for your confidence in choosing me. Interested patients will hopefully get a better understanding as to what is being offered to them following their weight loss and thus be better able to make an informed decision and complete their journey.

The decision to undergo any or all of the surgeries to be discussed is significant and sometimes overwhelming. I am hopeful that the information garnered here will help in your decision- making.

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A. Minor

B. Major

## WHEN IS THE APPROPRIATE TIME FOR BODY CONTOURING FOLLOWING MASSIVE WEIGHT LOSS?

Ideally this is when you reach your ideal body weight. This however is extremely variable. This is usually discussed with your bariatric surgeon before and or after your bariatric surgery. I tell my prospective patients when their weight has stabilized for three months, especially if they have reached their ideal body weight, that is a good time to start with their body contouring procedures. Sometimes even then I might feel that the patient should try to lose more weight to reduce potential complications. To do this I place them on an aggressively low carbohydrate diet. If you are contemplating body contouring I suggest you consult prior or close to obtaining your goal weight, to get an idea of what can be done for you, how many operations you may need and if your goal weight is reasonable to achieve.

## ARE THERE DIFFERENT PROCEDURES SPECIFIC TO MY NEEDS?

The simple answer is yes. The procedures that you may require are dependent on the amount and distribution of excess fat and skin remaining following your weight loss. Most patients know what part of the body they want operated on, but not the techniques available to them. An extensive examination of the patient is therefore needed to be able to advise the patient what may be done. There are six basic operations that I perform. There are multiple variations of each of these six procedures that depend on, your anatomy, the amount of excess skin and fat still present and most importantly on what you desire.

## HOW MANY OPERATIONS WILL I NEED?

There are six procedures that I offer to my patients. Multiple variations of each procedure are available. After finding out what procedures the patient wants, I usually suggest doing as many procedures in one surgical session as possible. I do this for three reasons.

1. To reduce the amount of time off of work as is possible.

2. To have as few anesthetics as possible.

3. To complete the patients journey as quickly as possible.

When necessary I have another Plastic Surgeon assist me to reduce the amount of time under anesthesia.

PROCEDURES

1. Lower body lift
2. Arm lift ( brachioplasty )
3. Breast lift and augmentation
4. Thigh lift
5. Upper body lift
6. Face related surgery

PRE-OPERATIVE INSTRUCTIONS.

Once the decision has been made to go ahead with any of the procedures, lab work is obtained. This includes a CBC, Electrolytes and EKG. Prescriptions for pain control and antibiotics are given, as well as Arnica pills (reduces bruising) and surgical scrub to be used when showering the morning of surgery. The patient is seen either two days or the day prior to surgery for a pre-operative visit. At this visit all final questions are answered and lab work is again reviewed. Photographs are then taken. Markings are then placed on the patient. All final payments are made at this visit.

A lot of patients ask about nutritional supplements. I am fine with patients who take none and those that are on a complex regimen of them. Patients caloric needs will be increased after their surgeries. I therefore suggest eating at least 2000cal. per day, splitting this between protein (100gm) and carbohydrates. If the patient's nutritional status is unknown (most patients diligently follow up with their bariatric surgeons nutritionist), I encourage them to get it checked. Discontinue all non-steroidal anti-inflammatory medications, vitamin E and any estrogen, two weeks prior to surgery.

I advise all of my LBL and tummy tuck patients to go on a liquid diet 2 days prior to their surgery. That includes very little to no dairy products. A compression girdle is supplied to these patients. They are also supplied with a measuring cup and form sheet for measuring their drain output thigh. We encourage patients who undergo an LBL or Thigh lift to obtain a walker, which really helps during their first week of recovery. Supplies as mentioned above are then given.

# LOWER BODY LIFT (LBL)

When this procedure is performed it always includes an abdominoplasty (tummy tuck), lateral thigh lift, monsplasty (lifting and if necessary reducing the mons area) and buttock lift. Variations include adding an auto augmentation of the buttocks and or hip area using a skin/fat flap, which are almost always a good option, especially when patients have reached their ideal body weight. Surgeons often use the term lower body lift synonymously with, Belt Lipectomy and Circumferential abdominoplasty. They however are not the same. Belt lipectomy results in a higher incision around the waist and buttock region and gets less of a pull to the lateral thighs. A Circumferential abdominoplasty is done to chase a pleat of skin in patients who have laxity laterally and in the buttocks, but don't need as an aggressive lateral thigh or buttock elevation.

I do not perform the belt lipectomy as it leaves the incision too high in the back, creates a boxy (masculine) appearance of the hip area and does not allow for an auto-augmentation of the buttocks.

A Lower body lift is almost always done first in patients seeking post weight loss body contouring often with breast and arm procedures at the same time. It is rarely done at the same time as thigh lifts unless a spiral lift is done. (See below)

## The Procedure

In the holding area prior to surgery, ted hose and SCD's (sequential compression devices) are placed and started. The patient is then given some pre-operative sedation and brought to the operating room. Intravenous antibiotics are now given. After induction with general anesthesia, we start the operation by placing a foley catheter. Carefully the patient is turned onto their tummy (prone) and appropriately padded. After the back portion of the operation is done, which once again includes suctioning of the lower back, lateral thighs and usually auto augmentation of the buttocks and hips, the patient is carefully turned back over onto their back and again appropriately padded. The tummy tuck part is now done. This includes suctioning of the upper abdomen and flanks if needed, monsplasty and umbilicoplasty (re-insetting the belly button).

If other procedures are being done as well, we then start on those at this point. The lower body lift usually takes from 4-6 hours depending on how much suctioning needs to be done. Very long acting local anesthetic (Exparel) is injected into the fascia and long acting (marcaine) along the incisions. This allows the patient to awaken almost pain free. A girdle and abdominal binder are placed and the patient then awakened and transferred to the recovery Room (RR). A PCA (pain pump) is

started in the recovery room. If I deem appropriate Lovenox (blood thinner) is started in the recovery room and given every morning the patient is in the hospital. The time in the RR is approximately one hour. When stable the patient is then transferred to the surgical floor.

Most patients will stay for two nights while the minority will stay for either one or three nights. We will get you out of bed the first night unless you get back to the floor too late. Only ice chips are allowed for the first day. On the second post-operative day we will try some liquids and if possible oral pain medication. When comfortable, able to get out of bed, taking liquids well and have voided, you are ready for discharge.

## POST-OPERATIVE INSTRUCTIONS AND COURSE

It is extremely important for the patient to follow the Surgeons post-operative instructions. This will reduce the risks for complications. No matter how badly or well the patient is feeling post-operatively, please follow the surgeons instructions as closely as possible. I emphasize this because when the Surgeons instructions are not followed there tend to be more complications. I always encourage my patients to call if unsure of the instructions or if any concerns arise during their post-operative recovery.

Every patient's recovery is different, but my instructions are the same for all. Your recovery is then appropriately modified by myself, when evaluating you during your post-operative visits.

Most patient's can drive in about two weeks. Depending on what kind of work that you do, from sedentary to very active, return to work can be as short as a week (especially if working from home), to six weeks. If possible I encourage patient's to try to get four weeks leave from work. In general the longer you can stay out of work the better. Complications such as severe dehiscence of the wound (separation at the incision line), may lead to a delay in returning to work. I try to work with your place of employment, when such complications occur. It takes about three months to really feel like yourself again. One of the reasons why, is that this is the time that it takes for most of the swelling to go away. Swelling which comes and goes can last for as long as six to twelve months, although this is rare.

Other than walking to the bathroom and around the house three or four times a day, you should be fairly sedentary. Remember to wear your ted hose stockings all the time, except when showering. Move your ankles up and down as much as possible. I encourage patients to shower on the third post- operative day. Safety pin the drains to old underwear. Remove all the dressings and gently wash (using your hand or soft sponge) with any soap directly over the incisions. Make sure all the soap is then rinsed off and gently pat dry (do not rub dry). Apply a thin layer of any kind of

antibiotic ointment, followed by non- stick gauze (Telfa or Adaptic), 4x4 gauze and the minimum amount of tape needed to hold the dressings. Do this on a daily basis. Strip the drains, as shown in the hospital, 4-5 times per day. Empty and record the drainage amounts a minimum of 3 times per day. If possible try shifting your weight, even if for only a few seconds, to relieve the pressure on that part that you are on.

My nurse will be in touch with you daily or every two days to answer any questions and to make sure you are doing well, as well as to check up on drainage amounts.

During the second week increase your activity, without lifting more than 8oz. I usually see you during this second week, back in my office, to make sure you are progressing appropriately and most likely remove some if not all of your drains. As long as we see no complications at this time I will be able to assess your condition regarding;

1 Driving

2 Return to work

3 Increasing your activities

4 Discussion of diet

If I am satisfied with your progress then we schedule a follow up in a few days if any drains remain or in 3-4 weeks.

PATIENT NOTES.

BRACHIOPLASTY (ARM LIFT).

This procedure is commonly performed in conjunction with Mastopexy (breast lift) and or LBL. It can also be done with any other procedure as long as there is enough time. Most of the time an extended or L brachioplasty is performed, which not only removes excess tissue from beneath the arm just to the side of the breast, but can also help reduce the amount of excess skin of the upper outer back (called a J- plasty by some Surgeons, as the incision is shaped like a J). The extension can go the other way removing excess skin from the forearm all the way to the wrist. If there is still a fair amount of fat remaining following the weight loss, I then suction these areas. This I believe improves the overall result, reduces complications and actually makes the procedure technically easier to do.

Pre-operative instructions.

As per LBL except for the liquid diet beforehand, which is not needed.

Procedure.

I will do the brachioplasty last if other procedures are being done at the same time. Under general anesthesia the markings are reinforced and infiltrated with marcaine and epinephrine. If I am going to do liposuction, a wetting solution is infiltrated into the areas that I intend to suction. The area of fat under the area to be excised and any adjacent areas of excess fat are then suctioned. I then incise the anterior incision along its entire length. The skin and any remaining underlying fat is dissected backwards close to the underlying muscle. I then check my pre-operative markings and redo them if necessary. The posterior incision is then made and all the excess skin and fat removed. Incisions are closed with one layer first and the two arms are then checked for symmetry, shape as well as making sure the correct amount of tissue has been removed. I rarely use drains. A final layer of buried skin suture is run. Antibiotic ointment, non-stick gauze and kerlex wrap are then placed.

Post-operative Instructions.

Leave the dressings on for three days. Remove the dressings on the third post-operative day and shower. Clean the incisions with any kind of soap and water. Rinse all the soap off. Pat the incisions dry with a towel. If there is blood sticking and staining the area, then clean with peroxide before washing with soap and water. Using an upper body girdle with long sleeves is a good idea but not essential. I usually don't us drains, however if I do use them, then standard drain care is continued. I suggest the patient be relatively sedentary for the first week and only lift objects of 1-2 pounds. The second week they can slowly return to normal activities.

PATIENT NOTES.

MASTOPEXY (BREAST LIFT) WITH AND WITHOUT AUGMENTATON (IMPLANT OR AUTO).

This is the second most common procedure that I perform following massive weight loss. It is the most commonly performed procedure following massive weight loss in the United States. It is frequently performed in association with an implant to increase the overall size of the breast, as well as to increase upper pole fullness of the breast. Multiple different techniques are used to lift the breast. These include;

1. Anchor or inverted T incision mastopexy. 80%

2. L- mastopexy. 15%

3. Vertical or lollipop incision mastopexy. 5%

4. Circum-areola or Benelli type mastopexy. 0%

These are listed in order of frequency used in my practice. I never use the Benelli after massive weight loss. I only use it vary sparingly in non- weight loss patients.

When an augmentation is also requested, most often an implant (either silicone or saline) is used. Sometimes enough fullness along the sides of the breast is present which can be used to auto-augment the breast

Pre-operative instructions.

The same as the previous procedures. The patient is seen in the office between one and three days before their scheduled surgery. Photographs are taken and the patient marked for surgery. If an augmentation is also being done the patient is resized again. My nurse discusses what size and make of bra you need to obtain. This is then brought to surgery by yourself. Prescriptions are again given at this point.

Procedure.

Once again this procedure is usually done at the same time as another procedure is performed. I always start with a vertical incision when an augmentation is also being done. This is because the implant takes up a lot of skin slack, therefore requiring less skin excision. A temporary sizing implant is then placed and an appropriate permanent implant chosen. This is placed in the submuscular position and the breast lift then done with the minimal amount of incisions as possible. All stitches are buried and of the dissolving kind. A minimal amount of dressings are used and the patient's bra then placed. No drains are used. If this is the completion of the operation, they are then awakened and transferred to the recovery room. When able to void and drink appropriately they are discharged.

Post-operative instructions.

I have the patient return to the office for their first post-op visit at around five to seven days. If an implant has been used, massage instructions are given at this time. If no implant is used the patient may return to work and generally normal activities in one week or even sooner if they feel up to it. If an implant has been placed at the same time I suggest waiting up to four weeks if an active job and two weeks if more sedentary. No lifting more then 2-3 pounds for two weeks and then increase at a very slow rate over the next two weeks. Patients may shower 48 hours post surgery. Wear bra at all times unless I state otherwise.

PATIENT NOTES.

## UPPER BODY LIFT

This is done for excess upper back roles that cannot be removed by either liposuction or the previously mentioned J-lift. The final scar is placed along the bra line. This is sometimes done in conjunction with a reverse tummy tuck and visa versa. The reverse tummy tuck is also an upper body lift, removing excess skin from the upper abdomen. This is done when there is a fold of skin that cannot be removed safely when doing a LBL or regular tummy tuck. It is usually done in conjunction with a breast lift hiding the scar in the breast crease. I always do these procedures after a LBL or tummy tuck.

## PRE-OPERATIVE INSTRUCTIONS

These are the same as for the other procedures.

## PROCEDURE

This is started with the patient lying on their tummy while under general anesthesia. The excess skin is removed and the incision closed with buried dissolving stitches. If this is all that is being done then dressings are placed, the patient awakened and transferred to the recovery room. If a complete upper body lift is being done then the patient is placed on there back and the reverse tummy tuck completed by removing excess skin and sewing it to the breast crease. Sometimes the incision goes all the way across the chest. I try as hard as possible not to do this because the scar in that position can be unsightly. If a breast lift is being done, then this is completed, dressings applied and the patient transferred to the recovery room after being awakened.

## POST-OPERATIVE COURSE

If these were the only procedures performed that day, then the patient can be discharged home that same day. No drains are used. The patient may shower after two days. Place a thin layer of any antibiotic ointment, non-stick gauze, regular gauze and minimal paper tape, on a daily basis and as needed. A bra as prescribed by us can also be worn if a breast lift was done at the same time. Most patients can

return to work at between one to two weeks. I will see the patient back in the office at five to seven days.

PATIENT NOTES.

# THIGH LIFT

Numerous different incisions are used for this according to the severity and direction of skin laxity. A lot of patients will still retain a significant amount of fat in their thighs following weight loss. I will then “deflate” the thigh using liposuction at a surgical setting prior to the thigh lift. This allows me to get a better result, by being more aggressive with the skin removal at a second surgical setting. This cannot be done when the thigh still has a lot of fat within. When there is significant skin laxity a vertical incision will always be needed. When this laxity is both in a vertical and transverse direction, an oblique incision in the groin and sometimes in the buttock crease, is needed. When skin laxity is high on the thigh and vertically oriented then an incision in the groin and buttock creases alone can be used. This is often termed a spiral thigh lift. This not only helps elevate loose posterior thigh skin, but also helps to better define and position the buttock crease and lower buttock contour. If skin laxity extends all the way down to the ankle, then the vertical incision can be taken all the way down to the ankle, keeping it on the inside of the leg. The thigh lift is often done at the same time as one or more of the upper body procedures.

## PRE-OPERATIVE INSTRUCTIONS

These are the same as for the other procedures.

## PROCEDURE

If a spiral lift is performed, it is started with the patient lying face down under a general anesthetic. Unlike a vertically oriented thigh lift, the spiral lift is often performed at the same time as a LBL. After completing the posterior buttock portion of the spiral lift, the patient is turned onto their back and the frontal portion completed. This entails removing excess skin from the front of the thigh and suturing the skin in the groin crease adjacent to the labia. It can then extend all the way to the lateral hip area. At this point if needed it will join up with the LBL incision, if done at the same time as that procedure. No drains are placed.

If a vertical incision is done either by itself or in conjunction with a groin or spiral lift then a drain is used. The excess skin is removed and the tissue edges repaired with buried dissolvable stitches. A girdle is sometimes placed immediately but not always. The patient is awakened and transferred to the recovery room. I usually have the patients stay in the hospital one to two nights.

POST-OPERATIVE COURSE

The patient is helped out of bed that evening. When in a chair or in bed, we try to keep the legs elevated as much as possible. The patient is discharged on the first or second post-operative day. They may shower two days after the surgery. Minimal dressings with some antibiotic ointment are used as they will be wearing a girdle. The patient is seen back in the office between five and ten days or sooner, if the drainage output is less than 30cc in a 24 hr period. The patient should be sedentary at home for two weeks with their legs elevated, occasionally being out of bed. They can return to work anywhere from two to six weeks, depending on their work and recovery.

PATIENT NOTES.

## FACIAL SURGERIES

These procedures include brow lift, upper and lower eyelid surgery, mini-facelifts, neck lifts and regular full facelifts. Most significant to extreme weight loss patients however is the relatively new technique of fat injections. I say relatively because although being performed for over twenty years, they are only now becoming more mainstream. They are particularly helpful to the weight loss patient as they can restore volume that was lost. Unfortunately more than one session of fat injections may be needed for permanent results.

COMPLICATIONS.

MINOR COMPLICATIONS.

Minor complications with these extensive procedures are common in the range of 90%: They include.

1. Suture (stitch) abscesses

2. Minor wound dehiscence

3. Seromas

4. Rashes

Suture Abscesses

These are very frequent and present anywhere from the first week after surgery to up to six months after. The area where they present gets red and often looks like a pimple. They are easily treated, by allowing the area to open. Wash with soap and water and apply a small amount of any kind of antibiotic ointment and a band-aid. If a stitch is obviously noted, it can be removed by gently pulling on it, or cutting it with a scissors. They will heal in 24 to 48 hours.

Minor Wound Dehiscence (suture line seperating)

I will talk about major dehiscence in the major complication section. Minor dehiscence occurs in about 25-50% of these procedures. These are scary when you see them but typically will heal themselves with appropriate local care. I like to use wet to dry dressing. A gauze sponge is minimally dampened with saline and gently packed into or over the wound. It is left to dry and then removed when the next dressing is done, which is two times a day. If the wound is really small a small amount of antibiotic ointment and a band-aid or gauze is used, also twice a day.

Seromas

These are collections of fluid that usually appear at about 2weeks post procedure, but can be seen at about 4-6 weeks later. If confirmed, they will need to be aspirated in the office. This may and usually does need to be done a few times, usually within days of each other.

They present as a localized area of swelling under the skin, sometimes soft but usually fairly firm.

Rashes

When these appear they usually represent a problem such as an allergic reaction to ( oral medication, topical antibiotic ointment or tape), or infection or inflammation. Rashes are not representative of a complication, rather a sign of something else. You should always let the doctor know if you develop one.

MAJOR COMPLICATIONS.

These are far more rare and occur in about 2-3% of my patients. They include:

1. Hematoma (collection of blood)

2. Tissue necrosis (skin and fat dies)

3. Major dehiscence

4. Infection

Hematoma

This usually occurs soon after the procedure. It will either present with increased swelling which is usually quite tense and or with a high rate of blood coming out of the drains. This blood with be bright red. Very rarely will these go away spontaneously. They usually need treatment which requires opening the incision close to where the swelling is and removing the blood and cauterize any bleeding that is found.

Tissue necrosis

This occurs mainly in the abdomen when doing a tummy tuck or lower body lift. Treatment is to remove the dead tissue and place appropriate dressings, often Silvadene and at a later stage wet to dry dressings with saline dampened gauze. The subsequent wound is then allowed to close itself (2-4 months). It can then be revised at a later date.

Major Dehiscence

This is differentiated from minor by the size and the fact that surgical intervention is usually needed. This type of dehiscence nearly always occurs when there is tissue necrosis. Debridement (removing non-viable tissue) with wet to dry dressings is usually the treatment of choice early on. When the wound is clean secondary closure can be undertaken in the operating room after discussing options with the patient.

Infection

Infections present as areas of redness, drainage and usually pain. When more severe the patient will develop a fever. Minor to moderate infections will usually respond

to oral antibiotics. Major infections most often require hospitalization with drainage of the infected areas and appropriate intravenous antibiotics.

## CONCLUSION.

I sincerely hope this has been informative for you. Undoubtedly you will still have questions since a book can be written on this subject matter, which I very well may do in the future. That is one of the reasons I made the PATIENT NOTES area, so that if downloading this there is space to immediately make some notes for you to remember. Please therefore do not hesitate to contact myself or office staff with any questions you may have.