BODY CONTOUR SURGERY-A SYSTEMIC REVIEW

Dissertation submitted to

THE TAMILNADU DR. MGR MEDICAL UNIVERSITY

In partial fulfillment of the regulations for the award of the degree of

M.Ch [PLASTIC SURGERY]

BRANCH III

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DECLARATION

I solemnly declare that this dissertation titled **BODY CONTOUR SURGERY-A SYSTEMIC REVIEW** was prepared by me in the department of Plastic, Reconstructive and Faciomaxillary Surgery, Madras Medical College and Rajiv Gandhi Government General Hospital, Chennai under the guidance and supervision of Professor & HOD Department of Plastic, Reconstructive and Faciomaxillary Surgery, Madras Medical College, and Rajiv Gandhi Government General Hospital, Chennai between 2010 and 2013.

This dissertation is submitted to the Tamilnadu Dr.MGR Medical University, Chennai in partial fulfillment of the university requirements for the award of degree of M.Ch (branch III) Plastic surgery.

Place : chennai

Date : 26.03.2013

CERTIFICATE

This is to certify the dissertation titled **BODY CONTOUR SURGERY-A SYSTEMIC REVIEW** was done under our supervision and is the bonafide work of **Dr.S.KRITHIKA**. It is submitted in partial fulfillment of the requirement for the M.Ch Plastic Surgery Examination.

Prof.R.GOPINATH MS ,M.Ch
Professor and Head of Department
Plastic, Reconstructive and
Faciomaxillary Surgery
Madras Medical College and
Rajiv Gandhi Government
General Hospital
Chennai-600003

Dr.KANAGASABAI, M.D
Dean
Madras Medical College
and Rajiv Gandhi Government
General Hospital
Chennai-600003

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CONTENTS

AIM AND OBJECTIVES

AIM

To study the functional, aesthetic ,and psycological outcome of body contour surgery

OBJECTIVES

1. To study the patient selection factors for body contour surgery.

2. To describe operative approaches for comprehensive spectrum of body contouring surgical procedures

3. To identify complications and pitfalls related to body contouring and describe how to avoid them

REVIEW OF LITERATURE

INTRODUCTION

Having hourglass figure and great body are becoming the need of the hour for both men and women. It instills sense of pride among individuals by not only enhancing the personality but also by boosting the confidence level of an individual. Aesthetic surgery is one of the most effective ways of improving and enhancing the look of an individual.

Unlike earlier days, where people were skeptic undergoing cosmetic surgery, there is an increase in the number of people in India undergoing them. People's Lifestyle, socio economic status, awareness, professional need, self image, phases of life, globalization has motivated people towards cosmetic surgery.

WHO defines health as "a state of complete physical, mental and social well being and not merely the absence of disease and infirmity". This harmony of well being is lost when a person feel he is physically less attractive. The goal of aesthetic body contour surgery is to eradicate physical characteristics that impede the free interaction of individuals. By undergoing surgery, these individuals wanted not to disavow their ethnic

backgrounds or cultures but to escape being rejected by the people with whom they come in to daily contact and who decline to associate with them.

Obesity – a forerunner of diabetes and heart attack, its incidence has increased in adults and children lately. In Tamil Nadu 20% of men and 25% of women are obese. 22% of Indian children are obese. These individuals have excess of undesirable fat especially around waist, which predisposes them to metabolic syndrome ie., increased rate of heart disease, diabetes, and stroke. Such obese individual are now opting for body contour procedures, when other interventions like diet and exercise fails to remove the undesirable fat from various parts of their body. also according to recent studies, undergoing liposuction decreases the risk of metabolic syndrome.

Both men and women equally opt for procedures to enhance their body image .even person diagnosed with gender identity disorder undergo body contour surgery to boost their self image and attain few characteristic physical features of the opposite sex.

HISTORY OF BODY CONTOUR SURGERY

"The sooner you make your first five thousand mistakes the sooner you will be able to correct them." Kimon Nicolaides

Nicolaides alluded to an artist attempting to convey thought, feeling, and emotion through the creation of form, gesture, and structure.

Leonardo da Vinci is known to have said, "The supreme misfortune is when theory outstrips performance"; this is never more poignant than in the attempt to recreate the human form surgically.

The development of procedures to recontour has been an evolving craft accelerated by a global increase in obesity. About 1 billion people are overweight globally and 300 million are obese, an estimate by the International Obesity Task Force.

Dietary, lifestyle, workplace, and medicinal interventions have proved to be largely ineffective at controlling obesity. An alternative, gastrointestinal tract "remodeling," bariatric surgery has only proven modality at this juncture. Developing in parallel with bariatric surgery,

the field of body contouring surgery has attempted to sculpt a pleasing form surgically.

Below is a table showing some important year and person ,who made a place in the history of body contour surgery.

1899	Dr. Kelly	Panniculectomy
Early 20 century	babcock	Dermolipectomies,with vertical incision
1924	Thorek	The first umbilicus-preserving abdominoplasty
	Passot	Utilized undermining as a modification of Kelly's original technique
1950	Vernon	Extensive undermining+umbilical traspositon and relocation
1967	Callia	aponeurotic suturing with infrainguinal incision
1970	Pitanguy	published a series of 300 abdominal lipectomies, a “bat-wing” torsoplasty
1970	Regnault	“W” incision.
1973	Grazer	“Bikini line” incision
	Somalo and Gonzalez-Ulloa	The belt lipectomy

The beginning of the 20th century	Drs. Kelly and Noel	Thigh dermolipectomy
1957	Lewis	Thigh lift
1988	Dr. Ted Lockwood	Described superficial fascial system (SFS) in thigh
	Beisenberger	Dermoglandular separation, Wise's pattern
	Skoog	Nipple transposition on a unilateral vascular pedicle
	Strombeck	Bipedicled technique
1963	Regnault	B type reduction
	Lassus	Vertical mammoplasty
	Benelli	Periareolar reduction
1921	Dujarrier	Suction lipectomy utilizing a uterine curette
1976	Aprad and Giorgio Fischer	Devised suction lipectomy, hollow cannula with suction, technique-criss cross tunnelling
	Pierre Fournier	Liposculpture -dry technique
1980	Illouz	wet technique, worldwide publicity for liposuction
1987	Klein	tumescent technique
1985	Hakme	miniabdominoplasty
1995	Lockwood	High lateral tension abdominoplasty
2000	Saldana	lipoabdominoplasty

The contributions of Thorek, Passot, Pitanguy, Baroudi, Grazer, Wise, Regnault, Lassus, Illouz, Klein, Lockwood, and others have provided the necessary armamentarium to approach a body contour patient knowledgably, thoughtfully, and adequately equipped to restore pleasing contour to the patients

METHODOLOGY (MATERIALS & METHODS)

The study was conducted in the Department of Plastic Surgery, Rajiv Gandhi Government General Hospital, and Madras Medical College over a period of 31 months September 2010 to March 2013.The proforma for the collection of data was made. All the relevant details of the patient during preoperative, surgical, and postoperative and follow up periods were collected and analyzed

This study is a prospective and retrospective study,where 62 patients are included, among them males, females, gender identity disorder –transgender females .

Subject selection:

Those patients needing body contouring

1. Obese patients with realistic concern about their contour deformity
2. Obese patient with unsuccessful attempt at weight loss with diet and excercise

3. Postbariatric-patients with steatomas (metabolically inert fat) producing deformity

4. Post delivery

Exclusion criteria

1. Facial contour surgery

2. Patient with intraabdominal pathology

3. Morbidly obese with co-morbid illness complicating anesthesia

4. Patient diagnosed to have body dysmorphic disorder

5. Those who are not willing to participate in my study will be excluded.

PATIENT SELECTION

Aim in patient selection

Good motivated patients with expectations and desire within realistic alm

During the consultation in out patient department we gather as much data as possible.minimum of three consultation is arranged before embarking on surgery

- Objective data about the patient
- Subjective information about the patient’s goals,
- Patient’s reason for presentation and motivation.
- Duration of concern and how often they think about the concern
- Expected percentage of improvement
- Patients perception of expectation of result rate
- Patients intelligence,
- Dependency on follow up care
- family backup-eg young children, responsibility and assistance in follow up care ,home help
- Body image,
- Perspectives on surgery, and
- Psychological makeup.
- Medical and surgical history,
- Family history,
- Medications, allergies,
- Smoking, drinking, and recreational drug use.
- Nutritional status and hygiene habits
- A detailed physical examination is performed, particularly directed to the areas of concern.
- Height and weight are taken to determine body mass index (BMI).
- Prior surgical scars noted.

FACTORS CONSIDERING IN PATIENT SELECTION

HIGH BMI

Patients with high BMI are at high risk of complications, including VTE, wound healing problems, and seromas

Precautions Taken

- Multi-speciality integrated approach involving anesthetist, bariatric surgeon, psycologists, psychiatrists cardiologists, pulmonologists, endocrinologists, physiotherapists are done
- Preoperative incentive spirometry advised
- Deep vein thrombosis prophylaxsis
- Short, focused procedures addressing only the functional issue of concern is critical.
- Minimal undermining during surgery is important in maintaining vascular and lymphatic integrity, which protects against wound healing problems and seromas.

DEEP VEIN THROMBOSIS

The risk of thrombosis in patients undergoing body contouring is high because of extended operation time, the size of the wound area and the potential fat trauma. Contributing risk factors are use of oral contraceptives, pregnancy, advanced age, recent surgery, coagulopathies and prolonged immobilization. Our Thrombosis prophylaxis include use of Perioperative compression stocking of lower legs,

- Low molecular weight heparin,
- Circulation promoting measures such as infusions of 2-3 litres of RL for dilution of circulating blood,
- Early mobilization

ACTIVE SMOKERS AND ALCOHOLICS

There is incontrovertible evidence that smoking causes postoperative complications including wound healing problems, pneumonia, heart attack, and herniation, and bleeding with a Valsalva-like cough. potential surgical

Such patients are encouraged to stop smoking and alcohol for a period of 4 weeks prior to surgery

PSYCHIATRIC DISORDER—BODY DYSMORPHIC DISORDER

Dissatisfaction with body image often drives individuals to pursue elective breast- and body-contouring surgery.

Body dysmorphic disorder (BDD) is described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition as comprising.

" (1) Preoccupation with an imagined or minor defect in physical appearance;

(2) Marked distress or impairment in social functioning resulting from the appearance preoccupation; and

(3) The preoccupation is not attributable to the presence of another psychiatric disorder".

BDD often coexists with mood and anxiety disorders, obsessive-compulsive spectrum disorder, substance abuse, eating disorders, and personality disorders. Patients affected by BDD do not benefit from surgical treatment, They don’t experience improvement in body image after surgery and may even express worsened feelings. BDD patients are a contraindication to elective surgery for enhancement. Hence these

patients are referred to pharmacologic therapy and cognitive behavioral therapy and are refused surgery.

INFORMED CONSENT

Preoperative and postoperative photos of good and average results of prior patients outcome are shown to patients .

All possible complications and their remedy are explained .surgical procedure are explained in detail to patients .alternate options are also explained and patient is asked to decide without any confusion or compulsion. adequate time is give to patient to decide ,atleast three minimum consultations are arranged before embarking on surgery

Preoperative general measures

- All body contour patients are admitted a day prior to surgery
- Investigation: all patients undergo basic investigation,complete blood count ,renal function tests, blood sugar,screening for sexually transmitted -HIV, Hbs Ag, VDRL
- Specific investigation:

- Gynecomastia -ultrasound abdomen and scrotum, hormonal assay for testosterone ,follicle stimulating hormone
- For abdomen contour surgery-ultrasound abdomen
- For breast surgery- mammogram

❖ Advised betadine bath/shampoo for three days prior surgery

❖ Preop breathing excercises / incentive spirometry encouraged

❖ Preoperative markings are critical and are done the previous day. They are confirmatory to the patient who should understand the exact areas to be addressed. Furthermore, there is distortion when the patient lies supine on table after anesthesia. Future surgical scar markings are marked and explained to patient in detail.

❖ Good informed consent obtained

❖ Preoperative photographs taken

LIPOSUCTION

Liposuction is done using the tumescent technique-introduced in 1985. It uses the largest volume of infiltrate and involves infusing 3 to 4 ml of the infiltrate solution for each planned milliliter of aspirate. Drug concentrations in the tumescent infiltrate solution vary, but typically they consist of a range of 30 c.c of 2% lidocaine and 1 c.c of epinephrine in a Ringer lactate ,with 10 c.c of sodium bicarbonate ,and 1 ml of hylase .Estimated blood loss with this technique is approximately 1 percent of the aspirate.the amount of tumescent injected and amount of tumescent aspirated are noted . in the aspirated fluid ,the lipoaspirate is measured and clearly documented.

Large volume liposuction: defined as a total aspirate of 5000 ml or greater ,it's a safe and effective procedure when patients are carefully selected and when anesthetic and surgical techniques are properly performed. Meticulous fluid balance calculations are done for these patients. Close postoperative monitoring is done for these patients to avoid volume abnormalities, as metabolic alterations and fluid shifts ,cardiac arrhythmia, cardiac standstill, fluid overload, and pulmonary edema can result from surgical technique.

Post operative follow

Patient is followed up At weekly interval for one month, then followed by once a month for 6 months. During follow up photographs are taken as record.

BREAST SURGERIES

BREAST AUGMENTATION

Patients and methods

Between 2010 and 2013, 18 cases of transsexual female underwent Augmentation mammoplasty and one female with unilateral hypoplastic breast underwent. They were aged between 23 and 37. Average duration of hormone therapy for the transgenders was 3 years. Selection was based on the Harris Benjamin’s criteria. All of them were subjected to detailed psychiatric assessment prior to surgery. Preoperatively a thorough clinical assessment was conducted to determine the implant characteristics its dimensions the preferred route of access and the plane of placement of implant. Everything was discussed with the patients before choosing the appropriate one.

Surgical technique

Markings

Patient standing and arms by the side. The midline is marked first from SSN to XS. The boundary of the existing breast tissue is then marked on all the four directions. Keeping this boundary as the reference the proposed boundary of augmented breast is then marked all around this utilizing the base diameter of the implant that was chosen. The inframammary incision line marked 1 cm above this boundary starting from the MCL to the AAL. The maximum length of incision we used is 4 cms. In order to have symmetry of both sides distance between SSN and upper pole of breast and the distance between NAC and IMF are measured equally on either side.

SSN - Suprasternal notch

XS - Xiphi sternum

MCL - Mid Clavicular Line

AAL - Anterior axillary line

NAC - Nipple aerolar complex

IMF - Inframammary fold

Anesthesia: General Anaesthesia

Position: supine

Procedure:

After tumescent infiltration incision placed along the proposed inframammary line starting from MCL to AAL. After just more than required pocket size creation along the subglandular plane is completed, heamostasis obtained then the implants were placed on both side and correctly positioned suprafascially. Trial stitches were made and patient is then changed to semirecombent position in order to check the shape, symmetry, level of NAC and the position of the newly formed IMF along the incision line on either side, to be equal. Once everything is confirmed, patient's position is again changed to supine and the incision line is closed in layers using monofilament absorbable sutures without any drain. Dressing is done with preoperatively decided autoclaved padded brassiere.

Postoperative care

Post operatively bathing is allowed after 48 hours, discharged after 3 days and trimming of subcuticular stitches were done on the 10^{th} post operative day.

REDUCTION MAMMOPLASTY

Patients and methods

Women with large breasts may suffer from disabling symptoms such as rashes, neck pain, backache, headaches, shoulder grooving, upper extremity neuropathy from bra straps, chest pain or have difficulty breathing when lying supine ,difficulty to do exercise. Between 2010 and 2013, Two of our patients are candidates for breast reduction. They were aged 23 and 37.the technique was chosen on breast size and degree of ptosis, medical comorbidities, and acceptable scars.

Both cases were operated using the Wise Pattern Breast Reduction with Inferior Pedicle

Advantage:

- Nipple elevation limit of 16 cm
- Also addresses axillary fullness

MARKINGS

The patient is marked in the upright position. The central axis of the breast is marked bilaterally and transposed below the level of the inframammary fold (IMF). The new nipple position is marked on this axis at the level of the IMF, 22–23 cm from the sternal notch. Limbs of 8 cm in length are designed from the nipple to define the new nipple-inframammary distance, and the distance between these two limbs varies depending upon the width of the nipple areolar complex and the degree of breast narrowing, usually on the order of 7–8 cm. Symmetry can be checked by comparing distances between each distal limb to the sternal notch with a tape measure. A wire nipple marker can be used to mark the ultimate 4-cm nipple areolar complex (NAC) centered around the apex of the limbs drawn. The IMF is marked. Markings then connect the distal portion of the limbs medially and laterally to the IMF. An inferior pedicle is marked symmetrically on the two breasts, at least

7 cm in width The new nipple areolar position is measured again as well as the existing NAC position to determine preoperative asymmetry. This should be confirmed with the patient. on the operating room table, the symmetry of markings may be further checked, ensuring that the distance from midline to the central breast axis is the same, as well as the distance of the pedicle from midline and the width of the pedicle

PROCEDURE

Anesthesia :general anesthesia

Position : supine with arms abducted ,supported by arm boards, with adequate padding

Markings on the breast confirmed to be symmetric with regard to midpoint marked on the IMF on each breast and the width and position of the inferior pedicle centered on the central IMF marking. A 4-4.5 cm is used to designate the new nipple areolar diameter, and this mark is incised with the NAC on moderate stretch .The central pedicle is then de-epithelialized with a knife, preserving the NAC. The breast and skin of the medial and lateral triangles resected .Skin flaps are raised superiorly

as these triangles are excised, at least 2 cm in thickness, making the resection specimens shape resemble tetrahedrons. The medial and lateral triangles of tissue are excised from the central pedicle laterally, ensuring that good blood supply is maintained on the pedicle. The new NAC and vertical limbs are then incised, connecting into the medial and lateral resection areas. The superior breast skin flaps are elevated as far as necessary to accommodate the breast tissue, up to the clavicles and above the pectoralis fascia. hemostasis is achieved .Dermal sutures are then placed to approximate the skin

A suction drain is placed, exiting out the lateral position and sutured into position with a #3-0 silk suture. The patient is brought to semirecombent position to assess symmetry, and any necessary corrections made.The weight of tissue removed from each breast is compared .The skin flaps vertically and horizontally are approximated in layers using # 3-0 vicryl absorbable sutures and skin with #3-0 ethilon. Dressing is done with preoperatively decided autoclaved padded brassiere.

Post operative care: bathing is allowed after 48 hours, discharged after 3 days, Suture removal done on the 10^{th} post operative day.

Scar management : a gentle moisturizer ,cocoa butter, shea butter, and/or vitamin E at least twice a day for two weeks . Silicone sheeting may be used. If hypertrophic scar develops then triamcinolone steroid injection given

MALE BREAST CONTOUR SURGERY

Patients and methods

Between 2010 and 2013, there were 20 cases of bilateral gynecomastia.among them five underwent liposuction alone and fifteen underwent liposuction assisted websters procedure .

Gynecomastia Liposuction

INDICATIONS

- Minimal to moderate cases of gynecomastia, either as a primary treatment or an adjunct to excision.
- Patient with minimal element of ptosis or skin excess.
- Patient with pseudoptosis or skin laxity e.g. after massive weight loss, as it allows for skin retraction

Advantage

- Minimal scars
- Flattens chest wall along with obliterating the inframammary fold

MARKINGS

Marking in upright position, concentric circles marking ,the central most circle indicate the thickest breast tissue under the nipple areolar complex, and the larger, outer circles in the periphery for feathering

PROCEDURE

Anesthesia: general anesthesia

Position : supine with both arms extended with arm table with adequate padding

Procedure

Two stab incisions are placed along the inframammary fold, one medial and one lateral in the axilla. Tumescent solution is infiltrated . For volume of tumescent solution, a ratio of 1–2 times the amount of anticipated aspirate should be infused, approximately 500–800 cc of tumescent solution for each side is aspirated.

After adequate time allowed for hemostatic effect approximately 8-10 mins , liposuction is done. Cannulas of varying lengths and calibers are selected to address different areas of breast. Liposuction is done with constant sweeping ,working from deep to superficial .More concentrated liposuction is performed under the nipple areolar complex and inframammary fold to obliterate it. The endpoint of liposuction is a visibly pleasing result, with uniform contour . Incisions are closed with a single #3-0ethilon simple suture. Firm Compression dressing with elastic bandages are wrapped around the chest

POSTOPERATIVE CARE

Hydration is encouraged after liposuction. Physical limitations for about a week. Patients may shower immediately and compression garments recommended for four weeks

LIPOSUCTION ASSISTED WEBSTER PROCEDURE

INDICATIONS

Nonobese, young males ,Focal gynecomastia with fibrous breast tissue under the NAC without skin excess or ptosis is most easily treated with local excision.

Liposuction is used as an adjuct to smooth the junction between the excised region of the NAC and the periphery.

MARKINGS

In the upright position. the palpable breast tissue is marked with a centre circle and a periareolar incision mark is made from 3 o'clock to 9 o'clock. For adjunctive liposuction breast tissue is marked.

PROCEDURE

Anesthesia: general anesthesia

Position :supine with both arms extended with arm table with adequate padding

Procedure

Tumescent solution is infused. Liposuction is performed either before or after the breast tissue is removed. Periareolar incision is then made around the NAC from 3 o'clock to 9 o'clock. Using cautery plane under the subcutaneous fat is developed and over the breast tissue down to the pectoralis major fascia. The breast tissue leaving apart from leaving A button of breast tissue under the NAC to allow normal nipple projection, is excised and delivered through the incision. careful hemostasis is achieved A suction drain is placed in the subcutaneous space. The dermis is approximated with interrupted, buried, absorbable #3-0 vicryl suture, followed by a running subcuticular #4-0 absorbable monocryl suture. Firm compression dressing with elastic bandages are wrapped around the chest.

POSTOPERATIVE CARE

When drainage becomes serous, drainage less -50 cc or less per day, drain is removed. Restricted upper body physical strain for a month .compression dressing for 2 weeks after the drain is removed.

Scar management :a gentle moisturizer ,cocoa butter, shea butter, and/or vitamin E at least twice a day. Silicone sheeting may be used. If hypertrophic scar develops triamcinolone steroid injection given.

UPPER ARM LIPOSUCTION

Liposuction in the arm is challenging, finding the balance between removal of subcutaneous fat to uncover a more muscular physique without removing so much that there is resulting skin redundancy.

Upper extremity liposuction was done for one patient, younger patients with thick subcutaneous fat and good skin quality.

ADVANTAGE

- ❖ Scarless
- ❖ Reduces bulk and improves the contour of the arm

DISADVANTAGE

- ❖ Skin laxity after liposuction
- ❖ Need for second-stage skin removal procedure

MARKINGS

Patient sitting, patients area of concern is marked in concentric ring as per adiposity

PROCEDURE

Anesthesia- general anesthesia

Position : supine with arms extended with double arm boards with adequate padding

PROCEDURE

A single, stab incisions are made in the elbow and axilla to address the areas of concern

Tumescent solution infused into the arm until it is turgid. After adequate time given for hemostatic effect of the epinephrine, a 3.0-mm cannula is used to perform liposuction suction assisted lipectomy used. Liposuction is complete when the desired contour is achieved Aspirate volume should approximate the volume of tumescent solution infused.

Access incisions are closed with a single #3-0 ethilon suture. Firm compressive dressings with elastic bandages given

POSTOPERATIVE CARE

Sutures are removed after seven days. The patient is instructed not to perform any lifting or upper extremity exercise for 1week. Compression garments adviced for 4 weeks

TRADITIONAL BRACHIOPLASTY

Brachioplasty was done for one patient , patient had arm adiposity with excess skin

INDICATIONS

Patients with skin redundancy contributing to poor shape

DISADVANTAGE

- Wound healing difficulties
- Visible, prominent scars.

MARKINGS

Patients are marked upright with the arms elevated at 90 degrees.An ellipse is to define excision along the long axis of the arm from axilla to elbow, or as far distally as the skin laxity extends. The upper aspect of the ellipse is marked along the bicipital groove anteriorly up to the axilla. The posterior portion of the ellipse is marked along the inferior portion of the posterior arm. The amount of tissue one predicts can be excised is not the amount of tissue excess that can be pinched along the lower arm: this amount of excision is an overestimate.

Accounting for skin closure over the structures deep to and including the subcutaneous fat, we need to adjust the mark down for less removal along the back of the arm. Another ellipse along the axillary axis is marked. This creates the classic fishmouth, or “T,” incision of the traditional brachioplasty.

PROCEDURE

Anesthesia: general anesthesia

Position: supine with arms extended with double arm boards with adequate padding,sandbag under scapula on either sides

Procedure: The arms are prepared and draped circumferentially, placing sterile towels over the wrists and hands.

Incision is made in the bicipital groove and in the axillary ellipse. Dissection is done through subcutaneous tissue straight down to the fascia overlying muscle and neurovascular structures and continued in that plane posteroinferiorly, undermining skin anticipated to be excised .blunt dissection to get the plane of dissection. The arm skin is then excised from distal to proximal in a stepwise fashion to ensure that there is no

over or underresection, Once the proximal-most portion is reached, dog-ear is worked out in the axillary crease posteriorly. During the axillary closure, the aim is to keep this incision within the axillary fold.

A suction drain is placed in the subcutaneous space exiting out the distal incision and traveling up to the axilla. The wounds are then closed. The deep fascia is approximated with interrupted #2-0 vicryl suture, and a deep bite of the subcutaneous tissue in the axilla is important to secure the wound closure. The dermis is approximated with buried #3-0 absorbable monofilament suture, followed by a running #4-0 monofilament absorbable subcuticular suture. The arms are dressed with non adherent gauze and absorbent pads and then gently wrapped with 4 inch elastic bandages.

POSTOPERATIVE CARE

The drain is removed when the drainage becomes serous and 50c.c or less per day ,Suture removal around tenth day . The patient is instructed not to perform any lifting or upper extremity exercise for 4–6 weeks to avoid dehiscence. Scar care includes massage, cocoa butter/shea butter/vitamin E creams, or silicone sheets in case of hypertrophic scar.

TRUNK CONTOUR SURGERY

ABDOMINAL LIPOSUCTION

INTRODUCTION

Liposuction of the abdomen is a commonly performed procedure, where by reducing subcutaneous fat which can result in conservative skin retraction give a good body contour.

INDICATIONS

- Localized fatty deposit in the abdomen resistant to diet and exercise.
- Secondary procedure after prior abdominoplasty
- Abdominal etching -superficial liposuction performed to simulate the appearance of muscle definition.
- As an excellent donor source for fat grafts

MARKINGS

Marking done in the standing position, and a contour map is drawn with concentric circles.the central most circle indicates the thickest subcutaneous fat layer. The larger, outer circles define the geographic region in the abdomen, such as the left and right upper abdomen and the left and right lower abdomen, with lateral areas marked as well .The upper midline is marked in preparation for suctioning and defining the linea alba.

PROCEDURE

Anesthesia:general anesthesia

Position:supine with arms extended with double arm table with adequate padding

Patient catherized,especially if anticipated liposuction volume greater than 4 liters. Graded compression stocking for both lower limb preoperatively

PROCEDURE

Stab Incision is made in the upper umbilicus and at either inguinal crease. incisions are made within the old scar if present. Liposuction not done in areas of scars, suspected areas of hernias, divarication of recti.Prepared Tumescent solution infiltrated into marked areas

If liposuction volume will be less than 2 liters, 50 cc of lidocaine may be placed in the tumescent solution. For recommended volume of tumescent solution, a ratio of 1 to 2 times the amount of anticipated aspirate should be infused.

After adequate time 8-10 mins allowed for hemostatic effect, liposuction begins. Cannulas of varying lengths and calibers are chosen to address areas of concern. The 3.7 mm Mercedes-style cannula which is the more versatile cannulas for the abdomen is used . Liposuction is performed with constant sweeping motion,working from deep to superficial . suction assisted liposuction is performed in our hospital. Upper midline is concentrated more to enhance and define the rectus abdominis muscle .

Visibly pleasing abdomen contour is the endpoint of liposuction .Incisions are closed with a single #3-0 ethilon suture. Absorbent pads placed against the incisions .Firm compressive elastic bandage dressing

POSTOPERATIVE CARE

Post op Fluid status monitored, patient encouraged to ambulate well. Hydration is encouraged for the first week after liposuction.

Physical activity restricted for about a week. Patients may shower immediately and compression garments advised for a period of minimum four weeks to help optimize reduction of bruising and swelling.

LIPOABDOMINOPLASTY

INTRODUCTION

2001- Saldana technique .Lipoabdominoplasty combines 2 traditional techniques, abdominoplasty and liposuction. The new concept is based on the preservation of the abdominal perforating vessels, which are branches of the deep epigastric vessels, by which about 80% of the blood supply of the abdominalflap is conserved compared with traditional

abdominoplasty. The lymphatic nodes and nerves are preserved, maintaining the cutaneous sensitivity of the flap to superficial pain and superficial touch caused by temperature, vibration, and pressure, which is an improvement on traditional abdominoplasty.

PRINCIPLES OF THE TECHNIQUE

- Superficial liposuction, described by De Souza Pinto was one of the fundamental principles of lipoabdominoplasty This procedure gives more mobility to the abdominal flap so that it can slide down easily and reach the suprapubic region.

- The second principle is the anatomic study of the exact localization of the perforating abdominal vessels so that they can be preserved during the procedure. Using selective undermining, it is possible to conserve at least 80% of the blood supply of the abdominal wall, reduce nerve trauma(The rectus abdominal muscle and the skin are innervated by the anterior branches of the 6th to 12th intercostal nerves that run along the abdominal perforating vessels) and preserve most lymphatic vessels.

INDICATONS

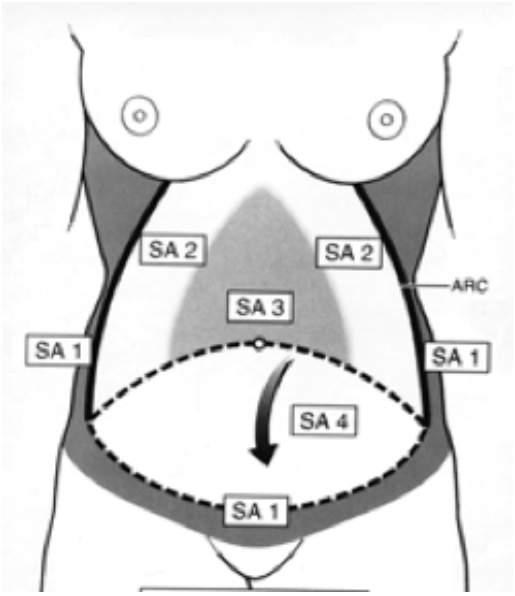
- Patients With Limited Skin Excess

- Unsatisfactory suprapubic scar who desire skin tightening. Eg. caesarean scar, with lower abdominal muscle weakness. Umbilical and infraumbilical hernias are also treated with this technique.

MARKINGS

On standing ,a contour map is drawn with concentric circles, the central most circle indicating the thickest subcutaneous fat . Most of the liposuction will be performed in the upper abdomen between the umbilicus and the costal margin, particularly over the linea alba and the flank areas .Marking is done by drawing a 12-cm horizontal suprapubic line that is 6 to 7 cm from the vulvar commissure.The marking for lower abdominalskin excision made, and the scar length explained to patient.

Anatomic regions for suction liposuction as an adjunct to abdominoplasty



- SA 1 –safe
- SA 2-limited
- SA 3-cautious
- SA 4 –portion of skin to be excised

DETAILS OF PROCEDURE

Anesthesia:general anesthesia

Position: Supine with arms extended with arm tables with adequate cushioning . A urinary cather inserted. antiembolism support stockings

Procedure

- **Infiltration:**the tumescent technique is used by infiltrating the abdominal region with a 1:500,000 saline solution with adrenalin, using an average of 1 to 1.5 L of the solution

- **Upper Abdomen Liposuction**: Liposuction begins on the Supraumbilical region with a 3- and 4-mm cannulas, removing the fat of the deep and superficial layers, extending to the flank as far as the submammary fold . The fat thickness is maintained to about 2.5 cm to avoid vascular impairment and contour deformities.

- **Lower Abdomen Liposuction**: Scarpa fascia an important anatomic structure of the abdomen should be preserved in lipoabdominoplasty. To facilitate its visualization and its preservation, the superficial fat layer and part of the deep layer need to be aspirated in the lower abdomen using a 6-mm cannula .After evaluation of the flap mobility and descent ,umbilicus isolation and total resection of the infraumbilical skin are performed.

- **Scarpa Fascia Preservation:**Preservation of Scarpa fascia is important for many reasons

  - Less bleeding because of the preservation of the inferior perforating vessels.

  - It creates homogeneous support for the upper flap, which becomes thinner in its descent.

  - It causes the contention of scars laterally and offers better adherence between the flap and the deep layers

- **Selective Undermining:** which is the second principle of lipoabdominoplasty is the preservation of the abdominal perforating vessels .Selective undermining is performed in the midline of the upper abdomen, between the medial edges of the rectus abdominal muscles. Tunnel undermining may reach the xiphoid, depending on the need for rectus muscle plication. The tunnel width may vary with the distance of diastasis because the perforating vessels followthe muscle separation.

Discontinuous undermining performed using the liposuction cannula facilitates the descent of the flap. De Souza Pinto identified a trabeculae ligament in the upper abdomen, at the base of the xiphoid, which should be released to allow further inferior descent of the abdominal flap to the pubic region so that excessive tension on the suture line is avoided.

- **Removing the Infraumbilical Excess :** Excess skin of the lower abdomen should be removed Subsequently, in the midline infraumbilical line, adipose tissue should be removed to expose the medial edges of the rectus muscles to perform the plication from the xiphoid to the pubis

- **Umbilicoplasty/omphaloplasty :**The ‘‘star-shaped omphaloplasty technique’’ is marked on the abdominal wall, and a lozenge shape is marked on the umbilical pedicle. The cardinal points of the umbilical pedicle are sutured, accommodating themselves on the cruciform incision of the abdominal wall skin. The scar results in continuous Z-plasty that offers little possibility of retraction

❖ **Closure of the abdominal wound**

Suturing is done in 2 layers, with 3-0 vicryl for the deep layer and 4-0 vicryl for the subdermis. The skin is sutured with 5-0 ethilon interrupted stitches. A suction drain is placed

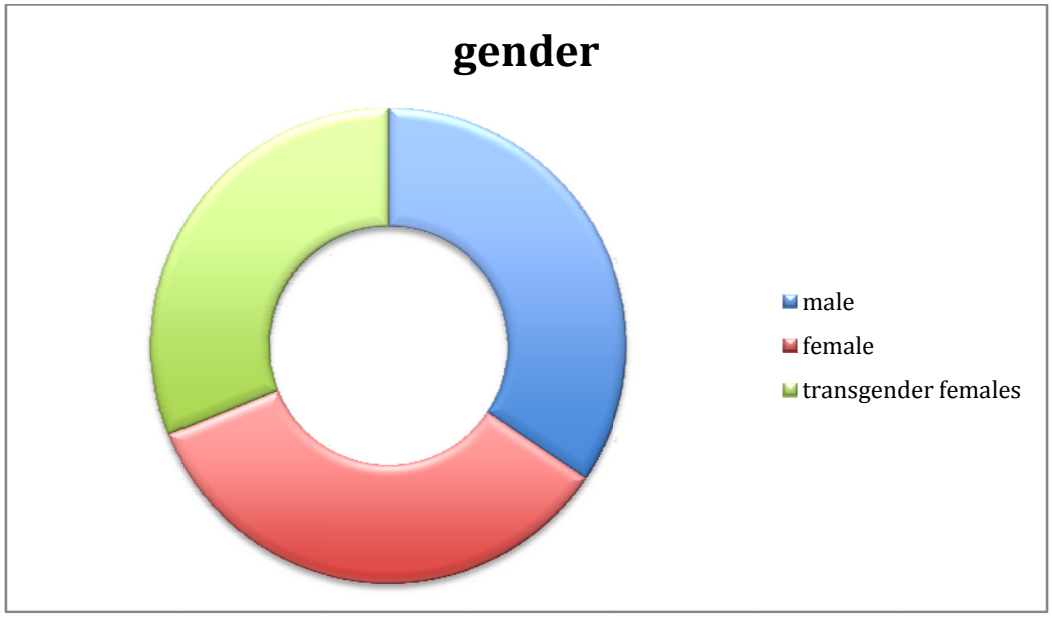
Firm compression dressing with elastic plaster applied.

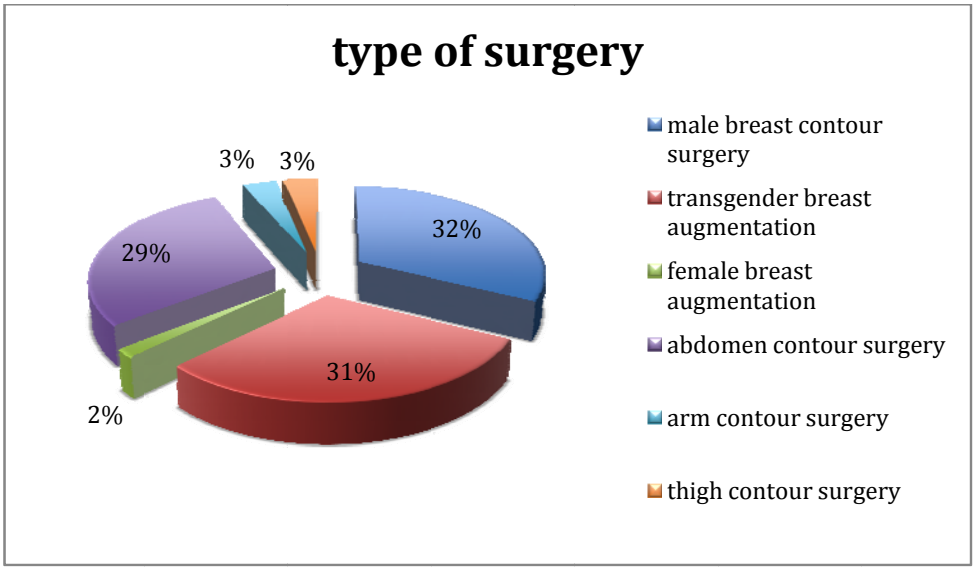
Postoperative Care

The drain is removed 1 to 2 days after surgery .The dressing is changed on the third day after surgery, the stitches are removed 9^{th} day except for those on the umbilicus, which are removed on the 12th day after surgery. Compression garments advised for period of four weeks

OBSERVATIONS AND ANALYSIS OF RESULTS

In thiscase study of 62 patients, below is a chart depicting the gender distribution and the surgery distribution .





AUGMENTATION MAMMOPLASTY

In all the 19 cases we operated, textured non anatomical highly cohesive low profile silicone gel implants of different size were used. The average size is 275ml. In all of them the preferred access of entry we used was the inframammary, and the preferred plane of placement is subglandular. More than 95% of them felt that they obtained their complete feminine feeling after breast augmentation and more than 75% had the self confidence to overcome their sexual inhibitions

Complications

Following table shows the complications that we encountered in our series and the methods by which they were managed.

Nature	%	Overcome by
Hematoma	3-6	Seen in the immediate PO period Mild - needed no evacuation
Infection	6	two cases had severe infection with implant exposure requiring implant exit & redo surgery
Altered sensation of breast	15	lower half, resolved completely after 3 to 4 months
Keloid	3	One case had keloid, managed conservatively
Capsular contracture	---	Textured implants and post operative exercises in all cases. Hence none seen
Implant rupture	---	None seen
Wrinkling	---	None seen

REDUCTION MAMMOPLASTY

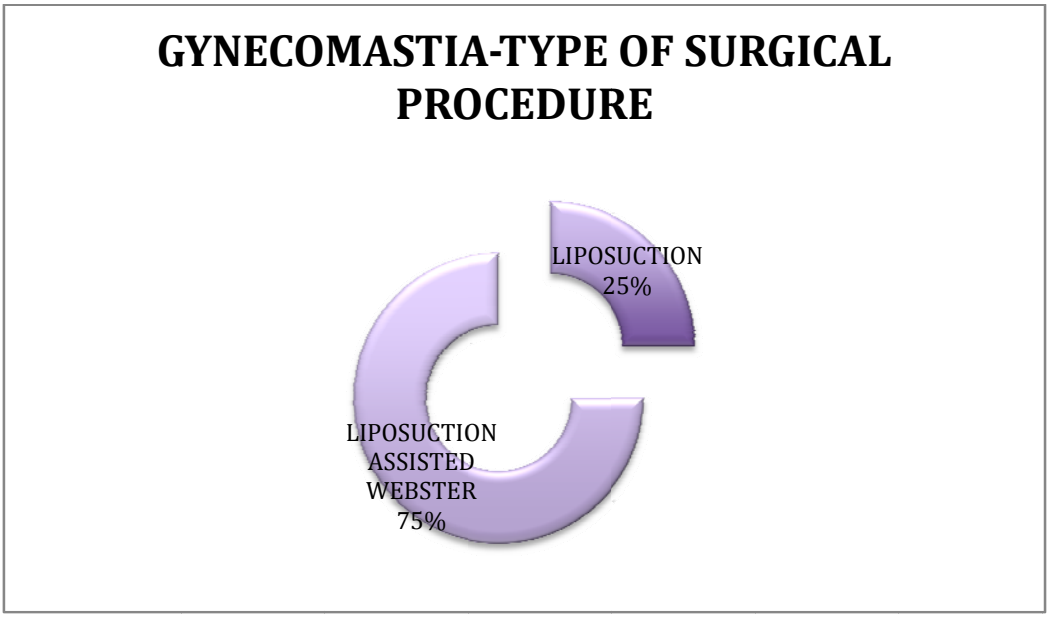
Among the two cases that were operated for reduction mammoplasty, both patient recovered very well. both surgery technique was done using the Wise Pattern Breast Reduction with inferior Pedicle .one patient developed hypertrophic scar. Scar management with silicone gel sheets. In both the patients, vertical reduction of breast length and symmetry of breast achieved. They were very happy with the aesthetic outcome. There was a reduction in the cup size, their social integration increased, boosting their self confidence

UPPER ARM BODY CONTOUR SURGERY

In this study two patients underwent upper arm body contour, one was liposuction and other brachioplasty. Both cases esthetic outcome and patients satisfaction were very good. Physical discomfort with a bulky arms was relieved ,and aesthetically pleasing trim arm was the result.

MALE BREAST BODY CONTOURING

Gynecomastias associated emotional trauma can have real consequences for adolescent boys afflicted with this condition. Surgical treatment is indicated for patients where enlarged breast persist beyond the age of mid adolescence when important social skills and interactions are being developed. In all the 20 cases we operated ,Surgical treatment modality either liposuction or liposuction assisted websters is decided by underlying nature of the breast enlargement.aim is Restoration of a normal chest contour with a minimum of scar ,which is achieved in nearly 95% of our patients .these patients returned to a normal existence and allow emotional maturity to develop unencumbered by the additional challenges gynecomastia can present.



Complications:

Following table shows the complications that we encountered in our series and the methods by which they were managed.

NATURE	%	OVERCOME BY
Hematoma	3-6	Seen in the immediate PO period Mild - suture was released
Infection	3	One cases had wound infection ,managed by antibiotics and dressings
Altered sensation of breast	15	lower half, resolved completely after 3 to 4 months
Skin Contour deformity	3	One case showed skin dimpling ,with nipple retraction
Skin discolouration	3	Hyperpigmentation

THIGH CONTOUR SURGERY

There were two ideal candidates for liposuction ,thigh lipodystrophy with no skin laxity, for whom both liposuction done .

Post operative ,the aesthetic and functional outcome of both surgery was good with no complication

ABDOMEN CONTOUR SURGERY

(ABDOMINOPLASTY,LIPOSUCTION, LIPOABDOMINOPLASTY)

In our study, there were 18 cases where abdomen contour surgery was done. Eleven cases were with ventral hernia. All the ventral hernia was repaired and reinforced with a prolene mesh. Three of patients with ventral hernia had a small umbilical hernia, which was treated with lipoabdominoplasty - saldhana technique, published in 2001. Patients with bigger hernia, Supraumblical hernias were managed with the traditional abdominoplasty. Patients with no skin excess, no abdominal muscle wall laxity were ideal candidates for liposuction .

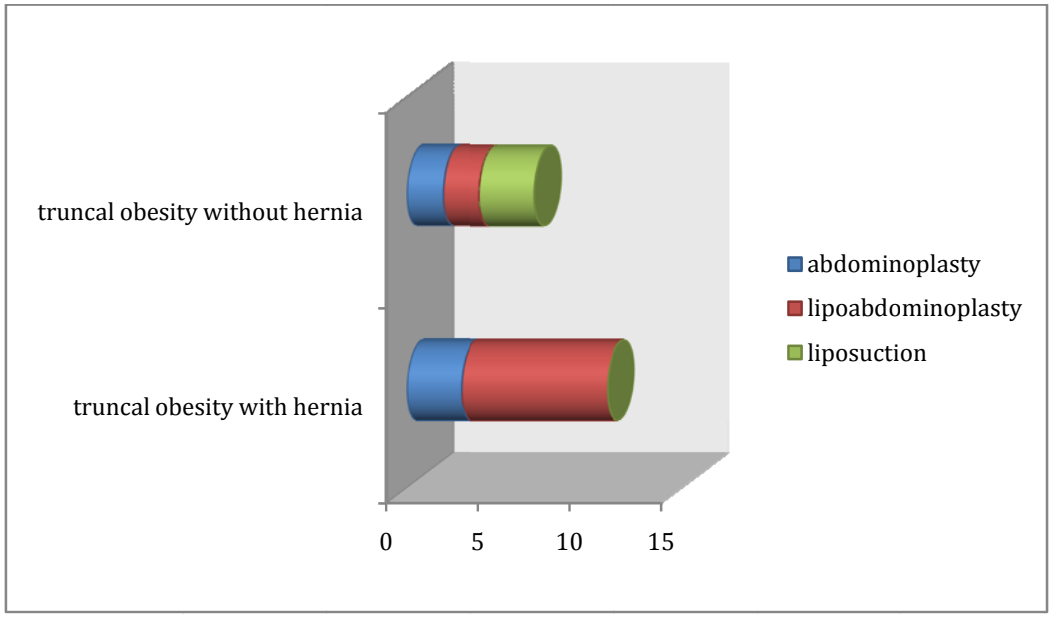


Chart depicting the type of surgery performed

Complications

Following table shows the complications that we encountered in our series and the methods by which they were managed

Nature	Percentage	Overcome by
Flap necrosis	15%	Debridement, Secondary suturing
Wound dehiscence	18%	Secondary suturing
Contour irregularity	3%	Conservative

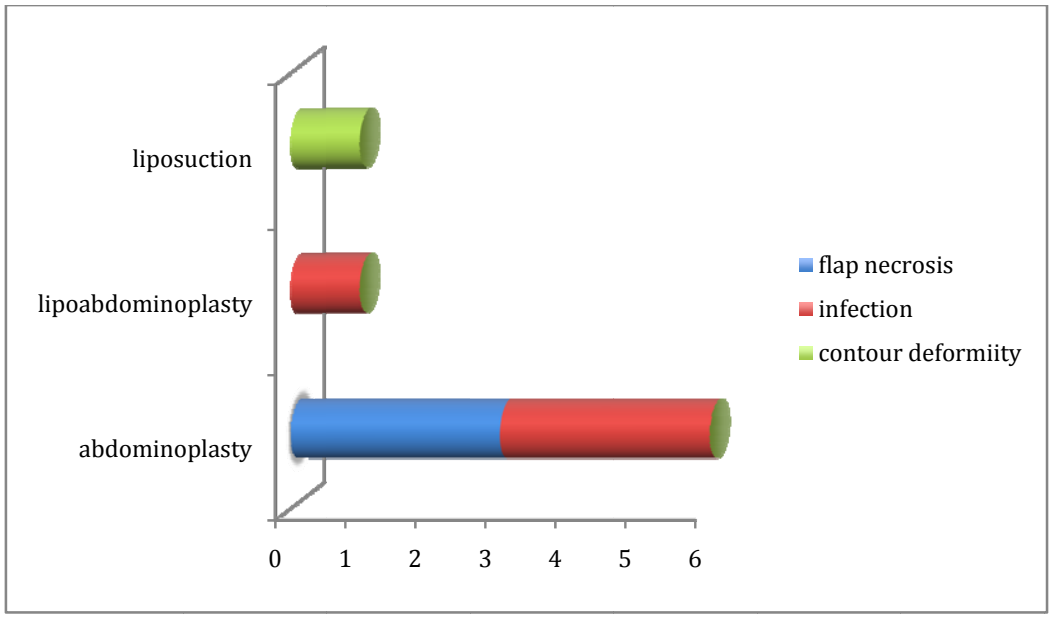


Chart Showing the complication rates for each procedure

DISCUSSION

Careful patient selection is important in ensuring success in body contour surgery.Patients who smoke, have coronary artery disease, have autoimmune disease requiring steroids, are diabetic with poor glucose control, have psychiatric problems, or are older than 50 years are at elevated risk for healing problems. Patients who are morbidly obese, particularly teenagers, are advised weight loss prior body contour surgery and clearly explained that these surgeries are not the management of obesity.the below discussed are our hospital protocol in approach to body contour surgery

AUGMENTATION MAMMOPLASTY IN TRANSGENDERS

Sex reassignment surgery in male to female transgender is always done in the following order, first the external genitalia conversion followed by breast augmentation procedure and finally by other feminizing body contouring surgeries. Breast augmentation among all is the one that greatly establish their feminine identity. Hormonal therapy given for at least a period of 2 years before proceeding to breast augmentation. Because whatever the amount of breast enlargement is

obtained by hormonal therapy, will be helpful in enhancing the overall shape of augmented breastespecially for subglandular placement of implants. In general low profile implants are used because the amount of skin stretch ability will be less compared to normal female persons.

Proper preoperative planning on an individual basis is very important in order to decide about the suitable implant, the route of placement as well as the plane of placement. This takes into account the shape of the chest wall, amount of existing glandular element, the skin stretch ability and its characteristics.

Meticulous dissection with careful attention towards obtaining perfect haemostasis, the adequacy of the pocket creation, accurate placement of the implant, and obtaining symmetry on both sides and perfect layered skin closure were all secrets behind a successful outcome[11]. The resultant shape and size of the augmented breast should fit exactly into the overall body contour.

Augmented breast should look natural and aesthetically pleasing to become successful. A successfully augmented breast in transsexual female greatly enhances the overall psychosocial outcome in them.

THIGH CONTOUR SURGERY

Liposuction lower extremity is good for patients with disproportional fat distribution in the leg. Lower extremity liposuction may also be used to treat lymphedema that does not entirely resolve with nonsurgical measures.The outer thigh has great results with liposuction as the fat is relatively fibrous and the skin relatively thicker than the inner thigh, with soft fat and thin skin, making postoperative contour deformity and skin laxity risky.If Skin laxity is anticipated, the need for second-stage skin removal is advised.

ARM CONTOUR SURGERY

Mostly women approach for such surgery due to physical discomfort or nonaesthetically pleasing arm .Women interested in contouring of the arm who would like to get improvement along the deltoid region and over the triceps are good candidates for liposuction of the arm. Patients with flabby arm skin are ideal candidates for brachioplasty. The scar in the arm is well explained to the patients .

BREAST REDUCTION SURGERY

In our case study ,both cases of breast reduction done with wise pattern , inferior pedicle technique which is known for its scars and flattened breast contour. The scars that are most prob- lematic lie along the IMF medially and laterally and around the NAC. Scars may be thicker if there is secondary wound healing. The scars require aggressive postoperative management.

Careful attention paid to not making the NAC too high. A high NAC may be hard to hide and is not easy to correct. The patient shown preoperatively ,made to understand the extent and lateral extent of incision .Adequate thickness on skin flaps and minimizing risk of overresection of skin is ensured to prevent skin necrosisto allowoptimal healing.Teenagers with macromastia may be prone to recurrentmacromastia, so this possibility is explained.

MALE CONTOUR SURGERY

Its s predominantly the adolescent age group that present to our outpatient department ,the emotional sequelae that can result during these very important formative years can have long-lasting effects on the

emotional and social development of the patient. Surgical treatment is directed importantly to restoring a normal body image with a minimal amount of cutaneous scar. early or mild gynecomastia are observed for a variable period of time during early adolescence to allows sufficient time for

The normal sequence of involution .endocrinologist opinion is sought but if social behaviors begin to become negatively affected by the condition, we proceed with surgical correction. Decision making for surgical procedure is as follows.

True gynecomastia, with no skin excess are managed by liposuction or excision alone. whereas gynecomastia with hard breast tissue with ptosis are managed by liposuction assisted websters.

ABDOMEN CONTOUR SURGERY

Women and men of variable ages and backgrounds pursue abdominal contouring surgery. The most common some scenarios are lipodystrophy with no skin laxity for whom liposuction is preferred. For a postpartum lady after a ceasarian section or hysterectomy ,for person with multiple scars, they suffer from diastasis, abdominal hernia and

abdominal wall laxityare best treated with Traditional abdominoplastyor lipoabdominoplasty. Lipoabdominoplasty has shown less complication rate compared to traditional abdominoplasty, even in this study. Patients with skin excess, with previous pfannenstiel scar, with umblical or infraumbilical hernia are ideal candidates for lipoabdominoplasty. Men tend to distribute fat in the peritoneal cavity more than women, they advised for abdominoplasty, as they don't benefit much with liposuction alone.

In this series of study, overall patients satisfaction was about 95%, only 5% of patients who encountered complications were unhappy

CONCLUSIONS

Having hourglass figure and great body are becoming the need of the hour for both men and women. It instills sense of pride among individuals by not only enhancing the personality but also by boosting the confidence level of an individual. globalization has motivated people towards cosmetic surgery.

The national statistic rate of divorce is highest is tamilnadu 4.8%, especially in city like Chennai, common cause of divorce is body consciousness leading to mental dissatisfaction. Self confidence of patient mostly due to body imaging. aesthetic surgery improves self image with good body contouring, increases libido and attractiveness of individual ,binds the marital status. Even in the difficult scenario women in that age group get more confidence in more professional job , more self esteem and positive thinking. They Can even start new life after time pass by after social stigma passes through.

Inspite of government chief ministers health insurance scheme not covering the cosmetic surgery, the lower strata income group now increasingly opt for cosmetic surgery .free surgical cosmetic procedures

done in our government hospital, change in the policy, attitude in our department in the past 3 years, more and more esthetic body contour surgeries done for lower social strata.

Good motivated patients with expectation and desire within realistic alm, get satisfied with the goal oriented aesthetic body contouring approaches. The number of dissatisfied patients, even with informed consent are less in our study. this may be related to the time devoted with patient, explaining all possible complication in the vernacular language, with early effective remedy for complication explained and reiterated to our patient in a considerate manner has brought this excellent result.

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PROFORMA FOR CLINICAL CASE STUDIES

NAME	:	PS No	:
AGE	:	ADM No	:
SEX	:	D.O.Adm	:
ADDRESS	:	D.O.Surg	:
D.O.Dis	:		
Ph no	:		
Weight	:		
Height	:		
BMI:			

PRESENTING COMPLAINTS :

HISTORY OF PRESENT ILLNESS :

PAST HISTORY :

CO-MORBIDITY :

PERSONAL HISTORY :

SMOKER/ NON-SMOKER :

TREATMENT HISTORY :

GENERAL EXAMINATION :

LOCAL EXAMINATION :

GIRTH MEASUREMENTS :

PROVISIONAL DIAGNOSIS :

INVESTIGATIONS :

PLAN OF MANAGEMENT :

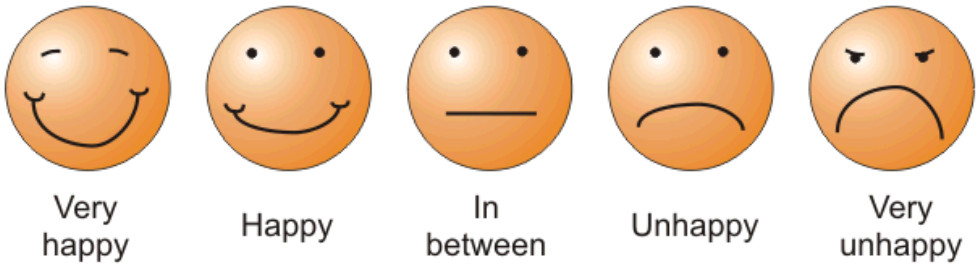
OPERATION : Date :

(Photographs)

FOLLOW UP :

(photographs)

PATIENTS SATISFACTION :



சுய ஒப்புதல் படிவம்

ஆய்வு செய்யப்படும் தலைப்பு:

ஊடுதுளைப்பான் சார்ந்த முன்னுந்தி தொங்கல் மூலம் தோலின் குறைபாட்டை மீட்டமைத்தல்

உடல் ஒட்டுறுப்பு
அறுவை சிகிச்சை துறை : சென்னை மருத்துவ கல்லூரி

பங்கு பெறுபவரின் பெயர் :

பங்கு பெறுபவரின் எண் :

பங்கு பெறுபவர் இதனை (✓) குறிக்கவும்

மேலே குறிப்பிட்டுள்ள மருத்துவ ஆய்வின் விவரங்கள் எனக்கு விளக்கப்பட்டது. என்னுடைய சந்தேகங்களை கேட்கவும், அதற்கான தகுந்த விளக்கங்களை பெறவும் வாய்ப்பளிக்கப்பட்டுள்ளது என அறிந்து கொண்டேன். ☐

நான் இவ்வாய்வில் தன்னிச்சையாகத்தான் பங்கேற்கிறேன். எந்த காரணத்தினாலோ எந்த சட்ட சிக்கலுக்கும் உட்படாமல் நான் இவ்வாய்வில் இருந்து விலகி கொள்ளலாம் என்றும் அறிந்து கொண்டேன். ☐

இந்த ஆய்வு சம்பந்தமாகவோ, இதை சார்ந்த மேலும் ஆய்வு மேற்கொள்ளும்போதும் இந்த ஆய்வில் பங்குபெறும் மருத்துவர் என்னுடைய மருத்துவ அறிக்கைகளை பார்ப்பதற்கு என் அனுமதி தேவையில்லை என அறிந்து கொள்கிறேன். நான் ஆய்வில் இருந்து விலகிகொண்டாலும் இது பொருந்தும் என அறிகிறேன். ☐

இந்த ஆய்வின் மூலம் கிடைக்கும் தகவலையோ, முடிவையோ பயன்படுத்திக் கொள்ள மறுக்க மாட்டேன். ☐

இந்த ஆய்வில் பங்குகொள்ள ஒப்புக்கொள்கிறேன். இந்த ஆய்வை மேற்கொள்ளும் மருத்துவ அணிக்கு உண்மையுடன் இருப்பேன் என்றும் உறுதியளிக்கிறேன். ☐

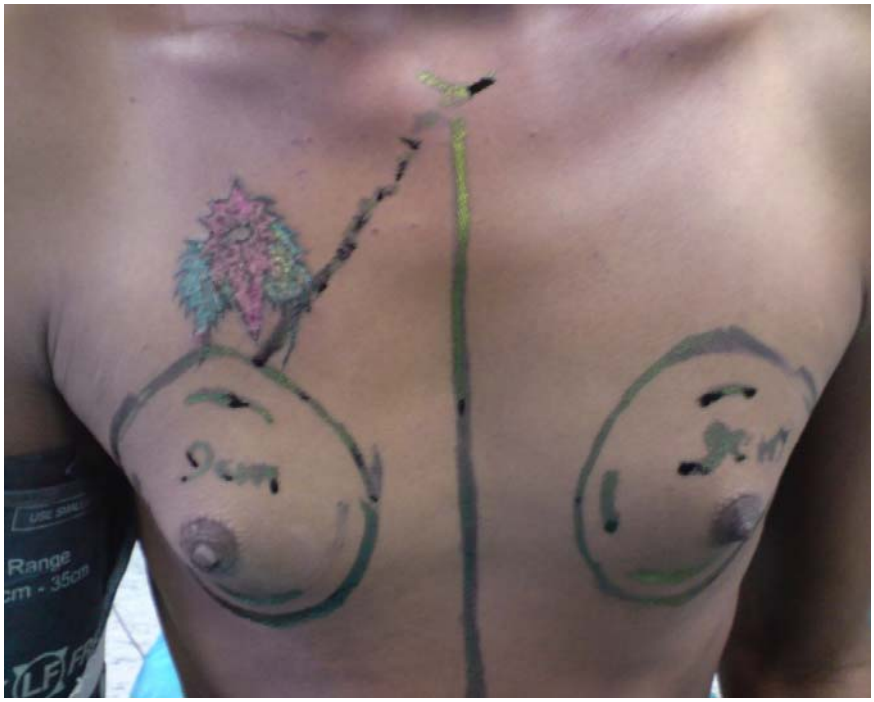
பங்கேற்பவரின் கையொப்பம் ..... இடம்..... தேதி

கட்டைவிரல் ரேகை

பங்கேற்பவரின் பெயர் மற்றும் விலாசம்.....

ஆய்வாளரின் கையொப்பம் ..... இடம்..... தேதி

ஆய்வாளரின் பெயர் .....



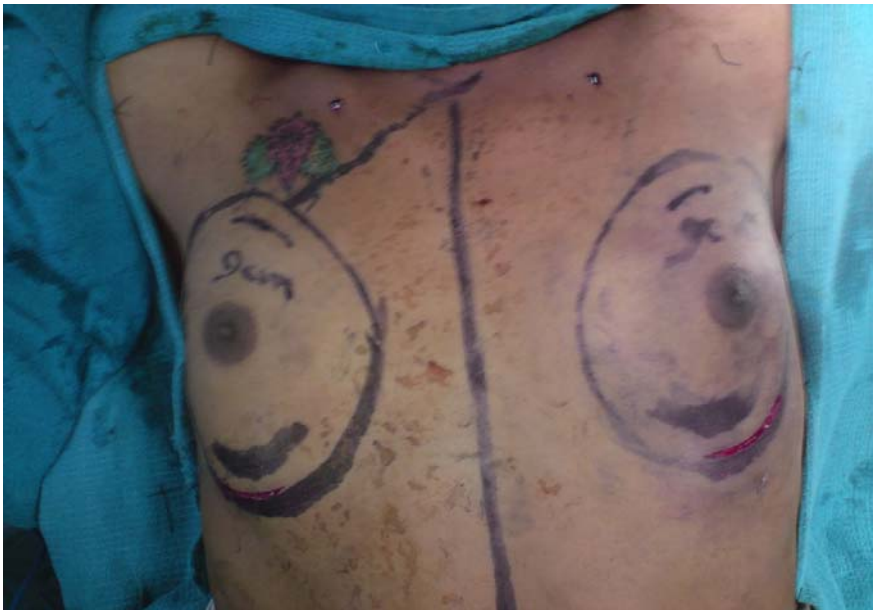
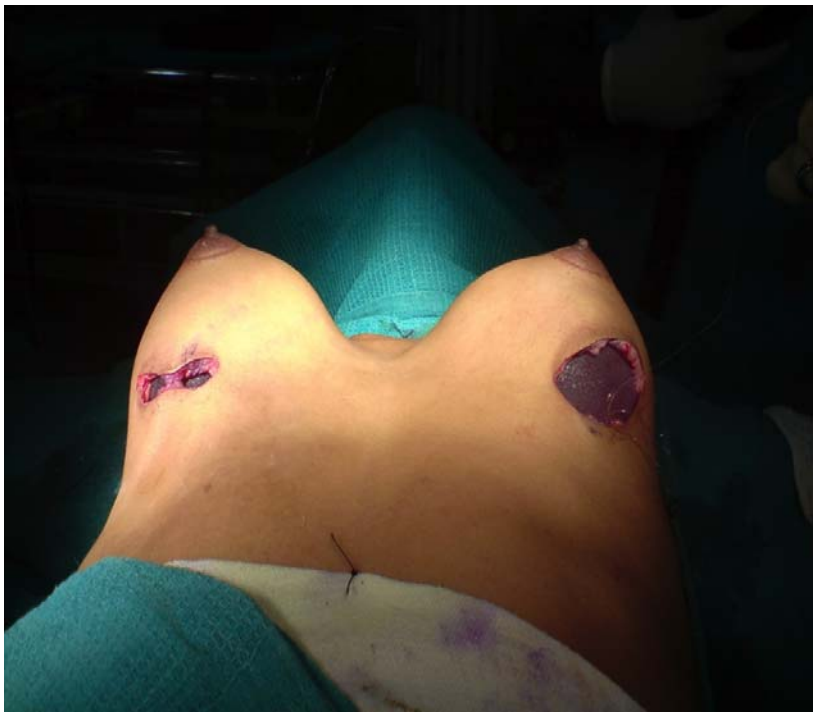


Fig: 1.1 – (**Top**):showing the preoperative markings made; (**Bottom**): shows the line of incision being made along the proposed IMF



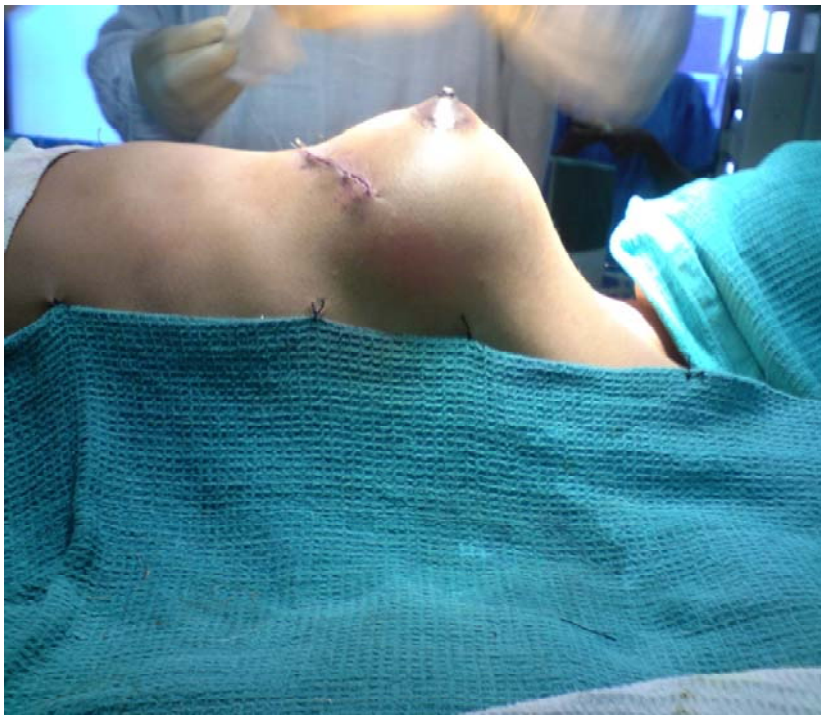


Fig:1.2 - (**TOP**): after placement of implants in the subglandular plane and (**BOTTOM**): after skin closure, final appearance.

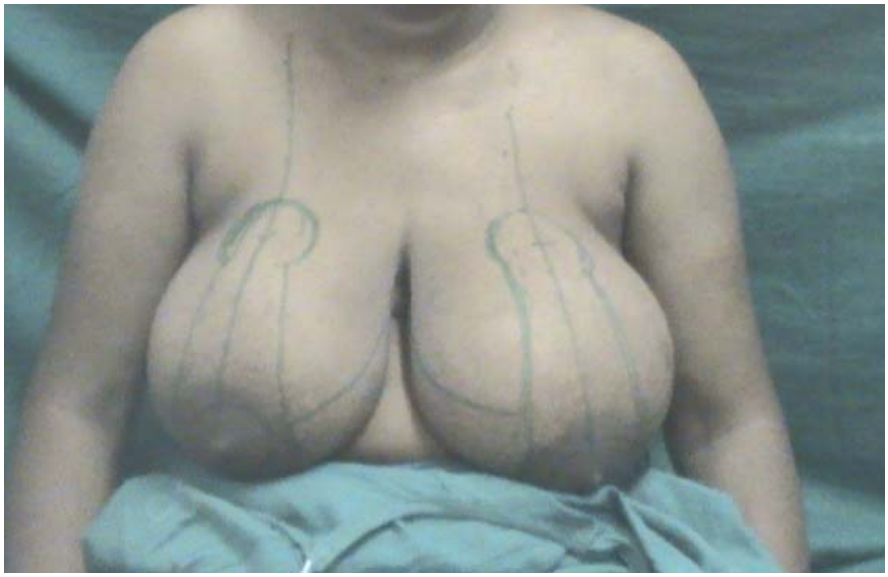


Fig : 2.1 - : 30 year old lady with symptomatic macromastia, frontal view with preoperative marking

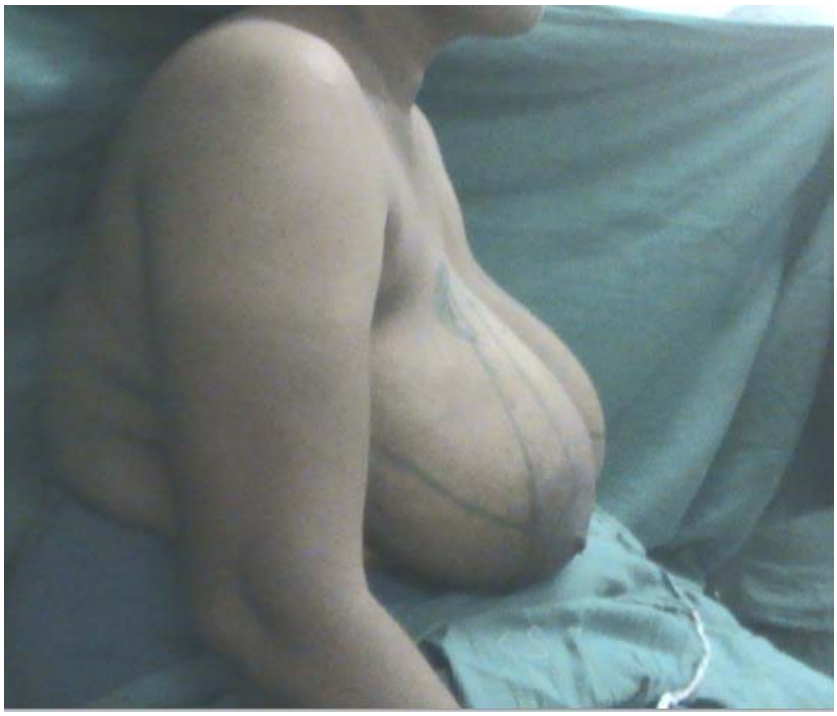


Fig : 2.2 - : Lateral View

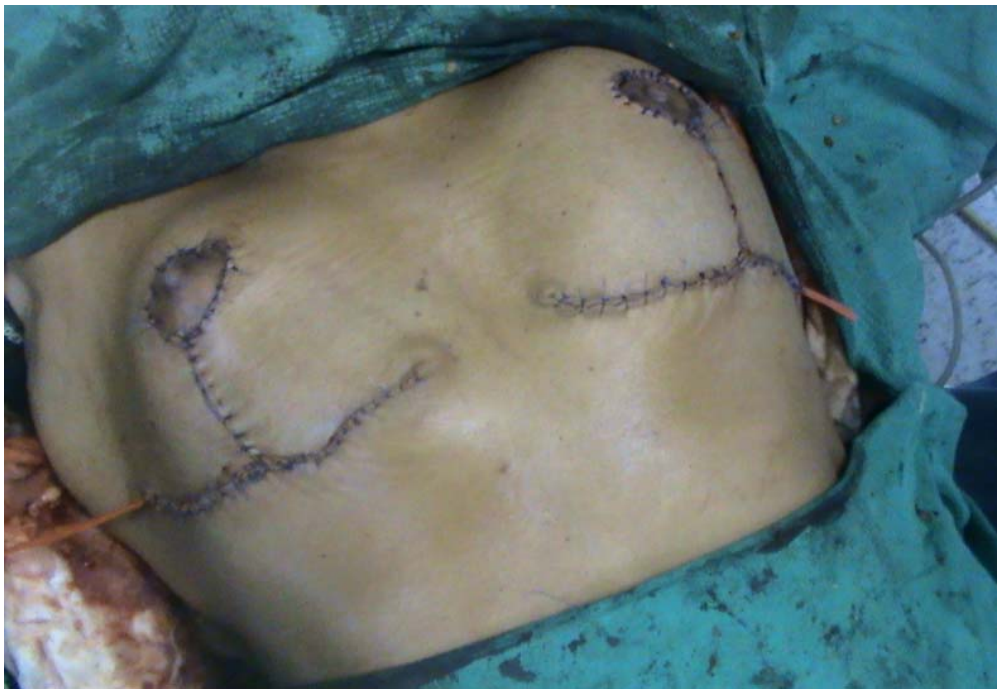


Fig : 2.3 - : Immediate Post Operative Final Suture Line

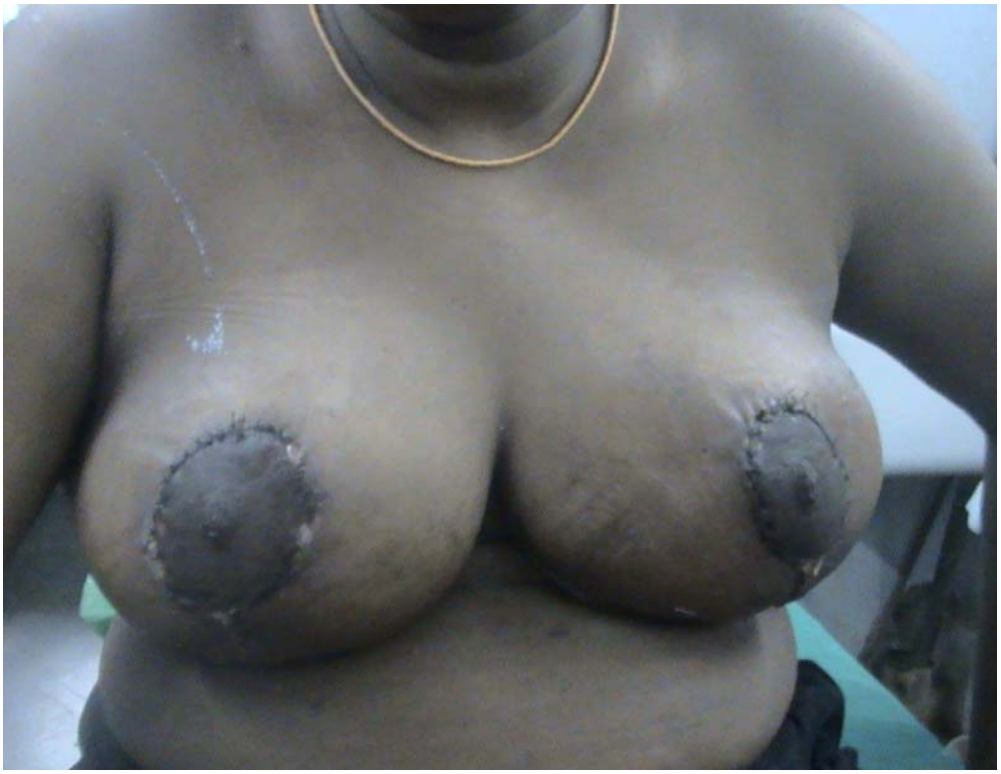


Fig : 2.4 - : Post OP Picture After Two Weeks

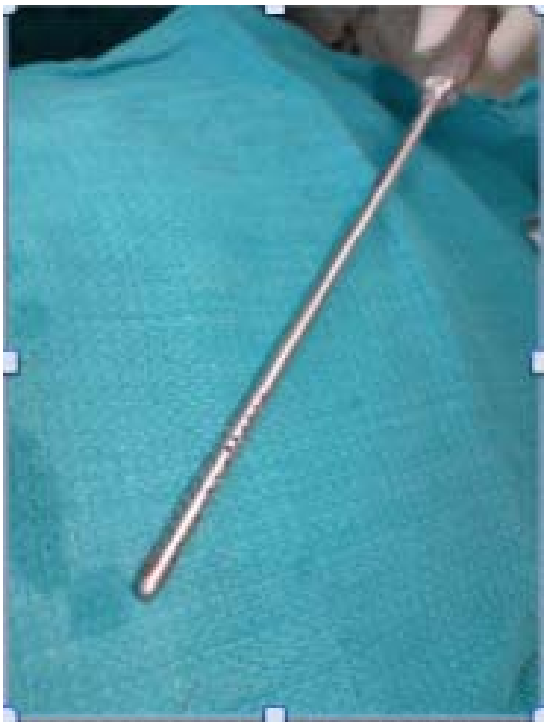


Fig.3.3. Liposuction infiltration cannula

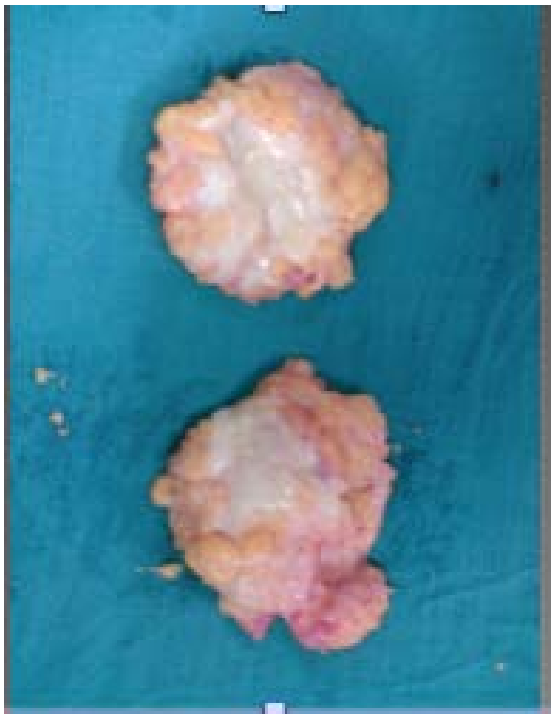


Fig.3.4. Excised breast tissue, below the both NAC delivered via the circumareolar incision

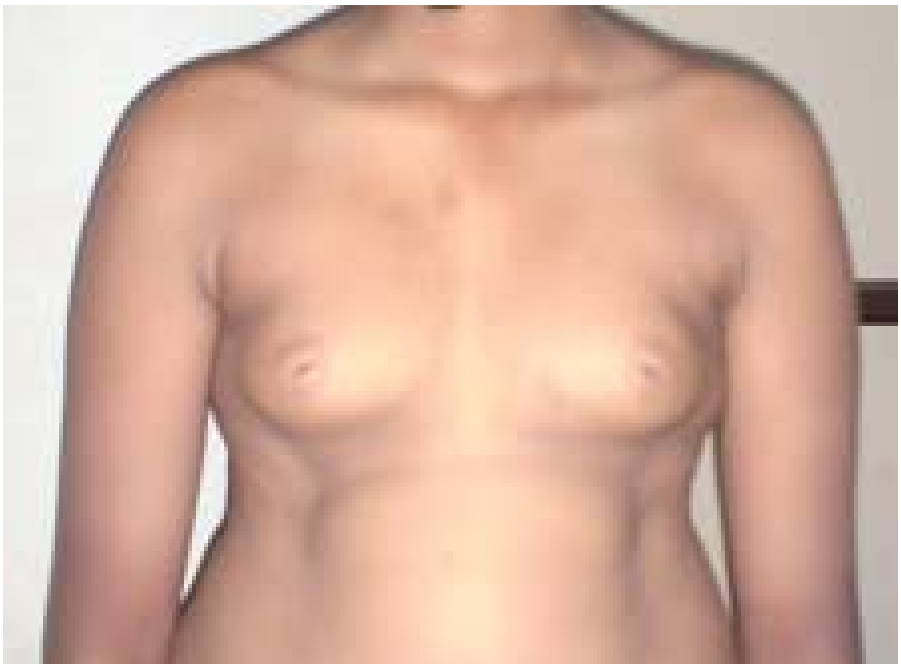


Fig 3.1, 25 year old young boy with bilateral gynecomastia,operated with liposuction assisted websters procedure

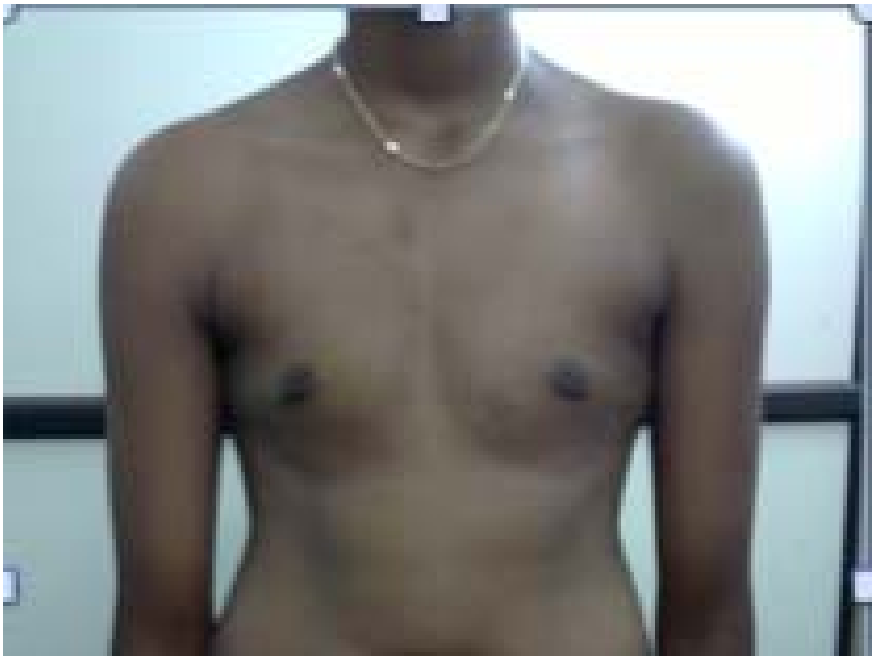


Fig 3.2, post operative result after 3 weeks after surgery

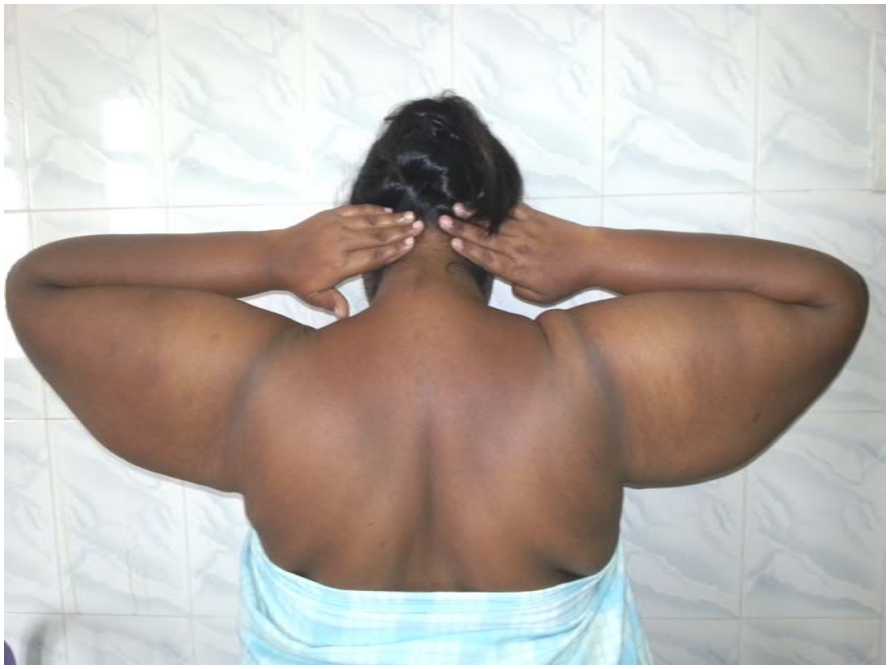


fig 4.1, 30 year old lady ,with bilateral arm adiposity, with thick subcutaneous fat and good skin ,underwent both arm liposuction.nearly 8ooml lipoaspirated from each arm

Fig 4.2 post operative result after three weeks

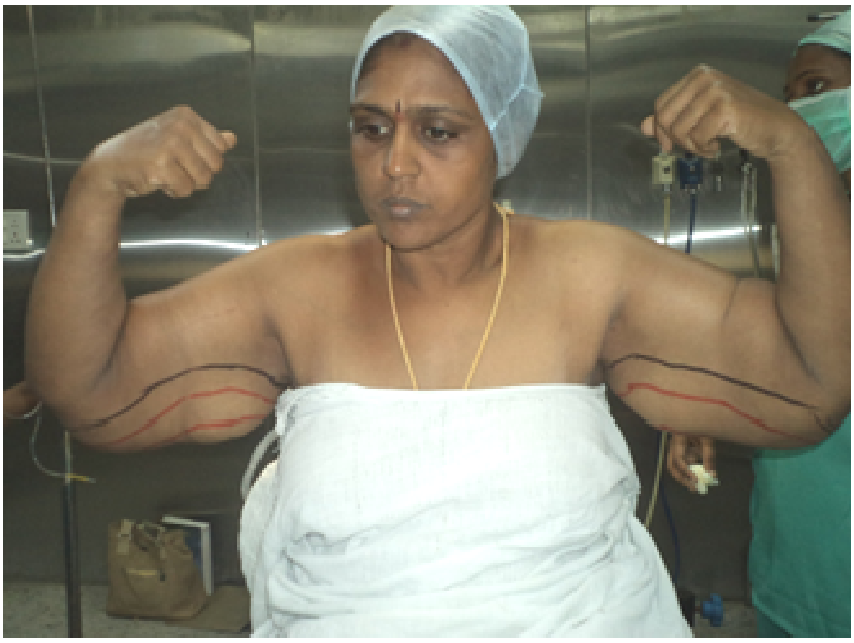


Fig 4.3, 40 year old lady with bulky arms with skin laxity underwent traditional brachioplasty

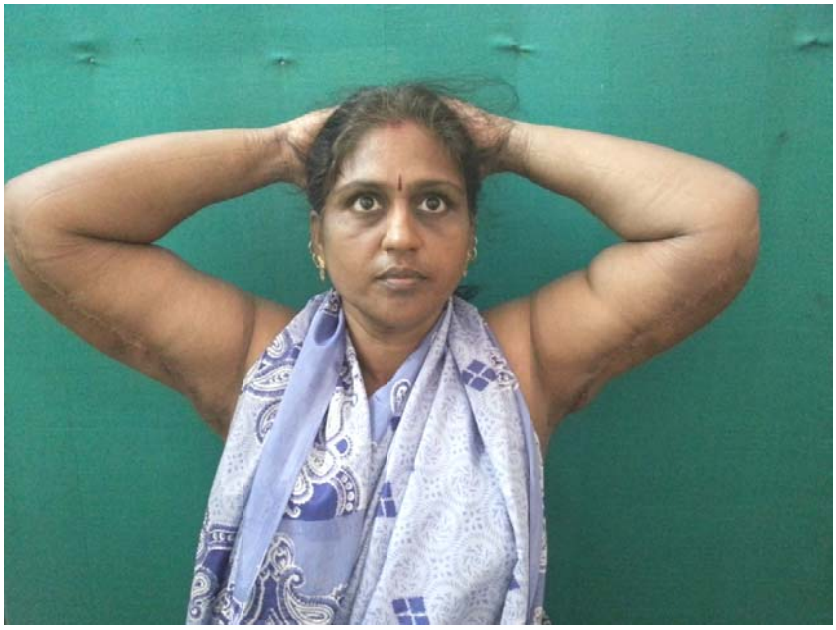
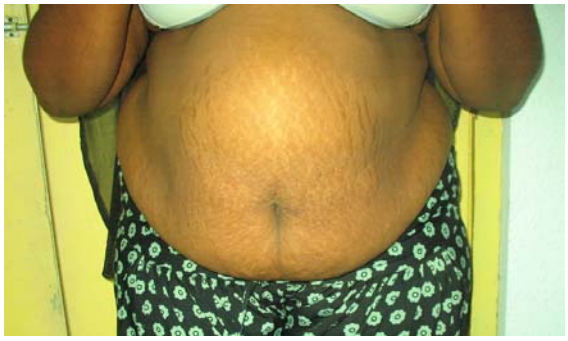
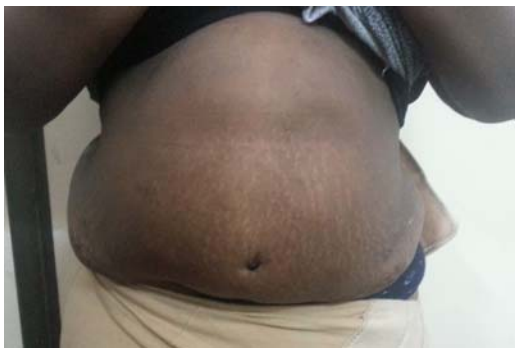
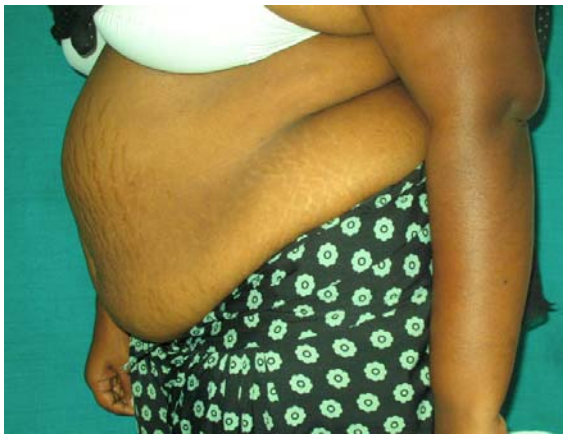
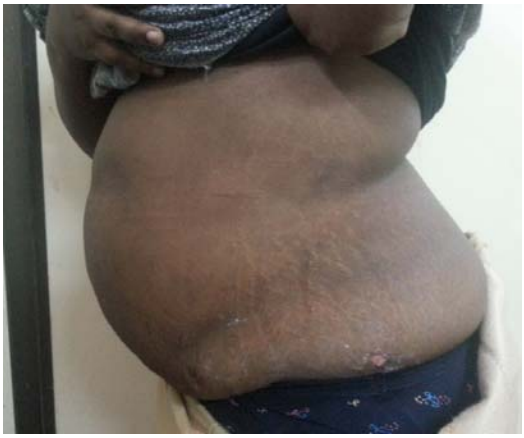
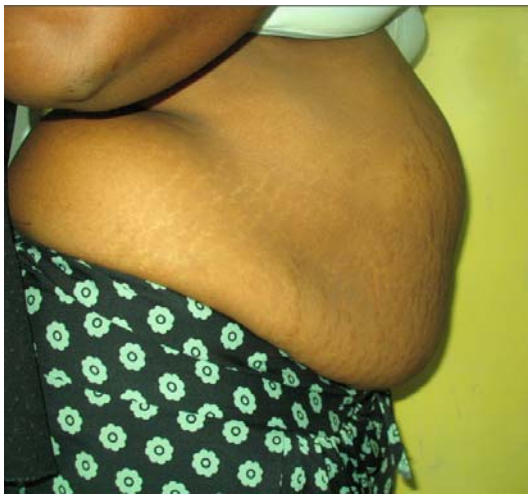
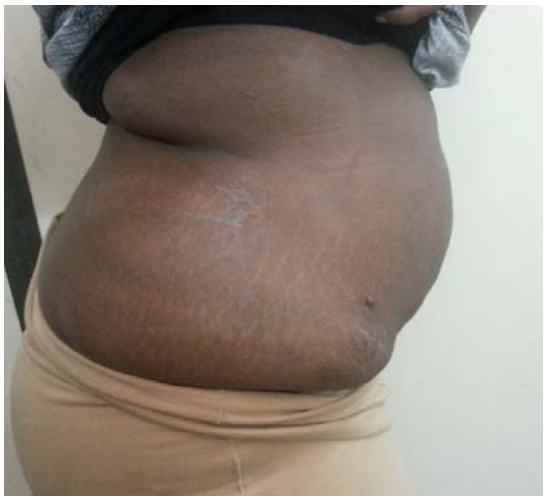


Fig 4.4, Post Operative results after three weeks

Case 30 year old house wife, before and after pictures afer undergoing lipabominoplasty

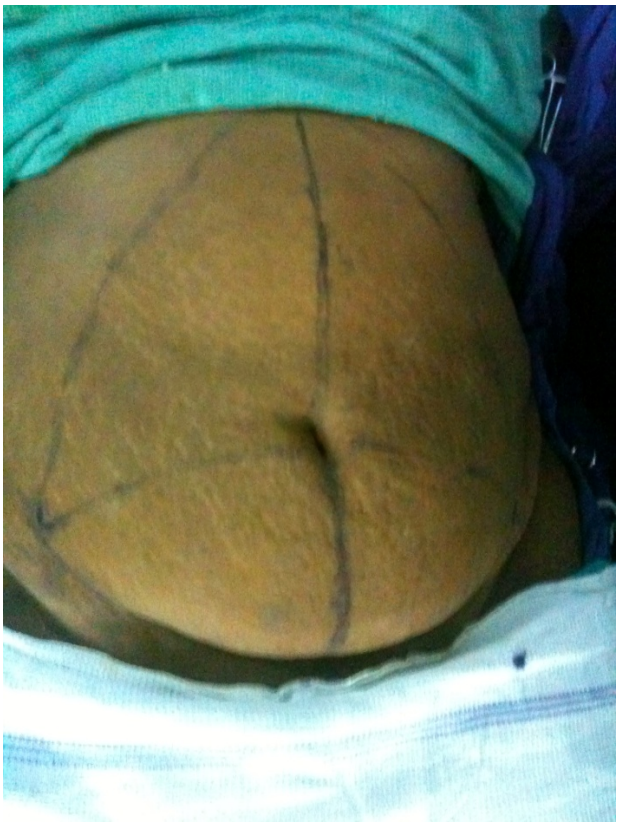


Fig.5.1 Preop markings before Lipoabdominoplasty

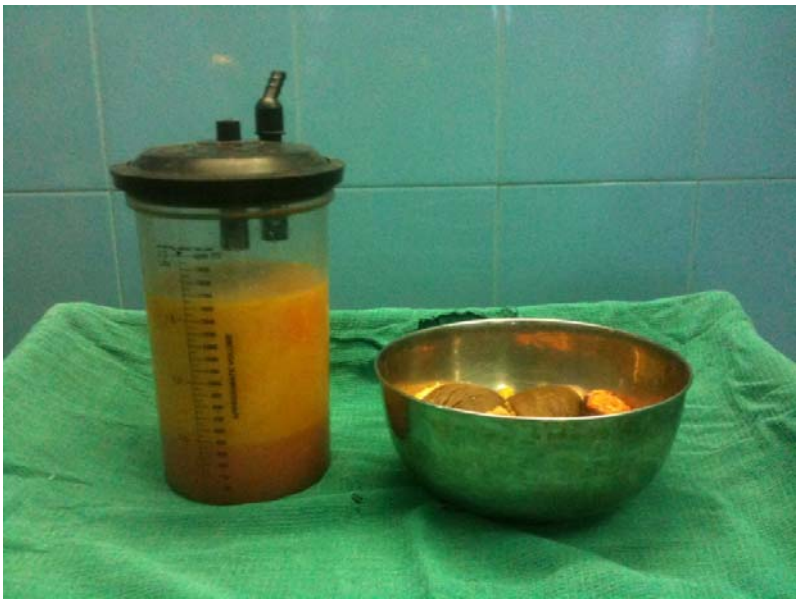
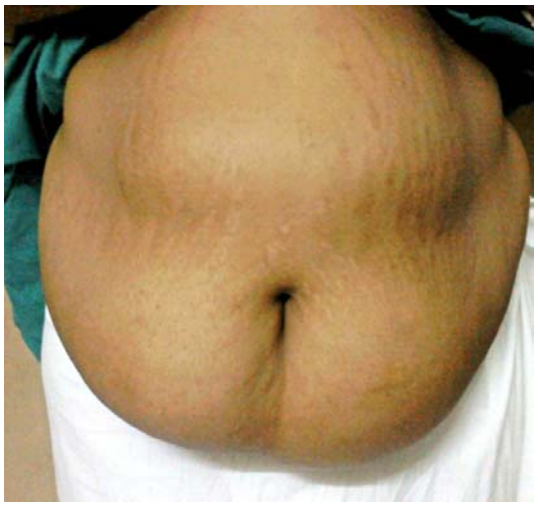
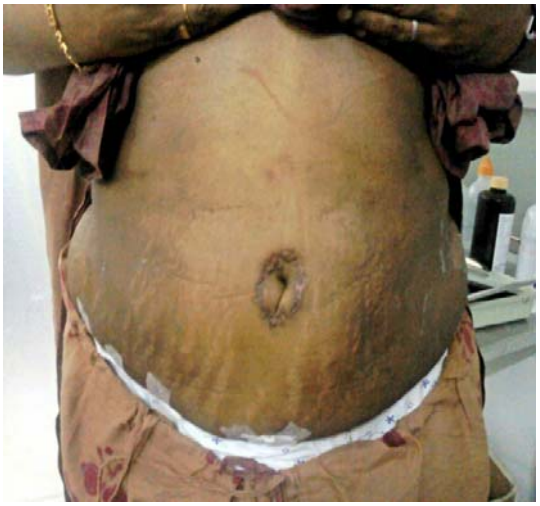


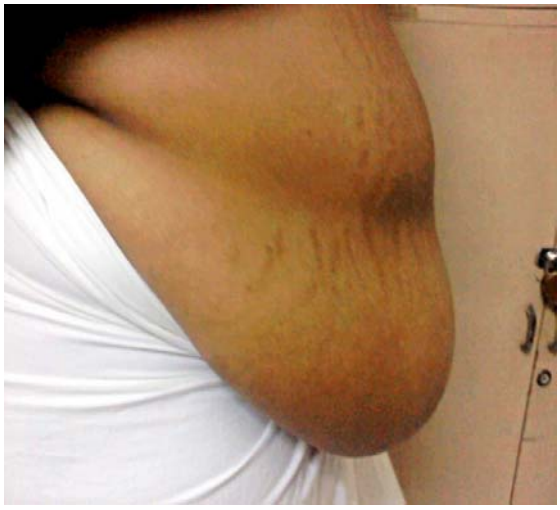
Fig.5.2 Lipoaspirate 2.5 litres with excised skin flap

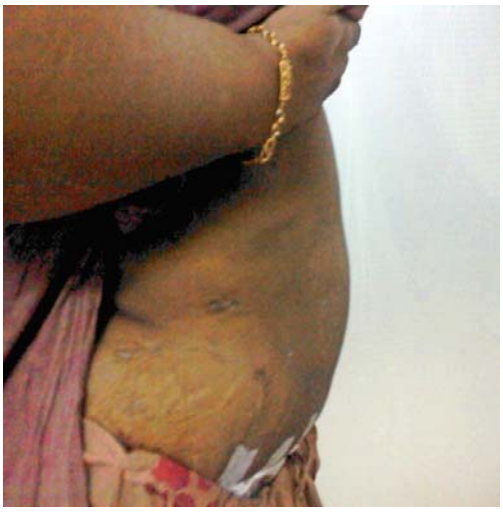
Case 2

28 year old lady, before and after Lipoabdominoplaty

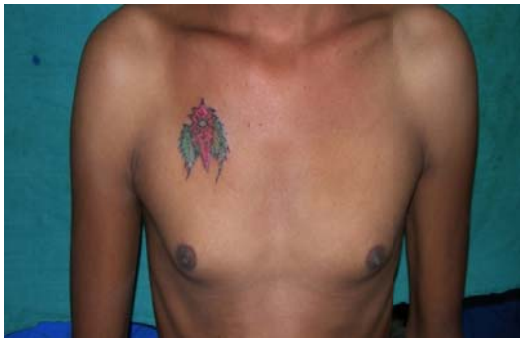
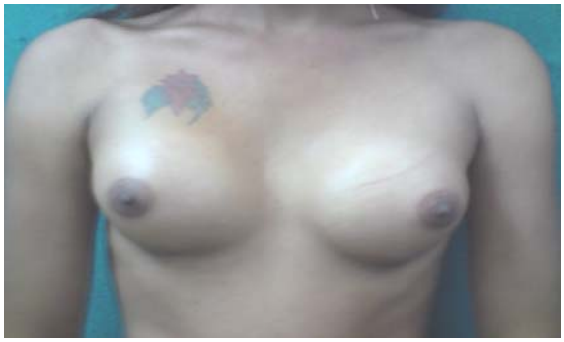






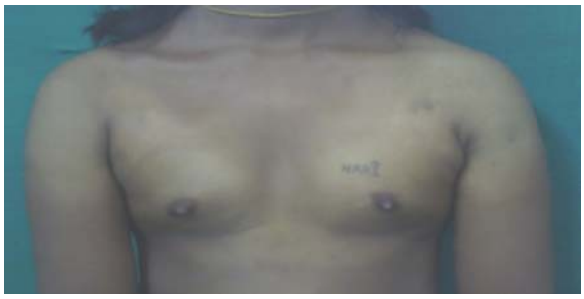
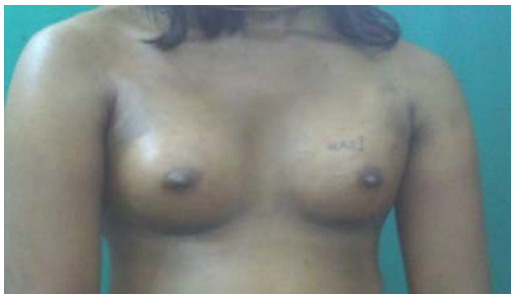


Case reports
Case: 1

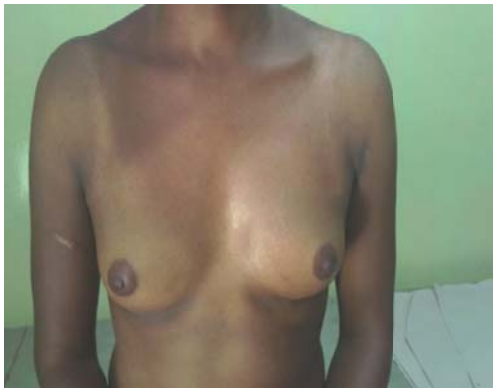
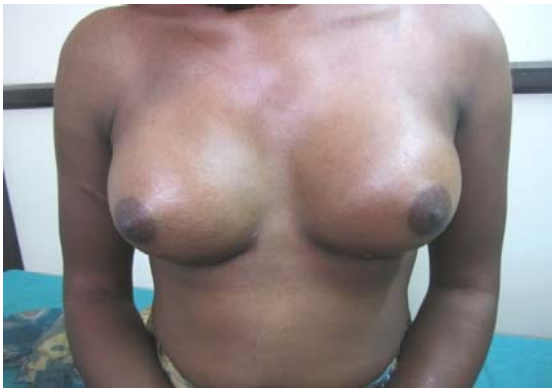
Patient a 25 years old transsexual female with an exomorphic bodily habitus having poor breast development after HT, augmented with 200cc implant

Case: 2

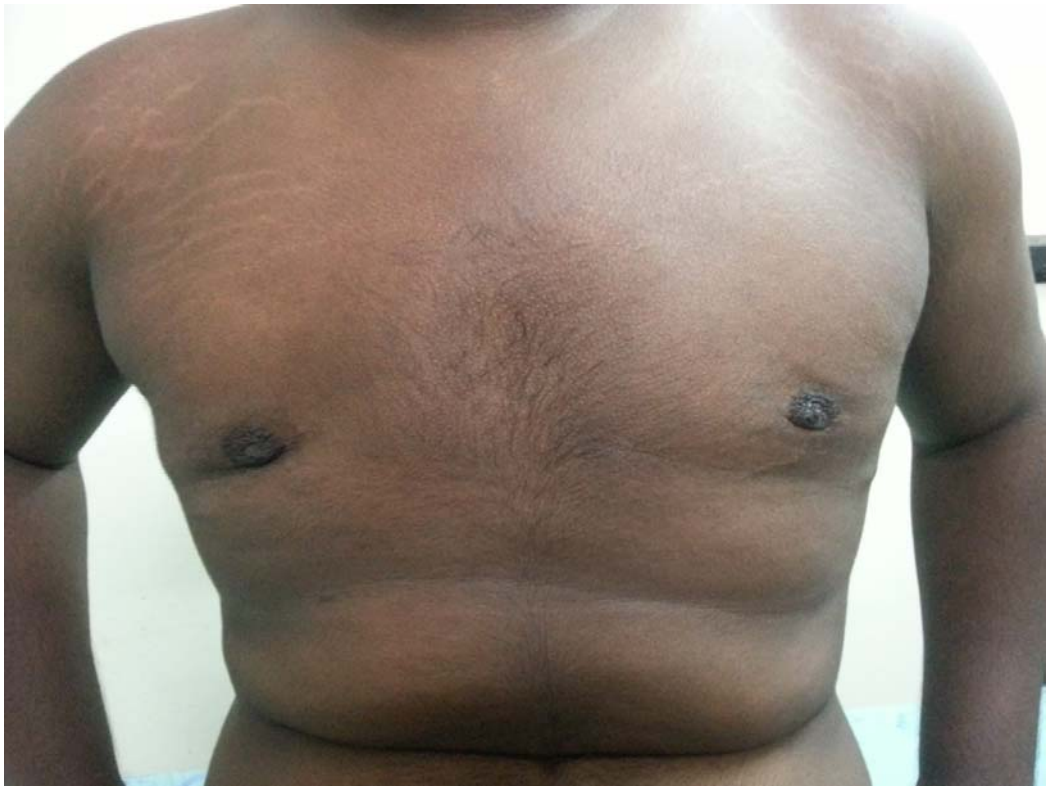



An endomorphic bodily habitus patient with pectusexcavatum abnormality having poor skin stretchability, 175cc implant inserted

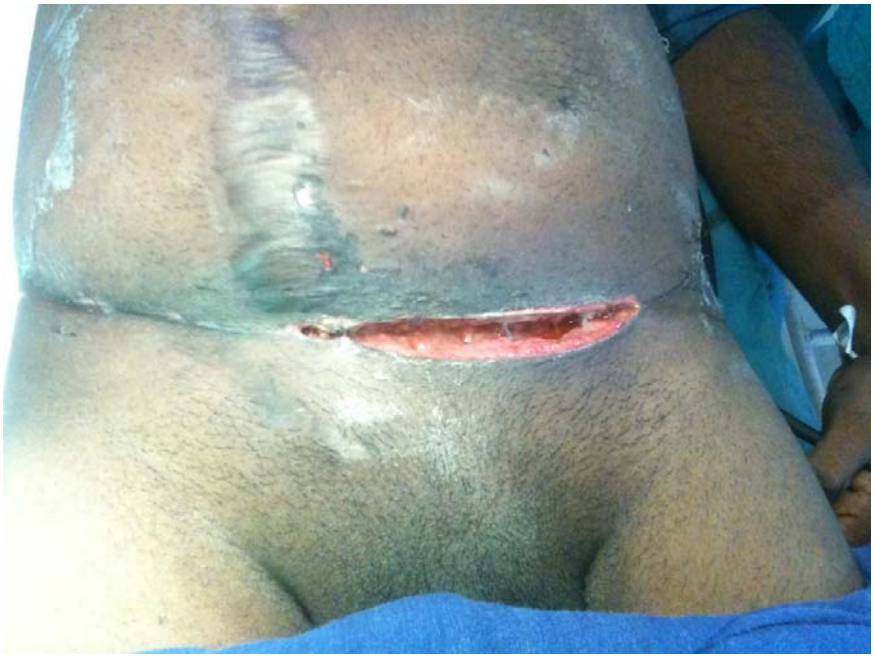
Case: 3

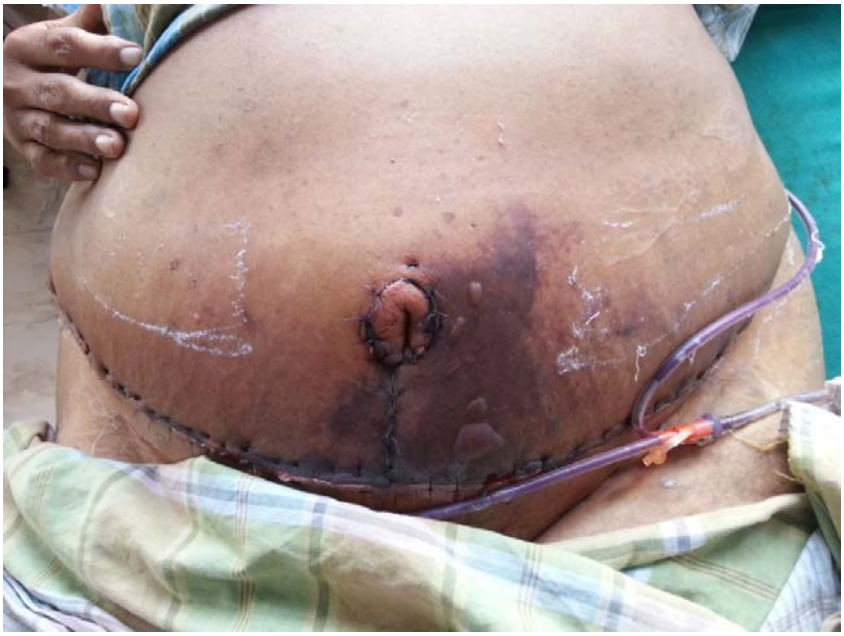
Patient with fairy adequate east development after HT needed augmentation. We proceed with larger 300cc implant in order to correct ptosis as well.



Post op complication of Gynecomastia – tethering of nipple, causing asymmetry



Wound infection leading to wound dehiscense in 40 year old male following abdominoplasty

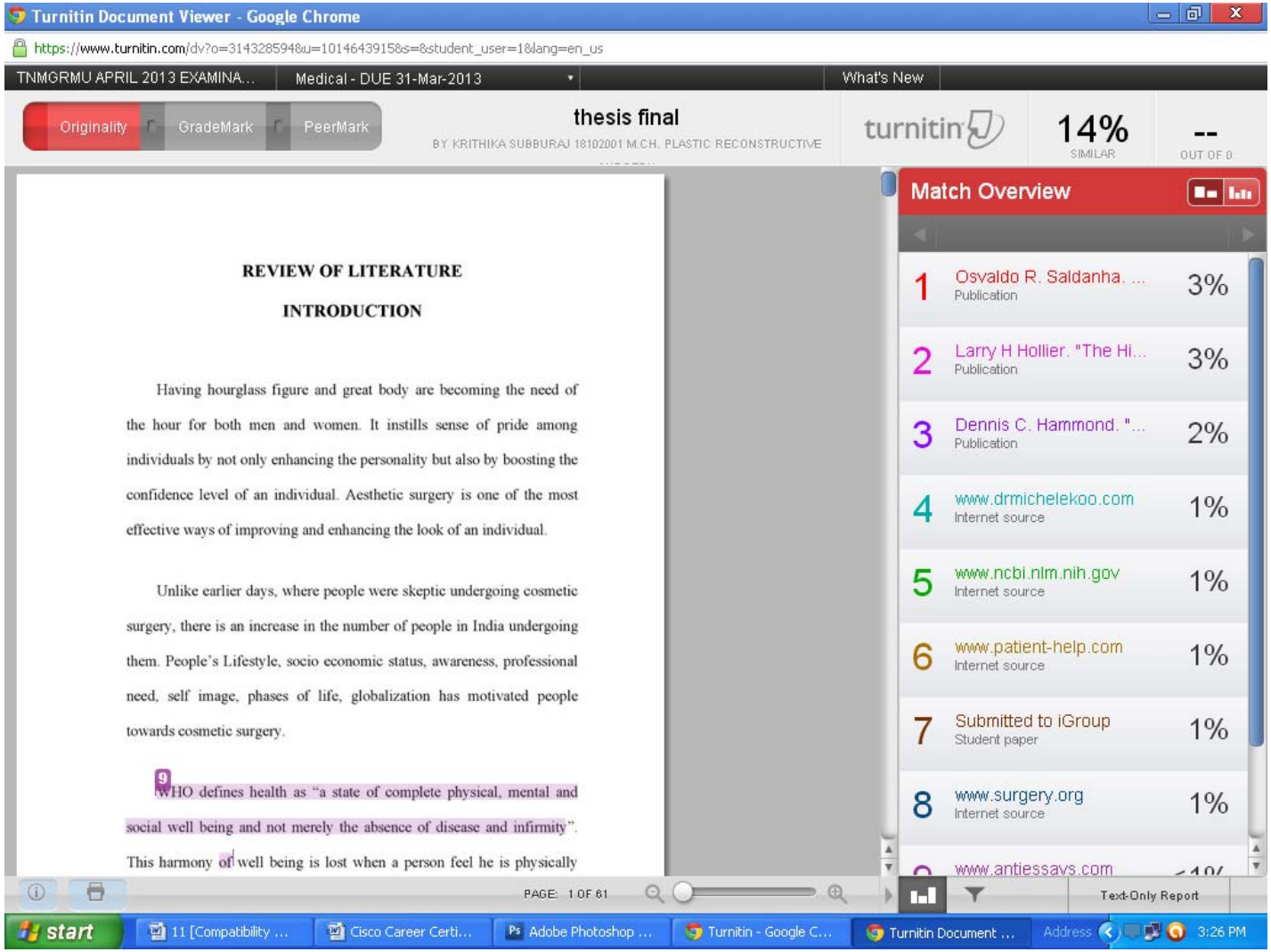


Flap Necrosis in a lady post op after abdominoplasty

S.NO.	NAME	AGE/ SEX	IP NO.	BODY MASS INDEX	DIAGNOSIS	SURGICAL PROCEDURE	COMPLICATIONS	SECONDARY PROCEDURES	PATIENTS AESTHETIC OUTCOME SATISFACTION
1	Malleswari	39/F	55734	30	Truncal obesity	lipoabdominoplasty	none	None	
2	Bhuvaneswari	65/F	56650	35	Truncal obesity with hernia	abdominoplasty	none	None	
3	Udhyakala	50/F	33272	32	Truncal obesity with hernia	abdominoplasty	flap necrosis	debridement and secondary suturing	
4	Jeyalakshmi	47/F	103791	31.2	Truncal obesity with hernia	abdominoplasty	none	None	
5	Anjana	47/F	23182	29	Truncal obesity with hernia	Abdominoplasty	wound dehiscence	secondary suturing	
6	Jaya	46/F	11686	35	Truncal obesity with hernia	Abdominoplasty	none	None	
7	Malliga	48/F	39067	40	Truncal obesity with hernia	Abdominoplasty	wound dehiscence	secondary suturing	
8	komalkiran	30/F	23432	40.1	truncal obesity	abdominoplasty	flap necrosis	secondary suturing	
9	Srinivasan	54/M	18673	30	Truncal obesity	abdominoplasty	wound dehiscence	secondary suturing	
10	Bhuvaneswari	65/F	56650	26	Truncal obesity with hernia	Abdominoplasty	none	None	
11	Rafat jahah	46/F	45444	32.6	Truncal obesity with hernia	Abdominoplasty	none	None	
12	Dhanalakshmi	30/F	13953	35.4	Truncal obesity	lipoabdominoplasty	none	None	
13	Shanthi	38/F	46271	24.1	Truncal obesity with hernia	lipoabdominoplasty	none	None	
14	Baby	37/F	54310	32.2	Truncal obesity with hernia	lipoabdominoplasty	none	None	
15	Ramya	35/F	22472	29.2	Truncal obesity with hernia	Lipoabdominoplasty	none	None	
16	Dhilshanth	28/F	17843	32	Truncal obesity	liposuction	none	None	
17	Leena ruban	23/F	1934/11	29.7	thigh adiposity	liposuction	none	none	
18	Deepika	22/F	23894	30	Truncel Obesity	Liposuction	none	none	
19	komalakiran	30/F	226/12	39	B/L - arm adiposity	liposuction	none	none	
20	Suganya	43/f	226/12	35	B/L - arm adiposity	Liposuction	prominent scar	conservative	
21	Sandhya	26/T	22613	32.1	GID,truncal obesity with thigh	liposuction abdomen a	none	none	
22	Reena	22/T	23788	24	GID,hypoplastic breast	B/L breast augmentati	altered sensation of breas	none	
23	Anjali	25/T	1945/11	20.4	GID,hypoplastic breast	B/L breast augmentati	altered sensation of breas	none	

24	Sabeena	24/T	3147	30	GID,hypoplastic breast	B/L breast augmentati	none	none	
25	Shama	26/T	9503	31	GID,hypoplastic breast	B/L breast augmentati	none	none	
26	Anandhi	27/T	20815	25.1	GID,hypoplastic breast	B/L breast augmentati	exposed implant	implant exit and redo	
27	kiran	20/T	23613	24.8	GID,hypoplastic breast	B/L breast augmentati	none	none	
28	Kareena	27/T	30793	27	GID,hypoplastic breast	B/L breast augmentati	hematoma	conservative	
29	Shalini	25/T	36047	29.7	GID,hypoplastic breast	B/L breast augmentati	none	none	
30	Geetha	31/T	38636	21	GID,hypoplastic breast	B/L breast augmentati	altered sensation of breas	none	
31	Akila	27/T	439262	18.1	GID,hypoplastic breast	B/L breast augmentati	none	none	
32	Jennifer	30/T	46296	29	GID,hypoplastic breast	B/L breast augmentati	none	none	
33	Priya	28/T	52344	26.7	GID,hypoplastic breast	B/L breast augmentati	hematoma	conservative	
34	Deepika	25/T	2633	24.9	GID,hypoplastic breast	B/L breast augmentati	none	none	
35	Sabeena	33/T	54700	30.1	GID,hypoplastic breast	B/L breast augmentati	altered sensation of breas	none	
36	Roja	21/T	60621	26.8	GID,hypoplastic breast	B/L breast augmentati	none	none	
37	Shama	23/T	65048	35.4	GID,hypoplastic breast	B/L breast augmentati	altered sensation of breas	none	
38	Ponni	32/T	97/11	36	GID,hypoplastic breast	B/L breast augmentati	keloid	conservative	
39	Farana	28/T	72245	35	GID,hypoplastic breast	B/L breast augmentati	exposed implant	implant exit and redo	
40	Sandhya	26/F	22613	30.5	Uniateral hypoplastic breast	Unilateral breast augm	none	none	
41	Suganthe	34/F	1676/11	37	B/L Symptomatic Macromast	Reduction Mammopla	none	none	
42	Usha	29/F	48/106012	40	B/L Macromastia	Reduction Mammopla	keloid	conservative	
43	Silambarasan	21/M	21-Jun	24.8	B/L Gynecomastia	Liposuction	none	none	
44	Rukmandhan	20/M	91349	22.7	B/L Gynecomastia	Liposuction	none	none	
45	Subramaniyam	28/M	84/11	20	B/L Gynecomastia	Liposuction	altered sensation of breas	none	
46	Senthil Kumar	23/M	103425	30.4	B/L Gynecomastia	Liposuction	none	none	
47	Selvarajan	33/M	58636	28	B/L Gynecomastia	Liposuction	none	none	

48	Senthil	21/M	91373	26.2	B/L Gynecomastia	Websters assisted lipo	None	none	
49	Pandian	22/M	244100	32	B/L Gynecomastia	Websters assisted lipo	hematoma	conservative	
50	Bala	26/M	39652	30.5	B/L Gynecomastia	Websters assisted lipo	altered sensation of breas	none	
51	Durai	13/M	41316	29	B/L Gynecomastia	Websters assisted lipo	none	none	
52	Prakash	21/M	31279	28.2	B/L Gynecomastia	Websters assisted lipo	nipple retraction	none	
53	thanraj	19/M	31359	25	B/L Gynecomastia	Websters assisted lipo	altered sensation of breas	none	
54	Kathir	26/M	65716	32	B/L Gynecomastia	Websters assisted lipo	none	none	
55	Rajkumar	19/M	821841	30	B/L Gynecomastia	Websters assisted lipo	altered sensation of breas	none	
56	Ajith Kumar	15/M	92081	29.1	B/L Gynecomastia	Websters assisted lipo	none	none	
57	Naresh Kumar	14/M	34294	24	B/L Gynecomastia	websters assisted lipo	hyperpigmentation of skin	conservative	
58	Praveen Kumar	28/M	92212	23.4	B/L Gynecomastia	Websters assisted lipo	hematoma	conservative	
59	Pradeep	25/M	76384	27.4	B/L Gynecomastia	Websters assisted lipo	none	none	
60	Rajiv	18/M	34256	28	B/L Gynecomastia	Websters assisted lipo	altered sensation of breas	none	
61	Kaviarasu	21/M	78343	25	B/L Gynecomastia	Websters assisted lipo	none	none	
62	Vignesh	14/M	2584/11	24.4	B/L Gynecomastia	Websters assisted lipo	none	none	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Unlike earlier days, where people were skeptic undergoing cosmetic surgery, there is an increase in the number of people in India undergoing them. People's Lifestyle, socio economic status, awareness, professional need, self image, phases of life, globalization has motivated people towards cosmetic surgery.
WHO defines health as "a state of complete physical, mental and social well being and not merely the absence of disease and infirmity". This harmony of well being is lost when a person feel he is physically
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