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**PURPOSE:** After weight loss, pregnancy, and/or aging, excess skin of the lower torso may be treated with abdominoplasty extended as lower body lift. Pittsburgh grade 3b-d transverse skin excess is often additionally treated by midline vertical excision, fleur-de-lys (FDL) abdominoplasty.\(^1\) Although loose skin removed and waist slightly narrowed, “esthetic cost” is full-length midline abdominal scar and flatness.\(^2\) Recently innovated oblique flankplasty with lipoabdominoplasty (OFLA) smoothly deepens the waist and raises lateral buttocks and thighs, leaving lower abdominal and waist-long scars.\(^3,4\) An unforeseen benefit is the circumferential removal of mid and lower torso skin excess, obviating FDL abdominoplasty.

**METHODS:** Oblique flankplasty is posterior rising extensions of lipoabdominoplasty. In 18 grade 3b-d abdominal deformity cases, vertical midline excision was replaced by flankplasty. The lipoabdominoplasty is planned with superior incision continuing across the lateral costal margin and the inferior incision across the iliac crests. The width of excision is confirmed through pinching. Drawings of the elliptical flank excisions are centered over the protruding flank bulges from the posterior iliac crest to the junction of the 12th rib and spine. The superior incision line extension of the abdominoplasty lies inferior and parallel to the posterior costal margin. This is a stable anchor closure line. After superior push of the descended lateral buttocks, the width of resection is determined by tissue gathering. Although prone, the inferior incision is made along the hip and obliquely through lower lumbar globular adipose to lumbodorsal fascia. The mobile lower flap of buttocks and lateral thigh is pulled toward the mid-back to adjust the planned superior incision. After that perimeter incision is completed, the intervening tissue is excised to lumbodorsal fascia. The superficial SFS layers of the buttocks are approximated to all SFS layers of the lower back with #2 Barbed PDO, including underlying fascia. Intradiscal running Monoderm completes closure. Buttocks may be lipoaugmented. Lipoabdominoplasty follows. Several months later, the breast and upper torso are reshaped with a Wise pattern mastopexy, J-torsoplasty, and spiral flap reshaping of the breasts can be performed.

**RESULTS:** OFLA achieves ventral abdominal skin tightness without FDL in 18 consecutive 3b-d abdominoplasty cases. Natural contours with deep smooth transition from waist to defined hips. All patients preferred flank scars over abdominal midline. One patient had a 2-month 4-cm wound delay. No seromas or tissue necrosis. No scar revisions. Secondary liposuction, lipoaugmentation, or BodyTite in 4 cases. Two saddlebags were improved. The lateral buttock was rounded rather than depressed.

**CONCLUSION:** In 18 grade 3b-d (severe) abdominoplasty candidates, OFLA improved esthetics with minimal complications and uniform patient satisfaction.

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**Facial Fractures and Mixed Dentition: What Are the Implications of Dentition Status in Pediatric Facial Fracture Management?**

**Presenter:** Nicholas C. Oleck, BA  
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**PURPOSE:** The stage of maturation of the pediatric facial skeleton at the time of injury has a significant impact on both facial fracture patterns and management strategies. For instance, the relative prominence of the pediatric cranium during the early years of life affords protection to the structures of the midface, whereas delayed aeration of the frontal sinuses may predispose younger patients to frontal bone fractures. The dentition status of a pediatric patient may have similar implications in the setting of facial fracture. In this study, the authors examine the effect of dentition status on facial fracture patterns and management strategies at an urban, level I trauma center.

**METHODS:** A retrospective chart review was performed for all cases of facial fracture occurring in the pediatric patient population at a level I trauma center (University Hospital in Newark, N.J.) between 2002 and 2014. A database including patient demographics, facial fracture and
RESULTS: A total of 72 patients with mixed dentition met inclusion criteria for our study and were compared against patients with primary (n = 35) and permanent (n = 305) dentition. The mean age at presentation was 9.2 years, with a male predominance of 68%. The most common fracture etiology was pedestrian struck accident (n = 23), fall (n = 21), motor vehicle collision (n = 12), and assault (n = 9). The most frequently identified facial fractures were that of the orbit (n = 31), mandible (n = 21), nasal bone (n = 19), and frontal sinus (n = 14). Additionally, 8 Le Fort and 4 nasoorbitoethmoid fractures were identified. Twenty-one patients (29%) required operative management for ≥1 facial fractures. Operative intervention was required in 38% of mandibular fractures, with 6 patients requiring only maxillomandibular fixation and 2 requiring open reduction internal fixation with titanium plating. Nine cases of orbital fracture (29%) were managed operatively: 2 with absorbable plates, 2 with Medpor implants, and the remaining with titanium plating. Management of all nasal fractures requiring operative intervention was accomplished through closed reduction. Concomitant injuries included skull fracture (n = 35), traumatic brain injury (TBI) (n = 35), intracranial hemorrhage (ICH) (n = 21), and long bone fracture (n = 12). Seventeen patients required admission to the intensive care unit. Patients with permanent dentition were significantly more likely to sustain frontal sinus and Le Fort fractures (P < 0.01), and skull fracture, ICH, and TBI (P < 0.01) as compared to those with mixed dentition.

CONCLUSION: The dentition status of a pediatric patient may have significant implications in both patterns of injury and operative management strategies in the setting of acute facial trauma. Our study finds that Le Fort and frontal sinus fractures were significantly more common in patients with permanent dentition. Severe concomitant injuries such as ICH and TBI were also significantly more likely in this cohort. A patient’s dentition status may also play a role in the decision for ridged fixation of mandibular and orbital fractures, and the method of maxillomandibular fixation in maxillary and mandibular alveolar fracture.

Circumferential Lower Body Lift With Auto-Buttock Augmentation: A New Approach

Presenter: Tim Sebastian Peltz, MD, PhD

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INTRODUCTION: With continuously rising body mass indexes in our society and the growing access to bariatric surgery, body lift procedures are becoming more and more common. These contouring surgeries are invasive surgical interventions, and indications have to be well thought through. One of the main problems in lower body lift surgeries is the resulting “flat buttock syndrome.” We want to present a new simple staging concept for the surgical contouring of the lower body and describe our method of auto-augmenting the gluteal region in a circumferential body lift. The aim of this research project was also to establish portable 3-dimensional (3D) scanning as an objective research method to evaluate body contouring surgeries.

MATERIALS AND METHODS: So far, 45 patients underwent a circumferential lower body lift procedure since 2017. Twenty-five patients underwent the procedures without auto-augmentation of the gluteal region, and 20 patients were operated including an auto-augmentation of the buttock area. To augment the buttock area, a modified perforator flap technique was applied (modified SGAP rotation flap). Results of both groups were compared regarding operating time, complication rates, and buttock projection result. Surface scans were performed with a portable Artec Eva high-resolution 3D scanner. Patients were scanned pre-surgery, directly post-surgery, and additionally, 12 months post-surgery.

RESULTS: Portable 3D scanning in an operative setting is practical and straightforward to perform. No harm or risk is added to the surgical procedure or patient. In the 20 patients who underwent the body lift procedure with SGAP buttock augmentation, a significant improvement of buttock contouring was detected immediately after surgery. Esthetic results can be individualized to patient’s wishes/expectations: by flap design (shape, width, length, thickness), by pocket dissection (shape, width, depth), and by flap fixation (sutures, infragluteal fold reconstruction). The pronounced projection improvements measured directly after the surgery were only detected to a smaller extend after 12 months, nevertheless, still improved in regard to volume distribution and projection when compared to the nonaugmented group. Complication rates were not significantly higher in the augmentation group when compared to the conventional body lift group.

CONCLUSIONS: The auto-augmentation of the gluteal region in a body lift procedure via “SGA perforator rotation flap” is safe, reliable, and an effective technique to overcome the undesired flat buttock problem accompanied with conventional lower body lift procedures. Three-dimensional scanning is an objective method to compare and evaluate techniques in body contouring surgery. More patients and longer follow-up intervals will show whether the improved buttock projection results achieved with SGAP auto-augmentation surgeries prevail over time.