Augmentation Gluteoplasty - the XYZ Technique

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INTRODUCTION: A woman with small breasts but proportionate waist and hips still has a feminine body, but one with flat buttocks and large shoulders or narrow hips will never have a totally feminine body, regardless of how beautiful her breasts are. So, the most important detail of a feminine body is the balance of its contour.

PURPOSE: The objective of this work is to share our experience performing the XYZ technique for buttocks enhancement described by Raul Gonzales, in 2004. With this technique we can easily insert an implant into the gluteus maximus with no risk of sciatic nerve compression and no limitations in the size of implant.

METHODS/TECHNIQUES: The incision is done directly over the intergluteal crease, preserving the sacral cutaneous ligament. After the skin drawing, of an inverted heart, the subcutaneous tissue is undermined just over the muscle fascia till the end of the drawing. Next step is a 6 cm muscle incision in the same direction of the muscle fibers.

The undermining should split the muscle at the middle, and the same amount of muscle should be left in front of and behind the implant. The point X is found introducing a finger into the muscle incision 2–3 cm deeper. This is half of the thickness of the muscle and this is our plane of undermining. Point Y is in the iliac crest 5 cm beyond the upper-posterior iliac spine and is our superior limit of undermining. The point Z, the lower limit of the undermining, is reached rotating the underminer from point Y towards the femur trochanter. Usually this pocket is enough to accept relatively large round implants as well as 350 or 400 cc in a medium-sized patient.

Once the implants are placed into the pockets the incision is closed from the muscle fascia till the skin, avoiding communication between the intramuscular pocket and the supra-facial subcutaneous one, to avoid seroma formation.

RESULTS: We have been using this technique routinely since 2006 in more than 300 patients.

CONCLUSION: With this technique we can easily find the 3 stop points of the undermining to insert an implant into the gluteus maximus avoiding the most common complication: the palpable implant for a too shallow pocket in the lateral areas.

Comparative Evaluation of Smoking in Plastic versus General Surgical Postoperative Complications: A Propensity-Matched Analysis

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INTRODUCTION: Smoking is an established modifiable risk factor for perioperative complications. This is especially relevant in elective plastic surgical (PS) than in urgent general surgical (GS) procedures. From 2005–2014, smoking rate among U.S. adults decreased from 20.9% to 16.8%. This study compares smoking prevalence in patients undergoing plastic and general surgical procedures, and the postoperative complication profile when smoking is isolated as an independent risk factor.

METHODS: We used the American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) database to examine smoking and 30-day postoperative complications for plastic and general surgical procedures. Patients were propensity-score matched (PSM) for demographics and comorbidities to isolate smoking and minimize confounders.

RESULTS: We examined 294,903 patients from 2005–2014. The smoking rates in GS cohort
paralleled national trends (R=-0.85); smoking rates in PS patients were significantly lower for all years studied (p<0.01). After PSM, GS smokers continued to be more comorbid than respective nonsmokers, with greater incidences of diabetes, hypertension, dyspnea, and prior cardiac surgery (p<0.01); PS smokers were not significantly different than respective nonsmokers. Smokers had increased rates of superficial surgical site infections (SSI) (p<0.01), PE (p<0.01), and MI (p<0.02) for GS, but not for PS cohort. Both PS and GS smokers had increased dehiscence (p<0.01), deep SSI (PS: p=0.01, GS: p<0.01), and reoperation (p<0.01). Patients with ≥11 pack-years experienced significant increases in deep SSI (PS: p=0.02, GS: p=0.02) and reoperation (PS: p=0.05, GS: p<0.01). In GS smokers, ≥ 21 pack-years was associated with increased sepsis (p<0.01), MI (p=0.04) and organ/space SSI (p<0.01), and ≥ 31 pack-years was associated with increased dehiscence (p<0.01). PS cohorts had increased rates of wound complications for both smokers and nonsmokers when compared to GS cohorts.

CONCLUSION: This is the first propensity-matched, large-scale database analysis isolating smoking as a risk factor for postoperative complications in PS and GS procedures. The contrast in smoking rates between GS and PS patients highlights the differences in patient selection for urgent versus elective procedures. Both PS and GS smokers had increased dehiscence (p<0.01), deep SSI (PS: p=0.01, GS: p<0.01), and reoperation (p<0.01). Patients with ≥11 pack-years experienced significant increases in deep SSI (PS: p=0.02, GS: p=0.02) and reoperation (PS: p=0.05, GS: p<0.01). In GS smokers, ≥ 21 pack-years was associated with increased sepsis (p<0.01), MI (p=0.04) and organ/space SSI (p<0.01), and ≥ 31 pack-years was associated with increased dehiscence (p<0.01). PS cohorts had increased rates of wound complications for both smokers and nonsmokers when compared to GS cohorts.

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