Video Article

Two Surgeons’ Approaches to the Upper Body Lift: A Video Discussion

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Abstract

Body contouring post massive weight loss is becoming increasingly more common. In this article and accompanying video, 2 experienced surgeons, Jeffrey Kenkel, MD, and Al Aly, MD, discuss the upper body lift procedure through a moderated discussion. The goal of this article is to elucidate the similarities and differences between the surgeons’ guiding principles and specific approaches to this procedure. Topics covered in this discussion include indications, intraoperative sequencing, male chest, brachioplasty, closing technique, postoperative complications, and the typical postoperative course.

Level of Evidence: 4

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Body contouring post massive weight loss is becoming increasingly more common. The upper body lift procedure is defined by a fusion of a brachioplasty, lateral chest excision, and accompanying breast/chest procedure (Video). This procedure is particularly equipped to deal with deformities of upper arm excess, upper and lateral back excess, and a variety of accompanying breast/chest deformities. In rare cases, a patient may require separate brachioplasty and a breast/chest procedure to address isolated deformities of the upper arms and the breast/chest areas, respectively. However, in most massive weight loss patients, we see the descent of the inferior mammary fold (IMF) along with upper back excess, which necessitates an upper body lift to address the arms, upper back, and breast/chest, in a coordinated fashion.

The 3 indications for an upper body lift are descent of the inframammary fold, upper or lateral back excess, and upper abdominal rolls, which are located in the superior abdomen immediately inferior to the breast. In addition, some degree of skin laxity in all 3 areas, lipodystrophy,
and the extent of the deformity should guide operative decision making. When contemplating the risk for complications and possible staged procedures vs the upper body lift, comorbidities of the individual patient should be considered.

When a massive weight loss patient is first examined for a potential upper body lift, it is important to focus on the position of the IMF with particular attention to the lateral aspect. If the IMF is displaced inferiorly, it is akin to the base of a “pyramid” being tilted. If the base/IMF is tilted by the weight loss process, then the pyramid or breast/chest will always be tilted no matter what is done to it to improve the breast/chest shape. Thus, when the base/IMF is tilted, the deformity cannot be treated with a breast/chest procedure alone. An upper body lift is required to place the base/IMF in the correct position; then, the breast/chest can be built on a properly positioned base/IMF.

In general, these patients are highly motivated and have already made a significant commitment to positively impacting their own health. Typically, the body is deflated after this change and can cause concerns when our patients look in the mirror. Preoperatively, it is most important to counsel on and prepare the patient for the postoperative scar burden. Dr Kenkel tells his patients they are “trading contour for scar.” Patients should also understand potential complications and be educated on the typical postoperative course. Being transparent in the preoperative period is the first step toward a successful operation. Finally, nutrition is important to the healing process and should be discussed with the patients to help combat the most common postoperative complications of wound healing.

The nature of the excess skin laxity in an upper body lift patient makes marking a complex process. Both Dr Aly and Dr Kenkel choose to mark patients the day before surgery and recommend this practice for a few reasons. Predictably, the day before surgery is not rushed and gives the surgeon the needed time to mark without pressure and answer any questions the patient may have. It also gives the surgeon an opportunity to review photographs of patient markings the night before surgery to decide if any modifications should be made. Patients typically appreciate this practice. Ultimately, photographs of markings are useful for future self-assessment and improvement over time. How to mark these patients for this procedure is out of the scope of this article but will be presented in a future article on techniques.

While intraoperative sequencing and techniques may differ slightly from patient to patient, in general, both surgeons prefer to start with the arms, move to the breast, and finish with the lateral chest. Dr Kenkel first suspends the arms over the head and then moves them back to the sides upon completing the brachioplasty portion of the operation. Dr Aly prefers to have the arms free to move while performing the brachioplasty. Dr Kenkel completes most of his cases with the patient in the supine position. Dr Aly starts most of his patients in supine and then goes to both lateral decubitus positions because he prefers the upper back excisions to go back horizontally.

One of the most important goals of the upper body lift is to restore the normal anatomy of the breast/chest, which most often involves returning the IMF to its proper position along with an upward lateral sweep. For the sake of simplicity, this discussion focuses on the male chest as it is easier to understand than the female, but the same principles apply to both. As the male breast sags, the IMF descends, especially laterally, and the nipple-areola complex (NAC) is medialized. The normal position for the IMF in the male is the inferior border of the pectoralis major. Accordingly, the normal position for the masculine NAC is at or above the IMF. In most patients, the NACs in large breasts may be too large and a reduction of the size is usually required. The ideal size of the NAC is roughly the size of a 20-cc plunger head. Both surgeons typically opt for a free nipple graft over a pedicled NAC as this gives more control over the placement of the NAC and bulk in the chest. In a small subset of Dr Kenkel’s ethnic patients, a dermal pedicle with a small portion of fat may be warranted to preserve vascularity to the NAC and avoid dyspigmentation. The female breast presents with a variety of deformities and is generally more complex than the male chest. A subsequent article will discuss in depth the techniques in both the male and female chest.

In the brachioplasty portion, Dr Aly prefers his incision to be placed posteriorly as the bulk of the deformity itself is posterior on the arm. This helps avoid the major structures of the arm in the bicipital groove and allows him direct access to the excess tissue. Dr Aly tends not to use liposuction in the arms. The process of putting fluid in the tissues as well as aspirating may distort the tissue and creates “a moving target” that he prefers to avoid. Thus, a patient with completely deflated arms is ideal so that a complete intraoperative tailor tacking can take place and help achieve consistent aesthetic results. In patients who present with generous lipodystrophy, Dr Aly will use liposuction to deflate the area to be resected to allow for accurate tailor tacking. While Dr Kenkel agrees that a posterior incision is the most direct approach for the arms, over the last 15 years he has opted for a more posteromedial incision to help combat scar visibility and improve the predictability of his results. The typical distribution of lipodystrophy in the arms is more posterior and lateral than it is medial. To target this lipodystrophy, Dr Kenkel does use liposuction in his patients to help him create a better contour of the arm. Both surgeons agree that the worst scar is at the bicipital groove because of the tension that is placed on the skin in that incision. Importantly, both surgeons agree that the traditional
T-type Lockwood brachioplasty technique does not work well in this procedure. The amount of excess tissue on these patients’ arms requires the surgeon to remove that excess by crossing the axilla and going on to the lateral chest wall.

The most common complications in this procedure are related to wound healing. As the incisions are particularly long and these patients can be nutritionally deficient, there is a risk for healing complications. Patients should be medically and nutritionally optimized as well as counseled on the possibility of postoperative wound care before surgery. The second most common complication in this procedure is seroma formation. Dr Aly does not use drains, but he closes as much dead space as possible while closing. Dr Kenkel does opt for drains in his patients with higher BMIs as well as those that require liposuction.

Postoperatively, both surgeons stress the importance of ambulating early, optimizing nutrition, and a supportive compression garment. Patients typically wear the compression garments for 4 to 6 weeks. Prineo tape (Ethicon, Inc., Raritan, NJ) applied intraoperatively is removed at 3 weeks postoperatively and scar treatment is started. Patients are approved to elevate their heart rate at 3 weeks with a goal of returning to daily activities and weight-based activities by 6 to 8 weeks. Finally, both surgeons acknowledge that there is a psychological component of accepting a scar that some patients may struggle with between 1 and 3 weeks. Typically, after 3 weeks, most of these patients begin to appreciate their shape change. The surgeon should be prepared for the possibility of initial patient regret and ready to support the patient through this initial stage of change.

Supplemental Material
This article contains supplemental material located online at www.asjopenforum.com.

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