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Senile Buttock Lifting (One Case)

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Abstract

After the massive weight loss, in the gluteal region, there is disagreement with the appearance of the form and has the desire to improve its appearance. This paper describes the combination in a senile patient, the application of buttocks implants and the technique of lifting the buttocks.

Keywords: Buttock; Implant; Torsoplasty; Senile

Introduction

The senile buttock lifting is usually done in patients who have lost a lot of weight (usually after a gastric bypass surgery or another type of Bariatric surgery) and associated with aging, so have loose skin hanging them around the entire body.

They are candidates for buttock augmentation that lack of projection in the gluteal region and have the desire to improve their form [1-3].

History of the procedure

Gonzalez Ulloa in 1977 was the first surgeon in proposing to rebuild the gluteal region, either by lifting buttocks or placement by the infragluteal fold of a subcutaneous implant. With this technique, aponeurotic expansion going from the dermis to the aponeurotic of the gluteal muscle should divide and left loose skin with own displacement of the implant, the results were poor aesthetic results [4,5].

It is of vital importance to mark when the patient standing, sitting and lying (**Figure 1**).

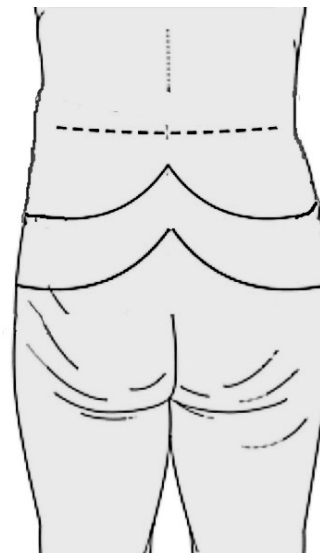


Figure 1 The part so iliac spine is identified and is marked.

When the patient is lying down, depression becomes a little more cephalic and the iliac spine is located in a most flow position. The iliac crest is palpable and is marked. As it feels, we find the trochanter its projection is marked.

Starting thorn iliac supero posterior measured 5 cm laterally by drawing a line straight into the iliac crest indicates the lateral boundary of the gluteus originally on the iliac crest. Draw a line from the side limit of the muscle of iliac crest brand to the postero-lateral trochanter appearance. In fact, this line is a projection of the imaginary line in the skin.

Prone, prior soapy water sterile asepsis and antisepsis with antiseptic sterilizing solution of over-oxidation, after isolating the anal orifice with antiseptic-impregnated gauze.

It is recommended to perform two parallel incisions, to prevent the tissue suffering of supra groove. The incisions are marked at 7 centimeters in parallel in the upper lateral part of the intergluteal sulcus to preserve the cutaneous sacral ligament. When influencing; the fascia is located 3 cm. from

the infragluteal fold. After affecting the skin, it is accessed obliquely, leaving a prominence in the subcutaneous tissue. This serves as a barrier of separation and protection of the spaces between the buttocks.

The subcutaneous cellular tissue was dissected with the fibres of the majeure gluteus muscle.

At this level, an opening is made between the medial gluteus muscle and the gluteus mayor, the inferior pyramidal muscle (sub-gluteal cell space described by Robles) [6]. The peeling should divide the muscle in half and the same amount of muscle is left front and behind the implant. If these principles are not fulfilled, we can end up dissecting deep or superficially or even leaving the muscles, either anteriorly or later. For the introduction of the prosthesis, the implant slides gently through the dissected spaces until its complete acceptance (**Figure 2**).

The contralateral implant is introduced, the reference position of the implants is revised, its placement and symmetry is assessed, and the suture is performed on three levels: muscle fibers and subcutaneous tissue with Vicryl 3-0 and skin with Nylon 3-0 [7,8].



Figure 2 The implant slides gently through the dissected spaces until its complete acceptance.

It was combined with the lifting of the buttocks, and the scars are located, in the posterior side, at the level of the iliac spine Antero Superior, approximately three fingers below the iliac crest.

In an approach in the lower back region, the incision extended posteriorly along the entire circumference of the patient's torso, through which excess skin and fat were eliminated (**Figure 3**).



Figure 3 Drainage tubes were placed to prevent fluid buildup.

Once the excesses of skin and fat are removed, it is closed in 3 planes. Drainage tubes were placed to prevent fluid buildup (**Figure 4**).

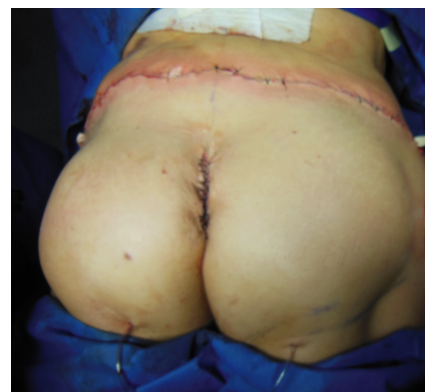


Figure 4 Early ambulation allows the implants to "settle" in position.

In the course of evolution, there are complications resulting from the trans operative management: Large undermining, which cause displacement and/or rotation of the implant, retraction of the skin, by accumulation of fluid in dead space, and asymmetry between other (**Figure 5**) [9-11].

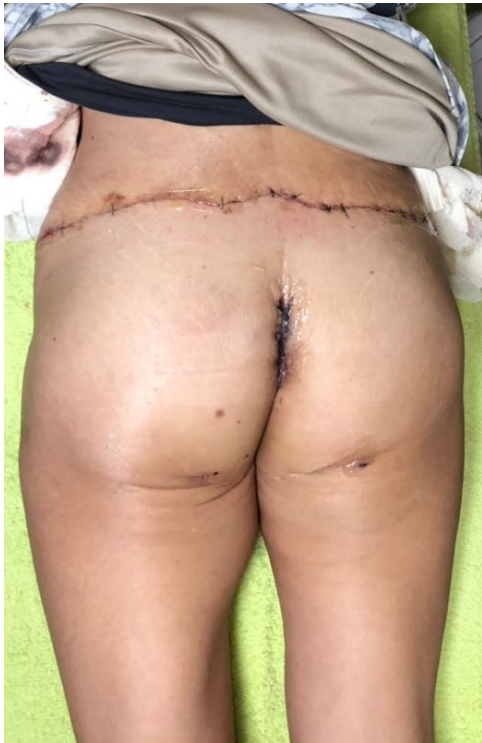


Figure 5 Appearance of the shape of the buttocks.

Case Presentation

It's a 73-year-old female patient, which concerned inconformity with the appearance of the shape of the buttocks. With this combination of techniques the folds of the back were smoothed and the buttocks were raised and with better shape. There is a lot of satisfaction in the patient for the considerable improvement in the appearance. Results of this procedure are shown in (Figures 5-8).



Figure 6 Left pre-surgical posterior view and (Right) post-surgical posterior view. a) After and b) Before.



Figure 7 (Left) Pre-surgical lateral view and (right) post-surgical lateral view.

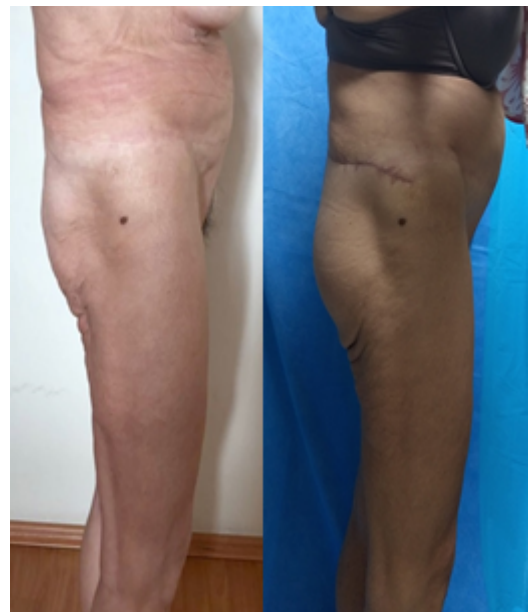


Figure 8 Left Pre-surgical lateral view and (right) post-surgical lateral view.

Discussion

The surgical techniques described have been extended to treat this population of patients. Sometimes there are complications resulting from the trans operative management: Large undermining, which cause displacement and/or rotation of the implant, retraction of the skin, by accumulation of fluid in dead space and asymmetry between other.

Conclusion

After the massive weight loss associated with bariatric treatments for obesity creating severe deformities, it has

accelerated the development of various medical and surgical procedures for body shaping and to give better shape to the gluteal region.

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