

Abdominoplasty



Abdominoplasty, commonly known as a “tummy tuck”, is a procedure that involves the excision of excess fat and skin to create a flatter, more youthful abdomen. The best candidate for an abdominoplasty is one who is well motivated to improve upon his or her present condition, who has maintained a stable weight appropriate for their body habitus and who has excess abdominal skin, stretch marks, fat and/or muscle laxity of the lower abdominal wall, also known as diastasis recti.

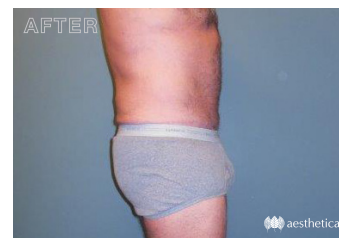
PROCEDURE: The tummy tuck operation involves making an incision that typically falls along the natural skin creases of the lower abdomen, usually correlating with the bikini line. The incision is then taken down through the skin and fat, creating a flap of tissue. The abdominal wall fascia and rectus muscles are identified. This flap is then dissected off of the abdominal wall up to the rib cage.

A small incision is made around the umbilicus (belly button) and the umbilical stalk is preserved. Once the flap is elevated, abdominal wall laxity (diastasis) is identified and is reduced by suturing the abdominal muscles together from the xiphoid process (sternum) down to the pubic crest. This draws the tissue in from either side, folding it in on itself, and burying it below. It brings the muscle bellies of the rectus abdominis muscles back into the midline position as they were prior to pregnancy. This obliterates the large stretched out fascial area between them. The result is a nice, flat abdomen.

The patient is then put into a flexed position, the abdominal skin and tissue is then drawn down and the

excess is removed. A new site for the belly button is identified in the midline of the flap of tissue. The umbilicus on its stalk is brought out and sutured into position. The umbilicus is a very key part of this operation. It is very important to create a very youthful looking umbilicus, which requires subumbilical defatting and appropriately placed stitches to draw the belly button down to create that youthful “innie” with hooding.

Since a significant amount of skin is typically resected, it is necessary to keep the patient bent so as to permit closure of the incision. Ultimately, the skin relaxes or stretches and the patient is able to stand in an upright position approximately one week postoperatively. Drains are placed underneath the abdominal flap and brought out through the pubic mons area at the time of surgery. These drains will typically be removed at about ten days postoperatively, although some may take longer depending upon the amount of output. The patient is kept overnight at the surgery center for safety purposes and for the comfort of the patient.



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RECOVERY: The patient will need to wear a compression garment, record the drainage that is collected, and remain in a jack knifed position as they walk at least three to four times a day. By about one week postoperatively, the patient is able to stand in an upright position. At about two weeks, the patient is able to return to sedentary work activities without any type of lifting or stress. Some may take up to three weeks to get up to this point. It is important to stress that the patient is restricted from excessive activity until eight weeks postoperatively in order to permit the sutured muscle of the abdominal wall to heal adequately so that it will not break open and become lax again. Initially, only the sutures are holding it together, which can be overcome by excessive stress exerted by the patient.

Two important points need to be made about abdominoplasty. First is that an abdominoplasty is not typically a weight reduction procedure, rather a body contouring procedure. That is why it is important that a patient be at their stable weight for their body habitus prior to surgery. Second, contraindications to abdominoplasty surgery are future planned pregnancies and medical conditions that may make the procedure unsafe.

COMPLICATIONS: *Abdominoplasty surgery is associated with potential complications, as with any surgery that is performed. Some common complications are listed below:*

Infection: Infection is uncommon but can occur 1-2% of the time

Hematoma: A postoperative collection of blood in the area of dissection is one of the more common complications. Occasionally, a hematoma will become significant enough that it will require an immediate return to the operating room for evacuation and control.

Seroma: Drains are placed at the time of surgery to drain the excess fluid that will occur because of a large area of dissection. A Seroma is an excess fluid buildup underneath the flap. If a seroma does occur, then it will require aggressive postoperative aspiration.

Skin slough: Skin slough is perhaps one of the most concerning complications but is very rare. When an abdominal wall flap is created at the time of surgery blood supply is decreased. If, for some reason, blood supply to the flap is inadequate or too little, then the skin will slough (die). If skin slough does occur, then it may require a return to the operating room for debridement and care of the wound. It may require re-advancement of the flap and other techniques to get it closed. Several operations may be required.

Scar formation: Generally the scars heal well, but occasionally they can become hypertrophic, leading to tender, elevated, irritated and red scarring.

Bowel perforation: When abdominal wall plication is undertaken, it involves suturing the outer layers of the musculofascial layer of the abdominal wall together rolling the diastasis inward. It is possible that the bowel can be injured at this point, especially in patients who have had previous surgery where the bowel may be stuck up against the abdominal wall in a thinned area in any unnatural manner. This is rare.

Pulmonary embolism: Pulmonary embolism can be a serious complication. It occurs when blood clots develop in the lower extremities during or after surgery which subsequently dislodge and travel to the lungs where they can block oxygenation of blood and possibly lead to death. To minimize this potential complication, patients are placed in compression boots preoperatively. They are engaged in early ambulation following surgery, as well as exercises in the bed to help increased blood flow in the venous system. A history of pulmonary embolus, a history of smoking, or obesity all increases this risk. You may be given a prescription for lovenox – A specialized blood thinner

Umbilical malposition: Occasionally the umbilicus or belly button which is often naturally off center pre-operatively, will be off midline postoperatively. Such correction may be a simple in-office procedure or a more complex situation where the patient needs to undergo general anesthesia once again.

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