Lower Body Lift

Body contouring of the trunk and lower body is accomplished by either liposuction alone, excision of excess tissue or a combination of both to achieve optimal results.

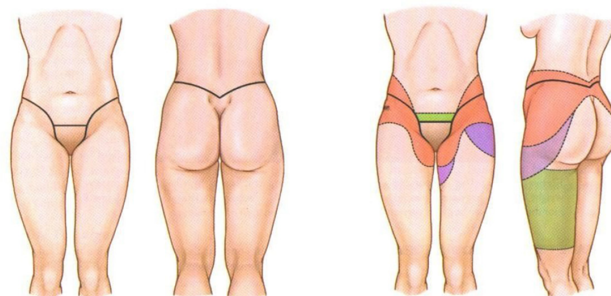
PROCEDURE: There is quite a bit of confusion as to what is involved in a lower body lift procedure. Oftentimes, individuals will confuse a belt lipectomy with a lower body lift. A belt lipectomy is not a body lift and only removes the excess fat and skin around the waist. There is minimal lifting with a belt lipectomy. If a true body lift is needed and desired, a belt lipectomy is inadequate and a much more extensive body lift procedure needs to be performed.

Patients who are a candidate for lower body lift surgery may also need to address the abdomen and inner thighs at a separate stage to optimize results. The typical candidate for lower body lifting and abdominoplasty is an individual whose aesthetic contour concerns are localized fat deposits of the abdomen, hips, thighs, buttocks along with significant skin laxity, excess skin, ptosis (sagginess) of the buttocks and abdominal wall laxity.

Abdominoplasty helps address most of the anterior trunk and to a small degree the anterior and medial thighs. Lifts of the lateral thigh, transverse flank and buttock and lateral posterior trunk (lower body lift) area help tighten a droopy buttock. Finally, there is the medial thigh lift, which addresses the loose skin and fat of the inner thigh.

Classic body lifting techniques do not adequately address skin laxity of the lower body or buttock ptosis. In fact, some of these procedures have been performed for quite some time. Ivo Pitanguy M.D. originally designed the thigh and buttock lift back in 1964. Since then, many modifications and improvements have been developed. Most recently, Ted Lockwood M.D. developed the concept of lower body lifting with the transverse flank, thigh, buttock lift, high lateral tension abdominoplasty and medial thigh lift. His focus is the concept of aesthetic restoration surgery, in which the entire lower body is restored to its youthful state as best possible.

As mentioned, there are many facets to restoring the lower body. In most patients, a tummy tuck will be performed first as a stage one procedure. Once this has healed (4-6 months), the patient will be taken back to surgery for stage two, in which a transverse flank, thigh and buttock lift will be performed. About 9-12 months after the stage two procedure, a third stage excisional medial thigh lift can then be performed to complete the procedure. Again, the appropriate approach to each patient is determined at the time of consultation and is based upon the patient's physical health, medical condition, concerns, presentation and understanding of the procedure.



Body lift surgery is a major operation. It is important that the patient not only be at a stable weight at the time of surgery, but be developing a lifestyle which will lend itself to not only a safe outcome in surgery, but a consistent and healthy pattern of dieting and physical exercise that will maintain the result. This will involve both short-term and long-term goal planning.

Lower body lifting is a combination of procedures that can yield stunning results. However, it is emphasized that it is a major procedure. In fact, some stages can last up to eight hours in the operating room, depending upon the amount of skin, the extent of skin laxity, and amount of fat.

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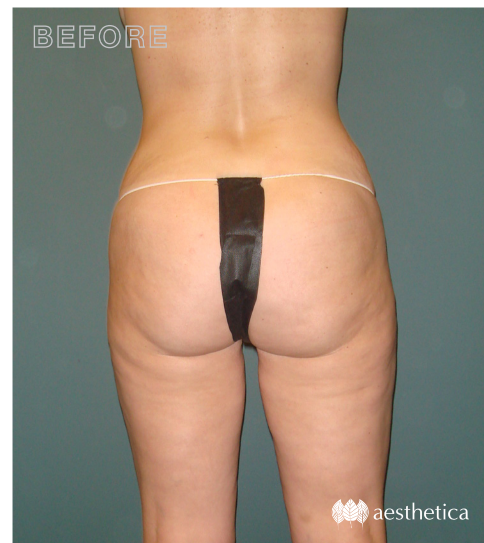
Lower Body Lift

RECOVERY: The patient is kept at the surgery center for 1 to 2 nights following surgery for the safety and comfort of the patient. Patients will need to wear a compression garment for 8 weeks. Drains will be placed at the time of surgery and will be removed around 10 to 14 days post operation depending upon the amount of drainage output that occurs. Ambulation is started after surgery and should be done three to four times a day minimum. About three weeks after surgery the patient can get back to sedentary-type work activities. Patients will be permitted to gradually increase activity with full activity resuming at 2 months post op.

COMPLICATIONS: Some potential complications and risks associated with these procedures are scarring, asymmetry, contour irregularities, infection, bleeding, hematoma, seroma, skin flap necrosis, pulmonary embolus (blood clots that travel to the lungs), alteration of sensation, vascular compromise, lymphatic injury with swelling of the legs, wound infection and breakdown (also known as wound dehiscence). Major complications such as blood clots with pulmonary compromise, wound infection or major necrotizing infections and death are rare. It should be noted that if complications do occur, they may even require re-operation and/or admission to a hospital. This may not be covered by insurance.



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