LIPOSUCTION for men

by **Steven Gitt, MD, FACS**

Liposuction is the most commonly performed cosmetic surgery procedure today. The evolution of the various liposuction procedures over the last 20 years is a story in and of itself. In the 1980s, dry liposuction was the standard, wherein the surgeon simply made an incision, placed the cannula into the soft tissues, and began removing fat. This fat came out as two parts fat and one part blood, limiting us to a total aspiration of 1500cc (which included 500cc of blood, the maximum amount before critical blood loss). Tumescent liposuction became popular in the early 1990s, wherein we pre-injected the areas to be treated with a dilute solution of lidocaine and epinephrine. The lidocaine decreased pain during surgery and for the rest of that day, while the epinephrine constricted the blood vessels, dramati-

cally decreasing blood loss. Now, because we could limit blood loss to 1 to 2 percent of the volume aspirated, we could be much more aggressive: aspirations of over 10-15 liters of fat became feasible in selected patients.

Ultrasonic liposuction (UAL) was introduced in 1995 and was favored because it liquefied fibrous fatty deposits such as those on the breasts, buttocks and back using ultrasonic waves from the cannula tip; the liquefied fat was more easily removed. As our experience grew, it became apparent that there was an increased rate of certain undesirable complications with UAL, so it has fallen somewhat out of favor. Power-assisted liposuction (PAL), where the cannula is reciprocated back and forth by an electric motor in the hand piece, has supplanted UAL as the procedure of choice over the last few years. PAL has the advantages of UAL without the increased undesirable complications.

Liposuction is a very effective tool in body contouring of post-bariatric patients. Some patients are unable to make their target weights and will benefit from more aggressively done "high-volume" liposuction (typically greater than five liters of fat removal), while most cases involve the need for body sculpting, wherein unsightly bulges and fat deposits are artfully removed. The most common areas that are treated in men are the flanks and abdomen.

In our practice, approximately 10 to 15 percent of our patients will feel the need for some type of "revision" or secondary touch-up liposuction surgery. Many patients ask if the fat will come back. There is a widely held notion that the treated areas will selectively re-accumulate any fat that is re-acquired. Nothing could be farther from the truth. Additional fat does not have the ability to selectively deposit itself into or away from any particular region. New fat is deposited on the body in the same pattern whether or not one has had liposuction. Likewise, we are all born with a certain number of fat cells. This number of fat cells does not change throughout our lives. The individual cells get larger (fatter!) or smaller depending on overall weight balance. So, when we remove fat cells with liposuction, those cells are gone, period, and they do not return. The remaining fat cells have to carry the weight, so to speak. In a nutshell, what is done is done in terms of fat cell removal, and some patients will need revisionary liposuction later on.

I am often asked who is a candidate for liposuction alone as a body contouring procedure. Well, my evaluation of the body contouring patient always takes into account not only the burden of excess fat, but also whether there is excess skin. Is it good skin or bad skin (stretch marks, scars, thin skin, etc.)? Are the underlying muscles spread out too far, as may happen with massive weight loss? Are there any hernias that have to be repaired, or is it just too much fat? Once we have diagnosed the problems, we can choose from our bag of surgical tools, including liposuction, minor or major tuck procedures, hernia repairs or any combination thereof.

How long a person should wait to have liposuction after weight loss surgery is another commonly posed question. We rely on three key factors to determine whether our patients are ready for body contouring surgery after massive weight loss (MWL): body mass index (BMI), fat deposition pattern, and extent and quality of the skin-fat envelope (ref. Al Aly et al.). In other words, has this patient reached a steady-state weight? Is the fat accessible (not intra-abdominal)? Is the skin thin and laden with striae (stretch marks)? Poor-quality skin will neither retract nor reliably hold sutures, and intra-abdominal fat is not accessible to liposuction. Lastly, we prefer our MWL patients to have been at their target weight for at least six months before we contour their bodies.

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