Disclaimer

This movie is an educational resource only and should not be used to make a decision on Abdominoplasty. All decisions about Abdominoplasty must be made in conjunction with Your Surgeon or a licensed healthcare provider.
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INTRODUCTION

Abdominoplasty, known more commonly as a "tummy tuck", is a surgical procedure to remove excess skin and fat from the middle and lower abdomen and to tighten the muscles of the abdominal wall.
Understanding the Problem

There are three relevant layers, the skin, the fatty tissue and the underlying muscle. The skin can be stretched with pregnancy, the fatty layer can increase with weight gain and the muscle layer may also be stretched or weakened with pregnancy and surgery.

In considering improvement of the shape of the abdomen, each layer of the abdominal wall affected has to be considered.

(Refer fig. 1 & 2)

Who is Suitable

A suitable candidate for the correction of the abdominal wall laxity will have stretching of the skin and muscle, or accumulation of fatty tissue. Generally this is considered a cosmetic improvement but, occasionally, functional problems due to the laxity of the muscle layer can increase strain on the lower back causing backache.

This usually occurs in older people. In addition, rashes can develop in the groin area beneath lax abdominal skin.

(Refer fig. 3)
Type A

The diagrams illustrate the types of scars you can expect after the operation. In some cases, the horizontal scars demonstrated may be supplemented by a low vertical scar - due to relocation of the umbilicus or to effect adequate skin excision.

This type of scar is known as the “Inverted T” incision and is utilised only when necessary as healing may be delayed when it is used. With the advent of “keyhole” surgery using endoscopes, all the scars are becoming shorter. But endoscopy has limited applications and may not be appropriate to your problem.

(Refer fig. 4)

Type B

The diagrams illustrate the types of scars you can expect after the operation. In some cases, the horizontal scars demonstrated may be supplemented by a low vertical scar - due to relocation of the umbilicus or to effect adequate skin excision.

This type of scar is known as the “Inverted T” incision and is utilised only when necessary as healing may be delayed when it is used. With the advent of “keyhole” surgery using endoscopes, all the scars are becoming shorter. But endoscopy has limited applications and may not be appropriate to your problem.

(Refer fig. 5)

Type C

The diagrams illustrate the types of scars you can expect after the operation. In some cases, the horizontal scars demonstrated may be supplemented by a low vertical scar - due to relocation of the umbilicus or to effect adequate skin excision.

(Refer fig. 6)
This type of scar is known as the “Inverted T” incision and is utilised only when necessary as healing may be delayed when it is used. With the advent of “keyhole” surgery using endoscopes, all the scars are becoming shorter. But endoscopy has limited applications and may not be appropriate to your problem.

(Refer fig. 6)

Type D

Your Surgeon will discuss the type and site of the incision with you. Type A and C scars are the most frequently used. Type B and D scars result from endoscopic surgery.

(Refer fig. 7)
Operation

This type of procedure is performed under a general anaesthetic and requires at least one night’s hospitalisation and often three to four days in hospital.

The length of skin incision and therefore the type and position of the final scar will be determined by the deformity you have and the need to tighten the abdominal muscles to achieve a flat abdomen.

The looser the abdominal skin and the more pendulous the fatty tissue apron of the lower abdomen, the longer must be the scar across the abdomen. This is so because of the geometry of the operation and has to do with the relative lengths of the base and hypotenuse of a right-angled triangle.

Your Surgeon will explain this because you need to appreciate why the transverse scar may need to be as long as it is. All efforts are made to keep this scar as short as possible and to locate it low on the abdomen beneath your bather’s line or underwear.

(Refer fig. 8 to 14)
Operation

It is sometimes not possible to reduce the fullness of the fatty tissue in the upper abdomen for fear of decreasing the circulation to the lower abdominal skin. In the interests of safety, this may need to be done at a subsequent procedure by liposuction.

However, in most cases where less undermining of the skin is required, reduction of all fatty tissue may be possible.

The wounds on the abdomen and around the umbilicus are sutured and often only dissolving sutures are used. This wound is supported with plastic skin or micropore tape for up to six weeks to give it every chance to develop a fine scar.

(Refer fig. 8 to 14)

Position After Surgery

Dressings are applied to the abdominal wounds and the patient is usually positioned post-operatively with the legs raised on pillows to take some of the tension off the tight abdominal skin. A supporting girdle is applied in the operating theatre to support the internal surgical repair.

Movement of the feet and toes is important post-operatively and mobilisation out of bed is encouraged as soon as possible in order to limit the chance of clotting in the deep veins. I.V. fluids are usually given for the first 24 hours and this would require attachment to an intravenous drip.

(Refer fig. 15)
Where indicated, injections are given to thin the blood and minimise the risk of deep venous thrombosis. Post-operative antibiotics are sometimes given as an additional prophylactic measure against wound infection. Infection is more common when operating on fatty tissue which has a poor blood supply.

(Refer fig. 15)

Risks & Complications

Scarring

Tightening of the skin of the abdomen and reduction of fatty tissue together with tightening of the abdominal muscles is achieved at the cost of an abdominal scar which can be quite long. The degree of tightening will govern the type, length and the site of scar and this will be discussed in your pre-operative assessment. However, it should be noted that abdominal scars are always red for a considerable length of time (some months) and even after the redness fades the scar is usually wider than a corresponding scar where no tension is applied to it. In some people and on some occasions, thickening of the scar can occur and this is called keloid or hypertrophic scar. Your Surgeon has little control over this scar healing tendency in your body.

Treatments can now be applied to improve scar hypertrophy if this was to occur, but occasionally it does require additional revisional surgery. Generally speaking the scars take six to twelve months to become flat and pale. Postoperative support of the scar with plastic membrane or tape can often improve the quality of the final scar. You will be given advice on this after your operation. Your Surgeon will do all he can to help you achieve an optimal result.

Numbness

Areas of skin numbness will be present after surgery and these are most frequent below the level of the umbilicus. Over a period of months, the degree of numbness and the total area involved will reduce, but occasionally a small area on the lower abdomen will remain permanently numb. This does not usually influence normal activity and if it does occur should not be regarded as a complication of the procedure.
Bleeding
As with any operation bleeding can occur in the post-operative period. The drain tubes will cope with any small to moderate bleeding and this will usually settle within 24 to 48 hours. Occasionally however, the drain tubes will not cope if the degree of bleeding is excessive and swelling under the skin will be seen. If this were to occur it would be necessary to return to theatre for drainage of the blood collection (haematoma) and to find the vessel that is causing the problem. In the long term however, there are no substantial side effects from this. It is usually not necessary to transfuse patients undergoing an Abdominoplasty procedure, except on the odd occasion where haemorrhage or bleeding is excessive.

Swelling
It is common in the early stages to find swelling of the lower abdominal tissues to be prominent and in some ways to detract from the initial results. This swelling is usually due to tissue fluid (oedema) and can be marked if liposuction is performed at the same time as skin excision. It will normally settle over a period of months. A tight girdle or surgical garment can be used to reduce the degree of swelling and Your Surgeon will advise if this is necessary. Other treatments such as ultrasound can be used to improve irregular swelling or lumpiness under the abdominal skin.

If large amounts of fat have been removed from the lower abdomen the fatty tissue remaining in the upper abdomen can cause the appearance of the swelling in this area. This cannot usually be removed at the time of surgery as interference with the blood supply to the skin can occur causing lower abdominal skin death or necrosis. At a later date liposuction in the area of the upper abdomen adjacent to the rib margin can be performed to reduce the fatty tissue in this area.

Swellings at the outer end of the lower abdominal scar can be prominent and this may also require additional surgery either by excision or liposuction to reduce these prominences called “dog ears”.

Skin Death or Necrosis
If the skin is pulled too tightly or lifted too widely on the lower abdomen the blood supply to that skin can be decreased to the point where the skin can die. This is particularly the case if the fatty tissue in the upper abdomen is reduced too much or if liposuction is performed at the same time as a full Abdominoplasty is performed. If this occurs it sometimes requires excision and skin grafting. Fortunately this is a rare complication. It is more likely to occur in patients who are or have been smokers.

However, in all cosmetic procedures, your surgeon is attempting to achieve the maximum improvement with the minimal risk of complications. The situation is different in every patient and how fare to go to push the envelope is always a difficult decision to take.
Wound Dehiscence

This means that the skin has not healed fully along the lower abdominal wound and may separate. Occasionally, it is possible to re-suture this area, but again it may require a skin graft to the raw area, in the short term and after healing is established the graft can be re-excised to improve the ultimate scar.

Vein Thrombosis

With any large abdominal or pelvic operation there is a chance of thrombosis developing in the veins of the calf and extending up to the large pelvic veins. If these clots break off and lodge in the lung the condition may become extremely serious. It is known as “Pulmonary Embolism”. Various prophylactic techniques are employed to reduce this small risk and cessation of hormone treatment may be necessary. In addition early mobilisation, the prophylactic use of anti-coagulant medication, and calf pumps all further reduce the risk of vein thrombosis.

Seroma

A seroma is a collection of fluid beneath the skin. Seroma is usually the result of friction of the skin flap over the underlying muscle layer. This friction causes fluid to form which is drained away by the post-operative drains.

Occasionally seroma formation may continue after the drains are removed and the patient has resumed normal activity. This causes a swelling in the lower abdomen that must be aspirated - often more than once or twice. Occasionally a seroma is not obvious and remains undetected. It may then discharge through the wound (usually at night) and soil the bed linen. If this occurs, do not panic. You are in no danger. Notify Your Surgeon as soon as practicable to have the problem managed until it settles.
Disclaimer

Although every effort is made to educate you on ABDOMINOPLASTY and take control, there will specific information that will not be discussed. Talk to your doctor or health care provider about any concerns you have about ABDOMINOPLASTY.

You must not proceed until you are confident that you understand this procedure, particularly, the complications.
YOUR SURGERY DATE

- READ YOUR BOOK AND MATERIAL
- VIEW YOUR VIDEO / CD / DVD / WEBSITE
- PRE - HABILITATION
- ARRANGE FOR BLOOD
- MEDICAL CHECK UP
- ADVANCE MEDICAL DIRECTIVE
- PRE - ADMISSION TESTING
- FAMILY SUPPORT REVIEW

Physician's Name: ____________________  Patient's Name: ____________________
Physician's Signature: _______________  Patient's Signature: _______________
Date: _______________  Date: _______________