

infection, flap necrosis, poor scars etc. By far the commonest complication is hematoma or seroma formation. Wide bore negative suction drains must be kept in place for at least 5-6 days to allow the flaps to adhere to the bed and obliterate the dead space and raw area. Once formed, they need drainage / aspiration. If not attended to early they lead to flap necrosis because extensive undermining compromises the flap vascularity. Since this surgery is performed in obese individuals where thick panniculus flaps are raised, they are always prone to fat liquefaction. Hematoma, seroma, fat liquefaction and flap necrosis make the patient prone to infection. The use of non-absorbable sutures and meshes has a potential of making these infections chronic. Flap necrosis is one of the most dreaded complications in plastic surgery. Thus, meticulous attention to detail especially with respect to tissue trauma, plane of dissection, hemostasis, tension of wound closure etc. is mandatory in getting a good result. When flap necrosis does occur it needs to be managed proactively. The necrotic flap is excised after the line of demarcation has appeared. A small wound may be allowed to heal secondarily or a thin split thickness skin graft is applied once healthy granulations appear.

As in any aesthetic procedure, it is mandatory to counsel the patients preoperatively to have realistic expectations from surgery. By and large majority of patients are extremely satisfied from this procedure. It has to be ensured that dermolipectomy is adequate and symmetrical. Liposuction must be used to give better contouring. Any secondary surgery is only undertaken after about a year to allow the tissues to resolve. Excessive flap resection is another very dreaded complication because it can lead to wound dehiscence and also pull up the pubic region or labia (in females). Further, it can lead to widening of the scars, which are difficult to correct as all laxity of tissues has disappeared because of surgery. However, scars do become supple and less noticeable with time. Hypertrophic scars also settle in due course with oil massage, silicone gel sheets, intralesional triamcinolone injections and pressure garments. 'Dog ears' in the flanks need revision after 4-6 months. Much of the abdominal striae get excised with dermolipectomy but the ones that remain are extremely difficult or impossible to correct. Placement of the umbilicus and its shape needs great attention to prevent it from having an 'artificial' look, being asymmetrically placed or being too deep. There is also a risk of partial or complete necrosis of the umbilicus.

### ABDOMINOPLASTY IN MALES

The number of men requesting abdominoplasty is much less than women, nevertheless, it remains a frequently performed aesthetic procedure in males. This is because of increasing incidence of obesity in society. In males also the shape of the abdomen reflects his fitness, health, and sexuality. Increasing body weight with loss of abdominal muscular tone due to lack of exercise are the prime reasons for altered abdominal contour.

Males present for abdominoplasty at an older age and higher weight. Their interest is often in a single region (abdomen) compared to women who generally want contouring of multiple regions like abdomen, thigh, arms etc. The male integument also varies a great deal from the females. It is less prone to overstretching and laxity, and therefore, excessive skin redundancy is generally observed in those who have undergone massive weight loss. With advancing age (from 25 years onward) the fat pattern changes in males. There is an 'internalization' of fat, with an increase in intra-abdominal fat

and a corresponding decrease in subcutaneous fat, as well as infiltration to and between the muscles. This change has the greatest impact on the appearance of the abdomen and is an essential fact for patient appraisal. Overall, there is a decline in lean body mass and a redistribution of fat which is reflected in an increase in the body mass index. The waist-hip ratio and triceps-skin fold thickness (which correlates with visceral abdominal fat) are valid measurement indices of these changes. Differences between the genders exist in the muscular layer as well. Women often present with a lower abdominal rectus muscle diastasis, creating a visible umbilical to pubic 'bulge'. In contrast, men often have a rectus diastasis in the upper abdomen, which contributes along with intra-abdominal fat to a 'bear belly' appearance. Because males have fewer variations in their presentations as compared to females the necessity for a variety of surgical procedures is less in them. Typically, 'liposuction', a 'full abdominoplasty' or a 'dermolipectomy with liposuction' is sufficient, in contrast to the wider range of procedures performed on women. In spite of these differences the endpoints of surgery are identical in males and females.

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