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# PANNICULECTOMY/ABDOMINOPLASTY

Panniculectomy is the medical term for the surgical removal of excess abdominal tissue which in lay term is called the "apron" or pannis. The Pannis is a redundant layer of skin and fat at the lowest portion of the abdominal wall. Because fat distribution is never even in all individuals, some people have significant deposit of fat at this most dependent part of the abdominal wall which further aggravates various complications especially back and joint pain. The "apron" (pannis) in an individual may weigh as little as 5 pounds, or as much as 120 pounds.

After the majority of your weight loss, "tummy tuck" abdominoplasty and panniculectomy can tighten loose sagging tissues. This surgery is designed to remove and re-drape redundant lower and middle abdominal wall skin and fat. An incision above the pubic region and extending towards the hips places the scar where it can be hidden by most clothing. The **s**kin and fat are separated from the underlying fascia (layer covering the muscles of the abdominal wall). In the standard operation this dissection continues up to the ribs exposing the vertical muscles (rectus muscles). The skin around the belly button (navel or umbilicus) is divided so the redundant tissue of the upper abdomen can be pulled down. This hole will frequently be pulled far enough down to be removed with the excess tissue. When less tissue needs to be removed, this hole may become a short vertical component of the lower scar. The abdominal wall muscles are then drawn together in the midline narrowing the waistline. This stitching firms the abdominal wall and removes some bulging. If you are also having a hernia repair it will be dealt with at this time.The repair of a hernia depends on the size of the hernia. The standard method of hernia repair involves making an incision in the abdominal wall. Hernia repair done concurently with a panniculectomy may include a midline incision as well as a "bikini line" suprapubic incision. Conversely, there may be no additional incision, other than the suprapubic incision, when the hernia repair is done concurently with the panniculectomy. This area, the hernia, is then repaired with sutures. Often a prosthetic material such as mesh, another plastic or biological material is sutured in place to strengthen the area and close the defect.

The skin flap is then stretched down, the extra skin, underlying fat and tissue is removed. A new hole is cut for the navel, if you choose to transplant your navel, and contoured to create its shape. There are other options that can be discussed with your surgeon for the look of a navel without the possible complications of the transplanted navel not taking in its new location.

There may also be some degree of Mons Pubis (the mound of fatty tissue just covering the pubic bone just above the pubic area) lift after panniculectomy.

The tissues are then sewn into place. Special tape strips may further align the skin. Temporary drain tube(s) are placed to remove fluid from under the flap. If present, you will be shown how to record the output from these drains. Dressings applied usually include one around the new navel and one over the main incision. You will be wearing an elastic garment around your abdomen. You will need to wear this support garment for about six weeks after the surgery. It helps to decrease swelling and promotes healing in the area. Complete abdominoplasty and panniculectomy usually takes two to three hours, depending on the extent of work required.

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Lost skin elasticity in older patients, which frequently occurs with slight obesity, can also be improved. Women planning future pregnancies should consider waiting. The muscles tightened during abdominoplasty can separate again during pregnancy. Skin restretched may again not return to normal proportions. Previous abdominal scars need to be evaluated during an in office examination to see if they might effect possible surgery. Prominent abdominal contour scars like those sometimes seen after Caesarian delivery and other surgery can be removed or improved.

Abdominoplasty and panniculectomy improves back pain, joint pain, skin infections and can enhance your appearance and your self-confidence. It will not necessarily change your looks to match your ideal or cause other people to treat your differently. Think carefully about what this surgery has to offer. Reasonable expectations are essential to a happy outcome.

**Planning your surgery**

You should come to the office prepared for an extensive consultation. Your surgeon will need to learn about your medical history, problems, surgery and current medications. Prior surgeries are important to tell your surgeon about. You will need to help your surgeon understand what bothers you. Redundant skin and adherent scars are a dynamic problem. While standing your surgeon will need to see how the skin drapes, where the extra tissue is located, check for hernias, and examine your scars. Your surgeon will then discuss what surgery has to offer. There are several different surgeries possible depending on the anatomical defect and the nature of your tissues. Your surgeon will then recommend what method of surgical sculpting is best suited for your problem and then discuss the risks, benefits and alternate methods of care. Understanding the benefits and limitations of surgery helps with realistic expectations.

The office examination permits an appropriate examination of the problem. At the time of your evaluation copies of:

- prior operative reports
- doctor's office notes
- laboratory results
- actual x-ray films (not just the reports)
- photographs before surgery

when available can help us better understand your needs. Your surgeon may ask for additional tests prior to surgery.

**How to prepare for this procedure?**

Your doctor will give you specific instructions to prepare for surgery but here are some general guidelines:

- Avoid aspirin, any aspirin containing medication or any other non-steroidal anti-inflammatories (NSAID), such as Motrin® or Advil®, for two weeks prior to treatment. Because aspirin thins the blood, it can interfere with normal blood clotting and increase the risk of bleeding and bruising 10 days prior to surgery.
- Smoking inhibits the healing process, so stop smoking at least 6 weeks before your procedure and if you start again, make sure it is after you are completely healed.
- Avoid drinking alcohol a few days before your surgery.

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- Make sure to follow any fasting instructions the night before and morning of your surgery. Your doctor may insist on an empty stomach depending on the type of anesthesia.
- Make sure that you arrange for someone to bring you home and to help you out for at least 24 hours after surgery.

Be sure to raise any questions or concerns that you may have about the safety of the procedure during your consultation.

**Recovery:** Although you may not be able to stand perfectly straight at first, you will be encouraged to get out of bed soon after surgery to promote blood circulation. In this early phase of healing, straining, bending and lifting should be avoided.

Although everyone heals at a different rate, you can expect that your recovery will follow this general time line: Your hospital stay will be one day. Your surgeon may need you to stay in the immediate area to maintain continuity of care for you and your fresh incision. **Call the office immediately with any unusual symptoms or concerns.**

| Within the first week | After several weeks | After a few months |
|---|---|---|
| ❑ It may be difficult to stand perfectly straight - that's okay, don't force anything<br>❑ Bruising and swelling will reach its peak.<br><br>❑ There may be drainage from the incision as well as the drains.<br><br>❑ Call the office with any changes in your incision, symptoms or concerns. | ❑ Drains are usually removed between 1-2 weeks after surgery<br>❑ You will no longer need to wear the support garment after six weeks<br>❑ You may gradually increase your activity and exercise<br>❑ You may return to nonstrenuous work (typically within the first 10 days)<br>❑ Bruising and swelling will continue to subside and you'll begin to see your results | ❑ You'll see a more accurate picture of the final result of your surgery<br>❑ Feelings of numbness or tightness will disappear. Your incision line may begin to fade from its reddish color (full fading may take a year or more)<br><br>❑ In the months following surgery, it's important to treat your healing skin with extra care - that means **avoiding sun exposure and no smoking.** |

**Complications:** This like any other major surgery can result in some major or minor complications in spite of all the precautions taken.

**PAIN:** Pain; by itself is not a complication but an expected event from surgical trauma, which is experienced differently depending among other things on ones threshold for pain. With an abdominal panniculectomy, the length of your surgical incision depends on the amount of tissue needing to be removed. The length of your incision may reflect the amount of pain and decrease your ability to move. Post-operatively, you are provided with the PCA pump until a point when pain pills or shots will control your pain.

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**SEROMA (DRAINAGE):** Surgery on fat tissue creates trauma, and along with old blood in the area, the body reacts by producing body fluid which further mixes with irrigation fluid used to wash clean the raw tissue surface during surgery. This collection in the wound is called seroma. In anticipation of seroma, two to four drainage tubes may be placed on either side of the abdominal panniculectomy wound, and usually removed when the output is scant and non-bloody. Most wounds remain swollen for up to 4 weeks. This usually goes down as the body absorbs the remaining body fluid. However, sometimes the rate of fluid production exceeds the rate of absorption resulting in body fluid drainage through the surgical incision. The quantity of drainage at times can be voluminous, and should that occur, please do not panic, but call the office immediately. This problem does not necessarily signify acute bleeding or infection but needs to be appropriately addressed.

**WOUND SEPARATION / DEHISCENCE:** This may occur up to four weeks following surgery for various reasons, but more commonly as a result of unequal tension along the incision following a sudden change in body position - as may occur during lifting, pulling or pushing action or when adopting a sitting or standing position. It is therefore recommended that you refrain from any physical activities that may endanger your wound healing, including: avoid lifting more than 15 pounds for six weeks, driving for 3 weeks and sex for 6 weeks.

**BLEEDING:** This may occur in 1-3 percent of cases in spite of the time we spend in controlling every exposed blood vessel. When this occurs following surgery, you may require observation or blood transfusion, or another surgery to explore the wound and control the bleeding.

**INFECTION:** Wound infections can develop due to the large incision area. In anticipation of this problem, patients are sent home with antibiotics for at least 10 days. Infected wounds may require daily cleansing and packing with gauze dressings along with additional antibiotics and more frequent office visits.

**SKIN BREAK-DOWN:** In rare occasions you may have sloughing off of part of the wound especially if there is a nearby scar from pervious abdominal surgery, hereby compromising blood flow to surrounding tissues. This may be managed with daily wound care, and rarely will require skin grafting. Finally, as hard as we try to preserve the umbillicus (belly-button) you may lose that during surgery or it may slough off subsequently if blood supply is not enough to sustain it. This may happen if there is an associated umbilical hernia, or scar tissue from previous surgery around the umbillicus which limits its blood supply. Preserving an umbilicus with poor blood supply due to associated hernia or scar tissue exposes the patient to more serious wound infection.

**NUMBNESS / DYSESTHESIA:** Because the nerves cut during surgery may not heal back exactly to their original form, they recover at different rates and some may not recover, leaving areas of decreased sensation and those of exquisite sensation even to the slightest touch. It takes up to six to eighteen months for nerves to show appreciable recovery.

**FIRMNESS/PUCKERING/ASYMMETRY:** After the procedure you may have or develop asymmetry or unevenness of incisional line. A symmetrical body appearance may not result. Factors such as skin tone, fatty deposits, bony prominence, and muscle tone may contribute to normal asymmetry in body features. Skin scarring or puckering; Scars may be unattractive and of different color than the surrounding skin. You may develop firmness to the area due to scarring or fat necrosis.

**BLOOD CLOTS:** Blood clots (deep vein thrombosis) can occur after the abdominal panniculectomy, just as in any other major surgery. The most common symptom is pain in the calf muscles or groin that worsens with passive movement and should not be ignored. The

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major concern is when the blood clot in the lower legs travel to the lungs (pulmonary embolism), which can be dangerous. Notify your nurse or call our office as soon as you notice a persistent pain in your calf so that the doctor can evaluate you immediately and order the necessary test. If the test demonstrates blood clots in the leg veins you may require blood thinners and this may prolong your hospital stay by about 3 days. Bloods clots can occur up to a month following surgery especially after a prolonged sitting position. Therefore, continue to move your legs and to ambulate as much as you can.

**GENERAL SURGICAL RISKS:**

- Surgical anesthesia - both local and general anesthesia involve risk. There is the possibility of complications, injury, and even death from all forms of surgical anesthesia or sedation.
- Deep Vein Thrombosis
- Pulmonary complications - Pulmonary complications may occur secondarily to both blood clots (pulmonary emboli) or partial collapse of the lungs after general anesthesia. Should either of these complications occur, you might require hospitalization and additional treatment. Pulmonary emboli can be life threatening or fatal in some circumstances.
  - Pneumonia
  - Atelectesis; blocked or collapsed airways
- Stroke
- Urinary Tract Infection
- Phlebitis (IV Site Irritation or infection)
- Wound Infection
- Gastric or Intestinal Perforation in the case of concurrent hernia repair
- Hernia and re-occurrence of hernia
- Sepsis (overwhelming infection)
- Abscess Formation