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## A New Technique for Gluteal Lifting Using Deepithelialized Dermal Flaps

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In this article, Handschin et al. [1] promote several modifications to the inferior buttock lift techniques previously described by Gonzalez [2] and Huemer et al. [3]. The main modifications include the division of the deepithelialized infragluteal crescent into upper and lower segments. The other adjustment is the subsequent anchoring of the deepithelialized flaps into the gluteal fascia instead of the ischial periosteum in order to recreate the inferior gluteal fold and provide the buttock lift. The authors describe the procedure in a series of eight patients with very good aesthetic results by postoperative analysis and patient satisfaction report and no recorded complications after a 2-month follow-up.

The inferior gluteal lift is a very powerful and effective tool in the appropriate candidate. It improves the inferior gluteal fold and the skin and subcutaneous tissue of the superior posterior thigh. The procedure is indicated in patients with mild buttock ptosis with excess skin and subcutaneous tissue in the inferior gluteal fold or “banana fold.” It can also be used to improve a double infragluteal fold, to correct infragluteal fold asymmetry, or to shorten a long buttock when combining it with an upper buttock lift. It is indicated when the maximum point of buttock fullness is at the mid to upper portion of the buttocks, which should coincide with the level of the pubic symphysis [4]. If the

maximum point of fullness falls below this line, then a superior approach and/or augmentation should be contemplated [5]. Furthermore, the inferior gluteal lift technique is contraindicated when the excess skin and subcutaneous tissue extends laterally toward the trochanteric area because this would force the incision to extend laterally, resulting in a long infragluteal fold.

It has been widely accepted that one of the features of aesthetically pleasing buttocks is a short infragluteal fold that does not extend past the union of the semitendinous muscle with the biceps femoris, which is medial to the midaxial line of the thigh [4]. The postoperative results depicted in the article demonstrate a successful creation of an inferior gluteal fold and improvement in the contour of the inferior buttock and posterior thigh skin. Yet, the resulting inferior gluteal fold is long and extends into the trochanteric area. Unfortunately, only one patient was depicted in the postoperative images.

We agree that avoidance of anchoring the dermal flaps to the periosteum of the ischial tuberosity would result in less postoperative pain as described by the authors. We routinely extend horizontal medial thigh lifts posteriorly into the inferior gluteal crease to create an improved infragluteal fold and lift the skin and subcutaneous tissue of the medial posterior thigh. In our experience with inferior gluteal lifts and horizontal thigh lifts, we have avoided scar migration and recurrence of ptosis by anchoring the superficial fascial system of the lower skin flap to the ischial periosteum with satisfactory long-term results [6]. We are concerned with the ability of the gluteal fascia to withstand the gravitational and muscle pull over a period of time. In their study, the patients were followed postoperatively for 2 months. It would be interesting to know whether the authors have experienced sustained long-term results without scar migration or ptosis recurrence.

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We are not as strict as Handschin et al. with the post-operative regimen in patients undergoing gluteal lift or autoprosthesis augmentation. We routinely combine the procedures with liposuction and have the patients wear compressive garments for 4 weeks. In our experience, isolated inferior gluteal lifts or horizontal thigh lifts do not require drainage since there is not a large dead space. Patients are allowed to sit and lie on their backs. Drains are placed when performing a superior buttock lift with autoprosthesis augmentation.

Interestingly, six of the eight patients in the series had undergone previous liposuction and lower body lifts. The fact that the patients sought correction of the buttock contour after a lower body lift emphasizes the importance of providing buttock volume at the time of a lower body lift to avoid a flattened and/or ptotic gluteal contour and patient dissatisfaction. Our preferred method of adding buttock volume during a lower body lift is an autoprosthesis buttock augmentation [7].

The authors revisit and demonstrate an effective alternative to achieving improved lower gluteal fold contour with very good symmetry and patient satisfaction reported. The procedure is effective in the appropriate candidate. It is an alternative if the patient refuses more aggressive procedures or extensive surgical scars. The procedure may be used to extend medial thigh lifts. It is still uncertain

whether fascial anchoring is as effective as ischial periosteal anchoring long term, although it may be less painful for the patient.

## References

1. Handschin AE, Mackowski M, Vogt PM, Peters T (2010) A new technique for gluteal lifting using deepithelialized dermal flaps. *Aesthetic Plast Surg*, 34. doi:10.1007/s00266-010-9447-4
2. Gonzalez R (2006) Buttock lifting: How and when to use medial, lateral, lower, and upper lifting techniques. *Clin Plast Surg* 33: 467–478
3. Huemer GM, Dunst KM, Schoeller T (2005) Restoration of the gluteal fold by a deepithelialized skin flap: preliminary observations. *Aesthetic Plast Surg* 29:13–17
4. Cuenca-Guerra R, Lugo-Beltran I (2006) Beautiful buttocks: characteristics and surgical techniques. *Clin Plast Surg* 33(3):321–332
5. Sozer SO, Agullo FJ, Palladino H (2008) Autologous augmentation gluteoplasty with a dermal fat flap. *Aesthet Surg J* 28(1): 70–76
6. Sozer SO, Agullo FJ, Palladino H (2008) Spiral lift: medial and lateral thigh lift with buttock lift and augmentation. *Aesthetic Plast Surg* 32(1):120–125
7. Sozer SO, Agullo FJ, Wolf C (2005) Autoprosthesis buttock augmentation during lower body lift. *Aesthetic Plast Surg* 29(3): 133–137