

## **Mr Michael Cadier**

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### **Thigh Reduction**

#### **Thigh reduction - General Information.**

The ideal thigh appearance is a smooth contour running down from the hips with taut skin. With a variety of processes, including a natural propensity, weight change and the ageing process the thigh appearance may become undesirable. Thighs can have areas of specific sagging – the upper inner thighs, or generalized sagging. There may be contour problems with areas of excess fat deposition (the upper outer thighs and inner knees are common sites). Many of these problems can be helped by surgery. Thigh reductions are frequently requested by patients who have undergone massive weight loss and may form part of a package of skin redundancy corrective surgery.

#### **What is a thigh reduction?**

There is no one operation to correct the thigh shape. In isolated bulges in patients with relatively taut skin liposuction alone may be beneficial. In patients where there is sagging in the upper inner thighs a medial thigh lift may help, or in generalized sagging a vertical thigh lift may be more appropriate. Frequently these procedures are combined with liposuction. Although thigh reduction surgery can provide very pleasing results, they are relatively uncommon operations as many patients will be put off by the scars and the limitations of the surgery. Also, in some cases simple weight reduction with toning exercises may be more appropriate.

## **Thigh liposuction.**

Thigh liposuction alone is a reasonably straightforward procedure, which leaves a few usually inconspicuous scars, is relatively low in risk and recovery is usually rapid. However, the effect of thigh liposuction alone will be limited if there is any skin excess or if the skin tone is poor. If these problems are present then the effect may be limited and in certain cases liposuction may be detrimental. Although techniques of ultrasound and laser assisted liposuction have over the years been proposed as means of skin tightening the effect is very limited and there is a potential risk of damage to the skin, which may lead to scarring or skin loss. The rest of this information sheet is not relevant to thigh liposuction alone.

Further details can be found in the Liposuction information sheet.

## **Medial Thigh Lift**

When there is an excess of skin in the upper inner thigh then a medial thigh lift may be appropriate. In this procedure fat is removed by liposuction under the skin to be removed to preserve the vessels, nerves and lymphatics, then the overlying skin is removed from the upper inner thigh leaving a scar that runs as close to the skin crease as possible in front and extending to the buttock crease behind. In the inner part of the thigh the scar is placed as high as possible but usually sits 1-2 cms below the crease, as a result of gravity pulling the scar down. When there is fat excess liposuction may be added. The operation usually takes one to one and half hours to perform under a general anaesthetic, and requires a one night stay in hospital post operatively.

## **Vertical thigh lift**

This operation aims to tighten up the whole of the thigh by excising a large ellipse of skin – in an up down direction – from the inner thigh. Again fat is removed by liposuction under the skin to be removed to preserve the vessels, nerves and lymphatics, then the overlying skin is removed. Frequently liposuction in other areas is also performed. Although this operation will

tighten the whole thigh it leaves a scar that is potentially conspicuous. The incision line is sutured in multiple layers to try to keep it as fine as possible, however, scars in this region may stretch and become red and raised for many months before gradually fading. This operation usually takes two, to two and a half hours, to perform, and requires a two night stay in hospital post operatively.

### **Circumferential thigh lift**

This is an unusual operation in which the whole thigh skin is elevated by a circumferential skin excision at the top of the thigh. It is reserved for cases usually where there has been significant weight loss. Because patients need to be turned the operation may take 3-4 hours and requires 2-3 days in hospital post operatively. The recovery is relatively prolonged.

### **Pre-operative advice.**

In order to optimize the result and minimize the risks a number of factors should be considered. Smokers have a much higher risk of developing complications. It is therefore advised that they should refrain from smoking for ideally four weeks prior to, and four weeks following surgery. Aspirin and related anti-inflammatories should be avoided for a similar time period. It is recommended that patients on the combined oral contraceptive, and hormone replacement therapy, should stop these for four weeks prior to, and four weeks after surgery, as they may be associated with an increased risk of deep vein thrombosis (DVT). For patients on the pill alternative forms of contraception should be used. Patients who are overweight also have a higher risk of complications, and abdominoplasties should not be seen as a way of losing weight. If patients are dieting they should aim to get to their desired weight pre-operatively. Mr Cadier and his team have the policy that such surgery will only be offered to patients with a Body Mass Index (BMI) of less than 36. The BMI is calculated from the weight and height, and there are many simple tools available on the internet to help perform this calculation. Patients with a BMI of 36 or over have much higher risks both from the surgery and the anaesthetic and the risks therefore potentially outweigh the benefits.

### **What happens before the operation?**

At the initial consultation with Mr Cadier after discussing regarding the specific concerns a full medical and surgical history will be obtained. Details regarding the operation, the aims, the limitations, the recovery and the risks will be discussed. Before the operation you will usually attend for a pre-operative nurse led assessment. You may require a blood test. Any significant health problems not previously identified may be discussed with Mr Cadier or the anaesthetist, and a further assessment may be required to determine suitability for the procedure.

At admission you will again be assessed by the nurses and you will be measured for a pair of compression stockings. These are worn to reduce the risk of thrombosis formation and should be worn for a minimum two weeks post-operatively. You will be seen by the anaesthetist prior to surgery and be able to discuss issues pertaining to the anaesthetic and also pain relief in the immediate post-operative period. You will also see Mr Cadier who may make some pre-operative markings and will take photographs for the medical records.

### **What to expect immediately after the operation**

Suction drains may be used to help reduce fluid accumulation under the skin. Your blood pressure and pulse will be taken regularly following your return to the ward. You will have an intravenous infusion (a drip), which is usually removed after 24 hours once you are able to tolerate diet and fluids comfortably. If you experience any pain or discomfort following surgery painkillers are given either by injection or as tablets. The day after surgery you will be encouraged to gradually increase your mobility. Assistance will be given with hygiene until you are able to manage independently. Following removal of your drains you will be advised to rest in bed. At the end of the operation you will may have been fitted with a pressure garment. This helps to provide support and also helps in the moulding process, especially when liposuction has been undertaken. You will be advised to wear this pressure garment for six weeks post-operatively.

### **What to expect after discharge.**

Your length of stay in hospital is variable and depends on many factors but is usually 2 days. Following the thigh reduction procedure dressings are applied where appropriate (in the groin region dressings are avoided) in the operating theatre. These dressings are usually left intact for seven days following surgery unless they become messy, in which case they are changed prior to discharge. Patients are invited to re-attend at 1 and 2 weeks post discharge for a wound check by the nursing staff and a change of dressings – these usually being required for a total of two weeks. Any skin tapes that are applied directly to the wound should be left longer if possible. From two to four weeks postoperatively (once the tapes have dropped off) the wound should be massaged once or twice a day with Vitamin E containing cream or lotion.

The wound should be kept dry whilst dressings are in place, or if there are no dressings for a minimum of 10 days, following surgery. During this period of time patients are advised to wash with a flannel. After this period the patients can get the wound wet provided there are no significant wound problems. Prolonged soaking in a bath should be avoided for three weeks postoperatively. Although the drains are usually removed before discharge, occasionally one drain is left in for an extra few days. You will then be asked to return to the hospital for removal of the drain. Occasionally following removal of the drains fluid accumulates under the skin. This is called a seroma and may require aspiration in the outpatients on several occasions. Some numbness around the scar lines is inevitable following the surgery. Although it will improve over time some permanent numbness around the scar will persist. Some bruising and some swelling are also inevitable. These increase with the magnitude of the procedure and are more pronounced when liposuction has been performed. The bruising usually resolves after 1-3 weeks, but the swelling may persist for 1-3 months and in some cases may persist longer. Using a pressure garment for a longer period is very occasionally required.

At discharge a letter will normally be sent from the ward to your General Practitioner informing them of your admission and of the procedure undertaken. Patients are encouraged to keep their GPs informed however should they wish the admission to remain confidential

please inform the ward staff and no communications will be sent.

### **What restrictions are their following surgery?**

For the first one to two weeks following surgery patients should rest and convalesce. They should refrain from driving or from undertaking any light housework. After this two week period light housework and gentle activities can be undertaken, gradually building up over a six to eight week period. However, heavy lifting or any vigorous sporting activities (aerobics, tennis, and badminton) should be avoided for two to three months following surgery. Most patients refrain from work for two weeks, however in those with physical jobs or whom recovery is delayed an additional 1-2 weeks may be required.

### **What about pain relief?**

The thigh reduction procedure can be associated with pain in the first few days following surgery. Regular pain relief is advised for the minimum of at least one week following surgery (usually a combination of anti-inflammatory medication and Paracetamol or Paracetamol / Codeine mixes). These should be prescribed prior to discharge from the hospital. Following the initial week pain relief should be taken as required.

### **What are the risks?**

The risks include the following;

- Bleeding
- Infection
- Minor wound breakdown
- Poor wound healing
- Sutures and plastic staples may extrude through the skin causing irritation
- Fluid accumulation (seroma) as described above
- Major wound separation
- Unfavourable scarring

- Asymmetry
- Fatty tissue under the skin might die (fat necrosis)
- Persistent pain
- Skin discoloration
- Persistent swelling (lymphoedema)
- Skin loss
- Numbness or other changes in skin sensation as described above
- Recurrent looseness of skin – some is inevitable
- Deep vein thrombosis and potentially life-threatening pulmonary embolism
- Anaesthetic complications
- Possibility of revisionary surgery

Bleeding under the wound may cause a haematoma – this is rare and usually occurs soon after return from the operating theatre. Most patients have to return to theatre for evacuation. There are not normally any long-term sequelae.

The commonest complication is wound infection. Occasionally antibiotics are required, and dressing may be required for a longer period. In severe infections wounds can breakdown, usually in the middle portion. This is a very unusual complication in non smokers, and patients of normal body weight. Patients who do smoke should refrain for 4 weeks before and at least 4 weeks after surgery. Usually the wounds will heal with simple dressings alone, though occasionally secondary surgery may be required.

In very severe infections the tissues can be damaged and skin loss can occur. Secondary surgery will almost certainly be required; very rarely this involves the use of skin grafts.

There will be scars. The location and extent will be discussed pre-operatively as this is the major problem with thigh reductions, as the scars may be very conspicuous. By careful suture technique and using a multilayered closure a good scar usually results however full scar maturation may take months or even 1-2 years. Some patients may however, develop a raised and stretched red scar (a hypertrophic scar) and in some cases additional measures including

silicone therapy, and steroid injections may be required.

Contour anomalies and asymmetries are almost inevitable, especially in patients who are more overweight. On occasions a revisional procedure (usually under local anaesthetic) is required to correct these problems, though usually only several months later.

Following any surgery there is a risk in developing a deep vein thrombosis (DVT). This is a clot in the calf vein of the leg. In itself it may result in pain and swelling. The risk is that should the clot separate from the vein it can move to the lungs resulting in a pulmonary embolism. This is a potentially life threatening situation. All attempts are made to reduce the risk using compression stockings during and for two weeks after surgery, using pneumatic compression devices on the legs at surgery and in the immediate post-operative period, by encouraging early mobilization, advising patients to stop the combined oral contraceptive pill four weeks prior to surgery and where it is felt appropriate using injections of blood thinning agents.

Provided that patients are realistic about the expectations and understand what can and what cannot be achieved as well as appreciating the inevitable scarring then patient satisfaction can be high.

Most of the time, the surgery and the subsequent post-operative recovery are uneventful. When complications do occur all attempts are made not only to remedy the problem in as speedy a manner as possible but also to optimize the final result. As with all cosmetic surgical procedures undertaken by Mr Cadier, there is a fixed fee policy, which means that no further charges are incurred for the treatment of complications that occur within 6 months following the initial surgery. **On the unusual occasions when revisional surgery is required, provided that this is identified and agreed to prior to six months following the original surgery, and undertaken within 12 months of the original surgery, then no charges will be incurred. Any subsequent revision or patients seeking revisional surgery after six months will incur costs.**

**About your Surgeon:**



Michael Cadier was educated at the French Lycée in London, studied at Oxford University and undertook Medicine at St Thomas' Hospital, London. After training in London, Salisbury and Bristol he became an NHS Consultant in the Supra-regional Plastic Surgery Unit in Salisbury in 1996, becoming Head of this Service in 1999. In his NHS practice he developed a breast reconstruction service in Portsmouth, and in 2000 was appointed as cleft surgeon to the newly established Spires Cleft Centre, for which he also became the first Clinical Director in 2002. He undertook yearly cleft lip and palate Charity missions in rural Pakistan from 1996 to 2009.

He has a busy aesthetic surgery private practice along the South Coast, undertaking the full range of aesthetic surgery procedures. He has performed over a thousand facelifts, and over 1500 breast augmentations, with similar numbers for all of the more common aesthetic procedures.

He is widely published, and lectures and teaches on aesthetic surgery both nationally and internationally. In 2006 he was invited to become an examiner for the FRCS (Plast). He is the Program Director for the South Coast Reconstructive Cosmetic Surgery Fellowship, was part of the first UK delegation in the CEN in cosmetic surgery (European regulation) and chaired the CSIC Royal College committee on Clinical Quality and Outcomes in Cosmetic Surgery.

The British Association of Aesthetic Surgeons (BAAPS) is the leading organization for aesthetic surgery in the UK. He was elected to BAAPS Council in 2006 and was President of BAAPS from 2014 to 2016. One of his key objectives is to ensure that UK plastic surgeons of the future will practice aesthetic surgery to the highest possible and with that aim he has helped establish a comprehensive national training program in aesthetic surgery.

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