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Peter Walker is an experienced and talented Cosmetic Surgeon operating in Christchurch, New Zealand.

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Blepharoplasty - Cosmetic Eyelid Surgery . . .

BLEPHAROPLASTY IS PERFORMED TO IMPROVE the appearance of the eyes by removing excess skin and/or fat from the upper and/or lower eyelids. This makes the skin less wrinkled, folded and puffy.

Why have it done? . . .

Excess tissue above and below the eyelids tends to make people look and feel old and tired. Skin laxity and excess tissue is often associated with swelling of the underlying fat and muscle. Excision of redundant skin, muscle and fatty tissue in the upper lid helps to produce a more wide awake look, whereas the removal of excess fatty tissue and the wrinkled skin of the lower eyelid has a rejuvenating effect on the face.

"Bags" (Lower lids) . . .

Puffiness of the lower eyelids or "eyebags" is caused by swelling or growth of fatty tissue behind the muscle in the lower eyelid. This becomes more apparent in men and women with age. It may become noticeable earlier in women who retain fluid premenstrually, after crying, or in people suffering from thyroid disease. Swelling of the fat below the eye stretches the overlying muscle and skin so that it becomes loose and wrinkled.

This swelling is often more apparent in the morning because fluid, which accumulates in the fat around the eyes as you lie flat, has not had time to disperse. For this reason, it often looks worse after a hard night. This accumulation tends to dissipate as you move about

Creases . . .

These are caused by skin ageing which leads to skin laxity. The skin may also be stretched by underlying fat and muscle action. The eyelid muscles can also be thickened by screwing up the eyes as in bright sunlight. Both the excess fat and thickened muscle can be corrected at the same time as the skin is redraped to produce a smoother appearance. Excess skin is also removed.

Upper lid laxity . . .

Loose upper lid skin can impair vision and produce a tired look. Laxity of the upper lid caused by looseness of the skin itself can be corrected by blepharoplasty, but if it is caused by heaviness of the eyebrow or forehead a browlift may be a more appropriate procedure.

Who can have the operation? . . .

Most people requesting blepharoplasty are in their middle years. Young people with an inherited problem of lax upper or lower lids, or fat herniation (fatty bulge), may seek treatment. Some people have such severe lid laxity that their vision is affected.

How long does it take to recover? . . .

Expect day-stay treatment if you are having either upper or lower lid surgery. You may need an overnight stay in hospital if you are having both lids treated. You will need eye pads on your eyes overnight to rest the eyes and cooling pads for two days afterwards. Dark glasses may be needed for two to three weeks to disguise any bruising. Avoid any over-activity or heavy lifting for two to three weeks.

You will need a week to 10 days off work depending on your job, especially if it involves looking

down or having your head down. Eyelids normally heal very quickly after surgery.

Before the operation . . .

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- An examination is necessary to find out whether the problem involves the upper or lower lids, or both. Your surgeon will try to decide whether it is possible to achieve the results you want by operating on the eyelids alone, or whether it may be necessary to do some other procedure, for instance, a browlift.
- The surgeon will probably examine your range of eye movements to exclude any preexisting muscle weakness and test your eyesight. If there is any doubt about your sight, you may be referred to an ophthalmologist for further investigation.
People who are blind in one eye, or who have greatly diminished vision in one eye, are generally advised against surgery in case the normal eye is damaged during the operation.
- The condition of your lower eyelid skin needs to be assessed to make sure it has enough tone to spring back properly. If it does not, the surgeon may be reluctant to recommend surgery on your lower lids.
- The surgeon will discuss the advantages and disadvantages of having either a general anaesthetic or using local anaesthetic with sedation. It is becoming increasingly common to use local anaesthesia for this operation.
A major benefit with local anaesthesia is that it allows the surgeon to assess more accurately the amount of redundant skin, particularly in the lower lid. This decreases the risk of removing too much skin which may lead to ectropion, where the eyelid turns out, away from the eyeball.
Local anaesthesia also decreases the possibility of overlooking any complications after surgery, particularly bleeding, which might otherwise go unnoticed if you were unconscious and unable to feel any pain or discomfort.
Patients are less likely to vomit after the operation with local anaesthesia. If vomiting occurs, it may cause bleeding and swelling around the eyes.
- Costs and hospital stay are often discussed at the initial appointment. These may vary widely.

Preparing for surgery . . .

Routine blood tests may be recommended. Any history of thyroid disease should be investigated.

The operation . . .

- Surgery will be carried out in a private hospital or daycare theatre.
- You may need to be admitted to hospital two hours before surgery.

The procedure . . .

- The surgeon will mark out the incision lines with a pen and will carefully anaesthetise the eyelid skin with injections of local anaesthetic.
- The operation on both upper and lower eyelids takes about one-and-a-half to two hours.

Upper lids . . .

- The upper lid incision is usually made in the upper eyelid crease where the eyelid folds naturally when you open your eyes. It should therefore be almost imperceptible when it heals.
- The loose skin above this line is carefully removed, together with the underlying muscle and any excess fat which is visible when the eyeball is pressed gently.
- The wounds are closed with a continuous suture of very fine synthetic thread, which is easily removed three days later.

Lower lids . . .

- The incision in the lower lid is made just below the eyelashes, extending into the fine wrinkling or "crow's feet" at the outer edge of the eyes. The skin and the underlying muscle are freed to reveal any excess fat lying in little pockets just below the eye. Three or four separate pads of fat are carefully dissected and removed. The edges of the fat pads are sealed to make sure they do not bleed after the operation.
- The tension of the eyelid skin and muscles is carefully adjusted. It is important that enough skin is preserved to retain normal facial expressions, rather than putting any excess tension on the lower lid.
When the operation is carried out under local anaesthesia, the surgeon may ask you to open your mouth and look up, to make sure that only the exact amount of skin is removed. After removing the excess skin, the wound is sutured with a fine filament of synthetic thread in the same way as the upper lids.
- After the operation a drop of antibiotic and steroid solution is put into each eye before they are covered with a thin layer of Vaseline gauze and some antibiotic ointment. Some surgeons cover the eyes with eye pads. Others use only cold packs. If you tend to get claustrophobic it

- It is important that someone takes you home after the operation if you are not staying overnight as you will not be able to drive yourself.
- Complete rest is essential for a couple of days after surgery. Do not try to watch television. Avoid any excess strain which may cause bleeding or excessive bruising. Do not lie flat as this will cause severe swelling and bruising of the eyes and may delay healing. Instead, keep yourself propped up in bed with pillows.
- You should wear dark glasses at all times for the first week after the operation when you are not actually bathing your eyes. This protects them from glare, dust and wind. You will not be able to wear contact lens for at least two weeks.
- Avoid eye make-up for a week to 10 days as this may irritate the eyes.
- Some surgeons may recommend that you use cold packs soaked in saline, or saline and witch-hazel, to minimise swelling after the operation. Others may use medications during the operation to minimise swelling. The homoeopathic remedy arnica is thought to reduce bruising.
- Your surgeon will want to see you three or four days after surgery to remove the sutures. There should be no difficulty in removing them if they are single threads of synthetic material. Some surgeons still use individual sutures, which can take longer to remove
- You may develop some discomfort after the operation at the outer corner of the eyes, which can feel tight. During the first week to 10 days after surgery, you may also develop a jelly-like swelling on the surface of the eye. This may be yellowish. This is known as chemosis and is a normal post-operative condition caused by disturbing the drainage of fluid away from the tissue covering the eyeball and eyelids. It may be treated with eye drops.
- Bruising around the eyelids is inevitable because eyelid skin is thin, sensitive tissue. This usually settles completely within a week to 10 days. At first, the swelling and bruising is blue or purple but it quickly changes to a yellowy discolouration as the swelling subsides. This colour change is quite normal and is caused by blood pigments breaking down within the bruise.
- After the sutures have been removed you may prefer to wear sunglasses for a week to 10 days to disguise bruising. Your eyes are likely to feel irritated at this stage rather than painful. After this time the eyes should look reasonably normal. But it may take about six weeks for them to settle completely and for the tightness and swelling to disappear at the corner of the eyes.

It may take another three or four months before the eyes feel absolutely normal. Within a week or two after the operation you will be able to wear eye make-up and feel confident in public.

Complications . . .

- **Haematoma:** (blood collection under the skin) This is a risk, particularly in the lower lid. If this occurs after the operation you may need to be returned to surgery to have the blood removed.
- **Bleeding:** If a lot of fat has been removed from the lower eyelids you may get some bleeding under the fine covering of the eyeball itself. A red staining may persist on the outer side of the eyeball for four to six weeks.
- **Tightness:** This may occur at the outer corner of the eye, or the eye may appear rounder than it was before surgery. This is generally caused by postoperative swelling and will settle within three to four weeks of the operation.
If the skin of the lower lid has been trimmed too tightly during the operation, there may be a persistent pull at the corner of the eye for several weeks or months. This usually resolves itself without any further surgery.
- **Numbness:** There is often some numbness at the base of the eyelashes for a few weeks, so be careful when using eye make-up as the lower eyelashes may be quite insensitive.
- **Over-correction:** The upper eyelids are often over-corrected for a better, long term result. This can leave the eyelids slightly open for some weeks while asleep. If this happens, you may need to use an eye ointment to prevent the eyes becoming dry or irritated.
- **Ectropion:** If too much skin has been removed from the lower lids, the margin of the eyelid is pulled down, exposing the white of the eye below the pupil. Permanent pull-down of the lid may be caused by excessive skin excision or deep scarring. There may be a gap between the lower lid and the eyeball itself so that tears cannot drain down the tear duct properly. It may be necessary to insert a small graft at a second operation to correct this, although this is rarely necessary. Ectropion usually corrects itself with time.
- **Excessive fat removal:** If too much fat is removed it may produce a sunken, hollow appearance in either the upper or lower lids.
- **Vision:** Your ability to see should not be affected by the operation. In fact, some patients claim they can see better after removing the excess skin from the upper lids. Blindness is an extremely rare complication following blepharoplasty and is caused by uncontrolled bleeding. No cases have ever been reported in New Zealand.
- **Further treatment:** A repeat blepharoplasty is very unusual.
- **Scars:** The thin scars may be noticeable for a short time but soften quickly and can be readily covered with make-up in one or two weeks after the operation. Your surgeon will advise you when it is safe to use make-up again.



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The Facelift Operation . . .

THIS OPERATION IS DONE TO IMPROVE the appearance of the face and neck. It is the only procedure which will correct wrinkling, drooping or loose skin in those areas. Excess fatty tissue which has developed below the chin or along the jaw-line may also be removed by a small liposculpture procedure at the same time.

A facelift will not remove the forehead or frown lines, or those at the corners of the mouth, on the chin, or upper lip. A browlift may be performed in conjunction with a facelift, to raise heavy eyebrows and improve forehead lines.

Why have it done? . . .

People seek advice about facial cosmetic surgery because they have become aware or concerned about the increasing looseness or slackness of their facial skin; the appearance or thickening of jowls around the jaw-line; and/or the development of creases and a generally heavy appearance of their face and neck. They often complain that these changes make them look much older and more tired than they really are.

The descent of the facial skin and fat is due to a loss of tone because the elastic and collagen fibres of the skin gradually lose their elastic recoil or tautness. This process may start in the twenties or thirties and, although it is exacerbated by exposure to ultraviolet light from the sun and smoking, it is basically determined by our genetic inheritance. Many patients say their mothers, aunts or grandmothers had similar wrinkles and appeared to age prematurely.

Some women feel they have to set back the ravages of time in order to compete in society or continue in employment, whereas most women who request facial surgery wish to restore a younger and more attractive appearance. Men also have facelifts for the same reasons.

Applying cosmetic creams probably does very little to reverse the ageing process. Fine wrinkling of the face can be arrested or reversed only by long-term use of Retin-A (vitamin A cream or gel), chemical peeling or laser resurfacing.

To get a realistic idea of how you would look after a facelift, try lying on your back and looking up into a mirror. This will cause any loose skin to fall backwards into folds in front of your ears and the back of your neck, and make the face and neck appear firmer. This is what surgeons are trying to achieve with a facelift. There should be no tension around your eyes or mouth. This natural appearance is the ideal result of a facelift - a mask-like, tight look is unnatural and undesirable.

How long does it last? . . .



This is an inevitable question and depends on the individual. On average, a facelift will last five to ten years. However, it can be said that most people who have had a facelift will always look younger and have firmer skin than they would have had if they had not had it done. So, in many respects, the effects of a facelift last forever.

Some women seek a small retightening procedure every few years. This is a simpler operation which can generally be done on a day-stay basis in hospital under local anaesthetic.

Who can have the operation? . . .

The operation is usually performed on people in middle age. Occasionally it is carried out on patients in their thirties if their face has aged prematurely. The operation is most suited to people with accelerated or marked facial ageing.

How long does it take to recover? . . .

Expect to be in hospital for one to two days. It is advisable to take two weeks off work for initial recuperation although it may be three to four months before you see the maximum benefit of the operation.

Before the operation . . .

It is important that you have thought very carefully about why you want to have a facelift. The facelift operation is not, as some magazines suggest, a relatively minor operation which is quickly and easily performed on an outpatient basis. If it is done properly, it is an exacting procedure which needs to be performed by a skilled surgeon, working under hospital conditions.

The surgeon will discuss your reasons for wanting the operation. A facelift procedure should not be considered as a remedy for depression, or a guarantee of future happiness. In fact, it is important that you are physically and mentally well at the time of surgery.

Discuss the actual procedure with your surgeon. Some surgeons cut along the hair line, others make incisions through the hair. Sometimes there are technical reasons for these differences in design, which may be influenced by the thickness of your hair or your hairstyle, or the requirements of the individual procedure. However, it is very important that you discuss these matters with the surgeons so that you can make sure you understand how the inevitable scarring will affect the way you wear your hair.

It is advisable to grow your hair a little longer before surgery to help cover the scars which are more obvious just after surgery.

Costs and hospital stay are often discussed at the initial appointment. These may vary widely - and often include liposculpture of the neck and sometimes dermabrasion of the top lip or laser resurfacing of fine facial wrinkles.

Preparing for surgery . . .



- If you normally smoke it is essential that you discuss this with your surgeon. Many surgeons will not do a facelift procedure on patients who smoke. Smoking may seriously delay wound healing.
- Your Surgeon may advise you to wash your hair with an antiseptic shampoo for three or four days before surgery to sterilise the hair and scalp.
You will be admitted to hospital either the night before or the morning of the operation. The surgeon will see you in the ward before surgery to mark out the site of the proposed incisions and dissections. A small amount of hair may need to be cut around the ears and temple before making the marks. Very few surgeons shave off any hair before a facelift procedure.

The operation . . .

The operation may be performed either with a general anaesthetic, or a local anaesthetic with an intravenous sedative.

The procedure . . .

- A facelift takes three-and-a-half to four hours and sometimes longer.
- The incisions are made along the lines previously marked out. There are three layers of tissue involved: the skin, the fat layer and the underlying tissue and muscle layer.
- The skin is gradually lifted and peeled off the deeper tissues in front of the ears, the temple, behind the ears and over the side of the head above the hair line, while carefully preserving the important nerves and blood vessels.
- Bleeding is controlled by sealing the blood vessels with diathermy.
- The surgeon may decide to tighten up the deeper tissues overlying the facial muscles to produce a more defined jaw-line.
- Excess fat beneath the chin or jaw-line is either auctioned or excised. The superficial muscles of the neck may be tightened by a variety of techniques to define the angle of the jaw and neck.
- The loose skin is then carefully redraped, rather than tightened, in front of and behind the ears. The amount of tension applied to the skin should be just enough to make the face look firm and taut without making it look masklike, and without changing the shape of the eyes or mouth.
- The skin is carefully trimmed and tailored to fit its new position along and behind the ear and sutured with minimal tension.
- Soft rubber or nylon drains may be placed under the skin to drain away any blood or fluid that may accumulate after the operation. These will be removed one to two days later.
- After all the wounds have been sutured, the head and neck will be wrapped in soft cotton dressings and bandages and you will be returned to the ward in a semi-sitting position.

Post-operative care . . .



- **Pain:** The drains may cause some discomfort but apart from this, there should be very little pain or discomfort. Severe pain is an indication that something is wrong, usually a haematoma.

The surgeon may change the dressings on the first day after surgery or they may be left untouched for several days until the first sutures are removed. You can usually go home on

the first or second day after the operation. The sutures are removed in stages over a five to nine-day period. Most will be removed as soon as possible to avoid leaving suture marks, but it is often necessary to leave a few sutures in to prevent the wounds separating in areas where there is any tension.

Most of the healing takes place within 10 to 14 days. Sometimes this may be delayed because of small areas of skin loss behind the ears, particularly if you are in the older age group or a smoker. There may be some residual bruising of the cheeks and neck for up to two weeks.

During the healing process the skin of the face and neck may feel quite tight. This tightness may be particularly annoying during the first few weeks, especially at night, but it gradually improves. Fine lines on the cheeks which were disguised by swelling after the operation will return within a few days.

Try to sit up as much as possible for the first week after the operation to reduce any swelling. The tissues beneath the skin will be unnaturally firm for several weeks. Small blood collections beneath the skin may feel hard. These lumps can be softened with massage and ultrasound.

- **Support:** It will take time before you and your friends become used to your appearance, so the support of a spouse or partner during this period is important. Some people become depressed at this time and may need the help of an experienced counsellor or therapist.

Complications . . .

- **Nerve damage:** During the operation small sensory nerves to the facial skin are divided, so there will inevitably be some numbness. Sometimes this is localised to a small area in front of the ears, but there may be diminished sensation over a wider area of the cheeks, behind the ears and occasionally up into the scalp. This usually clears within two to three months. As the feeling returns over a few weeks you may notice strange sensations in the facial skin as the nerves regrow. These sensations are quite normal and disappear completely with time. The most serious and rarest complication of the facelift procedure is damage to one or more of the branches of the facial nerves causing weakness (palsy) to some part of the face. Temporary weakness at the corner of the mouth or forehead may follow surgery. This is caused by bruising of a nerve or muscle. Normal movement usually returns within 6 to 12 weeks. It is very difficult for patients to believe full recovery is expected, so constant reassurance and support may be needed during this time. Permanent damage of the facial nerve is a very uncommon complication of facelift surgery.
- **Haematoma:** Occasionally a large blood clot may form under the raised skin flaps in the immediate post-operative period. The surgeon will take you back to theatre to clear the clot, stop the bleeding and resuture the wound. A large haematoma causes pressure on the underlying skin and may cause the affected skin to die and delay wound healing.
- **Scars:** It is unusual for patients to be left with obvious scarring. Scars in front of the ears become almost imperceptible. The only visible scar is that which runs from behind the ear, into the scalp, and this can usually be easily hidden by the hair. Delayed healing may cause scarring which will take longer to settle.
- **Hair loss:** Patches of temporary or permanent baldness may occur where the incisions are made in the hair but these are easily hidden. Sometimes generalised hair thinning may occur even if the scalp has not been directly affected by the operation. This appears to be caused by the general upset from the operation or the anaesthetic, rather than any local damage. Normal hair growth usually re-establishes itself within several months.

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Rhinoplasty - Cosmetic Nose Surgery . . .

RHINOPLASTY REMODELS THE NOSE. This may include straightening it, reducing a large or bumpy nose, or building up the bridge line with a graft of bone or cartilage. People request a rhinoplasty because they are concerned or unhappy about the shape of their nose. Sometimes this may be the result of an accident but most often it is because, after the adolescent growth spurt, a hump develops on the nasal bridge. Sometimes an unattractive family nose may cause embarrassment. The nasal tip may be large and ill-defined. All these conditions can be helped by rhinoplasty.

Who can have the operation? . . .

Surgery can be carried out any time after physical development is complete usually in the late teens or early twenties. Sometimes younger people with serious problems have rhinoplasty.

Nasal surgery after the age of 40 may be less satisfactory because as the skin ages and becomes less elastic it does not follow the contour of the altered nasal framework as well.

Surgery should be performed only if there is a good chance of achieving the result you want. If the deformity is minimal and hardly perceptible to anyone but yourself, rhinoplasty may not produce as much of a change as you expect.

How long does it take to recover? . . .

Expect to return home the same day or spend one day in hospital. You may have a plaster on your nose for 10 days. Some airlines will not allow you to fly for at least two weeks after surgery. You may need two weeks off work.

Before the operation . . .

You should have a good idea of the shape you would like your nose to be. At the same time, you need to be realistic as it is never possible to make your nose look exactly like a model's. Nor is it possible to predict completely the exact shape of the remodelled nose. However, your surgeon will be able to give you a good idea of how the nose can be changed.

At the first appointment you will be given a general outline of the procedure and an explanation of the possible type of correction.

The shape of your nose will be recorded with drawings or photographs. Photographs may be used for more detailed planning. Possible post-operative complications and care will also be discussed and you will be invited to return if you have any unanswered questions.

Preparing for surgery . . .

If you develop any sign of a cold, infection, boils or pustules on your face within a week to 10 days before the operation, you must let your surgeon know immediately so that appropriate treatment can be given, or the operation can be postponed.

The operation . . .

- The operation will probably be carried out under general anaesthetic in a private hospital.
- Cosmetic nose surgery takes between one and two hours.

The procedure . . .

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- Many patients are concerned they may choke or swallow blood from their nose during the operation. Modern techniques and equipment ensure there is little chance of any blood or mucus getting into your lungs.
- All the surgery is done through incisions made just inside the nose. The cartilage and bony

framework of the nose are refined and repositioned between the skin and the nasal lining. Recently there has been an increasing trend to lift the skin off the nose with an additional small cut across the columella (the small column between the nostrils). This is most often done if rhinoplasty is required for a second or third time and it improves access to the nasal skeleton. Your surgeon will tell you if this is needed.

With reduction rhinoplasty, the surgeon takes away as much of the bone and cartilage as required. If necessary, the underlying soft tissue is thinned and the skin trimmed at the edge of the nostril. The skin shrinks to fit the new framework of the nose.

To straighten a twisted nose, the septum (the partition separating the nostrils) may have to be re-aligned, but a badly twisted septum is very difficult to straighten.

In augmentation rhinoplasty, a cartilage graft or bone graft is used to build up the bridge and tip of the nose.

- At the end of the operation the incisions inside the nose are carefully closed with sutures which dissolve within five or six days. Light gauze packing may be put into the nostrils and the nose is taped to maintain its new shape.
- Finally, the nose will be covered with either plaster of Paris, or a light metal or plastic splint to maintain the position of the nasal bones.
- Immediately after the operation there will be some bleeding. You may be given a small pad to wear under the nose to collect any blood.

Post-operative care . . .

After surgery, rest and keep as quiet as possible. Have only a few visitors to avoid too much talking. You will be offered sedation if you need it.

- **Pain:** It is surprising how little pain you will have after the operation, but if you have any, let the nurse know.
- **Nausea:** This is common after general anaesthesia and is treated with antiemetic drugs.
- **Diet:** As soon as you stop feeling nauseated or vomiting you will be able to have a light, soft, or fluid diet, provided by the hospital. Avoid other food. Return to a normal diet when you feel ready.
You may be able to go home the same day if you are feeling well. If you go home, somebody else must drive.
- **Bruising and swelling:** If the nasal bones are repositioned there is always bruising and some swelling of the lower eyelids. Sometimes the bruising can be severe. Drugs can be given at the time of surgery to reduce this. Most of the swelling will go down within 48 hours of the operation. Cold packs, frozen used ice-bags and arnica may reduce bruising. Keep your head elevated until the swelling subsides. Extra pillows may help. Avoid unnecessary bending or lifting.
Do not try to blow your nose or put anything inside it for at least 10 days. The sutures just inside the nostrils can be easily disturbed. If you sneeze, and your nose bleeds, squeeze the tip of the nose until the bleeding stops. Notify your surgeon.
- **Washing:** Do not get the plaster or dressings wet. You can wash your hair when you go home, as long as your head is held right back and no water runs down your face.
- Do not wear heavy glasses or sunglasses which may rest on the bridge of the nose for three weeks after surgery in case you alter the position of the healing bones.
- If packing has been used it will be removed one or two days after surgery. The plaster and dressings will be removed 8 to 10 days later. The surgeon may recommend that you replace the plaster cast at night for two or three weeks, until the bones settle. The cast gives extra support if the nose is accidentally bumped in bed and helps avoid any displacement. If you have any concerns in the meantime, let your surgeon know.
- When the plaster comes off your nasal tip will still be swollen and numb for about six weeks. Swelling of the lower eyelids will have settled down almost completely. There will be some residual bruising over the cheeks. This can be covered with make-up and disappears in about 10 days. Numbness of the bridge and tip of the nose may persist for about three months, but most of the nasal swelling should go within two weeks of the operation.
- During the pre-operative consultations your surgeon will have emphasised that it takes many months for the nose to take on its ultimate shape. When the plaster is removed there will be swelling and discoloration of the skin and you may feel apprehensive about the final result. As time passes, the nose will improve in appearance. It may take quite a while to feel totally satisfied with the change. Most people are happy with the appearance of their new nose as soon as the plaster is removed but subtle changes in shape occur over many months. Marked alterations can often go unnoticed, even by close friends or family. While this is surprising, experience shows this is usually the case and if you wear your hair slightly differently or wear different make-up or clothes, others attribute any difference in your appearance to these more superficial changes.

Complications . . .

- **Bleeding:** While bleeding is the most common complication of rhinoplasty, it very rarely occurs. When it does, it is usually minimal and can be controlled by pinching the nasal tip gently. Heavy bleeding which requires readmission to hospital is extremely uncommon. Sometimes when the packing is removed after surgery, there will be minor bleeding. You will be kept at the surgery until it stops. Similarly, as the crusts inside the nose separate during the healing process, there may be minimal bleeding.
- **Infection:** This is extremely rare with rhinoplasty and is prevented by giving antibiotics at the time of surgery. Signs of infection are throbbing pain, redness, facial swelling and sometimes

nasal discharge. Report any of these signs to the surgeon.

- **Scars:** Because the surgeon works inside the nose, via the nostrils, and the incisions are made in the nasal lining, the scars are invisible. If any incisions are needed on the outside, these are carefully made in the groove between the nose and the cheek where they will be barely visible. These incisions are sometimes required to correct a flare in the nostrils if a large nasal tip is reduced in size.
- **Dissatisfaction:** The surgeon will have advised you that it will take months for the nose to achieve its final shape. Although the shape of the nasal bridge is largely determined by the time the plaster is removed, the shape of the nasal tip may change in a subtle way for many months. During this time there may be residual swelling or slight depressions, bumps or thickenings. Most of these will disappear with time. It is important that no corrective surgery is done until the nose has finally healed. We feel that further surgery is rarely advisable within a year.

Small irregularities can usually be easily corrected with secondary surgery. Sometimes more major remodelling may be required. You will be seen at regular intervals by your surgeon for several months after the operation and can discuss any concerns.

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Prominent Ears Correction . . .

THIS PROCEDURE RESHAPES THE EARS or corrects prominent ears so that they lie flatter against the head.

Why have it done? . . .

In some children, the ear cartilage does not develop with the usual folds so the ears protrude at an angle from the head. These are commonly known as "bat ears" because they resemble the ears of a bat which do not have the folds or creases found in human ears.

Other children may have ears that are unduly prominent and protrude from the head, even though the cartilage of the ears appears to be quite well - folded and creased. This is caused by the added depth of the hollow part of the ear which increases the angle from the head.

Prominent ears sometimes cause anxiety to either the child or the parents. They can affect the choice of hairstyle and frequently affect a person's lifestyle to the extent that he or she may avoid swimming because their ears protrude through their wet hair. At first it is the parents who are concerned that their child may be teased at school and may ask to have their child's ears corrected. It is usually inappropriate to operate on children before they start school. It is best if the child is old enough to understand the reasons for surgery. An older child or young person may feel concerned enough by adverse comments, either from their peers, older children or even adults, to ask about surgery. They are often encouraged by their parents.

Who can have the operation? . . .

Experience has shown that psychological reassurance seldom makes children with this problem feel any better, so early surgery is usually recommended. There is no reason why an ear correction operation cannot be carried out just before starting school or soon after.

Surgical Technique . . .

Methods of prominent ear correction have developed and evolved over the past 50 years. Early attempts to correct the ears simply involved removing a segment of skin behind the ears and pulling the ears back into a different position. Unfortunately, as the skin stretched or grew, the ears returned to their pre-operative state. Modern operations use incisions behind the ears. Through these incisions the ear cartilage is reduced in size and missing folds are created.

How long does it take to recover? . . .

Expect a day in hospital or an overnight stay, depending on the child's or parents' wishes. The ears are usually painful after surgery and hospital is recommended for a child to get adequate pain relief and rest. The ears will be covered with dressings and the head bandaged for several days to a week, depending on the surgeon. Some padding is needed over the ears at night for the first two to three weeks to avoid the ears being displaced. Sutures are left behind the ears for a week to 10 days. Swelling and tenderness may continue for six to eight weeks and it is wise to protect the ears from any injury in the first few weeks. A soft ski band should be worn at night for six weeks or so. Physical contact sport should be avoided for at least six weeks in case the ears are damaged. It may be three to four months before the ears take on their optimal shape and before tenderness completely subsides.

Before the operation . . .

The child or young person must be involved in the decision-making process with his or her parents and the surgeon. It is important to distinguish between ears which are prominent and ears which look unnaturally big. Children's ears often look unnaturally large until the skull is fully grown so operations to correct this appearance are inappropriate. The parents should understand that prominent ear correction places the ears closer to the head and creates folds if absent. Costs and hospital stay are discussed at the initial appointment. These may vary widely.

The operation ...

The operation can be done under general anaesthesia or using local anaesthesia. We find that local anaesthetic is appropriate only for older children or adults. General anaesthesia should be used for small children.

The procedure ...

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- Surgery takes about an hour-and-a-half to two hours for each ear.
- The surgeon injects local anaesthetic around the ear to make sure the area is quite numb and pain-free during the operation.
- If general anaesthesia is given, local anaesthetic may still be injected to help with bleeding during surgery and pain relief afterwards.
- An incision is made in the crease behind the ear. This avoids the possibility of noticeable scarring. The cartilage is then reshaped and the ear sutured into its new position.
- The newly formed folds or creases in the cartilage may be held in place with small sutures tied over cotton wool packs. After each ear has been reshaped it is wrapped in a dressing of loose cotton wool and gauze. The entire head is covered with a head bandage or netting.

Post-operative care ...

The ears will be sore and tender the first night after surgery but the pain should not be intense. If severe pain develops, it is caused by post-operative bleeding, infection or a tight bandage. Whatever the cause, the surgeon should be contacted for advice. The surgeon will remove the bandage and dressing 7 to 14 days after the operation. The sutures and packing are often removed at the same time. When the dressings have been removed the ears may still be slightly swollen and tender but this will settle gradually in the next few weeks.

Complications ...

Complications are unusual with ear correction surgery.

- **Post-operative bleeding:** This may cause pain. It is rare and is always correctable if recognised and treated early. Severe pain after surgery is almost always due to bleeding beneath the bandages. Small collections of blood may occasionally develop between the skin and cartilage and it may be necessary to release these when the dressings are removed. They do not usually cause any problem.
- **Infection:** This is a very rare complication but may occur if there are retained blood clots beneath the skin. A meticulous surgical technique and the use of antibiotics during surgery almost always prevent this problem. Infection may be a cause of severe pain.
- **Scarring:** Scarring is inevitable, but the scars behind the ears usually soften and become barely noticeable. Heavy scarring is unusual. Dark-skinned people have a greater tendency to produce heavy scarring.
- **Residual protrusion:** The operation will largely correct the obvious prominence of the main body of the ear but there may still be a tendency for either the lobe, or the top of the ear to protrude further from the head than the middle part (Diagram 4). The surgeon will make every effort to avoid this type of residual protrusion, but sometimes it is unavoidable because of inherent differences in the texture of the cartilage framework of the ear. If you look carefully at the ears after the operation one ear may appear to be a slightly different shape to the other. However, this is not usually noticeable to other people, as few people look at both ears simultaneously, or compare their shape unless there is an obvious deformity. In fact, few people have two identical ears.

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Dermabrasion ...

DERMABRASION IS A SURGICAL PROCEDURE used to smooth facial skin by removing the superficial layers. The technique is often used to improve the pitting of acne scars and the irregular or uneven scarring following accidents. It can be used to improve, rather than remove, the vertical crease lines which appear on women's upper lips.

The Technique ...

A variety of abrading techniques are used. The most common is a small abrasive wheel, driven by a compressed air or electric motor. The method produces a vaporised mist of blood and skin debris, so protective masks are required. Some surgeons have abandoned mechanical dermabrasion and use coarse wet and dry sandpaper manually, which accomplishes the same result more slowly. Smoothing the skin in any condition involves removing its high spots which "elevates" the low points towards the surface, for example, with creases and acne pits.

Healing ...

The quality of healing and the risk of complications depend on the depth of dermabrasion, the anatomical area being treated and the patient's skin type. To heal satisfactorily, the deep layers of the skin (deep dermis) must be left intact. This layer is the strong, elastic reinforcing layer of the skin. When the epidermis (the top layer of the skin) is removed, it must be replaced with epithelial cells which seal and waterproof the skin.

These epithelial (surface) cells spread over the new raw surface in the same way that they do in a healing graze or superficial burn. They come from the depth of sweat glands and hair follicles which have not been completely removed and are protected in the deep dermis.

Pigmentation (skin colour) is determined by the presence of active melanocytes. These pigment-producing cells which are present in the dermis will recolour abraded skin. But if the dermabrasion is too deep they are destroyed and pale skin (hypopigmentation) results when the area heals. Sometimes the remaining pigmentary cells may become over active and darken the skin, a condition known as post-inflammatory hyperpigmentation. When this occurs, it is very difficult to treat. Hyperpigmentation appears to be partly caused by exposure to ultraviolet (sun) light during the healing phase, and is more common in dark-skinned people.

Acne Scarring ...

Acne causes extreme skin damage, with deep scarring as a result of its inflammatory process. In the acute phase of the illness the skin is inflamed and firm.

The disease eventually burns itself out but as the scars mature, the skin becomes soft and lax as it has been deprived of many of its elastic properties and has aged as a result of the disease process. Many small, deep pits may be left, as well as softer, shallower depressions.

Dermabrasion is of limited use with acne. It is not possible to restore the elastic properties of the skin and the deeper pits are generally too deep to remove completely. Scar improvement is the most that can be expected from dermabrasion, rather than a perfect result.

Deep dermabrasion may remove more pits but the chance of scarring and pigmentary change as a result of the treatment is increased to an unacceptable level. This risk is greatest along the jaw line.

Scars ...

Some people advocate dermabrasion of irregular scars in an attempt to improve contour. It can be effective, however it should not be used until the scars have had maximum time to settle spontaneously. Other surgical techniques may provide a more satisfactory result. The dermabrading of irregular scarred areas in the healing phase may produce heavy, thick hypertrophic scarring and make the problem worse.

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Crease Lines . . .

Probably the most common use of dermabrasion is to remove the crease lines on the upper lips of women. The natural movement of the orbicularis oris (the muscle which surrounds the lip) is puckering, which tends to pull the overlying skin into creases, particularly in the upper lip, but also in the lower. With time, these creases become deeper and permanent. Smoking causes further damage to the deeper layers of the skin, as does excessive sun exposure.

Men do not have upper lip creases to the same extent as women for two principal reasons: the hair growth on the lip tends to reinforce and support the skin; and men do not go through oestrogen withdrawal as some women do towards the menopause.

Dermabrasion of the upper lip can be carried out either mechanically or by hand. Scar formation is uncommon as long as the area at the base of the columella (bottom of the nose) is avoided, and if the dermabrasion is reasonably superficial. The lower lip can be treated at the same time. The angle of the mouth should be avoided as it heals slowly. Also, if there is a crease between the upper and lower lips, tightening of the mouth may occur.

If the procedure is done with care and the realisation that most but not all of the creases can be removed, the results are usually gratifying. It may be necessary to wear makeup on the upper lip if pigmentary changes result.

Laser dermabrasion or laser skin resurfacing . . .

In the last year the technique of carbon dioxide laser resurfacing has been introduced to New Zealand. Many New Zealand plastic surgeons are trained in this technique. It is likely that laser resurfacing will replace mechanical dermabrasion. Laser resurfacing has several advantages - the carbon dioxide laser removes thin layers of damaged skin with precise depth control and the procedure is bloodless. It is possible to treat fine lines beneath the eyes with the laser which was not previously possible with mechanical dermabrasion.

The Procedure is less painful after surgery than dermabrasion because the laser seals tiny nerve endings. The healing time is shorter, usually seven to ten days.

Scarring is much less likely because the laser will not damage the deeper structured layers of the skin.

Pigmentary changes are also less likely because most melanocytes will be preserved. Otherwise the comments made about mechanical dermabrasion apply to laser resurfacing.

Anaesthesia for dermabrasion . . .

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Either local or general anaesthesia can be used. For small areas, local anaesthesia is advisable. It is easier for the patient not to have to undergo a general anaesthetic, plus local anaesthesia tends to plump up the skin and make it easier for the surgeon to work. General anaesthesia is required for large areas.

Post-operative healing . . .

The speed of healing depends on the depth of dermabrasion and avoiding infection. After treatment, a thick application of a topical antibiotic is applied to the raw skin. Sometimes greasy gauze and a thin dressing of cotton gauze are used to cover the antibiotic ointment.

For the first few days, the dressing tends to become moist and a little messy but it dries quickly and should be encouraged to do so. Putting more gauze on the wound tends to keep the wound soggy, which may increase the risk of infection and delay wound healing. Over a 10 to 14-day period the entire dressing gradually lifts off from the edges. It may be snipped off with scissors as it lifts, revealing new, pink healing skin. However, the dressing should not be removed prematurely as it leads to pain, bleeding, delayed healing and increases the chances of scarring.

If dressings are not used, the ointment-covered raw surface usually heals within five to seven days without any crusting or unpleasant restriction.

Management after healing . . .

Initially the newly healed area is pink and sensitive and requires protection from the sun. As soon as the dermabraded area has an intact surface, sunblock and moisturiser should be used routinely. Sunblocks decrease the chance of post-inflammatory pigmentation, and also prevent the new skin from being sunburnt.

Moisturiser used in combination with gentle massage helps to keep the skin soft and moist. It's worth adopting this routine indefinitely. Hydroquinone and hydrocortisone ointments are sometimes used after the operation to prevent overpigmentation and scarring.

Complications Of dermabrasion . . .

- **Scarring:** This occurs if dermabrasion is carried out too deeply close to the jaw line, around

the base of the nose; or if the area becomes infected in the healing phase. Scarring can be almost impossible and time-consuming to treat.

- **Infection:** Infection tends to cause tissue destruction which slows healing and promotes thicker scarring. However, it is very uncommon if a careful postoperative routine is followed.
- **Hypopigmentation:** This occurs if the dermabrasion is carried out too deeply so that the melanocytes are destroyed in the treated area, producing paler skin. It is impossible to treat and can only be disguised by cosmetics.
- **Hyperpigmentation:** Over-active pigmentary cells can result in a dermabraded area, particularly in people with darker skin. The reasons for this are not as yet well understood. Exposure to sun during the healing phase is a major cause and must be avoided. Hyperpigmentation is uncommon following dermabrasion in light-skinned Europeans, but very common in Polynesians, Indians and Chinese. On the whole, dermabrasion is not recommended for these people, unless it is done extremely lightly and after an initial test patch. Some improvement may occur over time if sun exposure is avoided. Otherwise, fade creams containing hydroquinone in combination with retinoic acid may help, but they are rarely completely effective and covering cosmetics may be required.
- **Sensory changes:** Newly dermabraded skin is sensitive for several weeks. Tingling and burning sensations are usual and not a cause for concern. Feeling usually returns to normal in six weeks or so.

Dermabrasion is a useful technique for dealing with some surface irregularities of the skin. Although the results are usually satisfactory in carefully selected patients, they are rarely ideal and in some cases it may be advisable to consider alternative treatment.

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Breast Reduction . . .

A BREAST REDUCTION (sometimes known as mammoplasty from the Greek word meaning "shaping the breast") makes breasts smaller by removing excess breast tissue and skin. It also repositions the nipples.

A breast skin reduction, or mastopexy, is undertaken on women who do not necessarily have large breasts but who feel they have lost their shape because the skin of the breast has stretched, usually after losing weight or breast-feeding. It is a very similar operation to breast reduction but only the excess skin is removed, leaving the breast the same size.

Why have it done? . . .

A breast reduction can remove physical problems, including backache and shoulder ache, as well as the psychological, emotional and aesthetic burden of having oversized breasts. Many women who seek breast reductions have suffered endless teasing throughout their school years. They say they are unable to exercise properly as they cannot swim, run or even walk comfortably and that they are restricted in the clothes they can wear. Their breast size may have adversely affected their relationships and they often feel harassed by unwelcome comments and gestures from men and sometimes other women. Breast reduction enables many women to undertake or regain a lifestyle which was previously impossible.

Who can have the operation? . . .

Women of any age can have a breast reduction. Many women who have a reduction are in their late teens or early twenties and have had heavy breasts since early puberty.

It is an equally useful procedure in older women, many of whom wish they had had surgery earlier.

How long does it take to recover? . . .

Expect two days in hospital. It can take two weeks before a daily routine can be resumed and four to six weeks before taking part in strenuous activities.

Before the operation . . .

In general, a breast reduction produces extremely satisfactory results. Most people who are involved in the treatment - surgeons, nurses and patients - say without hesitation that this is probably the best cosmetic surgical procedure and certainly the one that produces the most patient satisfaction.

However, it is important to realise that it is not possible to reduce or reshape the breast without producing scars - around the nipple, vertically from the nipple to breast crease and horizontally, under the breast, in the breast crease itself.

By using a careful surgical technique and taking care of the wounds after surgery, scarring can be minimised.

- **Breast-feeding:** Women often ask if they will be able to breast-feed after the operation. The breast reduction operation usually performed preserves both nipple function and some of the duct system, so there is a good chance that breast-feeding will be possible.
- **Nipple sensation:** There is often reduced nipple sensation for a few weeks or months. This varies with the type of technique used and will often correct itself. Some women experience more nipple sensitivity.
- **Planning:** The surgeon will measure you to show you where the nipple and breasts would be repositioned to be in proportion to your body build. This will give you some idea of what cup size you will be after the operation as it is largely dependent on the breadth of the base of the breast and your chest circumference. For this reason it may not be possible to reduce breast volume as much as you would like, without making your breasts appear unacceptably flat.

Determining the correct position of the nipple is one of the more important tasks of planning

the breast reduction operation. The nipples are positioned 19 to 22 centimetres from the sternal notch (or top of the breast bone) when you are in the sitting position, so that they lie halfway between the elbow and shoulder at the level of the crease under the breast or slightly higher.

Photos may be taken for your records and also to help with planning. Blood tests are routinely done. Cross-matching blood is no longer routine. Modern reduction techniques cause little blood loss.

The operation ...



- Most reduction operations are carried out in private hospitals. A general anaesthetic is required.
- The most important part of the procedure is to mark out the breasts accurately with an indelible pen before the operation. This can take some time.

The procedure ...

- The operation itself usually takes about three hours, depending on the size of the breasts and the degree of reconstruction necessary.
- A keyhole-shaped incision is made around the site of the new nipple position and the breast pedicle (a flap of attached tissue which has its blood and nerve supply intact) is outlined and dissected free.
In some women with very heavy, stretched or bulky breasts the pedicle may be too long to maintain the blood supply and nerve network. This rarely happens but if it does, the nipple is removed completely and grafted back or to the esliaped breast later in the operation.
- The nipple size is adjusted to blend in with the newly shaped breasts. To achieve this, some of the surrounding areola is removed.
- The pedicle is held out of the way while the underlying fat, tissue and skin from the remainder of the breast is trimmed away from the outer, inner and upper segments of the breast.
- Bleeding is stopped by sealing the blood vessels.
- The pedicle is then placed into the newly shaped breast and sutured inside the skin to prevent unnecessary scarring.
- **Drains:** Before the wounds are closed, one or more plastic tubes are inserted into each breast to drain away any bleeding. These are left in place for one or two days. They may be uncomfortable but should not be painful.
- Within two to three days the drains are removed, the dressings can be cleaned and you can go home wearing a supporting bra. Some superficial sutures may be removed before you leave hospital.

Post-operative care ...

- The dressings may be changed two or three times at your surgeon's rooms during the first 10 days or so after you go home. Sutures will be removed between 5 - 10 days after surgery. Skim-coloured adhesive tape, applied over the suture lines, helps to keep them as fine as possible after the sutures have been removed. (It takes approximately 90 days for full healing to take place so the tape should be used for three to four months.)
- You can shower two to three days after the operation.
- It is essential to wear a well-fitted bra day and night for at least six weeks after the operation to help shape the breasts. An ordinary supportive bra is suitable. Afterwards, a bra can be worn as needed or desired, provided the breasts are still given support at some time during the day or night. If your new breasts are not supported, they will stretch.

Complications ...



- **Haematoma:** This is unusual following a breast reduction. The use of drains helps prevent this complication. A large haematoma needs to be surgically drained, the site of the bleeding found and the bleeding stopped. Leaving a haematoma in place may delay wound healing.
- **Infection:** This is also uncommon following breast reduction. The use of intravenous antibiotics helps prevent infection, as does a careful surgical technique. An infection will delay wound healing, but will not usually affect the long-term result.
- **Grafted nipples:** These "take" and settle very well and are often cosmetically indistinguishable from the pedicle transfers, but they will always have reduced sensation and will not function for breast-feeding.
- **Scarring:** It can take 6 to 12 months for the scars to fade. Sometimes scars in the breast crease may become thickened and hypertrophic (enlarged), especially on darker-skinned people.
- **T-junction:** Six to eight weeks after the operation there may be a small amount of discharge at the T-junction where the flaps of skin have been brought together in the breast crease. This is normal and happens when the internal sutures are dissolving. The skin may pull away a little at this T-junction and you may need to use some antibiotic cream and a small dressing while it heals.
- **Cosmetic complications:** It can take 6 to 12 months for reshaped breasts to take on their ultimate shape. Don't be discouraged by their boxy or pointed appearance just after the

operation. It should be possible to adjust any small discrepancy in shape under local anaesthesia some time later. More significant problems with the appearance of the breasts - including descent or sagging of the area beneath the nipple; a nipple which is in an unnaturally high position, or a breast which is unnaturally flat or boxy in appearance - may require more extensive remedial surgery.

- **Lumpiness:** Firm areas may appear in the breasts from time to time, caused by local collections of hard fat or breast tissue. Sometimes massage and ultrasound can help soften this hardened tissue, but usually they soften with time. However, if you are concerned, tell your surgeon.

Cancer Risk . . .

There is no increased risk of breast cancer following breast reduction. In fact, having less breast tissue means less risk. It is still possible to have mammography to check for breast cancer and the interpretation of any results should not be a problem. Some surgeons recommend you have a mammogram soon after surgery to compare with later mammograms. But you should let the radiologist know you have had a breast reduction.

NOTE: Insurance cover: Cosmetic surgery is not covered by medical insurance, but you may get a refund of \$800 to \$1000, depending on your policy and the company with whom you are insured. Many surgeons feel insurance companies should provide full cover for such a functional procedure as breast reduction.

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Breast Augmentation . . .

THE OPERATION OF BREAST AUGMENTATION increases the size of the breast by placing a synthetic implant either behind the natural breast or behind the pectoral muscle, but not in the breast itself.

Why have it done? . . .

Breast development at puberty may be absent, minimal or asymmetrical. This may cause practical problems, for example, finding swimwear or clothing that fits well. For some women, the absence of "normal-sized" breasts may affect self-esteem and their perceived femininity.

A second group of women who seek breast augmentation are those whose breasts have atrophied (shrunk) after breast-feeding, and who wish to restore their breasts to how they were before having children.

Some women wish to have otherwise normal breasts increased in size for a variety of reasons, including occupational reasons, for example, modelling. Breast enlargement is occasionally carried out on males who are seeking gender reassignment (sex change) operations.

Who can have the operation? . . .

It is unwise to have breast surgery before full natural breast development is complete, except in severe cases of underdevelopment or asymmetry. Augmentation can be carried out in older women with a loss of breast tissue after breast-feeding. Enlarging the breasts for purely social or occupational reasons is a reversing trend. The benefits may not outweigh the potential hazards.

How long does it take to recover? . . .

Expect a day and a night in hospital. Light dressings need to be kept on the wounds and a supportive bra worn continuously for two weeks. Avoid heavy lifting for two or three weeks but you should be able to return to light work within a few days. There is no reason to restrict arm movement. Some surgeons even advocate taking up jazzercise or similar exercise quite soon after the operation.

Before the operation . . .

The surgeon will examine your breasts to see if you are suitable for the operation and discuss whether the operation is feasible and worthwhile. After examining you, another procedure may be recommended, for example, mastopexy a method of tightening and lifting the natural breasts.

You need to talk through your ideas about the size you want your breasts to be. In most cases, the surgeon will try to meet your requests. Sometimes it may not be technically possible to do so and it may be necessary to reach a compromise solution. However, the final decision on size is made during surgery and depends on the skin's elasticity and how well the implant fits into the cavity created during the operation.

Inquiries will be made about your general health and medical history and, in particular, any family history of breast cancer or other breast disease. You will also be asked if there is any history of autoimmune disease or arthritis-like conditions. You will be screened for these conditions if you decide to go ahead with surgery.

Implants . . .



Before the development of silastic implants early in the 1960s there was no satisfactory method of breast augmentation. Before that time, surgeons had used sponges or injections of wax or paraffin - none of which was successful and all produced severe complications. To avoid these problems, surgeons in the 1940s and 1950s used large grafts of fat and skin taken from the woman's own abdomen or buttocks. However, these were long and involved procedures with many complications and left a lot of scarring on the breasts and at the donor site.

More recently, other doctors tried injecting fat or liquid silicone directly into the breast area. These

procedures proved dangerous and ineffective and have been condemned by plastic surgeons.

Implants are a vast improvement on previous techniques. More than two million American women and an estimated 5000 New Zealand women have had silastic breast implants since they became readily available in the 1960s. They are made of a firm outer silastic shell and a soft jelly-like core which, at body temperature, has the consistency and moves almost like breast tissue.

Capsular contracture . . .

The body's natural response to the implant is to surround it with a layer of scar tissue that contracts with time. This can sometimes lead to a firm compression of the implant which becomes harder and spherical. Capsular contracture may be quite painful and sometimes requires the removal of the implant.

The recent introduction of textured-surface silastic implants has greatly reduced the incidence of capsular contracture. It alters the body's response to the implant by restricting the formation of scar tissue. Recent studies show that less than 10 per cent of women develop significant capsular contracture with these new implants compared with up to 40 per cent with the earlier, smooth implants.

Alternative types of implants . . .

Implants come in varying sizes and contain silastic gel, saline (salt water), or both. There are advantages and disadvantages with all three types.

Saline-filled implants are preferred by some surgeons who believe they are safer if the implant envelope ruptures or leaks. If this happens, the breast will flatten.

Double lumen implants have two compartments, an inner compartment that contains gel, and an outer compartment that can be inflated to the desired size, containing saline. The double lumen implants may be useful if breast sizes are uneven or if small adjustments in size are needed.

Silastic gel-filled implants are still commonly used in this country. They have an outer silastic shell and contain silastic gel. Augmentation with silastic gel implants produces the most "natural" breast enlargement. Implants containing biodegradable pyrollidone gel have recently become available. The gel within these implants is safely excreted in the event of rupture of the outer shell.

It is important to discuss the options available before surgery.

Positioning of implants . . .

Most implants are inserted through small incisions made in the crease beneath the breasts. Some surgeons make an incision in the areola (the darkened area around the nipple) or the armpit. The implant may be placed directly behind the breast tissue, or behind the pectoralis muscle which is behind the breast. The decision on placement position needs to be considered carefully.

There are distinct advantages and disadvantages with both techniques. For example, placement behind the breast itself may result in an implant which is not well covered and may therefore be visible. Placement behind the muscle may result in displacement, or movement of the implant during aerobic or body-building exercises. Your and your surgeon will need to consider these and other factors before a decision is made about implant position.

Breast Cancer . . .

A mammogram may be recommended before surgery to detect if there is any sign of breast cancer, particularly if you or your family have a history of the disease.

There is no evidence to suggest that breast implants increase the risk or cause breast cancer. Studies in the United States have shown no increased incidence of the disease in women with implants. In fact, there appears to be a lower incidence of breast cancer in women with breast implants. However, breast cancer is common, particularly in older women. Therefore, we recommend women with a strong family history of breast cancer (a sister, aunt or mother) should have a mammogram before surgery to detect any evidence of the disease and have regular examinations following the augmentation. CAT scanning, a newer technique for detecting abnormalities, may be recommended. This is comparable in cost. All women who have breast implants should be entered on a register for continued health monitoring, which should include annual breast checks and blood tests. Mammography can be difficult if women have implants. Women should always tell the person doing the procedure that they have implants.

Breast augmentation does not damage the breast tissue itself and you should still be able to breast-feed in future if you have children.

The operation . . .

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In New Zealand breast augmentation is almost always carried out in a private hospital under general anaesthesia. The procedure takes about one-and-a-half to two hours. Intravenous antibiotics are given at the start of the procedure to reduce the risk of any infection. Another dose is given after the operation. Small incisions about five centimetres long are made for the implants (Diagram 1). The first step is to create a pocket behind the breast, or underneath the muscle, to accept the implant (Diagram 2). After the surgeon makes the pocket, a check is made to control any bleeding before the cavity is washed out and the implants put in place (Diagrams 3, 4 and 5). Small plastic suction drains are inserted through the skin into the cavity to drain away any excess blood. These stay in place for about 24 hours.

The wound is closed in layers to keep it strong and to prevent dislodgement and/or exposure of the implant. When you wake up you will experience some pain in your chest but this can be controlled quickly with medication.

Post-operative care . . .

The surgeon will check that you are comfortable and have been given adequate pain relief. If there are no problems you will usually be discharged the day after surgery, when the drains have been removed.

Pain: After the initial post-operative phase, pain should be easily relieved with simple analgesics like paracetamol. Bleeding or infection can cause more intense pain and should be reported to the surgeon.

Dressings: These are kept to a minimum. A well-fitting, soft sports bra should be worn for two to three weeks to support the breasts and hold any dressings in place. Your surgeon will see you two or three days after the operation for a check-up and to change your dressings; and again about a week later to remove sutures. This is a painless procedure. If you have any concerns in the meantime, contact your surgeon.

Bruising is usually minimal and is most often confined to the outside of the breast. It usually fades within two to three weeks. You will be able to use your arms and even start active exercise within a week to 10 days of the operation. You can follow this with a gradual return to full activities. Restrict heavy activities for two to three weeks. Let your level of comfort be your guide. Avoid getting dressings wet for two days after surgery. There is little danger of dislodging the implants if you push them downwards on to the suture line.

Complications . . .

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- **Haematoma:** This is caused by an accumulation of blood inside the pocket created to accept the implant. A haematoma is usually detectable soon after the operation and requires immediate treatment. The implant would need to be removed and reinserted after the bleeding has been controlled.
 - **Infection:** Infection after breast augmentation, although rare, can cause major complications but is usually prevented by the use of antibiotics and a scrupulous surgical technique. If, however, infection does occur, the implants will need to be removed and the infection treated. Sometimes the implants can be replaced several months later, after the infection has settled.
 - **Wound breakdown:** Separation of the surgical incisions is also very uncommon but may follow an infection or massive haematoma formation.
 - **Capsular contracture:** This is the most common complication. It may occur at any time from several weeks to a year or so after surgery. All foreign material placed within the body generates scar tissue around it as the body attempts to wall it off or reject it. Some women may develop only a slight degree of contracture that may make the breasts feel a little harder than normal.
- At worst, a thick scar may form which forces the implant into an undesirable spherical shape which may also cause hard, painful breasts. To treat the problem it is preferable to surgically divide the scar capsule that has formed around the implant.
- **Nipple sensation:** Nipple sensation is often altered because of unavoidable damage to nerves during the operation. Sensation often returns to normal within a few weeks. It is rarely reduced permanently. Sometimes the nipples may be more sensitive after the operation because they are more prominent and may rub on clothing. If so, covering the nipples with soft padding may help until the sensitivity eases.
 - **Rupture and leakage:** There is no doubt that implants with thinner envelopes, which are now no longer in common use, allow small amounts of silastic gel to leak into the fibrous capsule surrounding the implant.

Sometimes the outer shell of implants can deteriorate, allowing the silastic gel to move freely within the fibrous capsule. The fibrous capsule prevents the gel from moving further. Leakage is often difficult to detect as it does not usually cause any pain or distort the shape of the breast.

The newer implants are very strong and unless they are subjected to extreme force, as may occur with a seat belt in a car accident, they are unlikely to rupture (unless the envelope has undergone some degree of deterioration as described above). If rupture occurs, any leakage is generally confined locally and the implant can be easily removed and replaced.

- **Auto-immune disease:** There is no sound scientific evidence that the presence of silastic gel implants produces auto-immune disease in humans. While it is possible that such

evidence will be found, the American Food and Drug Administration (FDA) and other responsible bodies in the Western world have so far been unable to find any evidence of auto-immune disease is a result of silicone-gel implants. Many research studies have been set up to answer these questions.

We feel, however, that caution is advisable by taking a thorough history and carrying out a medical examination to detect disease of this type before tile operation. This may include special blood tests and an extensive family history.

Cosmetic complications . . .

- **Placement:** Despite all efforts the implants may be asymmetrical. The placement of the implant may result in a breast which does not look natural, for example, if the breast is too full above the nipple. This may also be caused by some degree of contracture, which pushes the implant into an unnatural position. If the implant is placed behind the pectoral muscle, the breast may flatten out and take on an unnatural appearance when the muscle is contracted, for example, when you put you hands on your hips. For this reason, placement of the implant behind the breast, rather than behind the muscle, may be preferable.
- **Scarring:** The incisions are small and should heal well without leaving obvious scars. Women with pigmented skin may produce thicker scars.
- **Mammography and breast cancer:** Mammography is the most useful tool in the detection of breast cancer. A skilled radiographer will be able to modify the procedure to visualise most of your breast tissue if you tell him or her you have implants.

Note: At present, both saline and silastic implants are available for use in New Zealand. It is a condition of use with silastic gel implants that women interested in the procedure read the information book issued by the Ministry of Health, available from your surgeon or the Ministry. This is to ensure that everyone who has breast implants is fully informed of the possible risks. We recommend that all women who undergo augmentation have their names kept on a register so they can be contacted if new information becomes available.

A women's health information service has sponsored the development of a breast implant support group which has been active in counselling women with implants.

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Liposculpture . . .

LIPOSCULPTURE, OR SUCTION-ASSISTED LIPECTOMY, has been described as subcutaneous (beneath the skin) body contouring, as it allows the surgeon to reshape the body without the need for open surgical wounds or scars, except for minor skin puncture marks.

The procedure is used to remove fatty deposits from certain areas of the body, most often around the abdomen, hips, buttocks and thighs.

Liposculpture was developed in its present form in the early 1980s by French surgeon Dr Yves Gerard Illouz, who recognised the need to find a way of reshaping hips, buttocks or thighs without the disfiguring scars associated with the "body contouring" operations which were being carried out in various parts of the world at that time.

The advantage of this procedure is that the tissues beneath the skin are not extensively cut or separated from the under surface of the skin. This decreases the risk of damaging or destroying the skin, which was the major disadvantage of previous suction and open surgical methods.

Why have it done? . . .

To remove localised deposits of fat which cause unwanted bulges in areas that are out of proportion with the rest of the body. It is important to emphasise that this procedure should be used only for the treatment of localised areas of fatty disproportion, known as lipodystrophy, for example, around the thighs, hips, abdomen, knees or ankles. It is not, and cannot be recommended as, a suitable treatment for obesity.

Liposculpture can work well for people who have bulges that dieting and exercise cannot shift. It is a particularly useful adjunct for people who have given up on dieting because they have been unable to remove excess fat from certain areas. Liposculpture can sometimes act as the positive psychological boost to enable these people to persist with their diet and weight reduction programmes.

In some women, localised fatty deposits around the upper thighs, buttocks and abdomen are inherited, and no amount of dieting or exercise will remove them. The only way to reduce them permanently is to remove the fat cells which actually cause the bulging tissue. The fat cells are permanently removed with the procedure. However, it is important for patients to watch their diet after treatment in order to maintain the surgically achieved shape. Otherwise, fat may be deposited in some of the remaining fat cells in the area, causing a cobblestone effect, or it may be deposited in another part of the body and create another unwanted fatty deposit.

Who can have the operation? . . .

The success of the procedure is ultimately dependent on the type and tone of the person's skin. People most suited to liposculpture are those with localised fat deposits but who have firm skin.

It will not be effective if the skin is very slack, lacks elastic recoil or is badly stretched. The treatment is not recommended for people with loose skin either as the removal of fat leaves more excess loose skin, which may be more disfiguring than the extra fat. Liposculpture does not remove stretch marks or dimpling. However, with additional surgical procedures, it may be possible to tighten the skin, for example, around the inner thighs or abdomen. Skin from the centre or lower part of the abdomen may be excised at the end of the operation and, if necessary, the underlying muscles may also be tightened.

How long does it take to recover? . . .

This usually depends on how much fat is removed. Some people may feel uncomfortable even after a minor procedure, while others may feel relatively comfortable within hours. Expect to be in hospital on a day-stay basis for treatment of the outer thighs and knees or the lower abdomen and hips, where less than two litres of fat and subcutaneous tissue is removed. These procedures are generally regarded as very safe and relatively painless.



If a larger area is treated and more than two litres of fatty tissue is removed, you may be more uncomfortable and sore. Expect at least two or three days of discomfort following one of these larger procedures. Bruising may last for two or three weeks, but it will gradually decrease during this time.

Most people feel reasonably well after about 7 to 10 days, but it is generally advisable not to return to full-time work for two to three weeks. You will need to wear an elastic support on the treated areas for at least three weeks after the operation to help contour the skin and prevent fluid accumulation.

Before the operation . . .

The surgeon needs to determine whether you are generally overweight or just out of proportion. If it is a proportion problem, and the skin texture is good, liposculpture may be helpful. Measurements and photographs may be taken to record accurately the distribution of the excess tissue and your girth from breast to knee.

The surgeon will explain that the larger procedures are extensive operations which involve a lot of metabolic disturbance, post-operative pain and discomfort. Intravenous pain relief for the first 24 or 36 hours after surgery should help with this.

People who have extensive treatment and have more than three litres of fat and subcutaneous tissue removed may require a blood transfusion, but this is seldom necessary.

Although all blood in New Zealand is fully screened for HIV antibodies and Hepatitis B and C, to avoid any risk of infection through a transfusion, most surgeons now prefer to avoid blood transfusions to eliminate any possible risk.

Costs are usually discussed at the initial consultation and are variable, depending on the extent of surgery.

Preparing for surgery . . .

If the required blood tests are normal, hospital bookings and theatre times are arranged. To prepare your skin for surgery you may be given a prescription for a mild skin disinfectant solution, or you can buy it from your pharmacist.

It should be used to clean the skin twice a day at the end of a shower, from neck to ankles, front and back, to decrease the risk of infection. You may also take arnica tablets if you wish. This is a homeopathic treatment to prevent or minimise bruising.

The operation . . .

After being admitted to hospital, you will be visited in the ward by your surgeon to mark out the shape and distribution of the unwanted fat. You will need to stand while these markings are done as the fat deposits are more obvious than when you are lying down.

The procedure . . .

- In an extensive procedure, a catheter is inserted into your bladder after you have been anaesthetised to monitor your fluid output throughout the operation.
- Warmed intravenous fluids are given to replace fluid lost.
- Heated water blankets are used to replace heat lost during the operation.
- Large quantities of saline mixed with vasoconstrictor (to decrease blood flow) and local anaesthetic are injected into the areas to be treated. This decreases blood loss and post-operative pain and makes the operation technically easier than the previous "dry" technique.
- Small "nicks" of about three to four millimetres are made in skin folds where they are easily hidden after surgery. A cannula - a long, thin hollow tube - is inserted through each of the incisions into the fatty layer to treat one area at a time. The instrument is moved back and forth to break up the fat cells.
- After the tissues have been freed by this method the fat cells are suctioned out. When the surgeon is satisfied the area is adequately contoured, the procedure is repeated through another incision.
- Although the procedure is essentially quite simple, liposculpture still demands care to avoid producing ridges, furrows or hollows in the overlying tissues.
- The operation is normally done in stages, so that while a small part of the body is being treated, the rest of the body can be covered up to keep you warm.
- Antibiotics may be given intravenously during and after the operation to minimise the risk of developing any infection.
- The operation may last from one-and-a-half to three hours, depending on the extent of the surgery and the amount of fat to be removed.
- The wounds are closed at the end of the operation with tiny sutures and covered with dressings. Elastic stockings and garments are fitted and you are taken to the recovery room. By the time you return to the ward you should feel warm and quite comfortable.

Post-operative care . . .



- Pain relief: If you have had extensive treatment you may be given small amounts of analgesia

intravenously to minimise pain over the first 24-hour period. For minor procedures, mild pain-killers (for example, paracetamol) are adequate to relieve discomfort and you will be able to go home later in the day.

- If you have had extensive treatment you may require stronger pain relief, for example, Digesic. It is unlikely that this will be required for more than 12 hours, after which paracetamol should be adequate.
- Large liposculpture treatments require careful monitoring of your fluid levels after surgery. Your urine output will be monitored and intravenous fluid is continued until you are able to drink enough. After about 24 hours you should feel much better. The intravenous drip and the bladder catheter can then be removed.
- Once you are mobile you can go home. It is important to move about as much as possible to avoid problems with circulation. Deep breathing exercises help avoid any possible chest problems developing as a result of the anaesthesia.
- The sutures are removed within a week. By this time it should be possible to change the corset daily so you can have a shower.
- You should wear the elastic garment for three to four weeks after the operation to help control swelling and encourage the tissues to settle into the best possible position.
- Immediately after the operation you will be swollen and bruised and may not appear to be much slimmer than you were before. At first you will be carrying quite a lot of excess fluid in the subcutaneous tissues, but after 7 to 10 days this fluid starts to come away. You will pass more urine than usual getting rid of it.

Your size will reduce as the swelling subsides. The skin will become tighter as it is drawn on to the muscles, filling the space which was previously occupied by the fat. The contraction phase may last for about three months and you will become smaller and slimmer.

Swelling persists in some people and may take many weeks to disappear.

Liposculpture of the ankles that causes persistent swelling may need to be treated with massage, wearing elastic stockings and elevating the legs. Final results: It is not really possible to assess the final result for four to six months after the procedure. Most change will be seen in the first four, to six weeks. By six months, any small irregularities which were previously hidden by the subcutaneous swelling may become apparent.

A small revision operation may be necessary to "tidy up" these areas. This does not always happen but, in some cases, people feel happier if they know that any small irregularities can be treated at a later stage.

Localised bulges are usually treated successfully at one operation. However, if the disproportion was very extensive, for example, extending from the waist to the knees, a second or third operation may be required.

Small corrective operations may be done on an outpatient or day-stay basis - in the hospital, depending on the extent of the treatment. In general, these procedures are far simpler than the initial operation.

Complications . . .

- **Severe bleeding and fluid loss:** These are prevented by monitoring fluid loss and using effective replacements intravenously. If adequate fluid replacement is not given, shock and damage to vital organs may occur.
- **Skin necrosis:** Liposculpture too close to the skin surface, particularly in the lower leg or the front of the thigh, may lead to areas of skin death because of the blood supply being destroyed. This complication is very rare, but would require reconstruction with skin grafting or flaps.
- **Long-term swelling:** Persistent swelling is common in liposculpture involving the ankles or lower legs. It may require long-term support with compressive stockings and massage to help remove the fluid.
- **Patchy loss of sensation:** Areas of decreased sensation are common and inevitable after liposculpture, particularly in the outer thighs. It may take from three to six months to regain total sensitivity in certain areas.
- **Excessive fat removal:** The amount of fat removed needs to be monitored very closely during the procedure to avoid removing too much from certain areas. If too much fat is removed it may lead to hollows, as the loose skin shrinks and adheres directly to the underlying muscle. This is almost impossible to correct.
- **Scars:** You will have a small scar from each incision. These should fade and become almost invisible with time.
- **Inadequate cosmetic result:** It is better to remove less fat than to produce hollows, dents and adherence of the skin to underlying muscles because of excessive fat removal. For this reason, up to 30 per cent of patients may need small revision procedures. These follow-up treatments are usually minor and can be carried out under local anaesthesia.
- **Effects on oestrogen stored in body fat:** We do not believe that localised liposculpture, carried out for areas of lipodystrophy, is likely to affect oestrogen levels in pre- or post-menopausal women, so we would not expect an increase in osteoporosis in those women who have liposculpture in later life.



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Abdominoplasty . . .

ABDOMINOPLASTY RECONTOURS THE ABDOMEN by the surgical removal of fat and excess skin from the abdomen and sometimes the waist and hips. The underlying muscles in the middle of the abdomen (the rectus muscles) are often tightened at the same time.

Why have it done? . . .

Women usually want to have the operation because they don't like or don't reel good about the appearance of their abdomen and would like to be able to wear more fitted or tailored clothes without feeling self-conscious of their figure, particularly on the beach. A sagging, abdominal fold may produce other problems, including difficulties with hygiene.

Who can have the operation? . . .

Most are women who do not like the shape of their abdomen which has become stretched or droopy after child-bearing. A smaller group are women who have not had children, but who have developed a "pot belly" or a fatty roll in their lower abdominal skin, often since puberty. No amount of exercise or dieting has any effect on their shape. They appear to be genetically programmed to have fatty deposits in these areas.

Skin damaged during pregnancy can never return to its original condition. Exercise, dieting or the use of expensive lotions and creams will not improve the stretched tissue. The collagen and elastic fibres of the skin which usually hold it firm and tight may have been irreparably torn during pregnancy. Stretch marks are actually tears or wounds in the deeper layers of the skin. These small wounds have been repaired by poor quality scar tissue and thinner skin. The only satisfactory way of altering the appearance and shape is to remove the stretched skin surgically and reshape the area with abdominoplasty. An enlarged or protruding lower abdomen is treated in a similar way.

Procedures . . .

The removal of a large amount of skin and fat to improve the shape of the abdomen inevitably produces some scarring. Doctors and surgeons have designed and modified a range of different procedures over the past 50 years in an attempt to remove the excess tissue, leaving minimal scarring. While some of these operations have been beneficial, others have been far less cosmetically acceptable.

Currently there are two main surgical approaches to the problem.

1. Liposculpture of abdominal fat has vastly improved the results of abdominoplasty because of its ability to contour the fullness beneath the skin of the upper abdomen and hips which is otherwise difficult to remove.
2. The lower transverse excision is probably the most widely used operation and often called the "bikini-line abdominoplasty". In this operation the front of the abdomen and hips is freed up to the lower border of the ribs. The loosened skin and fat is then pulled down and any excess is removed by a transverse excision just above the pubic hair line. This procedure produces a transverse scar which can usually be hidden by underwear.

How long does it take to recover? . . .



If you are having only a small amount of skin removed, with no muscle tightening, you should be able to go home the same day. However, if you need extensive liposculpture of the hips and back, muscle repair and an excision of a large amount of skin and fat, you can expect to be sore and uncomfortable for a few days and may need to stay in hospital for two to three days.

You should be prepared to be off work for about two or three weeks if you have had extensive surgery.

You need to avoid heavy lifting for three or four weeks if the muscles have been repaired.

You can resume other activities depending on how comfortable you feel.

Before the operation . . .

During the pre-operative consultation and planning, the surgeon will want to know what concerns you - whether it is the stretch marks, loose skin, floppy tissue or just generalised thickening around the abdomen and hips. You will also need to provide information about previous pregnancies and/or abdominal surgery, which could have altered the shape or produced scarring. This may affect the decision about the type and extent of abdominal repair if you intend having more children. You will be weighed, measured and examined to record the distribution of skin, fat and stretch marks. The surgeon will then be able to tell you which particular procedure would be best and advise you about the length of the operation, time in hospital and costs. The costs of the various operations vary considerably depending on the extent, type and duration of surgery. If you decide to go ahead with the procedure your surgeon will arrange photographs, blood tests and make the hospital bookings.

The operation . . .

- Abdominoplasty is always performed under general anaesthetic in hospital. You will be admitted the day before surgery or the morning of the operation.
- Before the operation the surgeon will visit you to mark out the exact areas to be treated for liposculpture or excision.
- The actual surgical procedure depends on which operation the surgeon selects for you. It may take between two-and-a-half hours to five hours, depending on the extent of surgery and need for other associated procedures.
- A urinary catheter will be inserted after you have been anaesthetised to monitor your fluid output throughout the operation.

Lower transverse excision . . .

The abdominal skin and subcutaneous fat is lifted up as a flap from the level of the lower transverse incision up to the level of the rib margin. The numerous blood vessels coming up from the muscles to the subcutaneous tissue are sealed with heat. The umbilicus (stomach button) is left undisturbed on its pedicle (flap of tissue) in its original position, after separating it from the surrounding tissue. A new hole is made in the middle of the abdominal skin before the umbilicus is sutured into place. The outer covering of the underlying central abdominal muscles (the rectus sheath) is often tightened at this stage with non absorbable sutures to produce a firmer abdomen. The excess skin and subcutaneous tissues are drawn down and the redundant part of the flap carefully tailored to fit the transverse suture line. Sometimes it is necessary to extend the incision over the side of the hips to remove the folds which would otherwise remain. A careful multilevel wound closure is made.

Drains . . .

Drains are used with both procedures. When surgery is completed one or two small plastic suction drainage tubes are placed beneath the skin flaps of the sutured area, to drain away excess fluid. These are left in place for a day or two after surgery, or until there is little drainage.

Post-operative corset and stockings . . .

You may be fitted with an elastic panty-girdle or firm bandaging at the end of the operation to help support the lower abdomen. During the operation your legs will be supported with special anti-thrombotic stockings to prevent clots developing in the deep veins of the legs. You should wear these stockings until you are walking comfortably. Women who are taking high-dose contraceptive pills or who have a history of thrombotic conditions are at greater risk of deep vein thrombosis.

Post-operative care . . .

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The intravenous drip may be left in place for 24 to 36 hours after surgery. A urinary catheter may be left in place during the immediate post-operative period to avoid any unnecessary movement. You will be helped by a nurse when you want to go to the toilet and you will be given adequate pain relief, either orally or intramuscularly. Chest physiotherapy is sometimes used if there is any concern about uncomfortable breathing. The sooner you are moving about, the less likely you are to suffer from complications after surgery.

Recovery ...

It is very unlikely that you will feel severely incapacitated for more than two or three days, however extensive the procedure. Generally the lighter you are before the operation, the more quickly you will recuperate. The abdominal wall will feel tight, so it will take time to walk comfortably again.

Sutures will be removed in the clinic between 5 and 14 days after surgery. Drains may be left in place for a few days after you leave hospital. They are easy to look after at home. You may be advised to wear a supporting corset for about three weeks after the procedure. You will probably be able to shower a day or two after the operation and you can reapply light dressings yourself.

Activity ...

You should be able to walk without any real discomfort after 10 to 14 days. Gradually increase activity once you are out of bed, but avoid any heavy lifting or undue strain on the abdominal muscles for four to six weeks.

Complications ...

The most dangerous complications are those affecting the chest and breathing, or blood flow through the legs. Great care is usually taken to ensure these complications do not arise.

Chest problems ...

The most likely complication to develop after an abdominoplasty is the failure of the lower part of the lungs to expand fully. This is because it is painful to breathe for a short time after this procedure. Adequate post-operative pain relief and chest physiotherapy, which encourages deep breathing, are a great help in avoiding this problem.

Venous complications in the legs ...

Any long operation can cause the blood flow in the veins of the legs to slow and ultimately cause clotting. Women most at risk are those who smoke and who have been taking contraceptive pills.

Local complications ...

- **Infection:** This may occur in the wound, either deep or superficially, particularly if a residual collection of blood has been allowed to develop in the tissues beneath the skin. This is prevented by careful control of bleeding during the operation and giving broad-spectrum antibiotics during and after the operation.
- **Wound breakdown:** This is most likely to occur in people who are overweight before the operation, or in those patients who have had too much skin removed, where the tissue has been brought together too tightly.
- **Seromas:** Collections of fluid which build up after undermining (lifting) the skin may develop but are usually prevented by leaving drains in place for several days after surgery. A corset also helps prevent this complication by encouraging the skin to stick to the underlying muscles. Despite these precautions, seromas often still need to be drained.
- **Bad scarring:** This rarely results but is unpredictable. Poor quality scars often improve with time. Scarring is the result of the wound healing process which is unique to each person.
- **Inadequate treatment:** Sometimes surgical caution means that residual fullness is left in the hips and upper abdomen. This can often be treated at a later date with a small liposculpture procedure carried out with local anaesthesia.
- **Breast reconstruction:** Sometimes a lower transverse abdominal flap is used in breast reconstruction after mastectomy. A previous abdominoplasty procedure makes this method of breast reconstruction impossible.



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Birthmarks and Blood Vessel Disorders . . .

PINK OR RED BIRTHMARKS OR BLEMISHES are abnormal collections of blood vessels under the skin. They may be present at birth or develop later.

Abnormalities present at birth . . .

Port wine stains . . .

Approximately 1 in 300 people are born with a port wine stain, a condition involving dermal blood vessels. The abnormality may be inherited. People often seek treatment when the marks occur in cosmetically important areas, for example on the face. At birth the stain is characteristically flat but sometimes can darken and thicken as the person gets older. Unless there are other concurrent abnormalities, bleeding from the stain is rarely a problem.

Sometimes facial port wine stains are associated with enlargement of blood vessels, the membranes of the brain and the eye of the affected side. This is known as Sturge-Weber syndrome and the child may be blind on the affected side and prone to epileptic attacks.

Until the development of the argon, copper vapour, and pulsed dye lasers these stains were not treatable except with surgery which often left a cosmetic deformity as obvious as the stain. Treatment with cauterisation and radiotherapy had similar disadvantages.

In the early 1980s argon lasers were developed in the United States. The lasers are capable of dealing relatively selectively with port wine stains by damaging the blood vessels and preserving the skin but often left undesirable scarring. They are now outmoded.

Further technological research in New Zealand and Australia resulted in the clinical use of the copper vapour laser. This type of laser is available in Christchurch. In Auckland and Wellington pulsed dye lasers are available. This type of laser is generally regarded as the safest and most efficacious for treating port wine stains, particularly in children.

How does the laser work? . . .

Both copper vapour and pulsed dye lasers produce yellow light which is selectively absorbed by the red cells in abnormal blood vessels. The vessel walls are heated by conduction and the abnormal vessels are destroyed.

Treatment . . .

Port wine stains can be treated at any age after it is considered safe to give an anaesthetic. The application of laser light to the skin is painful - therefore either general or local anaesthesia is required for children. For adults it is possible to treat port wine stains with the pulsed dye laser with no anaesthesia.

It is advisable to try to complete treatment of port wine stains before the early teenage years when appearance becomes more important and self-image is developing. Because the course of treatment will involve several sessions at three-monthly intervals, some form of planning is necessary. Treatment is continued while the skin

continues to lighten, which often takes six to eight treatments.

Fade cream is sometimes used before treatment to allow the laser light to penetrate the skin more deeply. Fade cream prevents melanin, which can block penetration of the lights, forming in the skin.

Once the area to be treated is numb, laser light is scanned across the skin or pulses are placed on the skin. Great care is taken to protect the patient's eyes from the light. Laser treatment is quick, it usually takes less than 30 minutes for each treatment depending on the size of the area of treatment.

Side effects . . .



- The copper vapour laser produces considerable facial swelling which may persist for several days. Blisters also commonly form.
- The pulsed dye laser produces bruises on the skin which resolve within two weeks. Swelling and blistering does not occur.
- Scarring is more common with the copper vapour laser. The risk of scarring with the pulsed dye laser is very small, hence it is safe to use oil still children.
- Depigmentation - skin whitening - is more common with the copper vapour laser than with the pulsed dye laser.

After treatment . . .

The treated skin feels normal once it has healed but it is lighter in colour. However it is essential to protect the skin with sunblock for at least three months and moisturising of the area at night may be recommended. If this routine is not followed, unpleasant brown staining, known as post-inflammatory hyperpigmentation may appear in the treated area. This may fade with time. Realistically laser treatment cannot be expected to remove all birth marks completely. Approximately 20 per cent of port wine stains can be completely removed but the vast majority can be lightened so significantly that they are very much easier to cover with concealing make-up.

Strawberry birthmarks (naevi) . . .

These develop shortly after birth. They can occur on any area of the body, but most frequently appear on the head and neck. Unlike port wine stains, which tend to grow in proportion to the rest of the body, strawberry marks may grow rapidly to alarming sizes and may appear to damage nearby tissue.

If there are no complicating features, most of these marks will disappear by school age, leaving flat, white and slightly inelastic skin. It is advisable, therefore, to leave any surgical treatment until this time.

The growth of strawberry birthmarks may, although rarely, destroy tissue or obscure vision. If so, a paediatrician may recommend steroids to control their growth. Pulsed dye lasers have been used to shrink the superficial components of the naevi.

Haemangiomas . . .

These are blood-filled birthmarks which may be red or blue and sometimes raised or flat, depending on whether they are fed by high-pressure arterial vessels or venous fed by low-pressure vessels or both. Treatment of these abnormalities which may be associated with disorders of growth, blood clotting and bleeding - is not possible with laser surgery until the deep vessels, which are inaccessible to the laser, are treated by vascular surgery or embolisation. The superficial vessels can then be treated by laser.

Abnormalities which develop with age . . .



Spider naevi . . .

These small arterial lesions may occur at any age, most commonly in young women. Tiny vessels radiate in a spoke-like fashion from a central vessel. The key to treatment is to destroy the central vessel which feeds the smaller ones. Treatment consists of a short pulse of yellow laser light. This is usually effective with one treatment but may need to be repeated. The abnormality is replaced with either normal skin or a tiny white dot.

Facial veins . . .

This condition is common in fair-skinned people who have been exposed to lots of sun and wind. Despite popular mythology, facial veins are not usually the result of heavy drinking, although alcohol makes the face redder by causing the vessels to

dilate temporarily.

Unprotected exposure to sun and wind causes inflammation of the skin and development of fine new blood vessels on the cheek-bones and nose. These become more prominent with time and eventually cannot be covered except with thick layers of make-up. The key to cure is prevention, by wearing sun hats and sunblocks. These protect the skin from all types of ultraviolet damage which can lead to keratoses (sun crusts) and a variety of skin cancers, as well as broken veins on the face.

Facial veins are best treated with one of a variety of available yellow light lasers. Anaesthetic is not usually required for treatment.

Thread veins and leg veins . . .

Superficial leg veins are probably the most common cosmetic abnormality affecting the blood vessels in the skin. Thread veins usually appear on the legs of women in their twenties and become more obvious after a pregnancy or with using hormonal preparations, such as the oral contraceptive pill. Thread veins are often associated with varicose veins which are larger, puffier and bluer. The surgeon will want to know if there is a family history of venous disorders and you should be examined to exclude varicose vein disease, which would have to be treated first.

It may be possible to delay the onset of thread veins and varicose veins by wearing compression pantihose, particularly at times of venous congestion (when there is more pressure on the blood vessels), for example, before and during menstruation. These days, compression pantihose come in a variety of fashionable colours and textures and are generally indistinguishable from everyday pantihose.

Thread veins are easily treated with microinjection sclerotherapy. This technique has been available for 60 to 70 years but has only recently become popular.

Laser treatment is not satisfactory. Attempts to treat thread veins with the laser results in white streaky marks on the legs. This results from depigmentation of the skin which may be more unsightly than the vessels themselves.

Microinjection sclerotherapy is a demanding technique. It needs to be carried out with very fine needles under bright light using magnification. Sclerosant solution is gently introduced into the abnormal vessels through a fine needle.

The solution "shuts down" the vein, making it inactive. Often one puncture will allow the sclerosant to flow through the entire "flare" or venous system.

Very concentrated salt water is the most commonly used sclerosant. Salt is a natural component of blood therefore it won't cause an allergic reaction. Other sclerosants occasionally cause allergic reactions. The injections are a little painful. A stinging sensation is replaced with a dull ache which lasts for several minutes.

Pressure pads of foam rubber are often applied to larger veins. Compression pantihose should be worn continuously for 48 hours after treatment and during standing hours for about a week. Repeat treatments are almost always required at intervals of four to six weeks. Optimum results usually follow after two or three treatments.

Side-effects . . .

Complications other than transient pain are unusual.

- Ulcers may form on the skin after injecting the sclerosant into the skin, neither than into the abnormal vessels. The ulcers are usually tiny and heal leaving a very small mark.
- Bruising may result because of back bleeding into the skin. Compression pads and pantihose help prevent this. However, there is a risk of permanent staining of the skin at the injection site, particularly in the lower leg.
- Blistering may occur but usually clears in 7 to 10 days, with no lasting effects.
- The foot may swell if excessive sclerosant is injected around the ankle.
- Some vessels, particularly inside the knee, are difficult to treat.
- Even after successful treatment small blood vessels may continue to form.

Wearing compression pantihose and having a "tidy-up" treatment before summer will keep your legs virtually free of thread veins.

Varicose veins . . .

Varicose veins are a common disorder, particularly in women who often inherit the condition. It usually causes large, elevated, blue veins which rise above the surface on the legs. The disorder is usually caused by the abnormal back-flow of blood into the superficial vessels of the leg as a result of faulty valves. It is often made worse by

pregnancy, and may cause leg pain and unpleasant feelings of distension and swelling. Varicose veins are usually treated in hospital under general anaesthetic by ligation (tying) and avulsion (removing through tiny incisions in the skin).

Compression pantihose should be worn for a week after surgery. There is no need to rest after surgery, in fact, activity is encouraged. The sutures, are removed within five days to reduce the chance of suture marks.

After successful treatment of varicose veins the remaining thread veins can be treated with a course of microinjection sclerotherapy on an outpatient basis.

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Skin Cancer . . .

SKIN CANCERS ARE VERY COMMON IN NEW ZEALAND and often affect important parts of the body, particularly the face where good cosmetic results are important. Although the removal of most skin cancers is not difficult, the techniques of wound closure and reconstruction often require the expertise of a plastic surgeon.

Why is skin cancer so common? . . .

Fair-skinned people of Celtic descent helped to colonise New Zealand over the last two centuries and these are the people most susceptible to the disease. New Zealand has a sunny climate with little atmospheric pollution and extremely high levels of ultraviolet light, 25 per cent higher than equivalent latitudes in Europe.

There is no doubt that skin, particularly fair skin, exposed to ultraviolet light undergoes changes in its ability to repair itself, allowing cancerous changes to occur. Ultraviolet light damage is accumulative, so every time unprotected skin is exposed to ultraviolet light, it causes additional damage. Ultraviolet light is classified as UVA, UVB and UVC. UVA causes sunburn and genetic damage, that is, damage to the DNA of the cell nucleus and DNA repair mechanisms. UVB damages the structure of the skin, accelerating age change. UVB can even penetrate ordinary window glass and light clothing.

Dark-skinned people have a naturally high level of melanin (skin pigmentation) which absorbs ultraviolet light and helps prevent damage to growing cells.

Before World War Two people often wore hats and gloves. After the war it became socially acceptable to wear less clothing and, as a result, people exposed themselves to the sun more - and having a tan became fashionable. This trend, plus New Zealand's outdoor lifestyle, has inevitably led to an epidemic of skin cancer.

Over the past 10 years, publicity initiated by the medical profession and the New Zealand Cancer Society has succeeded in changing sun exposure habits. The dangers of excessive sun exposure have been well publicised. It is now common to see people wearing T-shirts at the beach and using sun creams and hats. We advise our patients to use sunblocks, avoid sunburn and cover up as much as possible.

Parents of young children sometimes choose to ignore this advice. Sunburn on young children, whose skin is highly susceptible to ultraviolet damage, will cause a high incidence of skin cancer in the future. It appears that there may be a direct link between sunburn in childhood and melanoma later in life. It is not unusual for a busy plastic surgeon to see 10 to 15 patients each week with skin cancer.

The pain, misery, inconvenience and loss of work and recreational time as a result of skin cancer is staggering. The public system cannot cope with the increasing numbers of people affected and the cost of treatment is increasingly carried by medical insurers and patients in the private sector.

Prevention . . .



Complete protection from the sun is both impossible and undesirable. The sun interacts with the skin to provide some essential nutrients, particularly Vitamin D. However, sunburn should be avoided by wearing suitable clothing and by using sunblock. Maximum protection is necessary between 10am and 4pm when ultraviolet light penetration of the atmosphere is at its greatest. Ultraviolet light is reflected from the sand, sea and snow and penetrates through clouds. Fair-skinned people should apply sunblock before leaving home in the morning and re-apply it every three or four hours if they are outside. It is a good idea to wear a cap or broad-brimmed hat as often as practical.

Sunblocks . . .

There is a variety of sunblocks on the market. The components either reflect or

absorb ultraviolet light before it penetrates the skin. For example, titanium oxide is often used as a reflectant and oxyphenobenzone as an absorbent. Both types are present in a sunblock. Sunblocks are advertised as having a specific sun protection factor (SPF). The figure indicates the time you may expose yourself to the sun before your skin becomes reddened or sunburnt.

In New Zealand during midsummer, 10 to 15 minutes' exposure is the average time before burning. An SPF 15 means you can be exposed to the sun for 15 times as long as the 10 minutes you could normally risk, that is, 150 minutes before burning occurs. It is advisable to re-apply SPF 15 sunblock every two hours or so. Despite some manufacturers' assurances, sunblock should be applied every two to three hours, especially after swimming, or if you perspire a lot.

It is essential that young children are encouraged early in life to protect themselves with hats and other clothing. Small children need to have their sunblock applied by an adult. Sunblocks can irritate some skins, especially those containing PABA (para-amino-benzoic acid). This may cause redness and itching. Look carefully at the labels or ask the advice of the pharmacist and try a variety of sunblocks until you can find one that suits your skin.

It is helpful to combine the use of sunblock with a moisturiser. A good habit is to apply sunblock during the day, shower in the evening, and replace it with a moisturiser. This replaces lost fluid from the keratin, the superficial layer of the skin and prevents the skin becoming dry and irritable.

Excessive exposure to the sun also leads to accelerated ageing and cataract formation on the eyes, among other problems.

Sunbeds deliver the same type of ultraviolet light as the sun, in controlled doses, but they are no safer than the sun. Ultraviolet damage adds up over the years whether delivered by sunbed or the sun itself. A tan is a protective mechanism and indicates that a degree of skin damage has occurred.

Common types of skin cancer . . .



Basal cell carcinoma . . .

This is the most common type. Growths often appear on the head and neck of elderly people but can be found on any sun-exposed area in much younger people.

There are two principal forms. The first type begins as a small, shiny nodule which usually grows slowly. The nodule may have tiny blood vessels on the surface and may ulcerate and bleed. If left untreated, it may damage adjacent important structures by direct invasion, particularly the ear, nose or eye.

The second type of basal cell carcinoma is a slow, spreading, superficial erosion of the skin. It begins as a flat, red patch which may spread radically, then heal and break down again and bleed. This form of basal cell carcinoma is more common on the trunk and limbs. There is seldom any pain with these cancers but people complain of a stinging, itchy sensation.

Squamous cell carcinoma . . .

Squamous cell carcinoma is most often seen in elderly people with badly damaged skin in areas which have had long-term sun exposure. It can appear in various guises. Dry and crusty patches precede crusty lumps forming on the skin. They may weep and are sometimes painful. If the crust is rubbed off, it exposes a mass of fragile tissue that bleeds easily. This is the cancer. This form of cancer can also be found on the mucous membranes of the lips as a crust or crack and may send cells into the lymph nodes of the neck, or spread into other parts of the body. If it is not treated it may spread and is occasionally fatal.

Malignant melanoma . . .

This is the least common but most feared form of skin cancer. The majority of melanomas are curable if treated at an early stage. In the past 20 years the incidence of melanoma has increased four-fold. About 200 New Zealanders die each year from melanoma and numbers are increasing. Only Queensland has a higher incidence of melanoma than New Zealand.

People who have repeated episodes of sunburn as children may be at particular risk from this form of cancer. There may also be an inherited element to the disease. Melanomas appear in a variety of guises. In men, they are most common on the trunk; in women, on the lower leg. Most begin as a small, flat mole which slowly grows

larger and darker. Less frequently, they develop from preexisting moles which increase in size, become darker and may bleed.

Melanomas may occur on any part of the body, including the mucosa (mouth, nose and genitalia) and hair-bearing surfaces. Diagnosis can be difficult, even for skilled practitioners, so it is important to seek advice if you are concerned. It is worthwhile becoming familiar with your skin and keeping a check on all visible areas. Get a friend or your partner to look at the area between the nape of the neck and base of the spine - the only part you can't easily see for yourself.

Moles ...

Moles are normal and everyone has a variety of them. Before age 16, new moles continue to develop and in old age they gradually disappear.

Ulceration, crusting, bleeding or darkening of any mole is always a dangerous sign. Some people have a condition called dysplastic naevus syndrome in which the moles have an increased tendency to produce melanoma. In these people, many moles may need to be removed to prevent cancerous change.

Treatment of skin cancer ...



- Basal cell carcinomas on the head and neck area should be treated with surgical excision and cosmetic wound closure. This involves carefully suturing the excised area to minimise scarring. To ensure complete removal, the specimen is examined under the microscope. In other parts of the body, laser or liquid nitrogen may be used but it must be accepted that the chances of recurrence of the disease after these treatments is higher than with complete surgical excision.
- Squamous cell carcinoma should be treated surgically and the tissue removed should be examined to ensure complete excision. Occasionally the growth may have spread to the lymphatic system or other parts of the body and further surgery may be needed.
- The only acceptable form of treatment for melanoma is surgery. Excision has to be wide enough to prevent any chance of local recurrence. Careful examination of the specimen is necessary to assure the patient of complete removal.

Most melanomas can be treated by simple excision and wound closure. Grafting or flap reconstruction is sometimes necessary. The majority of melanomas are small and shallow and have an almost 100 per cent cure rate. Conversely, the outlook becomes less optimistic as the depth and size of a melanoma increases. For this reason, patients who have had a deep melanoma removed must be checked regularly for at least two years after the excision. They should be encouraged to have regular checks after that time because there is a tendency for people who have had one melanoma to develop more.

Cosmetic surgery and skin cancer ...

While other forms of treatment may be successful in treating skin cancer, surgery is the only widely accepted treatment involving cancers of the head and neck. These areas are cosmetically important. Ideally, surgeons who have a solid background in techniques of wound closure and reconstruction of important features, such as eyelids, ears and noses should deal with skin cancer on the head and neck.

There are techniques available to plastic surgeons in which tissue can be replaced or repositioned to produce optimal cosmetic results. Reconstruction of the nose and eyelids, for example, requires a high degree of insight into the reconstructive possibilities and considerable technical skill. Plastic surgeons are trained for this responsibility.





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Scar Revision . . .

WHENEVER A WOUND IS MADE IN THE SKIN, a scar forms. This may happen accidentally, intentionally, or for a surgical operation. It is not possible to make any sort of wound without producing a scar. This is because the tissue which repairs the deepest part of any wound is always much more coarse (and less organised) than normal tissue.

Sometimes a scar is so fine that it is hardly noticeable, whereas other scars may be extremely disfiguring. Scars of the same type may even produce more disfigurement on one area of the body than another. For example, a narrow 2cm long scar on a person's back may be hardly noticeable, but a similar scar on the face of a young person may be disfiguring and obvious.

If the conditions are right for good scar formation, the resulting scar be visible only is a fine, white line. In less ideal conditions, the scar may be wide and thick, and sometimes may be raised, red, irritating and disfiguring for years. This latter type of healing is known as "hypertrophic scarring". Some of the reasons for differences in scar healing and "resolution" (settling) are now becoming apparent.

Factors affecting wound healing . . .

- Age
- Situation of the scar
- Direction of the scar in relation to the grain of the skin
- Type of wound closure
- Race
- Genetic factors
- Tension
- Security of repair

In general, old people and young babies form the least visible scars, whereas wounds in growing children, adolescents and young people with tight skin tend to produce unacceptable, raised, red, permanent scars. Although these differences may be due to changes in the growth potential of tissue at different ages, it now seems more likely that they are due to differences in the physical properties of the skin, particularly its elasticity or tension.

Skin tension . . .

Skin tension is currently thought to be the most important factor. Skin is like two-way stretch material that has more "give" in one direction than the other. In the direction where there is less give, the tissue fibres are constantly tighter and have less stretchability than those at right angles to them. This means incisions or cuts made in the same direction as this tension are subjected to less pull across their width than wounds made across the lines of skin tension. It also means they are more likely to heal better and with finer scarring than those made across these lines. Therefore, the location of the wound is most important in determining the way the wound heals and the type of scarring that is left.

Surgeons can now use this information to help with wound healing and reduce scarring by placing incisions, for example, the excision of a tumour, along the lines of skin tension whenever possible. Methods have been developed to enable them to predict accurately the direction of the least, or most, skin tension.

If an accidental wound occurs in the right direction of the skin tension it may heal on its own with relatively little scarring. However, if a wound occurs in the other direction it is likely to produce a noticeable permanent scar, even though it may have been carefully sutured and looked after.

In the past surgeons have tended to avoid operating on hypertrophic scars because surgical intervention often made them worse. Patients were usually advised that nothing could be done to help them until nature had run its course and the scar had started to soften spontaneously. This process often took several years and during this time people who had extensive scarring on their faces for example, had to endure the severe psychological and emotional trauma that went with it.

A more thorough understanding of skin tension has led surgeons to realise that there is generally no point in trying to improve the quality of scarring by excising the old scar and carefully closing the wound again in the same direction. If the conditions were not ideal for scar formation with the first wound, they are unlikely to be any better a second or third time. In fact, they may be worse because the excision of the scar will produce more tension and make the scarring more noticeable.

The multiple w-plasty procedure . . .

Surgeons have now devised techniques of correcting scars by changing the direction of the wound - and the eventual scar - by making a series of small saw-toothed flaps and darts which, when fitted together, produce a zig-zag effect. None of the lines of the zig-zag runs in the same direction as the old scar. Practical experience with this type of scar excision has shown that if it is done carefully, it will produce a remarkable improvement in the appearance of the scar and make it virtually invisible.

Skin Pigmentation . . .

One common factor which is still not well understood is the fact that wounds in people of certain races produce more persistent and troublesome scarring than in people of other races. This usually occurs in people with darker skin - Chinese, Indian, Maori, black Africans or black Americans and even people of Mediterranean extraction. All these groups are more likely to develop hypertrophic scars than people of Northern European descent. No one knows why this is, but it may be partly attributable to the organisation and tension of pigmented skin. Also, the behaviour of wound healing cells is probably different in people with darker skin.

Until more is known about the causes of these differences in scarring, surgeons have to be cautious in recommending surgery to people with darker skin and must always warn them of the possibility of post-operative scarring. There risk of developing either increased or decreased skin pigmentation around the wound, or in the areas of skin that are injured or grazed, either accidentally or surgically.

Keloids . . .

People occasionally produce quite large masses of raised, red scarring called keloids. These may develop from small wounds or even from skin blemishes, such as acne. These scars are different from the raised hypertrophic scars which seem to occur because of the effects of cross-tensional pull on wounds and which, in many cases, tend to improve with time.

Keloids do not resolve spontaneously and seem to behave like slow-growing tumours, gradually encroaching on to the surrounding skin, often with irregular claw-like extensions. They are usually resistant to treatment, particularly surgical intervention. Various surgical treatments have been devised to try to control keloids, but none has been very successful. There seems to be a strong genetic influence in the production of keloid scarring from parents or grandparents who have produced similar scars.

Treatment Of Scarring . . .

Prevention . . .

There are several measures which can be taken to minimise scarring which has resulted from elective surgical wounds:

- Care can be taken to align the wound along the line of maximum skin tension. The wound can be closed by internal suturing to avoid persistent crosshatch suture marks.
- After the sutures have been removed, the wound and the surrounding skin can be supported by adhesive paper tape. This relieves the wound of excessive stretch across its width while it heals completely. It can take four to six months for a wound to be strong enough to resist the pull of the surrounding skin, so in important areas it is necessary to maintain proper and adequate support of the wound for the longer period of time.

The paper tape can be worn without any inconvenience, especially if the skin is cleaned first with ether or alcohol to help the grip. It will withstand showering, normal exercise and swimming, and can be replaced weekly or when required.

Steroid treatment . . .

The irritation and tenderness from thickened hypertrophic scars can be reduced by injections of a strong steroid such as Triamcinolone or Kenacort-A. Steroids appear to decrease the metabolic activity of the cells, which causes the thickened scar process. By overcoming the increased activity of these cells, the scar will quickly soften and flatten within 10 days and become less irritating.

A second injection can be given after six weeks but the activity of these injections lasts for about three months, so time must be allowed for the injection to work completely before further treatment. It is important that the injections are not given too frequently because they may cause skin thinning, ulceration and the development of new, superficial blood vessels. Steroid injections will not eradicate the scar completely.

Surgical correction . . .

It is best to leave wounds to settle for as long as possible before trying to correct them surgically. The multiple W-plasty procedure is extremely effective for treating some resistant scarring. This can be carried out in hospital on a day-stay basis using local anaesthetic and sedation. Sometimes the operation may take two to three hours to complete successfully. For example, a scar extending from the corner of the mouth to the ear may take three-and-a-half hours to correct. This can be done quite successfully under local anaesthetic.

A scar revision operation must be done meticulously to produce ideal results. For this reason, surgery may be expensive because of the time taken for the operation.

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The Browlift . . .

THE BROWLIFT OPERATION CORRECTS the heavy overhanging folds at the outer half of the upper eyelids and lifts the outer parts of the eyebrows. It also improves the creases on the forehead and the central forehead frown lines.

A browlift creates a marked rejuvenating effect on the face by opening up the eyes and producing a much more wide-awake look.

Why have it done? . . .

Most people have the operation to get rid of the overhanging folds at the outer half of the upper eyelids and the heavy droop of the eyebrows. These heavy folds cause a dragging feeling in the eyelids and eyebrows, and frequently cause headaches because the frontalis muscle is in a state of constant contraction to lift the eyebrows.

If you find that it is possible to temporarily improve the droop or heaviness of your eyelids and eyebrows by holding up the skin of the forehead, it is likely that this can be permanently corrected with a browlift.

It is now accepted that in some people the standard upper eyelid blepharoplasty operation does not fully correct the excess or redundant tissue in the outer half of the eyelid. This is because some of the skin laxity in this part of the eyelid may be due to redundant skin from the forehead or eyebrow, rather than the eyelid skin itself.

Some people have a browlift to eliminate forehead and frown lines at the same time as a facelift. A browlift has no effect on the lower part of the face - around the cheek folds or the jowls over the lower jaw-line.

Who can have the operation? . . .

It is most common for people in their thirties and forties but it may be performed on much younger people who may have inherited heavy, droopy eyebrows and fullness in the upper eyelids.

How long does it take to recover? . . .



Expect one night in hospital after the operation and 10 days off work.

Before the operation . . .

Routine inquiries will be made into your general health. Costs of surgery and hospital stay are often discussed at the initial appointment.

Preparing for surgery . . .

- Some surgeons may advise you to wash your hair with an antiseptic shampoo for three or four days before surgery to sterilise the hair and scalp. Avoid hairspray and hair colouring before the operation.
- You will usually be admitted to hospital the night before or the morning of the operation.

The operation . . .

The operation is performed under general anaesthetic and usually takes one-and-a-half to two hours to complete.

The procedure . . .

- The incision is made across the top of the hair-bearing scalp, or just in front of the hair line.

- Once the incision is made, the skin of the scalp and forehead is peeled away and lifted off the underlying skull down to the bony ridge of the eyebrows.
- The important sensory and motor nerves for the forehead and scalp are carefully preserved.
- The muscles which cause the central frown lines are usually divided or removed. This involves excising the small muscles at the base of the nose and between the eyebrows.
- After the bleeding has been controlled, the skin of the scalp and forehead is pulled tightly backwards.
- Any excess scalp overlapping the suture line is carefully trimmed off for an exact fit. The scalp incision is then carefully closed with either sutures or staples before dressings are applied.

Post-operative care . . .



After the operation your head may be wrapped in dressings which are removed after one or two days.

Swelling: To minimise swelling after surgery you will be kept in a sitting position overnight. It is important for you to try to maintain this position as much as possible during the next week to 10 days, until all the swelling has subsided. At first there may be some swelling of the eyelids but this generally settles quickly and clears within a week.

Pain: There should be very little pain after the operation. Severe pain is an indication that something is wrong and you should report this either to the nursing staff or the surgeon as soon as possible. You should be well enough to have someone drive you home the day after surgery.

Sutures: These are normally removed in stages at the surgeon's rooms 5 to 10 days after surgery. It is helpful to keep antibiotic cream on the suture line until it has completely healed.

Recovery: This should be smooth and rapid after this operation. You can have your hair done at a hairdresser within two to three weeks.

At first there may be some numbness of the skin on the forehead. This improves within the first few weeks. Very occasionally there may be some weakness of the forehead muscles but again, this normally rectifies itself within a few weeks.

As a browlift tightens the forehead, there is an exaggerated elevation of the eyebrows for two or three weeks after the operation. The eyebrows come down to an acceptable level within a couple of weeks and the forehead will look smooth without looking unduly tight. Gradual movement returns to the forehead, although you will not be able to frown if the muscles concerned have been removed.

Complications . . .

Hair loss: Hair loss may occur in a few people on either side of the suture line. Others find that the hair in the front of the scalp becomes thinner for some months. This is not because the hair follicles have been damaged during surgery but is due to tissue swelling. Hair growth should be back to normal within six months. Small areas of permanent hair loss may occur. This can usually be easily concealed by altering your hairstyle.

Numbness: Because the incision is made high on the scalp to avoid damage to the sensory nerve supply, there should be very little permanent numbness of the forehead or scalp. However, there is bound to be some numbness at the top of the scalp, behind the suture line, because the nerves supplying this part of the scalp are cut with the initial incision. This small amount of sensory loss usually causes minimal disability or distress.

Scars: The scar line is about two to three millimetres wide but it is generally imperceptible through the hair. However, sometimes widening of the scar can occur, especially if the scalp is made very tight. If patches of hair loss persist, these can be repaired later with small hair transplant plugs.

Recent Advances . . .

Scars, numbness and hair loss can be reduced by applying the principle of minimally invasive surgery to the browlift. This type of surgery, also known as endoscopic surgery, has been used successfully by gynaecologists and general surgeons to operate on internal organs such as the ovaries, gall bladder and appendix, enabling a faster recovery and is now being developed by plastic surgeons for cosmetic surgery.

The best worked out procedure to date is the browlift. Instead of a cut across the top of the head, five short ones are made just behind the hairline. A tube, containing the telescope, and a specially designed long instrument can be passed through these cuts. The telescope is attached to a minute TV camera which relays a picture to a TV screen. The surgeon watching the screen gets a clear enlarged picture of the tissues being worked on. He/she can precisely free up the forehead and modify the frowning muscles without having to fold the forehead down. The released forehead can be held in its new position in a number of ways. Permanent suspension stitches can be placed so that they elevate the preferred part of the eyebrow. No hair need be removed.

This modification of the browlift has been used for only a few years and we are not yet sure if the long term results are as good or better than the conventional browlift, mentioned first in this chapter, but in experienced hands it appeals as a quicker, less invasive procedure with fewer side effects and a faster recovery.

These principles are now being extended to assist facelifts, breast augmentation and abdominoplasty.

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Endoscopic Surgery . . .

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Laser Dermabrasion or Laser Skin Resurfacing . . .

In the last year the technique of carbon dioxide laser resurfacing has been introduced to New Zealand. Many New Zealand plastic surgeons are trained in this technique. It is likely that laser resurfacing will replace mechanical dermabrasion. Laser resurfacing has several advantages - the carbon dioxide laser removes thin layers of damaged skin with precise depth control and the procedure is bloodless. It is possible to treat fine lines beneath the eyes with the laser which was not previously possible with mechanical dermabrasion.

The procedure is less painful after surgery than dermabrasion because the laser seals tiny nerve endings. The healing time is shorter, usually seven to ten days.

Scarring is much less likely because the laser will not damage the deeper structured layers of the skin.

Pigmentary changes are also less likely because most melanocytes will be preserved. Otherwise the comments made about mechanical dermabrasion apply to laser resurfacing.