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Combination cosmetic surgery: An individual surgeon's experience in non post-massive weight loss patients[☆]



Dear Sir,

Combination cosmetic surgery is a term used to describe the performance of more than one procedure to achieve unrelated aesthetic outcomes during the same operation. Patients request combined cosmetic procedures due to time constraints hence the wish for one recovery period, immediate gratification and financial considerations.¹ Although combined cosmetic surgery dates from the late 70's the literature regarding its safety has been conflicting.¹⁻³

Early concerns regarding combining cosmetic procedures included an increased need for blood transfusions and prolonged hospital stays,^{1,2} but this is not supported by recent reports which attribute complications to patient factors such as obesity rather than procedural complexity.³ Current reports in the non-PMWL population include abdominoplasty in combination with other cosmetic surgeries,³ but the overall patterns of combinations are not well documented.

Post-massive-weight-loss (PMWL) body contouring surgery has popularized combination cosmetic procedures and literature reports show that increasing the number of simultaneous procedures correlates with increased rates of seroma, wound dehiscence, wound infection and hospital stay.⁴ The consensus amongst anaesthetic colleagues has been that prolonged surgeries or those with multiple combined procedures increase the risk of perioperative complications.⁵ Our aim was to evaluate the procedural patterns and complication rates of combined cosmetic procedures in non-PMWL patients and compare these with the PMWL data published in the literature.

We undertook a retrospective review of a single surgeon's (CMM) experience of combined cosmetic procedures 2000–2012 with regard to their patterns and morbidity. We

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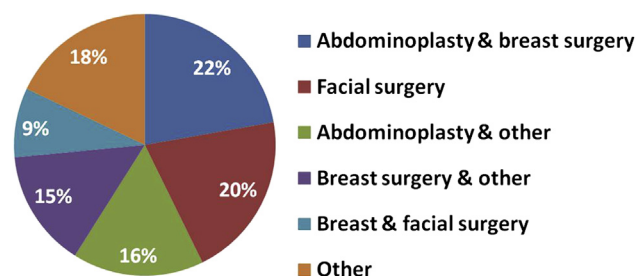


Figure 1 Mean number of patients per year undergoing combined cosmetic procedures. $n = 6$ pre 2009 (2007–2009) versus 15 post 2009 (2010–2012) ($p = 0.007$, Wilcoxon two sample test).

also included a 6 month prospective review of operating times for combination versus isolated procedures. PMWL patients and those undergoing operations in the same anatomical region e.g. abdominoplasty and liposuction of the flanks, or procedures which complement each other e.g. chin implant and neck lift, facelift and endobrow lift were excluded.

Over 12 years 117 non-PMWL patients underwent single-stage combined cosmetic surgeries (age 18–67 years, male to female ratio of 1:12). We found a significant increase in patient demand for combined cosmetic procedures from a mean of 6 per year 2007–2009 to 15 per year 2010–2012 ($p = 0.007$, Wilcoxon two sample test, **Figure 1**) which may be attributed to a combination of increased media coverage leading to popularisation of the “makeover” concept as well as reflecting the current economic climate since concomitant procedures are offered at reduced rates.

Most patients ($n = 100$) had two procedures in combination and only one patient underwent four, whereas Coon et al. found that PMWL patients⁴ have a greater proportion of three combined procedures (48%) compared to our cohort (14%). There was a wide variety of procedural combinations, the most frequent being breast surgery with abdominoplasty (50/117) whose total theatre time was shorter than the sum of the individual procedures in the prospective cohort ($n = 6$ versus 25; 5 h 20 min versus 6 h 4 min; $p = 0.11$, Student's *T* test). Although this difference did not reach statistical significance, combining cosmetic procedures reduced the operative time by 45 min which has practical significance. The most common procedural combination was abdominoplasty with breast reduction

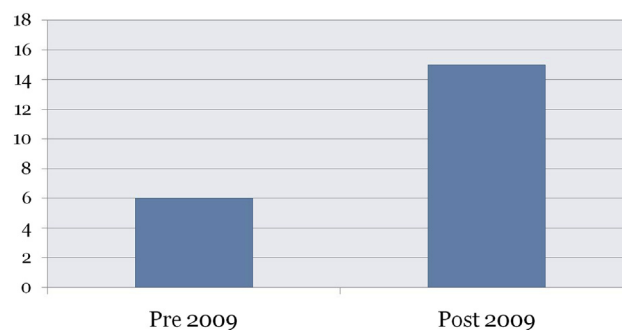


Figure 2 Spread of combined cosmetic procedures in non post massive weight loss cohort ($n = 117$).

($n = 11$), perhaps not surprising in view of the body habitus of many patients requesting breast reduction. Another notable combination was breast surgery with facial procedures which comprised mainly breast augmentations rather than reductions ($n = 9/10$). Those with breast surgery or abdominoplasty plus "other" most often included liposuction to non-adjacent areas (Figure 2). The rhinoplasty patients had the most heterogeneous list of simultaneous surgeries ranging from pinnaplasty through to a mini-abdominoplasty. According to the literature PMWL patients have a greater proportion of combinations containing abdominoplasty and limb lifting procedures compared to our non-PMWL cohort in whom breast and facial surgery is more popular.⁴

Major complications needing re-operation or readmission to hospital were encountered in 5% of patients (comprising of hematomas, wound dehiscence, pulmonary embolus) while 10% had minor wound healing problems that were successfully treated with conservative measures. Having three or more combined cosmetic procedures rather than two did not significantly increase overall complication rates in our study ($p = 0.73$, Fisher's Exact test). Unfortunately our numbers were too small to be able to analyse the effects on individual complications.

Conclusion

Combination cosmetic surgery is becoming increasingly popular. By understanding common combinations it may be possible to tailor surgical packages to patient demand. However, it is important to establish the safety of combined procedures and PMWL data has gone some way to doing that. Perhaps surprisingly there is less data on non-PMWL patients despite the longer period that these patients have been operated on. Our results suggest that increasing the number of combined procedures may not unduly increase duration of surgery or complications but further work will be needed before we are able to confirm this, particularly a direct prospective comparison between complication rates for combined versus individual procedures.

Conflict of interest

None.

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A mismatch in aesthetic training requirements and practice for the plastic surgery trainee



Dear Sir,

I am writing in response to the Hallam et al. paper entitled 'Implications of rationing and the European Working Time Directive on aesthetic breast surgery: A study of trainee exposure in 2005 and 2011' published in February 2013.¹ I am a year 4 Registrar in Plastic Surgery and I identify with much of what the authors expressed regarding the significant reduction in trainee exposure and operative training for aesthetic breast surgery. I feel this also translates to aesthetic surgery in general. It is often difficult to define what constitutes an aesthetic or cosmetic procedure when surgery is carried out to achieve or restore 'normal' anatomy. This leads into discussion as to what lies within the range of normal anatomy. This may then lead to debate over what is considered age appropriate normal anatomy. The term 'procedures of low clinical priority' (PLCP) has often been used to describe cosmetically orientated elective procedures with minimal or no physical symptoms. I can anecdotally state that I have seen a reduction in the number of PLCP being performed in National Health Service (NHS) practice since I entered the specialty in 2007. This has been due to the lack of Primary Care Trust funding in the current economic climate. This and the other factors discussed by Hallam et al. (European Working Time Directive regulations and a