

Liposuction of the Medial Thighs: Awareness of Anatomical Attachment Zones

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Complication

Liposculpture by tumescent syringe was performed on bilateral medial thighs of a 26-year-old female. The primary results were good. However, although the surgery was successful in symmetrically removing fat from the proximal medial thighs, creating the desired contact-free thigh space while walking, the patient was not happy. It became clear that the patient had an ideal linear look in mind for her inner thighs. She could not see her pre-existing natural hip adductor attachment indents when looking down before, until the proximal puffs of fat that had previously blocked her view were removed by liposuction. She remained obsessed with the fact that she could now see the indents from her standing view when she looked down, and she demanded that they be "fixed!"

Solution

Liposuction of the medial thighs is challenging. There exists in humans a natural bilateral potential indent at the midpoint of the medial thigh, created by the insertion of the hip adductor muscles on the medial aspect of the femur. This is one of the defined zones of adherence, where the fat overlying this insertion is often naturally thinner and more adherent to the underlying muscle fascia. Nature abhors straight lines and at the same time, patients can have unidentified false expectations of straight lines after surgery.

Skin irregularities tend to be noted more often at defined, three-dimensional "zones of adherence" where subcutaneous fat is adherent to underlying muscle fascia. In the

female, these zones of adherence are defined in existence at the mid medial thigh as seen in the patient's preoperative photos (Figure 1), and also occur at the lateral gluteal depression where gluteus maximus muscle and fascia attach to the greater trochanter of the femur, the gluteal crease where hamstring muscle group and fascia attach to femur, the distal posterior thigh, and the inferolateral iliotibial tract just proximal and lateral to the knee.¹

Because postoperative weight gain tends to create postoperative dysmorphia, patients must be educated as to their responsibilities for maintaining or losing weight. Patients often cannot accurately judge if they have gained or lost weight during the initial postoperative period. Photographs document size of fat deposits in areas of the body not addressed with liposuction. In this patient's case, a modest postoperative weight gain into the waist and hips after primary liposuction is noted.

Infrequently, significant irregularities may occur in the medial and lateral thighs. Techniques commonly used to improve contour irregularities include liposuction of any

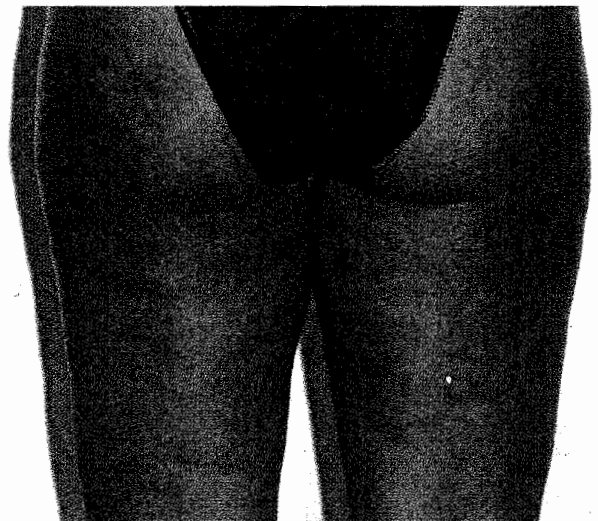


Figure 1. Preoperative liposuction inner thigh.

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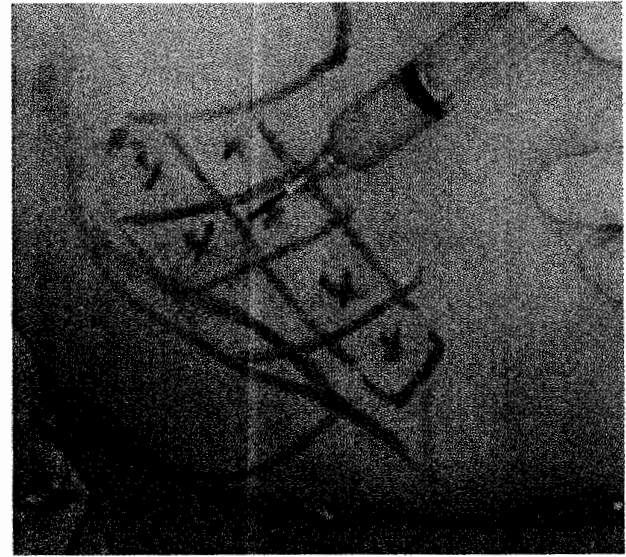


Figure 2. Left and right, intraoperative positions show autologous fresh fat graft placement.

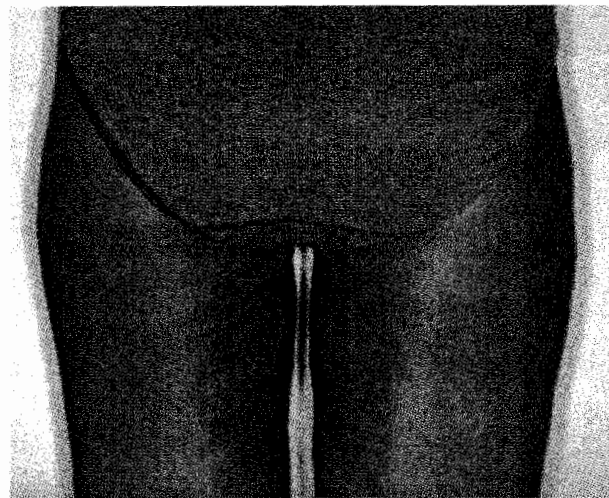


Figure 3. Postoperative liposuction inner thigh.

remaining areas of protuberance, liposuction around the area of depression or adherence, simultaneous fat grafting, and dermolipectomy. Between 94% and 96% of contour irregularities are improved or corrected using one or more of these techniques in 2 or more stages.²

The patient underwent a second procedure in which a small amount of fat adjacent to her mid-medial thigh creases was removed by tumescent syringe liposuction, combined with autologous fat transplant directly to the marked natural crease zone of adherence where the hip adductors insert onto the femur (Figure 2). The harvested fat is placed in 10 cc syringes and placed upright for 5 to 10 minutes. The serosanguinous fluid is discarded, after which the supernatant fat is immediately injected into the subcutaneous fat layer of the patient's irregularity.³ The patient returned for her 18-week postoperative exam, finally more satisfied with the more linear look she desired for her inner thighs (Figure 3).

References

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