In body contouring, the gluteal region is assuming an increasingly important role. Today it is possible to obtain good results with several different techniques and, contrary to previous experience, a low rate of complication and morbidity, well within safe and acceptable standards.

Gluteoplasty was introduced in 1965, when Bartes placed a silicone breast implant in the gluteal region, above the gluteus maximus. From 1969 forward, smooth implants were inserted, but because of the high number of complications—such as asymmetries, extrusion, and capsular contracture—lipografting became more prominent. González-Ulloa popularized and refined the technique of modern gluteoplasty. He was also the first surgeon to design, with Dow Corning, a line of implants specific to gluteoplasty, with six sizes and oval shapes. In 2004, Raul González first published the XYZ method for the placement of intramuscular gluteal implants, showing good results with a low rate of complications.

Despite advances in technique, the type and shape of gluteal implants remain controversial. Some surgeons prefer smooth implants, whereas others favor textured; many others limit their selection to elastomer implants, which can also offer good results. Round and anatomic implants are equally good options, but as is the case with breast augmentation, the results depend largely on the experience of the surgeon and the patient’s individual needs. At our clinic, the most common implant is the smooth, round silicone type; however, we have found

Case Report

Internal Suture Technique for Improving Projection and Stability in Secondary Gluteoplasty

Carlos Alberto Jaimovich, MD; Marcelo Wilson Rocha Almeida, MD; Leonardo Fernandes de Souza Aguiar, MD; Marcelo Luis Altenhofen da Silva, MD; and Ivo Pitanguy, MD

Abstract

The most common indication for primary gluteoplasty is the aesthetic correction of gluteal hypoplasia; secondary gluteoplasty is directed toward asymmetry from misplaced implants, trauma or infection of the implant, and treatment of congenital and acquired deformities. In this study, the authors describe a new suture maneuver designed to improve the result in secondary gluteoplasties. To reduce the empty pocket spaces and guarantee the stability of the new (smaller) implants, anchoring circular interlocking sutures are placed into the two sheets of the fibrotic capsule, which makes it possible to place the implant in a more favorable position.

Keywords

gluteoplasty, secondary, suture, technique

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that anatomic implants are better at filling in the gluteal contour in secondary cases, owing to the previously dissected pocket.

Dissatisfaction with implant volume is one common cause of reoperation, usually because the patient wishes to reduce the size of the implant; in these cases, the large implant pocket remains, diminishing gluteal projection. In the scientific literature, little has been written about the large implant pocket in secondary gluteal procedures. González described the use of anchoring sutures to close laterally large pockets for intramuscular gluteal implants where the dissection proceeds farther than the lateral limit of the gluteus maximus (including areas of the gluteus medius). Here, we present a new indication for this suture in the superior-medial part of the gluteal capsule.

**CASE PRESENTATION**

A 36-year-old female patient presented to us with a concern that her previously-placed gluteal prosthesis was too large (Figure 1), resulting in an artificial appearance. Round gluteal implants (high profile, smooth, 270 mL, bilateral) had been placed intramuscularly one year prior to her presentation in our clinic.

We selected bilateral quartz-type, low-profile, smooth 200-mL implants for the reoperation, to be placed intramuscularly. The quartz-type implant is filled with cohesiveness gel and has an oval base with two projections, high and low. The volumes range from 200 cc to 500 cc. The patient was marked (Figure 2) and placed under peridural anesthesia. After exposing the fascia of the gluteus maximus muscle, we identified the muscular fibers and the border of the sacrum. Two incisions of approximately 6 cm each were made in the direction of the fibers, about 0.5 cm laterally in the intergluteal fold. The incision proceeded bilaterally by digital dissection to approximately 3 cm deep, about half the width of the muscle, where the old implants were located and removed (Figure 3). The area between the incisions was deepithelialized. The subcutaneous tissue was incised at 45° on both sides, preserving the sacrocutaneous ligament.

After removal of the previous implants, it was verified that the new, smaller implants did not fill the lateral and upper part of the capsular space, which would render them mobile within the pocket and result in a loss of the desired projection. For this reason, after the new implants were inserted (Figure 4), an internal 2-0 nylon suture was placed in the superior-medial part of the gluteal capsule, attaching the two sheets of the fibrotic capsule to each other and thereby diminishing the size of the implant pocket.
As a result of the reduced pocket, the new (smaller) implant was well suited to the new capsular space. It was not necessary to cut the capsule to create edges for suturing, nor was it necessary to perform any additional maneuvers for anchoring the suture. The closure and drain placement were performed in the same way as a primary gluteoplasty. The patient recovered favorably and was discharged without drains on the first postoperative day. She presented with a hypertrophy of the intergluteal scar in the third postoperative month; it was resected and with favorable results. After six months of follow-up, the patient demonstrated no other complications and was satisfied with her result (Figure 5).

**CONCLUSIONS**

The results of our case report support the conclusions of the previous literature: Gluteoplasty can and must be performed safely, including rigorous planning and a detailed postoperative follow-up to identify and treat complications, some of which may require reoperation. In secondary gluteoplasties, the placement of an anchoring suture, as we describe here, offers a good aesthetic result that maintains gluteal projection similar to primary cases.

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