OPEN FORUM

Body Contouring

Subscarpal Dissection in High-Definition Abdominoplasty With 3-Vector Rectus Plication (SHARP) Technique: The 10-Step Path to Ensuring Safety and High-Definition Results in an Indian Cohort

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Abstract

Background: Unique aesthetic demands, varied skin tone, texture, body composition, and clinical histories of Indian patients have inspired the Subscarpal Dissection in High-Definition Abdominoplasty with 3-vector Rectus Plication (SHARP) technique.

Objectives: In this study, the authors primarily evaluate the effectiveness of the surgery by its safety, measured by major and minor complications. The secondary objective is postoperative patient satisfaction.

Methods: The authors report the outcomes of a cohort undergoing high-definition lipoabdominoplasty with 3-vector rectus plications over 14 months. The procedure includes 360° comprehensive liposuction of the back and abdomen, elevation of an abdominal flap, subscarpal dissection, dead space, excision of excess skin, umbilicoplasty, and layered closure of the skin flap. The authors present preoperative markings, a 10-step surgical technique, and postoperative care. Outcomes on safety and effectiveness were evaluated at 6 weeks, 3 months, and 6 months postoperatively.

Results: From January 2023 to February 2024, a total of 128 patients underwent surgery using the SHARP technique. Of these, 116 (90.6%) were female. The mean age of patients was 38.1 ± 9 years. The following complications were reported: seroma of the back in 10 (7.8%), and small wound dehiscence and necrosis were reported in 2 (1.6%) and 1 (0.8%) patient, respectively. Aesthetic outcomes at the 6-month mark were positive, with notable enhancement of natural contour and high patient satisfaction.

Conclusions: The SHARP technique is a useful option for high-definition abdominoplasty, with low complication rates and high patient satisfaction. In the authors' experience, the reproducible 10-step approach of this study provides a safe approach to abdominoplasty.

Level of Evidence: 4 (Therapeutic)

Lipoabdominoplasty has evolved significantly, yet its primary goal remains the aesthetic enhancement of lipodystrophy, skin redundancy, and myofascial diastasis. The main challenge for plastic surgeons is achieving an optimal abdominal contour that aligns with the patient's body habitus and anatomical features while minimizing complications.

Recent advancements have integrated liposuction with abdominoplasty to improve outcomes and reduce risks. Saldanha et al introduced the concept of lipoabdominoplasty, emphasizing selective

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flap undermining, preservation of scarpa's fascia, and liposuction to minimize complications and revision surgeries.[1] The use of quilting sutures by Baroudi and Ferreira effectively reduces seroma formation, enhancing procedural safety.[2] Pollock and Pollock further refined this approach with progressive tension sutures (PTSs), which minimize dead space and distribute flap tension, thereby reducing seroma incidence.[3,4]

High-definition liposculpture techniques, such as the VASER method introduced by Hoyos et al, have revolutionized fat extraction by preserving vascularity and enhancing aesthetic definition.[5,6] Additionally, modifications such as the TULUA (transverse plication, no undermining, full liposuction, neo-umbilicoplasty, and low transverse abdominal scar) technique, which incorporates transverse plication without extensive undermining and full liposuction, have improved vascularity and aesthetic outcomes while minimizing invasiveness.[7]

Building on these global advancements, we present the Subscarpal Dissection in High-Definition Abdominoplasty with 3-vector Rectus Plication (SHARP) technique. This approach integrates tailored modifications to achieve high-definition results while minimizing complications.

The objective of this study is to evaluate the safety and efficacy of the SHARP technique for body contouring, as measured by complication rates and patient satisfaction.

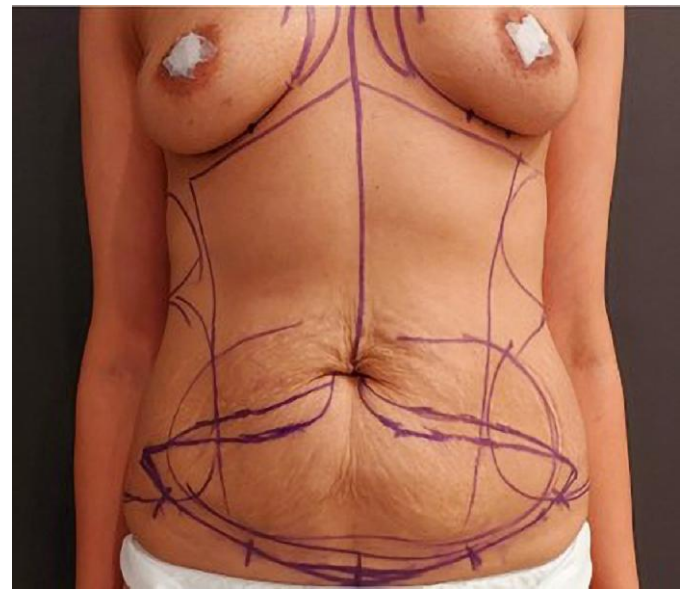


Figure 1. Preoperative surgical markings of a 39-year-old female.

METHODS

This was a prospective observational study during the period of 14 months. A total of 128 patients are included, and all were operated by the same first surgeon. The study has been approved by the GeneBandhu Ethics Committee (reference ECG014/2024).

The study included participants 25 to 60 years old, comprising postmassive weight loss patients, postpregnancy patients experiencing abdominal wall laxity, and patients with rectus diastasis coupled with abdominal wall laxity. Exclusions encompassed patients with substantial intra-abdominal fat and those with mild skin excess more suitable for alternative procedures. Patients with a history of bariatric surgery were excluded from this study.

Data were primarily collected on the outcomes of surgery, focusing on effectiveness, complications, and satisfaction levels. Additionally, background information on patients, including demographics, anthropometric measurements, and comorbidities, were recorded. Outcomes were evaluated at 6 weeks, 3 months, and 6 months postoperatively. Patient satisfaction levels were assessed with a 5-point Likert scale at 6 months.

Procedures

Preoperative Evaluation

Written, informed consent was obtained for the data collection, surgical procedure, and deidentified photographs. All the patients were examined preoperatively for abdomen shape, lipodystrophy, skin laxity, skin quality, previous scars, and divarication of recti/hernias and documented by photographs. Additionally, all participants were instructed to stop smoking at least 2 weeks before and 2 weeks after surgery to minimize potential complications.

Markings

Accurate marking is crucial for achieving safe and symmetrical outcomes in the SHARP abdominoplasty procedures. Markings were conducted with the patient in both standing and supine positions.

In the standing position, the vertical midline was delineated from the xiphoid to the pubic symphysis. Topographic marking of the linea semilunaris was performed on either side. Additionally, areas exhibiting lipodystrophy were identified and marked for subsequent liposuction. During the presurgery markings, the height of the scar was measured from the vulvar cleft.

Further marking involved delineating an inferior line connecting the anterior superior iliac spine (ASIS) on both sides, as well as marking a point situated 6 to 8 cm above the anterior vulval commissure parallel to the groin crease. This point, placed to be concealed later within the bikini line, ensures optimal aesthetic results while maintaining patient comfort and discretion. In certain cases, the incision can be extended laterally depending upon the amount of lateral skin excess.

In the standing position, a superior incision line was marked by gently pinching the excess lower abdominal skin, connecting the umbilicus and the ASIS on both sides. This line delineates the upper limit for skin excision (Figure 1).

Upon moving the patient to a supine position, another superior line was marked again by gently pinching the lower abdominal skin to accurately evaluate the extent of skin excess in the lying position. Notably, the standing superior line was conservatively marked, and the supine pinch superior line represented a more radical approach for skin excision. We have noticed that some patients' tissues are more pliable, and their skin excision can follow the radical superior line, and for some patients who have less pliable tissues, we do conservative superior line excision.

Procedure

All the patients underwent the following 10-step path under general anesthesia. All were operated on by a singular primary surgeon.

Figure 2. Liposuction of lower back in a 38-year-old female.

Step 1: Circumferential Separation, Aspiration, and Fat Equalization Liposuction of the Lower Back and Abdomen

The Separation, Aspiration, and Fat Equalization (SAFE) technique of liposuction was executed, beginning with the lower back in the prone position followed by the abdomen in the supine position (Figures 2, 3A, B).

First, tumescent fluid was infiltrated using a 4 mm basket cannula with PAL by Microaire cannula (Charlottesville, VA), ensuring optimal distribution. Next, VASER ultrasonic system (Solta Medical, Bothell, WA) was employed to facilitate lipolysis, enhancing the efficiency of fat removal. PAL by Microaire was then utilized for aspiration, ensuring precise and thorough extraction. To achieve harmonious contours, fat equalization was performed without suction. For abdominal liposuction, incisions were placed in accordance with planned skin excision areas. Deep-plane liposuction was carried out for all regions of the anterior and lateral abdomen, followed by superficial liposuction to refine abdominal etching and further enhance aesthetic outcomes.

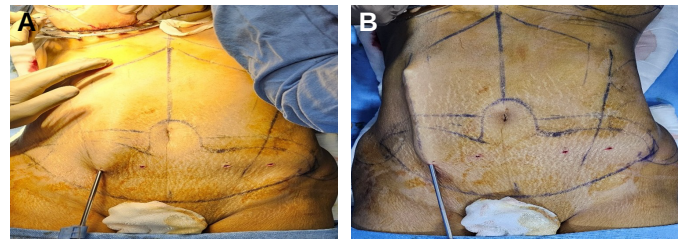


Figure 3. (A) Liposuction of the abdomen in deep plane and (B) liposuction of abdomen in superficial plane along the preoperatively marked zones. Patient is a 38-year-old female.

Step 2: Raising the Abdominal Flap

An incision was made over the inferior marking. The flap was then raised deep to scarpa's fascia along with the underlying subscarpal fat layer, baring the rectus fascia (Figure 4). The umbilicus was dissected all around to ensure its preservation. Continuing the dissection, the flap was further elevated superiorly with a width of 6 to 8 cm along the midline, extending up to the xiphoid process to expose the anterior rectus sheath.

Step 3: 3-Vector Plication of the Rectus Sheath

Transverse oblique plication of the rectus sheath was performed using 1 nylon by differential suturing below the umbilicus, that is, starting laterally to midline. The upper lateral point was approximated inferomedially lower point up to midline in a continuous manner. This technique serves dual purposes: it effectively reduces vertical excess and induces a horizontal narrowing effect, creating a flattering waist-cinching effect (Figure 5A, B, Videos 1, 2). Simultaneously, vertical midline plication of the rectus was conducted above the umbilicus using nonabsorbable sutures (1 nylon). This step addressed divarication of recti and rectified any horizontal excess, further refining the abdominal contours (Figure 5C). The intention of the 3-vector plication of the rectus fascia is to plicate the infraumbilical fascia in the horizontal direction to provide a flatter abdominal contour, in the vertical direction to enhance the definition of the abdominal wall, and obliquely to improve waist cinching and overall contouring. Anesthetists were asked to monitor peak inspiratory pressure before, during, and after the 3-dimensional (3D) rectus plication as an indirect tool to guide us about intra-abdominal pressure. Peak inspiratory pressure is the highest level of pressure applied to the lungs during inhalation. We made sure that the peak pressure difference before and after 3D plication was never >3 cm of H_2O. To mitigate postoperative pain, 20 mL of 0.25% bupivacaine was injected into the rectus muscle intraoperatively, promoting enhanced patient comfort.

Step 4: Monsplasty

The inferior abdominal flap was raised to elevate the mons pubis, and it was sutured to the rectus sheath fascia superiorly using 0 polydioxanone (PDS) sutures. This step not only lifts the sagging mons but also ensures that the tension on the suture line is reduced and prevents scar widening and migration postoperatively.

Step 5: Excising the Excess Skin and Subcutaneous Tissue

This procedure was conducted with the operating table in a straight position for optimal access and visualization. Infraumbilical excess

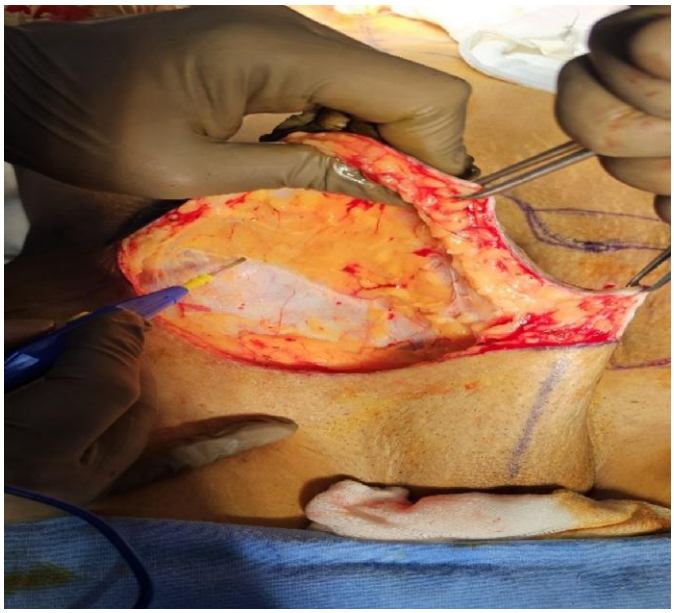


Figure 4. Subscarpal flap elevation taking all subscarpal fat in the flap baring rectus fascia. Patient is a 38-year-old female.

skin was excised laterally, extending up to the ASIS on both sides. Before excising any excess tissue, the reach of the flap was confirmed by repeatedly pulling the superior flap down to the lower incision, ensuring precise and adequate coverage. We have noticed that some patients' tissues are more pliable, and their skin excision can follow the radical superior line, and for some patients who have less pliable tissues, we do conservative superior line excision.

Step 6: Marking the Umbilicus Position

The flap was redraped and temporarily affixed to the inferior margin using a skin stapler. To determine the optimal position of the umbilicus, half the distance between the xiphoid and the pubic symphysis was measured and marked. Subsequently, an inverted crescent-shaped section of skin was excised over the marked area, allowing for precise repositioning of the umbilicus (Figure 6).

Following this, subcutaneous lipectomy was performed around the incision site to create a natural periumbilical depression, ensuring a seamless aesthetic outcome. To secure the umbilical stalk and prevent rotation, it was anchored at the 2 and 10'o clock positions to the anterior rectus sheath using 0 PDS sutures.

This technique ensures both vascular integrity and aesthetic harmony of the umbilicus.

Step 7: Progressive Tension Sutures

These sutures were applied along the midline from the xiphoid down to the umbilicus in the inferior direction, employing barbed PDS suture to reconstruct the natural linea alba. By recruiting superior abdominal skin and gently shifting it downwards, the sutures facilitate the restoration of anatomical integrity and contour.

PTSs were also used to suture the skin flap at the 12 and 6'o clock positions of the umbilical position. This ensured that tension around the umbilicus was borne by the skin flap and not the suture line.

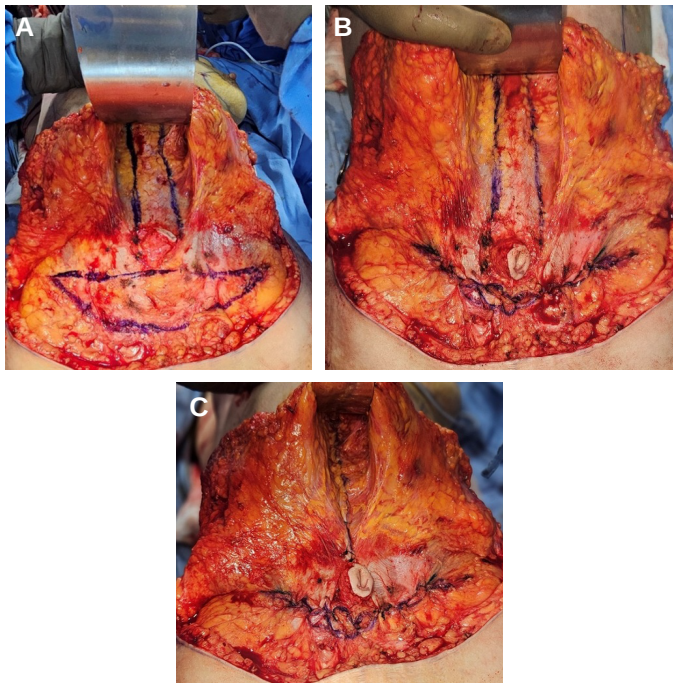


Figure 5. 3-Vector rectus plication. (A) Markings. (B) Technique of oblique horizontal plication. (C) Technique of vertical plication. Patient is a 38-year-old female.

Additionally, 2 to 3 tension sutures were placed on either side of the lower abdomen along the lateral margins of the rectus abdomens muscle. These sutures serve to secure the flap to the underlying rectus sheath along the margins of the rectus muscle, ensuring optimal fixation and stability of the reconstructed area.

Step 8: Umbilicoplasty

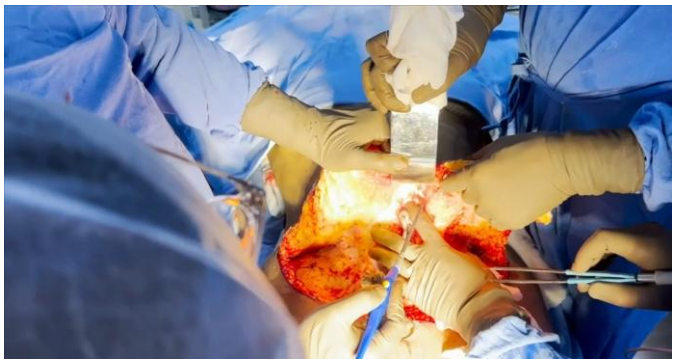
The separated umbilicus was repositioned and sutured to the skin flap with interrupted 3.0 monocryl sutures, ensuring precise alignment and secure attachment. Because the closure is performed in the above manner, the suture line comes in the sloping wall of umbilicus and hence is not visible.

Step 9: Abdominal Wall Closure

Closure was performed with the patient in a straight supine position. The superior and inferior flaps were aligned, and temporary staples were applied to ensure proper positioning. Any remaining "dog ears" were corrected to achieve symmetrical contours. To facilitate drainage and promote healing, 2 Romovac drains No. 18 were placed under the abdominal flap on either side and brought out over the mons pubis.

Closure was done in 3 layers. They are as follows:

1. The scarpa's fascia and deep subcutaneous tissue were closed with interrupted sutures using 1-0 PDS, ensuring structural integrity and support.
2. The subcutaneous layer was then closed with continuous 0 V-loc sutures, promoting even distribution of tension and minimizing the risk of tissue trauma.
3. Finally, the subcuticular layer was closed with continuous 3-0 monocryl sutures, ensuring a smooth and cosmetically appealing wound closure.



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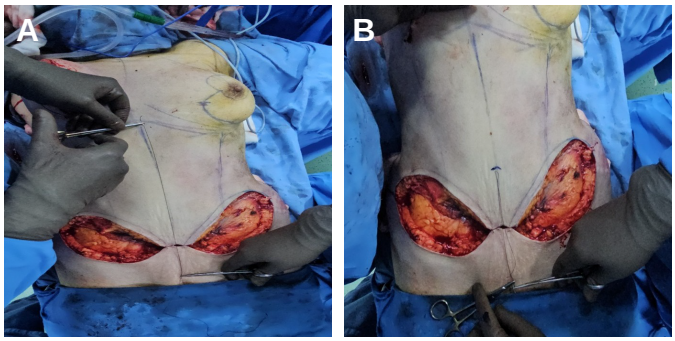

Figure 6. (A) Marking of umbilical location. (B) Midpoint of xiphisternum to pubis symphysis. Patient is a 38-year-old female.

Step 10: Compression Dressing

A paraffin gauze was delicately packed into the umbilicus to promote optimal healing and prevent infection. Subsequently, the suture line was dressed to protect the incision site and promote healing.

During the initial 24 h postsurgery, an elastic adhesive bandage dressing was applied to provide gentle support and compression. Following this period, the dressing was replaced with a compression garment, providing continued support and facilitating proper contouring during the healing process.

Postoperative Measures

In the postoperative period, all patients were placed in a Fowler position to optimize comfort and circulation. Mechanical deep vein thrombosis prophylaxis measures were implemented to mitigate the risk of clot formation. Pneumatic compression pump is routinely applied to all patients during intraoperative and postoperative procedures as an institutional best practice (Figures 7-9).

Additionally, each patient was mobilized the same day. Early mobilization commenced with patients encouraged to stand and walk after 6 h of surgery.

Oral antibiotics were administered for 5 to 7 days to prevent infection and were supplemented by topical antibiotics for 7 to 10 days to promote wound healing as our standard institutional best practice for prophylaxis. Drains were typically removed when the output reduced to <30 mL in 12 h which was usually within 36 to 48 h postoperatively. Patients were advised to wear compression garments with foam boards for 6 weeks to reduce swelling and promote optimal contouring.

Lymphatic massages were initiated on the third day postoperatively and continued for 3 months to enhance lymphatic drainage and reduce swelling. Scar management techniques, including massages and the application of silicone gel sheets, were employed to optimize scar healing and minimize scar appearance.

Patients gradually resumed light physical activity by the third week and commenced weight training exercises by the sixth week under supervision, ensuring a gradual return to full activity while minimizing the risk of complications.

RESULTS

The study included a total of 128 patients. The large majority were females (116, 90.6%). The mean age of the patients was 38.1 ± 9 years. The average BMI for most patients (101, 78.9%) was normal, and 23 were overweight (18.0%). Rectus diastasis or divarication of recti was observed in 95.3% of patients. Comorbidities, namely hernia, hypertension, and diabetes, were observed in 13 patients (Table 1).

Among the complications, seroma of the back was reported in 10 (7.8%) patients. Other complications noted were seroma lower abdomen, a widened scar, and a hypertrophic scar reported in 4 (3.1%) patients each. No secondary procedures or scar revisions were needed. Wound dehiscence and necrosis were reported in 2 (1.6%) and 1 (0.8%) patient, respectively (Table 2). The small dehiscence was <5 mm at midline in each case (2) and healed secondarily. In addition, 1 case had small necrosis, which was in the mid-suture line of the superior flap (1 × 1.5 cm) which also healed by secondary intention.

The satisfaction level reported was very high by almost all (126/128) with respect to abdominal shape, contour, and skin laxity (98.4%) each. Those who reported “satisfied” or “highly satisfied” about umbilicus shape and scar quality were 120 (93.8%) and 113 (88.3%), respectively (Table 3). A validated 5-point Likert scale was used to assess satisfaction levels at 6 months postsurgery.

DISCUSSION

In today’s social media-driven era, body-contouring procedures aim to accentuate the body’s shape, emphasizing defined contours and high definition. When it comes to abdominoplasty, the objective is to sculpt a slender waistline, enhance muscular definition, and

Figure 7. Patient is a 43-year-old female. (A, C, E, G) Preoperative and (B, D, F, H) 30 weeks postoperative.

achieve a natural, youthful appearance for the belly button by eliminating excess fat and excising loose skin.[8] We believe the SHARP technique helps to achieve these results.

In pursuit of superior results, we have refined and standardized our 10-step lipoabdominoplasty technique. Through this approach, we strive to deliver safe outcomes with the combined procedure, meeting the evolving aesthetic expectations of our patients. Our approach is suitable for a large subset of patients in our population who have substantial subscarpal fat but still demand high-definition results postabdominoplasty.[9] In our experience and observation, we have noticed that the Indian subset of the population has more subscarpal fat than our western counterparts. Moreover, such a subset of patients is more prone to wound dehiscence and healing issues. Our technique describes several steps to ensure the tension is mitigated at the suture line, and hence, healing issues are minimal in postoperative period.[2,10] However, this technique can be used for all ethnicities, and we have successfully used it in our experience too. Our 10-step SHARP technique of high-definition abdominoplasty helps us to ensure not only high-definition results but also reduced complication rates.

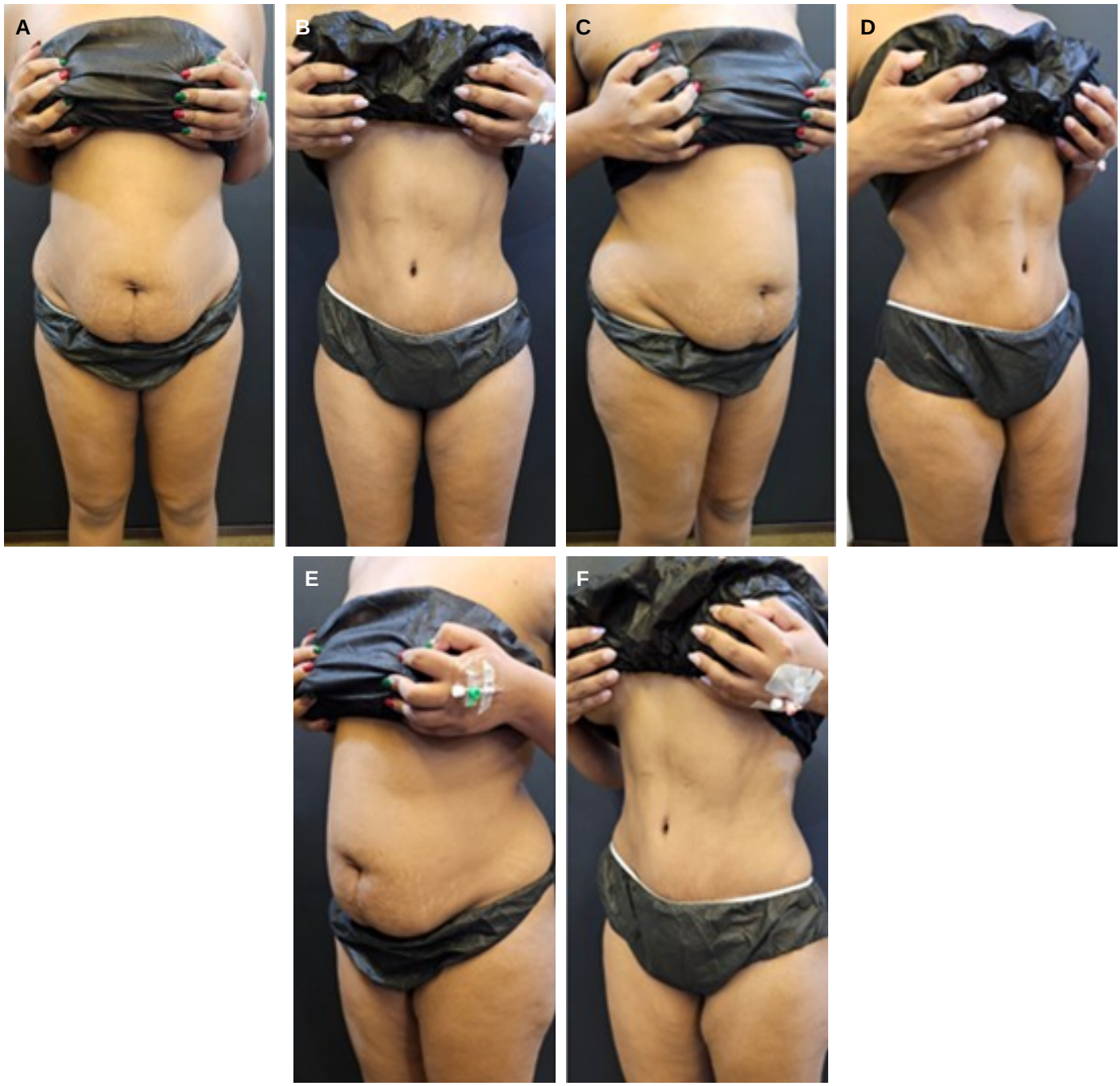

Figure 8. Patient is a 38-year-old female. (A, C, E) Preoperative and (B, D, F) 24 weeks postoperative.

In our liposuction procedures, we have integrated the VASER-Assisted High Definition Liposculpture by Hoyos.[6] This method involves the use of VASER technology to emulsify both superficial and deep fat layers, minimizing tissue trauma while allowing for sculpting of muscular anatomy with enhanced precision. Because the fat emulsification process using VASER is liposelective and atraumatic to perforators, it helps suction out fat to achieve great detail in muscular contouring while ensuring safety to the flap vascularity. By employing VASER technology, we also leverage its capacity for skin contraction, providing additional benefits beyond traditional liposuction methods.[11]

Saldanha et al's approach and modification of lipoabdominoplasty suggest that suprascarpal dissection of the flap preserves the lymphatic supply and, hence, reduces the chances of seroma formation.[12] However, in our experience, we have noticed that in our patients, there is a huge amount of subscarpal fat that needs excision to achieve good contouring.[9] Hence, we perform subscarpal dissection to help remove the fat above the rectus fascia.

Figure 9. Patient is a 29-year-old female. (A, C, E) Preoperative and (B, D, F) 26 weeks postoperative.

Knowing that this might cause a greater chance of seroma, we used PTSs to reduce the dead space and chances of seroma complication, as described by Pollock and Pollock.[3] Moreover, these PTSs, when used in the midline over linea alba as well as in the region of linea semilunaris, help achieve an attractive muscular contouring in our patients.[8] Another important advantage of PTS is to mobilize the above flap and shift it downwards toward the final suture line, which in turn reduces tension at the time of wound closure. This further ensures a reduced incidence of wound dehiscence.[2]

Saldanha's technique described in 2009 explained how vertical plication of the rectus is important, but the TULUA modification described in 2013 emphasized transverse plication without undermining above the umbilicus, coupled with full liposuction, neoumbilicoplasty with a skin graft, and a low transverse abdominal scar to improve vascularity.[7]

We believe that when the rectus expands in patients either because of weight gain or because of pregnancy, it expands in all 3 dimensions, and hence, it is physiologically important to tighten the

Table 1. Profiling of Study Patients

Parameters	No. of patients ($n = 128$)	Patients (%)
Age (years)		
<30	21	16.4
30-40	56	43.8
40-50	36	28.1
>50	15	11.7
Mean ± SD (range)	38.1 ± 9 (25-59)	
Gender		
Female	116	90.6
Male	12	9.4
BMI categories		
Underweight (<18.5 kg/m^2)	3	2.3
Normal weight (18.5-24.9 kg/m^2)	101	78.9
Overweight (25.0-29.9 kg/m^2)	23	18.0
Obese (30.0-32.0 kg/m^2)	1	0.8
Mean ± SD (range)	22.8 ± 2.5 (16.6-30)	
Median (IQR)	22.8 (21.1-24.3)	
Comorbidities		
Hernia	6	4.7
Hypertension	4	3.1
Diabetes	3	2.3

IQR, interquartile range; SD, standard deviation.

Table 2. Postoperative Complications

Postoperative complications	No. of patients ($n = 128$)	Patients (%)
Seroma back	10	7.8
Seroma abdomen	4	3.1
Widened scar	4	3.1
Hypertrophic scar	4	3.1
Wound dehiscence	2	1.6
Necrosis	1	0.8

rectus fascia in all these dimensions as well. Hence, we tighten the rectus fascia in a transverse oblique manner to achieve a waist-cinching or waist-narrowing effect (visible in Videos 1, 2). This transverse movement of the rectus ensures that the superior flap is shifted downward, reducing the tension on the suture line at the time of closure. This is important for reducing wound dehiscence and flap necrosis. Vertical plication was performed to ensure rectus fascia tightening in all 3 dimensions to restore the native anatomy.[8]

We understand that in the TULUA technique, which involves horizontal plication, the umbilicus gets pulled down so much that it has to be severed, and a neo-umbilicus needs to be created. However, because we do 3-vector rectus tightening, we do not need to tighten horizontally too much. This ensures the umbilicus is not pulled down that much. Infact, umbilicus position in our series is placed at the midpoint of the xiphoid and the pubic symphysis (see Videos 1, 2).

Lifting the mons in all cases and fixing the scarpa's fascia to the rectus fascia not only helps lifting the mons to achieve much more aesthetically pleasing results but also makes sure the surgical scar does not widen or migrate in postoperative period.[13]

Drawing inspiration from pioneers like Pitanguy, we have developed a scar that not only avoids crossing the ASIS but also remains discreetly hidden within the bikini line.[2,14] This approach ensures that patients can confidently wear swimsuits without any visible scarring.

For umbilicoplasty, we opted for the inverted smiley incision technique, which resulted in no obvious scarring in 128 patients. This contrasts with Saldanha's article, where the star-shaped technique was utilized. Notably, all our patients exhibited no obvious scarring, highlighting the success of our chosen approach.

Over time, we have refined and standardized our 10-step SHARP technique to consistently achieve high-definition results in abdominoplasty patients. Key points include marking positions in both the standing and supine positions, ensuring skin excision and closure are always performed with the patient in a supine straight position. Additionally, after closure, we have the patient flex to reduce suture line tension, optimizing healing. A critical aspect of our approach is initiating the procedure with back liposuction. We firmly believe that 360° liposuction is essential in every case because it facilitates superior skin redraping circumferentially.[15,16] Furthermore, in our patient subset, excising the subscarpal thick fatty layer yields a narrower waistline, enhancing the overall aesthetic outcome. The use of PTS is integral to our technique because it helps recreate the linea alba and linea semilunaris, contributing to the high-definition look desired by our patients.

Transverse oblique plication, as described in our procedure, helps in uniform tightening of the rectus sheath and shifts the superior abdominal flap inferiorly, which helps for better approximation at the suture line. We endeavor to preserve the natural belly button because it has cultural implications in many religions in India. The location of the belly button and its suturing technique as described above ensure attractive contours with no visible scars around the belly button.[8] An umbilical scar is a giveaway in abdominoplasty patients, and the steps described above ensure scars remain under the sloping edge of umbilical skin and hence are not visible.

Limitations

The study is from a single institution and single primary surgeon and has no comparison groups and no independent evaluators of the results. The 6-month follow-up is a limitation, and we feel that the surgical understanding and outcomes evaluation of both long-term complications and sustained effectiveness will benefit from a longer follow-up of at least 12 months. Additionally, the small sample size and the predominance of normal-weight patients may skew results. It is essential to explore the impact of weight variations on surgical outcomes for a more comprehensive analysis. Future studies should expand upon these results with longer follow-up.

Table 3. Distribution of Patient Satisfaction Levels

Patient satisfaction	No. of patients ($n = 128$)	Patients (%)
Abdominal shape and contour		
Very dissatisfied	0	0
Dissatisfied	0	0
Neutral	0	0
Satisfied	2	1.6
Highly satisfied	126	98.4
Umbilicus shape		
Very dissatisfied	0	0
Dissatisfied	0	0
Neutral	8	6.3
Satisfied	27	21.1
Highly satisfied	93	72.7
Scar quality		
Very dissatisfied	0	0
Dissatisfied	3	2.3
Neutral	12	9.4
Satisfied	50	39.1
Highly satisfied	63	49.2
Skin laxity		
Very dissatisfied	1	0.8
Dissatisfied	0	0
Neutral	0	0
Satisfied	1	0.8
Highly satisfied	126	98.4

CONCLUSION

The SHARP technique is useful for high-definition abdominoplasty results, with low complication rates and high patient satisfaction. Our reproducible 10-step approach provides a safe approach to abdominoplasty in our experience.

Supplemental Material

This article contains supplemental material located online at https://doi.org/10.1093/asjof/ojaf053.

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Disclosures

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