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VIEWPOINT
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Standardized Reporting of Weight Control following Body Contouring

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The three systematic reviews (SRs) of weight control in the body contouring (BC) population highlight the need for greater attention to consistent reporting of weight control metrics. Seretis et al's SRs of predominantly nonbariatric BC patients in 2013 and 2015 include studies with many liposuction-only patients, generally limited follow-up (3 months or less for several cohorts), metrics limited to BMI and absolute weight change, and inconsistent adjustments for tissue resection weight.[1,2] ElAbd et al's SR in 2020 and metaanalysis comparing postbariatric BC patients with postbariatric patients who did not undergo BC included a pooled analysis demonstrating significantly greater percent total weight loss (%TWL) and percent excess weight loss (%EWL) with the addition of BC surgery following bariatric surgery.[3] Although these calculations are helpful, the studies from which they are based are inconsistent in metrics reported, anatomic areas addressed with BC, adjustment for tissue resection weight, and time at which weight loss was calculated (maximum weight loss versus endpoint follow-up).[3] In addition, several more studies with large patient censuses and sufficient follow-up are not accounted for in these SRs due to lack of bariatric-only case controls and reference times based on BC surgery date rather than on bariatric surgery date.

Given the frequency with which BC procedures are performed, it should be realistic to define the weight trends of patients who undergo BC of specific anatomic regions. The variability in metrics reported in the literature has challenged this analysis. We propose a standardized system for measuring and reporting weight control following BC:

1. Prioritize %TWL and %EWL over other weight metrics (BMI and absolute weight change);
2. Report %TWL and %EWL at endpoint follow-up and at yearly intervals following BC;
3. Report results only for patients with a follow-up of at least 6 months;
4. Calculate %TWL and %EWL adjusted for weight of tissue resection;
5. Attempt to categorize results based on BC by anatomic area.

The utility of %EWL has been challenged in the bariatric surgery literature, as these values are highly dependent on patients' starting BMIs.[4] When %EWL is averaged over a cohort, significant weight loss in one patient of a higher starting BMI can offset weight gain in multiple patients with lower BMIs. The gold-standard metric is now %TWL, and focusing on long-term results rather than maximal %TWL is vital. Because of the frequency with which %EWL has been reported in the surgical literature, it is worthwhile to continue reporting this value in addition to the more ideal %TWL. It is also important to recognize that %TWL might be a negative value in these studies, as weight regain following BC is not uncommon.

Similar standardized recommendations for reporting weight outcomes have been advocated in the bariatric surgery community, and it is prudent for our field to also standardize weight control reporting to allow for higher quality comparisons among multiple studies.[5] As more centers evaluate the weight trends of the growing population of BC patients, adhering to these standardizations will enhance the quality of our collective data.

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