of which can clearly be seen immediately. This effect must be overdone to allow for the variable soft-tissue stretch that occurs when tissues are surgically manipulated and the internal breast scaffold of connective tissue is cut. In any technique, the initial correction is partially lost in some, and significantly lost in others. However, and this is the important point, in the presence of a hollowed-out and concave upper pole contour, it is better than doing nothing. It becomes a frustrating exercise to "defend" such attempts at upper pole correction. Measurements made on postoperative photographs are notoriously difficult to reliably compare, soft tissues from patient to patient vary, and surgical technique is individualized for each patient. Also, performing a study where one side of a mastopexy undergoes an upper pole shaping maneuver and one side does not would likely never accrue a single patient and would likely be unethical. Even if one could do such a thing, the presence of any breast asymmetry, which is the norm for the vast majority of patients, would diminish the power of comparison between the two breasts. Therefore, claims that such shaping maneuvers fail to have an effect on the upper pole are missing a key element, namely, the presence of an adequate control. Certainly, the effect of the lower island flap transposition procedure and other types of tissue-based shaping maneuvers can be subtle and difficult to measure, but to suggest that there is no effect to them is certainly arguable and could unfortunately and, in my opinion, wrongly discourage future attempts at improving our techniques for mastopexy. Eventually, it is up to each individual surgeon's training, experience, and technical expertise to successfully apply these and other technical modifications in the treatment of breast ptosis.

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DISCLOSURE

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Post–Bariatric Surgery Body Contouring Treatment in the Public Health System: Cost Study and Perception by Patients

Sir:

We read with interest the article by Poyatos entitled "Post–Bariatric Surgery Body Contouring Treatment in the Public Health System: Cost Study and Perception by Patients" published in the September 2014 issue of *Plastic and Reconstructive Surgery*.[1] Because of the high prevalence of obesity, there is a growing demand for bariatric surgery worldwide.[2]

The indications for bariatric surgery should be viewed in terms of individual patient benefit without anticipating that there will be cost savings to a health care system by offering this treatment. A recent meta-analysis showed that remission of type 2 diabetes occurs in approximately 77 percent of patients and resolves or improves in 85 percent. Dyslipidemia also improves or resolves in 70 to 95 percent of surgically treated patients, as does hypertension in 87 to 95 percent. Surgery also lowered cardiovascular event rates by 43 percent, cancer rates by 33 percent, and overall mortality by 30 percent.[3]

Health care cost assessment based on claims paid by BlueCross BlueShield for a period up to 6 years postoperatively for almost 30,000 patients who had undergone bariatric surgery failed to demonstrate a cost benefit for weight loss surgery compared with a comparison group of patients who did not undergo surgery but who had similar obesity-related diagnoses. Likewise, cost-effectiveness analysis of data from the U.S. Department of Veterans Affairs did not show a cost benefit for bariatric surgery.[4] The time horizon that is relevant for determining the financial case of any intervention can vary widely among payers in the United States. Given the significant turnover in commercially insured populations, early cost reductions are perhaps more important for payers such as BlueCross BlueShield to demonstrate a compelling business case for bariatric surgery. Payers such as Medicare or the Veterans Health Administration can accept longer time horizons to achieve health care cost reductions because they are typically responsible for enrollees over many years.[3]

It is disappointing that reduced use of health care money cannot be demonstrated in the early years following bariatric surgical procedures, because this economy could pay for the expenses of the plastic surgery. Post–bariatric surgery body contouring treatment is often regarded as cosmetic and therefore of low priority, which means funding is either unavailable or subject to various criteria. Bariatric surgery patients who desire body-contouring surgery perceive cost as a major barrier.[5]

We propose that post–bariatric surgery patients should have easier access to the plastic surgery procedures more in keeping with the pathway followed by breast cancer patients who are automatically funded for their oncoplastic procedures. For instance, some hospitals provide free health care to people with household incomes up to three times the federal poverty level. Plastic surgery grants help those who cannot afford surgery by funding all or part of the treatment costs. Postbariatric plastic surgery may be covered for some health insurance, and if it is not covered, there is a chance that the patient could get it added to his or her plan. If none of the above applies, the bariatric surgeons should advise their patients to save to have the plastic surgery procedures performed privately.

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Reply: Post–Bariatric Surgery Body Contouring Treatment in the Public Health System: Cost Study and Perception by Patients

Sir:

We would like to thank Dr. Valente et al. for their comments regarding our article entitled "Post–Bariatric Surgery Body Contouring Treatment in the Public Health System: Cost Study and Perception by Patients"[1] published recently in the *Journal*. They point out that indications for bariatric surgery should be individualized because, as two recent studies concluded, bariatric surgery is not always better in terms of cost benefit.[2] We agree that time horizons considered by different payers could explain these differences. The cost-effectiveness evaluation of bariatric surgery[3,4] requires long follow-up periods (in general, >5 years), but for private payers, the evaluation of shorter postoperative times can be more important. A second aspect to consider is not only the benefit in terms of weight loss (as the revision of claims paid by BlueCross BlueShield) but also the improvement of comorbidities[5] and quality of life.

The comparison between the pathway followed by oncoplastic patients and post–bariatric surgery patients to obtain funds proposed by Dr. Valente has two main drawbacks. The first one is the necessary postoperative bariatric period. Although the oncoplastic operation can be performed in one stage or initiated immediately in many cases, the postbariatric surgery always requires a gap of time to the weight loss and its stabilization.[6] The second one is the number of postbariatric operations required in each patient (mean, 1.66 in our series)[1] and the high costs of severe complications.

The basis of the financial problems with postbariatric surgery, from our point of view, is that in the absence of standard criteria arrived at by consensus between the American Society of Plastic Surgeons and the private payers, most of these operations are considered as cosmetic and therefore only a few are funded by the insurance providers. Also, the lack of consensus creates uncertainty when the plastic surgeon has to inform the patient about the probabilities of the inclusion criteria being fulfilled. Therefore, a first step could be an American Society of Plastic Surgeons proposal to the group of insurance providers to arrive at a consensus.

If this consensus existed, the patients with low household incomes who could not obtain complete funding should be able to obtain discounts or public grants to complete their treatment. Also, if there is no possibility for any help to afford this surgery, information about costs should be discussed in the prebariatric phase, and ideally by a plastic surgeon.[7]

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