To the Editor: We read with great interest the article on bariatric surgery by Presutti et al\(^1\) in the September 2004 issue of *Mayo Clinic Proceedings*. The authors provided an excellent review of the indications, details, and outcomes of bariatric surgery. However, we believe that they understated the considerable need that most of these patients have for reconstructive surgery, as opposed to “cosmetic surgery,” after their massive weight loss. The authors stated that “in most circumstances, such excess skin is a cosmetic problem.” We argue that the opposite is true. Patients with massive weight loss (especially those who have lost >45 kg) usually have substantial amounts of lax skin and tissue that can cause such problems as recurrent and severe intertriginous rashes, dermatitis, ulcerations, and wounds that are often unresponsive to medical therapy. They may also have functional impairments such as difficulty in accomplishing activities of daily living, ambulation, and personal hygiene.

The distinction between aesthetic or cosmetic surgery and reconstructive surgery is important. Cosmetic surgery involves improvement of normal structure and appearance. Reconstructive surgery tries to restore to as close to normal as possible those body parts that have been rendered abnormal due to disease, trauma, cancer, or, in this case, massive weight loss after obesity. We suggest that the surgical care of massively obese patients should be a 2-step process—bariatric surgery followed by reconstructive surgery to deal with the excess skin and subcutaneous tissue. Unfortunately, patients rarely hear preoperatively about this second phase of treatment.

We believe that primary care physicians would benefit from understanding this distinction and congratulate the authors on an otherwise superb article.

In reply: My colleagues and I thank Drs Knoetgen, Petty, and Johnson for their interest in our article, and we agree that patients with massive weight loss usually require further surgery to reduce excess skin. The challenge is convincing an insurance carrier that the skin presents a functional problem, unless, as discussed in our article, the patient has experienced recurrent dermatitis or cellulitis. We attempted to increase awareness of the need for additional skin reduction surgery by discussing the issue in a separate section within the article. Perhaps a better statement would be, “In a large fraction of patients after bariatric surgery, problems with excess skin and proposed surgical treatment are considered cosmetic issues by insurance carriers. However, because excess skin after bariatric surgery may introduce definite functional impairment for the patient, skin reduction surgery should instead be considered reconstructive.” This distinction is important because the goal of such surgery is to render to as close to normal as possible those body parts that have been rendered abnormal as a part of a disease process (ie, a goal of reconstructive surgery) rather than to improve normal body structure and appearance (ie, the primary goal of cosmetic surgery).

R. John Presutti, DO Mayo Clinic College of Medicine Jacksonville, Fla