Liquid silicone has been used extensively as an injectable soft-tissue filler. It is inexpensive, available “off the shelf,” minimally antigenic, and likely noncarcinogenic. Its simplicity of use has made it popular as a soft-tissue filler in some parts of the world for patients seeking rapid soft-tissue augmentation of the face, breast, and buttocks. However, multiple reports describe the complications of silicone injections such as cellulitis, abscess, ulceration, and foreign body migration. We present an unusual complication of granulomatous reaction secondary to silicone injection for buttock augmentation, with a literature review of this entity and treatment options. Our patient was a 54-year-old woman who underwent bilateral buttock augmentation in the Dominican Republic using percutaneous injection of liquid silicone. She presented to our facility 1 year after this procedure with pain and inflammation of both buttocks. She was diagnosed with multiple silicone granulomas. Her symptoms completely resolved with a 3-week course of minocycline. Granulomatous reactions to silicone may occur months to years after the silicone injection. The incidence of such complications may be increased when nonmedical-grade silicone is used, and hence, when these procedures are performed in developing countries. Tetracycline antibiotics, especially minocycline, may be used to achieve sustained remission. (Plast Reconstr Surg Glob Open 2016;4:e624; doi: 10.1097/GOX.0000000000000618; Published online 19 February 2016.)

CASE REPORT

The patient, a 54-year-old woman, presented to our emergency room with 4 days of erythema, induration, and pain in her bilateral buttocks (Fig. 1). Her medical history was significant for bilateral buttock augmentation performed once on an outpatient, approximately 1 year before in the Dominican Republic. We contacted the practitioner who performed the

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procedure by phone, but they did not have a record of the substance injected. The patient had a temperature of 101.2°F, and laboratory results showed a leukocytosis of 12.2 thousands/microliter. Because of the concern about the possibility of infection (which we have seen commonly in similar patients), the patient was empirically started on vancomycin and ceftriaxone pending further studies. Magnetic resonance imaging was performed, which demonstrated extensive edema of the gluteal subcutaneous tissue, numerous nodular foci likely representing injected foreign material, consistent with silicone, and no discrete drainable fluid. To rule out the infection and accurately diagnose the injected substance, we performed a deep tissue biopsy. This was sent for Gram stain and bacterial, fungal, and mycobacterial cultures—all of which returned negative. Pathology was consistent with a silicone granulomatous reaction associated with patchy acute inflammation (Fig. 2).

After review of the pathology, vancomycin and ceftriaxone were discontinued, and the patient was transitioned to twice daily 100 mg minocycline to treat this inflammatory reaction. She did not receive steroids. Her symptoms completely resolved within 3 weeks, and minocycline was discontinued (Fig. 3). Given the diffuse and extensive nature of her silicone injections and resolution of her symptoms with medical management, we decided against surgical debridement. She has not had any recurrence of her symptoms during 18-month follow-up.

**DISCUSSION**

Medical-grade silicone is a standardized sterile preparation with high purity and long shelf life. Its use as a soft-tissue filler has been described using a microdroplet technique (0.01–0.03 mL droplets of silicone) in the deep dermal or subdermal plane at 1- to 3-mm intervals with 4- to 6-week intervals between repeated injections. By using this technique, multiple authors have described satisfactory results. However, complications have been reported. Injection of large volumes of silicone can result in tracking along tissue planes to distant sites. Industrial or nonmedical silicone may be associated with high complication rates. Inexperienced practitioners may also be more apt to inject less judiciously. Furthermore, it can be challenging to determine the technique and materials used when such procedures are performed in foreign countries and present in the United States with complications.

Erythema, edema, and textural changes that occur immediately after the procedure are generally self-limited. Serious complications include chronic cellulitis and abscess formation, ulceration, pneumonitis, cosmetic irregularities and asymmetries,
perforation or injuries to critical structures, foreign body reactions, and migration of silicone. These can present even years after injection.\textsuperscript{3–7} Granulomatous reactions after silicone injection for buttock augmentation have only been reported in limited studies.\textsuperscript{8–14} A summary of available reports of silicone granuloma after liquid silicone injection for buttock augmentation is described in Table 1. The period between procedure and symptoms ranges from 5 months to 10 years. Almost all reported patients have been treated by unlicensed practitioners with an unknown grade of silicone.\textsuperscript{11} Most of the patients with this complication present with erythema, induration, and plaques (well-circumscribed, elevated, superficial, solid lesions) in the buttocks. Two of 8 patients described in the literature underwent this procedure in Dominican Republic similar to our index patient.\textsuperscript{8,14}

When patients present with an incomplete history, questionable circumstances, or unknown surgery, an accurate diagnosis is a key step in directing appropriate treatment. We have been successful in achieving diagnoses with a combination of laboratory studies, imaging, and tissue pathology. Perhaps most important at the outset is to rule out a severe or atypical infection, many of which we have seen in cosmetic surgical patients returning from surgery in the developing world.

The treatment of silicone granulomas can be challenging, and a number of treatment modalities have been described with varying degrees of success. Tetracycline antibiotics, mainly minocycline, have been reported to result in complete resolution of symptoms in multiple studies.\textsuperscript{21,22} This could be attributed to the inherent antiinflammatory and immune-modulating capacity of this drug. Other immunomodulating therapies, such as etanercept, have been described.\textsuperscript{8,23} Oral steroids may result in temporary resolution but seem to be prone to recurrence during tapering.\textsuperscript{21,24} Surgical excision may be considered if a granuloma is well circumscribed, but these injections are typically so extensive and diffuse that surgery can be complicated and disfiguring and complete silicone removal is often impossible.\textsuperscript{6}

**CONCLUSIONS**

Granulomatous reactions to silicone may occur months to years after silicone injection for buttock augmentation. The incidence of such complications may be increased when nonmedical-grade silicone or poor technique is used. Given the abundance of well-studied alternative substances and the relative success of fat grafting in larger volume cases, we do not perform liquid silicone injections. The use of tetracycline antibiotics, especially minocycline, appears to be successful at achieving sustained remission.

**REFERENCES**


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**Table 1. Disease and Treatment Characteristics of the Patients Diagnosed with Silicone Granulomas Secondary to Buttock Augmentation with Liquid Silicone Injection**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Age/Sex</th>
<th>Incubation Period</th>
<th>Material/Practioner</th>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pasternack et al\textsuperscript{8}</td>
<td>47/F</td>
<td>10 y</td>
<td>Medical grade/nonprofessional (DR)</td>
<td>Erythema, swelling of anterior legs</td>
<td>Etanercept × 2 mo</td>
</tr>
<tr>
<td>Pasternack et al\textsuperscript{8}</td>
<td>37/F</td>
<td>5 mo</td>
<td>Not described</td>
<td>Erythematos nodules and plaques in buttocks</td>
<td>Etanercept × 1 mo</td>
</tr>
<tr>
<td>Schwartzfarb et al\textsuperscript{9}</td>
<td>40/F</td>
<td>9 mo</td>
<td>Medical grade/nonprofessional</td>
<td>Recurrent cellulitis of right lower extremity</td>
<td>Prednisone × 30 mg daily (tapered) + minocycline</td>
</tr>
<tr>
<td>Altmeyer et al\textsuperscript{10}</td>
<td>38/F</td>
<td>1 y</td>
<td>Unknown grade/illegal practitioner</td>
<td>Erythematos plaques in bilateral gluteal cleft</td>
<td>Not discussed</td>
</tr>
<tr>
<td>Lopiccolo et al\textsuperscript{11}</td>
<td>29/F</td>
<td>3 y</td>
<td>Unknown grade/illegal practitioner</td>
<td>Fever, chills, pain nodules in buttocks and posterior thighs</td>
<td>Minocycline 100 mg bid × 4 wk + tetracycline 500 mg bid × 8 wk</td>
</tr>
<tr>
<td>Camuzard et al\textsuperscript{13}</td>
<td>63/F</td>
<td>9 y</td>
<td>Unknown grade/unknown</td>
<td>Inflammatory plaques on buttocks, hypercalcemia</td>
<td>Prednisone 30 mg daily × 3 wk (tapered) + minocycline 100 mg bid</td>
</tr>
<tr>
<td>Emer et al\textsuperscript{12}</td>
<td>30/F</td>
<td>Not described</td>
<td>Unknown grade/unknown</td>
<td>Edematous, indurated plaques and nodules of buttocks</td>
<td>Minocycline 100 mg bid × bid</td>
</tr>
<tr>
<td>Paul et al\textsuperscript{14}</td>
<td>47/F</td>
<td>9 mo to 2 y</td>
<td>Unknown grade/not described (DR)</td>
<td>Erythematos indurated plaques on the left buttock</td>
<td>Doxycycline 100 mg bid × bid</td>
</tr>
</tbody>
</table>

*bid, twice daily; F, female; DR, Dominican Republic.*