Extended Deep Plane Facelift

Incorporating Facial Retaining Ligament Release and Composite Flap Shifts to Maximize Midface, Jawline and Neck Rejuvenation

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KEYWORDS

• Rhytidectomy • Face lift • Deep plane facelift • Facial retaining ligaments • SMAS • Platysma • Neck lift

KEY POINTS

- Deep plane facelifting targets the mobile medial superficial muscular aponeurotic system, bypassing the lateral fixed superficial muscular aponeurotic system dissected in these techniques.
- Releasing facial and cervical retaining ligaments allows greater redraping of the superficial muscular aponeurotic system and platysma during rhytidectomy.
- Extending the deep plane flap inferiorly into the neck and incorporating a platysmal myotomy creates a platysma hammock to define the inferior mandibular contour and support the submandibular gland.
- Deep plane composite flaps of skin, the superficial muscular aponeurotic system, and malar fat can be repositioned to volumize the midface and gonial angle.

INTRODUCTION

To better understand the rationale behind deep plane facelifting and how it differs from lateral superficial muscular aponeurotic system (SMAS) facelifting (high or low), an understanding of the complex anatomy of the SMAS and soft tissues of the face is necessary. The SMAS layer was first described by Mitz and Peyronie in 1976.[1] The SMAS layer is continuous with the platysma muscle inferiorly and the temporoparietal fascia and galea aponeurotica superiorly. In the face, the SMAS lies between the subcutaneous adipose tissue, which compromises the superficial fat compartments of the face, and the underlying parotidomasseteric fascia, within which lies the facial nerves. The thickest SMAS is found in the lateral face overlying the parotid gland. The SMAS attenuates as it travels from lateral to medial in the midface, terminating at the lateral border of the zygomaticus major muscle[2] (**Fig. 1**).

Sub-SMAS dissection techniques, first introduced by Skoog in 1974,[3] tend to allow for both improvement of aesthetic change as well as increased longevity. The variance of SMAS mobility in different facial regions is important

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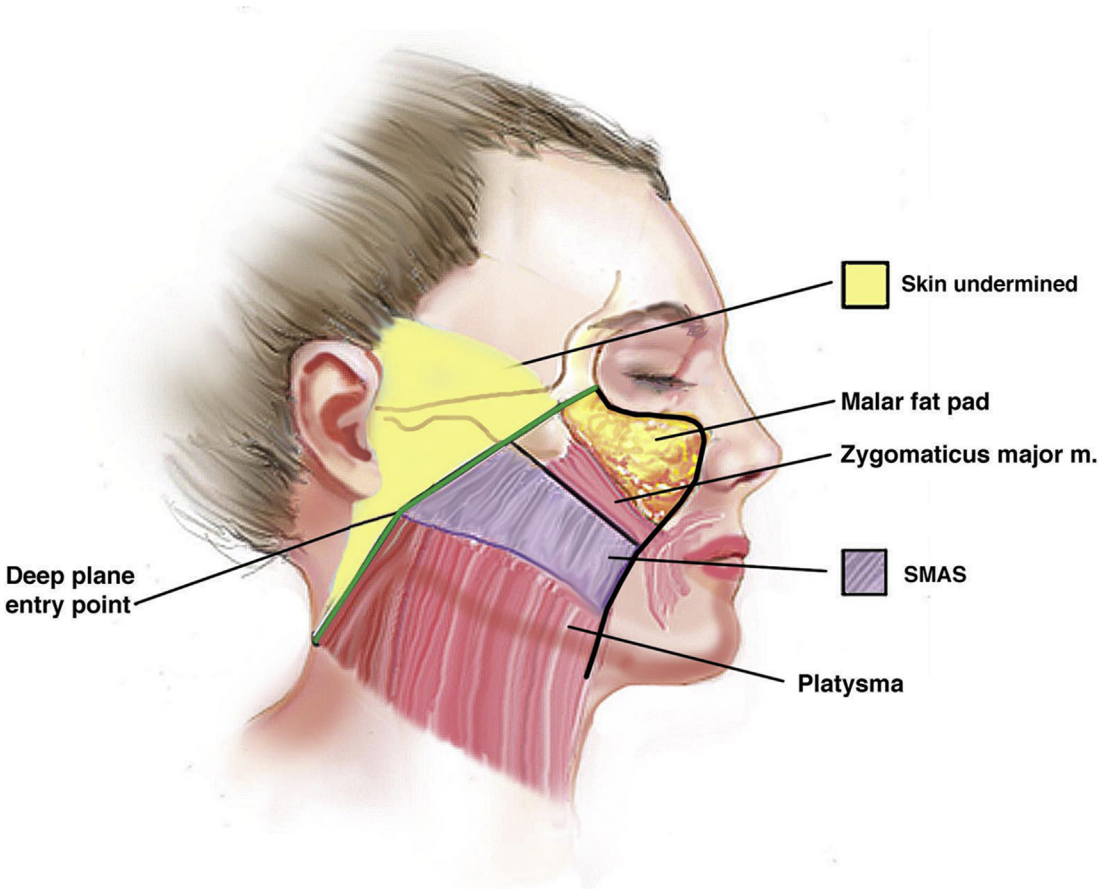

Fig. 1. The superficial muscular aponeurotic system (SMAS) is found in the lateral face overlying the parotid gland, is contiguous with the platysma inferiorly, and terminates at the lateral border of the zygomaticus major muscle. Medial to this point the malar fat pad overlies the zygomaticus musculature.

when considering the optimal areas for surgical manipulation during facial rejuvenation. The lateral SMAS overlying the parotid gland is generally fixed by the parotid cutaneous fascial attachments connecting it to the underlying parotid gland. We refer to this area as the "lateral fixed SMAS." Release of these attachments is required for successful mobilization and redraping of the SMAS. SMAS plication or imbrication techniques do not release these tissue attachments, so that redraping the jawline and medial facial tissues is more difficult. In contrast, surgical procedures that release the lateral SMAS from its deep attachments allow for more effective redraping of ptotic facial tissues.

As the SMAS extends medial to the parotid gland, it is not firmly adherent. A transition zone can be seen topographically in the aging face where the medial mobile SMAS descends and the lateral fixed SMAS does not (**Fig. 2**). The area of the lateral fixed SMAS involutes, creating a scalloping or concavity over the gonial angle, and the neck and jawline lie in the same plane with no distinct mandibular border. As we will discuss elsewhere in this article, deep plane facelifting adds volume and contour to the gonial angle through composite flap shifts, improving the definition of the jawline.

The deep plane facelift enters the sub-SMAS plane at a line that traverses from the angle of the mandible to the lateral canthus. This approximates the transition zone between the fixed and the mobile SMAS. Traditional low SMAS and high lateral SMAS techniques elevate the fixed SMAS that has not descended with age to access the mobile SMAS that has. The deep plane facelift bypasses lifting the lateral fixed SMAS and targets the descended mobile SMAS and medial soft tissues (**Fig. 3**). The fixed lateral SMAS is fibrous, adherent, and difficult to dissect. The mobile SMAS is areolar in nature and easier to dissect. We believe this variation in SMAS mobility makes facelifting procedures that place traction on the medial mobile SMAS instead of the fixed lateral SMAS more

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