Management of the Platysma in Neck Lift

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KEYWORDS

• Neck lift • Platysmaplasty • Platysmamyotomy • Platysmapexy • Platysma bands
• Platysma hyperfunction • Full-width platysma transection • Postauricular transposition flap

KEY POINTS

- Traditional treatment of platysma bands has consisted of corset tightening of the anterior platysma muscle borders or suspension of the lateral platysma borders to sternocleidomastoid or periauricular fascia. Despite numerous variations and modifications of these maneuvers they have largely failed, and treating platysma bands remains a frustrating and perplexing problem for many surgeons.
- Experience has confirmed that platysma tighening will not universally correct "platysma bands", and that our traditional view that all platysma bands were a homogenous problem and simply a product of horizontal platysmal laxity was conceptually flawed and the underlying cause of many decades of failed treatment.
- "Platysma bands" comprise a heterogeneous group of distinct problems and can be seen to be the product of not only horizontial laxity but longitudinal platysmal hyperfunction. As such, are often refractory to horizontal pulling. Proper treatment in such situations requires horizontal platysma transection to disrupt longitudinal muscle hyperfunction.
- Examination of the neck with and without platysmal activation allows one to distinguish between "hard" dynamic and "soft" adynamic platysma bands and their differing origins.
- Soft, adynamic bands change little during platysma activation and are predominantly a problem of loose skin or horizontal platysmal laxity. Hard dynamic bands become tight or exaggerated upon platysmal activation and indicate a problem of platysmal hyperfunction. These problems represent two disticnt enities, and as such will require different and specific treatment.

FUNDAMENTAL CONCEPTS IN THE TREATMENT OF PLATYSMA IRREGULARITIES

As surgeons have pursued improved outcomes in treating the neck and platysma, our understanding of the origin of platysma muscle irregularities has improved and platysma muscle treatment techniques have evolved. Experience has since shown that the traditional notion that platysma tightening will correct deep layer neck problems, including accumulations of subplatysmal fat, large submandibular glands, and protruding digastric muscles, was misguided, and that proper treatment of these problems requires deep layer procedures that address the actual anatomic problems present. Over time, surgeons have come to understand and accept that improved neck contour is not created by platysma tightening, but by deep layer maneuvers (subplatysmal fat excision, submandibular gland reduction, and partial digastric myectomy) that specifically target these problems, and these issues are discussed (see Timothy Marten and Dino Elyassnia's, "Neck Lift: Defining Anatomic Problems and Choosing Appropriate Treatment Strategies," and Timothy Marten and Dino Elyassnia's, "Short Scar Neck Lift: Neck Lift Using a Submental Incision Only," in this issue).

Experience has also confirmed that platysma tightening will not universally correct platysma bands, and that our traditional view that all

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platysma bands were a homogenous problem and simply a product of age associated horizontal platysmal laxity was conceptually flawed and the underlying cause of many decades of failed treatments. In reality platysma bands comprise a heterogeneous group of distinct problems, and for many patients they can be seen to be the product of not only horizontal laxity but longitudinal platysmal hyperfunction and, as such, are refractory to horizontal pulling. Proper treatment of these problems requires horizontal platysma transection to disrupt longitudinal hyperfunction or treatment by other like means.

The fundamental flaw in the platysma tightening approach is that it fails to recognize or address the underlying differences and differing functional origins of platysma bands. Examination of the cervicosubmental region with and without platysmal activation allows one to distinguish between hard dynamic and soft adynamic cervical bands and their differing physiologic origins (**Fig. 1**). Soft, adynamic bands change little during platysma activation and are predominantly a problem of loose skin or horizontal platysmal laxity. Hard dynamic bands become tight or exaggerated upon platysmal activation and indicate a problem of longitudinal platysmal hyperfunction. These problems represent two distinct entities, and as such require different and specific treatments.

Planning Treatment of the Platysma

Assessing platysma deformity

The cervicosubmental region of each patient must be carefully examined both at rest and during platysma activation if complete assessment of platysma condition is to be made. This examination is best accomplished by asking the patient to push the jaw forward and tighten the neck. It is often helpful if the surgeon demonstrates this maneuver first for the patient to be sure it is correctly performed. Frequently, an insignificant appearing irregularity at rest will be obvious upon muscle activation (see **Fig. 1**). Failure to recognize and appropriately correct these dynamic irregularities is the reason too many facelift patients seem to be improved in repose, but unnatural or bizarre in conversation, animation, and during other activities that result in platysma muscle activation.

Examination of the cervicosubmental region with and without platysma activation as outlined allows one to distinguish between hard dynamic and soft adynamic cervical bands. Soft, adynamic bands change little during platysma activation and are predominantly a problem of loose skin or horizontal platysmal laxity (**Fig. 2**A). Hard dynamic bands become tight or exaggerated upon platysma activation and indicate a problem of longitudinal platysma hyperfunction (**Fig. 2**B).

Treatment of horizontal platysma laxity and soft bands

If submental support is poor owing to horizontal platysma laxity or platysma diastasis and optimal improvement in the anterior neck is desired, an anterior platysmaplasty is planned (**Fig. 3**). Anterior platysmaplasty is the procedure in which the medial borders of the platysma muscle are sutured together to help consolidate the neck, reduce

Fig. 1. Dynamic assessment of the cervicosubmental region. The neck is examined in repose (*A*) and as the platysma is contracted (*B*). Dynamic platysma muscle irregularities as seen in (*B*) are often referred to as hard platysma bands.