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Specificity of facelift surgery, including mid facelift, in case of facial palsy

Spécificité du lifting facial en cas de paralysie faciale: place du lifting malaire concentrique

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Facial palsy;
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Barbed sutures;
Ectropion

Summary The asymmetry created by the facial palsy is of course a cause of demand for facelift surgery. As this lifting action is specific and different from the standard procedures, 3 zones of analysis are proposed: first the frontal and temporal areas with the direct eyebrow lift, second the neck and jawline with action on the depressor anguli oris for the non-paralyzed side and the anterior sub SMAS dissection and third the midface. A new and more simple technique of concentric malar lift is proposed. The first publication on concentric malar lift was made 11 years ago. Midface rejuvenation stays very challenging. As a proof of that, many authors prefer a partial rejuvenation of mid face with fat reinjection, with no effect on skin excess, even if all the MRI studies demonstrated no fat loss with time but only fat transfer. This proves that midface lift did not acquire enough simplicity, reliability to become a standard procedure. Six hundred concentric malar lift later, a technical simplification validated with 110 patients and 2 years of follow-up is proposed. The improvement is due to a new way to pass the threads deeply on the bone, using permanent barbed sutures. This surgery becomes easier and more efficient.
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MOTS CLÉS
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Résumé L'asymétrie créée par la paralysie faciale est bien sûr une source de demande de chirurgie de *face-lifting*. Comme cette action de rajeunissement est spécifique et différente des procédures habituelles, 3 zones d'analyse sont proposées : en premier, le front et la tempe avec la réalisation du lift de sourcil, ensuite le cou et l'ovale avec l'action sur le *depressor anguli oris* côté sain, la dissection prémassétérine sous le SMAS et enfin, la région centrofaciale. Une technique nouvelle et plus simple de lifting malaire concentrique est expliquée. La première publication date d'il y a 11 ans et le lifting centrofacial est resté confidentiel. Comme preuve de ceci, beaucoup d'auteurs préfèrent un rajeunissement partiel centrofacial avec la réinjection de graisse, sans effet sur l'excès de peau, même si toutes les études IRM démontrent que le vieillissement centrofacial se fait sans perte de volume mais avec seulement des transferts de volume. Ceci prouve que le lifting centrofacial n'a pas acquit suffisamment de simplicité,

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d'efficacité pour devenir une procédure standard. Six cent lifting malaire concentriques plus tard, une simplification technique, validée sur 2 ans et 110 patients est proposée. L'amélioration est due à l'utilisation de fils non résorbables crantés, passés en 2 fois et proches de l'os. Cette chirurgie est devenue plus efficace et plus facile.
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Lifting of the frontal and temporal areas

The specificity of reaction of these areas on the paralysed side is the non-stability of the elevation of the eyebrows after a standard frontal and temporal facelift surgery.

Effectively, the skin laxity and the inexistence of muscle resting tone induce a relapse of the eyebrow ascension.

Solution is simple: the direct suprabrow skin excision to realize the eyebrow lift is locally effective and the absence of mobilisation of tissues in the postoperative period favour a better healing process. The suprabrow scar is barely visible. This simple surgery, the direct eyebrow lift, can offer satisfactory results only if some technical points are respected:

- skin excision is performed just above the eyebrow;
- preoperative markings have to be traced with precision;
- the inferior incision line avoids to injure the hair follicles;
- the superior incision line is twice the distance between the desired position of the eyebrow and the inferior incision;
- medial zone of excision try to stay lateral to the medial eyebrow to achieve a nearly non-visible scar. Nevertheless, more medial excision can become mandatory in case of aged patient, with important eyebrow ptosis, to reshape and symmetrize the eyebrow head;
- cautery will be used as little as possible to preserve hair follicles;
- the inferior flap can be undermined, which increases the possibility of ascension of the brow;
- a first running suture with Vicryl 4/0 approximates the edges and a Vicryl 5/0 complete the wound margin approximation with an everting running suture. If eversion is not sufficient, a 6/0 Prolene, more superficial, can help.

Concerning the indication of frontal action, it is rarely necessary in children or young adult because usually frontal asymmetry is still limited.

The neck and jawline rejuvenation

For the neck, the paralyzed side has no platysma band and is even easier to treat. On the non-paralyzed side, more sophisticated techniques like the digastric corset or the hyolift can be used to block reoccurrence of the platysma bands.

For the jawline, the marionette fold is vertical on the non-paralyzed side and horizontal on the paralyzed side.

The treatment is usual on the non-paralyzed side. As the resting tone of the depressor anguli oris of this side is much higher than normal, a section of this muscle, associated with a botulinum toxin injection to block muscle regeneration, as proposed in the Face Recurve concept [1], can be positively associated. On the paralyzed side, with disappearance of the resting tone of the DAO, a more distal SMAS plication like described by Mendelsohn and Wong [9], can be useful.

The mid facelift is also specific

The preperiosteal techniques are not able to give sufficient stability of elevation and consequently an adapted lower eyelid repositioning. Two elements explain this insufficiency: the definitive atrophy of the orbicularis oculi muscle associated with decrease in lymphatic draining and the heaviness of the malar mound.

A vertical and subperiosteal mid facelift, like proposed with the technique of concentric malar lift, is more valuable to achieve a stable mid face repositioning. To make the technique more simple, many changes are proposed in this article.

Concentric malar lift: technical simplification

Midface aging

The repeated contractions of the orbicularis oculi muscle induce a medial transposition of the lateral canthus, a depression of the palpebro-malar groove and medially, of the tearthrough. This has been demonstrated in the Face Recurve concept [1] and confirmed by Val Lambros's work [2]. The mid-cheek furrow is created by two opposite movements: the horizontal and medial movement of the orbicularis and the posterior and lateral movements of the zygomatic muscles. The mid-cheek furrow is the area of skin at the junction between these 2 nearly opposite displacements.

Surgery

Preoperative markings

The curved line of the tear through depression, including medially the nasojugal groove and laterally the palpebro-malar groove, is first marked (Fig. 1). Next, the central prominence of the nasolabial fold is indicated. The third marking is the mid-cheek furrow. The malar mound is between the palpebro-malar groove and the mid-cheek furrow.

Infiltration with 30 cc of saline with epinephrine (1 mg per 1 litre) before surgery drastically decreases post operative bruises.

Subcutaneous dissection

A subciliary lower eyelid incision extends from the lacrymal point to 4 mm outside the lateral canthus (Fig. 2). The height of the subcutaneous dissection is the height of skin to be

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