Open Neck Contouring

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KEYWORDS

• Open neck • Contouring • Technique • Complications • Neck lift • Digastric corset • Anterior approach • Platysma • Lateral repositioning

KEY POINTS

- Lateral platysma repositioning (platysma suspension) using the first crease of the neck platysma key point alone or together with/submental approach to rebuilt the floor of the mouth using the digastric corset after subplatysma fat resection and the retaining ligaments between platysma, digastric and mylohyoïd muscle are rebuilt in the subhyoïd area/running barbed sutures are used.

Editor Commentary: *I met Daniel on several occasions and, while lecturing in Guadalajara for the annual Jose Guerrosantos Symposium, Daniel discussed his approach to rejuvenating the neck utilizing his "digastric corset" technique which I was unaware of. This chapter presents his logical approach to surgery of the aging neck including this novel approach to the submental area. I asked him and his co-author, Jean-Plilippe to describe the digastric corset since it appears frequently in his chapter.*

INTRODUCTION

We published in 2013 the technique of the digastric corset. We started from the observations of patients who were operated upon with platysma suspension and did not present with satisfying results in the submental area. Platysma bands were sometimes visible and in bulky necks the overall result was insufficient. We went to the anatomy laboratory and studied the anchorage of the platysma and the digastric muscles relative to the floor of the mouth. We found a retaining ligament between the anterior digastric bellies and the mylohyoid muscle which restricts the displacement of the anterior belly of the digastric laterally but no longitudinally. The platysma is adherent to the inferior aspect of the digastric muscle and through it to the floor of the mouth explaining some of the insufficiency of the lateral rhytidectomy approach in the area between the two anterior bellies of the digastric muscles.

The digastric corset is a running suture of the digastric-to-mylohyoid retaining ligament, performed through a small retro-chin incision after interdigastric fat removal. The medial displacement of the digastric fills the interdigastric fat hollow, tightens the floor of the mouth and displaces the platysma medial insertion. A second platysmal corset is performed to close the dead space and further tighten the anterior neck. The submaxillary gland is moved upward in a platysmal hammock, which avoids a specific procedure. The combination of digastric corset and cervico-facial rhytidectomy gives synergistic effects in the rejuvenation of the anterior neck with very good restoration of the anterior cervical angle even in cases of bulky necks (grade IV of Knize neck cosmetic deformities).

WHAT INCISION(S) DO YOU TYPICALLY USE IN THE THIN NECK AND THE HEAVY NECK IN BOTH YOUNG AND OLDER PATIENTS?

For moderate alteration of neck contour in thin necks (Knize grade I and II), we perform a cervicofacial rhytidectomy with lateral platysma suspension.[1] The incisions are those of classic facial rhytidectomy. Briefly, it starts in the hairs in the temple area with a stairlike broken line, in the preauricular sulcus down to the superior part of the

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tragus, on the free edge of the tragus down to the intertragal sulcus, around the ear lobe, in the retroauricular sulcus, and in front of the hairline horizontally, at the largest part of the auricle (**Fig. 1**A). Once in the hairs, the line is drawn upward for a few more centimeters, which hides the scar better, as suggested by Daniel Marchac (see **Fig. 1**B).

If medial platysma cords are not perfectly corrected by the clinical simulation test, meaning that the platysma is adherent to the digastric muscles and cannot be moved by a lateral suspension, we add a digastric corset.[2]

In young heavy necks, we perform an anterior neck approach alone. Isolated liposuction is reserved for a small deformity when fat is located electively in a subcutaneous position. If fat is accumulated in an interdigastric position, we perform a liposuction, digastric corset (where this fat is resected), and large skin undermining laterally to redistribute the skin excess of the midline to the submandibular area.

In older heavy necks, the neck approach is the same, but we also perform a lateral platysma suspension.

WHAT ARE YOUR INDICATIONS FOR LIMITING YOUR ACCESS INCISIONS TO THE SUBMENTAL AREA OR THE LATERAL APPROACH? IN WHICH CASES DO YOU USE BOTH INCISIONS?

We perform a lateral incision solely in cases in which clinical simulation of platysma suspension completely restores the anterior cervical angle using patient pictures (**Fig. 2**).

Young people complain that the anterior cervical angle, without aging signs, is an anatomic abnormality. A clinical observation might be an association of interdigastric fat hypertrophy, digastric malposition, floor of the mouth ptosis, or accumulated fat in subcutaneous tissue. Only in these cases do we perform an anterior cervical approach, sometimes under local anesthesia, without facial rhytidectomy.

In all other cases, with a mix of anatomic abnormalities and aging, we use a combined lateral and submental approach.

WHAT IS YOUR APPROACH TO DEFATTING THE NECK? WHICH FATTY LAYERS DO YOU RESECT (IE, SUBCUTANEOUS, INTERPLATYSMAL, SUBPLATYSMAL FAT)? WHAT ROLE DOES LIPOSUCTION PLAY IN YOUR TECHNIQUE, EITHER ALONE OR IN COMBINATION WITH OPEN TECHNIQUES?

We use liposuction to defat the subcutaneous and interplatysmal layers. We perform a liposuction when a pinch test of the neck tissues shows a thickness of 1 cm or more. We do not use other defatting methods because liposuction is reliable and has an extremely low morbidity in this anatomic area. We begin the surgical procedure after infiltration of an epinephrine serum solution (1 mgm of epinephrine for 1 L of infusate serum).

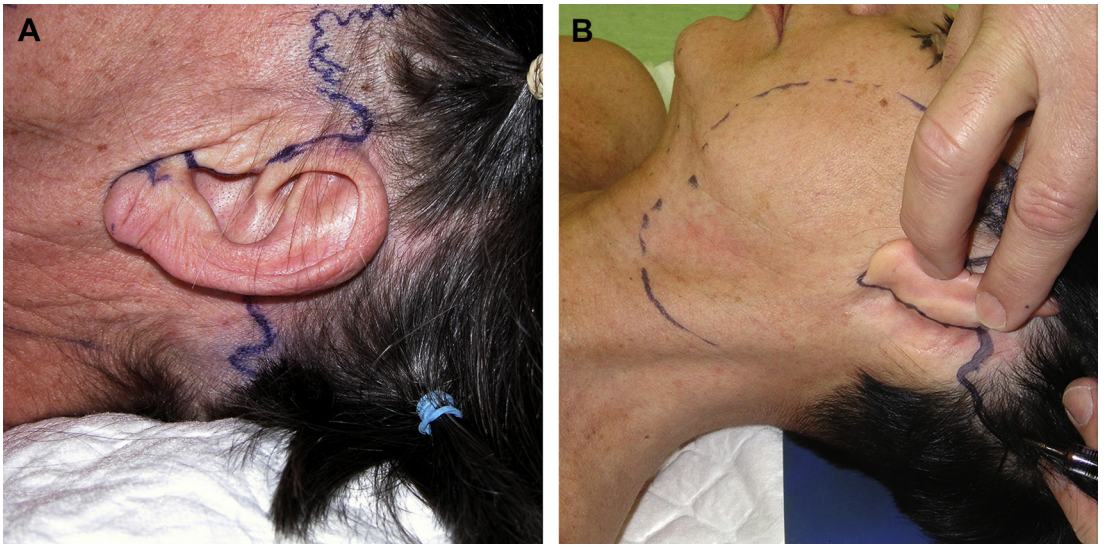

Fig. 1. (*A*) The preincision marking starts in the hairs in the temple area with a stairlike broken line, in the preauricular sulcus down to the superior part of the tragus, on the free edge of the tragus down to the intertragal sulcus, and around the ear lobe. (*B*) The line is placed in the retroauricular sulcus and in front of the hairline goes horizontally and then upward for a few more centimeters.