

# Management of the Midface During Rhytidectomy



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## KEYWORDS

- Midface rejuvenation • Rhytidectomy
- Multi-vector SMAS (superficial musculoaponeurotic system) lift • Midface lift

## KEY POINTS

- The multi-vector high superficial musculoaponeurotic system (SMAS) facelift is a natural extension of a traditional SMAS rhytidectomy.
- There is direct access to the midface with ample opportunity for improvement; the malar fat pad can be addressed directly; the nasolabial grooves and commissure-mandibular grooves can also be improved.
- The extended lower-lid midface lift provides direct access to the midface as well as the ability to provide a direct vertical lift of the midface.

## INTRODUCTION

The facial skeleton and bony structures of the face are thought to expand as we age.<sup>1–3</sup> The orbital socket diameter increases in size as we age with particular recession of the inferomedial infraorbital rim.<sup>4</sup> In the midface, the maxilla undergoes retrusion and resorption.<sup>5</sup> The maxillary angle decreased by about 10° between young (aged <30 years) and old (aged >60 years) individuals.<sup>6</sup> Moreover, there is significant development of elastosis of the overlying skin and superficial musculoaponeurotic system (SMAS). There are several telltale signs of aging noted in the midface that can be addressed during rhytidectomy to provide comprehensive and balanced facial rejuvenation. These changes include malar fat pad descent, increasing prominence of the tear trough, an enlarging infraorbicular crescent representing the ptotic inferior orbicularis as well as infraorbital fat,<sup>7</sup> increasing nasolabial grooves, and ptotic and festooning jowls creating a prominent prejowl sulcus.

Various surgical and nonsurgical techniques have been proposed and practiced to rejuvenate the midface. Among the nonsurgical techniques, thermal, radiofrequency, ultrasonic, and various lasers have all been used to refresh the midface. Fillers and injectables including autologous fat transfer have also been used to replace midface volume and mask the descent of anatomic structures. Among surgical treatments, several approaches have been used to rejuvenate and lift the midface, including malar implants, direct lift, multi-vector approach, multi-plane approach, transconjunctival approach, and orbicularis suspension. Many of these techniques, both surgical and nonsurgical, have been used in conjunction with one another and are not mutually exclusive.

One thing remains clear: in order to achieve comprehensive cervicofacial rejuvenation, rhytidectomy remains the gold standard. Tightening and repositioning of redundant skin and the SMAS is paramount to cervicofacial rejuvenation. Unfortunately, too often the midface is neglected

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leading to suboptimal overall rejuvenation and a continued tired appearance. Posterior SMAS imbrication or plication provides mostly posterior pull and does not adequately address the midface fat pads, nasolabial groove, or commissure-mandibular fold. However, proper midface rejuvenation can be achieved at the same time as cervicofacial rhytidectomy.

### TREATMENT GOALS AND PLANNED OUTCOMES

Patients undergoing cervicofacial rhytidectomy nearly uniformly desire comprehensive facial rejuvenation. Midface rejuvenation can easily be improved concurrently with rhytidectomy via a multi-vector, multi-plane approach or an extended lower-lid midface lift. The goals of midface rejuvenation include, but are not limited to, improving the jowl-mandible contour, improving the commissure-mandibular groove, improvement in the nasolabial groove, improving all 4 midface fat pads with repositioning, preserving the temporal hair tuft and posterior hairline, maximizing the cosmetic result, and finally achieving a natural nonoperated appearance. While planning for a surgical procedure, the practitioner must anticipate that different parts of the face and neck require different vectors of pull to achieve an optimal result. The midface in particular requires primarily a vertical lift. The techniques described in this article, multi-vector high SMAS 3-layered facelift with midface lift and extended lower-lid midface lift, achieve all of these goals.

### PREOPERATIVE PLANNING AND PREPARATION

The ideal patient is 40 to 60 years old, in good health, without any medical comorbidities or increased bleeding tendencies with significant cervicofacial elastosis, descent of the midface with jowling, prominent jowl-mandibular irregularities, prominent commissure-mandibular grooves, and of course realistic expectations of improvement. Photographic documentation should be obtained preoperatively in the anterior-posterior frame with and without smiling, in a bilateral three-quarter view, and in bilateral side-profile views with particular attention to having each photograph viewing the Frankfort horizontal perpendicularly.

### PATIENT POSITIONING

Preoperatively for marking, the authors recommend that patients be seated upright and awake. This *upright* position allows for the proper effects of gravity with respect to the facial architecture as well as certainty that there are no paralytic

anesthetics affecting the patients' musculature. Marking is done to demarcate the extent of dissection, the prominence of jowls, and any nasolabial or commissure-mandibular grooves. If an extended lower-lid midface lift is being done, extended lower-lid blepharoplasty incisions should be marked. Very importantly is the marking delineating the directions of the SMAS pull on different areas of the face and neck (**Fig. 1**). This protocol will ideally lead to a more predictable and natural looking result.

### PROCEDURAL APPROACH

For the multi-vector high SMAS facelift, perioperatively patients are supine with the endotracheal tube midline or to the left. The tube is secured to the central incisors with a 2-0 silk to allow for movement of the tube on either side of the face. Great care is taken not to allow the endotracheal tube to pull on the lip or the face. The patients' hair is tied posteriorly and taped out of the surgical field. Patients are then prepped with a half-strength povidone-iodine solution. Towels and sterile tape are then used to further isolate the surgical field.

Firstly, the planned facial incisions were injected with a total of 40 to 60 mL of tumescent solution consisting of a 0.25% bupivacaine hydrochloride (Marcaine), 0.5% lidocaine, and 1:100,000 of epinephrine. The temporal tuft and preauricular, postauricular, and posterior hairline incisions were made with a No. 15 blade; subcutaneous planes were raised in the postauricular area and preauricular area using the same No. 15 blade, and then facelift scissors were used to elevate the same subcutaneous plane anteriorly to a point approximately even with the zygomatic body; but no dissection was made up into the zygomatic body itself. The midface, submandibular, and cervical dissections were made; a 3-0 polypropylene (Prolene) suture was used to vertically raise the SMAS and the anterior cheek perioral area as



**Fig. 1.** Marking for multi-vector SMAS lift.

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