A New Paradigm for the Aging Face

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• Fat transfer • Facial rejuvenation • Ethnicity

Commonalities and differences exist for managing the aging face of the ethnic and nonethnic individual. This article explores the intersection and divergence of strategies for facial rejuvenation through the filter of a new paradigm for the aging face. This new paradigm is, in effect, the opposite of traditional lifting- and excisional-based rejuvenative surgery. Using facial fat transfer, adding to the face rather than subtracting from it, defines the new paradigm. Although facial fat transfer is universally applicable to almost any individual who undergoes aging, it is particularly beneficial for the ethnic face as a standalone procedure on many counts. First, many ethnic individuals of varying origins have greater skin melanin content that serves as a protective barrier against solar aging, which can create cutaneous elastosis and dyschromias. Accordingly, the aging process, particularly in dark-skinned individuals, can be almost entirely a manifestation of volume depletion with little evidence of gravity and skin damage. In addition, fat transfer can be used as a sculpting method to soften ethnic features and facial shape to create a more balanced appearance. This topic is studied in more depth in this article. Facial fat transfer can be a potent and primary method for reversal of aging in ethnic and nonethnic populations.

Before the role of facial fat transfer in different ethnicities can be understood, the logic behind its use in all individuals must be considered. Adding more adipose to an eyebag, fat to an already ptotic brow, or fat to a seemingly heavy jawline seems counterintuitive. Accordingly, how facial fat transfer is perhaps a revolution in thinking and approach to the aging face (in short a new paradigm) must be defined at the outset. The best way to regard facial fat transfer is to begin with the educational process of understanding and perceiving negative space. For example, rather than seeing the steatoblepharon of an eyebag, the eyebag can be considered to represent the fat that remains after a great percentage of fat has dissipated along the orbital rim and midface. Similarly, instead of seeing drapage of upper-eyelid skin and a ptotic brow, it can be envisaged that the bony orbital rim becomes more exposed over time and that the convexity of the brow contour needs to be restored rather than elevated due to perceived gravity (which in reality plays a negligible role in the brow). The best way to understand this phenomenon of deflation rather than gravity is to start with the patient's old photograph, which in almost every case exemplifies a fuller brow contour rather than an elevated one. The brow is one of the most difficult areas to understand that deflation rather than gravity is at play. The reader is encouraged to think of the brow as a balloon that deflates over time creating the perceived effect of sagging; filling would give the best results.

Currently, I rarely perform a browlift, because I find that it is simply unnecessary and, in many cases, counterproductive. The longer, almond-shaped eye of youth gives way to a bonier, rounder look that is exacerbated by browlifting and aggressive traditional blepharoplasty. In almost every circumstance, periorbital fat transfer is the mainstay of rejuvenative intervention that I rely on, and, in conjunction, I occasionally perform traditional blepharoplasty to enhance my fat transfer result rather than as a substitute for it. I perform an upper-eyelid blepharoplasty with a fat transfer for the upper-eyelid/brow complex only when it is warranted, which is in approximately 1 in 5 patients. I prefer a selective skin-only blepharoplasty,

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removing 2 to 3 mm of redundant skin, in the following cases:

1) When the eyelid skin hangs at or below the ciliary margin
2) When the skin edge appears "crêpey" and irregular, or preferably an upper eyelid that manifests both of these conditions

The reason to remove the extra skin in the case of skin irregularity is apparent. The reason to remove skin when the skin hangs at or below the ciliary margin is to minimize the drooping eyelid look if some of the fat resorbs and fails to achieve the desired esthetic objective.

With lower-eyelid steatoblepharon, the need to remove fat from the perceived eyebag is rarely indicated and the need to remove redundant skin almost never arises. I prefer to perform fat grafting alone for the lower eyelid in almost every case but, in approximately 1 in 10 cases, I perform a concurrent transconjunctival lower-eyelid blepharoplasty to manage the extra fat that will not, most likely, be sufficiently camouflaged with fat grafting to the inferior orbital rim. The situation in which I prefer a transconjunctival blepharoplasty with fat grafting to the inferior orbital rim involves eyebags that are so protuberant that they extend well beyond the orbital rim in an anterior-posterior position. In fastidious individuals who want the absolute best results for the lower eyelid, I offer to perform a concurrent lower-eyelid blepharoplasty but still try to manage expectations that there might nevertheless be some remaining perceived steatoblepharon. I almost never remove extra skin from the lower eyelid but instead choose to manage rhytids and flaccidity of the lower eyelid with skin resurfacing and botulinum toxin therapy. I find that traditional skin-muscle flap blepharoplasty carries too high a risk of changing the shape of the eye by altering the lateral canthus even slightly in any direction (medially, laterally, inferiorly, or superiorly).

Many patients (and surgeons) are surprised at how much the midface affects the look of the eyes. The gaunt, flattened terrain of the aged midface can contribute more significantly than almost any other facial feature, including the eyelids themselves, to the tired appearance of an eye. To help patients (and surgeons) appreciate the effect that a fuller midface contour has on the look of the eyes, I gently nudge the cheek into a fuller, rounder contour by pushing it up from below with my thumb to simulate volume (not lifting) and have the patient see that, with this maneuver, even though the lower-eyelid contour may be worsened, the eyes look more alert and the face looks markedly more rested in appearance. To understand why a malar implant fails to rejuvenate the midface, one must understand how an aged midface ages. With volume loss to the midface as people age, the bony malar eminence becomes more exposed (ie, the bony prominence is the hallmark of aging). A solid implant on the malar eminence worsens this bony look and thereby exacerbates aging. Fat transfer covers the bony prominence and blends it in with the surrounding contour depressions. Similarly, midface lifts fail to work because they lift deflated tissue upward and stretch the skin more over exposed bony terrain, which ultimately does not resolve the core issue, that is, volume depletion of the midface.

I mentally divide the central cheek into 3 zones (minus the buccal area, to be discussed later). The central anterior cheek, which corresponds with maximal cheek deflation along the mediosuperior to inferiolateral line of the malar ligament, is perhaps the most important region to fill for aging in most individuals. Pushing this area too forcefully can create an overexuberant appearance to the cheek and also over feminize a masculine face. The lateral cheek is defined as the region that overlies the malar bony eminence. In gaunt narrow faces, I prefer to augment this region more aggressively than in heavier faces or in individuals with prominent cheekbones. Trying to balance a face is an underlying objective with any facial esthetic endeavor (ie, creating harmony between various sizes of neighboring facial structures, without greatly disturbing personal identity). The lateral cheek also serves as an important area to augment for men to create a more structured outer cheek shape that can be masculinizing. The lower, medial, anterior cheek, which rests directly above the nasolabial groove and partially defines the upper border of the nasolabial fold, should almost never be augmented. It tends to become more pronounced in heavier individuals and makes the cheek look ptotic and heavy. Accordingly, in more heavily set individuals, placing fat more superiorly and centrally can offset this heavy appearance and create a relative narrowing of the face. Modest amounts of fat should be used in order not to create too fat a face.

The buccal area can be one of the most important areas to fill or one of the most important areas to avoid. In the heavier patient, the buccal region appears full and heavy. Filling the central upper anterior cheek as mentioned can make the buccal area appear smaller in these individuals. However, in the gaunt face, the buccal area can be a central focus to enhance to make the face appear more youthful. Most often, traditional perspectives for