The Superficial Musculoaponeurotic System and Other Considerations in Rejuvenation of the Lower Face and Neck

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KEYWORDS

• SMAS • Platysmaplasty • The heavy face • Imbrication • Facelift

KEY POINTS

- Visible anterior platysma banding can be addressed by various techniques and midline platysma plication or imbrication.
- Patients presenting with anatomic variations such as heavy face and neck or midface volume deficiency may require detailed counseling and realistic expectations, as well as condition-specific operative maneuvers for optimum results.
- Patient satisfaction is perhaps the single most important metric in a successful aesthetic facial plastic surgical practice.
- Proper vectoring techniques are critical to successful facelift outcomes and longevity.

Question 1: What is your go-to technique for handling anterior platysma banding when performing a lower face and neck lift?

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That there are many approaches to managing anterior platysma bands attests to the frustrations facial plastic surgeons have with the early recurrence of the banding.[1–4] Nascent face lift surgeons have the lessons of their residencies and fellowships in the forefront of their minds. With time and growing experience, the issue of this problem will become apparent. Meetings, seminars, courses, and videos will show the plethora of procedures addressing this problem. Eventually, a personal solution will be found and it is hoped that outcomes will improve.

This author's go-to techniques is the corset platysmaplasty. The patient is marked in the sitting position. The estimated area of submental undermining, the top of the thyroid cartilage, the

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Panel discussion

1. What is your go-to technique for handling anterior platysma banding when performing a lower face and neck lift?
2. A moderately overweight patient desires a lower face and neck lift. The patient has no intention of losing weight. Will you offer this patient surgery and why or why not? What is your approach to the heavy face and neck and how do you counsel this patient?
3. What is your mainstay procedure for repositioning the superficial musculoaponeurotic system and how, if at all, would you vary your approach?
4. A patient with moderate jowl and wattle formation desires a facelift. This patient also has marked sunken cheeks. What is your recommendation for rejuvenation of the lower face and neck in this patient? If you recommend an ancillary procedure and the patient refuses and only wants the facelift, would you proceed? If so, why? If not, why not?
5. What do you consider a successful outcome in facial rejuvenation? From "Hello" to "Goodbye", and technique aside, what is your philosophy on communicating with and educating your patients that contributes to a successful outcome?
6. How has your approach to rejuvenation of the lower face and neck changed over the last 5 years?

cervicomental angle, and the submental crease are delineated (**Fig. 1**). With the patient recumbent in the operating room, monitored anesthesia is commenced. The incision line is infiltrated with 1% lidocaine with 1:100,000 epinephrine and the area of the anterior flap elevation is infiltrated with 0.5% lidocaine and 1:100,000 epinephrine.

After 10 minutes have elapsed, a 2-cm to 3-cm incision is made just beneath the submental crease. The anterior neck skin is elevated by blunt scissor dissection with care being taken to leave a thin layer of fat on the flap if possible (**Fig. 2**). A pearl to keep in mind is that the tips of the scissors should always be seen beneath the flaps during this blind dissection, which provides assurance that the surgeon is safely in the correct plane (**Fig. 3**). Open liposuction is performed as needed in the submental area and beneath the body of the mandible.

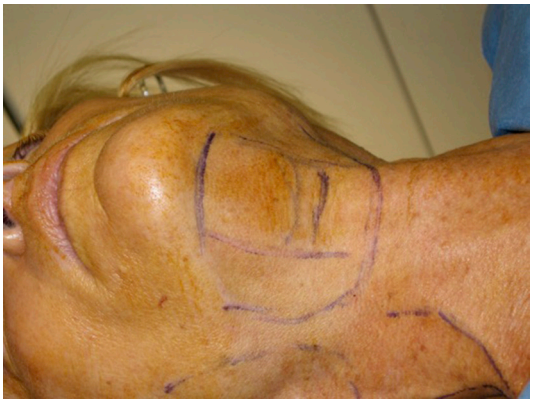

Fig. 1. Area of submental dissection. Incision in submental crease, hyoid bone, anterior platysma bands are marked.

Following liposuction, I elevate each platysma band for 3 to 4 cm from the mentum to the top of the thyroid cartilage. If one or both platysma bands is heavily redundant, I resect the medial edge as needed, usually up to 1 cm. I then divide the elevated bands laterally for 2 to 3 cm at the cervicomental junction (**Fig. 4**). I suture the bands together above this cut with 2-0 polydioxanone (PDO) Quill barbed absorbable suture (Angiotech Pharmaceuticals, Vancouver, Canada). The suture is double armed with the barbs facing away from the needles. I use a continuous simple running stitch from the cervicomental junction to the mentum with both needles. The barbs anchor into the tissue and no knot is needed. The incision is closed with 4-0 polyglactin 910 subcuticularly

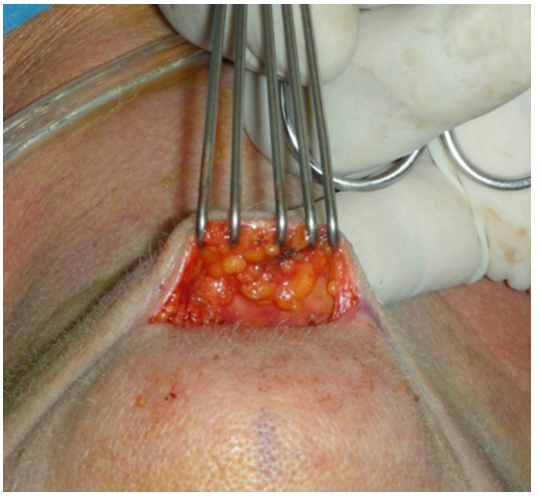

Fig. 2. Visible thin fat layer on the undersurface of the submental fat.