

Response to “Commentary on: Total Composite Flap Facelift and the Deep-Plane Transition Zone: A Critical Consideration in SMAS-Release Midface Lifting”

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In his commentary on my “Total Composite Flap Facelift and the Deep-Plane Transition Zone: A Critical Consideration in SMAS-Release Midface Lifting,”¹ Dr Sam Hamra characterized my article as a “deceptive infringement” on his own “composite facelift.”² I know that contemporary facelift surgeons stand in debt to Dr Hamra as a pioneer of SMAS-release facelift procedures. However, his critique stems from a fundamental misunderstanding and I take umbrage at many of his remarks. My article is neither a deception nor an infringement. I stand by my technique, its results, and its originality, as well as the potential value and novelty of my analysis.

Dr Hamra’s main critique is that my technique is not a “composite facelift.” This is true – but that claim is never made in my article. It is beyond a mere point of semantics that I refer to it instead as a “composite flap” facelift. I am using “composite flap” in its strict sense of plastic surgical anatomy: a flap which contains two or more elements, usually skin, muscle, and/or bone.³

Consistent with this usage, Tim Marten and Gerald Pitman have both (in recent textbook chapters) referred to the lateral dissection of a one-layer SMAS-release flap as a “composite flap,” *outside of the context of a “composite facelift.”*^{4,5} From Marten:

The high SMAS procedure can be performed using a two-layer lamellar technique with separate skin and SMAS flaps as advocated by Connell, or using a one-layer composite flap as practiced by Barton.”⁴

Dr Hamra states that my technique is neither “total” nor “composite,” but it is the addition of a musculocutaneous (Skoog) flap in the neck in contiguity with the one-layer facial flap which led me to use the term “total,” and Skoog’s original technique as published in 1974 has been described as a “composite flap” itself.⁵ My goal in choosing the title was therefore simple anatomic accuracy.

He further states that he:

published the arcus marginalis release,[8] zygomaticus orbicularis dissection,[9] and the septal reset.[10]... All of these are integral parts of a composite facelift, yet none are referenced by the author. The designation “Composite Rhytidectomy” is an original title, published in 1992 and multiple times thereafter, and should only be assigned to facelifts that accomplish the proven goal.

I did not reference these techniques because I do not use the subciliary incision that they require to supplement my facelift dissection (for aesthetic and functional reasons which I made clear in my article, and restate below). Dr Hamra seems to indicate that this incision and the transblepharoplasty orbicularis elevation are requirements for a

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composite flap. However, while the extent of elevation of the flap may be greater, the extra incision does not change its composition.

Beyond this, I felt the need to nominally distinguish my approach from a “deep-plane” dissection. While Hamra writes that my technique:

remains essentially a “deep plane rhytidectomy” with results falling far short of a satisfactory comprehensive facial rejuvenation. Even though he states that the orbicularis is included in the flap, the only thing important is the final result, which shows no evidence of orbicularis position change in any of the patients shown in this article. Deep plane facelifts, or malar fat procedures ... are essentially what he has described here ... ,

It seems more appropriate that anatomy rather than the “final result” should determine which dissection plane was used. A sub-orbicularis dissection plane is *not* a deep-plane dissection, according to Mendelson in his commentary on Hamra’s 2002 article:

The composite face lift introduced the concept of sub-SMAS dissection beneath the upper part of the anterior face (suborbicularis) but remained superficial (deep plane) beneath the central part of the malar fat.”⁶

Considering all this, I feel “composite flap” better describes both the facial and neck portions of my dissection.

Dr Hamra also suggests that a forehead lift is part of a composite rhytidectomy: “(t)he sine qua non of the composite rhytidectomy ... include(s) a forehead lift ...” Knowing, then, that “composite rhytidectomy” is not simply referring to the anatomy of the facial flap underscores that there is a distinction between the terms “composite rhytidectomy” and “composite flap rhytidectomy.” The idea of a browlift being obligatory is one that has obviously worked very well for Dr Hamra, but would not work in my practice. I agree with his principle (shared by Marten and many others) that the face and neck should always be rejuvenated together, and do perform many endoscopic browlifts, but patients in my geographic area often decline this procedure (as did the patient in Figure 1 [Supplementary Figure S5 in Mani¹]).

There are other aesthetic points on which Dr Hamra takes issue, and with which I respectfully disagree. I appreciate his observation that the orbicularis muscle ages inferolaterally, as opposed to the cheek fat which falls into the nasolabial fold. However, correcting it, as he advocates, with a superomedial vector via a subciliary incision has drawbacks resulting from disruption of the orbicularis retaining ligament, as Barton has noted.⁷ Elevating and suspending cheek tissues via a subciliary incision can leave the patient’s lower lid area looking frozen and often “stunned,” which one can see in many of the postoperative photographs in which this maneuver has been done. It also

has a higher risk of causing scleral show, even a fraction of a millimeter of which is noticeable in face-to-face communication. In point of fact, the photo set Dr Hamra presents in his commentary, probably as the consequence of suspending the orbicularis oculi along a superomedial vector, the medial portion of the lower eyelid margin has descended, visibly altering the shape of the eyelid aperture.

As I noted in my article, even for blepharoplasty, I avoid a subciliary incision for anything other than the occasional skin pinch. The inferior portion of the orbicularis oculi is one of the most important communicators of intensity, happiness, and other emotions in the face. It is a delicate muscle that should not be “trifled with” surgically. This becomes evident, for example, when treating actors and actresses who know their faces quite well from seeing them in movie close-ups. I am therefore loathe to risk altering this critical area of emotional expression.

With regard to the “cantilever effect” of the skin carrying the malar fat upward with it, Dr Hamra calls this observation “hardly remarkable or novel information.” I understand that he has pointed this out before, but I believe that the potential novelty of my analysis is that it specifically considers anatomic studies of the SMAS published in 2008 and 2013 which show anatomic and functional SMAS attenuation in the cheek.^{8,9} Illustrating how this “cantilever” effect can be lost when bilamellar dissection goes too far anterior would seem to have some usefulness. My case experience and timely switch away from the bilamellar technique based on intraoperative experience (which was supported by these studies) afforded an opportunity to analyze this effect with precise measurements.

Dr Hamra states that my technique has been published 25 years ago and modified by other surgeons since that time. However, the resurrection of the Skoog composite neck flap (which Hamra initially performed but abandoned for reasons he considered aesthetic) with the sub-orbicularis, sub-SMAS flap in the face in contiguity is a potentially new modification which has not to my knowledge been published. This was suggested to me by the expert reviewers during the revisions of my article. The composite flap neck dissection often extends all the way to the midline, and has clear benefits. It has enhanced my results and reduced neck irregularities, creating a smooth yet full jawline and stronger suspension of ptotic submandibular glands relative to platysma suspension with subcutaneous neck dissection (Figure 1C, D).

Finally, Dr Hamra criticized my photography as having variability in the lighting conditions. I understand the importance of the standardization of photographic environment. The flash and lighting conditions remained unchanged in my photo room with the exception of one of the photograph sets where the postoperative photographs were taken 2.5 years after surgery following a move to a new office (Figure 2 [Supplementary Figure S3 in Mani¹]). Dr



Figure 1. Example of a total composite flap facelift (later group). This 50-year-old woman complained of a scowling appearance and neck skin excess. She specifically did not want brow or eyelid rejuvenation. Examination showed marked ptosis of the deep facial tissues of the mid and lower face and platysmal laxity with marked neck skin excess. (A, C) Preoperative and (B, D) 12 month postoperative photographs after facelift with skin and SMAS left attached in the DTZ. She also underwent midline corset platysmaplasty with partial inferior platysmal transection. Elevation of midfacial highlights was significant in this case (20% on right and 11% on left). The incision is well camouflaged, and the jawline is youthful and full. The ptotic submandibular salivary glands have been suspended upward since platysma and skin are elevated together via the lateral dissection. Hence they are less noticeable postoperatively. Midfacial volume is restored without fat grafting or fillers. From Mani,¹ reprinted with permission from Oxford University Press.

Hamra sees my results as falling “far short” of a comprehensive rejuvenation, but – while I agree the changes are more subtle in some – I do not think the variation in lighting in this photograph set is the reason for the fairly

dramatic change in her appearance. I believe that in the remainder of the photographs within my main article, the lighting is very similar and the changes are at least partially accounted for by decreased sun exposure, the alterations in



Figure 2. Example of a total composite flap facelift (later group). This 57-year-old woman complained of looking “droopy” and much older than she felt. Examination showed severe ptosis of deep tissues of the mid- and lower face, laxity of the platysma, and upper and lower lid blepharochalasis. (A) Preoperative and (B) 30 month postoperative photographs after facelift with skin and SMAS left attached in the DTZ. She also underwent midline corset platysmaplasty with digastric shaving, partial midline inferior platysmal transection, upper blepharoplasty, and transconjunctival lower blepharoplasty with fat repositioning. Elevation of midfacial highlights was significant in this case (17% on right and 10% on left). From Mani,¹ reprinted with permission from Oxford University Press.

surface anatomy as well as the greater reflectivity of skin made smoother by a facelift (Figure 1A, B). Apart from this, I understand that this criticism comes from one whose standards of photography as well as of candor in analysis of short- and long-term results are unmatched.

Like all facelift surgeons I am indebted to leaders like Dr Hamra, as well as Tim Marten, Fritz Barton, and Bryan Mendelson, among many others, for their generosity in sharing their immense knowledge and experience. I look forward to future discussions surrounding the issues raised here. In this era where injectable fillers and “noninvasive” shortcuts have become all the rage, I feel ever more strongly about the need to maintain, perfect, and perpetuate the operation which is our highest art form.

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