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Refinements in Tailoring the Lift-and-fill Facelift

Ronnie A. Pezeshk, MD*; David A. Sieber, MD†; Rod J. Rohrich, MD‡

Individualizing facelift techniques through proper preoperative analysis is an important technique that can successfully enhance the patient's overall result.[1–5] Accurate preoperative analysis is key in the decision-making process for how the superficial musculoaponeurotic system (SMAS) is shaped and lifted. Techniques that center on SMASectomy and SMAS stacking with wide skin undermining allow for exceptional results without the need for an extended sub-SMAS dissection.[5–13]

The area to be undermined is first injected with 120 mL per side of dilute lidocaine (1:400,000) solution with epinephrine. Skin incisions and flap undermining are identical in both approaches. The procedure is started by creating a curvilinear skin incision parallel to the root of the helix followed by a separate intertragal incision. The incision continues following the lobule facial sulcus, leaving approximately 1 mm of facial skin on the lobule. Next, the incision is completed staying 2–3 mm onto the postauricular skin, then curving at the auricularis posterior down along then into the hairline. The skin flap is sharply dissected off the underlying SMAS as outlined below. These zones are not based on anatomical landmarks but are instead used to help simplify the flap undermining process. (**See Video [online]**, which demonstrates the authors' lift-and-fill facelift.)

There are 3 zones of dissection:

1. The first zone is composed of 2 lines: the first from the alar base to the tragus and the second from the tragus down to the anterior border of the sternocleidomastoid.
2. The second zone is from posterior to the sternocleidomastoid to the post auricular neck area.
3. The third zone is everything cephalic from a line drawn from the alar base to the lobule.

Differences in facial length must be recognized because altering the direction of SMAS movement can help balance final facial shape.[5,14] Facial analysis can identify variations in facial structure: long versus short and narrow versus wide. The most common combinations of these being long/narrow and short/wide.[15] Identification of the long side of the face will dictate the direction of SMAS pull, with long faces requiring a horizontal pull and short faces necessitating a more oblique vector.

Facial fullness is also an important factor to consider when deciding between SMAS plication (SMAS stacking) and SMASectomy. Faces with excess facial fullness need to have volume removed, which is accomplished with SMASectomy to create a more balanced facial structure. For the SMASectomy, only a superficial portion of the SMAS is excised, preserving the facial nerve branches below.[16,17] If the face is overly thin, then this may be corrected through SMAS stacking, which creates more fullness in the malar region.

Therefore, for the esthetic management of a long/narrow face, SMAS stacking with a horizontal vector of pull allows for malar fullness while correcting for excess facial length. Similarly, a short/wide face is best treated with SMASectomy and plication in a more oblique vector to maintain facial length while correcting for excess malar fullness, creating a more youthful look.

Filling of deflated facial fat compartments using autologous fat is an essential supplement to any rhytidectomy. The "lift-and-fill" technique has modernized facial rejuvenation, with precise volume augmentation as a compulsory component of complete facial rejuvenation.[15,18] We are able to accurately and precisely augment deflated facial fat compartments while the SMAS and its involved structures are selectively repositioned. The superficial and deep fat compartments as well as the lift-and-fill technique have been extensively researched with excellent long-term results.[15]

A complete understanding of preoperative facial structure allows for the surgeon to customize the lift-and-fill facelift technique to produce increased balance and correction of preoperative asymmetries. By altering the direction of SMAS pull and through the manipulation of SMAS volume, a complete restoration of malar fullness and facial width is accomplished.

Rod J. Rohrich, MD
Dallas Plastic Surgery Institute
9101 N Central Expy #600
Dallas, TX 75231
E-mail: rod.rohrich@dpsi.org

*From *Department of Plastic Surgery, The University of Texas Southwestern Medical Center, Dallas, Tex; †Private Practice, San Francisco, Calif.; and ‡Dallas Plastic Surgery Institute, Dallas, Tex.*

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REFERENCES

1. Rohrich RJ, Narasimhan K. Long-term results in face lifting: observational results and evolution of technique. *Plast Reconstr Surg.* 2016;138:97–108.
2. Rohrich RJ, Stuzin JM, Ramanadham S, et al. The modern male rhytidectomy: lessons learned. *Plast Reconstr Surg.* 2017;139:295–307.
3. Warren RJ, Aston SJ, Mendelson BC. Face lift. *Plast Reconstr Surg.* 2011;128:747e–764e.
4. Guyuron B. An evidence-based approach to face lift. *Plast Reconstr Surg.* 2010;126:2230–2233.
5. Barton FE, Jr. The "high SMAS" face lift technique. *Aesthet Surg J.* 2002;22:481–486.
6. Rohrich RJ, Ghavami A, Lemmon JA, et al. The individualized component face lift: developing a systematic approach to facial rejuvenation. *Plast Reconstr Surg.* 2009;123:1050–1063.
7. Stuzin JM. MOC-PSSM CME article: face lifting. *Plast Reconstr Surg.* 2008;121(1 Suppl):1–19.
8. Baker DC. Deep dissection rhytidectomy: a plea for caution. *Plast Reconstr Surg.* 1994;93:1498–1499.
9. Baker DC. Lateral SMASectomy. *Plast Reconstr Surg.* 1997;100:509–513.
10. Baker DC. Minimal incision rhytidectomy (short scar face lift) with lateral SMASectomy. *Aesthet Surg J.* 2001;21:68–79.
11. Baker DC. Lateral SMASectomy, plication and short scar facelifts: indications and techniques. *Clin Plast Surg.* 2008;35:533, vi–550, vi.
12. Wan D, Small KH, Barton FE. Face lift. *Plast Reconstr Surg.* 2015;136:676e–689e.
13. Barton FE, Jr, Hunt J. The high-superficial musculoaponeurotic system technique in facial rejuvenation: an update. *Plast Reconstr Surg.* 2003;112:1910–1917.
14. Barton FE, Jr. Rhytidectomy and the nasolabial fold. *Plast Reconstr Surg.* 1992;90:601–607.
15. Pezeshk RA, Small KH, Rohrich RJ. Filling the facial compartments during a face lift. *Plast Reconstr Surg.* 2015;136:704–705.
16. Roostaeian J, Rohrich RJ, Stuzin JM. Anatomical considerations to prevent facial nerve injury. *Plast Reconstr Surg.* 2015;135:1318–1327.
17. Zani R, Fadul R, Jr, Da Rocha MA, et al. Facial nerve in rhytidoplasty: anatomic study of its trajectory in the overlying skin and the most common sites of injury. *Ann Plast Surg.* 2003;51:236–242.
18. Rohrich RJ, Weinstein A. Reply: the assassination of John F. Kennedy: revisiting the medical data. *Plast Reconstr Surg.* 2014;133:895e.