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A Unified Approach to Facial Contours and Volume Correction: The Role of the Cheek and the Chin

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Background: Facial proportions and contours influence perceptions of beauty and youthfulness. In particular, the shape and definition of the midface and lower face impact the overall appearance of the face.
Methods: This review provides anatomical evidence to support a holistic approach to facial analysis and rejuvenation that starts with assessment and treatment of the midface and lower face to create an aesthetically desirable facial balance.
Results: The cheek and chin can be considered "anchors" or starting points within full-face treatment because of the noticeable impact of their treatment on the definition and contour of the entire face. Age-related changes in the cheek and chin affect overall facial appearance and can produce unintended facial emotional attributes such as looking tired, angry, or sad. Patients seek facial aesthetic treatment typically for a global improvement such as revitalization or genderization of facial features. Best practices in aesthetics have evolved from treatment of individual areas to a holistic paradigm that uses multimodal therapy to improve overall facial emotional attributes. Hyaluronic acid fillers are useful for volume replacement and smoothing abrupt transitions that develop with age throughout the midface, chin, and jaw. A combination of hyaluronic acid filler for volume restoration and sodium deoxycholate and/or onabotulinumtoxinA for volume reduction where appropriate may optimize lower facial contour.
Conclusions: This review highlights the importance of facial angles and contours as well as the significance of panfacial assessments and treatment, focusing on the relationships within areas of the face, specifically the midface and lower face, to optimize results. *(Plast Reconstr Surg Glob Open 2024; 12:e6219; doi: 10.1097/GOX.0000000000006219; Published online 4 October 2024.)*

INTRODUCTION

Individuals desiring aesthetic treatment for facial aging or congenital deficits may identify specific areas that are bothersome (eg, periorbital wrinkles, nasolabial folds)[1–4]; however, they commonly expect global improvement and facial harmonization to result from treatment, including a revitalized appearance.[1–5] In addition, improved understanding of the complex interplay between age-related changes in the bone, soft tissue, and skin has led to the recognition that alterations in one facial area can affect other areas.[6] Data on layperson perceptions of faces with a single area treated suggest that people judge others' facial appearances as a whole rather than focusing on individual facial features.[7] Therefore, best practices in facial aesthetic medicine have evolved from the treatment of individual areas to a holistic paradigm that considers the entire face and uses multimodal therapy to provide harmony and balance among facial features (ie, a panfacial treatment approach).[8–10]

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Facial aesthetic ideals that individuals may be seeking to achieve or restore with panfacial treatment include ideal facial contours, symmetry, balance, youthfulness, averageness (prototypicality), and sexual dimorphism (alignment with perceived gender-specific features).[11–13] For example, an inverted triangle, with wide, full cheeks as the upper vertices and a defined chin as the lower apex, is seen as emblematic of facial youthfulness and beauty.[2,14–16] Aesthetic literature also refers to the "ogee" curve—a concave arc flowing into a convex arc, forming an S shape—as the ideal contour of the cheek in profile, with the hollow of the midcheek leading into a defined malar region or cheekbone.[15,17] Similarly, the angle of the ramus of the mandible described by Liew and Dart[18] is globally recognized as an area in the lower face that impacts attractiveness.[16] Because the cheeks and chin are important to facial contouring and form the vertices of the inverted "triangle of youth," they are key aspects in a panfacial treatment approach.[15] This review provides anatomical evidence to support a panfacial approach to facial analysis and rejuvenation that prioritizes the treatment of the cheeks and chin. It describes a unified volume and contour restoration process with practical clinical guidance for treating the cheeks and the chin as well as illustrative case study examples.

Takeaways

Question: What is the role of the cheeks and the chin in facial aesthetics?

Findings: This narrative review with case studies demonstrates that the cheeks and the chin contribute to the harmony and balance of facial features. They are considered the anchors of facial shape. Evaluating and treating these key areas of the face together can create a harmonious and balanced facial appearance and increase patient satisfaction and well-being.

Meaning: Attention to facial definition and contour is a foundation for achieving optimal aesthetic outcomes, and focusing on the cheeks and the chin as the pillars of facial contour and treating them appropriately may optimize results.

IMPORTANCE OF THE CHEEK AND CHIN IN FACIAL AESTHETICS

Facial aesthetic ideals and preferences often relate to the shape and definition of the midface and lower face and may vary by gender, race, ethnicity, or culture.[5,12,19,20] For example, individuals of Asian descent may consider oval-shaped faces more attractive than faces with a broader lower jaw.[21] Cultural or ethnic ideal facial proportions may reflect differences in interzygomatic and intergonial width, midfacial height, and extent of chin projection and lip fullness.[22–24] Optimal facial proportions and contours also differ by gender.[25] The youthful feminine cheek is higher, fuller, and more projected in all dimensions than the masculine cheek.[20] The feminine apex of the cheek is more lateral and well defined, tapering to a narrower, less-prominent jaw and a smaller, less-projected chin, forming a heart shape.[14,26] Masculine faces are characterized by a flatter anteromedial cheek and a more medial and subtly defined cheek apex.[16] The ogee curve is also flatter in its lower concave region, ideally leading to a squarer, broader, more muscular jaw and a wider, squarer, and more projected chin.[12,27]

By contrast, the aged face is typified by depletion of volume caused by atrophy and descent of midfacial fat and soft tissue, which overlie the jawline and lead to blunted definition of the chin and jaw.[28–30] The aged face also exhibits a loss of homogeneity in aesthetic subunits and a decline in skin tone and texture.[30] Desired contours, symmetry, and balance deteriorate as age-related changes in facial elements develop at differing rates.[29,30] The desirable

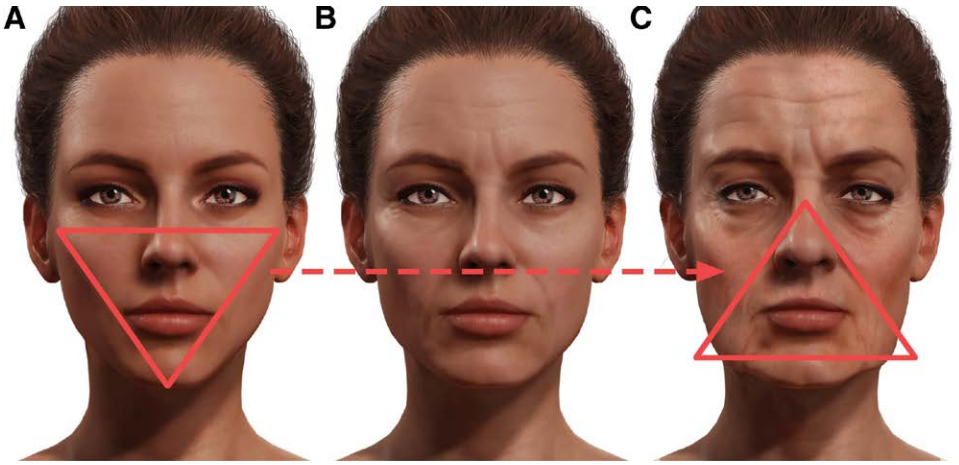

Fig. 1. The "triangle of youth" is a paradigm for facial proportions and contours associated with youth and beauty. A, The upside-down triangle signifies a full and wide midface at the base of the eyes spanning from either side of the cheeks and leading down to a defined chin angle as emblematic of the youthful face.[15] B-C, As aging progresses, the lower face widens from the descent of facial skin, fat, and muscle, reversing the triangle.[2,16,31]

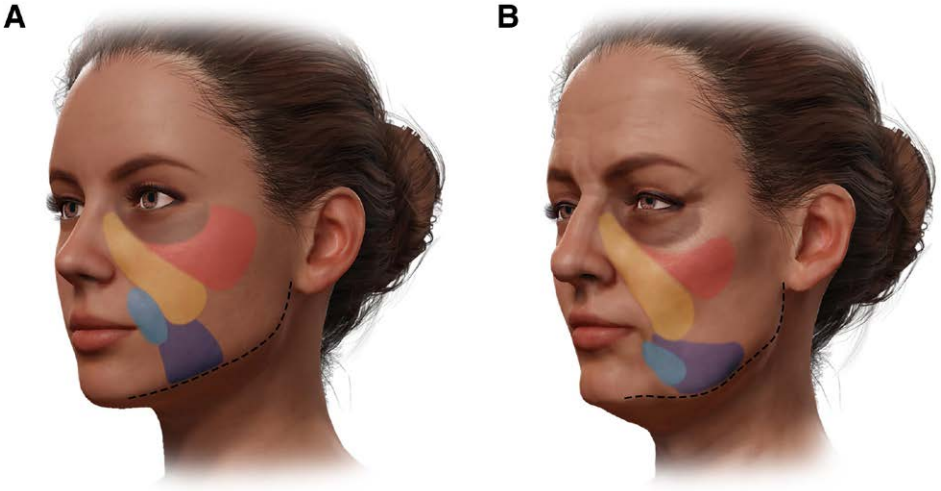

Fig. 2. Contour of the lower face. Changes in facial contour that develop with aging, as illustrated by the midface and lower face, (A) youthful and (B) aged. The youthful cheek exhibits fullness and a smooth, round, uniform shape. The junction from the lower lid to the cheek has a fluid contour with a concave shape. In contrast, the aged cheek is characterized by the formation of grooves resulting from descent of cheek skin, muscle, and fat, revealing segmentation between lid-cheek (brown), malar (red), and nasolabial (yellow) segments. Ogee curve restoration is a typical treatment goal.[16,28–30] The youthful lower face is characterized by fixed underlying fat pads, including the anterior of the malar (red) and nasolabial (yellow) fat; firm, elastic skin; and a well-defined jawline (black dashed line). In the aged lower face, jowls and labiomandibular folds, absent in youth, emerge. Jowls form as the skin loses elasticity and the inferior jowl fat pad (dark blue) descends beneath the jawline. Labiomandibular folds arise from the distension of weakened masseteric ligaments and inferior displacement of buccal fat (medium blue).[32]

facial "triangle" begins to overturn as deep medial and buccal fat pads in the midface atrophy and nasolabial and superficial cheek fat descend (Fig. 1).[2,15,16,30,31,33–35] Additional loss of support from maxillary recession and attenuation of retaining ligaments exacerbates the downward shift.[29,34,36] The resultant loss of cheek projection flattens the ogee curve; the cheeks seem hollow, the nasolabial fold and jowls become more prominent, and the skin slackens (Fig. 2).[6,16,28–30,32,33]

The contour of the lower face also deteriorates with facial aging (Fig. 2). A deep chin fat compartment below the mentalis muscle atrophies, leading to labiomental creases.[33] Mandibular resorption contributes to loss of projection of the chin.[37] The jawline loses definition with the descending tissue from above, mandibular volume loss, and development of the anterior mandibular groove and prejowl sulcus.[30,37] Redistribution of the superior and inferior jowl fat compartments and weakening of the mandibular septum holding these compartments in place cause the jowls to sag.[6,30] Stretching of retaining ligaments may cause indentations in the skin, and contraction of the platysma muscle may exacerbate soft-tissue descent and blur the boundary between the jawline and neck.[6,30,38] Lines and creases also develop in the skin related to habitual facial expressions, dynamic muscle movement, and aging-related muscle hypertonia.[31]

These changes in soft tissue, muscles, fat compartments, and bones can result in unintentional emotional facial attributes (eg, looking tired, angry, or sad).[8] For example, chin volume loss, descending oral commissures, and prominent labiomandibular folds ("marionette lines") may produce an overall look of sadness.[4,30,31,39] Hyperactivity of the depressor anguli oris and platysma muscles, loss of cheek support and descent of buccal fat, and downward pull of jowl fat may further exacerbate this effect.[30,32,40] Downturned corners of the mouth may impart an angry expression, whereas loss of volume in the cheeks may give an impression of tiredness.[4,8,41]

PANFACIAL APPROACH TO FACIAL REJUVENATION

Key concepts in the panfacial approach to facial aesthetic treatment are shown in Table 1.[4,5,8,9,24,41–44] Patients receive a pretreatment assessment that considers the entire face[5,9,45] and identifies the relevant contributing tissues (ie, skin, muscle, fat, bone).[8] Initial patient consultations should begin with identifying patients' aesthetic concerns and objectives for facial rejuvenation[4,8,24] and informing the patient that addressing a single area can lead to inadequate results.[42] For example, treatment of the prejowl region alone could give the impression of a wider chin.[46] It is important to encourage patients to recognize that all parts of the face contribute to its emotional attributes; therefore, a panfacial approach may improve these attributes.[8]

Treatment planning should involve individualized panfacial assessment and consideration of demographically based preferences that may underlie the patient's concerns.[5] For example, panfacial restoration in younger patients may focus on addressing congenital or acquired disharmonies such as lines that were present since

Table 1. Panfacial Approach to Facial Rejuvenation for the Clinician

Step	Goal	Guiding Question	Practice Recommendation
1. Discuss individual patient goals	Determine why the patient is seeking treatment	For what concerns is the patient seeking treatment? Does the patient seek to improve the overall emotional messaging of the face (eg, a tired or an angry appearance)?	Use the answers to these questions to develop a specific education plan in step 2 If a patient is seeking treatment for a specific area, discuss how that area may influence other areas[42] If a patient is seeking to improve overall facial messaging, explain how specific areas may be contributing to unintended emotional attributes[4,8,41]
2. Educate the patient on panfacial treatment	Inform the patient about the interrelated nature of facial expression of emotion and/or aging Build patient trust in clinician assessment	Is the patient seeking treatment in an area of the face that will affect other areas? What are the patient's aesthetic goals? What is the patient's background (eg, older age group, ethnicity/race, transgender/nonbinary)?	Use these answers to inform the treatment plan developed in step 3 If the patient is seeking treatment for a specific area, include other potentially affected facial areas in the treatment plan Ensure the treatment plan addresses individualized concerns that may arise from the patient's unique background[5]
3. Develop a panfacial treatment plan	Determine which regions of the face will be treated Determine the order of treatment	What areas require treatment to achieve the patient's goals? Is the patient unsure of specific areas for treatment?	If the treatment plan will include multiple regions of the face, treat the midface before the upper and lower regions of the face[24] Once the midface is treated, reassess appearance of the lower face and other areas to help ensure harmonious, balanced aesthetic results[9,43,44] If the patient is unsure of which areas to treat, recommend universally desired treatments such as adding volume to the cheek area[5,8]

childhood or caused by injury, whereas in older patients, age-appropriate restoration of facial contours may be the predominant goal.[5] When treating patients from diverse ethnicities, clinicians should be mindful of significant geographic and cultural variations in treatment approaches,[5] and they should consider whether individuals are seeking feminization, masculinization, or gender neutralization of facial features.[26,47] Professionals can guide discussions with patients about panfacial treatment by noting commonalities across age, ethnicity, or gender, such as the midface being one of the first facial areas to show signs of aging, and the overall improvement that adding volume to this area may achieve.[5,8]

Panfacial treatment can include a number of surgical chin or cheek aesthetic procedures to improve facial contour, such as genioplasty and augmentation using autologous or alloplastic implants; however, surgery may not be practical or appropriate for all individuals.[42] Nonsurgical treatments, such as injectable facial fillers or neurotoxins, are less-invasive, nonpermanent, and increasingly popular among those seeking aesthetic correction of the cheeks and the chin.[5,26,42]

The US HARMONY study demonstrated that a comprehensive, minimally invasive, multimodal, panfacial treatment approach resulted in significant improvement in patient satisfaction with facial appearance and psychosocial impacts.[9,48,49] The US HARMONY study was a rater-blinded study that evaluated patient satisfaction and aesthetic impact of a combination of fillers (VYC-20L, HYC-24L, and HYC-24L+) for facial volumization and treatment of lines and folds; onabotulinumtoxinA for treatment of upper facial rhytids; and bimatoprost for treatment of eyelash hypotrichosis.[9] Nearly all (99%) treated patients ($n = 100$) rated themselves as improved or much improved on the Global Aesthetic Improvement Scale. Patients reported that they were "very satisfied" with facial symmetry, balance, and proportions and reported looking fresh and rested. Furthermore, the authors emphasized that a panfacial approach to assessment and treatment may help prevent potential overtreatment of individual areas.[9]

In a 2019 post hoc analysis of the US HARMONY study, respondents aged 18 to 65 years viewed standardized baseline and 4-month posttreatment images of patients from US HARMONY and completed an online questionnaire indicating their perceptions of these patients.[50] Patients in posttreatment images were rated as more socially adept, friendly, successful, healthy, approachable, and educated versus patients in pretreatment images.[50] Therefore, panfacial aesthetic treatment had quantifiable positive impacts on social perceptions beyond age and attractiveness. Aesthetic treatments have also resulted in positive perceptions of the patient's appearance by significant others.[51]

Initiating Panfacial Treatment with the Cheek and the Chin

Cheek and chin rejuvenation has demonstrated a noticeable impact on the definition and contour of the entire face, providing an anatomical rationale to begin panfacial treatment with enhancing facial shape, the anchors of which are the cheeks and the chin.[3,8,15,52] Evidence supports volumizing with hyaluronic acid (HA) filler treatment in the cheeks and chin for greater patient satisfaction and superior clinical outcomes. HA fillers are used to replace volume and smooth the abrupt transitions that develop with age throughout the midface, chin, and jaw.[33,46,52] US HARMONY study investigators and other researchers have recommended treating the midface first

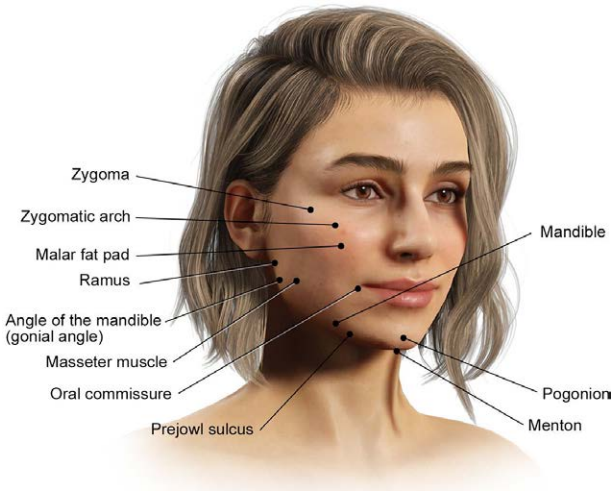

Fig. 3. Anatomical landmarks for cheek and chin/jaw rejuvenation.

when indicated to better determine the filler requirements and appropriate products for the full face and to achieve a natural-looking effect.[45,46] Facial reshaping may involve midface volume restoration as well as lower facial volume reduction using deoxycholic acid (for submental fat) or neurotoxin injections (for masseter muscle prominence or for elongating the chin or correcting a dimpled or misshapen chin).[53,54]

Favorable outcomes with injectable aesthetic treatments depend on many factors, including patient selection and safety profile. The cost of injectable treatments may not be feasible for all individuals.[19] Additionally, injectable facial treatments using HA, neurotoxins, or deoxycholic acid typically involve temporary side effects at the site of injection, which may include bruising, swelling, redness, pain, firmness, and tenderness.[9,55] Safety considerations and patient selection criteria for injectable treatments have been described in greater detail elsewhere.[4,56–60] Guidance on treating the midface and lower face follows, and locations of commonly treated facial regions are shown in Figure 3.

Midface

The youthful midface has a rounded cheek with smooth transitions to adjacent areas.[24,28] On posterolateral view, the ideal projection of the cheek ogee curve is similar to that of the chin.[17] Midfacial rejuvenation should restore the fullness of the cheek contour and its smooth transitions to the lower lid, nose, nasolabial, and lateral facial regions without abrupt demarcation of these as distinct regions.[24] Specific HA fillers may be used to correct radial cheek lines.[7,61] In patients with midface volume deficit, HA fillers can improve midface volume,[55,62] with high rates of patient satisfaction regarding symmetry, smoothness, attractiveness, and contour of the cheeks.[55]

Key Treatment Principles

Clinical data support injecting the cheeks first during HA filler treatment sessions that address multiple facial areas.[4,63,64] The aesthetic goals of treating the cheek with HA fillers include volume restoration, projection, and three-dimensional contouring.[55,62] HA filler characteristics contributing to successful treatment of the cheek region include medium to high G′ (elasticity) and cohesivity to provide appropriate lift capacity, resistance to shearing and compressive forces, and the capacity to adapt naturally to the dynamic muscle activity in this area.[31,65] Injection of HA filler with high G′ and high cohesivity into the deep supraperiosteal region is recommended to restore foundational support to soft tissue.[43,44] This approach produces a more natural outcome by avoiding the creation of a visible mass of filler gel under the surface of the skin.[43] HA filler with low G′, low cohesivity, and low water uptake may be injected more superficially to improve skin texture, smoothness, fine lines, and hydration.[31,43,65–67] Fillers with moderate G′ and cohesivity are suitable for injection to replace volume from descended or atrophied malar fat pads.[43] Because anteromalar, submalar, and posteromalar volume loss contribute to the formation of infraorbital hollows and nasolabial folds, before treating infraorbital hollows and nasolabial folds, it is prudent to assess volume correction in these areas after administering malar and perimalar injections.[44,64,68] One pivotal clinical trial found improvements in untreated areas of the face, such as infraorbital hollows (referred to as tear troughs in the study) and nasolabial folds, following treatment of the midface with an HA injectable gel (VYC-20L; Allergan Aesthetics, an AbbVie Company, Irvine, Calif.).[64] The percentage of patients satisfied with the appearance of their infraorbital hollows increased from 47.2% (110 of 233) at baseline to 84.7% (177 of 209) at 6 months after cheek augmentation, and the percentage of patients who reported being satisfied with their nasolabial folds increased from 31.2% (73 of 234) at baseline to 73.6% (153 of 208) at 6 months after treatment. A multicenter, evaluator-blind, randomized, within-subject, controlled study of cheek augmentation with facial fillers in adults with a moderate to severe midface volume deficit found more than 50-point increases in FACE-Q Satisfaction with Cheeks scores at months 1 and 3 after treatment compared with baseline.[55] FACE-Q Satisfaction with Cheeks data also demonstrated post-treatment satisfaction rates of more than 90% for cheek symmetry.

Lower Face

The lower one-third of the face is key to sexual dimorphism and has proportionally greater height in men than in women.[20,69] The width of the chin is equivalent to that of the mouth in men and to the medial intercanthal distance in women. Chin projection should be approximately in line with the lower lip in men and 1–2 mm behind the lower lip in women.[46] In both sexes, a well-defined inferior mandibular border from mentum to angle with no jowl overhang and a chin and jawline clearly defined as distinct regions are desirable.[70] Enhanced chin projection may improve the appearance of adjacent areas such as jowling or signs of aging in the neck.[71,72] In one retrospective study, 20 days after receiving treatment with an HA injectable gel alone (VYC-25L; Allergan Aesthetics, an AbbVie Company, Irvine, Calif.) in the chin, jawline, marionette lines, and

labiomental sulcus, 97% of patients rated their facial appearance as "much improved" or "very much improved" on the Global Aesthetic Improvement Scale.[72] The authors noted that redefinition of the jawline using an HA filler is a "potentially high-impact approach" for patients across various economic and biologic circumstances.[72]

Treatment of the chin with HA filler is a safe, effective, viable alternative to surgical chin augmentation.[72–74] Although surgical augmentation was long considered the gold standard for chin correction, a skilled injector can improve all dimensions of the chin using HA fillers and simultaneously address lateral oral commissures, mental crease, marionette lines, and prejowl and postjowl sulci.[71,75] A randomized controlled trial of 192 adults with chin retrusion demonstrated that an HA filler for chin volume restoration (VYC-20L) safely and significantly improved response on a validated chin retrusion scale at 6 months after treatment, with high rates of patient satisfaction and continued treatment benefit at 1 year.[74] In another study, an HA filler (VYC-25L) applied to the chin and jaw to treat patients with chin retrusion significantly improved glabella–subnasale–pogonion facial angle and increased patient satisfaction with the chin, lower face, and jawline, with physical improvements and patient satisfaction maintained beyond 18 months.[75,76]

HA fillers have also been safely and effectively used to restore jawline definition. A prospective, evaluator-blinded, multicenter, randomized study in approximately 200 patients with moderate or severe loss of jawline definition demonstrated the safety and effectiveness of VYC-25L injections along the jawline and chin for restoring loss of jawline definition, with significantly higher Allergan Loss of Jawline Definition Scale responder rates versus untreated control at month 6, high participant satisfaction, and treatment benefit lasting at least a year.[77]

Injectable treatments that reduce volume may also be an important aspect of lower facial reshaping. The Canada HARMONY study evaluated a combination of HA fillers, onabotulinumtoxinA, deoxycholic acid to reduce submental fullness, and a daily regimen of medical-grade skincare products. All patients ($n = 58$) had statistically significant ($P < 0.0001$) improvement from baseline at the final visit on the validated FACE-Q Satisfaction with Facial Appearance Scale (primary endpoint), with a mean score increase of 30.3.[49] OnabotulinumtoxinA injection is widely used for reducing excess masseter muscle volume that may result in a square-shaped face; it is injected into the masseter muscles to diminish lower facial bulk and reshape the face to the desired inverted triangle.[78] Injections of deoxycholic acid or onabotulinumtoxinA have been used successfully to improve the shape, projection, and contour of the chin.[53,54]

Key Treatment Principles

The aesthetic goals of treating the chin with HA fillers include improvement in proportion (widening for masculinization and tapering toward the center or pogonion for feminization), projection, and contouring.[76] Improvements should be seen in the lateral oblique profile view.[46,71,79] The HA fillers most appropriate for the chin will have high G′

Fig. 4. Potential outcomes of cheek and chin treatment. Case example of a Hispanic woman aged 25 years (A–D) before and (E–H) 2 weeks after treatment for aesthetic concerns of the midface and lower face. The patient had chin retrusion with a lack of lip–chin transition, an asymmetric lower face with a smaller angle of the mandible on the right (*Continued*)

and medium to high cohesivity for greater lift capacity and contour enhancement and to resist deformation. Resistance to compressive forces is necessary to accommodate the high compression and tight skin and muscle over the bone that characterize this region.[43,65] Recommended injection areas to improve chin projection and to augment chin length are the pogonion and the menton area, respectively.[46] The HA fillers should be injected in the prejowl region above the mandibular line and deeply into the mentalis muscle to project and lengthen. To complement this approach, HA may be injected more superficially in the same region to smoothen the area.[46] The recommended injection areas to restore jawline definition are the chin, prejowl area, and the mandibular line, angle, and ramus.[46] The inferior and superior limits of the injection area are, respectively, the mandibular border and the horizontal area approximately 1.5 cm above the mandibular border.[46] When injecting along the jawline, it is critical to locate the facial artery at the antegonial notch (about 1 cm from anterior masseter muscles) and inject away from the artery exit, in the preperiosteal or subdermal plane.[4,44] Injection depth for the chin is subdermal, supraperiosteal, or a combination of both.[4,72]

UNIFIED APPROACH TO CHEEK AND CHIN REJUVENATION: CASE EXAMPLES

The treatments that may be applied to the cheek and chin and the potential outcomes of treatment are demonstrated by the case examples presented in Figure 4 and Supplemental Digital Contents 1–3. (**See figure, Supplemental Digital Content 1,** which shows a case example of a Latino man aged 43 years, **http://links.lww.com/PRSGO/D546**) (**See figure, Supplemental Digital Content 2,** which shows a case example of a White woman aged 60 years, **http://links.lww.com/PRSGO/D547**.) (**See figure, Supplemental Digital Content 3,** which shows a case example of a White woman aged 47 years, **http://links.lww.com/PRSGO/D548**.) Example videos on treatment of the cheek and chin are shown in **Videos 1–3**. (**See Videos 1** and **2 [online]**, which show a case example of a Hispanic woman aged 25 years treated for aesthetic concerns of the midface and lower face.) (**See Video 3 [online]**, which shows a case example of a Latino man aged 43 years treated for aesthetic concerns of the midface and lower face.)

CONCLUSIONS

A harmonious and balanced facial appearance is the foundation of achieving optimal aesthetic outcomes that can lead to high rates of patient satisfaction and positive psychosocial outcomes. This review highlights the importance of facial angles and contours and the significance of full facial assessments and treatment, focusing on the relationships between areas of the face, specifically the cheeks and the chin, as the pillars of facial contour whose treatment may optimize results. This information aims to provide education for clinicians that encourages holistic assessment and treatment of interrelated facial areas in their patients.

Fig. 4. (Continued). side, and a hypoplastic midface. Fillers were administered as follows: each cheek, VYC-20L HA injectable gel 2 mL (Allergan Aesthetics, an AbbVie Company, Irvine, Calif.); chin, VYC-25L HA injectable gel 2.3 mL (Allergan Aesthetics, an AbbVie Company); right jawline, VYC-25L 0.8 mL; and left jawline, VYC-25L 2 mL. Posttreatment results demonstrated improved facial balance and harmony through better vertical alignment of the forehead, nose, and chin; improvement in the facial profile; improved midface projection; and improved lower facial symmetry and definition. Photographs courtesy of A. Moradi, M.D.

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DISCLOSURES

Dr. Moradi is a consultant, clinical research investigator, faculty member, and advisor for AbbVie; a consultant, advisor, steering committee member, European summit expert, and clinical research investigator for Galderma; consultant, advisor, and clinical research investigator for SkinMedica; consultant, speaker, and clinical research investigator for Alastin; honorarium recipient for Evolus; clinical research investigator for Recros Medica; and clinical research investigator, consultant, and stockholder for Glo Pharma; advisor and consultant for Teoxane; clinical research investigator for Symatese; and sponsored publication author for IQVIA/Endo. Dr. Montes is a speaker, trainer, clinical trial investigator, and advisor for AbbVie. Dr. Humphrey is a speaker, consultant, and investigator for AbbVie. Dr. Grunebaum is a consultant and researcher for AbbVie and Galderma. Dr. Bertossi receives research grants for investigator-initiated and sponsored trials and is a speaker and trainer for AbbVie. Dr. Dimitrijevic is a full-time employee of AbbVie and owns AbbVie stock. Dr. Sangha is a full-time employee of AbbVie.

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