

Reoperative Surgery of the Face

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INTRODUCTION

There has been an acceptance of cosmetic surgical procedures in the general population. No longer is cosmetic surgery only for the wealthy and famous. Cosmetic surgery is now featured on television, the internet, and openly discussed in tabloid magazines. This increased exposure is related to a significant increase in the amount of plastic surgical procedures being performed. The baby boomer generation has generally embraced plastic surgical procedures and many of these patients have had face lift procedures performed. The American Society of Plastic Surgeons has estimated that there were 112,933 face lift procedures performed in 2008. While this number is lower than in previous years, likely due to economic reasons, a substantial number of face lift procedures are still being performed. This same population of patients continue to desire to maintain their more youthful appearance and therefore they are seeking rejuvenation following an initially successful procedure and thus the topic of secondary face lifting is gaining significant importance.

There is a paucity of peer-reviewed literature regarding secondary face lifting²⁻⁷. The published series have very few patients included in their series. In addition, of the few patients presented, there are even fewer patients where the surgeon performing the secondary procedure actually performed the primary face lift. Cardoso de Castro and Braga presented a series of 19 patients who underwent secondary face lifts³. The type of surgery that was performed for the primary operation was not noted and there was no notation if any of the 19 patients had the primary procedure performed by one of the authors. Guyuron et al⁴ presented a series of 33 patients who underwent secondary face lifting. Of these patients, the senior author only performed both the primary and the sec-

ondary procedure in 3 patients. The type of surgery performed at the primary procedure was not presented nor was the technique of the secondary procedure noted. The outcomes were based on survey data with patient recollection defining much of the data. In their series, they found that the average time from primary to secondary face lift was 8.48 years. Morales presented no objective clinical data in his paper, but does bring out several clinical pearls regarding secondary face lifts⁵. de le Torre et al presented a series of 14 patients who underwent a re-elevation of the malar fat pads⁷. The average time to the need for a secondary procedure was 40 months.

In an effort to clarify further the longevity of a consistent face lift technique, the authors reviewed a series of 42 patients over an 8 year period where the senior author performed both the primary and the secondary procedure⁸. The average length of time from the primary procedure to the secondary procedure was 11.7 years. The reasons for early failure of the primary procedure were noted as well as any associated complications. There were 9 patients who required a secondary facelift prior to 5 years from the primary facelift (21.4%). Reasons for early secondary facelifting (within 5 years of the primary) included: loss of skin elasticity (5 patients), increase in subplatysmal fat and skin neck folds due to weight gain (1 patient), loss of elasticity secondary to protease inhibitors for HIV infection (1 patient), loss of skin elasticity due to corticosteroid use (1 patient), and residual fullness of digastric and residual submental fat (1 patient).

The authors found that a secondary SMAS flap was able to be elevated in 38 patients (90.5%). Three patients required SMAS plication (7.1%), and one patient (2.4%) only required secondary fat contouring. In the patients where a secondary SMAS flap was elevated, there were two patients with temporal branch paresis and three patients with a marginal mandibular branch paresis (11.9% with nerve paresis).

All of the nerve injuries resolved completely and there were no permanent nerve injuries. There were no hematomas that required evacuation. There were no skin sloughs.

PREOPERATIVE FACIAL ANALYSIS

A careful preoperative analysis must be performed prior to undertaking a secondary facelift. The secondary face lift patient is going to be older and is likely to have acquired more medical problems since the time of the primary surgery. Indeed, Guyuron et al⁴ found that 42% of patients presenting for secondary rhytidectomy had developed a new medical problem and 58% of patients had been started on a new medication since their initial face lift. Obviously these patients will need clearance from their primary care doctors prior to undertaking any secondary procedure.

It would be ideal to have copies of the operative reports from any previous procedures that had been performed. It is oftentimes difficult to get copies of these reports because of the interval of time that has passed from the primary to the secondary procedure. We also like to have the patient bring in photographs of themselves at 5-10 year intervals to understand their more youthful appearance when they felt like they looked good.

We begin with a careful and comprehensive facial analysis. A careful notation is made of the scars from previous procedures. This analysis also includes a careful analysis of the hairline of the forehead, temples, postauricular and occipital areas. Any distortions of the hairline are recorded and will be incorporated into the operative plan for the subsequent procedure.

The forehead and eyebrows are examined next. The distance from the eyebrows and orbital rim to the hairline is noted. The position of the eyebrows relative to the orbital rim is documented and the amount of elevation required to restore the brow to an aesthetic configuration is noted at the medial brow, midbrow, and lateral brow. An assessment is made of the amount of transverse forehead rhytids and a relative assessment of the strength of frontalis muscle contraction to gauge the amount of thinning that may be required of the frontalis muscle. The number of creases in the glabella and their configuration from corrugator supercilii contraction is noted as is the number and depth of creases from the procerus muscle. An assessment is then made of the depressor supercilii by having the patient close their eyes tightly against upward resistance on the medial brow.

The upper eyelids are then examined. Many secondary facelift patients have previously had blepharoplasty procedures performed. The amount of excessive sagging skin is noted after the eyebrow has been restored to its appropriate position. The amount of bulging fat in the medial, central, and lateral aspect of the upper eyelid is noted. The level of the eyelid is documented for any possible eyelid ptosis. Typically the authors have not performed aggressive blepharoplasty procedures at the time of brow, face, and neck lifting. A previous aggressive blepharoplasty procedure

with a large skin resection may result in an inadequate brow lift for fear of creating lagophthalmos with the brow lift.

Attention is next directed to the lower eyelids, face, and neck. A careful assessment is made regarding the amount of excess skin available for the procedure. The skin laxity that is found in the secondary face lift is typically more vertical rather than more horizontal as is typical with the primary face lift. The amount of excess skin is noted anterior to the tragus, anterior to the earlobe, and in the temporal region. An assessment is made of vertical excess skin in the cheek and both in one half of the neck and the whole neck. The amount of skin available needs to be correlated with an assessment of the patient's previous incisions and other needs with the secondary procedure (ie. creating a preauricular hollow, or creating hollowness in the submental area) to properly plan the procedure.

The lower eyelids are then evaluated. The position of the lateral canthus as well as the position of the lower eyelid relative to the iris are noted. The tone of the lower eyelid is noted as well. An assessment of the amount of excess fat in the medial, middle, and lateral lower eyelid compartments is made as is an assessment of the amount of excess skin. The authors have typically avoided lower eyelid blepharoplasty at the time of face lifting. A well executed SMAS face lift will improve the appearance of the lower eyelids by about 30%. Also, with the significant skin and subcutaneous tissue changes that result from the face lift procedure, the surgeon may be tempted to be more aggressive removing lower eyelid skin with the possibility of postoperative ectropion.

An assessment is then made of the malar area and the crow's feet region. Many patients have fullness in the area below the infraorbital rim. This is localized edema and it is not cured with the surgical procedure nor do medications such as diuretics improve the situation. It is important to explain this to the patient so that when the fluid and fullness recur following the procedure the patient understands that this is not a failure of the procedure. The soft tissues have fallen off of the malar eminence in both the primary and secondary face lift patient. This ptosis of the soft tissues to the fixed line of the nasolabial crease leads to an increase in the size of the nasolabial fold and a deepening of the nasolabial crease. It also results in a skeletonization of the malar area and when combined with the soft tissue ptosis in the region of the mandible the aging face develops a boxy and angular configuration rather than the heart shaped configuration of youth. The use of the SMAS to reposition the soft tissues of the face restores the softness over the malar areas and decreases the thickness of the nasolabial folds⁹. Traction on the SMAS does not deepen the nasolabial crease.

The presence and severity of crow's feet are noted. Undermining over the orbicularis oculi muscle to the area of the lateral canthus and the lateral aspect of the lower eyelid will result in a significant improvement in the appearance of the crow's feet. In addition, an assessment must be made regarding the depressor portion of the orbicularis oculi muscle. This portion has been termed the "depressor orbic-

ularis oculus lateralis” by the authors. When this muscle is strong it will oppose any lifting of the lateral brow and will result in failure of lifting of the lateral brow with the brow lift procedure. The strength of the muscle contraction can be tested by having the patient smile and apply traction to the lateral brow. If the muscle action is strong, it can be divided to weaken the depressor action^{10,11}. When the restraining communications between the orbicularis oculus and skin (smile creases) are released, 60% or more of the lower eyelid excessive skin is reduced by the shift of the face lift flaps. If the smile creases/connections are not released, there is no effect from the face lift on the lower lids. The release of the muscle/skin connections also facilitates the change in direction of the nasojugal groove from the diagonal direction of older age to the horizontal direction of youth as seen in their earlier photographs.

An assessment of the perioral area is then performed. The patient is asked to smile and the animation of the perioral area is observed. This is especially important in the secondary patient to document the status of the facial nerve preoperatively. The oral commissures are then evaluated to see if there is a dour (fishmouth) and downturned appearance of the mouth. Utilization of the SMAS with adequate mobilization and precise vector placement of the main SMAS flap or a third superior SMAS flap can elevate the corner of the mouth. The authors prefer this approach to perioral rejuvenation rather than using excisional approaches such as those advocated by Weston et al¹³.

The presence of fine vertical lines (smoker’s lines) is also noted. The author’s treatment of choice for these lines is dermabrasion at the completion of the face lift procedure. Typically the upper lip is treated at the time of the face lift. Dermabrasion usually results in improvement of the dark pigmentation of the lips and better color blending than other techniques. Phenol peels microscopically show aging of the skin with disruption of the elastic fibers and collagen. Laser produces a smooth burned appearance that does not hold up with continued sunlight exposure. Dermabrasion shows on biopsy of upper lip skin to show a great amount of collagen build up, which contributes to the smooth appearance. This is equivalent to having a filler injected. If circumferential perioral dermabrasion is needed, the lower lip and chin are done at a second stage some time later. Circumferential perioral dermabrasion results in difficulty for the patient to open their mouth in the perioperative period. Finally, an assessment of the patient’s lips is made and if they are quite thin, the lips may be augmented with fat grafting or fascial grafts.

An assessment of the chin and neck is then performed. The laxity of the skin is noted as above. The neck is inspected for submental scars and their location. Frequently these scars are actually placed into the submental crease and they must be disregarded for the secondary procedure. The most inferior level of the skin fold is noted because the extent of the skin incision in the occipital area is perpendicular to this crease. The submandibular gland size and prominence is noted. The neck is examined for large digastric muscles that may create prominence in the sub-

mandibular area as well as interfering with an aesthetic cervicomenal angle and submental area. The presence of jowls and tight mandibular ligaments is noted. The presence of platysmal bands is noted and an assessment is made as to whether the bands are tight and require transection of the platysma muscle. The position of the cricoid cartilage and thyroid cartilage are noted. The neck is also inspected for any irregularities that may be present as a result of the primary surgery.

Finally, a careful assessment of the ear is performed. The sensation is assessed to make sure that the great auricular nerve is intact. The angle of the dangle of the ear lobe from the axis of the ear is noted. This should normally be 10-15° posterior to the ear axis¹⁴. Unfortunately some surgeons tether the earlobe anteriorly in a pixie ear configuration. This is usually as a result of excessive skin removal and a failure to have placed the ear into the appropriate position when tailoring the skin at the primary procedure. To correct this deformity requires an additional 4-5 mm of excessive skin anterior to the earlobe to allow the ear to transpose posteriorly at the time of the secondary procedure. This deformity may not be able to be completely corrected at the secondary. Patients with long old appearing earlobes with a deep crease may benefit from a wedge excision of the earlobe. Trimming the caudal margin of the earlobe is best for long old appearing earlobes without a deep crease¹⁵. The length of the earlobe is important if the face lift makes the patient appear 15-20 years younger, then the old appearing earlobes would not be consistent with the younger face.

VECTORS OF AGING

The vectors of the aging face are an inferior lateral and anterior displacement of the soft tissues¹⁶. These soft tissue changes are responsible for the characteristic appearance of the aging face with enlargement of the nasolabial creases and the development of jowls. The soft tissues seem to fall off of the malar eminence and the boxiness and angularity of the aging face. The secondary facelift, however, has little laxity in the anterior-posterior direction and most of the skin laxity is found in a vertical direction. However, this direction of skin laxity makes it difficult to correct some deformities that may be the result of the primary surgery.

An example of this problem is seen in the case of the pixie ear deformity (Figure 69-1). In order to adequately correct this deformity about 5-15 mm of skin must be advanced posteriorly in order to transpose the earlobe posteriorly. When that same patient has fullness in the preauricular area coupled with the pixie ear, an additional 1 cm of skin may be required to make a concavity anterior to the tragus, which makes the skin of the tragus appear thin. Careful attention must be paid to the timing of the surgery informing the patient of what can be achieved and what cannot be achieved with the secondary surgery. If understanding is limited, the limitations and possibilities should be written in a letter to the patient.



Figure 69-1. Ear lobe pulled forward and inferiorly—Pixie ear deformity.

PROBLEMS SEEN AFTER PRIMARY FACELIFTING

Perhaps one of the most important points that can be made for face lifting, which has been presented at teaching courses for many years by Dr. Connell, is that performing a good primary face lift procedure is the key to setting up a secondary face lift. Conversely, a poorly planned and executed primary face lift will make it difficult and nearly impossible to obtain a quality result from the secondary facelift. The primary SMAS face lift technique employed by the authors is designed to obtain a maximal result from the primary procedure and yet will also allow for the performance of a safe and aesthetically pleasing secondary face lift. Those surgical techniques that are designed for speed using techniques such as shoving scissors underneath the skin flap will result in imprecise dissection of the skin flap and SMAS distortion with the inability to raise a secondary SMAS flap.

There are many problems seen in evaluating patients for secondary face lifting that may need to be addressed. Starting at the temporal area, there may be a widened scar extending vertically from the root of the helix cephalad into the temporal hair. A widened scar indicates that there was too much skin (hair bearing skin) excised and this may also result in distortion of the hairline in the temporal area. This may also result in widening of the distance between the lateral canthus and the temporal hairline (Figure 69-2). Displacement of temporal hair by non-hair bearing preauricular skin will result in a loss of hair, which looks like a widened scar in the temporal area and may also lead to loss or distortion of the sideburn area (Figure 69-3). The face lift scar



Figure 69-2. A-B, widened scars in the hairline (temporal)—from too much tension on the scar.

should then pass inferiorly following the curve of the helical rim and should not be a straight line scar (Figures 69-4 and 69-5). Further inferiorly, the scar should follow the margin of the tragus and should not be placed anterior to the tragus. Ignoring this point leads to scar visibility because it ignores the natural color change from the tragus out onto the cheek and after the skin resection two different colors of skin are juxtaposed next to each other (Figure 69-6).

For a natural unoperated appearance a small crescent of skin must be left attached to the earlobe to preserve the natural earlobe-cheek junction (Figure 69-7). Conversely, one must not keep too much skin attached to the ear lobule (Figure 69-8). In the postauricular area, the incision should be made close to the ear-postauricular skin junction. If the incision is onto the concha, a webbing will develop where



Figure 69-3. A-B, Non-hair bearing skin transposed into temporal scalp with loss of sideburn.

the incision transitions to the occipital skin (Figure 69-9). Skin removal in the neck should be mainly in a posterior direction perpendicular to the neck folds.

For eliminating hair shifts, which prevent wearing short hairstyles and wearing the hair upward, the incisions in the occipital area should follow the hairline except at the most posterior aspect where the dog ear is transposed into the occipital hair. The incision described in articles and textbooks extending from the postauricular incision into the occipital hair will often transpose non-hairbearing skin into the occipital hair and create an unusual triangular area of alopecia (Figure 69-10). Widened scars in the occipital hairline are the result of wrong direction of skin shift or from excessive skin resection (Figure 69-11). To avoid excessive skin resection, the cervicomentral angle should be at 90° when tailoring the skin.

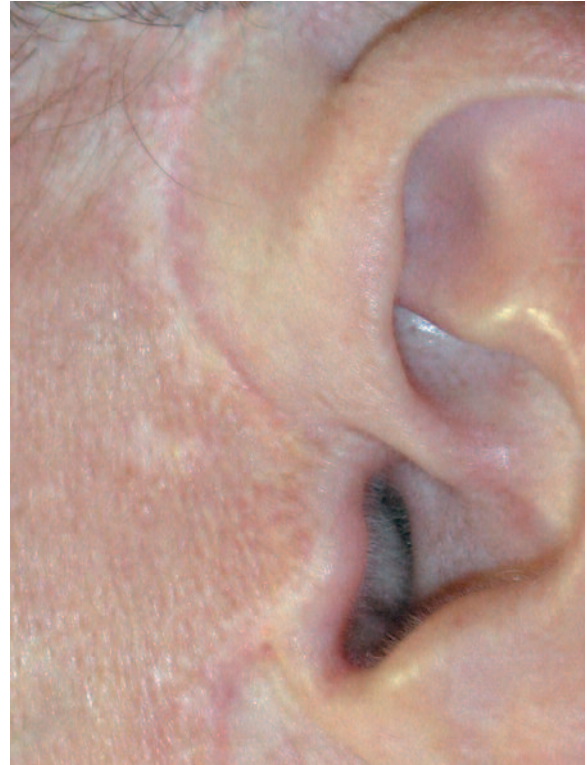


Figure 69-4. Scar not following curve of helix.

Great care must be taken to create a natural appearing scar around the ear. Some of these issues have been touched on above. The scar should follow the curvature of the helix and should not be a straight line. The scar should be follow the margin of the tragus and should not be anteri-



Figure 69-5. Vertical scar in front of helical rim rather than following curve.



Figure 69-6. Scars placed anterior to tragus with visible color change.

or to or behind the tragus. The skin should be tailored such that the tragus has a definite beginning and ending (Figure 69-12). At the caudal end of the tragus, the incision should turn 90° and should then turn 90° again to run along the an-



Figure 69-7. No crescent of skin attached to the ear lobule (incision in the crease causing an unnatural appearance).



Figure 69-8. Too much skin attached to ear lobule.

terior margin of the earlobe. Many surgeons make no effort to define the tragus. The tragus needs a concavity superiorly and a color change ending caudally, which sets the visual height of the tragus. Creation of a depression anterior to the tragus will make the skin look thin over the tragus.

Following a primary face lift, there may be some contour irregularities in the neck and there may be some areas of the neck that were not treated or were inadequately treated. The platysma muscle may have some tight bands that were not released. There may be hollowness in the central neck from overresection of fat. The digastric muscles may have not been addressed at the primary and will create prominence in the submandibular area when looking downward or even when looking straight ahead (Figure 69-13). The submandibular glands may be enlarged leading to fullness in the submandibular area.

The hairline must be given great consideration at the time of the primary face lift. These issues have been emphasized above. Many of these deformities can only be treated using hair transplants^{17,18}.

TIMING

The timing of the secondary surgery will be based on careful evaluation of the patient. In the author's series of secondary face lifts, the time from the primary face lift to the secondary face lift averaged 11.9 years⁸. There were 9 patients who required a secondary procedure earlier than 5 years following the primary. Of these 9 patients, 8 of the patients had a significant loss of elasticity of the skin most commonly due to solar damage, but there was also loss of elasticity due to corticosteroids and protease inhibitors used to treat HIV infection. One of the patients had some neck irregularities associated with a sudden increase in weight.



Figure 69-9. Web of scar in postauricular area from scar being placed up onto the concha.

Ideally the timing for the secondary surgery would be when the patient is ready for the procedure. However, if there are significant distortions, e.g. the earlobe is pulled forward and there is a lack of a preauricular hollowing, that would require recruiting significant amounts of skin it may be preferable to have the patient delay the procedure in order to try to correct any distortions as a result of the primary procedure.

AUTHORS PREFERRED TECHNIQUE

The eyebrow position is marked relative to the orbital rim and then with the brow in the desired position (if a simultaneous brow lift is to be performed). The corrugator and procerus muscle creases are marked. Any bulging of the corru-



Figure 69-10. Non-hair bearing skin transposed into occipital scalp.



Figure 69-11. Widened scars in the occipital hairline.

gator muscle is marked. If there is strong function of the depressor portion of the orbicularis oculi muscle this area is marked for planned division. The malar pivot point for the SMAS is then marked. This should correspond to the high point of cheek projection and is usually a finger breadth below the lateral canthus. The vertical and horizontal limbs of the planned SMAS elevation are marked. The mandibular ligaments are marked as well as the position of the cricoid cartilage and thyroid cartilage. The external jugular veins are also marked.

Sequential compression stockings are placed on all patients prior to the induction of general anesthesia. General anesthesia is induced using an endotracheal tube that is

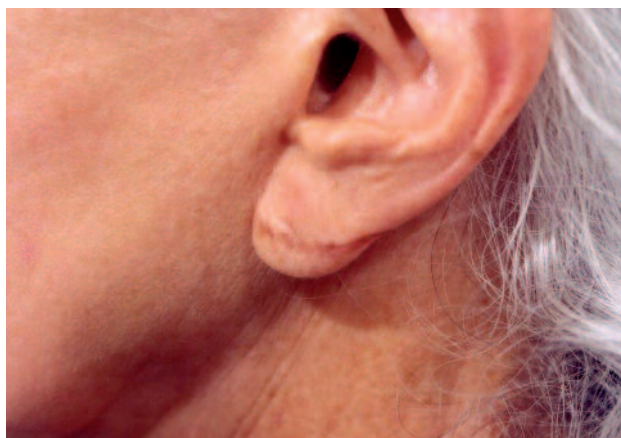


Figure 69-12. Tragus without definite beginning or end-also with ptosis of earlobe.



Figure 69-13. Prominent digastric muscles-also with too aggressive liposuction at inferior border of mandible.

placed through the nose. The use of a nasal tube allows for a more precise correction of the neck. The patient is then carefully padded and a Foley catheter is placed. Intravenous antibiotics are given-typically Ancef for those patients who do not have allergies. The scalp, face, and neck are prepped with povidone-iodine soap and the area around the eyes are prepped with povidone-iodine solution. After patient is draped, local anesthesia solution is infiltrated using 0.5% lidocaine with 1:200,000 epinephrine solution.



Figure 69-14. Extent of undermining. The cross-hatched area represents the regions undermined through the submental incision including the anterior neck, submental crease, chin, and mandibular ligaments."

The sensory nerves are first blocked and then the incision lines and the lines of planned SMAS incision are blocked. The authors have not utilized tumescent infiltration because they believe that it compromises careful flap dissection and may compromise skin viability¹⁹.

The temporal and occipital incisions are planned based on the amount of skin shift associated with the face lift. Frequently in the secondary face lift, the temporal incision is made at the hairline to prevent any widening of the distance from the lateral canthus to the hairline. The preauricular incision follows the curve of the helical rim and then runs along the margin of the tragus to the color change at the inferior aspect of the tragus. In the secondary face lift patient, a pretragal incision may have to be employed until there is enough skin recruited to allow movement of the scar to the margin of the tragus. At the inferior aspect of the tragus, the incision turns perpendicular and then turns perpendicular again to run inferior adjacent to the earlobe. A small cuff of skin is left attached to the inferior aspect of the earlobe.

The postauricular incision extends close to the postauricular sulcus until it turns to join the occipital incision. The postauricular incision where it transitions to the occipital scalp should usually be made lower than in the primary surgery. This can be moved more cephalad if the proper vector of skin shift permits at the time of tailoring of the skin flaps.

The submental incision is placed posterior to the submental crease even if the incision was made at the crease for the primary. Male patients are asked to grow out their beards for at least 2 days to allow for placement of the incision parallel to the hair follicles.

The skin is undermined anteriorly only as far as necessary to permit a different directional shift of the skin from the directional shift of the SMAS, which is usually in a more superior direction (Figure 69-14). The anterior cheek, which has connections from the SMAS to the skin, is not undermined because this would lose a major support of the SMAS to the incisions in the temporal area and would not

Figure 69-15. Postauricular scars due to skin necrosis from pressure dressing.



make the pleasing concavity that occurs when the attachments from the anterior SMAS to the skin are left intact. The rotation point of the SMAS is planned so that there would be an enhancement of the projection over the malar area. The neck is dissected caudally to below the level of the cricoid cartilage. Through the submental incision the submental crease and the osseocutaneous mandibular ligaments are released. No attempt is made to release the mandibular ligaments in a subSMAS plane.

It is important to take great care in raising the skin flap. If the flap is raised too thick, the SMAS will be incorporated into the skin flap. If the flap is raised too thin, there may be a compromise to the viability of the skin flap. In the authors series of secondary face lifts⁸, a secondary SMAS flap was able to be raised in 91% of patients whereas plication was utilized in 7% of patients due to an inadequate SMAS. Paramount to raising the SMAS is an appropriate skin dissection. In male patients, the appropriate plane is just below the hairbulbs of the beard. Female patients are much more difficult because there may be difficulty in being able to tell whether one is dissecting in the plane of old scar tissue or if one is dissecting within the SMAS. The flaps are elevated with a combination of direct light and transillumination. Transillumination may be less precise if the skin elevation in the primary procedure was close to the subdermal plexus of vessels.

The SMAS flap is then elevated. The amount of release is performed based on the preoperative assessment of the patient's needs. The transverse limb of the SMAS incision

is typically above or at the superior border of the zygomatic arch and extends medially through some of the inferior portion of the orbicularis oculi muscle and out to the malar pivot point. The inferior limb of the SMAS incision runs about one centimeter anterior to the tragus and extends inferiorly into the neck within one centimeter of the anterior border of the sternocleidomastoid muscle. Division of the SMAS is performed between two Allis clamps that are lifting up on the SMAS to avoid injury to the facial nerve. The SMAS is then grasped with the Allis clamps and the SMAS flap is raised before releasing the zygomatic liga-



Figure 69-16. Neck scars due to pressure dressing.

ments and masseteric cutaneous ligaments. When the desired effect occurs with traction on the SMAS, the undermining is discontinued. The SMAS flap can then be advanced posteriorly and superiorly and stapled temporarily into position. The flap may be bifurcated or trifurcated as needed²⁰.

In the secondary face lift patient a SMAS flap can be elevated in most patients. It may be difficult to raise a secondary SMAS flap in those patients who have had an anterior SMASectomy²¹ performed because the SMAS is thin in these patients. If the patient has had the SMAS rolled downward over the zygomatic arch or a Vicryl mesh has been inserted at the time of the primary surgery there is a significant limitation in the improvement of a secondary SMAS procedure²². In secondary face lift patients a pretragal SMAS flap may not be available to transpose to become an occipital flap.

Once the SMAS flap has been mobilized, modifications of the neck are performed. As needed these modifications include transection of the platysma, defatting of the neck with open liposuction or direct defatting, removal of subplatysmal fat, tangential resection of the digastric muscle, and reduction of the submandibular glands. The submental fascia is approximated and invaginated to prevent hollowing under the neck. Most secondary face lift patients require transection of the platysma below the level of the cricoid cartilage to improve tight platysmal bands.

The SMAS flaps are then overlapped superiorly to the temporal fascia and the SMAS flaps are inset. Following this two closed suction drains are placed and the skin is tailored. The skin shift seen in the secondary face lift patient is more vertical than posterior. If the skin laxity allows, one may be able to get the postauricular skin up to the level of the previous scar. Skin closure in the temporal and occipital areas is performed using half-buried horizontal mattress sutures using 4-0 nylon. An intradermal 5-0 Prolene is used in the temporal area. The incisions around the ears are closed using interrupted and running 6-0 nylon sutures. Simple interrupted 4-0 nylon sutures are used to close the postauricular incision.

The procedure is not completed, however, following the surgery. The patients are observed overnight with a nurse at the bedside. They are then able to go home on the morning of postoperative day one. They are seen in the late afternoon of postoperative day one where the drains

are removed in most cases. Rarely, the drains will be removed on postoperative day two. The patients are seen postoperatively on days one, two, five, seven or eight, and nine or ten. The preauricular sutures are removed on day five. The remainder of the sutures are removed in the next five days. No compressive facelift dressings are used because they may lead to skin necrosis (Figures 69-15 and 69-16).

The patients are given specific activity and wound care instructions. The patient is not to turn the neck from side to side, but is to move shoulders and neck as one unit. They are to avoid yawning, but smiling is okay. The patient is not to have a pillow behind the head, but is to use a small pillow or towel rolled up and placed behind the neck. The cervicomenthal angle should be greater than 90 degrees. The patient is not to eat in bed, but may eat from a coffee table with one elbow on the knee. They are to take a liquid or soft diet with small bites for 10 days. Ice filled gloves or frozen bag of peas covered with stockinette to eyelids and crow's feet areas are used continuously for three days except while eating. Patient is to lie flat to reduce swelling to the lower eyelids. The patient should shampoo hair daily for two weeks beginning on the 3rd postoperative day using their regular shampoo. Water may run over the incision sites, including the eyes. If patient had dermabrasion of the upper or lower lip, no ointment of any kind is to be placed on the lips or dermabraded area. There should be no driving for 10 days after the operation. The hair should not be tinted for one month following the surgery.

COMPLICATIONS

The patients are all given informed consent regarding the various risks of face lifting including scars, hematomas, seromas, skin slough, swelling, bruising, numbness, facial nerve injury, and sensory nerve injury. The number of complications is surprisingly low. In the authors series of 42 patients where both the primary and the secondary face lift was performed by the senior surgeon, there were no hematomas or skin sloughs. In patients who had a secondary SMAS flap elevated there were two cases of temporal branch paresis and three cases of marginal mandibular branch paresis (11.9% of secondary SMAS flaps). However, there were no permanent facial nerve injuries⁸.

INFORMED CONSENT

CONSENT FOR OPERATION, ADMINISTRATION OF ANESTHETICS, AND THE RENDERING OF OTHER MEDICAL SERVICES

Date:

Name of Patient:

I hereby authorize and direct, my surgeon to perform the following operation upon me.

.....

.....

Consisting generally of Face and Neck Lift with Crow's Feet Correction, Coronal Brow Lift, Upper Eyelid Correction (Fat only), Dermabrasion to Upper and/or Lower Lip, and/or to do any other therapeutic procedure that (his) judgement may dictate to be advisable for the patient's well being. The nature of the operation has been explained to me and no warranty or guarantee has been made as to the result or cure.

I hereby authorize and direct the above named surgeon and/or his associates or assistants to provide such additional services for me as he or they may deem reasonable and necessary, including, but not limited to, the administration and maintenance of the anesthesia, and the performance of services involving pathology and radiology, and I hereby consent thereto.

I understand that the above named surgeon and his associates or assistants will be occupied solely with performing such operation, and the persons in attendance at such operation for the purpose of administering anesthesia, and the person or persons performing services involving pathology and radiology, are not the agents, servants, or employees of any surgeon, but are independent contractors, and as such are the agents. To assure the highest quality in patient care, all approved facilities participate in a scheduled Peer Review Mechanism. I give consent for peer physicians to review my records.

Personnel and facilities are maintained to assist your physician and surgeon in his performance of various surgical operations and other special diagnostic and therapeutic procedures. These surgical operations and special diagnostic or therapeutic procedures all may involve calculated risks of complications, injury or even death, from both known and unknown causes and no warranty or guarantee has been made as to result or cure.

The following points have specifically been made clear:

- There are, of course, scars as a result of this surgery. Every effort will be made to conceal or to make them as inconspicuous as possible.
- There may be swelling in the face, which can persist for several weeks.
- There may be bruising for several weeks.
- There may be scattered areas of numbness over the face and neck following the surgery, which may persist for an indefinite period of time.
- There are usually areas of numbness in the area of the browlift surgery and above the incision, which persists for months following surgery. When the sensation returns there may be sensations of tingling, itching, and other strange sensations in the areas, which were numb before. In addition, headaches are not expected, but they may occur.
- That no guarantee has been made as to the amount of percentage of improvement either in terms of apparent age, or the permanency of the results.
- That, at times, fluid or blood may accumulate in the operative sites, which may require aspiration or drainage.
- That, rarely, nerve damage can occur, which might cause a varying amount of facial paralysis.
- There may be discoloration for an indefinite period of time.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure.

I consent to be photographed before, during, and after the treatment; that these photographs shall be the property of the above doctor and may be published in scientific journals and/or shows for scientific reasons with the understanding that the name shall not be given in the use of any of these materials.

I agree to keep the above doctor informed of any change of address so that he can notify me of any late findings, and I agree to cooperate with the above doctor in my care after surgery until completely discharged.

I am aware that if dermabrasion is done that the color and texture of this treated skin may be somewhat different than the surrounding skin and the treated area will remain red or pink 6-8 weeks or possibly longer.

I have read the above consent and fully understand the same and do authorize the above doctor to perform this surgical procedure on me.

Your signature listed below constitutes your acknowledgement (1) that you read and agreed to the foregoing, (2) that the operations or special procedures have been adequately explained to you by your attending surgeon and that you have all of the information that you desire, and (3) that you authorize and consent to the performance of the operations or special procedures.

.....
Patient or Legal Representative/Date

.....
Relationship to Patient

.....
Print Patient or Legal Representative Name

.....
Witness Signature/Date

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

.....
Physician/Date

..... Original placed into chart

..... Copy given to patient

PEARLS AND PITFALLS

Many of the pearls and pitfalls of secondary face lifting have been addressed above. There are a few very important points. The surgeon must carefully analyze the amount of skin available and the skin shifts. The elevation of the skin flap is critical to both ensure flap viability and an adequate SMAS for soft tissue support.

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