Correcting “Witch’s Chin” by Excising the Ptotic Soft Tissue

The witch’s chin presents most commonly in older patients in whom the chin pad has sagged below the jawline. This sagging often leaves the chin with an inadequate projection and creates what appears to be a deep submental skin crease. Of course, other varieties of chin ptosis exist. Many patients have what I call “dynamic ptosis,” in which the ptosis appears or becomes exaggerated only with smiling. Some patients with chin ptosis have too much, rather than too little anterior chin projection, and I have to decide whether this is excess bone or excess soft tissue. Other patients have a shallow submental skin crease or no crease at all.

Most of the described methods to treat chin ptosis involve either filling in or smoothing out the apparent submental hollow that is commonly associated with chin ptosis. I say this hollow is “apparent” because I believe that in most patients, what seems to be a deep crease is actually not very deep at all. This crease is relatively fixed in place and appears deepened by virtue of the tissues drooping above. Thus, if the ptosis is associated with a submental depression, I correct this depression primarily by eliminating the ptosis. It is interesting that Dr. Lesavoy also discards the submental skin crease, but does so by deepithelizing a strip of skin and burying it.

I tailor my repair to fit the problem. If the chin droops or projects too much, I excise the drooping or projecting tissue, which may be just fat, just skin, or both, and I remove only what is necessary. If the chin also lacks forward projection, I add it, usually with an alloplastic implant, which is stable and just the right size. I do not lift and suture the ptotic tissues because, based on my experience, they will fall again.

Preoperatively, certain skin markings are helpful. With the patient sitting upright, I draw a transverse line forward on each side of the chin to represent the extension of the ideal jawline. If the patient’s problem is primarily dynamic ptosis, I draw the lines while he or she is smiling. The two side lines are then connected across the front of the chin. The subcutaneous tissue (not the skin) caudal to this line is the ptotic tissue that needs to be excised. I mark a submental skin incision a millimeter or two caudal to the submental skin crease. This line must run the full width under the chin, from one side to the other. I do not predetermine how much skin, if any, is to be removed.

I use a scalpel to incise the skin, but perform the rest of the dissection with the needle-tip electrocautery set on coagulating current. I elevate a superiorly-based chin skin-fat flap, which has very little fat on it caudally and becomes progressively thicker superiorly, since the fat that is left attached to the flap will remain over the bone postoperatively. When the flap has been raised to the level of the transverse line drawn on the chin preoperatively, I remove the oval area of excess fat from the bone, along with, perhaps, just a little muscle, almost down to the periosteum. An alloplastic implant is added when appropriate.

After redraping the flap over the bone, I gently push the flap caudally so that it overlaps the incision edge comfortably, and then mark the strip of skin that is to be removed from the flap. This strip contains the submental skin crease. In some cases, particularly in a young patient who has a dynamic ptosis only, or when a chin implant has been added, I do not remove any skin from the chin. A light compression dressing can be applied or a small suction drain can be placed under the flap. If a seroma is detected postoperatively, it should be aspirated. I usually instruct my patients to take antibiotics for a few days.

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