Facelift: The Full Endoscopic and Biplanar Approach

My approach to facelift is individually tailored to the patient's needs. For younger patients - aged up to their late forties - I use a full endoscopic technique without skin excision. For older patients who require total facial rejuvenation, I use a combination of the endoscopic and the so-called biplanar facelift technique. For the forehead, I use three to five slit incisions, depending on what I want to achieve. I usually make four incisions to remove the corrugator muscles and to elevate the head, the central portion and tail of the brow. This is a purely endoscopic technique. If an upper eyelid excision is required, then I do it in a second stage with the patient under local anesthesia.

For the rest of the face, particularly the central region, I use the biplanar technique, in which I approach the central sphere of the face through lower eyelid incisions. With the aid of the endoscope, I elevate the mid face at the subperiosteal plane. I release the zygomatic and other muscle attachments, as well as the periosteal attachments in the lower sections of the mid face. I then perform a limited subcutaneous undermining to the point of overlapping the deep subperiosteal dissection with a more superficial dissection. This subcutaneous dissection allows me to remove the excess skin and gives me an extra vector of pull, providing even greater improvement of the ptotic cheek and nasolabial fold.

The excess skin from the lower eyelid is then evaluated and removed using standard techniques. It is very important to judge the amount of laxity of the lower eyelid, as well as the canthal malposition, when using this technique on the mid face, because if the canthal ligaments or the lower eyelid in general is lax, there might be a tendency for scleral show or worse, possible ectropion. Thus, the canthopexy is an integral part of the operation if the patient has these two indications. In mild cases, a simple plication of the canthus is enough to give a little tension to the lower eyelids and avoid possible scleral show or ectropion; a more extensive repositioning will change the shape of the eyelid.

I don't think the degree of swelling from the subperiosteal dissection in the periorbital area is significantly different from that with the deep plane, sub-SMAS procedure. Once you disrupt the SMAS attachments, you're going to see swelling regardless of the technique used.

My approach to the neck area is based on the amount of skin excision needed. If there is an obtuse cervicomental angle with excess fat pad and good quality skin, I don't need to resect the skin posteriorly. Through a submental incision, I remove the excess fat superficial to the platysma, do a wide subcutaneous undermining, and then remove any excess fat in the subplatysmal layer. If the anterior belly of the digastric muscle is loose, I plicate it.

Next, I do the modified corset, which extends from the thyroid cartilage to the tip of the chin, with interrupted sutures. I believe that interrupted sutures work best because they allow me to better distribute the tension in each one of the sutures. In most young patients, the excess skin will redrape as the convexity changes to a concavity, so this isn't a problem in terms of skin resection. But if a patient has a lot of excess skin, then I will do a skin excision in the retroauricular area.

I use the endoscope in the neck when I want to separate the platysma from the submandibular gland. This separation avoids a tethering effect on the submandibular gland as the platysma is plicated in the midline. The magnification provided by the endoscope allows a clear view of the nerves deep to the platysma.

The fact that I perform subperiosteal dissections in most of my patients doesn't mean that I don't use the other techniques; I often do. I believe future surgical approaches will be combinations of the techniques that we are using now, and they will have to be adaptable to each patient's needs.