The Pre-sideburn Incision Preserves the Sideburn

I perform a large number of secondary face lifts on women and have seen their sideburns climb higher and higher until the lower temporal region becomes barren of hair. I initially used the pre-hairline incision only for the secondary face lifts of patients who had a sideburn at the root of the helix or higher, going around the sideburn and then directly upward—not anteriorly—and leaving the sideburn width about 3 cm anterior to the ear. Thus, the sideburn is not elevated and is not a part of the dissection. From that point the dissection is subcutaneous. I now use this incision almost exclusively unless a woman has a low sideburn to begin with, in which case I use a conventional incision. Thus a woman can retain her sideburns regardless of how many face lifts she might have in the future. I believe it is preferable to have a fine incision line rather than barren skin around a sideburn.

Surgeons have generally made the incision parallel to the direction of the hair follicles. However, in view of Dr. André Camirand’s work, I have found that if one goes more perpendicular to the direction of the hair follicles, or just makes a straight perpendicular skin incision, the stems of the hair follicles will grow through the incision and make it less visible. I make the incision almost 90 degrees to the axis of the follicles.

To create a favorable scar on closure, I make the first pilot incision at the anteroinferior corner of the sideburn. To prevent the scar from spreading, less tension should be placed on this incision than on the conventional temporal pilot incision. The same is true of the second pilot incision at the posterior limits of the sideburn, as well as the third incision in the temporal region. I then trim conservatively so there won’t be too much tension on the wound edges. I don’t carry my temporal incisions in the hair too far posteriorly because this results in too much tension. In fact, I have even stopped excising temporal skin in the posterior direction with both the pre-sideburn incision and the post-sideburn incision. I have found that by simply bringing it upward superiorly without any posterior excision I no longer have necrosis at the wound edge. I close the pre-sideburn area with half-buried mattress sutures tied on the hair-bearing side and then with a continuous, fine, over-and-over suture, which is removed in 5 days. The deep layers are held by the half-buried mattress sutures, which can stay in place for 2 weeks. I do not use subcuticular sutures within the hair follicles.

If I am performing a coronal brow lift at the same time as the face lift, I will bring the vertical incisions down as pre-sideburn incisions that go all the way through the fascia to reflect the forehead flap. I will then close the fascia—the galea—and proceed with the subcutaneous dissection. I do the forehead lift first because it seems more logical to me to proceed that way. I get the upper part of the face elevated and then proceed to the lower two thirds of the face. I strongly believe that if you are going to perform a blepharoplasty, even if it is only a lower lid blepharoplasty, then you should do the brow lift first. However, I acknowledge that some world-class plastic surgeons do the upper lid blepharoplasty first. It is my philosophy that a brow lift and blepharoplasty are like shortening a pair of pants or a skirt. First you pull it up to the waist, then you see how much to take off the bottom.

Most patients heal very well and they like keeping a sideburn, even though an anterior scar is present. This

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needle can be milked out of the needle tracts. Cross-
tunnel molding is not possible.

10. Fat is used for area fills, and collagen is used for der-
mis fills. They are not interchangeable. I believe that
the use of fat has not caught on because it has been
used like collagen, a task for which it is ill suited. In
addition, fat injection does not replace the SMAS
face lift; the two procedures accomplish different
things. Ultimately, the characteristics of the face
requiring improvement—not the technical prefer-
ces of the surgeon—should define the treatment.

applies not only to women but occasionally to men who
cannot grow a beard below the level of the middle of the
ear. It is always a good idea to ask the male patient pre-
operatively whether he could grow long sideburns when
they were fashionable. If he says no, then this incision
would be better for him than the conventional incision.
Even in secondary face lifts in which the initial incision
was made in the scalp but is followed by a pre-sideburn
incision—creating an island limited by incisions anterior-
ly and inferiorly and a scar line posteriorly—the tissue
survives nicely.

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