Letter to the Editor

Midface Lift Techniques Revisited

To the Editor:

I believe it is always very interesting to try to find new techniques. However, the approach presented in E. Ronald Finger's article, "Transmalar Subperiosteal Midface Lift: Early Results With a Simplified Approach" (Aesthet Surg Q 1996;16:261-7), seems to me to be absolutely unsafe, because the incision of the periosteum is done in the dangerous region of the crossing of the frontal branch of the facial nerve.

If the effect is clearly demonstrated on the soft cheeks, the result is not good for the low eyelids, because the scleral show is increased by a lateral or even downward pull, as is clearly seen in Figure 7, B and D (reproduced on the next page).

Also, the author did not quote our article, G.-F. Maillard, B. Cornette de St. Cyr, and M. Schefflan, "The Subperiosteal Bicoronal Approach to Total Facelifting: The DMAS—Deep Musculoaponeurotic System" (Aesthetic Plastic Surgery, 1991;15:285-91). (This is probably the safest approach currently described.)

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Dr. Finger's reply:

To address Dr. Maillard's polite dissent: Dr. Maillard's article represents an excellent technique. There are other fine articles regarding midface lifts that were not included in the bibliography of my article. My article was not intended to be a review of the literature. Dr. Maillard's article is included in the bibliography for my follow-up article, "Transmalar Subperiosteal Midface Lift Update: A Review with Technical Modifications, Suggestions and Limitations" (to be published in the May/June 1998 issue of Aesthetic Surgery Journal).

To address Dr. Maillard's criticisms: Not everyone who wants or needs a midface lift also wants, needs, or should even have a coronal lift. The transmalar approach to the midface lift is safer in regard to the temporofrontal branch of the facial nerve than any procedure traversing the zygomatic arch. The incidence of nerve injury in my series of 77 cases is zero. If the procedure is performed as described in my original article, the entry to the midface—which is only the spreading of tissue—is anterior to the nerve by 2 cm or more.

The scleral show in Figure 7 is also seen in the preoperative view. This was congenital,
and the patient did not consider it a problem. There is obviously only upward pull, with a small amount of lateral pull on the tissues with the transmalar approach, as I clearly described in the article. I also explained that mild laxity of the lower lid can be corrected with the procedure.

I do, however, appreciate Dr. Maillard’s contributions to this subject and his criticisms. They are thought provoking, which is healthy for us all.

Figure 7. A 53-year-old woman after endoscopic forehead lift, rhytidectomy with transmalar midface lift, and upper and lower lid blepharoplasty. A and C, Before surgery. B and D, 8-month postoperative results. The preexisting ectropion could have been improved by carrying the subperiosteal dissection over the lateral orbital rim. Alternatively, a lateral canthopexy should have been performed. The patient is currently scheduled for this procedure.