Editor’s note: My thanks to the moderator, John H. Hartley, Jr., MD (board-certified plastic surgeon and ASAPS member, Atlanta, GA), and to panelists John William Little, MD (board-certified plastic surgeon and ASAPS member, Washington, DC); Timothy J. Marten, MD (board-certified plastic surgeon and ASAPS member, San Francisco, CA); and Bruno Ristow, MD (board-certified plastic surgeon and ASAPS member, San Francisco, CA), for sharing their opinions and clinical experiences.

Dr. Hartley: The first patient is a 44-year-old woman who wants facial rejuvenation surgery (Figure 1, A). She usually wears her hair swept up. Dr. Marten, where would you put your incisions on this patient?

Dr. Marten: In choosing where to make the temple portion of the face lift incision, the existing amount of temporal “skin show” must be considered in conjunction with the amount of cheek laxity. This allows an estimate to be made of the degree of sideburn displacement that will occur when the face lift flap is shifted. If a large shift is predicted, placement of the incision along the temporal hairline should be considered. If the shift is small, the incision can be placed in the “traditional” location on the temple scalp.

This patient has modest cheek laxity and sideburn hair that sweeps posteriorly. Although the choice would and should be hers, an incision on the temple scalp probably represents the best compromise. Preauricularly, it would sweep down in the groove between the helix and cheek, along the margin of the tragus around the lobule, and back up in the auriculomastoid groove, turning posteriorly at the level of the root of the helix or the anterior crus of the antihelix, extending along the occipital hairline and into the hairline at the junction of thick and thin hair (Figure 1, B).

Dr. Hartley: Would you make a sub-sideburn incision?

Dr. Marten: Sideburn displacement should be minimal if a superficial musculoaponeurotic system (SMAS) technique is used and the skin flap is shifted posteriorly rather than superiorly. A sub-sideburn incision is inconspicuous if it is placed artistically beneath the sideburn and it does not extend out onto the face, because hair always grows inferiorly there. The need for such an incision would be decided at the time of surgery.

Dr. Hartley: Dr. Ristow, do you agree with that?

Dr. Ristow: Superior to the ear, I go straight up, as opposed to tilted backward because that facilitates a shift of the flap to avoid a defect in that area. I would go fairly high, because I like to go below the galea and lift the corner of the eyebrow, releasing the ligaments there. I would bevel an incision at the hairline under the sideburn to accommodate a significant shift of the skin to leave the sideburn precisely where it is. Like Dr. Marten, I would put the incision exactly at the groove behind the ear, and then I would follow the hairline. Initially, I make a wide-angle incision at the level of the ear canal in the retroauricular area. If I want to move that incision higher toward the end of the procedure, I can do so after evaluating the viability of the skin (Figure 1, C).

Dr. Hartley: After you leave the posterior auricular sulcus, do you follow the margin of the hairline, or do you enter the scalp?
Dr. Ristow: I follow the margin of the hairline 2 or 3 cm, and then I plunge into the scalp, designing a lazy S, continuing for 5 cm or so. Any incision going straight into the scalp creates a stair-step deformity and gives a poor pull vector for the neck.

Dr. Hartley: Dr. Little, what would you do for this patient and why?

Dr. Little: I don’t join my face lift incision with my brow incision. I perform a lateral brow incision running 4 cm from the lateral temporal crest. I leave the rest of the scalp intact because I use a sub-sideburn incision on virtually everybody. I prefer a superiorly directed vector for the skin in most individuals, so every incision of mine begins as a V-shaped incision below the sideburn. The hair pattern is always directed downward, so there is zero incidence of a visible scar. As you remove more skin, there is a greater dog-ear at the converging point of rotation in front of the sideburn. If that scar is made as a transverse line, the dog-ear accumulates in the pre-temple, and it can be difficult to deal with. If you construct that sub-sideburn incision as a V with the point directed downward, so that the rising limb anteriorly is at a 45-degree angle, any dog-ear that forms around your rotation point is hidden within the hairline.

Dr. Hartley: So you have no vertical extension of the incision?

Dr. Little: None. Coming up for the posterior half of that V, I encompass that little hairless area behind the sideburn and in front of the extension of the root of the helix and follow the root of the helix around. As I come out of the retrotragal position, I don’t want to take a direct line to the prelobular incision, because there’s a tendency to contract there. I often leave a 5- or 6-mm square of skin right over that tragus. If the tragus needs more accentuation, that little square can be deepithelialized and folded on itself. I would actually excise some of the redundant lobule anteriorly. Of course, when I insert the lobule, I direct it posteriorly between a 15- and 30-degree angle. I come up on the surface of the posterior concha maybe about 1 cm, and as I reach the height of the retroauricular sulcus, I just continue that incision straight up; typically that’s about 1 cm of hairless gap until I reach the superior hairline.

When I reach the superior hairline, I create a 45-degree back-cut for about 1.5 cm through the hair. I call this incision an “omega incision” because it looks like a hairpin up and down the ear anteriorly and posteriorly with a transverse component in front, and a shorter transverse component in back; sort of an
upside-down omega (Figure 1, D). I find that I can accomplish everything I need to in the neck without coming back into the posterior hair or in any way crossing that hairless skin that’s behind the concha.

Dr. Hartley: Do you extend this incision vertically up into the hair and then cut back?

Dr. Little: Yes, at about a 45-degree angle for 1.5 cm. The only hair I ever remove from any face lift is the tiny dog-ear that occurs at the back cut in the posterior hairline, and it’s usually no more than the size of your small fingernail. I certainly don’t remove hair in the temple scalp.

Dr. Hartley: The second patient is a 64-year-old man whose primary concerns are his jowls and neck area (Figure 2, A). Dr. Marten, how would you treat this patient?

Dr. Marten: The primary difference between the male and female face lift is management of beard shift in men. It is important to prevent sideburn displacement in men, because they have fewer means to disguise such deformities. As a result, I have a lower threshold for placing the temporal incision along the temporal hairline in men.

I believe a retrotragal incision is less conspicuous than a pretragal incision in men because of the color-texture differences between finer, softer tragal skin and coarser, ruddier cheek skin. Beard shift onto the tragus can be effectively prevented by intraoperative epilation. This can be accomplished by destroying beard follicles protruding from the undersurface of the flap with a needle-tip cautery. This is easier if the patient is asked not to shave for 2 days before surgery and the tragal flap is

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turned over a fingertip. This pushes follicles out of subcutaneous fat.

Dr. Hartley: What about the beard that’s going to be shifted behind the lobule?

Dr. Marten: Beard shift behind the ear is generally not a problem for most men, but shaving right up against the lobule is. Because of this, I leave a slightly larger cuff of skin when making the perilobular incision in men than in women to ensure a beard-free area along the lobular-facial sulcus.

Dr. Hartley: How would you blend the incision into the occipital hair?

Dr. Marten: The postauricular incision would continue up in the auriculomastoid sulcus and would turn posteriorly over the mastoid at the level at which the superior and anterior crura of the antihelix diverge. In this position it will be hidden by the pinna. It would then continue along the occipital hairline and be tucked into the scalp at the junction of thick and thin hair (Figure 2, B).

Dr. Ristow, what would you suggest for this patient?

Dr. Ristow: I would perform an incision on the crest of the tragus in this patient because of the color tones of his skin, and I would treat the follicles as Dr. Marten explained. On the earlobe, I leave a larger flap attached to the ear than is generally recommended in the literature. I leave a transition of approximately 5 to 7 mm of skin (Figure 2, C).

Dr. Hartley: Dr. Little, how would you advise this patient?

Dr. Little: I tell male patients who want the retrotragal incision that they may require secondary electrolysis. If they accept this, I will in fact hug the lobule instead of leaving a flap beneath the lobule. If not, I would not hesitate to use a pretragal incision composed of a series of scallops and include the same sort of cuff around the lobule that was discussed. I would stay within the retroauricular sulcus all the way up to the vertical hair (Figure 2, D).

Dr. Ristow, do you defat the pre-tragal skin?

Dr. Ristow: The area of the defatting or thinning the flap is very short, not more than 8 or 9 mm. The incision should never be retrotragal because the transition is nice only if the suture is delicately put on the crest of the tragus. The depression in front of the tragus should be purposely recreated with an absorbable suture.

Dr. Hartley: Dr. Marten, what are your thoughts?

Dr. Marten: The term retrotragal is misleading. The incision should be made along the tragal margin or tragal crest. Here the scar, if visible, will fool the eye and appear as a tragal highlight. Attempts to make the incision on the inside of the tragus, wrapping the tragal flap around it, will obliterate natural anatomy and appear bulky and unnatural. Defatting is not as important as trimming the tragal flap so that enough skin is retained to fill the pretragal hollow. If this is done, it is not necessary to recreate the hollow with sutures.

Dr. Hartley: The third patient is a 53-year-old woman whose primary concern is her aging face. She had a face lift when she was 46 (Figure 3, A and B). Dr. Little, how would you go about placing the incisions in this patient for a secondary face lift?

Dr. Little: I certainly would encourage sub-sideburn incisions in this situation. As I perform the marginal incision, I roll back out of the ear and off the tragus and leave a major V-shaped flap based posteriorly that could drop back down and cover a portion of the meatus. I trim my flap, whether on a man or a woman,
to exaggerate the V-shaped nature of that flap to the greatest degree possible (Figure 3, C).

Dr. Hartley: You’re talking about just above the tragus?

Dr. Little: Yes, the tragus point itself. I try to have the tragus point exaggerated on the flap that I place back over that structure because, again, it’s so easy to obliterate this interesting little structure. Therefore I exaggerate it.

As I trim the flap, I would exaggerate the V-shaped area so I have two V-shaped flaps, one based on the cheek flap and one based on the ear. When I was working behind the ear I would harvest a V-shaped graft from the vertical wall of the concha and suture it into the tragal remnant. The tragus reconstruction would then present three layers: lining, support, and cover.

Dr. Hartley: Could you roll that tragus back?

Dr. Little: When I’ve tried to do it, I have not been successful.

Dr. Hartley: What would you do with that notching behind her ear (Figure 3, B)?

Dr. Little: With a secondary face lift, I follow the pattern of the prior surgeon. There’s no sense trying to do my omega incision. With secondary face lifts, we don’t remove the same amount of skin, and we don’t need as much skin motion as we think.

Dr. Hartley: Dr. Marten, what would you do with this tragus and the retroauricular area?

Dr. Marten: The patient has a retracted tragus and an open auditory canal. The tragal cartilage is there, but it has been pulled anteriorly. Simply releasing skin traction won’t allow the cartilage to return to
a normal position because it is stiff and fibrotic. I treat this problem the way I would treat a prominent ear. Skin is elevated off both sides of the tragal cartilage, and its anterior surface is scored. This allows it to return to an anatomic position. A mattress suture is placed to hold it in the corrected position. Skin is then recruited from the cheek, carefully redraped, and trimmed (Figure 3, D). Creating a second postauricular incision is often productive and usually necessary in secondary face lifts to avert further hairline displacement.

Dr. Hartley: Dr. Ristow, do you have any comments about the tragus?

Dr. Ristow: As far as the tragus is concerned, it is tight and scarred forward. I would release it by cutting its anterior base. Following this release I would use a 5.0 nylon suture from the base of the concha through the tragus across the auditory canal to secure it back. Then I would redrape the skin, leaving the 5.0 nylon suture for about 5 days (Figure 3, E).

Dr. Hartley: The fourth patient is a woman in her fifties with very sparse hair who had a rhytidectomy (Figure 4, A and B). She wants the scars improved and is considering another face lift. Dr. Little, how would you treat this patient?

Dr. Little: You have to be careful in some secondary face lifts when converting a pretragal incision to a retrotragal, because the skin won’t always move back, particularly if you elevate superiorly. If I’m not sure, I believe it’s better to create an island of tragal skin and wait until...
the end of the procedure to ensure that the tragus can be covered properly without pulling it forward.

Posteriorly, I elevate skin to the level at which the posterior scar traverses her hairless retroauricular skin to at least the level of the Frankfort’s line, which would be about 1 cm above what you see (Figure 4, C).

Dr. Hartley: Would you make your incision just above the scar and then see how far you could pull it up and take it up to that level?

Dr. Little: I would assess the amount of skin, and it’s unusual even in a secondary situation that I would recruit less than 1.5 cm.

Dr. Hartley: Dr. Ristow, please go over the approach you would make here.

Dr. Ristow: The incisions are too far forward; the surgeon has not mastered the forces of tension here. In the retroauricular area, I would curve a wide flap just above where that white line of the incision is, abandoning the previous incision, coming down to the hairline and making a lazy S (Figure 4, D and E).

Dr. Hartley: Dr. Marten, how do you feel about this?

Dr. Marten: It appears the previous surgeon tried to smooth the glabella by creating lateral tension on the forehead. This is always a mistake and most likely explains the poor temple scar. Dr. Little is correct that, in spite of initial impressions to the contrary, there is often little residual loose skin in a secondary or tertiary face lift, and it can be a mistake to assume that all pretragal scars can be moved to a retrotragal location. If I am not certain that there is enough skin, I will make my initial incision along the existing pretragal scar and decide after the cheek flap has been elevated whether there is
enough skin to move the scar to a retrotragal position (Figure 4, F).

Dr. Little: I want to speak against temple-tightening on the basis of scalp excision. Tension can be created by suturing the frontalis-galeal border of the anterior flap to the deep temporal fascia, but with no scalp excision. Leave the redundancy of skin there to minimize the scar.

Dr. Hartley: The fifth patient is a woman in her fifties with hypertrophic scars (Figure 5, A and B). Dr. Little, how would you treat her “pixie ear lobe”?

Dr. Little: Assuming sufficient skin is recruited, I would bring it up underneath the earlobe and shorten the lobule as well. I would ensure that my lobule inset went back at an angle and that I undercut the lobule to eliminate the attached earlobe (Figure 5, C).

Dr. Hartley: Dr. Marten, what would you do differently?

Dr. Marten: This is difficult to correct because the tissue needed to make the repair was mistakenly discarded at the original operation. Scars such as these are the result of the erroneous excision of skin over the long axis sternocleidomastoid muscle from the apex of the postauricular flap. This occurs because, when the patient is on the operating table, the shoulders rise and an apparent, but false, redundancy appears along this vector. This skin, in reality, will be needed when the patient stands and the shoulders drop. It is also needed for side-to-side head tilt.

Correcting this patient’s “pixie ear lobe” will not be possible unless several centimeters of skin can be recruited along the jaw line. Correction of the postauricular hypertrophic scar will require like redundancy to be available from the neck. If this is not present, it is probably best to postpone surgery and treat the scars with intralesional steroid injections.

Dr. Hartley: Dr. Ristow, do you have any final comments?

Dr. Ristow: I believe the great secret of our specialty is really the correct management of tension. The more mature we become with experience, the more we learn to control that. One has to place suture tension only in one key point and then redrape the skin without any tension to avoid these unsightly scars (Figure 5, D and E).

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-Brunno Ristow, MD

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