Secondary Face Lift

Editor’s note: My thanks to the moderator, Robert W. Bernard, MD (board-certified plastic surgeon and ASAPS member, White Plains, NY), and to panelists Sherrell J. Aston, MD (board-certified plastic surgeon and ASAPS member, New York, NY); Phillip R. Casson, MD (board-certified plastic surgeon, New York, NY); and Stanley A. Klatsky, MD (board-certified plastic surgeon and ASAPS member, Baltimore, MD), for sharing their opinions and clinical experience.

Dr. Bernard: The first patient is a 70-year-old nonsmoker who underwent a deep plane face lift about 10 years ago (Figure 1). She wants to see improvement in the jowls, cheek, neck, and jaw line. You will notice that there is some asymmetry of her face. She has had no nerve damage. She has what appears to be a pretragal incision. Given that this is a secondary face lift, how would you approach treating this patient?

Dr. Klatsky: She does have facial asymmetry and upper eyelid ptosis. She also looks as if she has some orbital dystopia where the right side of the nasojugal groove is lower than the left. Her asymmetry also reflects into the modiolus, the right corner of her mouth is lower than the left, and she shows more relaxation, at least in the frontal view, on the right.

She has either a relaxed platysma or it could possibly be a ptotic submaxillary gland. I am not really concerned with what plane has been dissected. Sometimes we may be fortunate enough to have this information, but many times we simply have no way of knowing. I am concerned, however, with the placement of the incision. The photograph shows an incision anterior to the tragus that is hypopigmented, as well as a little dart near the earlobe that is also white.

Most likely, I would approach this patient with a retrotragal incision. If I believed that the hairline would be shifted significantly, I might consider a pretricheal (anterior hairline) incision. I cannot tell from this photograph whether the patient’s previous incision was within the hairline because her hair covers it. To address her prominent nasojugal fold and raise her malar fat pad, I would use a lower lid approach to a malar pexy, suspending the malar fat pad to the lateral canthal periosteum. I would also imbricate the SMAS vertically, as well as posteriorly and anteriorly near the modiolus. By “selective imbrication” at the level of the modiolus, I could raise the corners of the mouth and have essentially a double layer of SMAS imbrication.

For her neck, without being able to “lay on hands” and see whether the problem is the platysma or the submaxillary gland, I can’t tell if a submental incision is necessary. The patient’s jaw line is not particularly ptotic, so the face lift would probably be more of a vertical lift with a short scar.

I do not believe I would have to extend the incision all the way back into the mastoid area from what I see on the lateral photograph. I would undermine the skin from the temple region all the way to the lateral canthus and...
around or on top of the orbicularis using a Colorado cautery (Colorado Biomedical Inc., Evergreen, CO). The skin can be repositioned over the orbicularis without transecting the muscle. By shifting and redraping the skin, one can improve the crow’s-feet area.

Dr. Aston: I would like to comment on a few of Dr. Klatsky’s points. First of all, if you want a short incision and a very cephalic lift—that is, a vertical vector lift—then you may find it difficult to convert to a retrotragal incision. When you suspend in a vertical direction, on a secondary lift, you often reduce the amount of pretragal skin. So if I were going to try to change that incision to retrotragal, I would do that after I had elevated the flap and rotated it. Otherwise, I might end up being short of skin and pulling the tragus forward.

I see the patient has already had her sideburn lifted; I would make a transverse cut under the sideburn and take out a triangle of skin. I would not go anterior to the hairline at all. The patient has had a deep plane procedure, which means that her SMAS platysma layer can be dissected again, and I probably would do so. Along her jaw line, as Dr. Klatsky said, you won’t know how to approach it until you can feel it and look at it. But on the right jaw line there is probably a little fat lying over the top of her submaxillary gland. At least the front view suggests a little fullness in that area.

I do not do midface lifting through the lower eyelid. This woman already has scleral show, so I would work on her with an ophthalmic plastic surgeon who could do a canthoplasty.

This woman is a little flat over her cheekbones. You could reposition the malar fat pads with a finger-assisted malar elevation type procedure, a malar fat pad dissection, as described by Owsley, or an extended SMAS procedure. Any of these would help, but with this patient’s anatomy, a lot of fullness will remain low on the nasolabial fold. Regardless of the procedure you select, there will not be the kind of fullness over the malar bones that you would like, and some of the nasolabial fold will return after a few months.

Dr. Casson: My only other comment is with regard to the facial asymmetry. I would certainly point this out to the patient before surgery to avoid any misunderstanding. I would try, as Dr. Klatsky said, to correct it with imbrication. I think imbrication is something that we really do not do enough of in a secondary face lift. As far as the incisions are concerned, I would make a preauricular incision approximately where it is now, if I could pull the skin back without distorting the tragus. I would then complete the incision as retrotragal, which I prefer. It should be remembered that in a repeat face lift there might not be enough skin excess to give a “natural” look.

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—Sherrell J. Aston, MD
**Dr. Bernard:** The second patient is a 61-year-old woman who is also a nonsmoker (Figure 2). She underwent SMAS plication about 9 years ago. She wants to improve the appearance of her jowls, nasolabial lines, flat cheeks, and neck. And as an ancillary issue, she appears to have a rather indistinct jaw line and a submaxillary gland that is somewhat prominent.

**Dr. Casson:** I would try to correct the distortion of her earlobe, if possible, by performing aggressive undermining of the skin so that the earlobe could be repositioned correctly. I would use a submental incision to remove fat along the lower border of the mandible and insert a small chin implant. I would also tighten the platysma by making an SMAS incision along the zygomatic arch and then back to the area in front of the ear, then inferiorly between the earlobe and the lower neck. I would suture the recreated SMAS layer to the mastoid area with 3-0 PDS sutures (Ethicon Inc., Somerville, NJ).

**Dr. Klatsky:** I do not believe this patient needs too much skin undermining. On the profile, it is apparent that she has a step off between the lower lid skin and the cheek. I like approaching this type of patient through the lower lid to lift the cheek and smooth the crow’s feet without the use of filler material. I always do a pexy of the undersurface of the orbicularis muscle to the lateral canthal periosteum, usually 1 or 2 sutures, and support the lower lid region with some Steri-Strips (3M Company, St. Paul, MN) until all of the edema has subsided, which is usually about 5 days. I would probably do imbrication, as well as a little direct fat contouring along the anterior cheek with Metzenbaum scissors (Mopec, Inc., Detroit, MI).

I agree with Dr. Casson that a small anatomic chin implant would give this woman a more attractive submental profile. As far as the submaxillary gland, I have tried all kinds of things. I have not resected them, although some have reported doing that. I am always concerned that our aging population may need their salivary glands later, and to resect them for cosmetic purposes concerns me. I have had some limited success suspending the glands by tightening the platysma (vertical imbrication).

**Dr. Bernard:** Dr. Aston, could you address the area just anterior to the fullness in the submaxillary region where there appears to be some redundant or crepey skin and a very indistinct jaw line? Do you believe this requires a chin implant, or is there something else that you might consider to help redrape that crepey skin?

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—Stanley A. Klatsky, MD
skin and perhaps improve some of the cords in that area?

**Dr. Aston:** Looking at the patient’s profile, the distance from the angle of the mandible to the mentum is definitely short, and I would agree with Drs. Casson and Klatsky that she needs a chin implant. But she also has a bit of anterior platysma laxity. I believe you have to feel her neck to see what is there. I would probably do generous skin undermining to free up the wrinkled skin under the jaw line on the right side. After seeing what the muscle is like, I might decide to suture it together in the midline to help deepen the cervicomental angle and take a little notch out of the platysma over the thyroid cartilage, just to break the band. It depends on how much of this area is fat, how much is muscle, and how much is anterior laxity. I could probably give the patient a little posterior mandibular contouring by a partial lateral division of the platysma, about a 3 to-5-cm cut at about 6 cm below the mandibular angle. And you can do that even if you work on the anterior platysma as long as you leave the platysma intact over the submaxillary gland.

In terms of the midface, I would have to evaluate the quality of the SMAS, but if she had a prior SMAS imbrication only, I would suspect that you could get a good flap. I would dissect the SMAS/platysma flap from the zygomatic arch to below the jaw line, down low in the neck, and then by doing a partial division posteriorly I would rotate the flap upward to contour the jaw line.

**Dr. Klatsky:** From the front view, it appears that she might have had prior lipoplasty of her neck. It looks like she has a depression just below the chin and the kind of fullness that we sometimes see if the submental fat pad has been removed.

**Dr. Aston:** I think Dr. Klatsky brings up a good point. The front view does suggest that somebody has removed the fat from the submental area; and often, just because of the mechanics of getting to the areas just lateral to that depression, some fat remains. It may be that the chin implant, removing the fat lateral to the midline, and lateral tightening of the platysma would do a good job of contouring the anterior neck.

**Dr. Bernard:** The third patient is a 77-year-old woman who is in good health, not a smoker, and underwent a “skin only” face lift about 11 years ago (Figure 3). She wants improvement in her neck with attention to those obvious cords, and she would like better definition of the jaw line, the mentum, and the sternomandibular trough. Dr. Aston, what would you do?

**Dr. Aston:** Well, I think we can do a lot to improve this patient’s appearance. On the front view, the neck and the jaw line almost blend together. You see a slight mandibular contour. On the profile, there is really no separation between the cheek, jaw line, and neck. They all appear to be in one plane.

We also can see that the patient probably has some tension on the face flaps from the first procedure because she has a bit of pixie ear. Certainly, the ear is sewn down to the face flap without an earlobe. Now the fact that she supposedly had only a skin flap or skin dissection initially means that we should be able to improve this patient’s appearance. The fat has obviously been taken out of the submental area, and the real question is: has part of her platysma also been

Figure 3. This 77-year-old woman is a nonsmoker, in good health, who underwent a “skin only” face lift about 11 years before. She wants improvement in her neck with attention to the visible cords, and she would like better definition of the jaw line, mentum, and sternomandibular trough.
removed? If so, then improvement will be more limited. The patient would get a great result with a full-width platysma transection. This helps define the jaw line all the way from the angle of the mandible to the mentum, because it decreases the neck size relative to the jaw size. I would suture the muscles together in the midline, do a full-width transection, and take the fat off the platysma after transecting the muscle and rotating it to a new position.

You have to do a wide skin undermining on this patient. I would probably do a high SMAS dissection to improve the midface as much as possible. But my primary focus would be on improving the patient’s jaw line.

**Dr. Bernard:** Dr. Aston, do you believe she has a “witch’s chin”? And if you think so, would you correct it?

**Dr. Aston:** She has a deep submental crease, which is probably accentuated by an old scar. If you place your incision just a few millimeters in front of the existing scar, de-epithelialize the scar, leave a little bit of fat, and then bring the flap back over to close, you can improve the appearance.

**Dr. Casson:** It is important to tell this patient that, at age 77, her results would be less than perfect. Having said that, one of my priorities would be to lift the tip of her nose. She also needs a lot of work around her eyes. She needs canthopexies, especially on the left.

**Dr. Bernard:** Considering some of the comments that Dr. Aston made, what technique would you use specifically to improve the jaw line and mandible?

**Dr. Casson:** I do not think I would make another submental incision until I had tried to release the marionette line area by undermining all the way across the midline and onto the lower border of the mandible.

**Dr. Klatsky:** I prefer a posttragal incision, and I believe the patient will have adequate skin for that. I would make a submental incision. She has a square jaw, and it appears as if the mandibular ligaments were probably not released at the time of her initial surgery. I would open up her anterior neck through a submental incision. Near the mandibular ligament, you have a closer mechanical advantage than working posteriorly down into that area. I do wide skin undermining and come all the way out to the lateral canthus from the anterior region subcutaneously.

I like to work on top of the orbicularis muscle. I am actually in the deep subcutaneous plane, and I like to use a Colorado cautery because I believe it helps me when I release the little fibrous bands that create some of the wrinkles in the crow’s feet area. When the skin is redraped, I believe it improves the crow’s-feet significantly.

I work along that region into the lower eyelid area, and I can almost reach to the midline. I may use an anterior SMAS flap to improve the jaw line rather than doing a complete transverse incision.

When performing an anterior transection of the platysma, I have found that it is important to transect lower than you might expect. Otherwise, you get a “window shade” effect and may create a V-type deformity in the submaxillary region from the retraction of the platysma. In this patient, I would wait to see what the platysma and the fat looked like. I also would approach the mid cheek through the lower eyelid approach and perform a malarpexy, as I described earlier. The patient has a lot of wrinkles from sun damage and she could probably benefit from dermabrasion of the upper lip.

**Dr. Bernard:** Looking at the patient in the frontal view, you can see a tremendous amount of light reflecting off her nasolabial folds. But really, the area just above the nasolabial folds, which is creating that deep valley, is the cheek fat that has slid off the malar prominence. How would you address this problem?

**Dr. Aston:** I believe that area could be very difficult to correct. You will not be able to get the thickness that is in that nasolabial fold all the way back to the normal apex of the malar fat pad, but I would attempt to do so.

**Dr. Casson:** I might even do some lipoplasty there to reduce or debulk that area a little bit. I think that the combination of lipoplasty and plication might help.

**Dr. Aston:** I think that Dr. Casson makes a good point. It is not very often that I do lipoplasty in that area of the face, but if you work open, under direct vision, with a 2.4-mm cannula, you can feel and see exactly how much fat you are removing. Surgeons get in trouble in the mid-
face area when they perform too much lipoplasty or suction close to the skin and try to make the folds flat. This can cause wrinkling along that area. Dr. Casson’s suggestion is appropriate for a patient with a thick, fat upper portion of the nasolabial fold.

**Dr. Bernard:** The fourth patient is a 71-year-old woman (Figure 4). She underwent an SMAS procedure about 8 years before, and now she would like improvement in the jowls, nasolabial fold, and cheek area. Dr. Casson, let’s start with you.

**Dr. Casson:** She looks as though she has a facial asymmetry. The zygoma on the left side is more prominent than on the right, and I certainly would point this out to the patient. To correct it surgically, I would use a small zygomatic implant on each side, probably making the one on the right a little bigger.

Overall, the patient has a pretty good result for 10 years after operation, and I would repeat the SMAS lift. She does not have a lot of loose skin in the neck area, so a short scar technique should create a nice improvement.

The patient has a very deep tear trough on the left, so maybe a little fat graft or an injection of fat would be helpful. She does not have the kind of skin that does well with laser, in my experience, although she looks as though she may have had some laser resurfacing.

**Dr. Klatsky:** In the front view, the patient appears to have a square jaw. She has little jowls with deepening of the marionette lines. It looks as if the left side is deeper than the right side. The junction between the lower eyelid skin and the cheek skin has a significant amount of periorbital wrinkling. She has deep nasolabial folds. It looks as if there may be a suggestion of some cording of the platysma and there could be a little separation of the anterior platysma. On the profile, however, she shows what appears to be a little loose skin and a tendency towards a witch’s chin. What I would do is reasonably wide skin undermining. I would perform selective imbrications, more of a vertical lift, and a limited postauricular incision. I do not believe that she needs to have a lot of skin removed.

I use small suture ligatures to control bleeding along the lower border of the mandible; this avoids damage to the ramus mandibularis.

—Phillip R. Casson, MD
folds. I would want to smooth out the transition zone of the lower eyelid and cheek, and I would perform lateral canthopexies to support the lower eyelid.

**Dr. Aston:** Because her neck looks reasonably good, I would probably do a short scar procedure on her. With that technique, being under the orbicularis muscle, you could improve the tear trough problem but not totally correct it. If, on examination, her neck skin was looser than it appears on the photographs, then I would not opt for a short scar; I would just go up into the mastoid area. I agree with what Drs. Casson and Klatsky said. I would not address the bit of hanging chin that she has. The potential for making the problem worse is as great as the chance of making it better. She is the type of patient who, every time she animates her face, makes those deep nasolabial folds more prominent. I always tell these patients, “You are going to have more of this fold than you want to have even after I do everything I know how to do.”

**Dr. Casson:** I think the injections that Dr. Klatsky recommended might help this woman. Using the Coleman fat injection technique with blunt needles, I have had some pretty nice results with the nasolabial folds—not at the time of the surgery, but about 2 or 3 months later.

**Dr. Bernard:** Does anyone have any closing comments?

**Dr. Casson:** When plastic surgeons were doing the more aggressive defatting some years ago, I think that, many times, after a year or so, the skin was sitting right on the platysma. When you reoperate on those patients, you have to be very careful. I think that most of the facial nerve injuries that I have seen, either in my patients or in consultation, have been in secondary face lifts. In the submandibular area, the ramus mandibularis is at risk in secondary patients when too much fat has been removed. These injuries are often the result of cautery use. I use small suture ligatures to control bleeding along the lower border of the mandible; this avoids damage to the ramus mandibularis.

**Dr. Aston:** I believe that we are all more conservative today in the neck area—with what we do to the platysma, and with defatting—than we were 15 years ago, and I think our results are better for it. Dr. Casson is making a point that I would like to amplify a bit because when you do a secondary face lift, no matter what technique was used, the planes are not always the same. You can easily get out of your plane of dissection and go too deep in the midface. Facial nerves may be visible, particularly in older patients in whom the deep tissues are rather thin but even in people who have a thicker fat layer. Because of the scar tissue and adhesions from the first surgery, one has to be very careful in doing secondary lifts.