Buccal Fat Pad Removal

According to the author, buccal fat pad removal is a minor procedure that adds relative prominence to the cheek area. For optimal results, he suggests augmenting the malar area with hydroxyapatite granules. Here, he describes his technique. (Aesthetic Surg J 2003;23:484-485.)

Although not a primary focus of aesthetic surgery, removal of the buccal fat pads to thin the face is a minor procedure that may significantly improve the upper cheek area. This is something of a controversial procedure, but that is most likely because few surgeons actually have experience removing the buccal fat pad. Some of the hesitancy may be based on a lack of familiarity with the anatomy of this region.

Three-dimensional computer tomography studies demonstrate that the volume of the buccal fat pad is not always symmetric, particularly when a patient has experienced facial trauma.

Imaging studies also demonstrate that buccal fat pad growth is significant between the ages of 10 and 20 years, increasing from 4000 mm³ to 8000 mm³. Over the next 30 years, the buccal fat pad declines to 7000 mm³.¹

The most common aesthetic procedure involving the buccal fat pad is removal to reduce the submalar prominence. After performing this procedure many times, I think that its effect, in most cases, is slight. However, buccal fat pad removal gives relative prominence to the cheek area and is very simple to perform. In my view, the very best results in this procedure are achieved with the use of hydroxyapatite granules on the malar area and simultaneous removal of the buccal fat pad. Sometimes this can produce quite a dramatic change.

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Place your finger on the patient’s cheek to locate the inferior border of the malar prominence. Move your finger posteriorly until you identify the ascending ramus of the mandible. Locate this area intraorally and move your finger up to the neck of the mandible. Lateral to this should be the buccal fat pad area. Make a small incision and gently tease apart the underlying soft tissue by advancing scissors or a long hemostat. A filament of connective tissue must be penetrated. After this is accomplished, the yellow buccal fat from the fat pad simply wells out.

There are very few blood vessels in the buccal fat pad, and it is most important to tease the pad out carefully to ensure that it does not break up. After the buccal fat pad has been delivered, explore further to make sure that all portions of the fatty material have been removed. Perform a very light closure of the mucosa and advise the patient to exercise the jaw soon after surgery. Apart from some initial slight pain and stiffness, there are usually no functional problems associated with this procedure.

Results tend to vary because of variable facial anatomy and fat pad volume. In some patients, results are good, but in other patients — particularly those with round faces, in whom improvement is most desired — results may be disappointing. In round-faced patients, or in men who desire a well-sculpted face, the results of buccal fat pad removal can be optimized through augmentation of the malar region. Concavity in the lower cheek, coupled with augmentation over the zygomatic area, can provide dramatic emphasis to the lower cheek. This may be done with a preformed implant, but that is not my choice. The use of hydroxyapatite granules is by far the simplest and least expensive means of augmentation.

**Malar Augmentation With Hydroxyapatite Granules**

Malar augmentation with hydroxyapatite granules may be performed before buccal fat pad removal. First determine what result the patient wishes to achieve and mark the desired area of prominence. Then, through an upper buccal sulcus incision, dissect up to the zygomatic region, where the periosteum is elevated. When you create an adequate pocket, fill it with the necessary volume of hydroxyapatite granules. It is important that the entry
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Second Thoughts

point be as small as possible and that the periosteal cavity be maintained at the exact size required; otherwise, granules may escape. In placing the granules, there is no need to overfill; you get, more or less, what you see. It is not necessary to close the pocket; you can then remove the buccal fat pad.

The buccal fat pad is modified in some way in about 5% of my patients who present for aesthetic facial surgery. The procedure to remove the fat pad is exceedingly simple and should be virtually complication-free. I believe that as surgeons become more comfortable with operating in this area, more indications for buccal fat pad removal or transfer will be recognized. I have no hesitation in recommending this procedure to my patients when I think it is indicated (Figure 1).

Reference


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1090-820X/2003/$30.00 + 0

Figure 1. A, C, Preoperative views of a 34-year-old woman. B, D, Postoperative views 1 year after malar augmentation with Proplast implants, (Interpore Cross International, Irvine, CA) removal of the buccal fat pads, rhinoplasty, and lip augmentation.