Editor’s Note: My thanks to the moderator, Timothy J. Marten, MD (board-certified plastic surgeon and ASAPS member, San Francisco, CA); and to panelists Bruce F. Connell, MD (board-certified plastic surgeon and ASAPS member, Santa Ana, CA); Joel J. Feldman, MD (board-certified plastic surgeon and ASAPS member, Cambridge, MA); and William J. Little, MD (board-certified plastic surgeon and ASAPS member, Washington, DC), for sharing their opinions and clinical experience.

Dr. Marten: The full, obtuse neck is an interesting and perplexing problem that aesthetic surgeons frequently encounter. The first patient is a 28-year-old woman with longstanding neck fullness and no prior surgeries (Figure 1). Dr. Feldman, what anatomic abnormalities underlie the appearance of this woman’s neck, and what treatment options would you offer?

Dr. Feldman: In addition to her obtuse neck angle, this patient appears to have a small chin, poor definition of her jawline, and either an enlarged or malpositioned submandibular salivary gland. I cannot tell much about the subplatysmal tissues just by looking at the photos. Although I feel every neck carefully, I really don’t decide what needs to be done underneath the platysma until surgery, when I proceed step-by-step, peeling away one layer after another, systematically examining each layer as I get to it, and only then determining what needs to be done. I suspect that this patient would need to have some subplatysmal fat removed after she has had a subcutaneous lipectomy. Once that was accomplished, I would inspect the suprathyroid or perihioid fascia to see if it needed to be released.

In the process of performing a subplatysmal lipectomy underneath the medial platysma, I would open into the capsule of the submandibular salivary gland, and if the gland appeared to be large or fixed by intracapsular adhesions low in the neck, I would either resect a portion of the gland or perform a fairly thorough intracapsular release and repositioning of the gland. Then I would assess the anterior digastric muscles to see if they needed a low release just above the hyoid, or, if they were somewhat plump, a midline plication. If the anterior digastrics were very large, I would shave them superficially with the cautery. Then I would finish with a corset platysmaplasty. I would not do any transections of the platysma. In this patient, I would use a submental incision and a three-quarter-length incision hidden in the sulcus behind the ear (on each side). I would not resect any skin from her neck.

Dr. Marten: Why would you use the incision behind the ear?

Dr. Feldman: First, it allows me to see into the lateral neck so I can more easily defat the lateral neck and lateral jaw line. Second, it allows me to undermine over the mastoid area and in the lateral neck thoroughly enough so that I can redistribute excess skin without having to remove any. If she had a very well-defined lateral jawline, I would only use a 1.5-cm incision behind each earlobe to permit lateral undermining and to place a drain, and I would accomplish everything else in her neck through a 3.5-cm submental incision placed in the least visible location just under the chin.

Dr. Marten: You have mentioned a perihioid fascia release. What benefit is achieved by that maneuver?

Dr. Feldman: After the excess subplatysmal fat has been removed, I frequently see white fascia “bow stringing”
just above the hyoid. If this is present, I take my needle-tip electrocautery and very lightly release the fascia in a transverse direction, or I remove small bits of the fascia to deepen and define the suprahyoid angle. When I do the subplatysmal lipectomy, I am also releasing and removing some of that tight perihyoid fascia. Once the excess fat is removed, I see whether I have to release or excise more of it.

**Dr. Marten:** Dr. Little, would liposuction alone be adequate treatment for this patient?

**Dr. Little:** Perhaps liposuction with a significant chin implant would suffice. The lateral view with her neck extended may be misleading; it looks like she has good chin support. I use chin implants in only 5% of my patients, but I would certainly use one in a young patient like this. Together with liposuction, this may possibly achieve a good result, but the operative word here is “may.” It is sometimes difficult to know from a picture the contribution of the subcutaneous fat versus the deep fat (or what I call the suprahyoid adipose fat pad).

**Dr. Marten:** If you were able to palpate her neck, how would you make that decision?

**Dr. Little:** I would palpate the “wattle,” placing her neck in a neutral position, and ask her to swallow. If there is a pronounced movement of the mass between my fingers, then I know there is a major subplatysmal fat collection; if not, the mass is more subcutaneous. Deep fat is very different from subcutaneous fat. It has a high fibrous content like “suet” and has a great deal more density. In the typical challenging neck, it is 3 or 4 times thicker than the subcutaneous component. What is interesting in all of these necks is that there is great variability, and there are exceptions to all of these general rules.

**Dr. Marten:** Do you agree that her surgery could be performed without removing any skin?

**Dr. Little:** It certainly could be done that way. I am impressed by the results Dr. Feldman obtains without removing the skin, but for the most part, I find the skin component of the neck a real help in treating an extremely difficult neck. I do not think avoiding a subtle preauricular scar is a real victory if you need to remove skin to achieve the best result.

Since 1995, I have not placed a scar in any primary case that extended beyond the retroauricular sulcus. I would not need a scar in that hairless area even in these difficult patients. For this patient, what will help more than skin removal is to treat her jaw. In particular, the labiomandibular line is visible. That jaw fat accumulation that drops across the jawline would be improved by a simple subcutaneous elevation. This is a uniformly effective procedure, but it requires undermining to the oral commissure, which I do in about 95% of face lifts.

This is where Dr. Feldman and I differ. I admire the result he is able to achieve without removing the skin. I would prefer not to add the incision, of course, but I would not try too hard to avoid it if there were

![Figure 1. This 28-year-old woman has longstanding neck fullness and no prior history of surgery.](https://academic.oup.com/asj/article-abstract/25/4/387/190221)
some other improvements that I could bring to her face at the same time.

**Dr. Marten:** Dr. Connell, how do you think the fat is distributed in this woman’s neck, and would you approach her any differently?

**Dr. Connell:** I think the obtuse neck is formed by multiple features. First, the outline of the mandibular border suggests that there is subcutaneous fat obscuring it. When she looks straight ahead, there is a concavity over the submaxillary gland and also behind the anterior belly of the digastric muscle. Second, there does not appear to be a definite problem with the size of the submaxillary gland, but I would have to determine that by palpation. Third, when she looks straight ahead, it appears that the anterior bellies of the digastric muscles have been elongated, and when she looks downward, there is a significant amount of fullness in the neck. Last, most likely there is a large amount of subplatysmal fat and very little subcutaneous fat between the skin and the platysma muscle. At the time of surgery, the contour may still be pleasing when you flex the neck on the table. It may not be necessary to do any transection of the platysma muscle at the cricoid. If the platysma muscle were short, it would not retract. I would prefer cutting a short platysma muscle at the cricoid level, whereas Dr. Feldman just said he would make the neck contour deeper by going directly to the hyoid through the fascia.

My thoughts on treatment are, first, she has a young face with good skin elasticity, and the correction can be accomplished with only 1 incision placed about 1 cm behind her submental crease. Second, there is no skin excess, and all of the excess skin will go into the new concavity of the neck. Third, most likely some subcutaneous removal of fat by suction or scissors along the mandibular border would be worthwhile. Fourth, there is most likely a large amount of subplatysmal fat and a very large anterior belly of the digastric muscle.

I use drains in these patients. I would place the drain behind the earlobe and just tunnel under so that I could place a round drain that passes under the platysma muscle into the subplatysmal area. After I open the muscle, I invaginate the muscle edge and pass the drain under that. I perform these maneuvers any time I do work on the digastric muscle.

This patient could be improved with the submental incision alone. I don’t think I would need access to the lateral neck. Results are surprisingly satisfactory without a postauricular incision.

**Dr. Marten:** Thank you. Our next patient is a 65-year-old man who has had no prior surgery (Figure 2). Dr. Little, what are the anatomic abnormalities underlying his problems and what treatment options would you offer?

**Dr. Little:** The abnormality is typical aging. He has a weak genial position. He has that same obtuse line across the neck as the prior patient, and again, descending jaw fat is evident. His jaw definition between the face and the neck is curvilinear. This is a patient in whom I would absolutely treat the lower face with the neck (and not try to separate one
from the other) because one of my goals would be to achieve as pristine a jawline as possible to emphasize the separation between face and neck.

Does he have a glandular problem? He may, but it is as likely that it is just descending jaw fat and a little bit of a skin plica associated with that. Again, palpation will provide the answer. I find myself performing less and less submaxillary gland surgery. If I am disappointed with a slight showing of the gland after surgery, I am quite confident that 5 or 6 cc of structural fat will help camouflage it, particularly in robust individuals.

I would not attempt this surgery without correcting his jaw contour at the labiomandibular line, and I think that is critical in achieving a good result. I would follow all the steps that Dr. Feldman outlined. This is a neck that I would open.

Only 25% of the neck procedures I do are open, because I have learned to treat the face in a purely direct vertical vector as opposed to a partial vertical vector. I can treat 75% of the necks without opening them, except for occasional subcutaneous liposuction. But I would open all of the necks we will discuss in this panel because they are all tough cases.

Looking at this patient’s neck, you can see it is difficult. There is a big, thick piece of subplatysmal fat that extends to that same fascial plane that Dr. Feldman discussed. I would not want to remove anything between the 2 digastric muscles. I would not want to use the old-fashioned approach to the subplatysmal fat that excises the midline only, emphasizing a central hollow afterwards. But I would certainly want to excise fat down to the plane of those 2 muscles, and as I reach the hyoid, simply amputate that pad perpendicular to the neck. This would also weaken that fascial area that Dr. Feldman mentioned. In terms of the submandibular glands, I find myself treating these less now than even 4 years ago, before I was quite as confident of my fat grafting technique as I am today.

This patient has what appears to be a class III relationship between his upper and lower jaws, but you would have to check his dental relationships. Regardless of his occlusion, it is an appearance that is neither attractive nor desirable. In a man, I would definitely consider augmentation of the upper lip white roll and the upper lip vermillion, not to give him a thick vermillion but to get that forward “kick” and projection. That would improve the attractiveness of his profile and the balance between his lips. This can be accomplished in only about 5 minutes if your nurse helps by extracting and preparing the fat, as mine does.

**Dr. Marten:** Dr. Feldman, do you think it is possible to perform a neck lift on this patient without performing a face lift or removing skin?

**Dr. Feldman:** Yes. Many patients, like this one, only want their necks done and do not want a face lift. I would perform an isolated neck lift on this man. He would have to understand that the little bit of relaxation along the labiomental fold would not be improved, but that is probably not what bothers him. What he wants is a better neck contour and better jawline definition.

I think this could be accomplished without removing any skin from the neck. I would use what I call a “full-length sulcus incision.” It begins at the front edge of the earlobe and then runs all the way up the full length of the sulcus behind the ear to the very top of the ear. This provides adequate incision length to take in the loose skin over the mastoid so that pleats and folds will not form behind the ear. You need a lot of incision length to do this smoothly.

He has a small chin and needs a chin implant. He also has enlarged submandibular salivary glands. To give him a really good-looking neck, I would resect a good portion of the superficial lobes. However, if for some reason he did not want me to do a partial gland resection, I would perform an intracapsular release and repositioning because his gland is “malpositioned” too low and too medial in the neck. Inside the capsule, I would thoroughly release the dense medial adhesions along the lateral edge of the anterior digastrics, and also release the connective tissue on the superficial and deep surfaces of the gland, so that the superficial lobe could be pushed up underneath the jawline. Then I would hold the lobe in its repositioned location with a corset platysmaplasty. Sometimes release and repositioning works well if the gland is not too big.

In this patient, you can also see a swelling below the earlobe covering the lateral jawline; I think it is an enlarged parotid gland. Sometimes you can plicate the fascia over the gland to flatten it a bit, but he will always have fullness there.

He needs a little subcutaneous defatting along the jawline, and he needs a subplatysmal lipectomy. He may also need a perihyoid fascial release and some work on the anterior digastrics, but I would not know this for sure until I actually saw the tissues. After I had complet-
ed the subplatysmal surgery, I would perform a corset platysmaplasty and neck skin redistribution.

Dr. Marten: Dr. Connell, do you feel there is merit in the idea of removing skin from the anterior neck using Z-plasties, W-plasties, and similar procedures?

Dr. Connell: Dr. Tom Cronin of Houston was doing that about 50 years ago. He liked this technique, but all of the patients I have seen who have had it always find the scars very objectionable. I have never done it and never will because you can always remove the skin from a posterior direction and not have that unsightly scar that looks so bad when you turn the head from side to side. If you look at the photo of patient 2 when he looks down—for him and almost all patients, that is how the face will appear 12 to 18 months from now when he is looking straight ahead. His “gazing down” photograph reveals how he will look in about 18 months when he is looking straight ahead. I would do a neck lift alone on this patient, knowing full well that he will need a face lift pretty soon, within the next 18 to 24 months. But my preference would be to do a face lift.

I would start with a face and neck lift incision behind the crease, release the osteocutaneous ligament, open the platysma muscle (only between the hyoid and chin), and remove the subplatysmal fat very carefully. I would not want to accentuate his large thyroid cartilage. If his glands had redundancy, I would work on them. The platysma muscle is soft and not a good support. I do not think he needs a transection of the platysma muscle at the hyoid or any place else. I think we can really expect improvement with the face and neck lift and precision fat removal.
**Panel Discussion**

**Dr. Marten:** Dr. Feldman, why do you think the 2 procedures this patient underwent produced suboptimal improvement?

**Dr. Feldman:** It is hard to tell what was done. I think he may have had just a little closed suction lipectomy, which is probably a very good thing because a difficult problem that I see is an overaggressive attempt to achieve a good neck contour using just liposuction (when the patient mostly needs a subplatysmal lipectomy), leaving the neck with too little fat on the under surface of the skin, as well as skin platysma adhesions, dense subcutaneous scarring, and contour abnormalities that are sometimes very difficult to correct. So I always prefer to see a patient who has had just a little liposuction rather than too much. Fortunately, this patient seems to have had only a little.

As Dr. Connell said, the patient first needs to have more subcutaneous fat removed above and below the jawline, and I agree. Then I would assess the submental plane and the hyoid angle. I would remove whatever subplatysmal fat is necessary, and then release or resect peri-hyoid fascia if needed, then release or plicate the extero digastrics if necessary. I cannot tell if his submandibular glands are enlarged or malpositioned. Palpation of the neck is an important and helpful part of the preoperative examination, but sometimes I am not sure what I am going to do to the glands until I feel them and perhaps look at them at surgery, after the excess fat has been removed.

**Dr. Marten:** Dr. Little, the patient said that a suspension suture was placed during his second procedure but produced little improvement. Do you use suspension sutures, and, if so, why or why not?

**Dr. Little:** I do not use them, but some very good surgeons do. The suspension suture was really the innovation of Jose Guerrerobastos; he used it effectively, and then Giampapa extended their use. I do not depend on permanent suture fixation, but there is more and more of it being done. We are lifting brows now with sutures, and some people are lifting the entire cheek with sutures, and it seems to be the procedure of the moment. My view is that it really doesn’t provide the kind of natural result I aim for. I have removed a number of them, but I have never placed one.

Is that small longitudinal area within his missing beard a scar from the “weekend” neck lift?

**Dr. Marten:** Yes, that is a scar from his prior surgical procedure.

**Dr. Little:** What a shame! What is typically done on the “weekend face lift” is heavy laserig from the undersurface of the skin and the undersurface of the platysma. The thought, I guess, is that the resulting contracture might function just like a permanent suture. Unsatisfactory results are common in areas of the country where these types of procedures are commonly performed, and I have found that if I don’t remove that excess gritty midline fat that extends down the front of the neck, I cannot get a really elegant contour. I also need to make room for the infolded platysma edges from the corset platysmaplasty.

**Dr. Marten:** Dr. Connell, do you think there is a role for suspension sutures in neck contouring?

**Dr. Connell:** I do not like to rely on suspension sutures because of bad experiences trying to hold structures to bone. If there is too much weight on suspension sutures, the fat is not going to hold indefinitely. Results need to persist for decades, not just until the fascia stretches out.

**Dr. Feldman:** I no longer use midline-to-mastoid sling sutures. For a
number of years I did use them as an adjunct to the corset platysmaplasty. But I found that patients often complained of a lot of tightness in the neck when the suspension sutures were used. Five or 6 years ago, I stopped using them completely, and simultaneously, patients stopped complaining of neck tightness. With a good corset, sling sutures are not necessary. If a corset is not done, a purse-string type lateral platysma suspension suture can be useful.

**Dr. Marten:** Thank you. Our next patient is a 61-year-old woman with long-standing neck fullness and no prior history of surgery (Figure 4). Dr. Feldman, what is your diagnosis of her problems and how would you approach them?

**Dr. Feldman:** She has a prominent jowl, which for me simply means tissue hanging over the jawline. She also has a prominent nasal labiomandibular fold, a little bit of chin ptosis, and an oblique neck. Again, I suspect the neck fullness represents a combination of excess subcutaneous and subplatysmal fat. I would do a neck lift alone in this patient if she did not want a face lift, but she would have to understand that if I did a neck lift alone, I could eliminate the jowl, but the labiomandibular fold would not change.

If this patient had long hair and liked to pull it back in a ponytail, I would use full-length sulcus incisions and a submental incision, and remove no skin from her neck. But if the patient who has a good bit of skin laxity wore her hair cut short with hair always covering the occipital hairline, then I would use an occipital hair-edge incision and remove some neck skin. If I did consider using an occipital incision, I would be certain that the patient had no history of incision scar hypertrophy.

To correct her chin ptosis, I would remove her submental crease within a narrow ellipse that included a little chin skin above the crease. Then I would perform all of the subcutaneous and subplatysmal maneuvers that I have already talked about. With the postauricular incision starting just in front of the earlobe, I would be able to see easily into the lower cheek and along the jawline so that I could trim off the jowl fat and give her a really clean jawline without a face lift. I think the jawline is part of the neck, and so I never leave the patient with a bad looking jawline when I am performing an isolated neck lift.

**Dr. Marten:** Dr. Connell, do you feel you could treat this woman with a neck lift alone or would you also perform a face lift?

**Dr. Connell:** I would not perform a neck lift alone because I feel it is like painting one wall of a room. That face will look a lot worse if her neck looks better. If you look at her gazing downward, that is how she will look in 12 to 18 months. Her face will look really bad, but her neck will look good. That does not agree with my sense of aesthetics.

In terms of her jowl, years ago, I used to trim off the jowl. But now, by giving the SMAS good support, the fat is returned to the face, making patients look 20 years younger with more fullness instead of a hollow look. I would perform a SMAS flap face lift.

I think she could look at least 15 to 20 years younger if her earlobes

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**Figure 4:** This 61-year-old woman with long-standing neck fullness has no prior history of surgery.
were resected. I would shorten her earlobes; the earlobe elongates with aging and can make one look much older. I also would dermabrade her upper lip.

In terms of excising the crease, which many of my colleagues used to do, to shape an attractive neck you need all that vertical skin, and with the chin down, you are going to raise the neck. Removing skin at the crease in the horizontal direction would not be advisable because if that osseocutaneous connection that forms the crease is released, the crease disappears and never returns. The disappearance of the crease is because the osseocutaneous connection that forms the crease is resected. The wrinkles in front of her ear will disappear if you make incisions along the edge of the tragus.

Her neck consists primarily of sagging platysma muscle and skin with a moderate amount of fat behind it. So I would not do a neck lift alone on this patient.

Dr. Marten: Dr. Little, do you feel that you could treat this patient with an isolated neck lift or would you perform a face lift?

Dr. Little: I agree with Dr. Connell on this point. One thing that certainly does not accompany natural aging is the presence of a fatty fullness over the anterior mandible associated with a near pristine neck. The treatment of the jowl is critical here, as well as subcutaneous fat that extends from the angle of the mouth along the jowl; that is why I suggest the face lift. The wonderful thing is that this woman can have a transformational rejuvenation in which she will look 20 or 25 years younger, or more.

Another thing I want to mention is the dropped chin, and Dr. Feldman has written extensively on this subject.

What I do now, in 75% to 80% of patients, is a mentalis lift. The only muscles that function as an elevator of the lower lip are the central small, paired mentalis muscles. Through a 1-cm incision at the base of each of the canine teeth, I thoroughly free the chin pad from the frenulum down to and over the mandible border, and then extend the dissection laterally to free up the origins of the 2 depressor muscles, depressor anguli oris and depressor labii inferiors (this latter technique was first described by Marinetti from Marseilles).

I allow the 2 depressor muscles to reset themselves higher, and with a single 2-0 absorbable monofilament suture placed in the chin pad, I raise that structure to the highest soft tissue at the frenulum as a single suture, not quite violating the mucosa there. That will visibly pull the chin pad vertically. I also perform this maneuver on patients who do not have a dropped chin, but I think it is especially important for patients with a dropped chin pad, like this one. My goal is to achieve elevation of the lower lip and to cover the lower teeth. One of the surest signs of aging is elongation of the upper lip with coverage of the upper teeth, but even more so drooping of the lower lip with exposure of the lower ones. I would gladly send her to Dr. Feldman if she insisted on doing the neck alone and tell her that he would do a good job.

Dr. Feldman: Dr. Connell suggested that he would not take any skin out of the neck vertically; neither would I. But removing a millimeter of skin below a deep submental skin crease, to release it, does not shorten the neck. I would take out just a millimeter below the crease to remove the shoulder that rolls down into the crease, and then remove a small amount of skin from the chin side that is above the crease. If you are treating very minor chin ptosis, you can take out a small amount of skin and subcutaneous fat from the chin side. That is sometimes all you need to do to correct a minor degree of chin ptosis, and it does not have to be any more complicated than that.

Dr. Marten: Thank you. Our last patient is a 58-year-old man with no prior surgery, a very unusual cervical configuration, and a poor cervical profile (Figure 5). Dr. Connell, what do you see as his problems and how would you advise him?

Dr. Connell: Judging from his contour, he is not an easy patient to treat. It looks like his primary problem is the sagging skin, but he also has wrinkling in the posterior triangle that I feel needs to be addressed. He has deficiency of chin projection and a very large protruding thyroid cartilage. The outlook for improvement is very good, but to get a strikingly handsome result would be difficult.

I would perform a face and neck lift using SMAS support. I feel like we can get a pretty good look at the tissues around the mouth. Using a proper vector, that angle of his mouth that is hanging downwards can be moved up to a neutral position, and this will yield a great improvement.

His neck has a special problem. I do not see sagging fat; it looks like mostly sagging skin and muscle. I would do a face lift, provide deep layer support, and in addition, I would undermine all of that posterior or triangle skin. All these patients need the anterior mandibular ligament released. I would place a silas-
tic implant, extending from the anterior mandibular area around the chin to the other side. There are many approaches to this patient that could produce much improvement. I would use a SMAS face lift and certainly not take any fat off the neck.

Dr. Marten: Are you saying that this patient also would not need subplatysmal fat removed?

Dr. Connell: I think if you deepened the concavity superior to the thyroid cartilage, any more than just smoothing it, it would result in a neck that looks even more unusual, with that big thyroid cartilage having an almost cartoon-like appearance.

Dr. Marten: This patient also has what sometimes has been referred to as a “low hyoid,” and there is an abnormally positioned digastric muscle on each side. Do you feel that digastric muscle surgery is indicated?

Dr. Connell: From the side view, I see no outlines of digastric muscle. When he looks downward, there is no large bunching in the area. So I suspect he is better off leaving the digastric muscles alone, because deepening in that upper area is not going to make his neck look good.

Dr. Marten: Dr. Feldman, how would you approach this patient?

Dr. Feldman: He has what I call a “firm oblique” neck. If you felt his neck, you would feel the muscles of the floor of the mouth extending down to the front of the neck. There is no excess subcutaneous neck fat in this patient except, perhaps, just a little in the submental area.

Years ago as you pointed out, people used to call this a “low hyoid” neck. But I think in most of these cases, the hyoid is not particularly low, but these patients have excess, very fibrous, gritty subplatysmal fat that is pushing out against the superficial cervical fascia and platysma muscle, stretching it. These patients rarely present with paramedian platysma muscle bands, even though the platysma edges may be very widely separated, because the platysma is so tightly stretched.

To give this patient a pleasing cervicomental-hyoid contour, you have to dissect beneath the platysma muscles and remove that excess subplatysmal fat. Frequently, the perihyoid fascia is “bow strung” and you have to release the fascia just above the hyoid. These patients also frequently may have bow strung anterior digastric muscles that need to be released, and this is the type of patient who may need a near complete transection of the anterior digastrics to create a flat submental plane and a well-defined hyoid angle. Then I would complete the procedure with a corset platysmaplasty.

I agree with Dr. Connell that if you deepen his cervicomental angle, you will make his Adam’s apple more prominent. It’s a trade off, but I think that this man would have a better-looking neck and a better overall appearance if he had a well-contoured hyoid angle with a somewhat prominent thyroid cartilage, but that is something to discuss with the patient.

Dr. Connell: Do you notice how his cervical vertebrae come off his shoulders? He has a strange angle to
his neck from his kyphosis. His neck would look better if he could get it straight. It looks like the leaning tower of Pisa, falling over to one side, making his neck look unusual.

**Dr. Marten:** Dr. Feldman, how much of a digastric muscle can one remove? Can it all be removed, or do you limit yourself to a certain portion of the muscle?

**Dr. Feldman:** In this man, it is likely that I would not remove any of the digastrics. I would just do a release. I have removed almost all of the digastric or transected it almost completely in a few patients without a problem, but that is infrequently needed.

When I have a very bulky anterior digastric, I may remove as much as half of the superficial surface, but I do that only once in a while. If the patient has a submental convexity before surgery that becomes more prominent with swallowing, that suggests poor muscle support in the floor of the mouth. I would approximate and in-fold the 2 anterior digastrics along the midline to flatten them and to reinforce the support there. Excising muscle would further weaken the support.

**Dr. Marten:** Dr. Connell, is there a limit to how much digastric muscle you will remove, or do you remove as much as is necessary to create the contour you want?

**Dr. Connell:** You can get the contour you want and still leave a sliver of muscle. Taking it all out will permit it to slip through the sling and make the posterior belly much fatter because of the slipping. I always leave a slight connection to the mandible anteriorly to keep it from sliding through the sling.

**Dr. Marten:** Dr. Little, do you feel genioplasty would help this man?

**Dr. Little:** I do not see this as a neck problem, but as a face problem. If you look at the distance from his relatively short earlobe down to his mandibular angle, and you reach up and feel that same distance on yourself, your distance will be 2 or 3 times as great as his in that area. He has an effeminate appearance, and when he gazes down, the comic figure that comes to mind is Andy Gump. He has inadequate bony support for his lower face. That is why his Adam’s apple is so low. It is hard for a man to look masculine when the bony lower face is so small.

I would perform a chin augmentation. My preferred augmentation along the mandible border and in the angle is structural fat, and I believe what Sydney Coleman tells me: when you place fat against the bone, the fat works, acts, and looks like you have done a bony augmentation. The only question I have is whether or not I would waste any time trying to improve his neck, because I think that the potential for dramatic improvement from working on his neck alone is extremely limited. The problem is that if you undermine and make the incision, you will not be able to place the fat in there at the same sitting.

I would probably place the fat first. I would drop his mandibular border at least 1 cm, which is what I believe Coleman would do. Then I would lower his angle and augment the chin, which can be accomplished with a silicone implant or by fat alone. I use chin implants in less than 5% of facelifts, but I use fat in the chin in at least 10%.

Dr. Connell alluded to the loose posterior skin that creates a strange posture. I do not know if that is caused by the kyphotic aspect of his skeleton or if he was just photographed in an unusual position. That is something to be determined. When I see loose skin posteriorly, I use the full omega incision. Most commonly, I use it in the abbreviated form as a hidden retroauricular incision. But the full version brings the retroauricular incision into the hair above the ear. This allows posterior dissection of the scalp 6 cm to the perforating greater occipital bundle, which would allow me to elevate and treat all of that apparently loose skin without a visible posterior scar.

I do the full omega incision that I used to use on all patients in just 20% of patients now, and he might be one of them. It is the facial deficiency that makes his neck look weird. I think he needs mandibular augmentation. My preferred material is fat.

**Dr. Marten:** Dr. Feldman, how do you treat patients with marked posterior cervical wrinkling?

**Dr. Feldman:** I think you do have to be careful not to do 2 things: First, if you perform a vertical-type lift behind the ear, you will exaggerate these folds. Second, if you do a lot of skin undermining behind the ear, you loosen the skin and you can exaggerate the folds. This is a situation in which I probably would remove skin from the lateral neck by making an incision just a few millimeters behind the occipital hairline. With that approach, I can undermine the lateral neck skin and pull back perpendicular to vertical skin folds and parallel to horizontal skin creases, so I can unfold the folds and prevent horizontal creases.
from being rotated upward into an unnatural orientation. In this particular patient, if the lateral neck fold did not bother him, I would leave it and do his neck lift through a submental incision and small incisions behind his earlobes.

**Dr. Marten:** Dr. Connell, how do you manage the posterior neck wrinkling?

**Dr. Connell:** Actually, just releasing the attachments makes a big improvement. If there is some skin shift in that area, results can be good. The main benefit seems to be undermining and releasing all of these connections between the muscles and the skin. In that area, there is not much shifting of the skin needed. But I think if the patient looks really good every place else, and especially on a woman, it just does not look good to have all those folds. I am pleased with the results of just undermining, usually through an incision that goes along the hairline.

**Dr. Marten:** Would any of the panelists like to add anything?

**Dr. Little:** I do not think vertical movement enhances these folds at all. You can see that the pleats are posterior or transverse. When I move all that skin in the vertical anterior direction, I simply do not get the same result that Dr. Feldman suggests. I never find justification for a scar that leaves the posterior sulcus. Although I am not advocating or recommending it, using a posterior midline excision with a V to Y closure at the hairline is a quick approach to correction of this area in an extreme situation. I did this on 2 occasions in the past with satisfactory results, and both people were particularly pleased with it.

**Dr. Marten:** My thanks to you all for taking time from your busy personal and professional schedules to share your insights and opinions.

Reprint requests: Timothy J. Marten, MD, 450 Sutter Street, Suite 826, San Francisco, CA 94108.
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