Panel Discussion

Revisional Neck Surgery

Gerald Pitman, MD; Sherell J. Aston, MD; Joel J. Feldman, MD; Keith LaFerriere, MD

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Dr. Pitman: The first patient is a 61-year-old woman who is seeking rejuvenation of her face and neck (Figure 1). Fourteen years ago she underwent a superficial musculoaponeurotic system (SMAS)—platysma face and neck lift and lipoplasty of the neck. Dr. Aston, how would you treat this patient?

Dr. Aston: I see laxity in the lower portion of her face. In the front view, I see prominent labiomandibular folds and platysma laxity under the chin that does not appear to extend down to the first cervical crease. In the three-quarter and profile views, I see some laxity along the jawline and in the jowl area, so she would benefit from a secondary face lift.

In the grimace view, there is some weakness of lower lip depressor function on the left evidenced by diminished pull down of the left lower lip and less dental show on the patient’s left side. We do not know what work was initially done to her face. However, work on the anterior neck surface with platysma plication, or dissection in that area, could obviously damage the marginal mandibular branch. The damage could have occurred with a lateral platysma SMAS dissection.

Dr. Pitman: She had lipoplasty of the anterior neck and lateral SMAS elevation.

Dr. Aston: Then I suspect the damage was connected with undermining of the SMAS platysma flap.

Dr. Pitman: Would the past injury influence your present approach?

Dr. Aston: Not really. I would counsel her, pointing out that she has lower lip weakness along with platysma laxity, making absolutely sure she understood. I would be aware of the weakness when dissecting, but it would not stop me from operating. Lipoplasty marginal mandibular injuries usually recover.

Dr. Pitman: Would you approach her neck anteriorly, as well as laterally?

Dr. Aston: I would not. In the grimace picture, she has no significant banding. The little platysma laxity evident in this picture does not extend down as far as the first cervical crease. In patients such as this, I usually do a wide lateral platysma dissection with the SMAS to get a significant rotation and flap elevation. She does not have a major problem in the anterior neck. I think her jawline is, for the most part, well developed. There is some fullness in the jowl area, and, on the right side, the mandibular angle is a bit more blunted, without the good contour apparent on the left. I would possibly, on the right side, perform a small partial platysma transection, laterally only, for 2.5 to 3 cm, to get more jawline definition posteriorly. I probably would not go into her anterior neck.

Dr. Pitman: Dr. LaFerriere, what would be your approach to treating this patient?
Dr. LaFerriere: Looking at the right lateral view, you can see she has had a parotidectomy or some other surgery on the right, based on what appears to be a scar. From the grimace view, she has absolutely no platysma function on the right. I wonder if the depression of her lips (right more than left) could possibly be related to stronger nerve function on that side rather than an inherent weakness on the left. The only thing I would do differently, and probably because it is a revision lift, would be not to attempt a SMAS flap. I would probably do a relatively short skin flap, especially because she has had a parotidectomy, or some other surgery, on the right. I would do a plication, or possibly a SMASectomy type lift. If the irregularities in the neck completely cleared when simulating a face lift pull, I would probably not go into the neck either. It looks as if (when she animates) the platysma is not really a major problem. The two bands evident under the chin could be skin bands rather than platysma muscle bands, especially...
because she does not have platysma function on the right. Other than that, I would agree with Dr. Aston’s plan.

**Dr. Aston:** Has she had a parotidectomy, Dr. Pitman?

**Dr. Pitman:** The patient gave no history of having had a parotidectomy.

**Dr. LaFerriere:** She does not have platysma function on the right; you can see the muscle on the left. You can see a big difference in her smile, even up into the cheek. If she did have a parotidectomy, or some other surgery, and there is no platysma function on the right, the other option would be to have a nerve stimulator stimulate the branch to the platysma on the left and possibly even consider transecting it to make her neck more symmetrical. I would discuss this with her at length before doing it. I realize that is a relatively unconventional approach, but she has a relatively unconventional grimace.

**Dr. Pitman:** Dr. Feldman, is there anything you would like to add?

**Dr. Feldman:** I would approach treating this patient’s neck differently. I think she does have short upper paramedian platysma bands along with small jowls overhanging the medial jaw line. There may also be a small submandibular salivary gland bulge on each side. There is little if any excess fat in the neck, and the neck skin is smooth other than those two moderately prominent transverse skin creases. She also has a very slight degree of chin ptosis. I suspect that this patient has not had a parotidectomy. I think there is a good chance that the mild lower left lip depressor weakness that she displays when smiling may have been caused by her previous neck lipoplasty. It is then possible to injure one of the marginal or cervical branches of the facial nerve.

The improvement of neck and jawline contour is relatively simple in this case. I would do an upper platysma approximation or a corset platysmaplasty to correct the platysma bands and perhaps vertical buttressing pleats in the platysma over the gland bulges, along with subcutaneous trim of the jowl fat to clean up the jawline. To achieve this, I would use a submental incision and a postauricular access incision on each side without removing any skin from her neck. The transverse skin creases in the neck will be improved, but not entirely eliminated, simply by undermining and releasing the skin creases from their underlying attachments to the superficial platysma fascia. Her small degree of chin ptosis is easily correctable with a leveling technique, which simply means reapproximating the subcutaneous fat and the skin at an even level on each side of the submental incision.

**Dr. Aston:** I would like to add another point. I am careful not to place great stock in the grimace picture in terms of planning treatment. You may often have several different photos, each of which creates a slightly different impression of the anterior neck, depending on how much tension the patient exerts on one side or the other. This can be a problem, particularly when there is greater weakness on one side, as I believe is the case with this patient. I use the grimacing pictures primarily to document anatomy and demonstrate the platysma muscle.

**Dr. Feldman:** I agree with that completely.

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the resection. I am not, however, recommending submandibular salivary gland resection to other surgeons who are not already comfortable with this maneuver. Gland resection surgery can be difficult and potentially dangerous in inexperienced hands.

If partial resection of the glands, for some reason, was not appropriate, I would do a careful intracapsular mobilization of the superficial lobes and then attempt to tuck the glands up and under the mandibular border using stout vertical submandibular platysma muscle pleats executed in conjunction with a corset platysmaplasty. I would construct these muscle pleats using a running 2-0–gauge permanent monofilament suture.

The submental hollow can be filled by rolling in platysma muscle during fabrication of the platysma corset. If the platysma muscle edge had been resected at a previous surgery, then the platysma probably would need to be sharply undermined for several centimeters on each side to allow the widely separated muscle halves to stretch and slide to the midline for the inverting approximation.

The excess chin skin should be excised transversely so that the resection blends into the line of the submental incision. To better define the jawline, I would do some subcutaneous defatting along and just under the mandible on each side under direct vision, possibly including the resection of fat from the lateral buccomandibular triangle, which is found between the upper medial edge of the sternomastoid muscle and the lateral jawline. However, in this patient it appears that the tails of both parotid glands may be somewhat enlarged, accounting for the fullness in the area below the earlobes.

**Dr. Pitman:** Dr. LaFerriere, do you have anything to add to Dr. Feldman’s comments?

**Dr. LaFerriere:** I have some questions. Dr. Feldman, if you performed a corset platysmaplasty and a vertical platysma plication overlying the gland, do you think you could get enough improvement without actually having to resect the gland?
Dr. Feldman: I think I could get a nice improvement, with only a reinforcement of the overlying platysma if the gland bulges were small. When the glands are this big (particularly the one on the right), the gland bulges often appear to be flattened at 1 month after surgery, but then at the 3-month postoperative visit, a big bulge is usually seen again. If, however, I did not want to do a gland resection, I would certainly try to tuck in the gland using a vertical muscle pleat and a two-way submandibular cable restraining suture woven through the platysma and tied to itself at the mastoid fascia behind the lower ear. I should also mention a structure I call the “malpositioned gland,” which is a gland that is fixed in an abnormal medial and inferior position by congenital intracapsular adhesions. These dense fibrous connections first have to be released inside the medial capsule before the gland can be repositioned and then held laterally and superiorly by the platysmaplasty.

Dr. LaFerriere: I would agree with your caution on resecting the gland. I think, even to someone who is very familiar with the anatomy, there is risk of injury to the marginal mandibular branch of the facial nerve. I personally do not resect glands. Over the years, I have done a number of submandibular gland incisions through a direct approach for functional reasons. But in this limited approach, through a submental incision, I stay away from actually trying to resect the gland.

Another option in this patient is splitting the posterior SMAS flap and then bringing the inferior portion back very tightly, attaching it to the sternomastoid fascia so it can improve the ptotic submandibular gland and posterior jawline.

A third option I have used with reasonable improvement is a sling suture, as Giampapa et al. described a number of years ago, interlocking in the midline, bringing the anterior platysma borders together, and then sutureing the ends back to the sternomastoid fascia. This tends to suspend the ptotic gland and improve the definition of the posterior mandible. I have used Gore-Tex (WL Gore & Associates, Elkton, MD) for the suspension suture and buried the end in the sternomastoid fascia. I do not do this routinely, but I have done it in the past, and it is still a much simpler and safer approach than excising the gland directly.

Dr. Pitman: Dr. Feldman, would you like to respond?

Dr. Feldman: I certainly agree with Dr. LaFerriere that if the surgeon is not really familiar with the gland resection procedure, he or she should not do it, because it can result in dangerous bleeding. Dr. LaFerriere is also correct in that some of the marginal or cervical branches of the facial nerve lie in the subplatysmal plane just superficial to the thin gland capsule, and if the surgeon is not careful the capsule can be easily torn in some cases with possible injury to a nerve branch. So the bottom line is that you really have to know where you are going; but that said, partial gland resection can be done safely, and over the years I have done hundreds of gland resections without a problem. For a big gland like this patient has, in my hands, that is the only sure way of getting a good correction of the bulge. I agree, however, that sometimes suspension or restraining sutures can improve things without gland resection, but I think the patient should be told ahead of time that the likelihood is that a bulge will reappear to some extent later on.

Dr. Pitman: Dr. Aston, do you have any comments?

Dr. Aston: I certainly agree with the cautious approach. I do not resect submandibular glands for reasons that have already been voiced. Over the years, I have tried suspension sutures; I have also tried plication sutures. They look good early on but after a few months I wonder why I did anything at all because the bulge reappears. Rarely, there is permanent improvement, but with glands like this I find it very difficult. There is one other thing I would point out on these pictures: she has already had a significant skin trim with tension on her earlobes. So, when this face lift is redone, it’s important to trim the skin around the earlobes really carefully. You probably would not remove any skin right at the earlobe, so, hopefully, you can get that skin tucked up under the earlobe to reestablish an appropriate lobe appearance.

Dr. Pitman: The next patient is a 62-year-old woman requesting improvement in the appearance of her neck (Figure 3). She had face and neck surgery 16 years ago (of an unknown type) and reported a history of skin slough (of an unknown type) and reported a history of skin slough in her left lower cheek and upper neck. Dr. LaFerriere, how would you help this patient?

Dr. LaFerriere: I would like to know the cause of the skin slough. Was or is she a smoker? A brittle diabetic? Did she have some type of collagen vascular disease? If there is still a problem, that would certainly influence anything I would tell her.

Dr. Pitman: For the purposes of this discussion, let us assume she was not a diabetic or a smoker.
Dr. La Ferriere: It looks to me as if she had a combination of overresection of fat and, probably, platysma in the lower neck. She could have possibly had a hematoma or seroma in the neck that also led to the scarring, which is significant. The thyroid cartilage is very prominent. It looks to me like a lot of work was done in the neck and that it was overresected. She has poor skin quality, and this would significantly influence what I would do.

I would talk to her at length about her goals. I assume she would like to have the jowls taken care of, as well as the neck. She does have prominent jowls and a significant prejowl depression. The chin is full.

I think the secondary lift is risky if any conditions such as smoking are still present. I might consider, in terms of the face, a short skin flap and a plication of the SMAS because this is a secondary lift. I would probably do some small cannula lipoplasty of the jowl area and possibly consider fat transplantation to the prejowl area to achieve a smoother jawline. I would approach the neck with a generous submental incision, and I would try to free the skin and the scarring to see if there are any identifiable anterior platysma edges. I certainly would consider bringing the platysma together in the midline.

If she decided that she didn’t want to lift the face and her neck was really her main concern, I might consider an even wider submental incision, extending laterally under the jawline, undermining and freeing the skin from the scar, and trying to remove or redrape the excess skin. I would do some minimal small cannula jowl lipoplasty and fat transplantation in the prejowl area. She certainly would get improvement from this.

Dr. Pitman: How would you counsel this patient regarding her expectations and quality of result after a secondary procedure?

Figure 3. This 62-year-old woman wants improvement in the appearance of her neck. She had face and neck lift surgery 16 years ago with a history of skin slough in her left lower cheek and upper neck.
Dr. LaFerriere: I would be somewhat guarded. I would tell her that it is a difficult procedure with no guarantee of a wonderful result. However, I do think improvement could be achieved, using relatively conservative measures.

Dr. Aston: From her profile, and looking at her submental skin crease, the bulge behind it, and the depression, it makes me wonder if, originally, her submental skin incision was placed too far posteriorly. There may be a little bit of fat anterior to the submental incision. You have to examine the patient to make an accurate assessment, palpating the tissue to know what you are dealing with. I would ask her to animate and then examine her platysma. From her right profile view, the skin definitely needs redraping. It looks as if there was a minor slough just below the earlobe on the right side. The neck may be improved, but I don’t think you can improve it adequately without redraping the facial skin. I would determine how to proceed after I saw her animate and palpated the neck. From the front view, you certainly do not see a lot of platysma banding. There may be a little platysma banding on the right.

I would make a submental incision in the submental skin crease, clean it up, and suture the platysma together. Alternately, I could just use a lipoplasty cannula and then widely undermine her skin. I am not worried that she had skin slough before, looking at the way it has healed from this photograph. But if I were feeling and looking at the skin, and it is thin, I would do a subSMAS dissection with the skin attached instead of raising a skin flap or a separate SMAS flap. That way, you can redrape her facial skin without a problem.

Dr. Pitman: Dr. Feldman, would you like to comment?

Dr. Feldman: I would be optimistic about significant improvement in this patient. I think the skin above, along, and below the chin and jawline needs to be widely freed and then smoothly draped. Some excess submental and jowl fat needs excision, but fat also needs to be added to fill an overly defatted area just above the right medial jawline alongside the chin. To fill this area, fat could be injected at a later, separate procedure. Alternatively, a superiorly-based subcutaneous fat flap, cut from the adjacent jowl fat, could be rotated anteriorly to fill that gap. I would excise no skin from this neck. In addition to a submental incision, I would use a three-quarter length postauricular sulcus access incision on each side, beginning the incision in the skin crease just in front of the earlobe. This lateral access incision would allow me to easily undermine and look under the skin along and above the jawline. I think this could be done safely on the left side, even though she had a superficial skin slough there in the past, if the skin flap were elevated with a 3 mm fat cushion and handled gently, and no tension were placed on the skin closure (which would not occur if no skin was excised laterally from the neck). A midline approximation or tightening of the platysma might also be necessary, and the left submandibular salivary gland may need a partial resection or tuck-in depending on what was found at surgery.

Dr. Pitman: Dr. Feldman, you have said that you would excise no skin in the first two patients. Could you expand on that, explaining your reasoning?

Dr. Feldman: When the skin appears to be only moderately smooth and taut, even though it may be stretched a good deal by an abundant amount of excess underlying fat or hanging slightly below the chin, if the skin is not really crepey in appearance, particularly in the lower central neck, then a wide skin undermining will not only allow the lax skin to shrink down a good deal, but it will also allow whatever noncontracted skin remains to slip and slide downward and backward where it can be unobtrusively accommodated. In 70% of the neck lifts and face lifts that I perform, I remove no skin from the neck and confine the access incisions behind the ears to the postauricular sulcus. That way I can avoid using occipital incisions that have a potential for hypertrophy or might be visible when the hair is clipped very short or pulled back in a tight ponytail. The avoidance of an occipital component to the incision also preserves a better blood supply to the neck skin flap. I have found that in most cases, once I have appropriately recontoured the subcutaneous and subplatysmal tissues, snugged up the platysma, and adequately undermined neck skin, the flap will settle smoothly onto the remodeled subcutaneous platform without the need for skin excision. However, in 30% of patients who do have a good deal of neck skin laxity, I will excise some skin along occipital hair-edge incisions if there is no history of scar hypertrophy.

Dr. Pitman: This patient’s skin (Figure 3) is neither smooth nor taut.

Dr. Feldman: Actually, to my eye, her skin looks reasonably smooth and taut. It is not the kind of very lax, or
crepey, or weathered skin that generally does not shrink down well. I suspect that she may have had a submental seroma or hematoma that led to the puckering that we see. Once her skin has been widely freed, I think that it will shrink down smoothly and allow her to have a nice result.

**Dr. Pitman:** The next patient is a 65-year-old woman complaining of fullness in the neck (Figure 4). She underwent a face and neck lift with lateral SMASectomy and anterior platysma plication 1 year ago. Dr. Aston, how would you approach this patient?

**Dr. Aston:** In her front view, it appears that she has a little depression in the prejowl area related to her previous procedure. Although that may be attributed to her anatomy, I have seen this before, and from the profile views, she still has some fullness in the submandibular area. The submandibular gland is a bit lower on her right than on the left. I think you can improve her neck and give her a better cervicomental angle. I would like to feel the anterior neck to determine whether it is fat and not muscle. If it is fat, you could get by very well with lipoplasty, and I also would undermine her skin. I would lift her because of the laxity. I think you might be able to clean up her neck with some lipoplasty, undermining, and fat contouring as Dr. Feldman proposed. But it would not be easy to flatten the submandibular area the way she would like or the way we would like to see her. Nevertheless, I think you can make her significantly better. As Dr. Feldman recommended for an earlier case, filling her prejowl area with a bit of fat would be worthwhile.

**Dr. Pitman:** Dr. LaFerriere, would you do anything different?

**Dr. LaFerriere:** I do not think I would do anything different in this patient. I would really want to know how much of that is fat and how much is submandibular gland. I suspect it may be fat. I don’t know why, but it does not look like gland to me, but I would have to feel it and see.

I am concerned that she has mentalis hyperfunction, and along with her lower lip complex, this might be suggestive of a previous weak chin. I wonder if she had ever had previous jaw advancement. If she has, I would not be overly aggressive. She has already had a platysmaplasty, and I think if we could improve it with lipoplasty, she might not even need the neck done. I would try to do everything posterior and then fill her prejowl depression with a fat transplant. Certainly, I could improve her mandibular contour. How to do that can only be determined by examining the patient.

**Dr. Pitman:** Dr. Feldman, what would be your idea for treating this patient?

**Dr. Feldman:** She probably has bulging submandibular salivary glands, although, as Dr. LaFerriere pointed out, the submandibular bumps could be caused by excess fibrous fat clinging under the eave of the jawline, which can produce a pseudo enlargement of the glands. In this case, I would first remove the excess submandibular fat and then see if there is still a gland bulge present. In addition, this patient has poor jawline definition. She also has prominent prejowl notches. She has moderate jowling and a full and slightly ptotic chin. I would use a submental incision and a three-quarter–length sulcus incision for access. I would release the mandibular ligaments just under the skin, which I think would eliminate her prejowl notches, and then trim the jowls and defat along and just about the jawline on each side. If I found that the glands were enlarged and if she were agreeable, I would partially resect the glands, but if she was not agreeable, or if there was some other contraindication, then I would attempt to tuck up the glands with vertical buttressing pleats and two-way woven cable sutures in the overlying platysma.

**Dr. Pitman:** How would you deal with her prominent chin?

**Dr. Feldman:** At the preoperative consultation, I would pull the chin pad downward to differentiate the volume and location of soft tissue from bone, and base my approach on what I see and feel. I suspect that I would decide to at least remove some excess fat from the lower chin. To do that, I would turn back a properly beveled skin-fat chin flap, and then remove an oval of remaining fat sitting on the mentalis muscles. Then I would pull the flap downward to see if it overlapped the submental incision, and if it did, I would mark and trim off a narrow strip of excess skin along the flap edge. The removal of a disc of subcutaneous fat and possibly a little lower chin skin would vertically shorten the soft tissue chin pad and also make it appear less proud.

**Dr. Pitman:** Dr. Aston, any other comments?

**Dr. Aston:** Frequently, in chins like this, I will deepithelialize a small ellipse just behind the submental skin crease.
When I close the flap or put the subcutaneous tissue together, I can flatten the submental skin crease rather nicely, and that is a simple way to get an improvement.

**Dr. Pitman:** Would anyone like to comment about how to improve the cervicomial angle of the neck?

**Dr. Feldman:** I would first do an appropriate subcutaneous defatting, either by an open fat resection technique or by lipoplasty, and then reassess the contour and definition of the hyoid angle. After the subcutaneous defatting, if there still were some blunting of the angle present, or if the submental plane did not seem to be perfectly flat, then I would open the platysma along the midline and remove the appropriate amount of subplatysmal fat overlying the anterior digastrics and hyoid bone, and possibly also further down the midline. After that, if the suprahyoid angle was still not as crisply defined as I wanted, I would next transect or remove a little of the white fascia (investing deep fascia) bridging...
Dr. LaFerriere: I agree; she probably should have had a face lift rather than just lipoplasty initially. I think you should look at the perioral area. If there is sagging in the perioral area as well as her jawline, she definitely could use a lift. When you look at her neck, it is fairly irregular, which is not at all uncommon after lipoplasty in this kind of patient. She does have mild anterior bands, at least in the superior portions. From a grimace view, I would like to see if the bands extend down in the neck, and I suspect that they would. She also has a mildly weak chin.

I would address all of those problems in a secondary procedure. I would perform a standard extended SMAS lift, which would correct most of the jowling and improve the perioral area. I would make a submental incision and perform a platysma plication. If there are any fat irregularities, I openly sculpt them to make them much smoother, and I think she would be a good candidate for that.

Dr. Pitman: Would you carry your retroauricular incision into the occipital hairline for exposure or skin removal?

Dr. LaFerriere: I do not perform many short scar face lifts because I can camouflage the incision behind the ear and drape everything nicely. I think they are great for marketing, but I do not think it makes a lot of difference because I can line up everything very nicely so the patient can wear any hairstyle.

Dr. Pitman: Dr. Feldman, is this another patient in whom you would not remove any skin from the neck?

Dr. Feldman: Yes. I would use a submental incision because all of the important surgical action in this neck will take place up front. I would basically call this a “submental neck lift” except, these days I also use a little 1.5-inch “helper” incision behind the earlobe on each side to blindly undermine the lateral neck and to make it easier to exit the neck suction drains behind the ears at the end of surgery. I would not use occipital incisions in this patient because I don’t think she needs to have any skin removed from her neck. On profile view, she has somewhat of an oblique cervicomental angle, which in the other views of her neck appears to be caused by a combination of recurrent short upper paramedian platysma bands and midline submental fullness. This submental fullness is caused either by some remaining excess subcutaneous fat or excess subplatysmal fat, or both, or possibly large vertically tilted anterior digastric muscles. I cannot discern which it is from the pictures. She also has persistent or recurrent jowls along the medial jawlines. As Dr. LaFerriere pointed out, her chin is a little weak.

So, through the submental incision, I would trim the jowls and defat the submental midline above and between the platysma as needed. I would release the suprahoid fascia if that were needed, and I might possibly also do a low release of the anterior digastrics above the hyoid if that was needed, depending on what I found in surgery. If the digastrics were big, I would shave them down with electrocautery and then put the platysma edges together securely with a corset platysmaplasty to obtain a smooth and flat submental plane. Finally, I would insert a small chin implant.

I would also like to make one additional comment about this patient. The likelihood is that she is probably...
bothered by her labiomandibular folds, and if so, then a lower face lift combined with a neck lift is called for. But, I also see a lot of patients like this who tell me that those little folds outside the corners of the mouth don’t really bother them. For those patients, an isolated neck lift, which always includes a jawline clean up, is a reasonable choice in lieu of a face-neck lift.

**Dr. Pitman:** Dr. Feldman, how do you know that jowling is not from skin laxity as opposed to excess fat? If the jowling is due to laxity, can you deal with the laxity through a 1.5-cm incision behind the ear?

**Dr. Feldman:** It is never just skin when it hangs over the jawline like that. There is always sagging fat, which is the real culprit. The little earlobe base incisions are just used for blind lateral neck skin undermining, never for fat removal. The defatting of the jowl is done through the submental incision. I undermine the skin along and above the jawline, and release the mandibular ligaments, and then I look directly through the submental incision and remove the glob of excess jowl fat with the extended micro-tip electrocautery so there’s no bleeding. It is very easy, it is dry, and you see everything you are doing. You just clean up the jawline superficial to the platysma SMAS layer and the jowl is gone.

**Dr. Pitman:** What happens to the skin in the jowl? Where does it go?

**Dr. Feldman:** The overlying skin just shrinks down after the sagging and excess fat has been removed. Simple as
that. You don’t have to lift a jowl to eliminate it. Of course, it’s very important to leave an adequate cushion of “essential fat” under the skin when you elevate the flap. You don’t want to replace a jowl with a depressed notch along or under the jawline.

**Dr. Pitman:** Dr. Aston, would this also be your approach?

**Dr. Aston:** I think that if we could see the rest of this patient’s face, we would find that there is midface laxity. The labiomandibular folds are part of the midface laxity. In my hands, I would get the best result if I did a face lift procedure. Most people I see, requesting this kind of neck lift are more concerned about that midfacial laxity and the laxity from the corner of the mouth to the jawline than they are about a little band in the front of the neck. Of course, you all have seen some excellent results that Dr. Feldman has demonstrated with his technique.

I would like to point out a couple of things that have not been mentioned. When we look at her front view, we can see that the platysma band is actually thicker on her right, than it is on the left. If you compare the two profile views, it is confirmed that the platysma on the right side is a bigger structure and the cervicomental angle actually looks a little better on her left than on her right. Certainly, I would approach the platysma anteriorly, and I would do a platysma approximation in the midline. I am not as aggressive with the platysma as Dr. Feldman, but I would sew that platysma together, and I resect a small triangle of the right and left platysma at about the level of the thyroid cartilage to break the continuity of the bands up front.

I would also like to point out that we have mentioned a chin implant. Looking at her from the front view, you see that her chin is weaker on her left than on her right. Her profile view confirms the need for a chin implant. You have to customize that chin implant, shaving a portion of it from about the mid chin on the right side; you need a bit more augmentation on her left than the right, and I do that frequently. I probably customize 90% of the chin implants I place on the basis of the anatomy of the mandible.

**Dr. Pitman:** Any rebuttals?

**Dr. LaFerriere:** The only comment I would make is that I would be concerned about over-operating on someone like this with regard to the digastrics.

**Dr. Pitman:** Thanks to all the panel members for their analyses and comments.

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**References**

