The Minimal Access Deep Plane Extended Vertical Facelift

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Abstract

Background: Modern facelift techniques have benefited from a “repopularization” of shorter incisions, limited skin elevation, and more limited dissection of the superficial musculoaponeurotic system (SMAS) and platysma in order to shorten postoperative recovery times and reduce surgical risks for patients.

Objectives: The authors describe their minimal access deep plane extended (MADE) vertical vector facelift, which is a hybrid technique combining the optimal features of the deep plane facelift and the short scar, minimal access cranial suspension (MACS) lift.

Methods: The authors retrospectively reviewed the case records of 181 patients who underwent facelift procedures performed by the senior author (AAJ) during a two year period between March 2008 and March 2010. Of those patients, 153 underwent facelift with the MADE vertical technique. With this technique, deep plane dissection releases the zygomatico-cutaneous ligaments, allowing for more significant vertical motion of the midface and jawline during suspension. Extended platysmal dissection was utilized with a lateral platysmal myotomy, which is not traditionally included in a deep plane facelift. The lateral platysmal myotomy allowed for separation of the vertical vector of suspension in the midface and jawline from the superolateral vector of suspension that is required for neck rejuvenation, obviating the need for additional anterior platysmal surgery.

Results: The average age of the patients was 57.8 years. The average length of follow-up was 12.7 months. In 69 consecutive patients from this series, average vertical skin excision measured 3.02 cm on each side of the face at the junction of the pre auricular and temporal hair tuft incision (resulting in a total excision of 6.04 cm of skin). Data from the entire series revealed a revision rate of 3.9%, a hematoma rate of 1.9%, and a temporary facial nerve injury rate of 1.3%.

Conclusions: The common goal of all facelifting procedures is to provide a long-lasting, natural, balanced, rejuvenated aesthetic result with few complications and minimal downtime. The MADE vertical facelift fulfills these criteria and often yields superior results in the midface and neck areas, where many short scar techniques fail. Furthermore, this procedure can be performed under local anesthesia, which is a benefit to both patients and surgeons.

Keywords

facelift, superficial muscular aponeurotic system, minimal access cranial suspension lift, SMAS, MACS, deep plane facelift, sub-SMAS facelift, vertical facelift, short-scar facelift, facial rejuvenation

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Over the last 30 years, facelift techniques have progressed from a more limited skin elevation with no treatment of the superficial musculoaponeurotic system (SMAS) to more extended elevation of the skin and SMAS, but more modern techniques have seen a resurgence of less invasive methods. Today, shorter incisions, limited skin elevation, and more limited dissection of the SMAS and platysma have become popular, with the goal

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of shortening postoperative recovery times and reducing surgical risk. At one end of the pendulum is an extended SMAS facelift; the surgical options become progressively less invasive from there, from a lateral SMAS-ectomy to SMAS plication and multiple microimbrications of the SMAS.3-5

Historically, because of the limited efficacy and longevity of less invasive facelifts, many anatomical studies were performed in an effort to understand the complex layered architecture of the face. One hallmark study was published by Mitz and Peyronie,6 who described the SMAS and sub-SMAS elevation surgical procedures. In this way, our evolution in anatomical understanding of the SMAS, platysma, and underlying facial structures—and the subsequent return to less invasive procedures—was fueled by the desire for more significant and durable results in the midface, jawline, and neck. These modifications from a traditional subcutaneous facelift to lifting of deeper structural elements yielded more substantial long-term results in those areas. They also resulted in minimal skin tension at the closure, which allowed for optimal healing of the incisions.2

With respect to the skin, techniques incorporating extended skin flaps were developed in an attempt to redrape redundancy in the jowl and neck, but these maneuvers can carry greater potential for complications such as subcutaneous irregularities, facial hematomas, and periauricular skin necrosis, especially in smokers and patients with compromised vascularity. To minimize those risks, deep plane facelifting evolved to rely on reduced subcutaneous dissection. Hamra popularized the traditional deep plane technique, lifting the SMAS and skin as a compound unit with a thicker, well-vascularized flap. In that procedure, the flap is elevated in a sub-SMAS dissection in the inferior cheek, transitioning to a supra-SMAS plane immediately superficial to the zygomaticus muscles in the superior medial cheek.7,8 This dissection releases the zygomaticocutaneous ligaments that limit vertical elevation of the midface and resuspension during facelift surgery.

The deep plane facelift resulted in a more youthful, natural restoration of the face by lifting the midface and lower face, producing a more harmonious balance between the upper and lower portions of the face. The inferior limit of the sub-SMAS dissection in a deep plane facelift is the inferior border of the mandible; this protects the marginal mandibular branch of the facial nerve. Inferior to the angle of the mandible, the face is lifted in a preplatysmal dissection extending 8 to 10 cm below the mandible. Following a preplatysmal dissection, all redundant anterior platysma is excised and closed via a submental incision, creating countertension in the neck as compared to the lower face. There is limited subplatysmal dissection in the lateral neck from the standard facelift incision. The SMAS and skin are suspended in a superolateral oblique vector. The incision of the deep plane rhytidectomy extends superiorly past the anterior temporal hairline and posteriorly into the postauricular hairline.

The minimal access cranial suspension (MACS) lift was developed to address concerns about large incisions, prolonged recovery due to extensive dissection in the face and neck, and the “lateral sweep” phenomenon, which occurs over time after a facelift procedure in which the skin and SMAS were lifted in a superolateral vector.9,10 The MACS lift rejuvenates the face by applying a vertical vector to the deep tissues and overlying skin. It is performed through a preauricular incision with a limited posterior limb. However, there is no release of the malar mound and SMAS; it utilizes three microimbrication sutures anchored to the deep temporal fascia to address the midface and the lower half of the face and the neck. The zygomaticocutaneous ligamentous attachments of the midface are not dissected and released with the MACS lift, thus limiting vertical release and suspension of the midface. The MACS lift is usually paired with submental liposuction to correct the cervicomenal angle and any existing submental laxity, since there is no platysma dissection in the neck. This has led to less aesthetic and less durable results in the neck, which has necessitated additional anterior platysmal work.10

In our practice, approximately one-third of facelifts are performed on patients who underwent a prior lateral SMAS-ectomy or MACS lift. These secondary procedures are designed to address early recurrent jowling and changes in the patients’ necks. Prado et al demonstrated that more than 50% of the patients on whom they performed a MACS lift or lateral SMAS-ectomy required a secondary “tuck-up” procedure within two years postoperatively to correct recurrent jowling and redundant skin.11 The superiority of deep plane techniques over more limited SMAS plication and imbrication techniques has been demonstrated intraoperatively, with objective neck and jowl skin excision measurements at one year.12,13 In fact, Kamer et al noted that their revision rate was 71% but was less frequent following a deep plane facelift than after a SMAS facelift.14

We have experienced similarly-high revision rates with SMAS-only procedures, so we developed a minimal access deep plane extended (MADE) vertical vector facelift in an effort to rejuvenate the middle and lower thirds of the face and upper neck, utilizing a short scar with no posterior limb hairline incision. In this procedure, the incision extends 2 cm superior to the earlobe facial junction along the posterior concha of the ear. This hybrid technique combines the optimal features of the deep plane facelift and a short-scar MACS lift.15 The deep plane dissection releases the zygomaticocutaneous ligaments, allowing for more significant vertical motion of the midface and jawline during suspension. As a result, the nasolabial groove is effaced, and the malar volume is positioned vertically higher, giving a more youthful appearance to the malar area. Additionally, our technique utilizes an extended platysmal dissection with a lateral platysmal myotomy, which is not traditionally included in the deep plane facelift. This deep plane dissection—combined with an extended lateral platysmal flap releasing it from the anterior border of the sternocleidomastoid muscle—allows for significantly greater superolateral motion of the midline platysma in comparison to SMAS purse-string suture techniques. Furthermore, the lateral
platsmal myotomy allows for separation of the vertical vector of suspension in the midface and jawline from the superolateral vector of suspension that is required for neck rejuvenation. This obviates the need for additional anterior platysmal surgery.

**METHODS**

**Patients**

Candidacy for a MADE-vertical facelift relies on a thorough physical examination of the patient. We have observed success of this procedure in patients from 40 to 70 years of age, even where there is significant anterior platysmal cording and submental skin excess. Anatomical variants that may predispose patients to failures in the submental region with this technique include retrognathia, a low anterior hyoid, and a short vertical height of the neck (for which more aggressive submental surgery is required). Additional procedures that can concurrently address unfavorable cervicofacial contour issues include submental liposuction, platysmal plication, subplatysmal fat excision, and anterior digastric plication.

Our physical examination procedure included an evaluation of how the patient’s face and neck would “redrape” when traction was placed on the skin along the vertical vectors to be utilized in this facelift technique (Figure 1). This helped to determine whether the patient was a viable candidate in whom we could forego the posterior hairline incision of traditional facelifts. For this part of the exam, the surgeon placed three fingers at the deep plane entry point (the line coursing from the angle of the mandible to the lateral canthus) on both sides of the face and moved the skin vertically (Figure 2) to assess whether the submental and platysmal skin laxity is corrected with this tension. If the submental area was corrected, no posterior hairline limb incision or any anterior platysmal surgery was necessary. If the patient still had significant horizontal neck skin excess with this maneuver and platysmal cording still existed, the abbreviated incision associated with our MADE lift was not advisable, as neck redundancy would persist or recur postoperatively. In those patients, a posterior hairline incision would be necessary to remove the horizontal neck laxity and anterior platysmas plication for midline platysmal redundancy.

In retrospectively evaluating our cases, we found that 181 facelifts were performed over a two-year period in the senior author’s (AAJ) practice. Of those, 28 (15.5%) were not candidates for the MADE vertical lift due to anatomical variants, including retrognathia, a low anterior hyoid, short vertical height of the neck, and excessive platysmal laxity and cording. The remainder (153 patients; 84.5% of the total caseload) underwent facelifting with the MADE technique.

**Preoperative Marking**

With the patient sitting upright, several important anatomical landmarks were outlined preoperatively, including the path of the temporal branch of the facial nerve and the deep plane entry point (which proceeds from the angle of the mandible to the lateral canthus). The anterior temporal hairline was marked beginning 1.5 cm above the tail of the eyebrow and tracked along the inferior hairline of the sideburn, into the hairless recess between sideburn and auricle, turning downward into the preauricular crease, continuing posttragally, and then following the crease of the lobule-facial junction. The mark was carried behind the earlobe-facial junction, superiorly onto the posterior concha for 2 cm.

**Operative Technique**

**Anesthesia.** The MADE vertical facelift can be performed under local anesthesia, conscious sedation, or general anesthesia. Approximately 20% of patients elected to undergo this procedure under local anesthesia (0.5% lidocaine with 1:200,000 units of epinephrine, mixed in equal parts with 0.25% bupivacaine with 1:200,000 units of epinephrine); the remaining patients chose intravenous sedation. The local anesthetic was infiltrated along the incision and over the entire area of subcutaneous and deep plane dissection.

**Incision and undermining.** The skin incision was made with a No. 10 blade. If the MADE vertical facelift was being performed as a sole procedure, the temporal incision was
extended superiorly to a greater degree than more traditional facelifts. If this procedure was taking place concurrently with a lateral temporal lift, the anterior temporal hairline incision was shortened. The temporal hairline incisions were made in a trichophytic fashion perpendicular to the hair shafts, to allow hair regrowth through the scar once the facelift flap was trimmed and inset. The earlobe was held in a retracted position, for countertension. The incision was extended 2 cm superior to the earlobe-facial junction along the posterior concha of the ear, never crossing onto the mastoid skin. This maneuver conceals the incision even when the patient wears her hair in a ponytail postoperatively. The subcutaneous flap was initially dissected with a No. 10 scalpel and Brown forceps. The dissection was continued with facelift scissors, with the tines pointing upward. The surgeon consistently palpated the thickness of the flap for any irregularities with his nondominant hand. The subcutaneous dissection was then continued anteriorly to the deep plane entry point and inferiorly 5 cm below the hyoid bone. The preplatysmal subcutaneous dissection extended into the neck below the angle of the mandible and up to the cervical midline (Figure 3).

An incision was then made through the SMAS with a No. 10 scalpel, extending from the angle of mandible to the lateral canthus (the deep plane entry point). From that point, the subcutaneous flap and SMAS were dissected bluntly as one compound unit anteriorly in a sub-SMAS plane in the inferior cheek. Facelift scissors were then inserted and spread perpendicular to the branches of the facial nerve. A lighted retractor was used to elevate in that plane. The plane of dissection was then advanced with a blunt dissector (model 502-5Z; Karl Storz, Tuttlingen, Germany) anteriorly to the level of the facial

Figure 2. (A) This 61-year-old woman presented with facial ptosis, platysmal cording, and submental laxity. (B) The patient is shown undergoing our preoperative maneuver demonstrating how the anticipated vertical vector elevation along a deep plane entry point in the face will treat platysmal cording and submental laxity. For this part of the exam, the surgeon places three fingers at the deep plane entry point (the line coursing from the angle of the mandible to the lateral canthus) on both sides of the face and moves the skin vertically to assess whether the submental and platysmal skin laxity is corrected with this tension. If the submental area is corrected, no posterior hairline limb incision or any anterior platysmal surgery is necessary. If the patient still has significant horizontal neck skin excess with this maneuver and platysmal cording still exists, the abbreviated incision associated with our MADE lift is not advisable, as neck redundancy will persist or recur postoperatively.
Figure 3. Intraoperatively, the incision at the anterior temporal hairline extends behind the tragus, around the lobule, and onto the posterior concha with no posterior limb hairline incision. The extent of subcutaneous undermining is shown. The subcutaneous undermining is extended in a preplatysmal plane 5 cm below the hyoid bone and extends to the cervical midline. The deep plane entry point starts from the angle of the mandible to the lateral canthus. The anterior limit of the deep plane dissection is the nasolabial fold superiorly and the facial artery inferiorly. The inferior limit of the deep plane dissection is subplatysmal 5 cm below the mandible.

Figure 4. This intraoperative photograph shows the deep plane flap elevated superior and inferior to the zygomaticocutaneous ligaments, which will later be dissected connecting the two pockets.

At that point, the zygomaticocutaneous ligaments were carefully divided with vertical blunt spreading via facelift scissors, which remained in a plane superficial to the mimetic musculature, thus connecting the superior and inferior pockets. After the ligaments were released, this dissection yielded a thick musculocutaneous flap composed of skin and malar fat pad of the cheek superiorly and the SMAS and platysma inferiorly. This process released the malar mound, including the malar fat pad, and allowed the midface to be elevated vertically.

Attention was then turned to the dissection of the deep plane flap at the angle of the mandible. The SMAS, platysma, and anterior border of sternocleidomastoid muscle interface were dissected. An intraoperative marking was made from the deep plane entry point at the angle of the mandible, extending inferiorly along the fascial attachments of the anterior border of the sternocleidomastoid muscle to the platysma (Figure 6A and 6B). The fascial attachments were released with a No. 15 scalpel while the assistant held the edges of the tissue with Adson-Brown forceps. The dissection was continued under the platysma, 5 cm below the angle of the mandible. This important maneuver released the dense fascial attachments of the platysma from the sternocleidomastoid muscle, which allowed for greater vertical mobilization (Figure 6C). The last step before vertical suspension of the deep plane flap and extended lateral platysmal flap was dissection of a cuff along the deep plane entry point. This cuff facilitated suture suspension of the flap. The cuff was created with small snips of a facelift scissors.
Intraoperatively, hemostasis was achieved with bipolar cautery, and the tissues were irrigated with gentamycin irritant. A No. 10 French Blake drain with a Jackson-Pratt bulb was placed into the patient’s upper neck, with the puncture site behind the ear.

Suspension sutures. A total of three 3-0 nylon suspension sutures were placed with a PS-2 needle to suspend the flap to the temporalis fascia such that the flap was advanced with a vertical vector with great tension on the SMAS but none on the skin. Firm bites 1 to 1.5 cm long and 0.5 cm deep were placed into the cuff of SMAS dissected earlier in the procedure. These three sutures were run from the leading edge of the composite flap at the deep plane entry point to the deep temporal fascia. There was no cabling of the suspension suture at these points.

This vertical redraping of the face above the mandible reduced vertical platysmal redundancy but limited the available platysma for superolateral redraping.

After vertical suspension, a lateral platysmal myotomy of 3 cm was performed approximately 1 cm below the mandibular angle, and the platysma was elevated off the sternocleidomastoid muscle. This allowed for separation of the vertical vector in the face from the superolateral vector on the platysma, which is required for durable neck rejuvenation. A fourth suspension suture was placed along the extended lateral platysmal flap. This suture was anchored to the mastoid fascia and pulled in a superolateral vector (Figure 7), which yielded a more aesthetic postoperative contour of the jawline. If we think of the vertical vector as representing an inverted bucket handle, the vertical suspension supports the submental region (Figure 1).
Figure 6. (A) The point of dissection and release of the platysma from the anterior border of the sternocleidomastoid muscle inferior to the angle of the mandible. The preplatysmal dissection plane in the neck can also be seen. (B) The intraoperative photograph demonstrates the same maneuver. (C) Another intraoperative photograph shows the platysma released from the anterior border of the sternocleidomastoid muscle and connected to the deep plane flap. The angle of the mandible is exposed, as demonstrated in Figure 6A.

Figure 7. Three vertical face suspension sutures are separated by a lateral platysmal myotomy from the fourth superolateral neck vector suspension suture.
Skin redraping and resection. Similar to the MACS lift, one of the most important features of the MADE vertical lift is vertical skin redraping. The traditional deep plane facelift has a superolateral component of skin redraping in the face, causing a skin excess in the postauricular and earlobe areas, which necessitates a posterior hairline limb incision for redraping. Alternatively, the skin redraping in our vertical technique places the majority of the excess skin anteriorly, with minimal skin excision required posterior to the lobule (Figure 8). Excising skin vertically on both sides has a tightening effect on the skin in the submental region, as shown in the marking photos (Figures 1 and 2). We routinely find that the deep plane entry point essentially merges with the newly-dissected incision line (Figure 9).

Intraoperatively, the skin resection of the cheek flap was carried out by following the anterior temporal hairline. The earlobe was pulled upward and had to be set back with a small skin incision, to place it back in its natural position. The posterior neck skin was pulled up vertically behind the earlobe to support it postoperatively, preventing a “pixie” ear deformity and elongation of the earlobe. Again, this did not require a posterior limb hairline incision.

Vertical mattress sutures were placed in the anterior temporal hairline. The posttragal incision was closed with an interrupted 5-0 plain gut suture on a P-3 needle. The anterior facial incisions were closed with a 5-0 nylon suture on a P-3 needle, and the postauricular incisions were closed with a 4-0 nylon suture. For patients with more advanced aging and rhytidosis, some bunching of the skin in the superior portion of the anterior temporal hairline incision is expected but will settle.
over time in several weeks. A video of the surgical procedure is available at www.aestheticsurgeryjournal.com. You may also use any smartphone to scan the code on the first page of this article to be taken directly to the video on www.youtube.com.

RESULTS

In this series, 153 consecutive patients (seven men and 146 women) were treated with a MADE vertical facelift. Their average age was 57.8 years (range, 36-75), and the average length of follow-up was 12.7 months. We examined the amount of vertical skin excision in 69 of these patients (138 operated facial halves) and found that an average of 3.02 cm was excised on each side of the face at the junction of the preauricular and temporal hair tuft incision, resulting in a total excision of 6.04 cm of skin.

Six patients (3.9%) from our series underwent a revision at one year postoperatively. Of the patients presenting for revision surgery, three required a “tuck-up” procedure; two patients required direct excision of submental neck skin; and one patient required submental liposuction. There were relatively few complications in this series. Three patients (1.9%) experienced hematoma, one of which required additional surgical intervention and two of which were managed conservatively with needle aspiration. Two patients (1.3%) had temporary nerve injury (one marginal mandibular and one temporal) that resolved within six weeks. There were no cases of permanent nerve injury. One patient required removal of one nonabsorbable 3-0 suspension suture due to palpability on the surface. We believe that this low incidence of suture show is due to the thickness of the deep plane facelift flap, but it is acceptable to use Mersilene (Ethicon, Inc., Somerville, NJ) or PDS suture (Ethicon, Inc., Somerville, NJ) as a substitute for the suspension sutures. Clinical results are shown in Figures 10-14.

DISCUSSION

The advantages of our MADE vertical lift lie mainly in its combination of the optimal features of the MACS lift and the deep plane facelift. The MADE procedure involves a short, anteriorly-based incision that curves immediately behind the ear/lobule, extending superiorly 2 cm onto the posterior concha but never crossing the mastoid skin, thus preventing the need for a posterior hairline limb incision. The MADE incision is approximately 2 cm longer than a traditional MACS lift incision, which stops on the anterior surface of the ear lobule. Therefore, the MADE vertical lift allows for more vertical release of the malar mound and a larger degree of vertical elevation of the aged face, made possible by release of the zygomaticocutaneous ligaments in the deep plane. This caudocranial vertical lift rejuvenates the midface by repositioning the malar fat pad. The procedure conserves facial volume by repositioning the deep facial tissues, as opposed to excising them (as in a SMAS-ectomy). It produces more significant neck rejuvenation by combining extended lateral platysmal dissection off the sternocleidomastoid muscle with a lateral platysmal myotomy; this allows for further release and redraping of the metalized platysma (Figures 10-12).

Several authors have advocated a lateral subplatysmal dissection with myotomy, but limited dissection can restrict the degree of neck mobilization, leading to recurrences of lateral platysmal bands.16–18 There are deep cervical retaining ligaments in the neck that anchor the platysma to the fascia of the sternocleidomastoid muscle, which limits its mobility. The MADE vertical facelift releases these ligaments, allowing the neck flap to be advanced superolaterally and thus obviating the need for a submental incision and central platysmal plication. The release and resuspension of the retaining ligaments in the neck yields a durable and long-lasting result.

Cadaveric studies were performed by the senior author (AAJ) to quantitatively analyze the superolateral motion...
Figure 10. (A, C, E) This 61-year-old woman presented with significant upper neck submental laxity, bilateral platysmal banding, jowls, marionette grooves, and midface ptosis. (B, D, F) One year after MADE vertical facelift under local anesthesia. Note the improved definition of the mandibular line. The patient’s platysmal banding was flattened as a result of lateral platysmal redraping due to an extended lateral platysmal flap and platysmal myotomy. Rejuvenating effects in the middle one-third of the face included improvement in the nasolabial fold, vertical elevation of the cheek, and increased midface volumization.
of the medial edge of the platysma after SMAS plication versus deep plane facelifting. Measurements were taken of the lateral distraction of the medial edge of the platysma muscle during lateral tightening of the SMAS-platysmal complex. These measurements were taken for the following procedures: SMAS/platysmal plication, deep plane facelift, and deep plane facelift with inferior release of the platysmal edge below the angle of the mandible. The medial edge of the platysma was distracted 2.2 vs 9.4 mm when comparing SMAS/platysmal plication and deep plane facelift. The results showed that a traditional deep plane dissection allowed for 427% greater superolateral motion of the midline platysma in comparison to SMAS purse-string suture techniques because the maneuver redrapes and flattens anterior platysmal cording, obviating the need for concomitant platysmal plication in primary rhytidectomy, which is required for heavier necks with the MACS technique. We have been disappointed by the morbidity and poor long-term results of anterior corset platysmaplasty, as noted by Baker. One of the most common problems we have noticed with that procedure is submental fullness related to lateral volume transfer of the aged platysma to the midline of the neck.

The learning curve for the MADE vertical lift involves becoming facile with deep plane facelift flap elevation and becoming comfortable with tailoring the skin in the temporal region, as the majority of the skin is excised anteriorly instead of postauricularly (as in traditional lifts). Our overall incidence of temporary facial nerve injury was 1.3%, with no permanent nerve injury. We believe that our incidence of facial nerve injury is lower than that in other series because the entire deep plane dissection is performed bluntly without electrocautery or sharp dissection. In our practice, it takes approximately two hours to perform a MADE vertical facelift. This is a relatively short operative time because only one flap is elevated, instead of redraping the SMAS and skin separately, and the greater redraping of the platysma eliminates the need for anterior platysmal surgery.

Our experience is that patients heal quickly after a MADE vertical facelift. We believe that there is relatively little postoperative downtime because there is a more robust blood supply in the thicker deep plane flap as compared to the traditional subcutaneous flap and because the plane of dissection is subfascial and essentially bloodless (as compared to a subcutaneous plane, where much bleeding occurs due to the subdermal plexus) (Figure 13).
Figure 11. (A, C, E) This 54-year-old woman presented with moderate upper neck and submental laxity, jowls, marionette grooves, and severe midface ptosis. (B, D, F) One year after MADE vertical facelift under local anesthesia. Note that the patient’s nasolabial groove has faded and her malar volume is in a higher vertical position, giving a youthful malar augmentation effect, which can be best appreciated in the three-quarter view. In the lower third of the face, the patient demonstrates better definition of the mandibular line with reduced jowls and neck laxity.
Figure 11 (continued). (A, C, E) This 54-year-old woman presented with moderate upper neck and submental laxity, jowls, marionette grooves, and severe midface ptosis. (B, D, F) One year after MADE vertical facelift under local anesthesia. Note that the patient’s nasolabial groove has faded and her malar volume is in a higher vertical position, giving a youthful malar augmentation effect, which can be best appreciated in the three-quarter view. In the lower third of the face, the patient demonstrates better definition of the mandibular line with reduced jowls and neck laxity.

The vertical vector in the MADE lift is paramount to achieving a natural-appearing result. Traditionally, facelifts have a superolateral vector of traction on the SMAS. The skin is often reoriented with an oblique vector that does not rejuvenate the face but makes it appear flatter. The “lateral sweep” phenomenon can occur over time because vertical ptosis of obliquely-redraped skin reoccurs, resulting in a curtain-like deformity. The end of the more limited skin flap of SMAS rhytidectomies can also be seen as a subcutaneous irregularity, producing an unnatural result. Interestingly, since the deep plane entry point represents a virgin plane in the post-SMAS rhytidectomy patient, it is a great choice for reorienting the vertical vector of the face (Figure 14).

The debate regarding the “best” facelift technique is ongoing and involves experienced surgeons with different aesthetic and surgical philosophies. There will probably never be a definitive answer to this question because of the highly-subjective nature of aesthetics, variability among surgical techniques and patient anatomy, and specific patient desires. However, the common goal of all facelifting techniques is to produce a long-lasting, natural, balanced, aesthetic result with few complications and reduced downtime. The MADE vertical facelift fulfills all these criteria.

CONCLUSIONS

The MADE facelift, which relies on a combination of the optimal features of the MACS lifts and deep plane facelifts, is distinguished by its use of a short, anteriorly-based incision that curves immediately behind the ear/lobule, extending superiorly 2 cm onto the posterior concha but never crossing the mastoid skin, thus preventing the need for a posterior hairline limb incision. This procedure can be performed under local anesthesia to concurrently rejuvenate the neck, submental area, jowls, lower third of the face, and midface. It can be effectively combined with other minimally-invasive rejuvenative procedures such as autologous fat grafting, laser resurfacing, and lip augmentation. The authors believe that this procedure yields superior results in patients from 40 to 70 years of age, even when there is significant anterior platysmal cording and submental skin excess.
Figure 12. (A, C, E) This 49-year-old woman presented with a significant obtuse neck angle, low anterior hyoid, short neck, and excessive subplatysmal laxity. (B, D, F) Eighteen months after MADE vertical facelift, chin augmentation, and submental liposuction under general anesthesia. Note the better definition of the mandibular line and submental contour. Rejuvenating effects in the middle one-third of the face include improvement in the nasolabial fold, vertical elevation of the cheek, and increased midface volumization. This patient experienced postoperative ear lobule deformity and flattening of the tragus, likely due to thick skin, severe facial liposis, and a heavy face.
Figure 12 (continued). (A C, E) This 49-year-old woman presented with a significant obtuse neck angle, low anterior hyoid, short neck, and excessive subplatysmal laxity. (B, D, F) Eighteen months after MADE vertical facelift, chin augmentation, and submental liposuction under general anesthesia. Note the better definition of the mandibular line and submental contour. Rejuvenating effects in the middle one-third of the face include improvement in the nasolabial fold, vertical elevation of the cheek, and increased midface volumization. This patient experienced postoperative ear lobule deformity and flattening of the tragus, likely due to thick skin, severe facial liposis, and a heavy face.

Figure 13. This 54-year-old woman is shown one day (A) and seven days (B) after undergoing a MADE vertical facelift.
Figure 14. (A) This 49-year-old woman presented after having undergone a lateral SMAS-ectomy procedure one year prior (performed elsewhere). Her preoperative photograph shows a “lateral sweep” deformity with subcutaneous irregularities. (B) One year after MADE vertical facelift, which reoriented the vertical vector of her face and corrected residual jawline and neck ptosis.

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