Commentary on: High Superficial Musculoaponeurotic System Facelift with Finger-Assisted Facial Spaces Dissection for Asian Patients

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I have been asked to write a discussion of the article entitled “High Superficial Musculoaponeurotic System Facelift With Finger-Assisted Facial Spaces Dissection for Asian Patients” by Drs Ryu and Moon. The authors stated that few facelift procedures are designed specifically for Asian patients and that the facial characteristics of Asian patients make it difficult to achieve satisfactory results. After their study, they concluded that more studies are needed to redefine suitable facelift techniques for Asian patients.

The authors’ description of their surgical technique is comprehensible and concise, their diagrams are clear and support their surgical description, and their intraoperative photographs help to illustrate the procedures that they described. There are pre- and postoperative photographs of 2 patients that show aesthetic improvements. However, both sets of photographs make it impossible to ascertain the portion of the result that is purely related to the facelift technique described because both patients have had fat injections in multiple areas of the face, including the upper medial malar area, the nasolabial folds, and the cheeks. Of the 53 consecutive patients who underwent facelifts using the high superficial musculoaponeurotic system (SMAS) with finger-assisted facial spaces dissection technique, 40 patients underwent fat grafting, 11 patients underwent brow lifts, 7 patients underwent upper blepharoplasty, 13 patients underwent lower blepharoplasty, and 18 patients underwent submentoplasty in medial platysmorrhaphy and subplatysmal fat debulking.

A brief summary of the authors’ technique is as follows: After skin flap elevation, an incision was made through the SMAS along the superior border of the zygomatic arch and anteriorly obliquely to the malar prominence. A vertical incision was then made in the preauricular area and followed inferiorly to the anterior border of the sternocleidomastoid muscle. The SMAS flap was dissected anteriorly, which released the zygomatic ligaments and massesteric ligaments to expose the zygomaticus major muscle and nerve branches. Finger elevation of the malar fat pad was performed via the prezygomatic space, which was entered between the orbicularis oculi muscle and the zygomaticus major muscle. Finger dissection was also done to the mandibular ligament near the premasseter space between the platysma muscle and massesteric fascia, as described by Mendelson. The SMAS flap was then pulled parallel to the vector of the long axis of the zygomaticus major muscle and brought to the edge of the original SMAS incision, where redundant SMAS tissue was excised. The preauricular SMAS flap was transposed postauricularly and fixed to the mastoid fascia, and the skin flaps were redraped and excised with no tension.

The authors’ description of their technique states that “the orbicularis oculi and platysma were connected and included in the SMAS flap dissection.” When I perform the finger-assisted malar elevation (FAME) procedure, the orbicularis oculi muscle remains attached to the skin flap, to which it is well adhered. My fingertip dissection goes under the lateral border of the orbicularis oculi muscle and into the prezygomatic space. My SMAS flap dissection extends to the lateral border of the prezygomatic space, just medial to the zygomaticus major muscle.

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Drs Ryu and Moon were concerned about the extra protrusion of the zygomatic bone in Asian patients, and for this reason they excise the excess SMAS tissue at the level of the transverse SMAS incision. Many non-Asian patients have asymmetry of their face, with greater malar prominence on one side than on the other. I often perform different SMAS procedures on the 2 sides of the face. Specifically, if there is greater prominence in the malar and zygomatic areas on one side, I will excise the SMAS on that side, advance the elevated SMAS flap, and suture it in the temporal area to obtain more fullness in the zygomatic and malar areas on the weaker side.

The authors also correctly noted that some facelift techniques fail to address the sagging midface; however, the midface is improved with an extended SMAS facelift technique, the high SMAS facelift technique, and a facelift combined with a FAME procedure. It is worth emphasizing certain elements of the authors’ discussion, particularly to help organize the thinking of readers who are in the beginning of their practice. An extended SMAS flap is a SMAS dissection that involves the release of all of the deep retaining ligaments, specifically the zygomatic ligaments, which suspend the soft tissue over the zygomatic eminence, and the masseteric ligaments, which are responsible for supporting the soft tissue of the cheek. Releasing the zygomatic ligaments makes it easier to reposition the malar soft tissue and to some extent the nasolabial fold, and releasing the masseteric ligaments makes it easier to reposition the lower face. The traditional high SMAS technique, as described by Barton and Hunt, consists of a limited skin dissection, a composite elevation of the skin and SMAS flap up to the lateral border of the zygomaticus major muscle, and subcutaneous dissection medial to the zygomaticus major muscle. The technique that I use, as described by Marten, is a lamella dissection of the skin and SMAS flap, which allows each flap to be pulled with different vectors and amounts of tension.

Drs Ryu and Moon appropriately note that caution should be taken when releasing the zygomatic and masseteric ligaments to avoid injury to the facial nerve branches, zygomaticus major muscle, and parotid duct. They note that vertical traction on the SMAS flap during the dissection process helps to delineate ligaments that need to be released. Mendelson7 proposed the concept of facial spaces, and he concurs that the FAME technique is a nontraumatic, relatively easy dissection in the prezygomatic space, which is essentially a potential space in which one can put his or her finger over the body of the zygoma. In my experience, fingertip dissection can be taken all the way down to the base of the prezygomatic space near the nasal alar. Both patients that Drs Ryu and Moon described were good candidates for a prezygomatic space dissection because they had significant fat volume medial to the zygomaticus major muscle without extensive skin excess. Patients with this anatomy respond well to a FAME dissection because it repositions the malar fat and skin at the same time. If there is a large amount of excess skin in the medial face and prominent nasolabial folds, I prefer to perform wide skin undermining to redrape the excess skin.

The authors stated that the main disadvantage of the SMAS technique with finger dissection of the facial spaces is the relatively long duration of postoperative edema. I have found that the duration varies more by patient than by technique, given that some patients who undergo a FAME procedure do not have a protracted bout of edema.

It is also worthwhile to keep in mind that is not always necessary to perform a SMAS flap procedure in order to obtain an excellent facelift result. Many patients can experience a good result with a SMAS imbrication or SMASEctomy technique. It is my opinion that different patients should be treated with different facelift techniques. There is no one procedure that is appropriate for all patients, and many patients benefit from a different technique on each side of the face.

Disclosures
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REFERENCES