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Fig. 2.12. The left image shows the position of the youthful malar fat pad (A). The second image (B) shows the author's 8-year-old son, the author at 56 years of age (C) and the author's father at 83 years of age (D). Progressive hard and soft tissue atrophy, ptosis and volumetric aging changes are evident and predictable across a family tree. (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 1.12. Page 8)

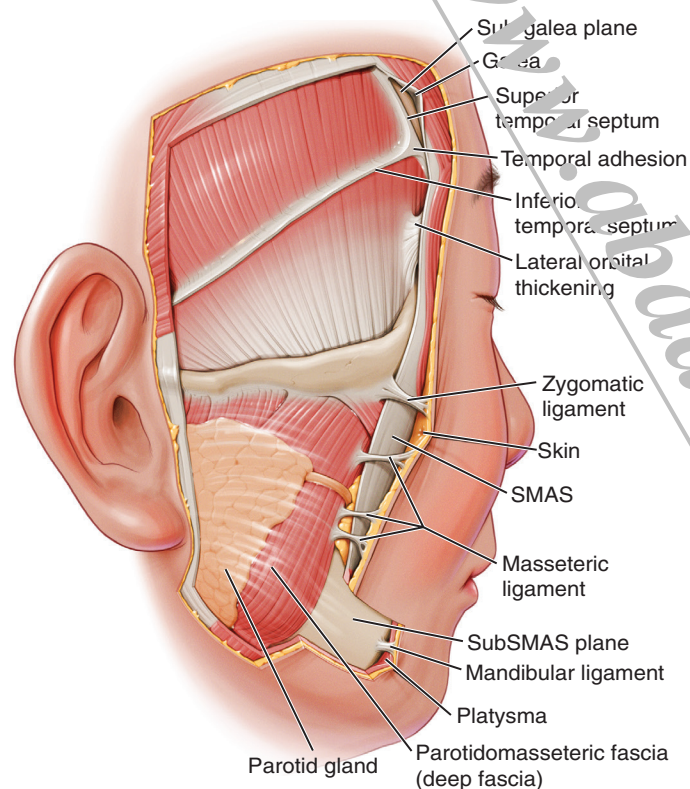


Fig. 2.13. This image shows the true ligaments and other connective tissue connections that support and stabilize the soft tissues of the face. SMAS, Superficial muscular aponeurotic system. (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 1.13. Page 8)

Nasolabial Folds

The nasolabial fold is a very unique structure as it is one of the earliest signs of aging and is disdained by most people early on in their life. It is also a very unusual structure because it is absent at birth, present at death, and diminished with facial nerve damage. There is a saying in cosmetic surgery that despite all technology and advances, the nasolabial fold "remains undefeated."

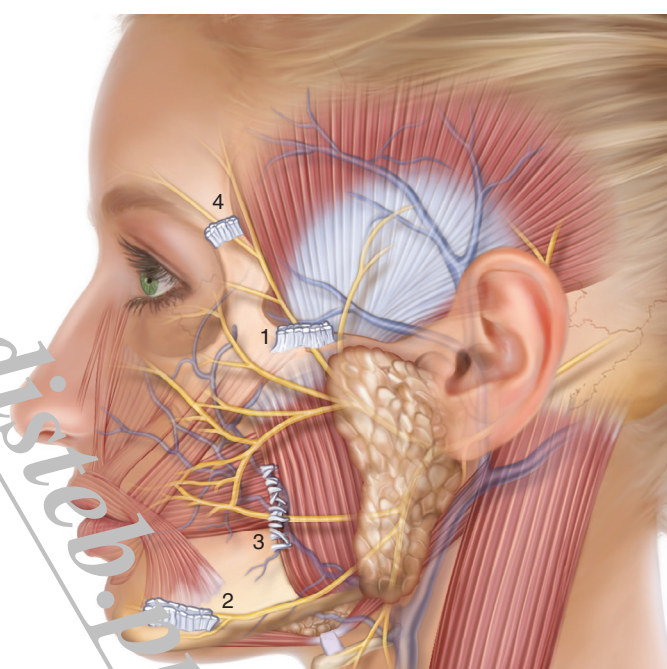


Fig. 2.14. Shows a drawing of some of the significant cutaneous retaining ligaments that contribute to facial aging and addressed during facelift surgery. 1, zygomatic; 2, mandibular; 3, masseteric; 4, parotid. (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 1.14. Page 8)

The aforementioned midfacial changes and related ptosis produce a deepening of the nasolabial folds. Maxillary skeletal regression and loss of dental vertical dimension are also contributors. The dermal muscle insertions of the levator labii superioris, zygomatic major/minor, and the risorius cross the superficial muscular aponeurotic system (SMAS) to form the nasolabial fold. The nasolabial fold is also formed by the muscular SMAS (modiolus) and the nonmuscular SMAS (subcutaneous tissue and fat). A muscular and tonic modiolus and SMAS supports the nasolabial fold in place, which prevents forward protrusion contributing to a deep (concave) nasolabial fold. The loss of muscle tone of the modiolus and SMAS with the resultant ptosis contribute to the deepening of



Fig. 3.19. Patients feel very confident when they see a modern, safe, and well-equipped facility. Giving them a personal tour allows the surgeon to show their commitment to excellence. One of the operating suites (A) and postanesthetic suites (B). That day we send a follow-up personal note card thanking the patient for coming to the office and invite them to contact us with further questions. If we do not hear back from the patient in 6 to 8 weeks, a “tickle” letter goes out reminding them we are at their service for questions or concerns, and the staff member who sat in the evaluation calls the patient to see if there are any questions that she may answer. (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 2.14. Page 22)



Fig. 3.20. A final preoperative appointment to review all consents, financial matters, and surgery-related questions is imperative for maximum communication.

Day of Surgery

The patient arrives at the office NPO and changes into a hospital gown. It is very important to give these patients a warm robe and to keep them out of the hustle and bustle of the office. Nervous patients in skimpy gowns in cold rooms with a lot of activity is not the environment you want. Remember we do this every day and can be immune to the comfort and privacy required.

In our practice, the anesthesiologist meets with the patient that morning before surgery. If there are any significant medical or anesthetic concerns, a meeting would have been scheduled several weeks before, but for routine cases on healthy patients,



Fig. 3.21. Preoperative photographs are taken at the presurgical meeting with and without makeup. (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 2.15. Page 24)

the anesthesia evaluation is performed the morning of the surgery. I also meet with the patient and caregiver to make sure there are no last-minute questions or concerns. I always maintain an upbeat bubbly attitude and tell the patient I am very excited to be their surgeon and everything will be fine. I then mark the patient with a surgical marker for the specific procedures.



Fig. 6.7. This example of poor incision planning shows not only an unnatural preauricular incision scar but also poor posterior incision planning and tensioned suture lines.



Fig. 6.9. This image illustrates pretragal bearded skin that can become part of the new tragus if improperly planned. This patient would benefit from a pretragal incision.



Fig. 6.8. Simple means of correctly marking the helical attachment incision is to move the superior portion of the ear forward to create a crease (A) or to simply place downward pressure on the marking pen which will allow the marker to sink into the skin to the correct junction (B). (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 3.32. Page 53)

natural junction of these arcs, an extremely aesthetic incision is produced and has become my preferred approach on both genders. There are few straight lines on the head and neck, and a straight line pretragal incision is not preferable in my opinion (see Fig. 6.13). Gentle curves in the correct junction of ear and cheek skin is the key to acceptable incision scars in both males and females.

A distinct tragus is essential for a natural appearing facelift and a blunted tragus accentuates the external auditory canal (Fig. 6.17). A retrotragal incision is preferable as long as the surgeon has

mastered tragal flap contouring and reconstruction of the natural appearing tragus. If a surgeon cannot craft a natural tragus or repeatedly experiences tragal blunting, they are better off performing a preauricular incision. As stated, when a pretragal incision is used, it should never be a straight line, but rather consist of three distinct crescents: one crescent around the helical attachment, one around the tragus, and one at the lobe border. These crescents serve to break up the scar.

After the tragal portion, the incision continues inferiorly traversing the incisura to the lobe. Some surgeons make a right-angle

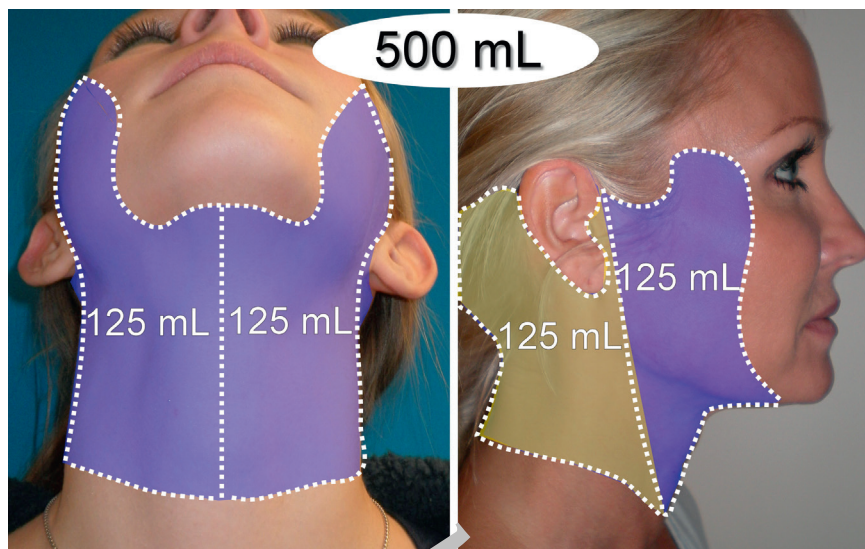


Fig. 6.36. These images show the distribution of a total of 500 mL of tumescent solution for facelift surgery. Basically, the right and left preauricular and postauricular regions are infiltrated with 125 mL. The same amount is infused in the anterior cervical region. (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 3.54. Page 61)



Fig. 6.37. This image shows tumescent solution injection using an 18-gauge 3.5-inch spinal needle (A, B, C). Blunt cannulas are also available.

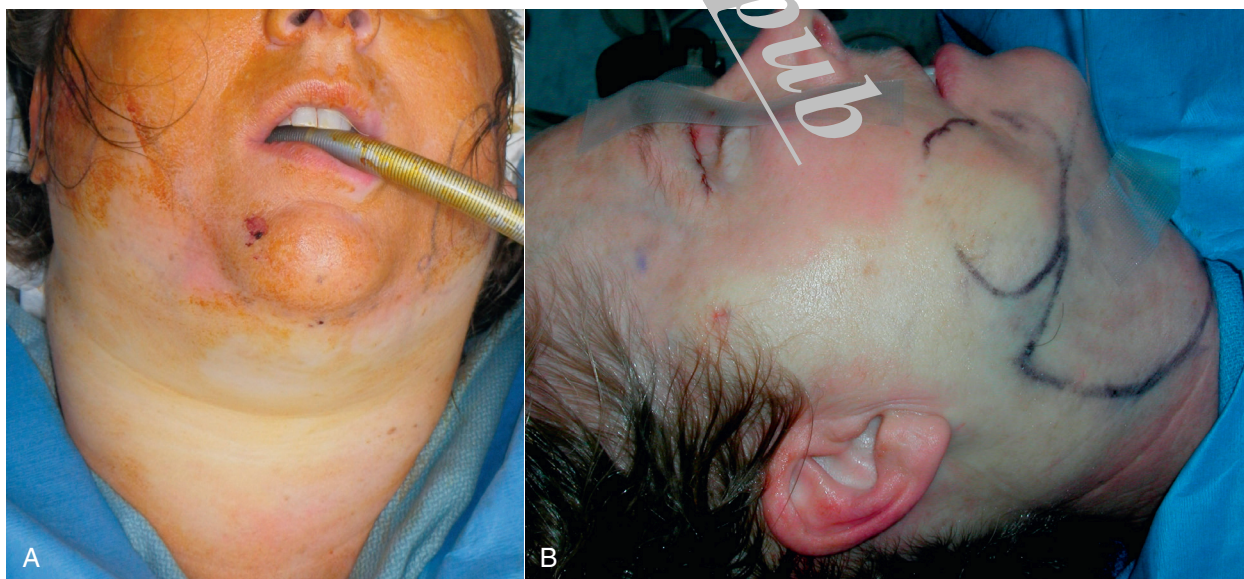


Fig. 6.38. These images show sedated patients 15 minutes after injection of tumescent anesthesia (A, B). The skin blanching signals the hemostatic and local anesthetic effects and the patient is ready for surgery.

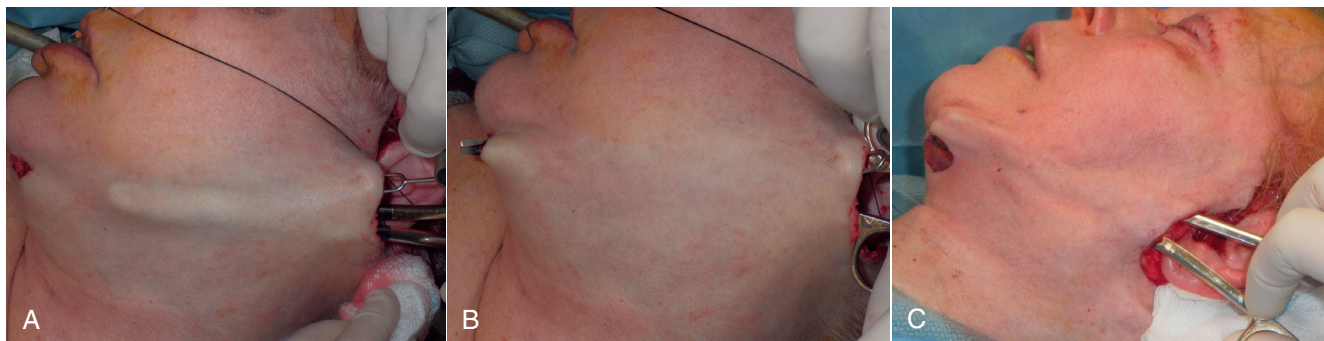


Fig. 6.95. The posterior flap dissection is carried inferior and medially to communicate with the anterior dissection pocket (A, B). The right image (C) show the approximate position of the mandibular ligaments which must be disrupted to have a passive dissection in the region.



Fig. 6.96. This graphic illustrates the extent of dissection of all flaps. This graphic is more consistent with a large facelift and the smaller lifts would have slightly smaller dissection extension. (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 3.98. Page 79)



Fig. 6.97. These patients are shown after the platysmaplasty and right and left preauricular and postauricular dissection where all the subcutaneous tissues are freed simultaneously when performing the balanced technique where all dissection is completed at once (A, B).



Fig. 8.2. This patient insisted on a short scar facelift and because of the limited postauricular incision, sustained significant skin bunching. The bunching took almost one year to resolve and the bottom images show the patient 12 months later. Surgeons are to be careful about being talked into a deeper procedure than the patient actually need. (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 3.200. Page 123)

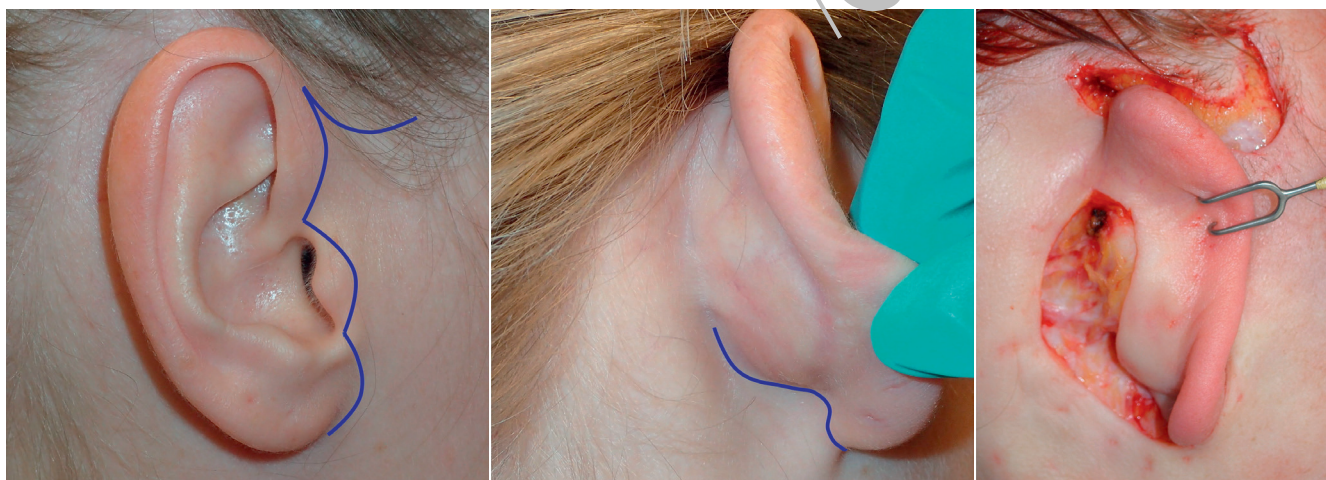


Fig. 8.3. This image shows the incision markings and actual incision in a short scar type facelift.

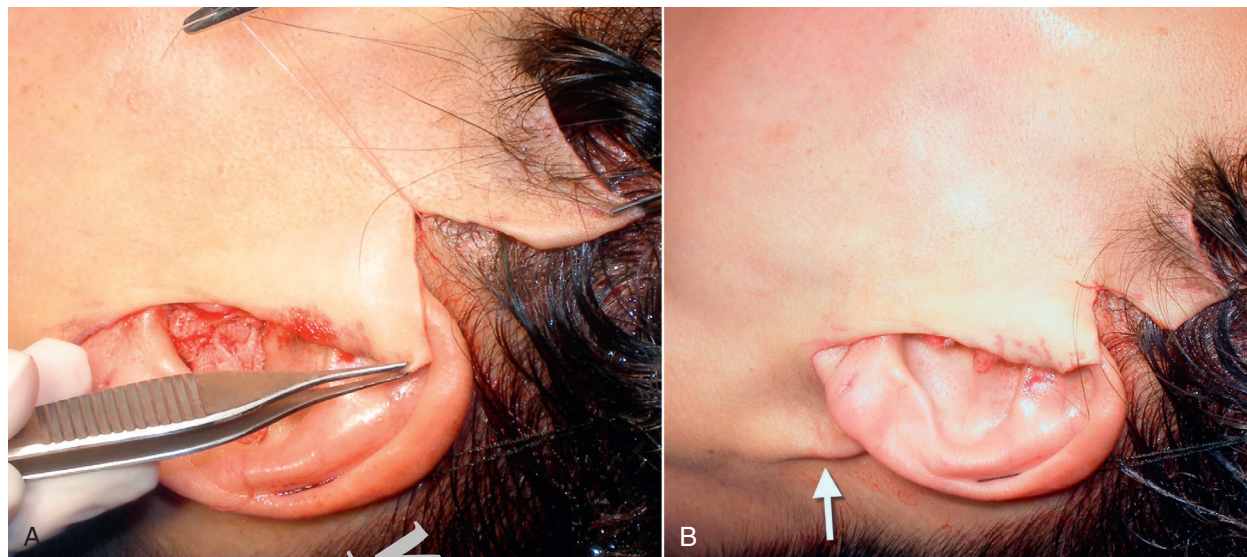


Fig. 8.11. The left image (A) shows a skin cutback in a short scar facelift and the right image (B) shows the flap suspended. Note the typical posterior auricular skin bunching seen with these procedures (white arrow). (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 3.209. Page 126)



Fig. 8.12. The left image (A) shows the outline of the excess skin to be trimmed, the center image (B) shows the preauricular skin being excised, and the right image (C) shows the temporal skin excision. (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 3.210. Page 126)

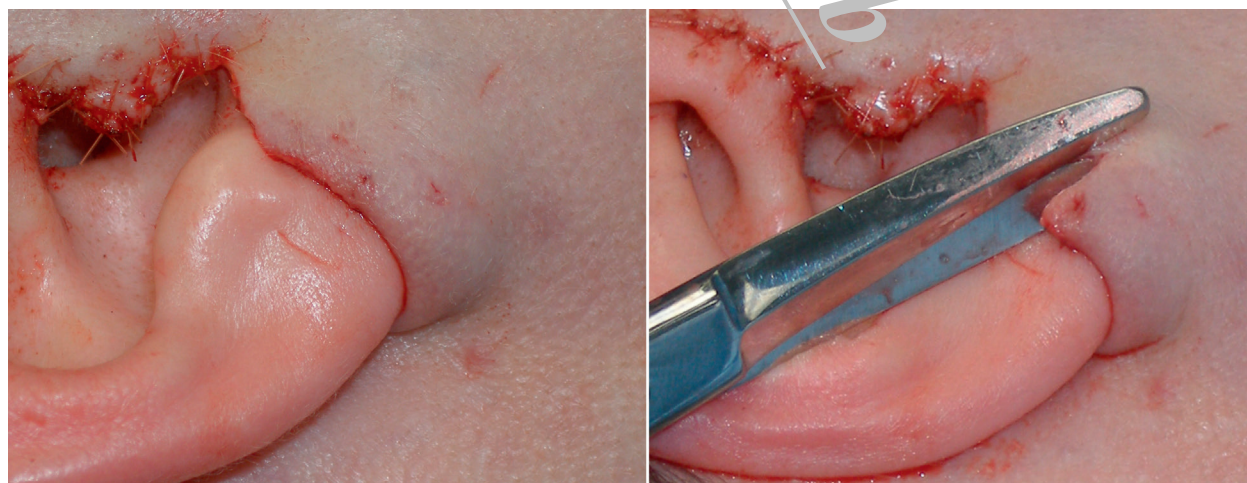


Fig. 8.13. The lobe is delivered with a very conservative cut back. In many cases, no cutback is required and the lobe can simply be pulled out. (From Niamtu, J. *Cosmetic Facial Surgery*, 2nd ed. (2018). Philadelphia, PA: Elsevier. Fig. 3.211. Page 127)