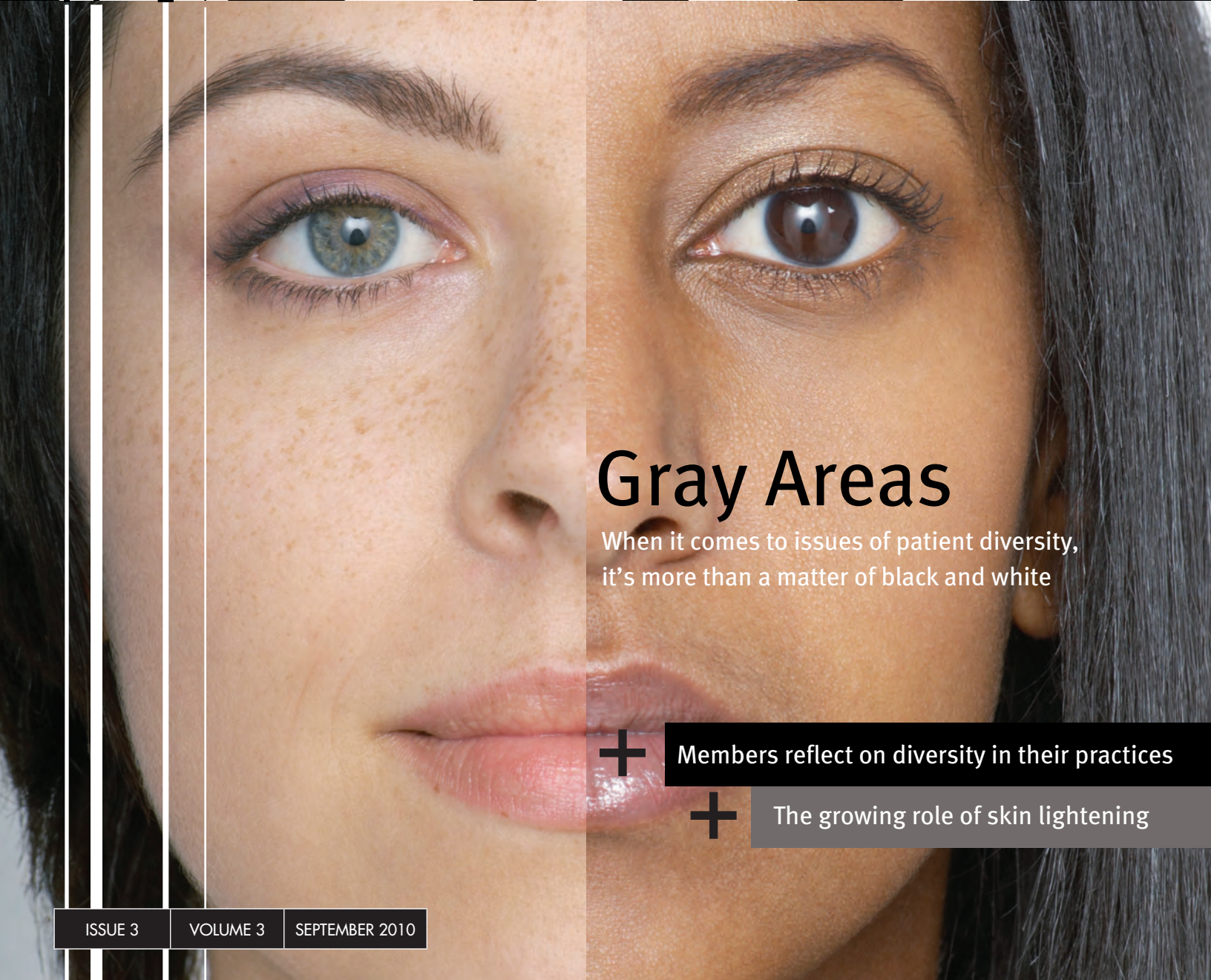


SURGERY



Gray Areas

When it comes to issues of patient diversity, it's more than a matter of black and white



Members reflect on diversity in their practices



The growing role of skin lightening



Procedural discussion...

Joseph Niamtu III, DMD

Facelift surgery: one size does not fit all

Facelift surgery (rhytidectomy) is probably one of the most misunderstood cosmetic surgery procedures by both patients and sometimes surgeons. This procedure has been described in some form for almost a century, and “new” techniques have come, gone and come again during this period. Like most contemporary techniques, the media- and headline- grabbing doctors have tried to profess minor procedures with major results. Like alchemy, you can’t make gold out of water!

Ask a typical patient “what is a facelift?” and you are not likely to get the same answer twice. Many patients think a facelift includes brow, eyes, cheeks, etc. Others think it is a procedure that can be done with threads of filler. Some patients think the recovery is 6 weeks and the procedure costs \$20K, while others think they won’t miss any work and expect to pay a few thousand dollars. Astute surgeons must take the time to educate the patient on exactly what a facelift is, what exactly it will do and not do, and what are the differences in options for recovery, safety, longevity and budget. It sounds simple, but can actually be complex. One big part about having patients is making them understand what to expect. Cosmetic surgery is not a place for surprises.

I personally perform an average of 2 facelifts a week, and it is one of my favorite procedures. I also think that rhytidectomy is the ultimate rejuvenation because it is one of the few cosmetic procedures where the result is always exposed; changing the face garners more emotion and reaction than virtually any other body part.

DIAGNOSIS

It never ceases to amaze me that patients come to a consult and grab their submental skin and shake it and want it gone, but look in disbelief when I tell them they need a facelift. “A full facelift?” is a frequent response, which again underlines the need for serious patient education. “What is a full facelift anyway?”

I explain to patients that facelifts come in three sizes: small, medium and large. In my experience, the small facelifts are OK up to the early fourth decade, the medium lifts are the choice for patients from 45 to 60, and the large lifts are for older patients. Having said this, there are exceptions for each situations such as age, skin quality, fat and skin excess. These can be extremely variable. No two facelifts are the same.

A happy patient is an educated patient, and we spend significant time discussing the incisions, recovery, complications and the patients’ responsibilities concerning healing. In addition to my normal consents, I have a consent detailing “what your facelift won’t do”. This was necessitated early in my career when a facelift patient returned and complained that her brows and ears were not improved. I also have a special consent for smokers and for those patients that reject my recommendation and opt for a more conservative procedure.

WHAT PROCEDURE SHOULD I DO?

It is perfectly normal for all patients and surgeons to want to do or have the most conservative procedure possible. That is common sense and human nature. The problem is that there is a lot of hype flying around concerning minimally invasive facelifts. I want to say, up front, that I am not a huge fan of “corporate” facelifts. I agree that, in facelift surgery, there is a time and place for all procedures, and I agree that a given percentage of the population will benefit from short-scar procedures. Having said that (and this is solely the author’s opinion), I feel that the average facelift patient is not a candidate for these minimally invasive procedures. So there, I said it! I am sure some readers are cringing as they diametrically oppose this opinion.

The pretense of a short-scar procedure is to perform a facelift without a posterior incision. This is more conservative, saves time and money, and has a shorter recovery. It is not, however, magic. The reason that facelifts evolved with posterior incisions was that posterior release and vector is needed to address the lower face and submentum. Most short-scar procedures can adequately address mild to moderate jowling, but fall far short of the “heft” needed to address lower-facial aging. One of my quandaries is: “why do some surgeons go so far out of their way to avoid several inches of posterior incision?”

There are numerous answers to this question. One answer is because it is more conservative, and that makes sense. Another answer is because the patient has minimal aging and only needs a conservative procedure; another appropriate response. Other reasons include the fact that these lifts are easier and appeal to beginners and the fact that they can be performed with local anesthesia. Many practitioners do not have the training or ability

to utilize IV anesthesia, so this may be the only type of lift they can offer. None of these reasons make any difference if the procedure is appropriate for the amount of aging. If the patient has more aging than the short-scar will address, then it is not the correct procedure. Learning short-scar rhytidectomy is a great adjunct for the novice surgeon, but trying to apply it to the average facelift patient will generally produce compromised results. Facelift surgery is not one-size-fits-all.

What really bothers me about promotional, corporate facelifts is the fact that they are advertised as “revolutionary and new”, neither of which is true. Too often, patients needing larger lifts are lured to this hype. In my observation, they get a short-scar lift without platysmaplasty. This is fine for younger patients, but falls short for those with more aging. I, as well as many colleagues, frequently see patients that are unhappy after being promised big results with a small lift.

PROCEDURE

The short-scar or “weekend” facelift can be performed with local and tumescent anesthesia, but I prefer IV sedation. Patient selections include those with mild to moderate jowling and mild neck and submental laxity. I frequently perform a simultaneous chin implant (if needed) to enhance the profile. I explain to these patients exactly what this lift will and won’t do and underline the fact that they will experience temporary (and sometimes permanent) bunching behind the ear.

The incision is similar to traditional facelift in the temporal and preauricular area, but is much shorter posteriorly usually ending in the mastoid region (Figure 1).



Figure 1. The short-scar facelift is basically the same as the anterior component of traditional rhytidectomy but stops in the mastoid region.

Approximately 40 cc’s of tumescent solution is injected in the preauricular region and about 40cc’s is injected inferiorly to several centimeters below the angle of the mandible and over the mastoid region (Figure 2).

Patients with fat submental or jowl fat deposits may be addressed with liposuction during the procedure.

Using a #15 blade, the incision begins in the temporal tuft region, where it is beveled in a trichopytic manner to promote hair regrowth

through the incision scar. I prefer to keep the incision within the temporal tuft and not anterior to it.

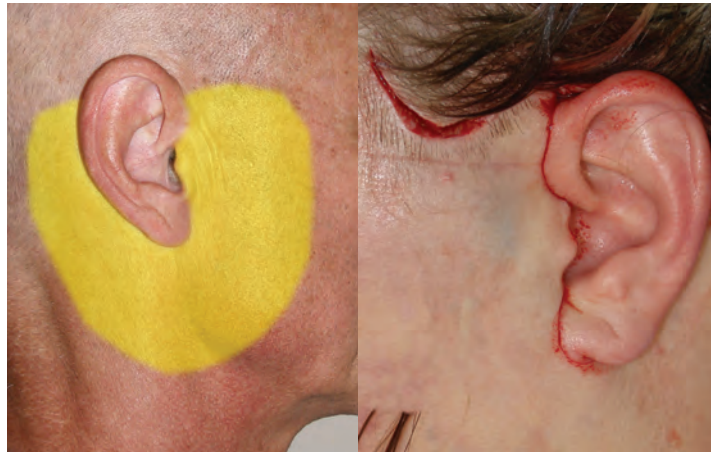


Figure 2. Tumescent anesthesia is infiltrated in the subcutaneous tissues over the areas of proposed dissection.

Figure 3. The short-scar incision is shown.

The incision then follows the helical attachment, where it is important to keep the incision at the junction of the cheek and ear skin for optimum scar production. Failing to do so can make a noticeable scar if made anterior or posterior from this juncture, as the color and texture of these skin regions are different. On females, I always use a retrotragal incision, whereas on men a pretragal incision can be used to prevent hair-bearing skin on the tragus – it can be difficult to shave. Figure 3 shows the preauricular incision.

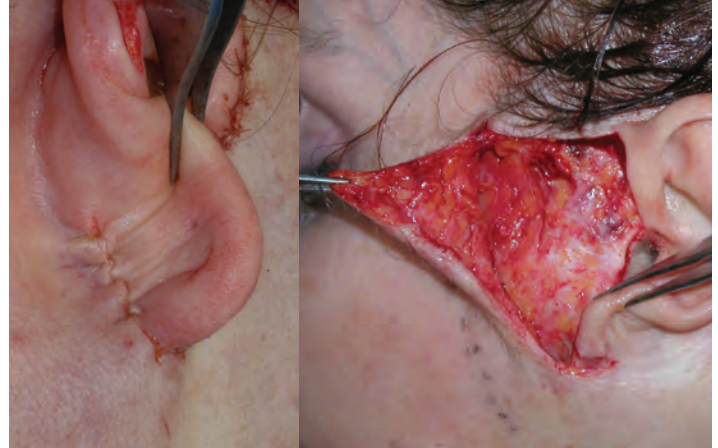


Figure 4. The posterior incision is shown (sutured)– it generally stops in the mastoid region but can extend more superiorly.

Figure 5. A conservative lipocutaneous flap is shown. The extent of this flap dissection is commensurate to the amount of aging.

The incision extends around the earlobe and proceeds several centimeters superiorly in the post auricular crease (Figure 4).

At this point, subcutaneous dissection proceeds in a manner to create a lipocutaneous flap with fat on the dermal and the SMAS side. These smaller lifts generally entail a 3-5 cm dissection anterior and inferior to the ear (Figure 5.)

The SMAS is addressed in numerous ways. Many surgeons prefer purse-string sutures with smaller and larger lifts, but when performing short-scar lifts, I personally address the SMAS the same

way I do in larger lifts with SMAS plication or SMASectomy. Although both are effective, most of the short-scar lifts are done for faster recovery, and I believe that SMAS plication, being less disruptive, enables a somewhat faster recovery (Figure 6).



Figure 6. This image shows typical SMAS plication sutures positioned to address multiple vectors including posterior platysma suspension.

After the SMAS is addressed, skin cut backs are made and key sutures are placed at the temporal and mastoid region; the excess skin is trimmed (Figure 7). Some authors advocate a more vertical skin pull with short-scar techniques, but I favor a more traditional, superior/lateral vector. One of the keys to this step is to properly manage the bunched tissue in the mastoid region. Some



Figure 7. This image shows the excess skin with a cut back in the temporal region and 4-0 Vicryl key suture in place.

authors advocate a horizontal mastoid incision, which is effective but leaves a visible scar – this is unacceptable. The bunched skin can be managed by manipulating the flap in the most effective vector, making very small, releasing incisions that will be hidden by the pinna. Using skin hooks to manipulate the bunched tissue is also effective. Most cases will also involve some post-auricular skin excision (Figure 8).

HEALING

When performed as a sole procedure, healing is generally uneventful, and many patients can return to work in less than a week. Obviously, this is never promised as swelling, bruising and healing, in general, are variable from patient to patient. Women who can cover their incisions with hairstyles can return to work earlier.

Out of 80 facelift surgeries that I performed last year, only 4 were short-scar lifts. I believe this reflects my opinion that these lifts are best for younger patients with minimal- to very- moderate aging, and that the average facelift patient better benefits from traditional lifts with anterior and posterior incisions. Figures 9 and 10 show short-scar facelift results.



Figure 8. Skin excision and close attention to the distribution of post-auricular skin bunching is used to aesthetically deal with this region and is a drawback of short-scar technique.

Figure 9. This patient underwent short-scar, "Weekend" facelift and full-face-CO₂ laser resurfacing and is shown before and 8 weeks after the procedure.

Figure 10. This patient underwent short-scar facelift with simultaneous chin implant.

This article will be continued in the next issue of *SURGE* to discuss traditional facelift options. ■

by Peter Lisborg, MD



Peter Lisborg, MD

Klagenfurt, Austria

This is the beginning of a new feature in *SURGE*: an International member column. In what follows below, Peter Lisborg, MD writes about the state of cosmetic surgery in Austria, the strides that have been made, and the challenges that lay ahead.



Cosmetic Surgery in Austria

Although Austria has a great history in art and culture in general, cosmetic surgery is still in its adolescence. As in many other areas, the trends seem to hit Europe about a decade after developing in the USA.

The demand for aesthetic improvement and the performance of cosmetic procedures was initially limited to the upper echelon. Electronic mass media, improving safety, and lower prices have led to a true boom in the USA. Europe is slowly following. The problems and challenges involved with cosmetic surgery are really identical across the Atlantic; they are just happening in Europe a few years later.

The AACS recently surpassed the member toll of 2,500. Comparatively, the number of 52 members in the Austrian Academy seems quite modest.

However, when one considers the population of the two countries, Austria is well-represented. The Austrian Academy of Cosmetic Surgery was established 11 years ago, 1999, by seven doctors.

The initial purpose was to share knowledge and exchange expertise concerning the expensive new laser systems we had purchased. We were five dermatologists and two general surgeons. The numbers soon grew as did the mutual interest in other areas of cosmetic surgery. As many of us were International members of the AACS, we readily recognized that the aims of our societies were truly international; basically we all have the same problems.

We initiated a number of American-style workshops for educational purposes, inviting some of the most renowned cosmetic surgeons to Austria. Bob Jackson, Jane Petro and David Palaia were faculty in our first breast workshop in 2004. Tony Mangubat and Angelo Cuzalina followed at Body Contouring and Breast Workshops. Ed Lack was symbolic president at our 8th Annual Meeting in Vienna, 2007. Just a few weeks ago, Patrick McMenamin and Joe Niamtu helped out at our first cosmetic face surgery workshop. For a small society, the Austrian Academy has been quite active and has had outstanding support from leading individuals of the AACS.

Although the trends in cosmetic surgery appear to be the same, the regulation of medical products is certainly something that differs greatly. The FDA is well known for its strict criteria and is often criticized for being too slow. In Europe, we have the CE approval which is comparatively easily attained. One example: in the USA, you have four or five hyaluronic acids with FDA approval – in Europe



we have over 100 with CE approval! Titanium-coated breast implants were also on the market in Europe with CE approval. Following the first batch of serious complications, they were removed. If we had the choice, we would certainly take the FDA despite any pitfalls.

The need to initiate a multidisciplinary organization to promote safety and education in cosmetic surgery was also recognized a lot earlier in the USA. The 26th Annual Scientific Meeting of the American Academy of Cosmetic Surgery (AACS) was just celebrated in Orlando. The Austrian Academy is to celebrate its 11th meeting. The establishment of training programs and guidelines has already been accomplished in the USA with fellowship programs and board examinations. In this respect, the rest of the world is still in its baby shoes.

In the last decade, the European Academy of Cosmetic Surgery (EACS) was established in an attempt to fill the international void regarding multidisciplinary societies. The EACS, with solid support from the AACS, looked very promising at the beginning. Unfortunately, there were too many diverging interests and a lack of solid statutes so that the EACS eventually went under. This motivated the Austrian Academy to adopt the statutes of the successful AACS, hoping to avoid a similar development.

Until today, the Austrian Academy has slowly, but surely, prospered. Nevertheless, such small societies struggle. In small countries, the need for guidelines and training programs is just as important but practically impossible to implement. The AACS would welcome international members to fellowship training and board examinations but that is legally impossible as doctors need licences.

So we are left with an unsatisfying situation – outside the USA, there is no regulated training program and no chance of board certification.

Without neglecting the development of the Austrian Academy, we must recognize the true need for a functioning, international, multidisciplinary cosmetic surgery society. The initiation of such a society was proposed at the 26th Annual AACS Meeting in Orlando during the International Roundtable. The success of such a society will essentially depend on its structure and statutes. It has therefore been suggested to adopt the statutes of the AACS one to one.


The founding meeting of the WACS has been planned in Split, Croatia, this September 8-12 (waocs.org).

Cosmetic surgery is prospering in Austria. The economic crisis hasn't hit the Austrian market as severely as elsewhere. More and more doctors get frustrated with the lack of possibilities in a social medicine system and turn to cosmetic medicine as an escape. This, of course, poses a great challenge as there are no official training programs. Taking on this challenge to offer structured training, board examination, and ultimately to improve patient safety, is a common goal. ■

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