Facelift surgery is the most comprehensive cosmetic facial procedure, and the most impressive and emotional cosmetic surgery anywhere on the body. Mediocre breast, belly, and buttock surgery can be easily camouflaged by clothing, but the face is always exposed. From an emotional standpoint, any cosmetic surgery procedure can improve self-confidence and provide a more youthful appearance, but it is the face that is seen and focused on in primary visual encounters. Giving an older person a younger face is an impactful experience.

The public is diverse on thoughts of surgical enhancement. Some people believe they have earned their wrinkles, whereas others disdain anything unnatural. Having said that, the average person with excess neck skin and jowls would jump at the chance to reverse them if they knew the outcome was natural and affordable.

This brings up the first tenant of cosmetic surgery diagnosis: “why is someone having cosmetic surgery?” Although this sounds trite and obvious, the answer to this question can have a lot to do with the success or failure of the biopsychosocial part of cosmetic surgery. My practice is limited to cosmetic facial surgery, so 100% of the patients that come to see me are doing so because they perceive defects in their appearance. Most of these patients have obvious defects that are normal signs of aging, such as excess eyelid tissue, facial wrinkles, jowls, and extra neck skin. We are all going to get it, so in that sense, there is no escape. The difference is how these aging changes play into the everyday life of patients. The key word to discern from the first several minutes of a facelift consult is “normal.” Is this patient’s assessment and motivation for having surgery normal? A normal scenario is a 46-year-old woman who presents for consultation and says, “Dr Joe, I exercise daily, I watch what I eat, I live a healthy lifestyle, but when I look in the mirror, these darn eyelid bags, make me look and feel older than I am.” An abnormal scenario is a 33-year-old man who presents with the chief complaint of a minor dorsal hump and states that he cannot maintain a female relationship because of his deformity. He may have lost jobs or done poorly in personal relationships because of his perceived horrendous nasal deformity. He may think that people avoid him socially or stop at traffic lights and make fun of him; that complete strangers continually stare at his deformed nose, or chin, or hair line, or mole or anything else that signals body dysmorphic disorder. If you have never personally experienced this condition, it difficult to sit and listen to someone who for all intent and purpose looks totally normal describe this litany of negative social encounters. Body dysmorphic disorder is a real condition, and if the surgeon is not astute enough to realize this disorder, these patients can become very negative, frequently litigious, and sometimes physically, even deadly violent.

**Good surgeons know how and when to say “NO”**

Everyone that performs facelift surgery has invested innumerable hours of education and hundreds of thousands of dollars to get to the point where they can offer these procedures. As any young, just into practice surgeon will attest to, it is hard to say no to a patient that has an aging face and a checkbook. We have strived to get to the point where we can perform competent surgery and here sits a patient with facial aging and $15,000. “How or why would I tell them no?” “They will just go to the guy down the street!” “I love surgery and could use the income.” These are all natural responses, but operating on unstable patients can be one of the worst experiences of a surgeon’s professional life. You may gladly pay twice the surgical fee to make them go away; they can and will make your life miserable. Always remember Niamtu’s first law of surgery: If things do not seem right, do not accept that patient. This is frequently litigious and sometimes physically, even deadly violent.

I occasionally encounter a totally normal patient that turns out to be a management nightmare, and conversely start out with a patient that has some warning signs but their surgical
experience is an actual delight. You cannot win every time and we all get fooled once in a while. Some good "red flags" on patient behavior that may cause the surgeon to reevaluate taking the case include the following:

- Patients with known body dysmorphic disorder or psychiatric condition
- Any overly narcissistic or immature patient
- Unfriendly or impersonal patients
- Patients that do not smile or make eye contact
- Patients that are too busy or too important for surgery
- Patients that speak negatively about previous surgeons but are complimentary to you
- Patients that will not listen and just talk
- Patients that are having surgery for the wrong reason, such as a failing marriage, promotion, or in the midst of a loss
- Patients that cannot decide on a surgical plan or say "do what you think I need"
- Patients that are overly impulsive and want to book surgery at first evaluation appointment
- Patients with unrealistic expectations
- Patients that "know" more about a procedure than the surgeon
- Patients that tell the surgeon what procedure to do and in extreme detail
- Patients obsessed with online cosmetic surgery bulletin boards or cosmetic surgery sites
- Young patients that have already had numerous surgeries or request surgeries generally performed on older patients
- Patients overreacting to a small flaw
- Patients that complain about financial arrangements or are pushy about discounts or are otherwise "shoppers"
- Patients that insist on absolutely no photographic documentation or are resistant to give important information, such as cell phone numbers, and insist on "secrecy"
- Patients desiring surgery with intense familial disapproval
- Patients that you or your staff does not like (rude or pushy)
- Patients that have someone else speak or call for them
- Celebrities or patients that think they are celebrities

Although some surgeons ask these patients to first see a psychiatrist, I never do that. It is embarrassing and many patients are resentful. If I have a patient that I believe will be a management problem (and perhaps a future legal problem), I simply tell them "Mrs Jones, I have analyzed your entire case and I simply don’t think I can make you happy or meet your expectations. I think you are a fine person, but feel you would be better served by another surgeon."

The art of the consultation

The physical consultation

A cosmetic surgery consultation is not that much different than any other type of consultation and should be a two-way forum for information. In our office, the patient is first seated by our cosmetic coordinator, who makes sure all the paper work is in order and begins a brief interview of what the patient is interested in discussing. We have widescreen monitors in each operatory and we can bring up the Web site to enhance the discussion (Fig. 1).

After 10 to 15 minutes with the staff I enter the room. I always shake hands or otherwise touch the patient because I think it creates a bond (Fig. 2). I introduce myself as "Joe" and sit down eye level with the patient. I always ask some question that has nothing to do with surgery. Usually what they do or where they work and engage in some informal conversation. I think this is important on multiple levels. First of all, many doctors are so formal that they seem robotic to patients. By engaging the patient, you show a more personal level and it relaxes them. Unlike the typical oral and maxillofacial surgery consultation, cosmetic surgery patients are frequently nervous. Think about it; someone is looking you in the eye and discussing their physical shortcomings and it can be stressful for them. Often these patients are sweating when I examine them, so anything that can relax them is useful.

Next, I hand the patient a mirror and ask them what bothers them. In the case where the patient asks me "what do you think I need," I let them know in no uncertain circumstances that I will not do that, I need their input and they must take responsibility in their diagnosis (Fig. 3).
This article discusses lower facial diagnosis, but in reality all consultations must be comprehensive. Talking about numerous procedures on numerous areas of the face can be confusing so I like to break it down to upper face, middle face, lower face and neck, and skin. This four-unit discussion can be easily comprehended by the patient.

The biggest task in the upper face is to get the patient to realize the importance of a brow lift if they are a candidate. Otherwise, upper lid blepharoplasty is discussed. Midfacial diagnosis includes rhinoplasty, cheek implants (or other midfacial cosmetic enhancement), and upper lip. Some facelift patients look tighter after surgery but not younger. Contemporary cosmetic surgeons appreciate that adding volume in the form of midface augmentation through injectables or implants results in far greater rejuvenation than rhytidectomy alone.

Lower facial diagnosis includes lower lip and perioral region, chin position, and most importantly jowls and neck skin. The remainder of this article focuses on lower facial diagnosis and treatment.

What exactly is a facelift?

Simple as it sounds, most patients have no idea what constitutes a facelift. For some people it is a "midfacelift" that is done inside the mouth and elevates the cheeks; for others it is the surgical procedure with incisions in front of and behind the ears that tightens the lower face; and for still others, it is a browlift, lids, and lower facial tightening. To add to the confusion there is now the "S lift," the "quick lift," the "lifestyle lift," and the "vampire lift." For the purpose of this text...
(and what I believe to be accurate) a facelift is a procedure called a "rhytidectomy," where the lower face, jowls, and excess neck skin are tightened by making a submental incision and incisions in front of and behind the ears. The deeper layers of the superficial musculoaponeurotic system (SMAS) are in some way tightened and the excess skin is removed from in front of and behind the ears. To my mind, this is a facelift. When a patient talks about a "full" facelift, they probably mean a classical rhytidectomy with other procedures, such as a brow lift, eyelid surgery, and so forth. Because not every surgeon performs a submentoplasty or platysmaplasty with a facelift, that part of the definition also may vary.

New minimally invasive procedures have arisen where "less is supposedly more" and it is in vogue with some surgeons to perform "short scar" facelifts with minimal incisions. These frequently have some catchy corporate name and are heavily marketed. Unfortunately for the patient, they are much less than a true facelift and in my experience provide less result and longevity compared with traditional rhytidectomy. Any time someone names a facelift or procedure, I am automatically suspicious. These lifts have become fashionable for numerous reasons, such as extreme marketing, that they are small lifts and easy to perform, and that they can be performed without anesthesia or much surgical experience. I predict they will be a fad and this is underlined by my personal experience where I have seen many unhappy patients that paid a lot of money for a "corporate" lift when they should have had a traditional lift to comprehensively address their aging concerns (Fig. 4). These small lifts are fine for a very young patient with minimal aging, but are not effective for the average patient in their early fourth decade. What further bothers me is that these lifts are advertised as "medical breakthrough" and "revolutionary." I have chapters from textbooks from the 1920s that show the exact same type of procedure, so it is far from new. It is important to be able to advise patients on these various types of "facelifts" so they know the real deal from the "less than a facelift" procedure. Some of these "facelifts" are not even lifting surgical procedures, but only filler injection with unfair and deceptive marketing. Unfortunately, anyone can call any procedure a facelift, so it is important for the surgeon and patient to compare apples with apples.

At this point in my practice I perform about 90 facelifts per year, which averages two to three per week. Because this is one of my most frequent surgeries it obviously occupies a large percentage of my consultations. Real surgical facelifts come in three sizes; small, medium, and large. The smaller lifts are the short scar type and are only suited for young patients. They are only effective for minor jowling and minor neck skin excess and I never perform platysmaplasty with the short scar lifts. Out of 81 lifts last year, only one was a short scar lift, which explains my feelings and usage of this lift. My medium lift is also called a "mini lift" and this is a procedure for patients with moderate jowling and moderate neck skin excess. This lift involves a preauricular and postauricular incision with about a 4- to 5-cm dissection all around the lift and more often than not not a platysmaplasty. Finally, my most common lift is the "comprehensive facelift." This is a traditional rhytidectomy with preauricular and postauricular incisions and always includes midline platysmaplasty and usually SMASectomy. The flap dissection is much larger and extends to the lateral canthus and may approach the zygomaticus major region and nasolabial folds. This is the required lift for most patients older than 50. When I am discussing facelift with my patients, it is usually this procedure. Fig. 5 shows typical patient candidates for small, medium, and large facelifts and Fig. 6 shows the incision and dissection limits for a small and larger lift. Figs. 6 and 7 show platysmaplasty and posterior auricular incision, both of which are critical for a real facelift. The required surgical skill, length and complexity of procedure, recovery, and longevity of result increase from small to large lifts. The short scar lift, with its limitations, is an excellent way to learn facelift surgery. If and when I do perform a short scar lift, I always have the patient sign for permission for me to convert to standard lift if I believe that the result would warrant more aggressive surgery (Figs. 8 and 9).

When discussing the type of lift with a patient, one must tailor it for the patient’s health, recovery, budget, and expectations. Most American Society of Anesthesiology 1 and 2 patients can tolerate any type of facelift as long as their health conditions are controlled. Recovery is frequently the determinant of what type of lift to perform. A short scar lift may allow a 6- to 7-day recovery, whereas a minilift is about a 10-day recovery, and the comprehensive lift is at least 2 weeks. When discussing result and longevity, you get what you pay for, not in money, but in recovery. Short scar lifts may have 4- to 5-year longevity, minilifts 5- to 8-year longevity, and

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**Fig. 4** This image shows three patients that presented to my office for "redo facelift" within 2 to 3 years of having a "miracle facelift" by another surgeon. All three of these patients were extremely unhappy with the lack of improvement and lack of longevity of the tightening. I personally believe that none of these patients were even candidates for this type of small lift but were marketed into it. One size lift does not fit all.
comprehensive lifts can last over a decade. Unfortunately, many surgeons sugar coat recovery and longevity. One must keep in mind that patients have to restructure their entire life to recover and usually play it very close because they cannot miss work. If a surgeon attempts to downplay the true amount of recovery time to sell the case, the patient can undergo a lot of scheduling problems trying at the last minute to get more time off of work. This can create a lot of resentment and reputation damage. Always be forthright with a patient’s expectations. Again, this includes what to expect from a lift. Do not recommend a short scar lift and tell the patients that it will look and last like comprehensive lift. The small lifts are really attractive to patients because they cost less and have less recovery. I frequently have a 50 year old or older present with the request of a short scar lift. I have to explain to them that the longer recovery is not such a bad thing, because reversing a half century of aging by sitting out 2 weeks is not unreasonable. There is another reason to avoid small lift on older patients, and that is reputation. I once did a short scar lift on a patient that really needed a larger lift and let the patient talk me into it. Although her result was obviously improved, the result was less than I could have achieved with a more comprehensive lift. Even though the patient signed a special consent stating that her results would be less, she began complaining that she still had some lose skin and her friends believed she had a bad lift. This is what got my attention and made me realize that by compromising my standards, I affected my reputation. Even though the result was typical for a short scar lift, the patient’s friends did not know what type of lift she had, they just knew that Dr Niamtu did her facelift and she still had laxity that was increasing in several years. The moral to this story is to always maintain high standards and do not let manipulative patients influence your treatment plan because it can come back and bite you.

While discussing manipulation, it is also not uncommon for patients to downplay their medical problems. For obvious reasons the OMS must be vigilant in surgical work-up and preoperative evaluation. For the average OMS that performs short surgical procedures on young healthy patients, facelift surgery can be a large jump. It is rare that a patient has just a facelift because most patients include other surgeries, such as blepharoplasty, laser, browlift, and laser skin resurfacing. Now the OMS is faced with an older patient population with some level of medical compromise and a surgery that can last more than 4 hours. These patients can be a game changer for the average oral and maxillofacial surgery practice and much has to be rethought. Although the average dentoalveolar patient does not require any special preoperative work-up, a facelift

**Fig. 5** The patient on the left may be a candidate for a short scar lift, the middle patient for a “mini lift,” and the patient on the right requires a large (comprehensive) facelift.

**Fig. 6** The image on the left shows the typical short scar facelift incision (blue) and the typical extent of skin undermining with such a lift (white dotted line). The figure on the right shows the typical incision pattern (blue) and the typical extent of skin undermining (white) for a larger facelift.
patient may require physician history and physical, blood work, electrocardiogram, chest radiograph, and specialty consultations. The health and welfare of the patient is always the most important thing and these patients must be treated differently. Anesthesia concerns also play a big part in the facelift experience. Most cosmetic surgery is no longer performed in hospitals, but rather in office surgery centers. OMSs are in an excellent position to incorporate these procedures, but the process may involve significant changes.

Facelift surgery can be easily performed under the same intravenous sedation techniques used for dentoalveolar procedures, especially when tumescent anesthesia is used. In my first 5 years of cosmetic surgery, I did this hundreds of times. OMSs have the anesthesia training, the surgical training, and the facility. Although a great start, I do not believe that this is enough. The political climate with competing specialties is such that a cosmetic surgery complication in a "dental" office would be amplified and could be used against the surgeon. This will happen in the best circumstances and is a reason to be better and safer than the competition. I believe the best way to control this is to have the office fully accredited by one of the major health care agencies. For the past 12 years, my office has had full accreditation by the Accreditation Association for Ambulatory Health Care. This is not an easy task, but by oral and maxillofacial surgery standards is easily achievable for the average OMS (Fig. 10). It makes one a better and safer surgeon with a better and safer office and is also a great marketing tool for patient confidence. Words cannot describe how this has enhanced my practice and reputation. Finally, although most OMSs do not use anesthesia support, it is more of a standard of care with cosmetic surgery and having a certified registered nurse anesthetist or physician anesthesiologist for longer cases is an advantage for all involved.

Putting it all together

So, you are sitting in a chair looking a prospective facelift patient. You have made the determination that the patient is in good health, can take 2 weeks off of work, can afford the procedure, and will probably schedule surgery. There is still a lot of work to be done; again, before the patient leaves they must understand what a facelift is and what a facelift does. One way to assist in conveying what to expect from a facelift is to lay the patient back in the chair into a horizontal position and looking into a handheld mirror. By eliminating gravity, the patient can see the effects of browlifting, cheek augmentation, and jowl and neck skin improvement. It is important for the patient to realize that a classic rhytidectomy provides little or no improvement of the central face.

Although some patients get excited and want to schedule surgery at this evaluation appointment, I do not allow it because there are a lot of other variables that must go into this decision process, including discussing with family and procuring a caregiver. The patient is presented with a printed form outlining all the procedures we discussed and the respective fees so they can study this at home. I also ask them to read the entire portion of my Web site that deals with the procedures they are contemplating. I give them my card and staff contact

Fig. 7 Short scar facelifts only use an anterior incision (shown in blue). Traditional facelifts utilize the anterior incision (blue line), a post auricular (solid yellow) posterior hairline incision (dotted yellow). It is the post auricular and hairline incisions that provide the ability to address the neck skin to provide a long lasting and natural lift. Many surgeons go to surprising extents to avoid several inches of incision which is behind the ear which is hidden anyhow. Most patients past the forth decade will be better served with both anterior and posterior incisions.

Fig. 8 Most short scar facelifts omit platysmaplasty. This is also a very integral part of facelift surgery for a natural and long-lasting effect. Omitting platysmaplasty limits the full potential of neck tightening, sculpting, and banding improvement. (A) shows the splayed anterior platysmal bands and (B) shows the bands sutured together after platysmaplasty.
information and tell them to contact us if they have questions. We also let them know whom to call to actually schedule the procedure. The patient is also given a packet of more information about our office and procedures and preoperative forms, in case they decide to return for surgery.

Tying up loose ends

When the patient calls back to schedule, they must pay a $500 nonrefundable deposit to hold the appointment and are also scheduled a final preoperative appointment. The preoperative appointment requires a lot of work on the part of all parties and we also prefer to have the patient’s caregiver present. When they arrive for this appointment, all consent forms are reviewed and preoperative pictures are taken. The nurse explains the procedure to the patient and reviews the consent forms, and then I come into the room and repeat the process to identify any problems. Smokers must sign a special consent reviewing the potential problems related to smoking and facelift. I also have a special form titled “What your facelift won’t do.” This form addresses the fact that facelift surgery is mainly for the lower face and will not improve the upper face without additional procedures. It also discusses that skin wrinkles, perioral wrinkles, and dark spots are not improved with just a facelift. Personal shortcomings, such as obesity, short neck, and obtuse cervicomental angle that may limit the effect of the lift are also discussed in this document. The patient pays the full surgical fee at this appointment and receives all their postoperative instructions. Most of the patients presenting at this appointment have by now had their medical work-up, which is reviewed. All additional diagnosis charting and measurements are made and a note dictated at this appointment.

My staff and I must make the assessment as to whether this patient has the qualified and required caregiver support commensurate with their procedures. We have been duped numerous times where the patient signs a form that they do in fact have a qualified caregiver, only to have them show up for surgery alone in a taxi. We now confirm in advance and personally speak to all caregivers to make sure a responsible adult will be present. Some patients may require private duty nursing, which is arranged at this visit.

Multiple facial surgical procedures can produce a drastic recovery including pain, extreme swelling, concomitant healing issues, and psychological issues. The first week is not a fun time and it is our job to prepare the patient for all these issues including recovery, diet, medication, wound care, and transportation. A lot happens at this final preoperative appointment and its’ importance cannot be overstressed.

Summary

Facelift surgery is unique in many ways and for 100 years has stood the test of time as the most dramatic, effective, predictable, and accepted cosmetic lower facial procedure. From public misconceptions to patient confusion, a lot of information must be exchanged for successful diagnosis, recovery, and result. It requires a qualified surgeon that operates in a safe environment and knows his or her limitations. Any surgeon can make incisions and pull skin, but to truly master this procedure is a commitment. It is hoped that this article covers some of the more esoteric considerations of this awesome operation.

Further readings