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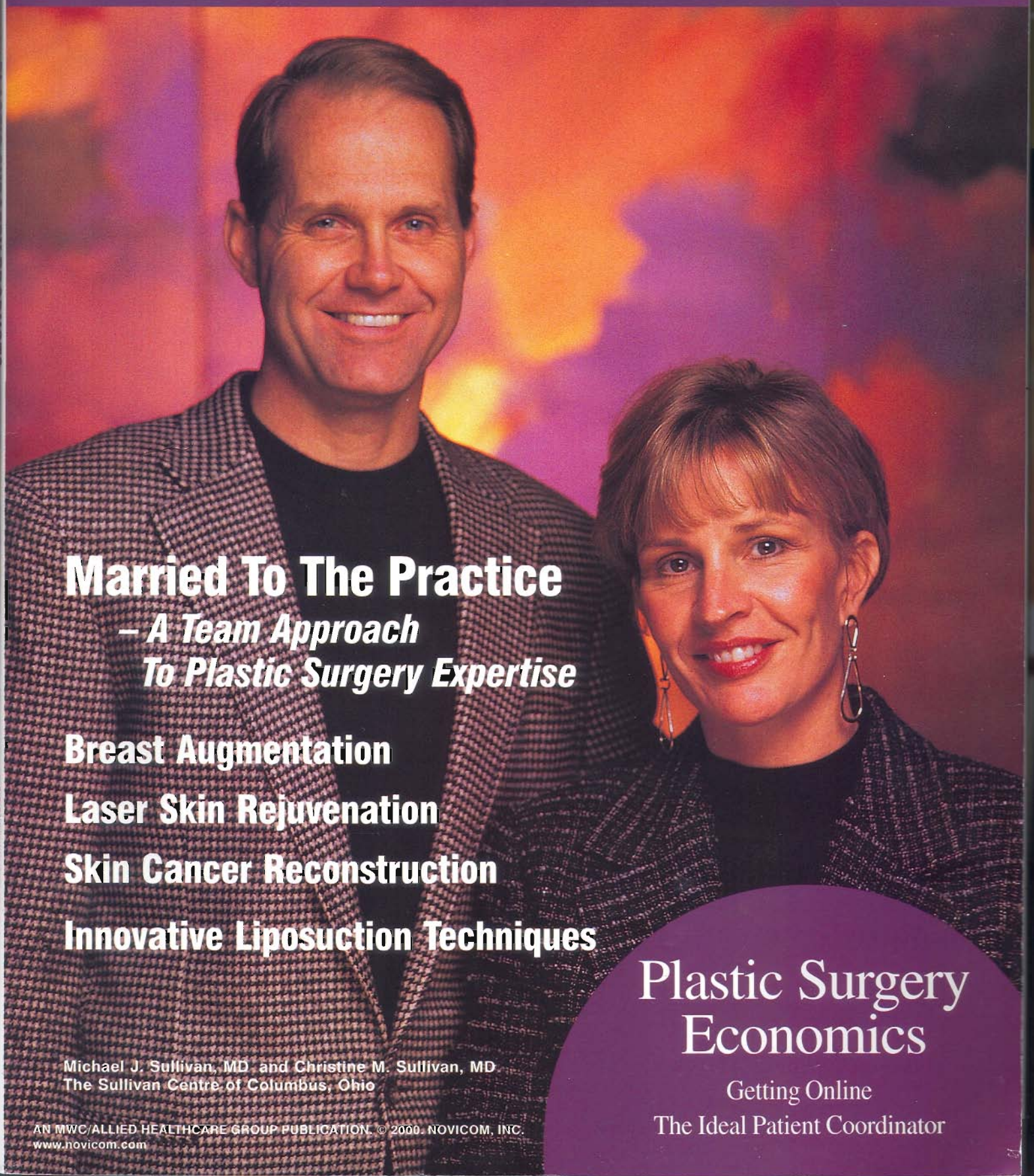

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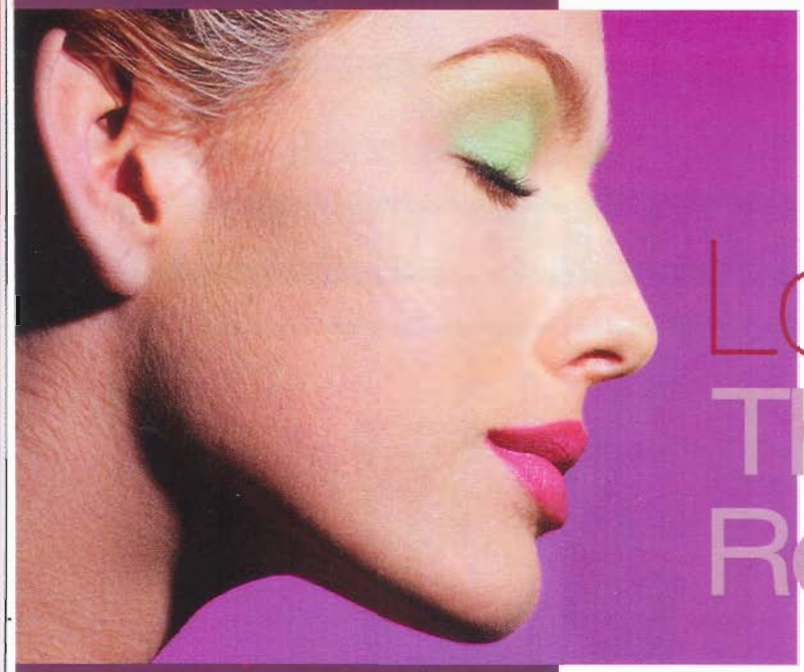

Lower Third Facial Rejuvenation

by Joseph Niamtu III, DDS

Cervicofacial liposuction in concert with other cosmetic procedures can enhance both appearance and self esteem.

Few procedures have impacted cosmetic surgery in the past 20 years as has liposuction. Virtually every person wants it somewhere someday.

Cervicofacial liposuction can make an immense difference in one's appearance and self esteem. Since the areas liposuctioned in the head and neck are much smaller and more vascular than the areas that undergo body lipo, there are fewer complications and lidocaine or epinephrine toxicity is basically a nonissue.

Cervicofacial liposuction is frequently performed as an isolated procedure, but more commonly in concert with a multitude of cosmetic procedures intended to rejuvenate the lower face and neck. Although the mean age of rhytidectomy patients is decreasing, many patients still fear or desire to put off "the big one." Cervicofacial liposuction combined with such procedures as platysmaplasty, genioplasty, suspension techniques, perioral laser resurfacing and lip augmentation can result in drastic improvements and provide selected patients with a "cushion" of time before rhytidectomy.

I frequently combine lower third facial techniques to enhance the hard and soft tissue profile. The procedures are relatively simple, are performed in the office environment and involve minimal recovery time. I do not call this a "weekend neck or face lift" for various reasons. The procedure definitely takes more than a weekend to heal, as most patients require five to 10 days. Baby boomers are looking for "wash-and-wear" surgery and deceptive nomenclature only confuses the already confusing issue.

Patient Evaluation

The ideal patient for lower third facial rejuvenation has a normal hyoid position, a retrognathic profile, minimal neck skin redundancy and jowling and isolated submental liposis. Moderate platysmal dehiscence and minimal neck skin reduncancy are easily addressed.

Poor patients are those with generalized obesity, low hyoid position on lateral cephalogram, prognathic profile and significant neck skin redundancy.

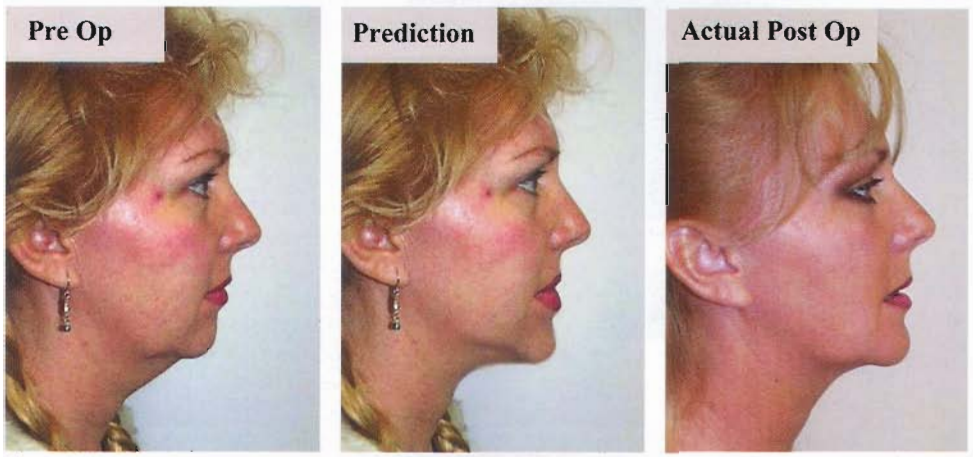

Figure 1

There are many positive reasons for using digital imaging in cosmetic surgery, and its use in cervicofacial techniques can be a significant advantage. Pre- and post-operative images are essential for office records, medico-legal reasons and critical evaluation of surgery. In addition, with presurgical prediction morphing is simple and can provide the doctor and patient with a relative and accurate representation of a surgical outcome.

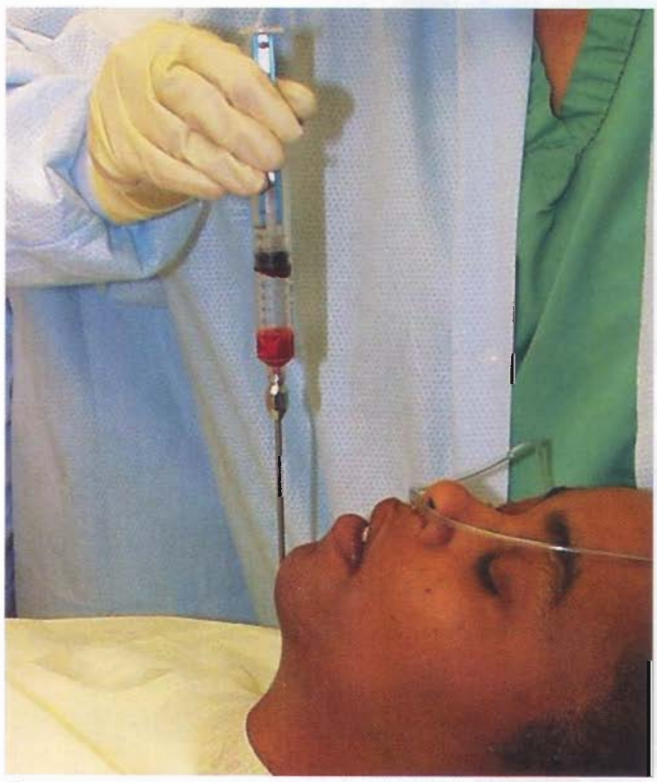

Figure 2

Often, lower facial rejuvenation techniques can make a drastic difference in the appearance of a patient. Some patients cannot appreciate such drastic changes and digital imaging can give them an idea of their expected outcome. I have had patients refrain from surgery because of a predicted outcome that the surgeon thought was quite positive.

Beauty is in the eye of the beholder, and digital imaging can provide the potential beholder with a sneak preview. Obviously, the surgeon must possess the experience to be able to provide an accurate representation of the surgical outcome. It is always better to underestimate the result and explain this to the patient. In addition, our office uses the following disclaimer:

I have been shown proposed surgical alterations on a computerized imaging device. I understand that the images I have seen are purely for purposed of illustration and discussion and that the final outcome of my surgery may not match those illustrations. I realize that surgery is not an exact science and results depend on many factors, including my individual healing characteristics. I understand that there may be no clear relationship between the computerized images and my final surgical result. Differences may occur despite the best efforts, or due to conditions or events beyond the control, of the surgeon, staff or other persons involved in my surgery.

This problem is illustrated by an actual letter from the records of a malpractice carrier, written by an unhappy patient to her surgeon as follows:

"I came to see you for advice on liposuction on my chin area. It was you who suggested that my nose was an area for improvement. I trusted your judgement. You promised me an improvement in my appearance and even put the image of my 'new' nose on a computer screen. The results aren't close to the image you presented."

Our office makes a composite image of pre-op, prediction and post-op photos to better comprehend the ability to predict (Figure 1).

Figure 1 illustrates the use of computer imaging for surgical prediction.

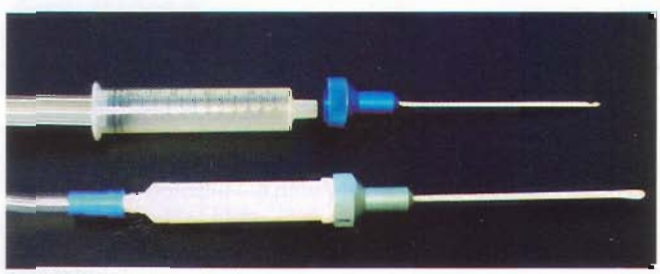

Figure 3

Techniques

One of the key elements in cervicofacial liposuction is to adequately mark the relevant anatomy to better treat the compromised areas and avoid significant structures. Patients are best marked in the upright position and observed in the supine po-

sition preoperatively to appreciate the "surgical view."

Important structures to mark are the area of submental liposis, the mandibular border, the sternocleidomastoid muscles and the thyroid cartilage.

I prefer office ambulatory anesthesia, although most of these procedures may be performed with local anesthesia. After routine prep and drape, a tumescent solution is prepared by mixing a standard 20-cc bottle of one percent xylocaine with 1:100,000 epinephrine with 180 cc's of normal saline solution. A stab incision is made just below the submental crease and 50-150 cc's of tumescent solution is injected with a small diameter infusion needle in the submental and cervical regions.

Figure 4

Figure 5

The author most commonly uses a closed syringe technique in order to preserve the suctioned fat for transfer (Figure 2). If no fat preservation is required, the Tumi tip can be connected to a wall suction adapter (Figure 3). A 60 cc syringe with a Tumi tip using a 3-mm accelerator cannula. The cannula is indexed so that the suctioning portals never contact the dermis. 15-30 cc's of fat is frequently suctioned from the submental area and an additional 20-40 cc's if the entire neck is treated.

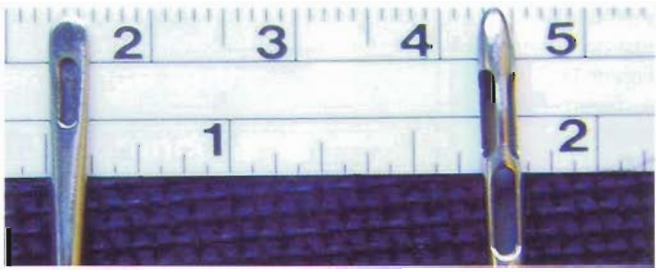

Figure 6 – Small-sized cannulae available for cervicofacial liposuction.

A stab incision is made in the earlobe crease, subcutaneous blunt dissection is performed with the infusion cannula and 15-25 cc's of tumescent solution is injected in the jowl area. It is also injected in the inferior mandibular border if necessary as identified by the preoperative markings. The infralobular approach is used to preserve the marginal mandibular nerve as well as to define the inferior mandibular border (Figure 4). If platysmaplasty is to be performed or the cervical area is to be liposuctioned, these areas are infused as well.

Figure 5 shows mandibular jowling illustrated on a CT scan.

The same or a smaller cannula is placed into the infralobular incisions and the previously outlined jowls are suctioned and the mandibular border defined (Figure 6). Care must be maintained to stay superficial as not to injure the marginal mandibular nerve.

If platysmaplasty or sling suspension is planned, a submental crease incision is made and open liposuction or lipectomy may be performed if necessary.

If a chin implant is planned and the submental area is opened, the implant is placed through this incision. I currently use Gore-Tex chin implants and always secure the implant with screw fixation. If no submental incision is necessary, an intraoral incision is commonly used (Figure 7).

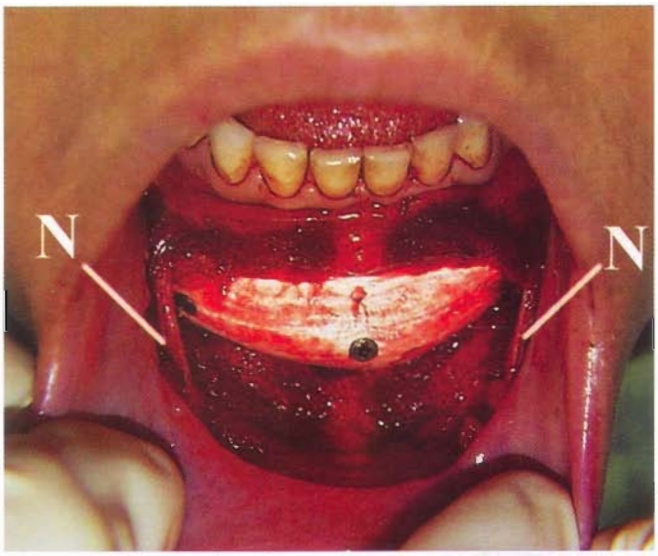

Figure 7

Adjunctive Procedures

Although any cosmetic procedure may accompany lower facial rejuvenation, the author frequently combines sling suspension or platysmaplasty with cervicofacial liposuction. In addition, perioral laser resurfacing and lip augmentation with Gore-Tex, fascia or fat may be performed (Figure 8).

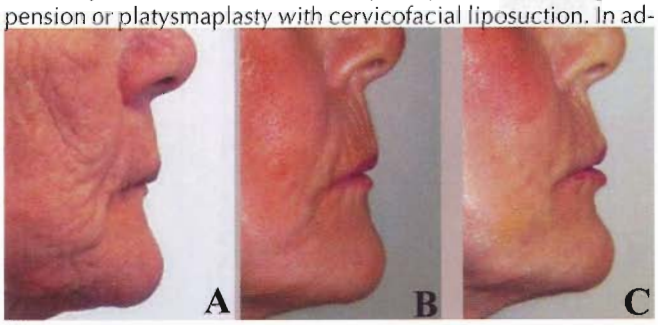

Figure 8

Figure 8 shows the progression of lower facial rejuvenation. Figure 8A illustrates the preoperative profile, Figure 8B shows the post CO^2 laser resurfacing result and Figure 8C shows the final result after white roll Gore-Tex augmentation and fat

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Figure 9

transfer to the upper and lower lips.

Additionally, some facial deformities warrant functional correction in addition cosmetic camouflage. Figure 9 shows a patient with a significant mandibular Class II malocclusion contributing to significant retrognathia and verical maxillary excess with asymmetry causing midface hypoplasia and an excessive gummy smile. The post-operative result illustrates cosmetic mid and lower face improvement solely as a result of properly aligning the facial skeleton to correct the malocclusion. This patient could have further benefited from a genioplasty, but declined.

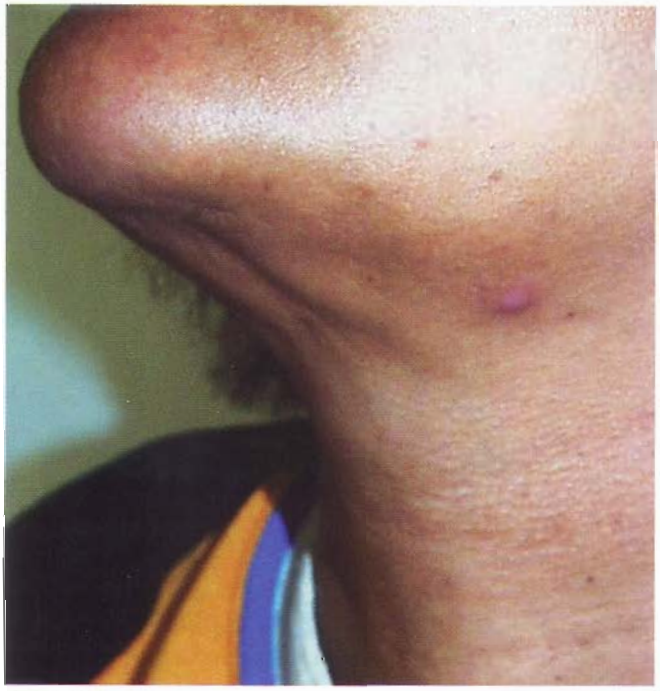

Figure 10

Post-operative

Like any liposuction, post-operative compression is paramount and various compression dressings are available. They are placed immediately and worn for four to five days continuously and at night for several weeks. Post-operative results are usually immediately apparent but can be obscured by edema and hematoma formation, which usually resolve within 10 to 14 days.

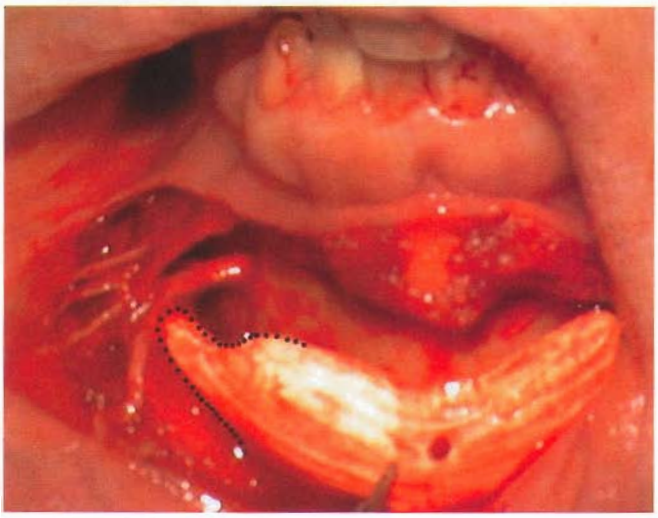

Figure 11

Post-operative antibiotics, analgesics and tapering oral steroids are prescribed.

Complications

Cervicofacial liposuction and associated rejuvenation techniques carry few significant complications. Post-operative hematomas should be aspirated. It is not uncommon to experience submental induration that may take weeks to resolve. Patients should be counseled preoperatively about this risk and instructed on post operative heat and massage. Dimpling and furrowing are rarely seen unless the cannulae excessively contact the dermis. Minor defects usually improve with time.

It is important not to oversuction the neck or submental areas. What is left behind is as important as what is removed. In this sense, liposculpture is probably is a more accurate term as opposed to liposuction. Over-resection especially of the subplatysmal fat, can result in a submental concavity cobra deformity), which can be very difficult to correct (Figure 10).

Mental nerve dysesthesia is not uncommon and usually resolves in several weeks. Intraoperatively, regardless of the approach, the distal implant tails should be trimmed if they impinge on the neurovascular structures (Figure 11).

Again, the patient should be informed of potential complications preoperatively. As the saying goes, a problem discussed before surgery is a sequella and a problem discussed after surgery is a complication.

Infected chin implants should be aggressively treated. In my experience, an infected implant may possibly be salvaged with drainage and irrigation if the implant is fixated to bone. Mobile or grossly infected implants should be removed. My surgical infection rate for chin implants is quite low, but in those cases in which infected implants have been removed, the patient usually experiences a significant degree of augmentation presumably from the implant pocket fibrosing. ■

About The Author

Joseph Niamtu III, DDS, is in group private practice of Oral/Maxillofacial and Cosmetic Facial Surgery in Richmond, Virginia.