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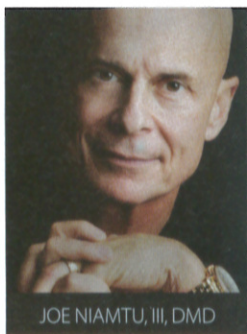
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# Dressing and Drains in Facelifts

Joe Niamtu, III, DMD, has one question for surgeons who use dressings and drains on facelift patients: Why?



JOE NIAMTU, III, DMD

The use of drains following elective procedures has received significant attention in the past few years. Proponents of drains argue they reduce the incidence of seroma and hematoma. Opponents see little increase in these side effects when drains are not used and argue that patients

will resume normal activities faster following surgery if they are not saddled with uncomfortable drains and dressings. Cosmetic facial surgeon Joe Niamtu, III, DMD, of Cosmetic Facial Surgery in Midlothian, Virginia, authored the paper "Facelift Drains and Dressings: To Be or Not to Be?" in the May 2012 issue of *Dermatologic Surgery*. The paper examined the outcomes of 120 facelift cases performed over two years using a "minivent" system for 24 hours in place of drains and heavy dressings. He concluded that dressings and drains offer no benefit in reducing seroma and hematoma and make recovery less comfortable for facelift patients. In addition, in cases where resurfacing lasers are used during facelift, they may cause harm by abrading raw skin and contributing to delayed healing and possible scarring.

"If there are two things that patients hate, it's drains and dressings. If there are two things that doctors love, it's drains and dressings," says Dr. Niamtu. He notes that during his years of medical school and training, the use of dressings and drains on facelift patients was always emphasized, despite growing evidence that showed they didn't serve a purpose in most of these procedures. "I think that we develop a way of doing something and it passes through our educational system oftentimes as dogma," he says. "Anything we do should be evidence-based. If I teach residents and I ask them, 'What are you going to do?' My next question is, 'Why are you going to do that?'"

Dr. Niamtu says the reason dressings in particular might be overused is that they were so critical in times when surgical techniques were less refined than they are today. Dressings helped to control bleeding and keep wounds clean when anesthetics tended to be flammable and before antibiotics were commonplace, he says. Today, however, doctors should question whether it is worth it to send patients home "with all their Frankenstein packing and scare their family."

In place of traditional dressings and drains, Dr. Niamtu places two 14-gauge, two-inch intravenous catheters obliquely, lateral to the cervical midline at the level of the hyoid. The catheters, which must be placed unobstructed in the subcutaneous plane, are taped to the skin to prevent displacement and left in place for 24 hours. Fluff gauze, retained using an elastic mesh dressing, is placed passively (without compression) over the catheters to contain drainage. He gives the patient's caretaker extra gauze and instructs them on how to change it once saturated. "It is not uncommon to undergo two to three dressing changes on the first night after surgery," notes Dr. Niamtu. The catheter "vents," and all dressings are removed at follow-up the morning after surgery and no dressing is reapplied.

"It's simplified my life and simplified my patients' lives, and it certainly hasn't jeopardized my surgery," he says. "When I look at a surgical procedure, I try to look at it and try to figure out all the different steps involved and why we do them. I think that most doctors have a little scientist in them. How do we make this better? How do we make this easier?"

"Like anything else, people should do what works best in their hands," he says. "There are some people who really believe in it. They may say their patients heal quicker or their patients are more comfortable. But in the 100 cases or so I did in that paper, it didn't make a bit of difference." ♦

**Brandon Lowrey** is the associate editor of *Surgical Aesthetics*.