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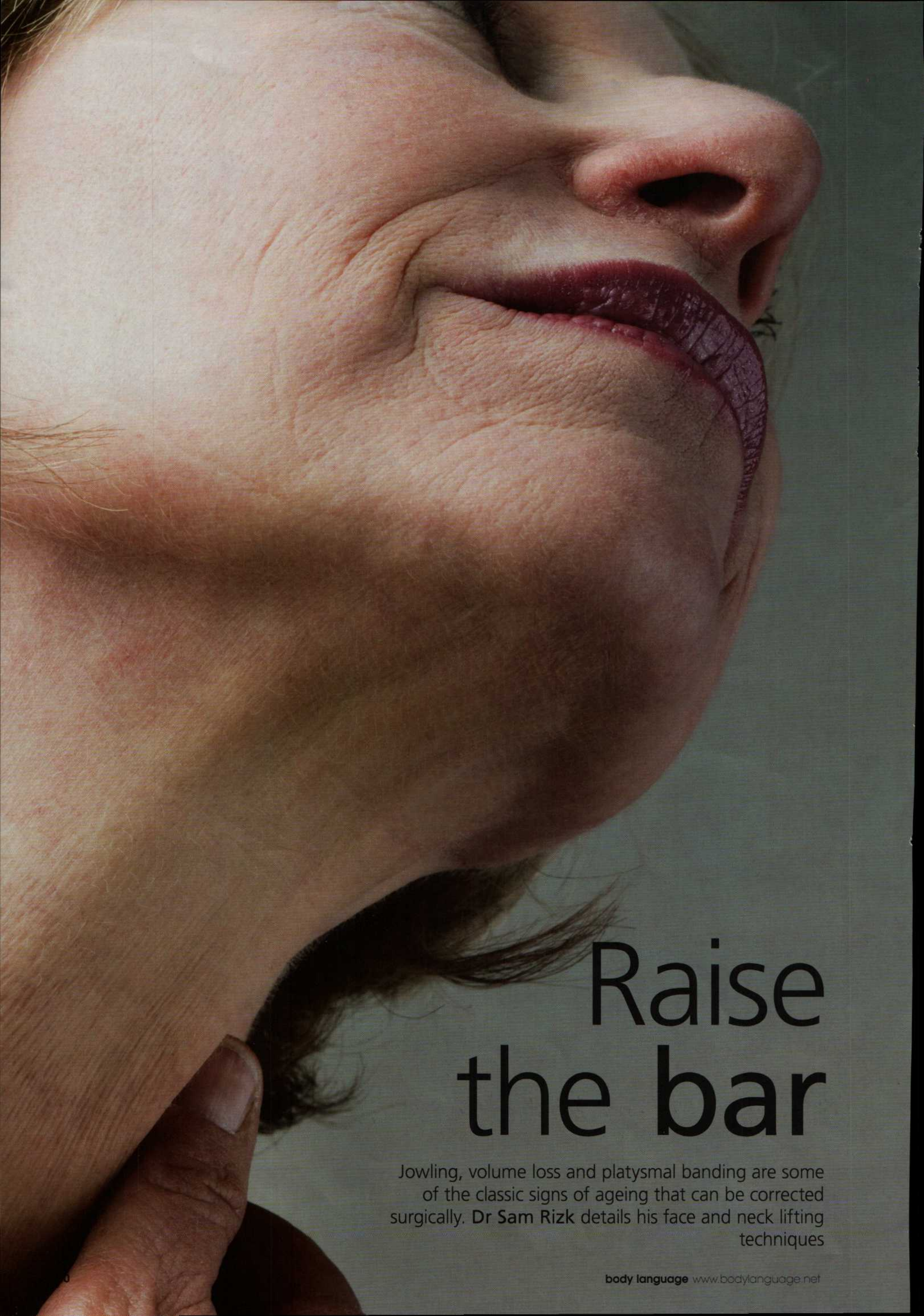


Raise the bar

Jowling, volume loss and platysmal banding are some of the classic signs of ageing that can be corrected surgically. **Dr Sam Rizk** details his face and neck lifting techniques

As clinicians, we must have a concept of what is beauty and what is youth. My concept of beauty includes a well-defined jaw line and a full cheek. I like to deliver a beautifully sculpted neck in my lifts. I do not like to see the upper face become too tight, because you start to get unnatural lines. My facelifts tend to focus on the jowls and the neck area, and I am less aggressive in the upper facial area, which I prefer to fill with fat or other substances.

If we were to look at a very aged face, we would typically see a hollow medial fat pocket, eye bags, volume loss in the cheeks, jowls, platysmal bands and thinning, photodamaged skin. We would also see a droopy nose, flattening of the upper lip and deepening nasolabial folds in most patients.

I have developed a customised approach to platysmal bands. I focus on cheek temporal volume, nasolabial fold volume and the jawline and neck, and perform more aggressive work in those areas as needed. My facelifts are not designed to be tight in the upper face, but I favour a more aggressive approach in the lower face and neck to restore a defined and sharper silhouette.

In some cases, I will start to perform partial lifts in patients in their 40s. I can do an isolated neck lift, progressing to a neck and jowl lift in the late 40s and early 50s. For patients in their 50s, 60s, and 70s, I will perform a much more aggressive facelift procedure as needed that addresses the brows, upper and lower eyelids, as well as the face and neck.

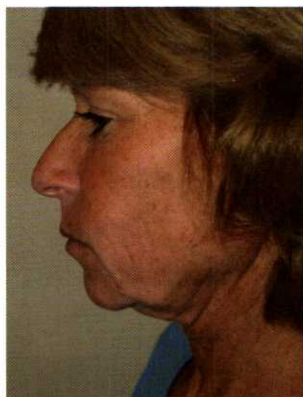
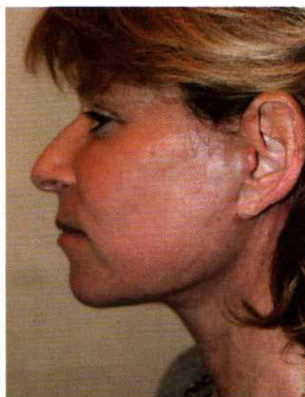
I have effectively incorporated the use of fibrin sealants in my lifts as patients achieve a more rapid recovery, as well as high definition endoscopy to get a better view of the mid- and lower face and the neck. When I make the submental incision. I am often very aggressive with the submentoplasty, so I am able to visualise what I am doing using the high definition telescope system down to the suprasternal notch.

For autologous fat transfer, I used to centrifuge the fat. I do not use this technique anymore because I think that the centrifugation of fat actually destroys the fat cells. I have been using the Cytori PureGraft System since 2010 with good results.

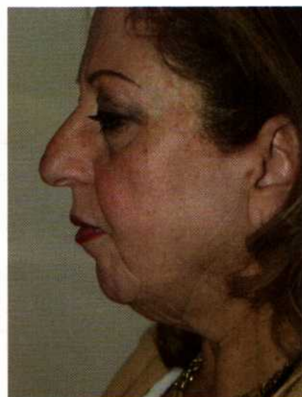
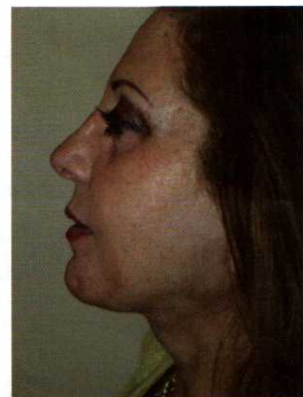
In terms of neck banding, the platysma is not usually adjacent and very dehiscent in the midline. As we age, this dehiscence goes all the way from the submental down to the suprasternal notch. Very often I will see an extra piece of fat pad superficial to the digastric muscle and deep for the platysma muscle.

My lifts are very deep in the posterior area of the platysma. I raise the posterior platysmal flap to the mastoid periosteum to get a better lift on the jawline. I then go deep over the masseter muscle in the jowl region. If you elevate the platysma, you can achieve a better jawline. If you just suture it and pull it, the platysma will tend to relax much faster. So I elevate about 2 centimetres in the posterior border of the platysma and attach it to the mastoid periosteum, rather than to the sternocleidomastoid muscle. If you attach it to this muscle, it will loosen because it is a loose structure. By pulling the posterior border of the platysma to the mastoid periosteum, you get a more natural looking jawline that lasts for quite a long time. For younger patients in their early 40s, I will often do only an isolated central lift, progressing to a lateral neck lift and then to central versus lateral neck lifts using the high definition telescope system.

I perform a submentoplasty in all men because there is usually a significant amount of submental fat and their necks tend to drop quicker. In most men I will resect the medial platysmal cords within the submental fat. In women who present with a heavy neck formation, I will perform a very aggressive submentoplasty. In a very thin woman with isolated neck banding and no subplatysmal fat, I will also do a submentoplasty to attach the platysmal cords together down to the hyoid bone. Below the hyoid bone I cut the platysma and allow it to relax back down. I will also sometimes inject botulinum toxin following surgery because very thin women will tend to have those bands. With larger

50 year old female before and three weeks after lower facelift, necklift and full-face Fraxel-CO2 laser for sun damage. The neck was further defined using the 3D high definition telescope technology

55 year old female shown before and two weeks after: facelift; necklift; chin implant; upper and lower blepharoplasty; laser around eyes and mouth; and rhinoplasty

women, you have to do a submentoplasty to resect the subplatysmal fat if you want to get a good result in the neck.

Prominent submandibular glands can present a problem in some patients. In those cases I will sometimes tuck the gland with a suture up underneath the mandible. I find it helps about 20–30% of patients. I will not resect the submandibular gland for cosmetic purposes as I have found that it dries the mouth too much.

If there is a negative vector and the cervico-mental angle is insufficient, I will sometimes place a chin implant. I use the chin implants mostly with men and in around 20% of women. In the central neck with no skin laxity and just submental fat, I will do either liposuction or liposuction superficial to the platysma with a platysmaplasty and removal of subplatysmal fat. If the patient just has skin laxity, I can sometimes do a lateral neck lift without submentoplasty. If there is submental fat and laxity of the platysma, I will tie the muscle.

I performed a study looking at 2000 lifts over the course of eleven years of isolated neck lifts and SMAS lifts that I performed early on in my practice. I progressed to modified deep plane and short scar lifts. I looked at the benefits of Tisseel Fibrin Sealant, which showed a significant advantage during surgery, especially in men to decrease haematoma rate. Autologous fat transfer was used in some patients as well as high definition endoscopy.

Tisseel Fibrin Sealant is different from platelet rich plasma in that it is much stickier so I am not using Tisseel Fibrin Sealant to inject factors that improve healing. I use it primarily to decrease the haematoma rate. It is as sticky as Crazy Glue, so when I spray Tisseel Fibrin Sealant in the neck, I have to make sure that the flaps are perfectly coated. I spray it only when I have established the planes of elevation and performed the deep work. I apply the Tisseel Fibrin Sealant and apply pressure for four minutes. You have to be careful using this technique because if you misalign the flap, you will not be able to separate it very easily.

My study data examined the age range, SMAS lifts, modified deep plane, short scar, isolated neck lifts and submentoplasty and fat transfer. I had seven haematomas, two in the submental region, six seromas and two infections. One of the infections was associated with MRSA, which was related to pets licking the patient's face after surgery. I always advise all my patients who have dogs or cats to clean their sheets and to keep pets outside their rooms, and to avoid letting the pet lick their face during recovery.

Technique

My technique for liposuction above the central platysma is to use a 2.5 mm cannula. I open the area under the platysma and look with the high definition telescope to the suprasternal notch. I will remove the central fat at the medial border of the platysma. I will then tie the platysma together with a 3-0 PDS suture and then cut the platysma below the hyoid.

In a typical central-only neck lift, I will tie it together in the midline, make a cut at the hyoid and then let it relax down. I make a cut at the hyoid so that I can pull the platysma laterally; I do a platysma elevation with a flap to mastoid periosteum laterally.

One patient I saw underwent a chin implant and submentoplasty. My old technique, which I now reserve only for patients with severe herniation of fat down below the hyoid, was to cut some of the cords and tie it all the way down. I only do that if I feel there is herniation of fat significantly below the level of the hyoid. Although I do not see it frequently, in these cases I do not transect the platysma but tie it all the way down below the hyoid. After the platysmal tie, I like to see a slight concavity in the region. If it is flat, it will always bulge a little after the surgery so I remove some more fat in the area at the end of the procedure. The platysma is pulled to the mastoid periosteum after raising a posterior platysma flap to get a beautifully defined jawline.

I have eliminated the orbicularis suspension from my facelifts because it causes too much malar oedema. For my facelift patients to recover more rapidly, it is important to go over the masseteric fascia and raise the jaw fat pad in that direction. This is not vertical lift; it is almost a posterior lateral lift.

The vertical lift can tend to distort the eyes and I have seen too many crow's feet from this technique. It can also create a slightly Asian appearance, therefore I prefer the posterior lateral lift. While the vector in the neck is almost parallel to the jawline, in the nasolabial line I go almost vertical. I do not make my incision vertically as the vertical incisions of the older lifts can tend to reposition the hairline too much. I place my incision in the hairline, preserving the temporal hair tuft but allowing the scar to be hidden.

For male neck lifts and very difficult necks, I perform aggressive subcutaneous liposuction and mentoplasty. About 30 per cent of my patients are men and this trend has been increasing steadily in my practice. I perform quite aggressive subcutaneous liposuction and mentoplasty in the more difficult male necks. I also transfer fat to the periocular region and zygomatic arch and submalar region in younger men, when appropriate.

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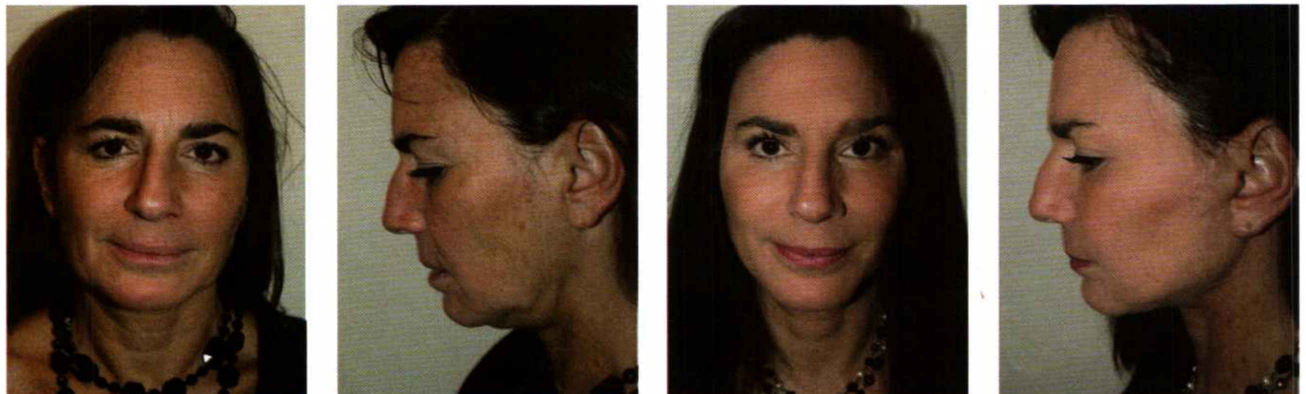

This 50 year old patient underwent a facelift and necklift as well as upper and lower eyelift, endoscopic partial browlift and Fraxel CO2 laser to the full-face. Patient is shown before and six weeks post surgery. There is still some residual swelling but note the definition achieved in the jawline and cheek region. The result continues to improve months after surgery