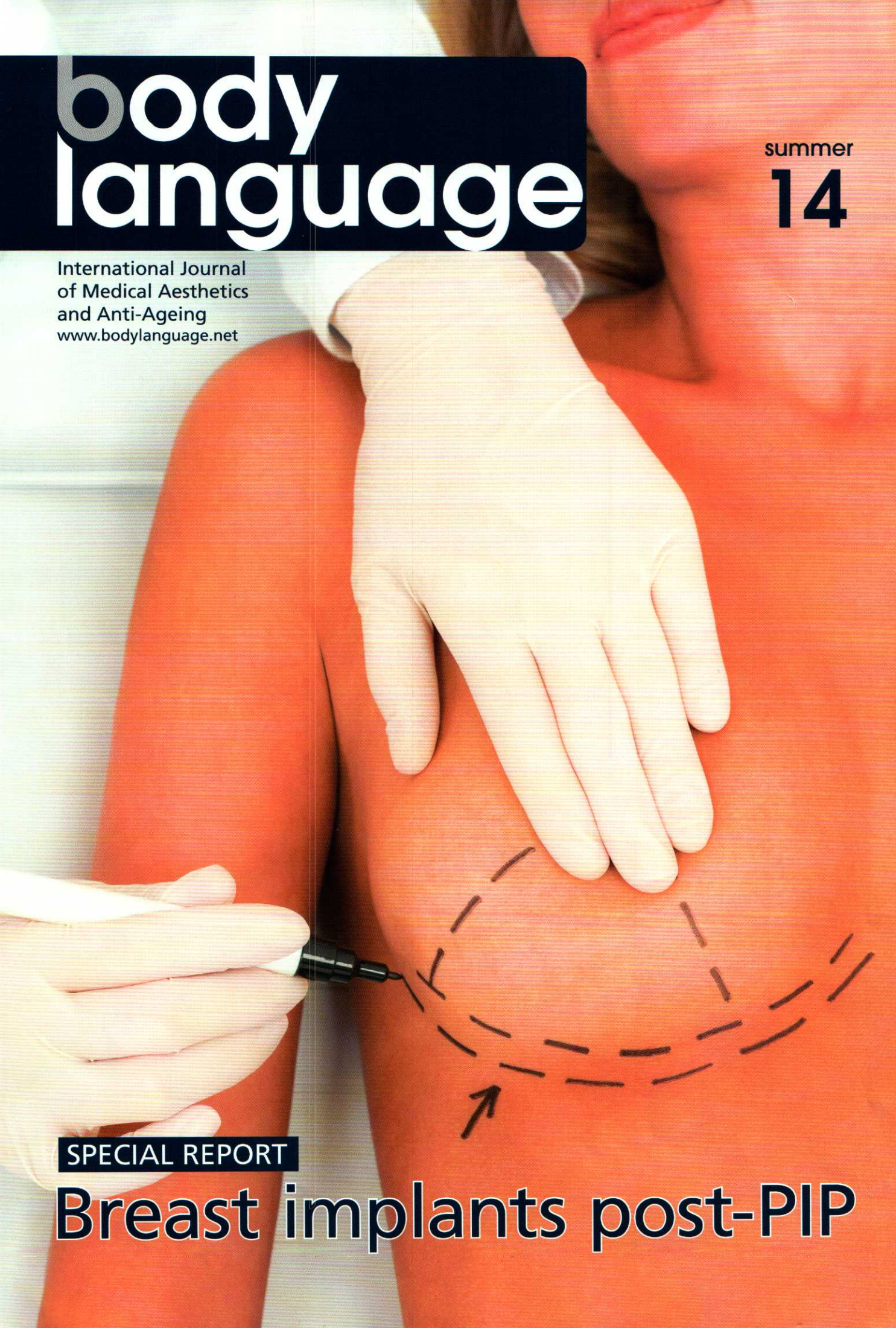
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SPECIAL REPORT
Breast implants post-PIP

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Dr Timothy Flynn is a clinical professor at the department of dermatology, University of North Carolina at Chapel Hill, and medical director, Cary Skin Center

Dr Michael Kane is a consultant plastic surgeon with a private practice in New York, USA

Dr Sam Rizk is a consultant plastic surgeon and director of Manhattan Facial Plastic Surgery in New York

Mr Shailesh Vadodaria is a consultant plastic surgeon based in London

Our panel talk about techniques relating to the face and neck; forehead rejuvenation, neck lifting and dimple surgery are among the topics discussed

Full facial

Q How would you deal with a patient with eyelid and brow ptosis who wanted further treatment for their forehead lines?

Dr Derek Jones: If the patient has notable brow ptosis and there is underlying asymmetry, we need to even out the brow before we do anything with the lid. You can try to elevate the ptotic brow or drop the other brow. Patients don't usually like to drop anything. So I would try some unilateral treatment to their depressors around the superior lateral aspect of the orbicularis oculi.

Dr Tim Flynn: If it is a volume problem—for example, temporal atrophy—we need to even out the volume. The brow ptosis is a result of that. The frontalis is probably working the same but this volume issue is keeping the brow lower. I would start with volumisation.

Dr Michael Kane: Around six years ago, a 71-year old woman came in to my clinic and had a facelift, necklift and upper and lower blepharoplasty. She also had some toxin injected resulting in severe right sided lid ptosis following injection. She recently came to me and complained about her forehead lines.

She clearly had disinsertion of her levator and an overworked forehead. She was using her frontalis as an accessory eyelid elevator. So I wanted to inject her with some toxin. I wanted to knock out her depressors and differentially weaken her frontalis. I explained this to her. She was obviously at high risk of eyelid ptosis, which she had six years ago when she last had toxin. I told her she would have a 10-20% risk of worsening her ptosis; she already had lid ptosis.

But she said that was unacceptable to her. She didn't want to go through that again—last time, her lid ptosis was terrible and lasted for months. She didn't want any risk so there was little I could do. She didn't want toxin and was very particular about the products she was happy being injected with. I ended up injecting her horizontal lines very superficially with Juvederm through a 32G needle.

Q How do you treat horizontal forehead lines with toxins?

Dr Derek Jones: Successfully treating horizontal forehead lines is not as easy as it looks. Toxin in this area is quite complicated. Botulinum toxin A diffuses, so when you inject, there will be an action halo.

We must also differentiate between the muscles that pull the brow down and those that pull it up. Those that pull it down are the procerus muscles; the corrugator muscle, which extends to the midpupillary line; the depressor supercilii; and the lateral orbicularis oculi.

The frontalis is the sole muscle that lifts the brow. In terms of maintaining or enhancing brow elevation, we must concentrate on the frontalis and maximise its function.

We could all use a different injection pattern but, done correctly, we can all get a good result. So if I'm trying to raise up the temporal brow, I put 3-4 units in the tail of the brow. You can get a lateral brow elevation of up to 2-3mm.

But another way is to treat the medial brow. In studies, the Carruthers' have shown, in doses varying from 20–40 units, an average of 2–3mm temporal brow elevation with Botox. They are knocking out the depressor muscles.

Q Are many patients having the endoscopic brow lift? Or is it losing popularity?

Dr Michael Kane: Hopefully it's fading away. I think the endoscopic brow lift is the worst operation that is regularly carried out on patients. If you look at people as they age, their brows hollow out and their medial brows raise.

The tail of the brow goes down. The classic endoscopic brow lift raises the medial brow and does almost nothing to the lateral brow.

It gives people an unnatural look. Luckily, numbers of these procedures have been going down every year.

Q Would you ever treat the frontalis by itself, without treating the depressor muscles, to get rid of horizontal forehead lines?

Dr Michael Kane: Very rarely. The only people I would do that in are people who have had brow lifts. They will want their brows to be knocked down a little—even a millimetre can make a difference in

these patients.

Dr Tim Flynn: Horizontal eyebrows look good in men. So we don't have to worry so much about dropping an arched brow because many men already have a horizontal brow. Obviously for people who need the frontalis to see, then we have to pay careful attention.

I would say male versus female, just look at the anatomical considerations. And few practitioners now just use toxins alone—it's more of a fillers and toxins practice. So if you're worried about brow position, just use some hyaluronic acid.

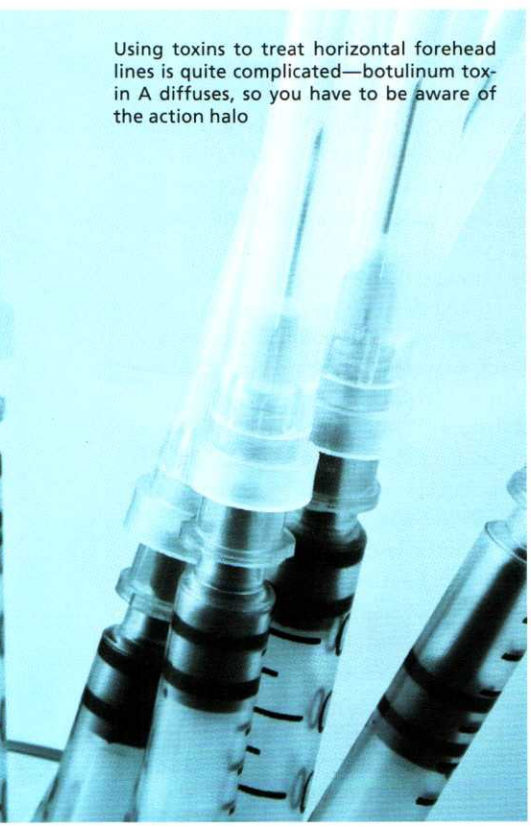
Dr Derek Jones: Be very respectful of the frontalis muscle. It's a difficult muscle to play around with—many of us just put a lot of toxin in the frontalis for horizontal lines and it really does alter the position of the brow.

I would usually only do this in young patients, under the age of 30–35 where they have tight skin and brow depression isn't an issue.

Even knocking out the frontalis without addressing the muscles pulling the brow down is going to give you some ptosis. It creates that "Botoxed" look—if it's done properly, you don't get that look.

Q Could you explain how the Cytori PureGraft system works?

Dr Sam Rizk: The system is based on osmosis. You have to have at least 60CC of fat, which is then put through the system. Through the osmotic process, it removes the fat you don't want during the augmentation, such as blood. I used to use a centrifuging system as well but I believe the Cytori fat lasts longer.



Using toxins to treat horizontal forehead lines is quite complicated—botulinum toxin A diffuses, so you have to be aware of the action halo

Q When you do your necklift, do you undermine the whole neck?

Dr Sam Rizk: If there is loose skin, you have to do a lateral lift. If there fat and platysmal bands, then I would do my submentoplasty. But I would also lift it laterally, to pull the platysmal border laterally. And you always have to undermine all the skin.

Q Do you have any tips on protecting the marginal branch of the facial nerve, especially when you're aggressive around the platysma area?

Dr Sam Rizk: You have to make sure, when you do liposuction, that you're below the mandible and above the platysma, so you don't injure the marginal branch.

When I do my lateral neck lift and do the subplatysmal flap, I never close my scissors in the subplatysmal layer. So I always spread—staying about 2cm below the posterior platysmal border, and I never close my scissors. I'm always dissecting.

So if you stretch the nerve, you're not going to injure or cut it. If you get bleeding under the platysma, do not cauterise that area. Bleeding in that region will always stop.

Q While you are doing a chin implant and performing your platysmal truncation, do you do a separate incision or go through the same incision?

Dr Sam Rizk: I always do it from the submental incision. I feel that there is a lower infection rate. So in those cases, I will do my platysmaplasty first, then do the chin implant from the same incision.

Q Do you do a SMASectomy or a plication?

Dr Sam Rizk: I never do plication of the SMAS. I feel that it causes distortions and never really lasts. I don't really use SMASectomy except in very young people. Instead, I do a modified platysmal flap; a deep plane platysmal flap. SMASectomies are good for patients with a full face, so you don't lose volume. The problem with SMASectomy in a thin person is that you're aggravating the volume loss so it starts to get irregular.

Q How long does the fat generally last with the PureGraft system? Do you need to do it in another session or at the time of surgery?

Dr Sam Rizk: In two to three years, you'll have a 30–50% retention rate. I always advise my patients that they may have to come back for a touch-up procedure.

Q How do you inject the fat?

Dr Sam Rizk: I use a microcannula wheel system. I don't use a syringe, which I feel is very inaccurate around the periocular region. You just can't control it, especially with fat cells.

With Cytori's wheel, you click it and get a very accurate deposition of fat in the periocular region. It's a very risky area so you have to go very deep. And you can't over-inject, otherwise you get lumps. So I find the wheel system is better than the injection system.

Q Are you doing multi-layer injections in the periocular area?

Dr Sam Rizk: No, I'm only doing deep injections on the periosteum. I have had problems injecting into the subcutaneous layer under the eyes—it clumps up and looks bad. And it never goes away.

I've had to go back a few times and pick it out directly so I stopped doing subcutaneous injections in that area.

Q Why do you do fat injections and not fillers?

Dr Sam Rizk: I feel fat injections have less reactions and they last longer. Usually, I'm doing them with a facelift, so it's not like a separate procedure where I'm getting the fat.

So in my patient population, I'm usually doing it in conjunction with a surgical procedure. Now, if you don't have a surgical practice, there are a lot of fillers you could use in addition to fat.

You could end up injecting 20–30CC of volume in the malar and sub-malar region which, using fillers, would be very expensive.

Q Is cheek dimple creation surgery a relatively new procedure?

Mr Shailesh Vadodaria: Dimple creation has been around for decades. In terms of longevity, in my patients so far, I have observed that there is no control over the contraction of scar tissue so I don't give any guarantees about size, shape or depth.

I noticed that when I used bedded material, the chances of infection are increased so I stopped. Then I used Monocryl, but realised there is a possibility that the knot would slip, which can cause procedure failure.

I don't overdo the procedure for more striking results. I'm ruthlessly honest with patients that it is easier to do the procedure again rather than having a dimple with reduced facial animation.