

Facial Cosmetic Surgery

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DIEPENBROCK

FACIAL COSMETIC SURGERY

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Renewedlook.com



Patient Evaluation

- What is your Chief Complaint?
- How did you hear about us?
- What are your expectations?
- Have you ever had cosmetic surgery ?
- Have you ever had surgery?
- Who is going to take care of you after surgery?
- Do you have any upcoming engagements?
- Do you have any medical conditions?
- Do you take any medications?
- Do you use herbal medications?

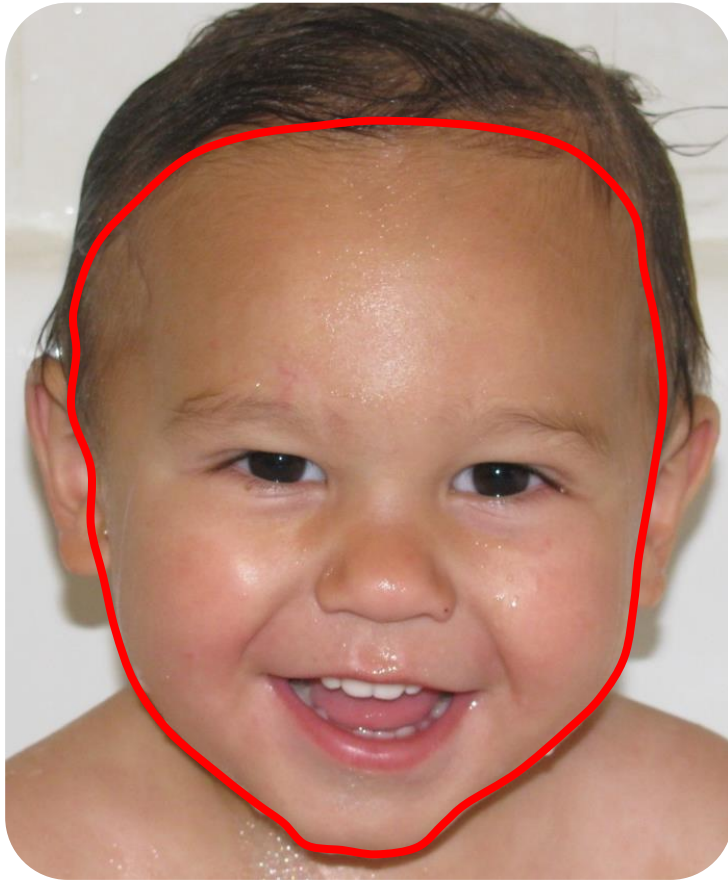


WARNING

- Patient has unrealistic expectations
- Brings in photos
- Says “I want to look like...”
- Constantly talks negatively about other surgeons
- Constantly compliments you and your work
- Is rude to your staff
- Lies on health history/past surgical history
- Wants “guaranteed results”



The Aging Face









Four “R” of Facial Rejuvenation

- **Relax** muscles – neuro-modulators
- **Replenish** volume – fillers, fat, implants
- **Resurface** skin – lasers, peels, micro-needling, lasers, RF devices, cosmeceuticals
- **Redrape** tissues – facelift, brow lift, blepharoplasty, etc
- Minimally invasive modalities are useful in younger patients with early changes
- More invasive surgical procedures needed with advanced aging

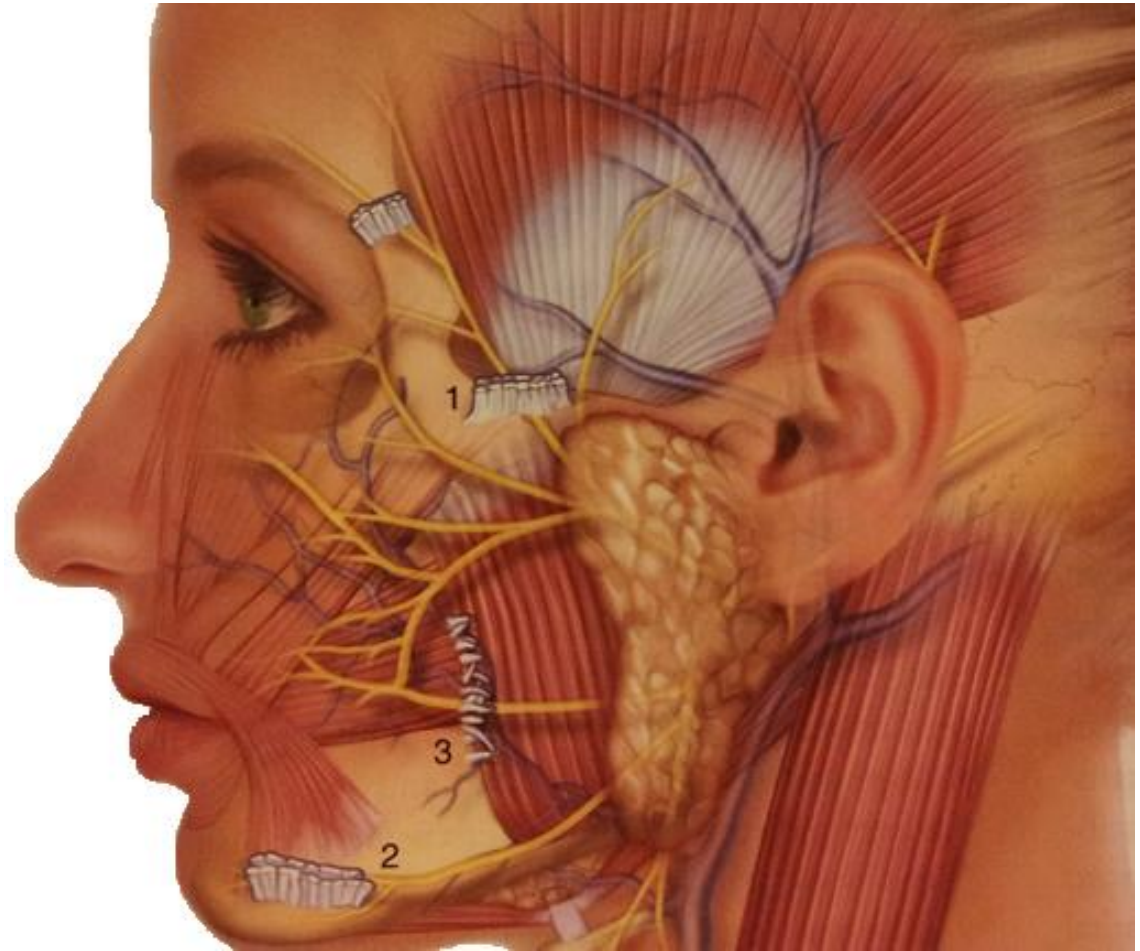
Facial Retaining Ligaments

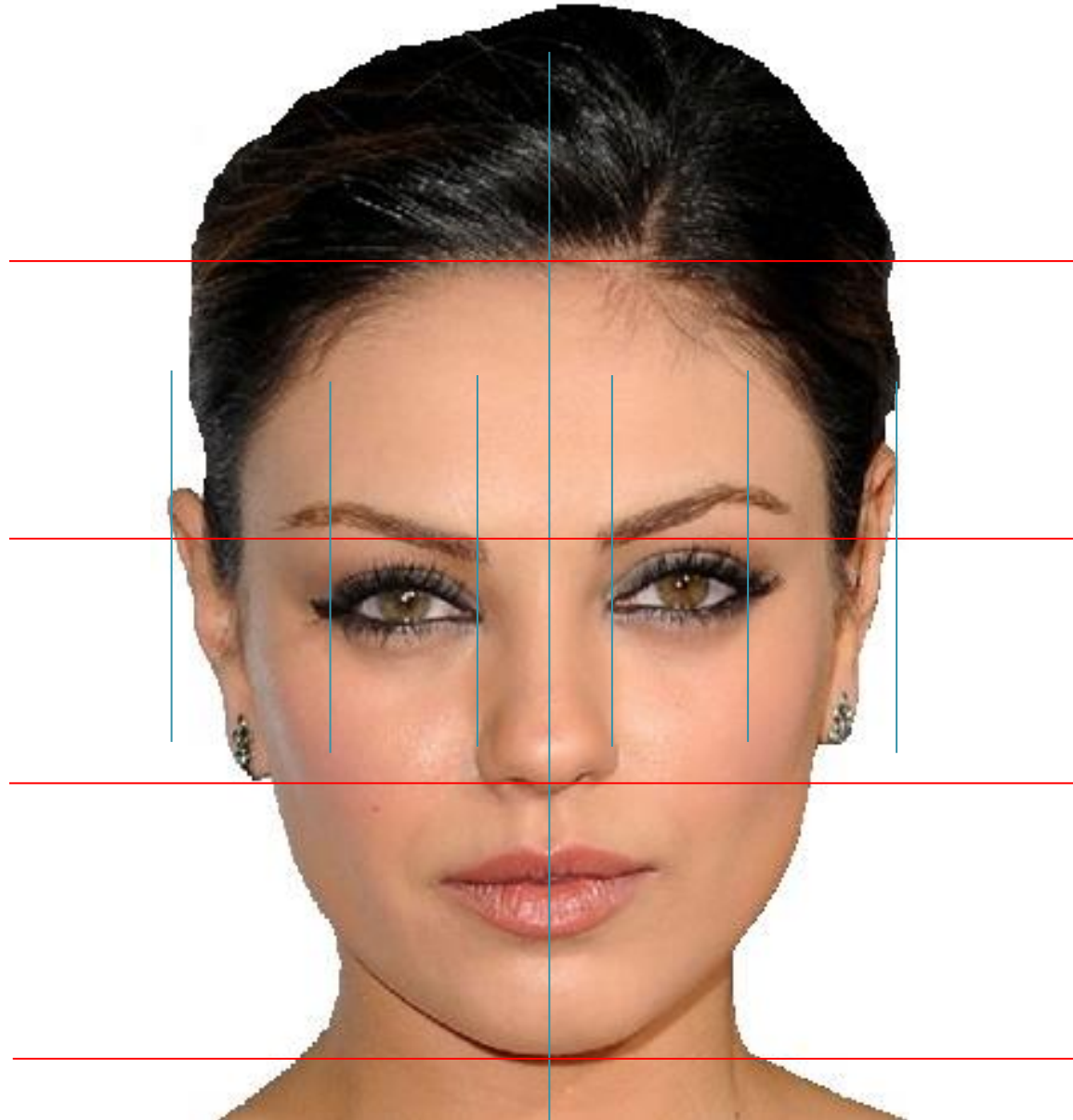
Osseocutaneous: fibrous bands with osseous (periosteal) origins and dermal insertions

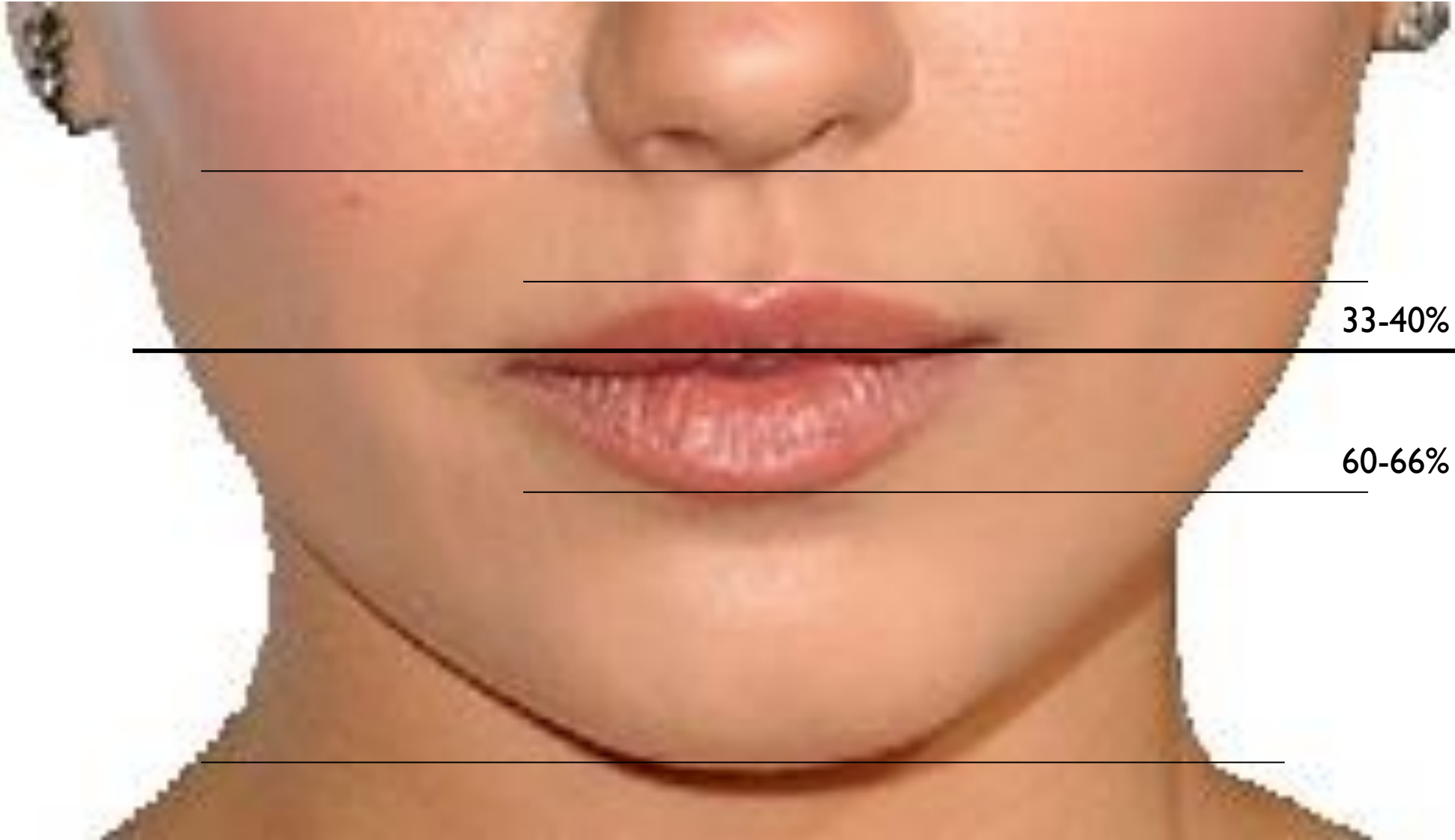
- Zygomatic
- Mandibular

Soft tissue-to-soft tissue ligaments: Coalescence of superficial and deep fasciae

- Parotid
- Masseteric
- Zygomaticus minor
- Zygomaticus major
- Masseteric
- Risorius







33-40%

1/3

60-66%

2/3

Lower 1/3rd

Upper lip

1-2mm anterior

Lower lip

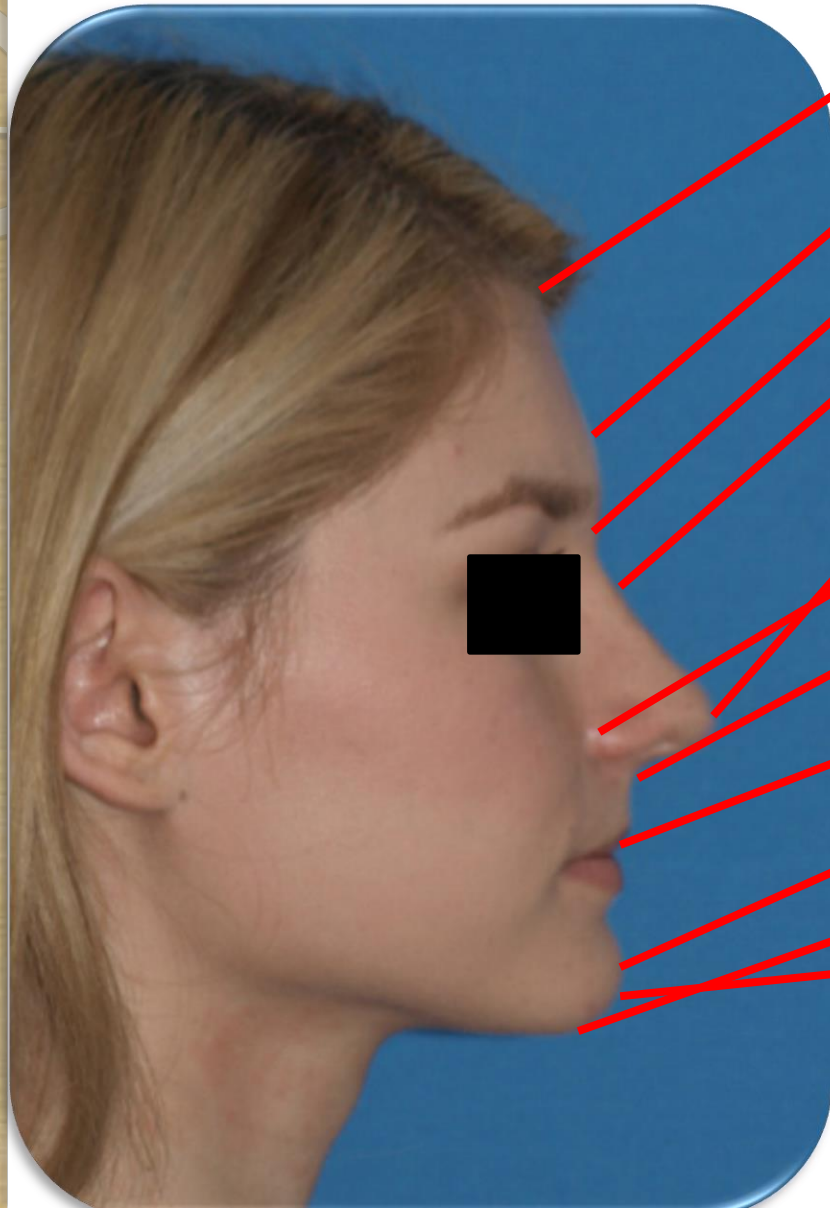
At perpendicular line

Chin

2mm posterior



Facial Analysis



Trichion- frontal hairline

Glabella- most prominent point of midsagittal forehead

Radix- root of nose

Rhinion- junction of bony and cartilaginous nasal dorsum

Nasal Tip- anteriormost projection of nasal tip

Alar crease- lateral aspect of nasal ala

Subnasale- junction of columella and upper lip at base of nose

Stomion- where lips meet

Pogonion- most anterior aspect of chin

Menton- lower border of contour of chin

Gnathion- point at junction of tangents to menton and pogonion

Cervical point- point at junction of tangents to menton and anterior border of neck

Upper 1/3rd



- Ptosis
- Rhytids
- ll's
- Lateral hooding
- Fat atrophy
- Fat herniation
- Saggy eyelids
- Sun damage



Middle 1/3rd



Loss of orbicularis oculi tone

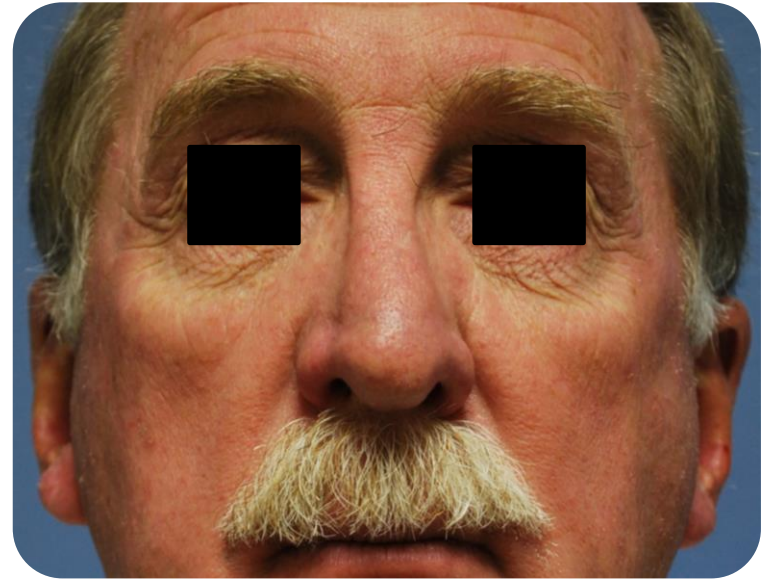
Descent of malar soft tissue

Fat pseudoherniation

Deepened nasolabial fold



Medial and lateral canthal tendon laxity



Lower Facial 1/3rd



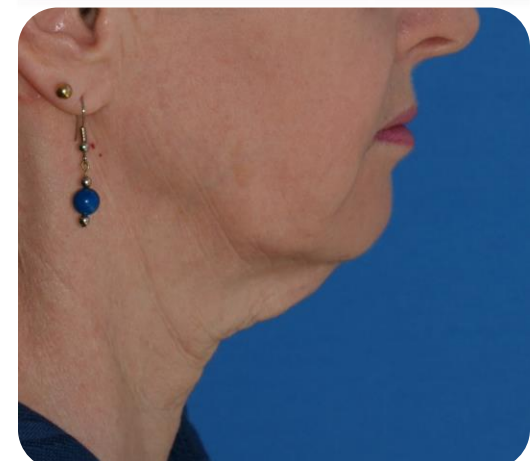
Perioral: Marionette lines, downward turned lips, loss of muscle tone, atrophy of lip elevators, depressors, modiolus



Jowls: Dehiscence of mandibular septum into submandibular compartment



Chin: Mentalis atrophy, skin changes, loss of VDO



Neck/Submental: Platysmal dehiscence, fat atrophy, dehiscence of mandibular septum



Upper 1/3 and Periorbital Rejuvenation

- Analysis
- Patient evaluation
- Surgical procedures
- Non-surgical procedures
- Complications

Conditions

Hair loss (androgenic alopecia)

High forehead

Low forehead

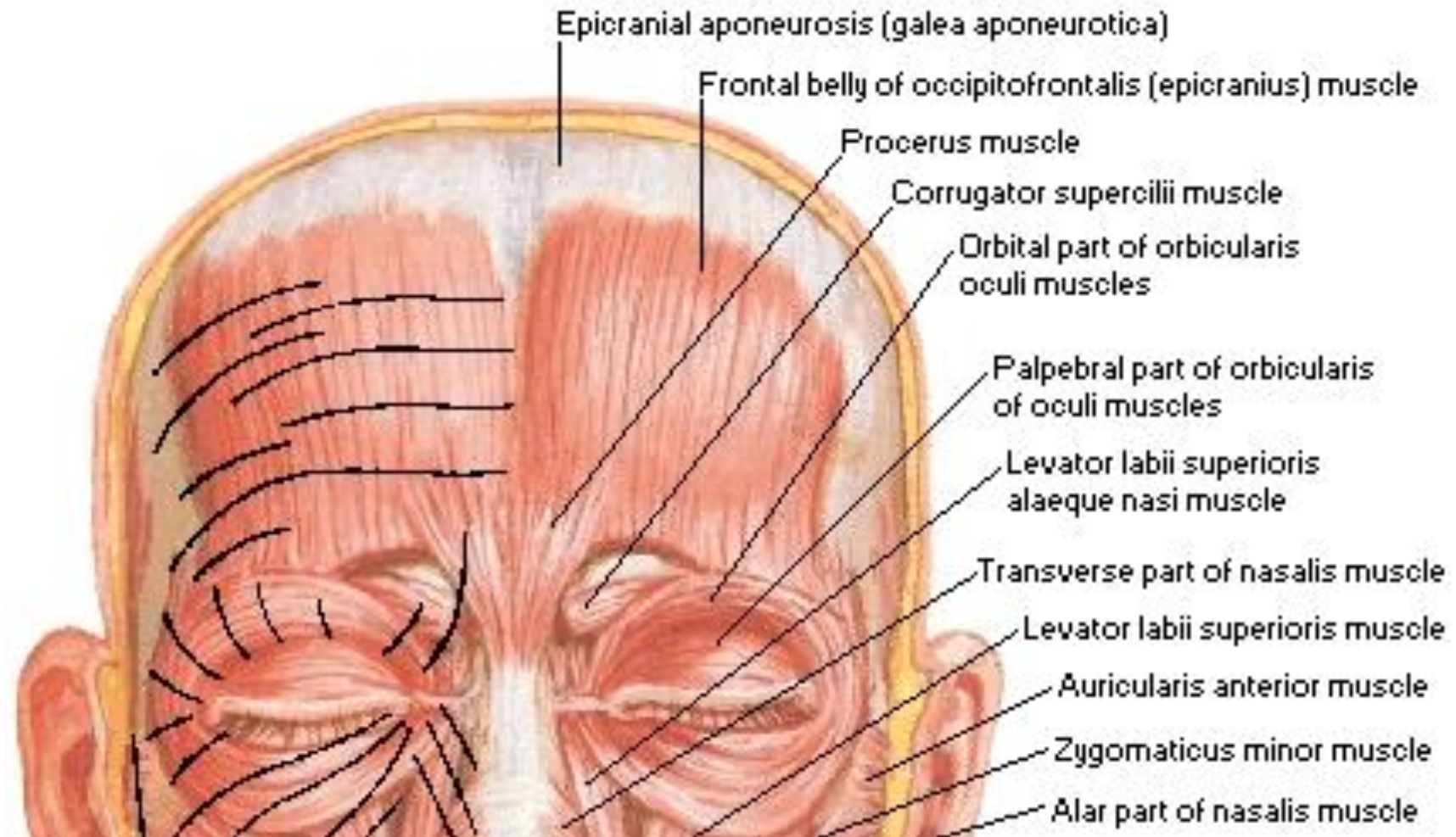
Brow ptosis

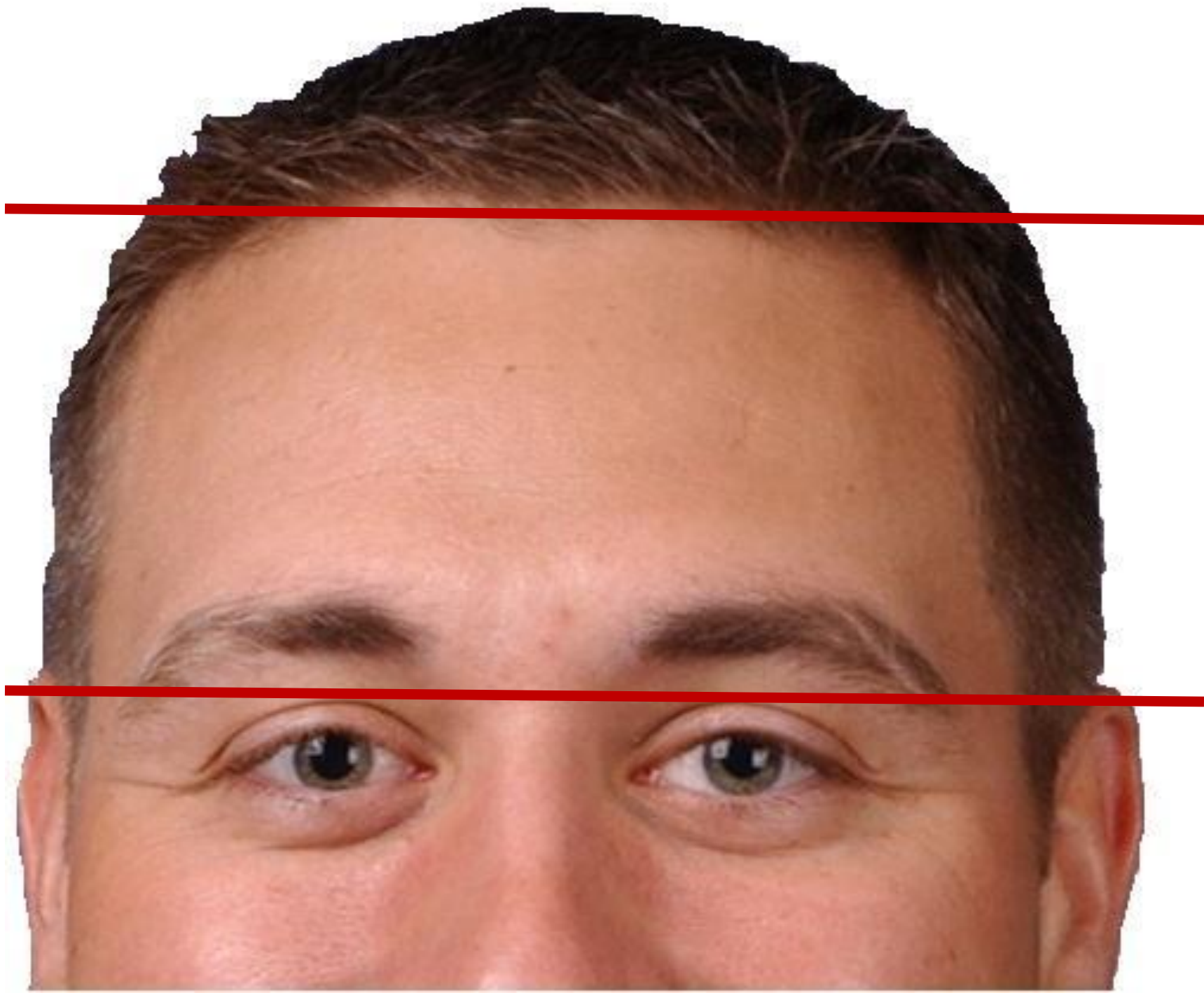
Dermatochalasis (upper and lower eyelid)

Fat herniation

Rhytids

Solar damage

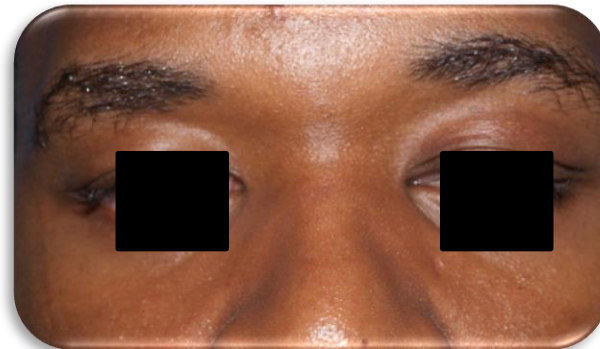




Upper 3rd



- Ptosis
- Rhytids
- II's
- Lateral hooding
- Fat atrophy
- Fat herniation
- Dermatochalasis
- Dyschromias



Brow Exam

- Brow ptosis, symmetry
- Visual Field Defects
- Lateral hooding
- Measurements:
 - Central upper lid margin to central inferior brow edge = 10 mm or more
 - Female: Highest point of brow 10-12mm above supraorbital rim
 - Male: at or 1-2mm above supraorbital rim

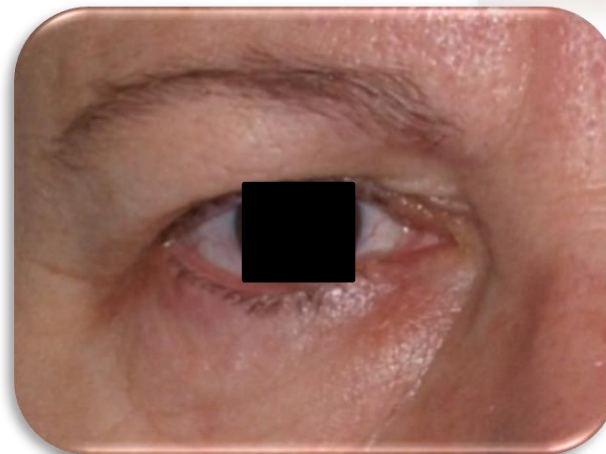


Procedures

- Hair transplant
- Forehead shortening
- Browlift (multiple techniques)
- Upper lid blepharoplasty
- Lower lid blepharoplasty
- CO2 laser skin resurfacing
- Chemical peel
- Neurotoxins
- Fillers
- Fat grafting

Upper Eyelid Exam

- Evaluate excess skin (dermatochalasis)
- Herniated/pseudoherniated fat (steatoblepharon)
- Skin quality
- Tissue edema (blepharochalasis)
- Obicularis Occuli hypertrophy
- Lid ptosis (MRD1; MRD2)
- Xerophthalmia
- Visual Field Defects
- Previous Surgery



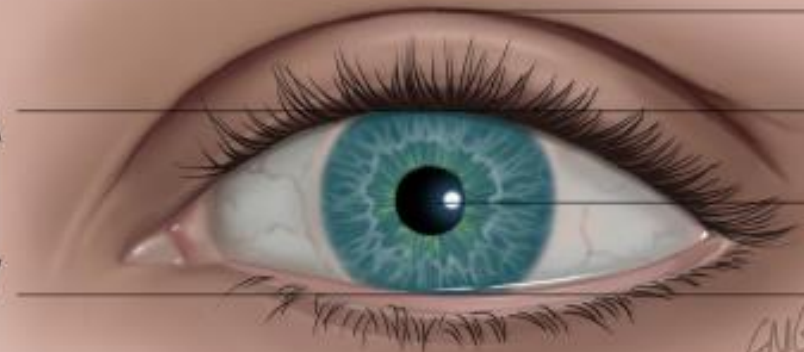
Vertical palpebral fissure ~10mm

Horizontal palpebral fissure ~30mm



~10mm (male ~2mm)

Brow
Superior orbital rim



MCD ~10mm (male ~7mm)

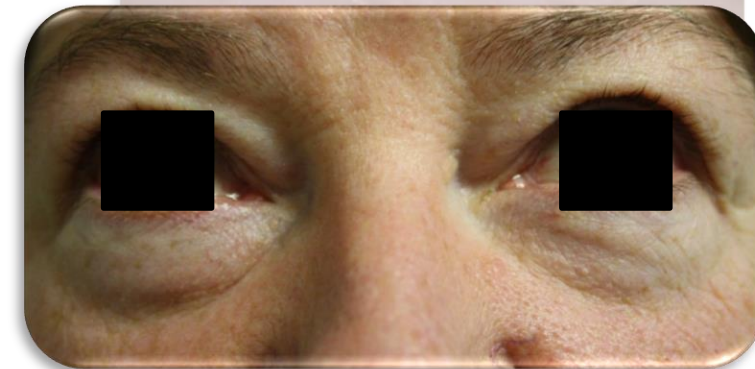
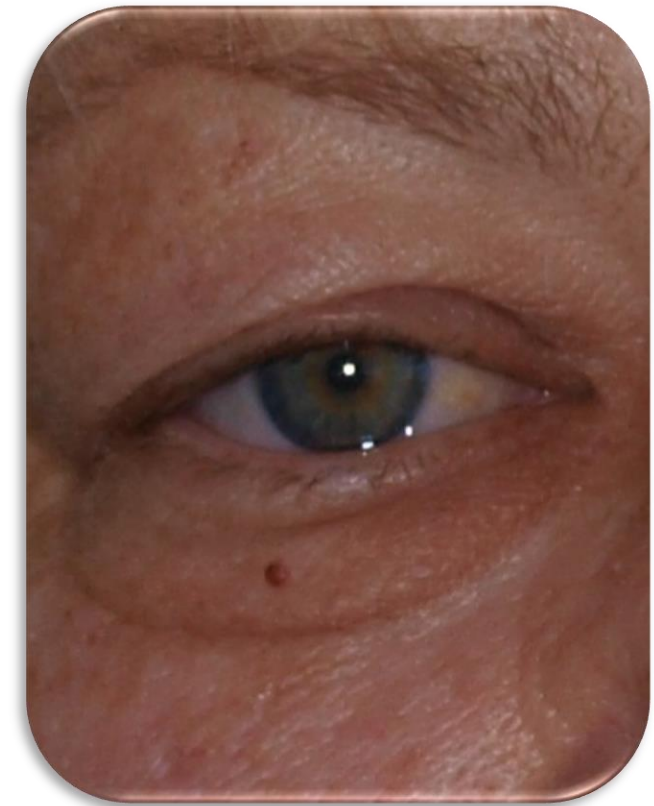
MRD₁ 4-5mm

MRD₂ 5-6mm

Upper lid crease
Upper lid margin
Light reflex
Lower lid margin

Lower Eyelid

- Evaluate excess skin (dermatochalasis)
- Herniated/pseudoherniated fat (steatoblepharon)
- Skin quality
- Tissue edema (blepharochalasis)
- Obicularis Occuli hypertrophy
- Lid retraction (MRD2); excessive scleral show
- Obicularis muscle hypertrophy
- Ectropion/Entropion
- Lower eyelid laxity
 - Distraction test (<7mm)
 - Snap test (1 sec)
 - Pull test (does punctum move?)
 - Scleral show
 - Bell's Phenomenon

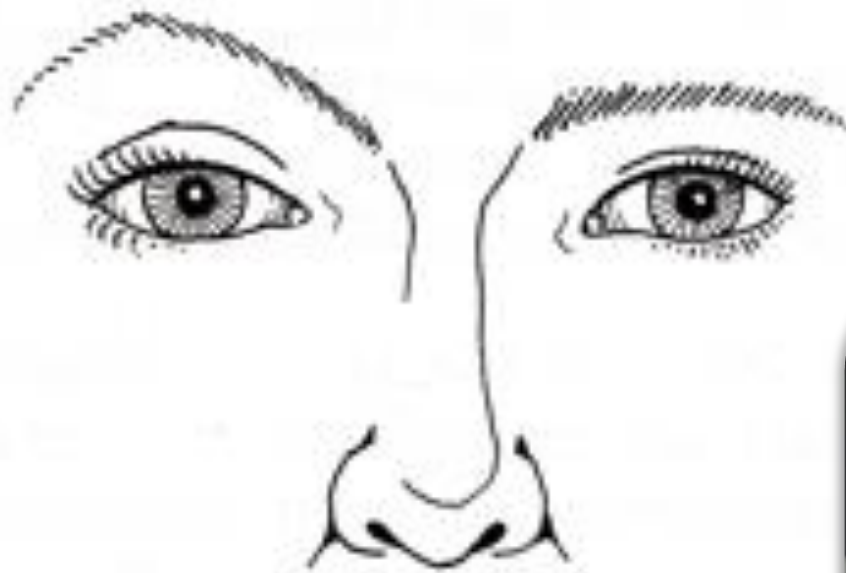




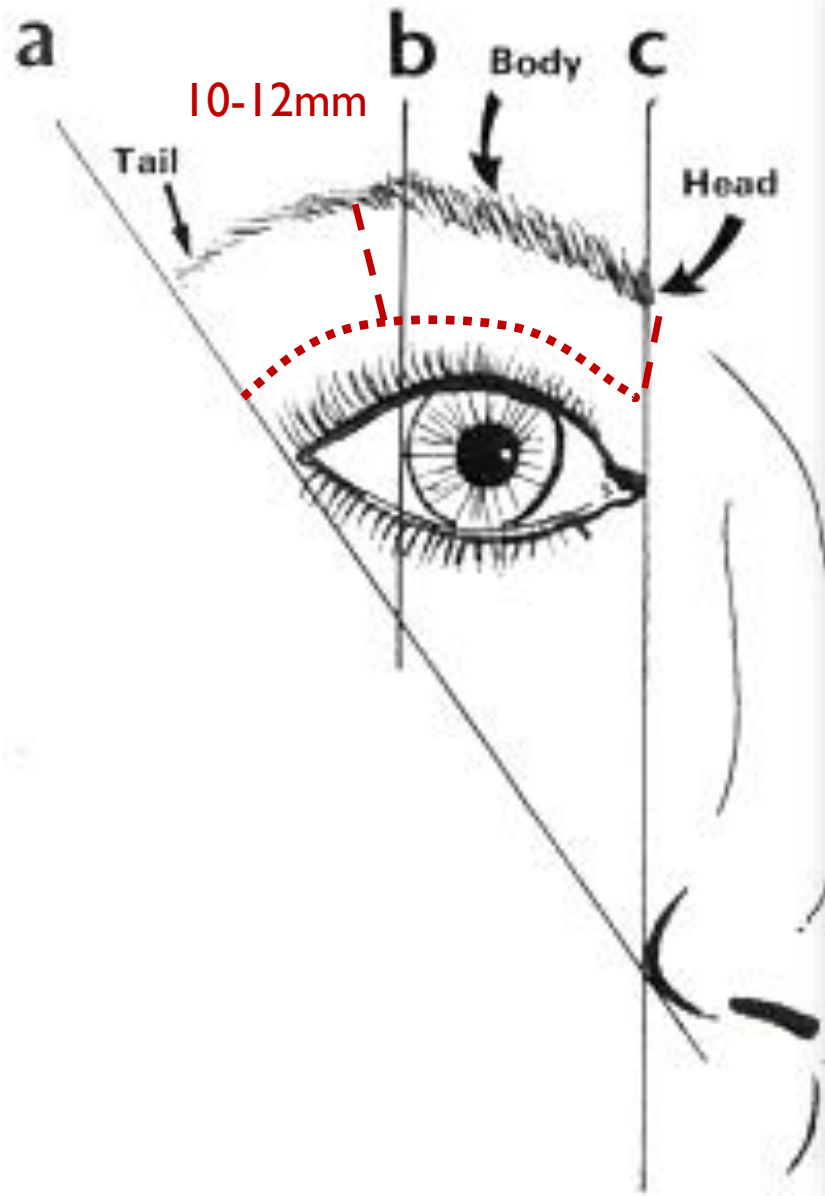
BROW and LID POSITION

Female

Male







Browlift

- Endoscopic
- Tricophytic
- Pretricophytic
- Direct
- Coronal
- Brow pexy
- Chemical



Browlift

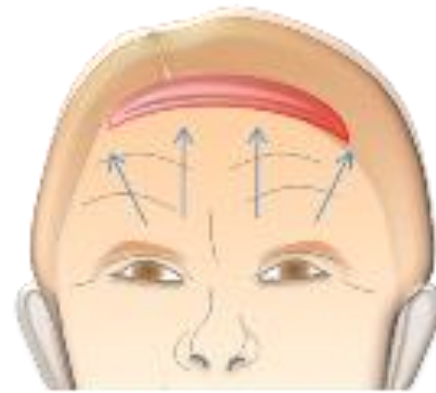
Linear

Crenated



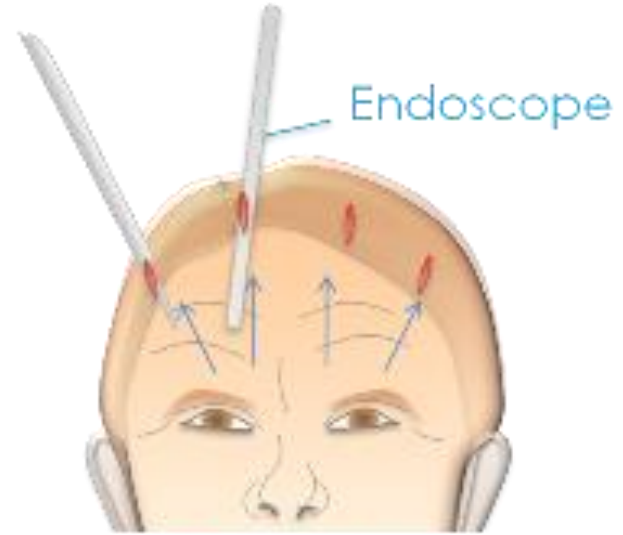
Direct

A certain amount of skin is removed above the brow. The incision can be either linear or crenated (see above).



Pretrichial Incision

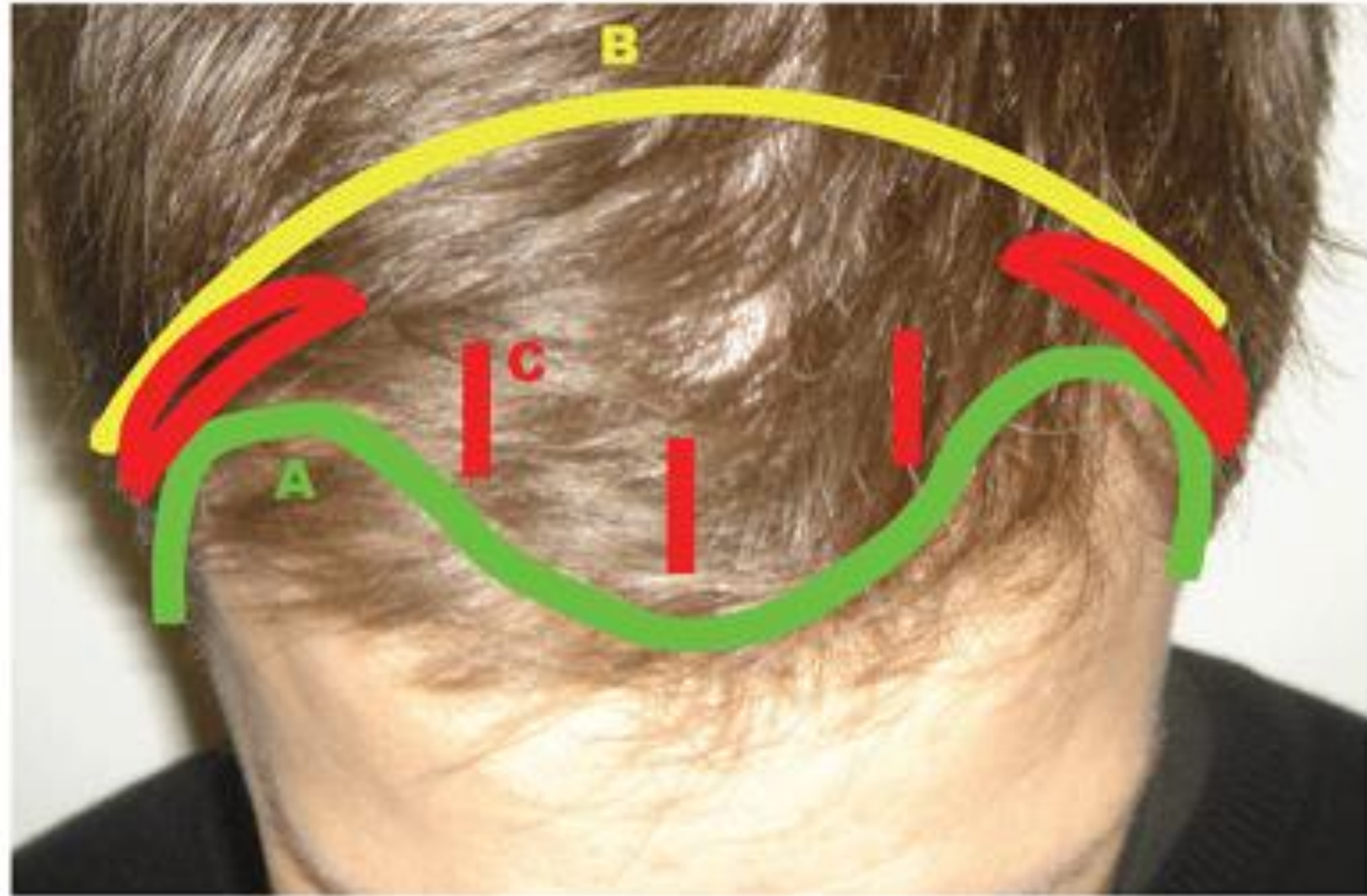
The incision and skin removal is performed at the hairline, minimising visible scarring.

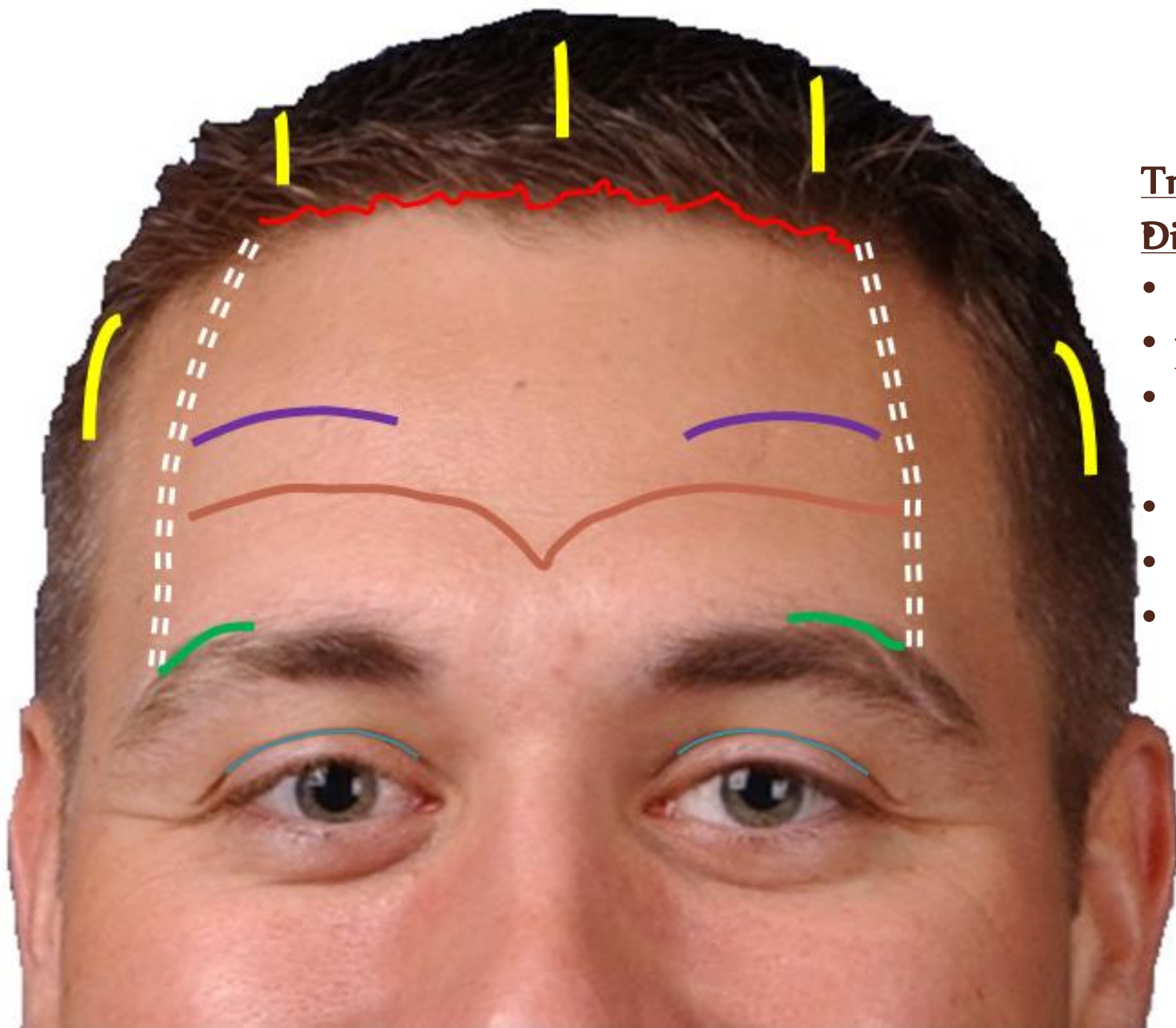


Endoscopic

Several small incisions are made behind the hair line. The forehead is then lifted and sutured, leaving small, well hidden scars.

Browlift





Trichophytic Brow Lift:

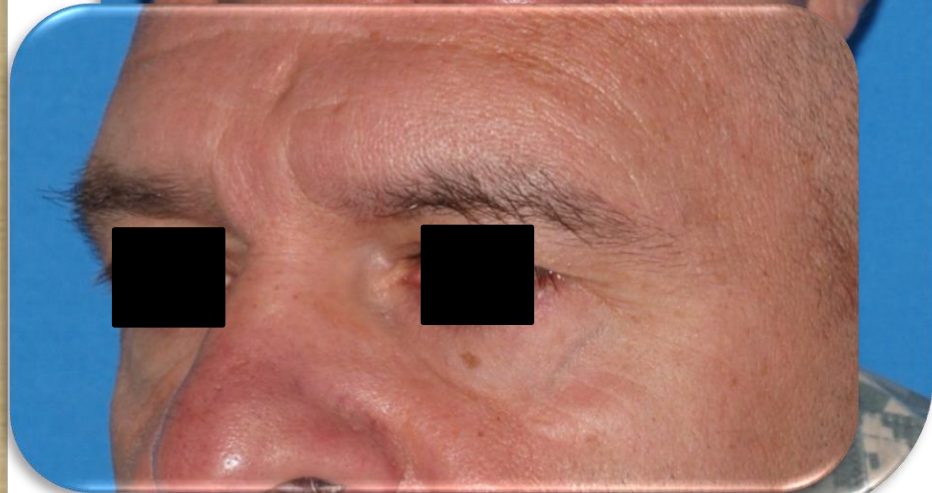
Direct Brow Lift:

- A 5mm distance behind hairline.
- Endoscopic Brow Lift.
- Shorter incisions in forehead to directly
- Easy dissection
- temporary incisions to
- address lateral hooding
- Lengthens forehead

Direct Browlift



Indirect Browlift (Brow Pexy) and Upper Blephs



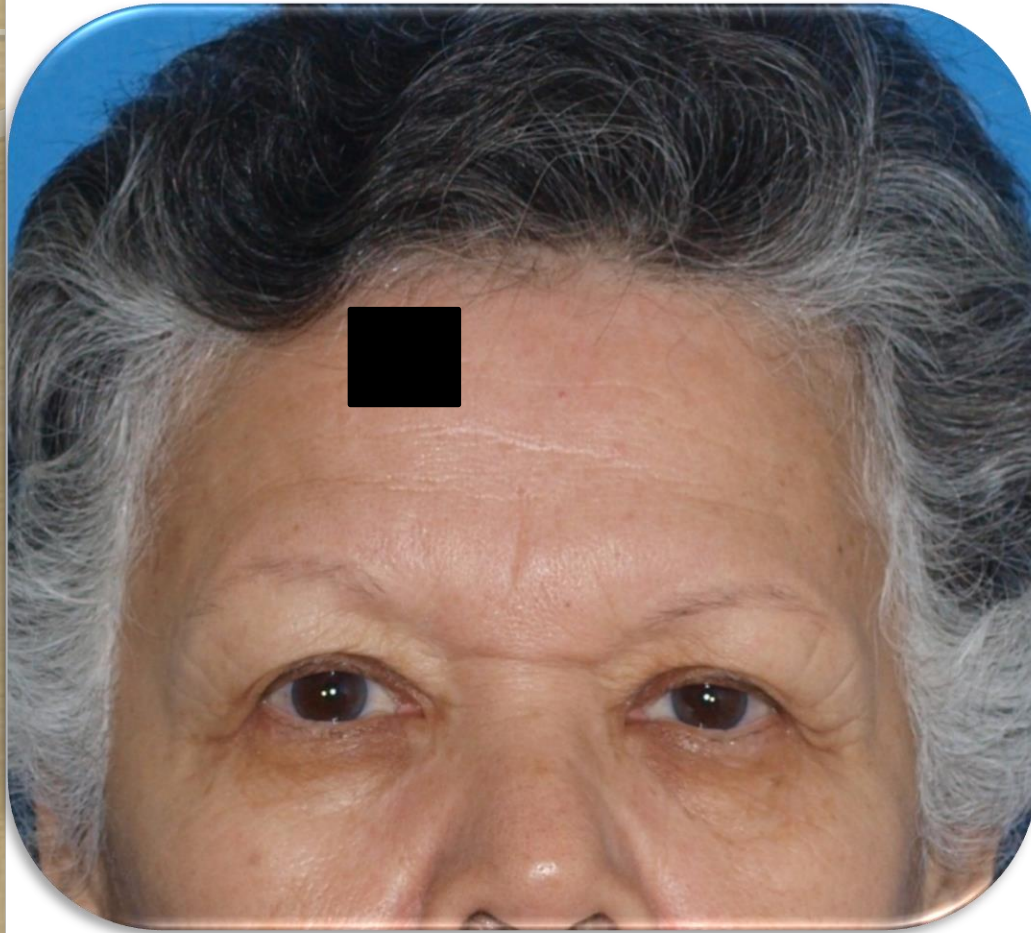
Trichophytic Browlift



Trichophytic Browlift



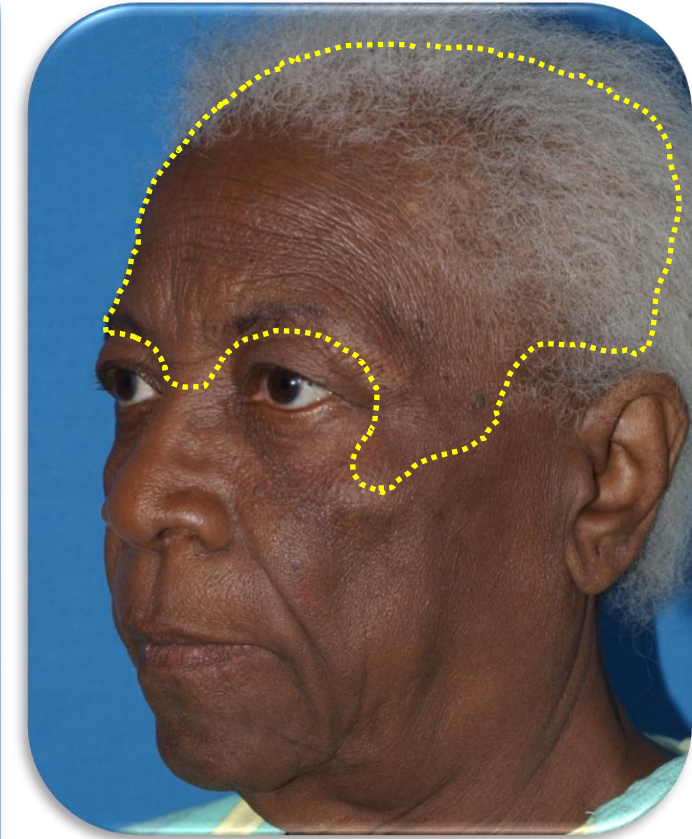
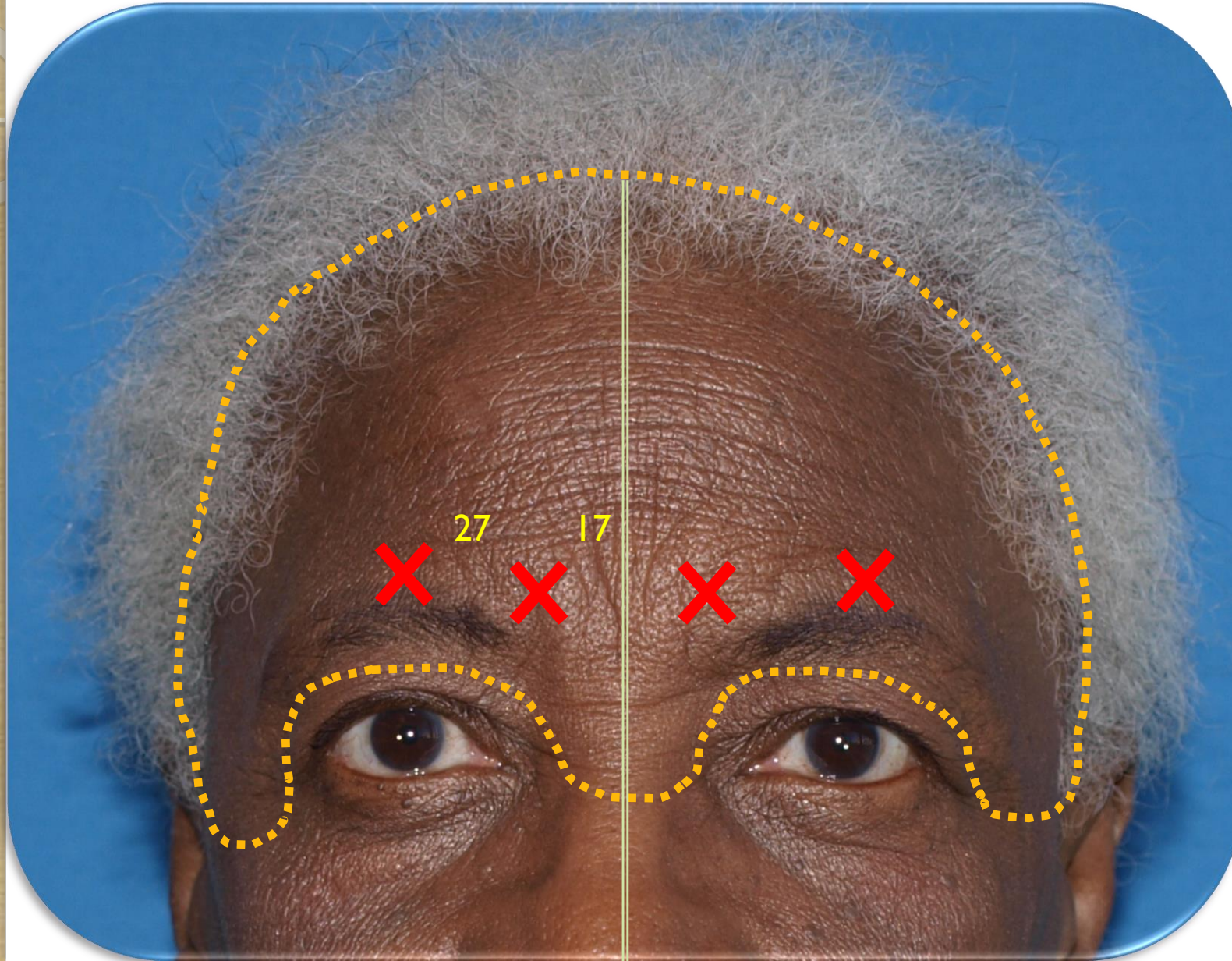
Trichophytic Browlift, Upper Blepharoplasties, and Ptosis Repair



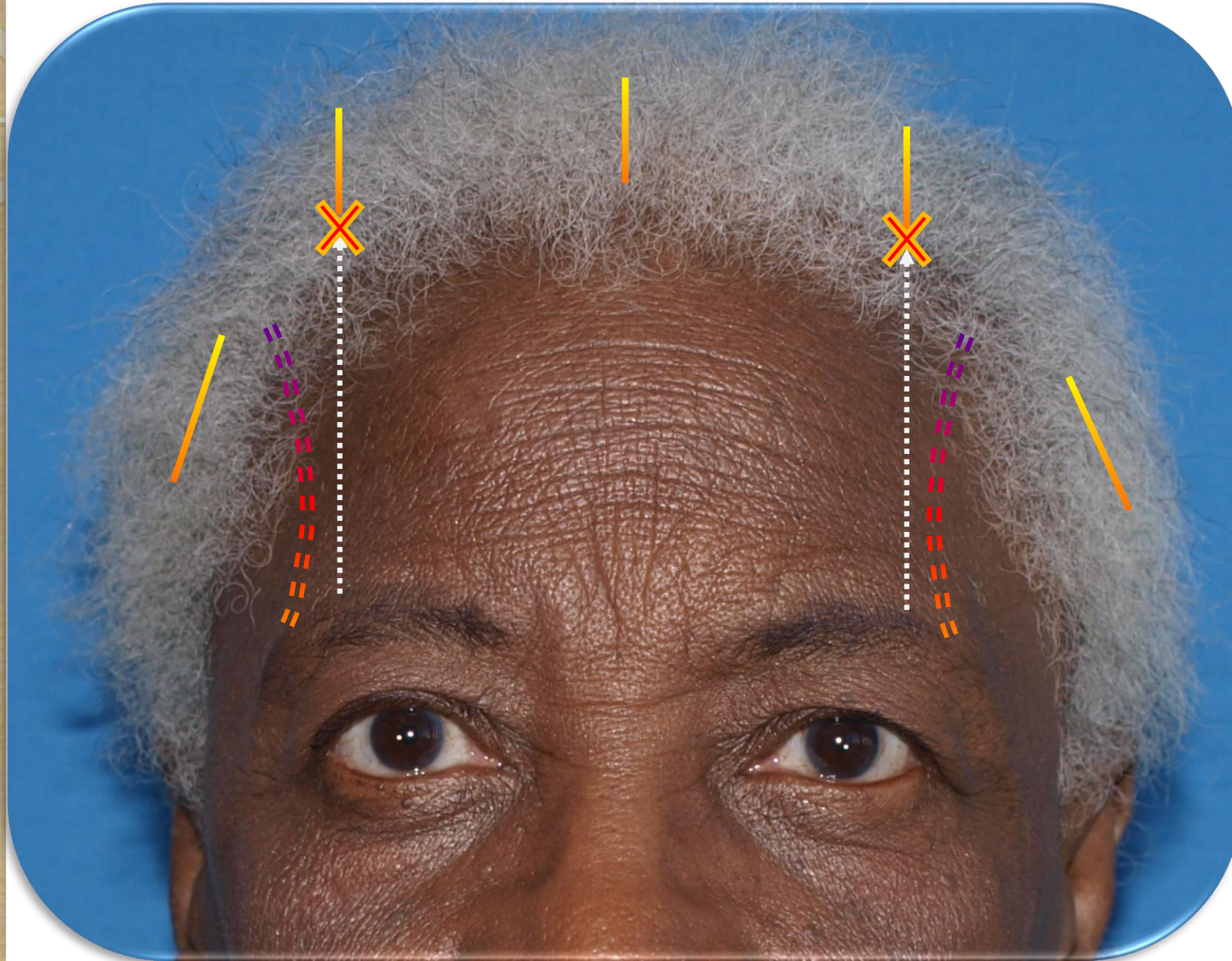
Endoscopic Browlift and Upper blephs



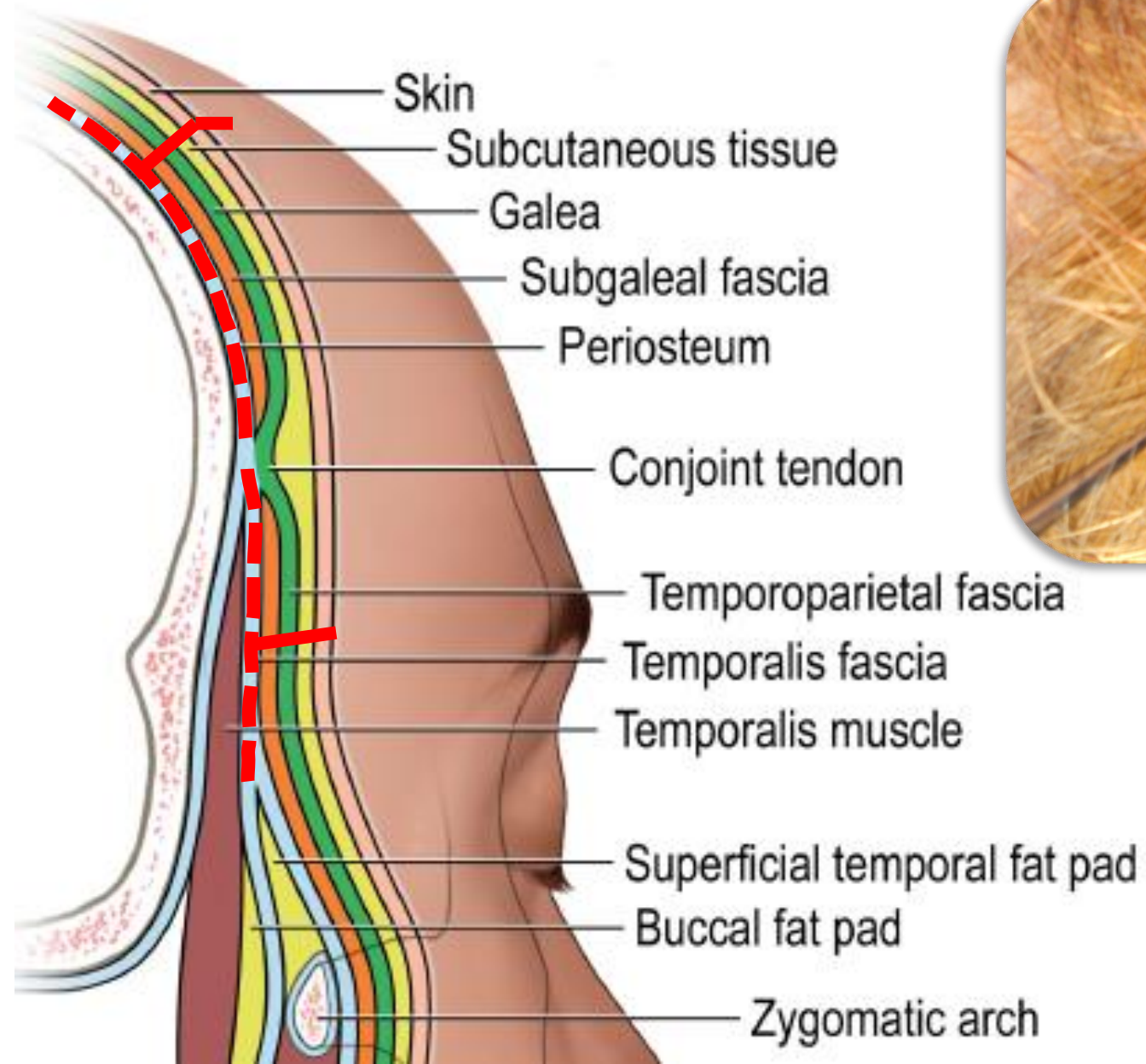
Endoscopic Browlift



Endoscopic Browlift



Endoscopic Browlift



Endoscopic Browlift



Endoscopic Browlift

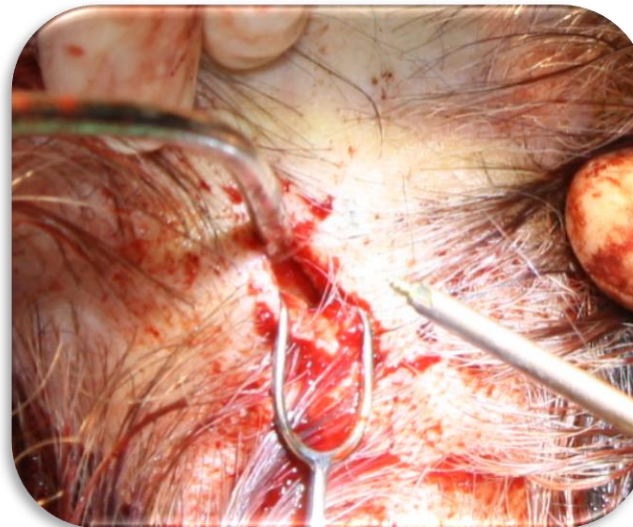
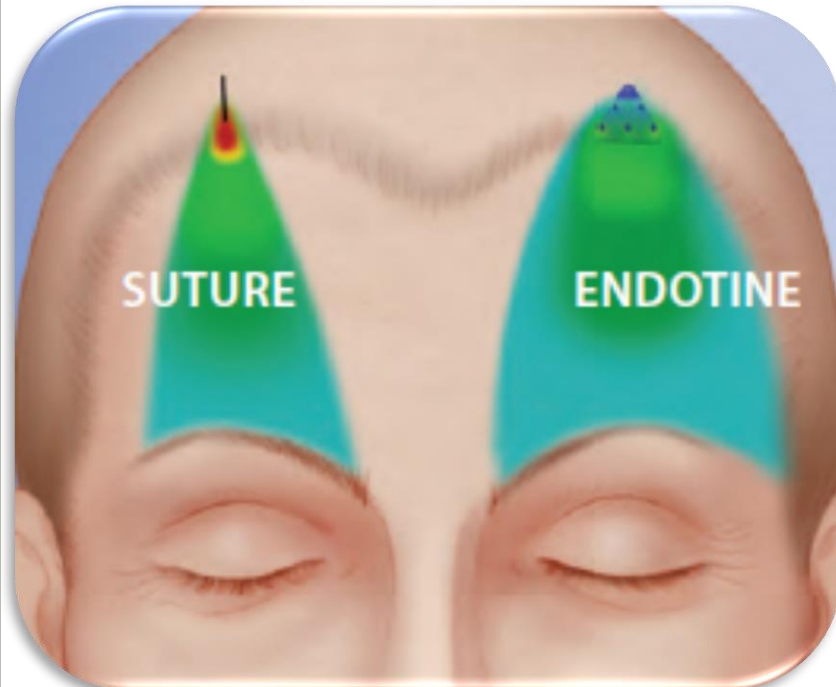


Fixation techniques

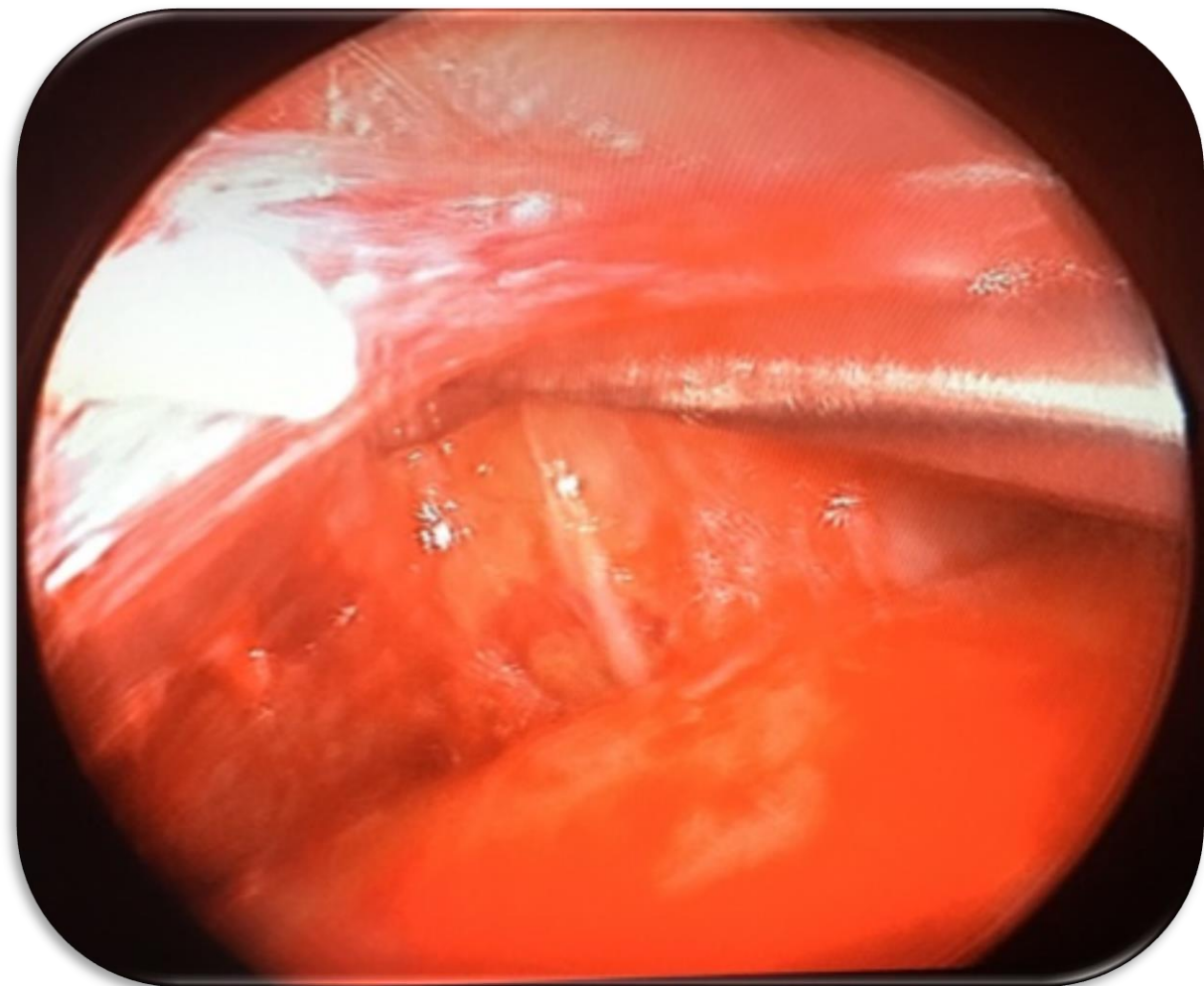
Polylactic acid/Polyglycolic acid

Bone Tunnels

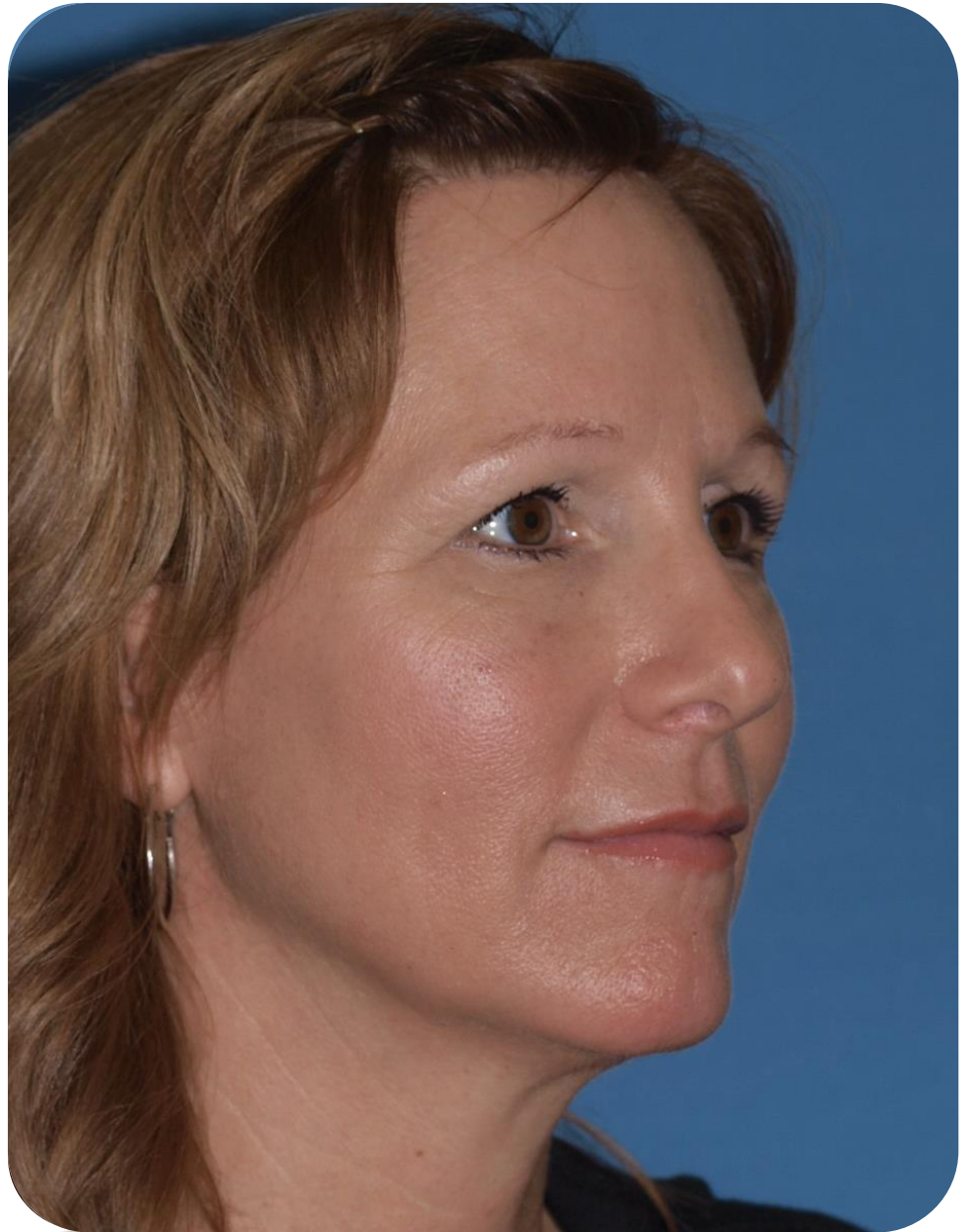
Screw fixation

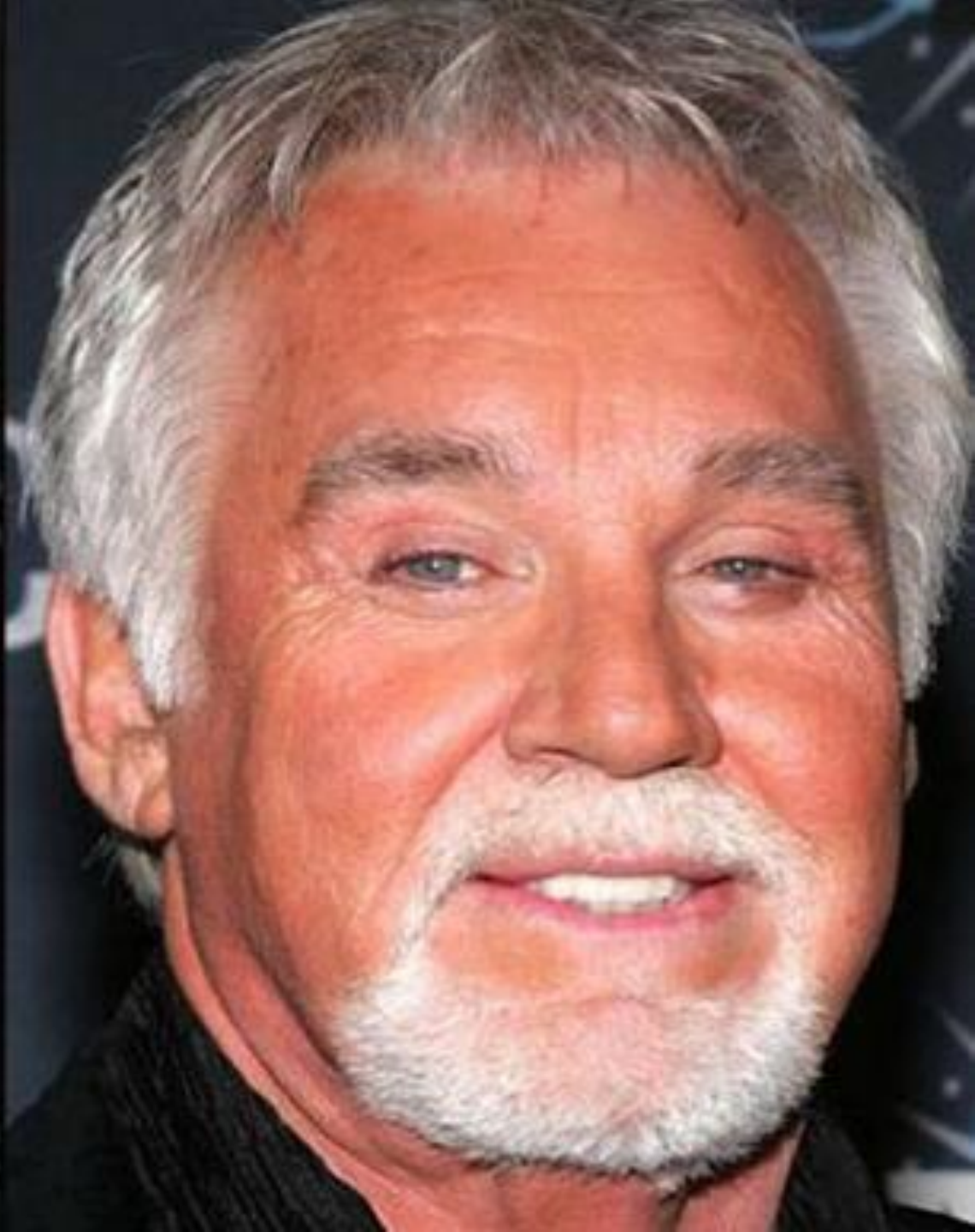
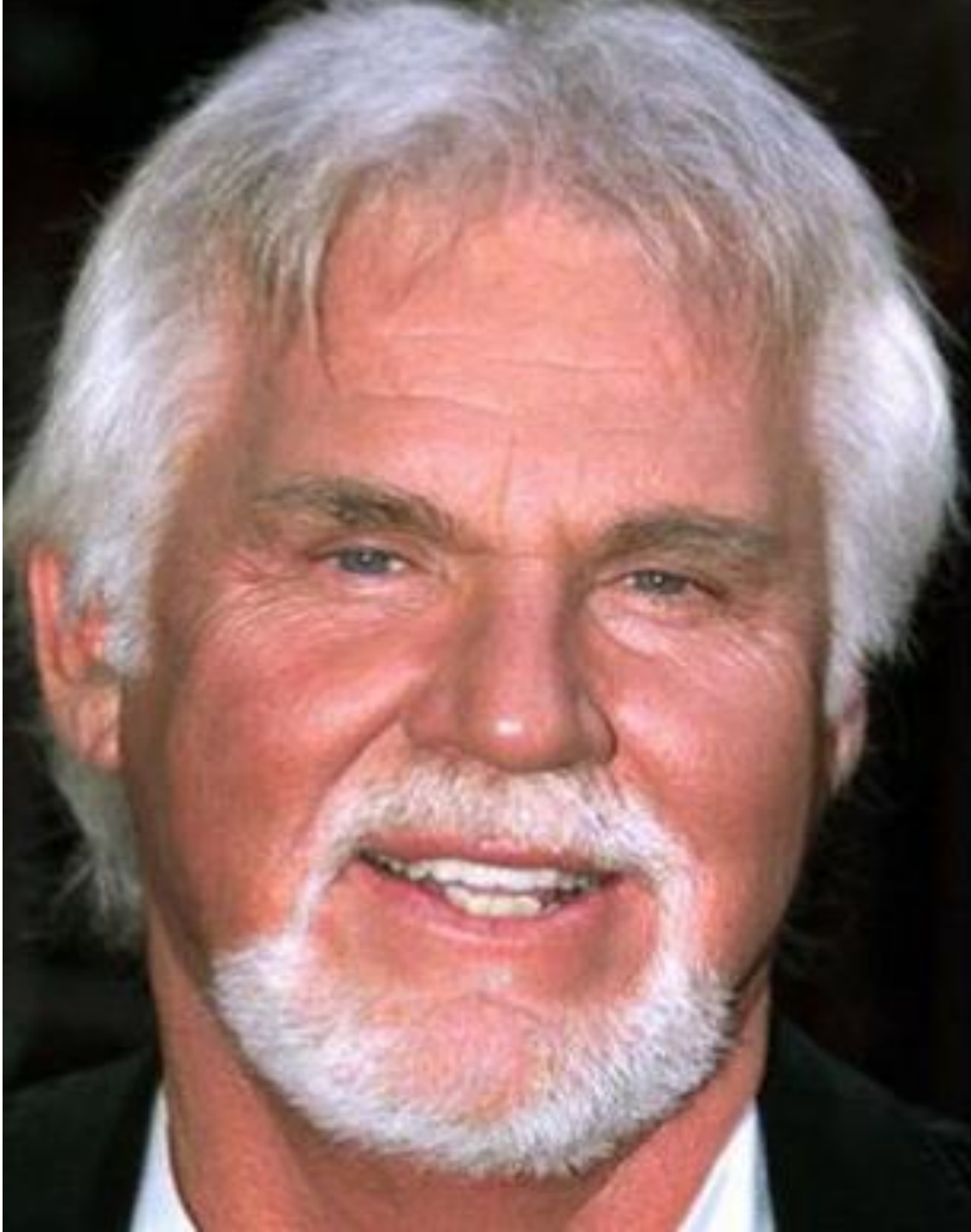












History of Facelift

- Initially elliptical (fusiform) excision of redundant skin
- 50's "classic" facelift in use; subcutaneous only
- 1974 Skoog develops subfascial approach
- 1976 Mitz and Peyronnis defined the SMAS
- 1980's-90's deeper planes being developed (Hamra; deep plane and composite lift)
- Subperiosteal dissection, High SMAS lifts, Connell and Maren 1995
- MACS (Minimal Access Cranial Suspension Lift) lift, Tonnard 2009

Pre-Operative Eval

- Diabetes
- Smoking
- Collagen-vascular disease
- Psychiatric history
- Steroid use
- Hypertension
- Prior surgery
- ASA/NSAIDS
- Herbal meds



Pre-Operative Eval



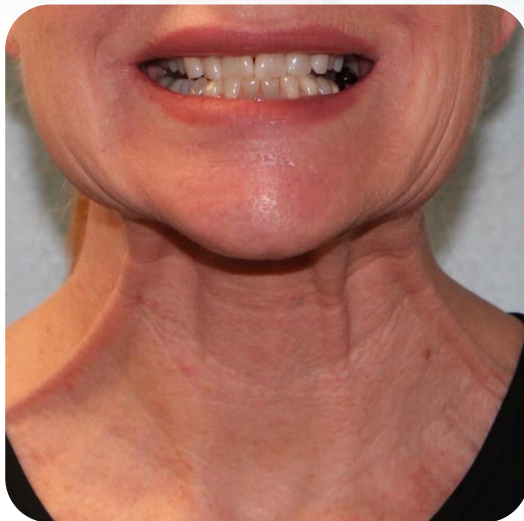
Submental Adiposity



Submandibular Gland Ptosis



Cervical Skin Laxity



Platysmal Banding



Jowling



Deficient Genial Projection

Dedo Classification



A **Class I** normal younger patient with a well defined mental angle, little fat, and good skin and platysma tone.

Class II laxity of the cervical skin without significant fat deposition or muscle pathology. The skin must be redraped so wide undermining is required but a submental incision is usually not needed. A standard rhytidectomy with plication of the SMAS-platysma complex is usually all that is required.

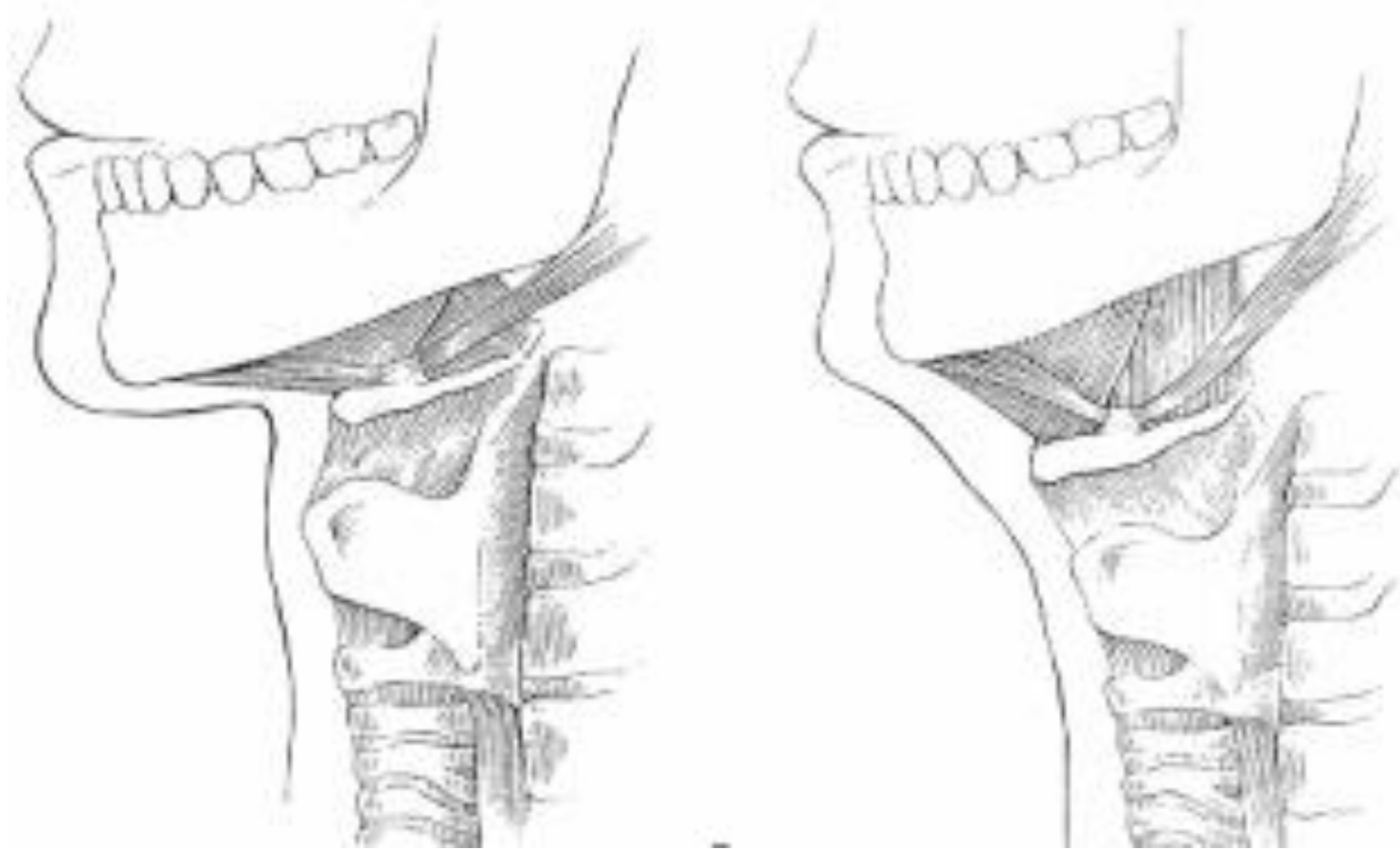
Class III pathologic layer of subcutaneous fat, which is either genetic or acquired and liposuction is usually required to improve the cervical contour.



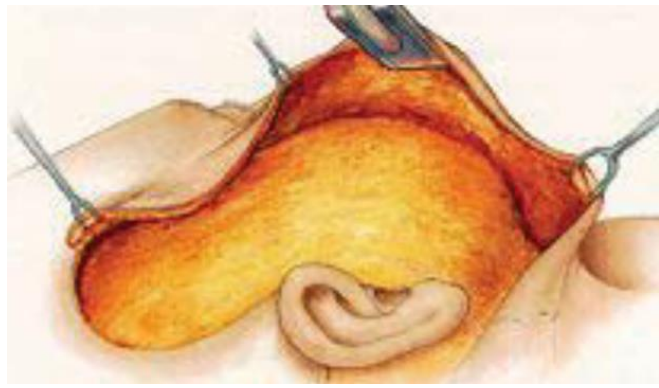
Class IV varying degrees of platysma pathology, which must be diagnosed by voluntary facial grimacing preoperatively. This is usually evident as anterior cervical cording, but it may be difficult to assess the platysma due to fat accumulation. These patients require some form of surgical manipulation of the platysma.

Class V retrognathia that contributes to their neck pathology and may require chin augmentation or mandibular osteotomies.

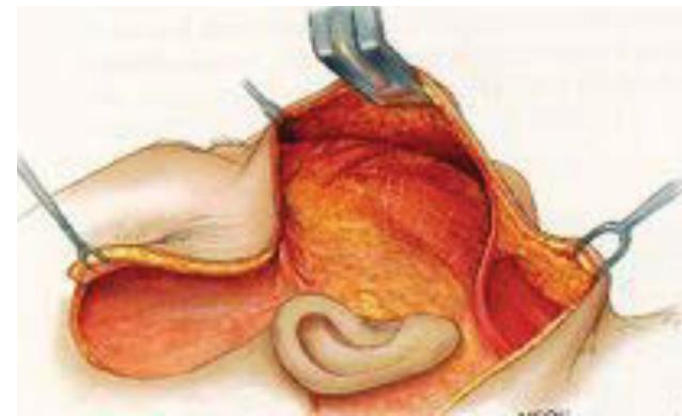
Class VI patients have an abnormal hyoid position. The hyoid is either too low or the mandible-to-hyoid distance is too low, limiting the effect of submental surgery. Patients with abnormally low hyoids (normal is at C4) need to be counseled preoperatively because there are currently no effective procedures to elevate the hyoid and their surgical results will likely be less than optimal.



Ideal hyoid is high and posterior for optimal cervicomenal angle



Skin Flap



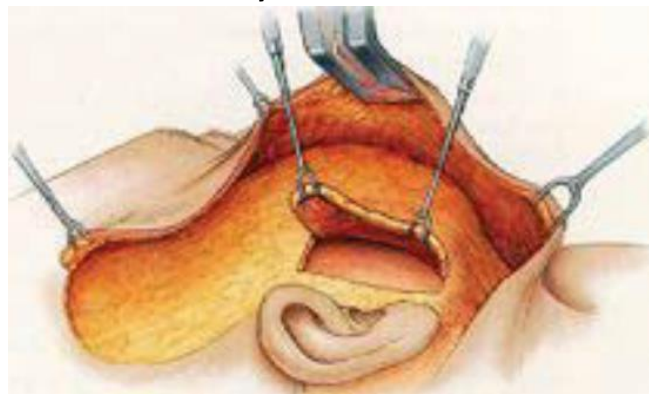
Deep Plane



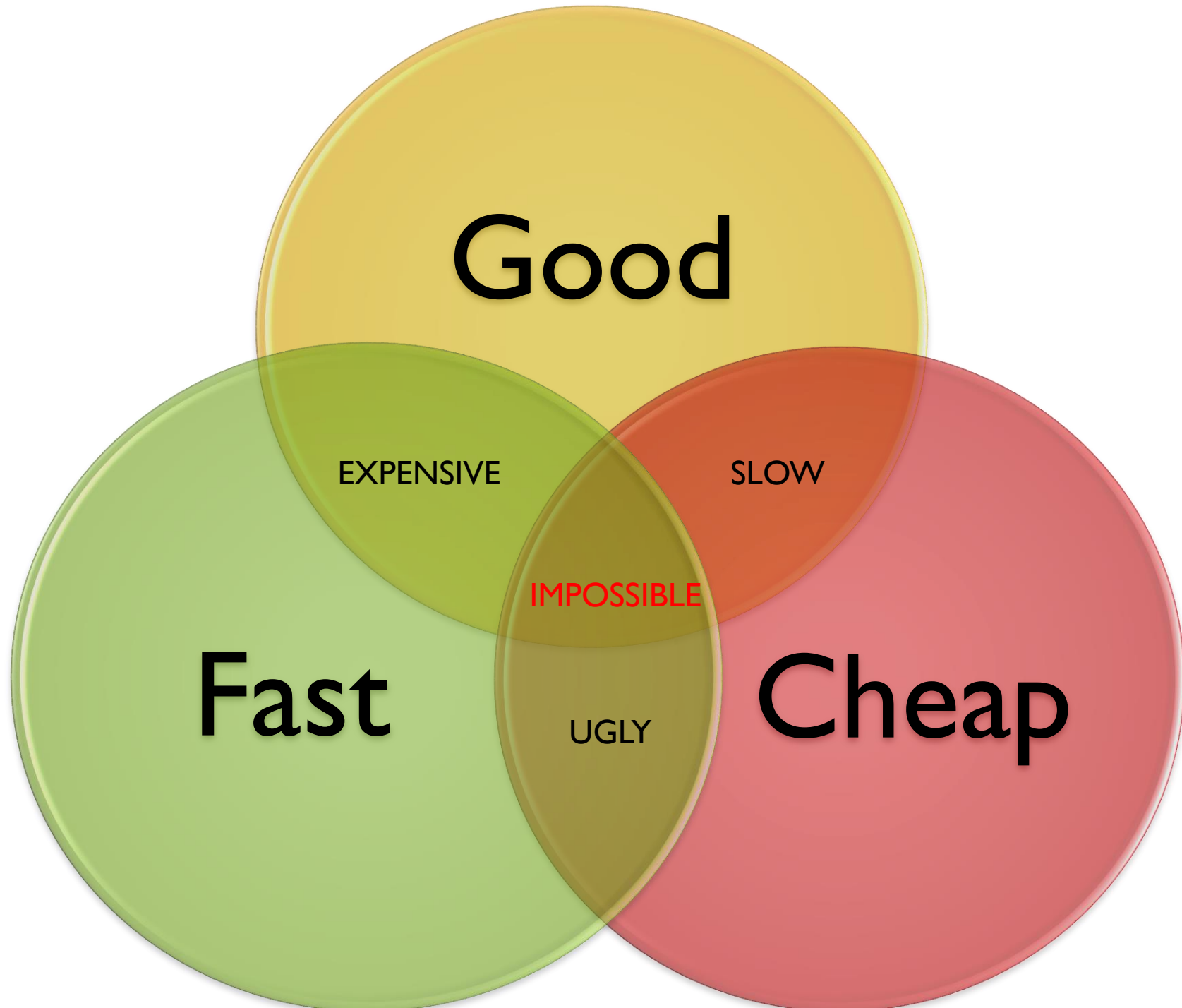
Skin Flap with Plication



Subperiosteal



Sub Musculofascial



The Latest and Greatest?

S-Lift

Quicklift

Lifestyle Lift

Weekend Lift

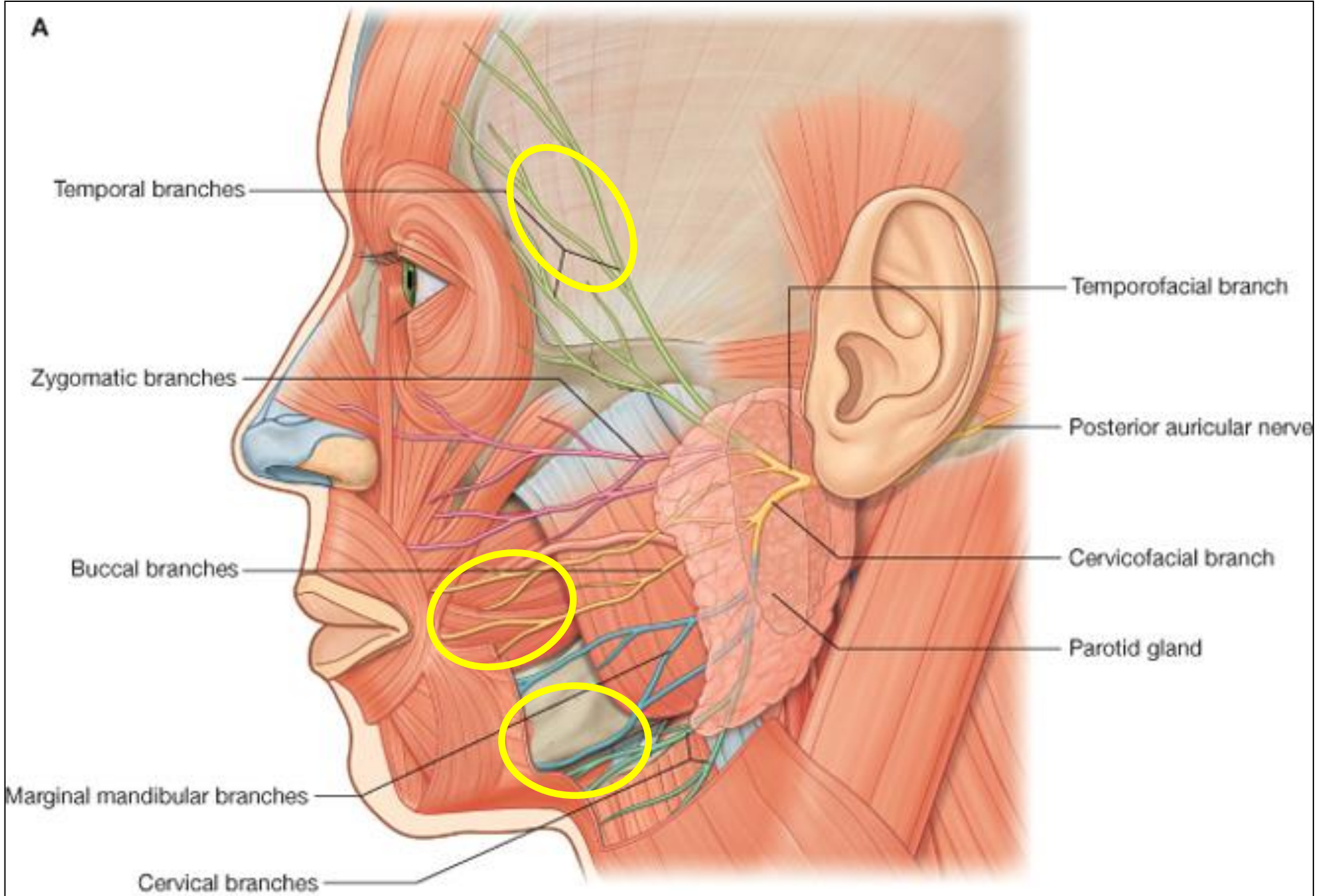
MACS-Lift
The Better Lift



LIFESTYLE LIFT

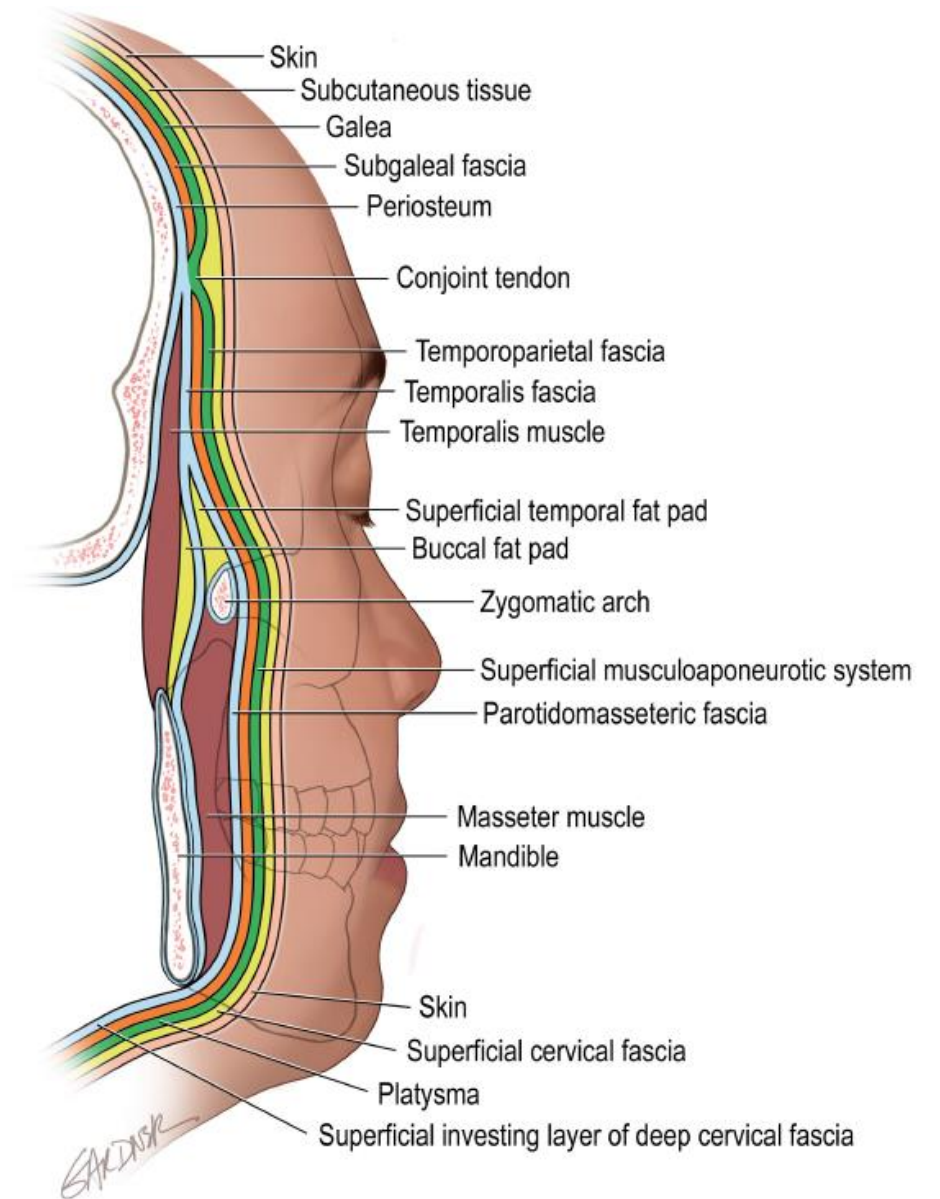


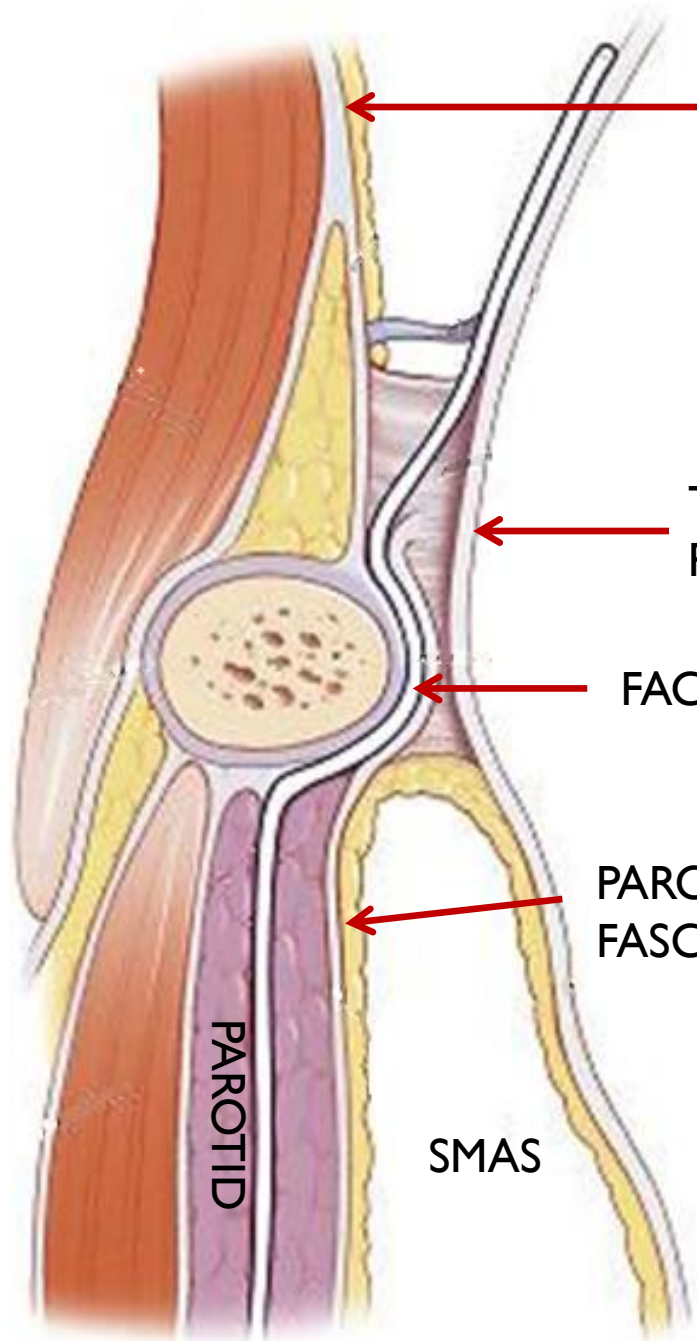
A



The SMAS

- **Superficial Musculo Apneurotic System**
- Contiguous with platysma in the neck and galea of the scalp
- Superior and posterior vector of pull
- Branches of CN VII become superficial past the parotid masseteric fascia
- Temporal branch most commonly injured as it crosses the arch





TEMPORALIS
FASCIA

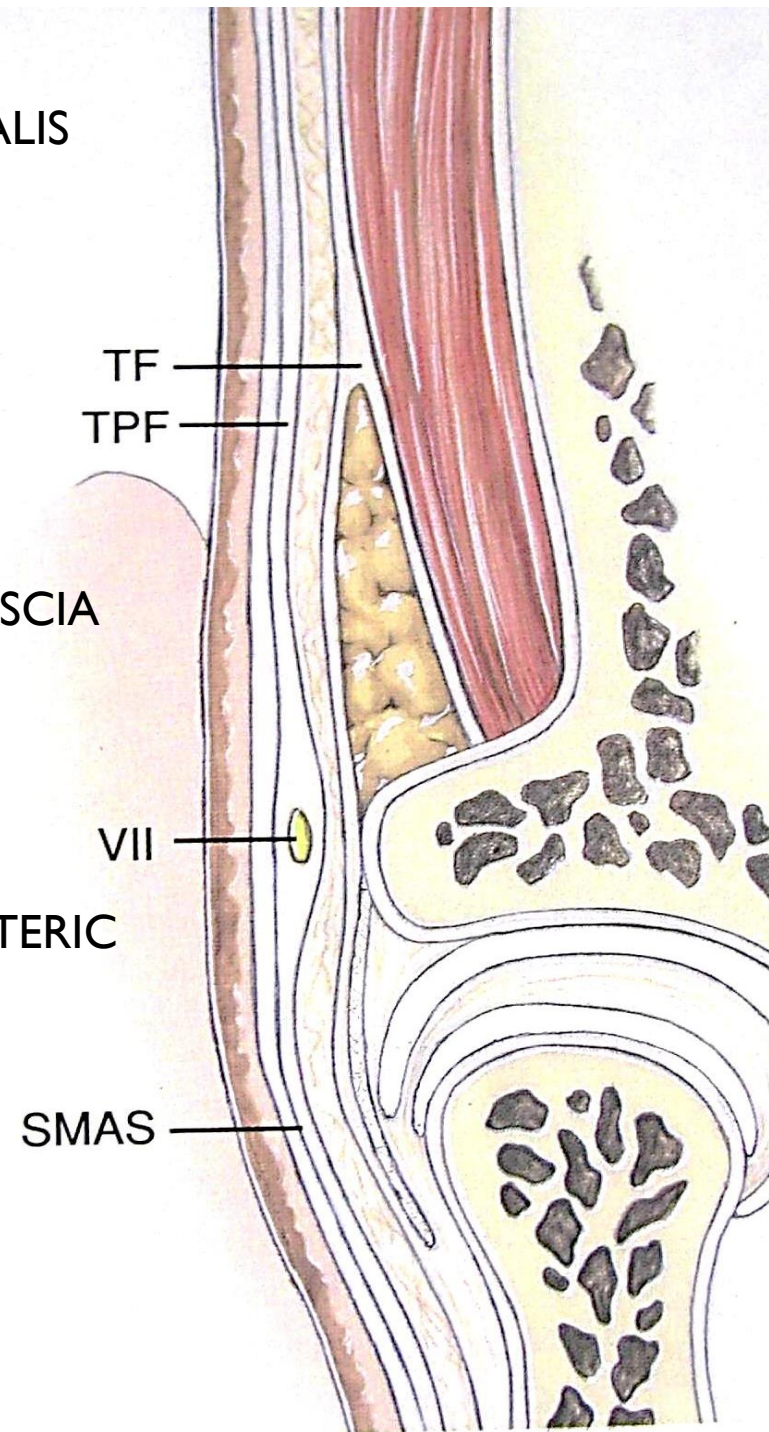
TEMPORAL-
PARIETAL FASCIA

FACIAL NERVE

PAROTID-MASSETERIC
FASCIA

PAROTID

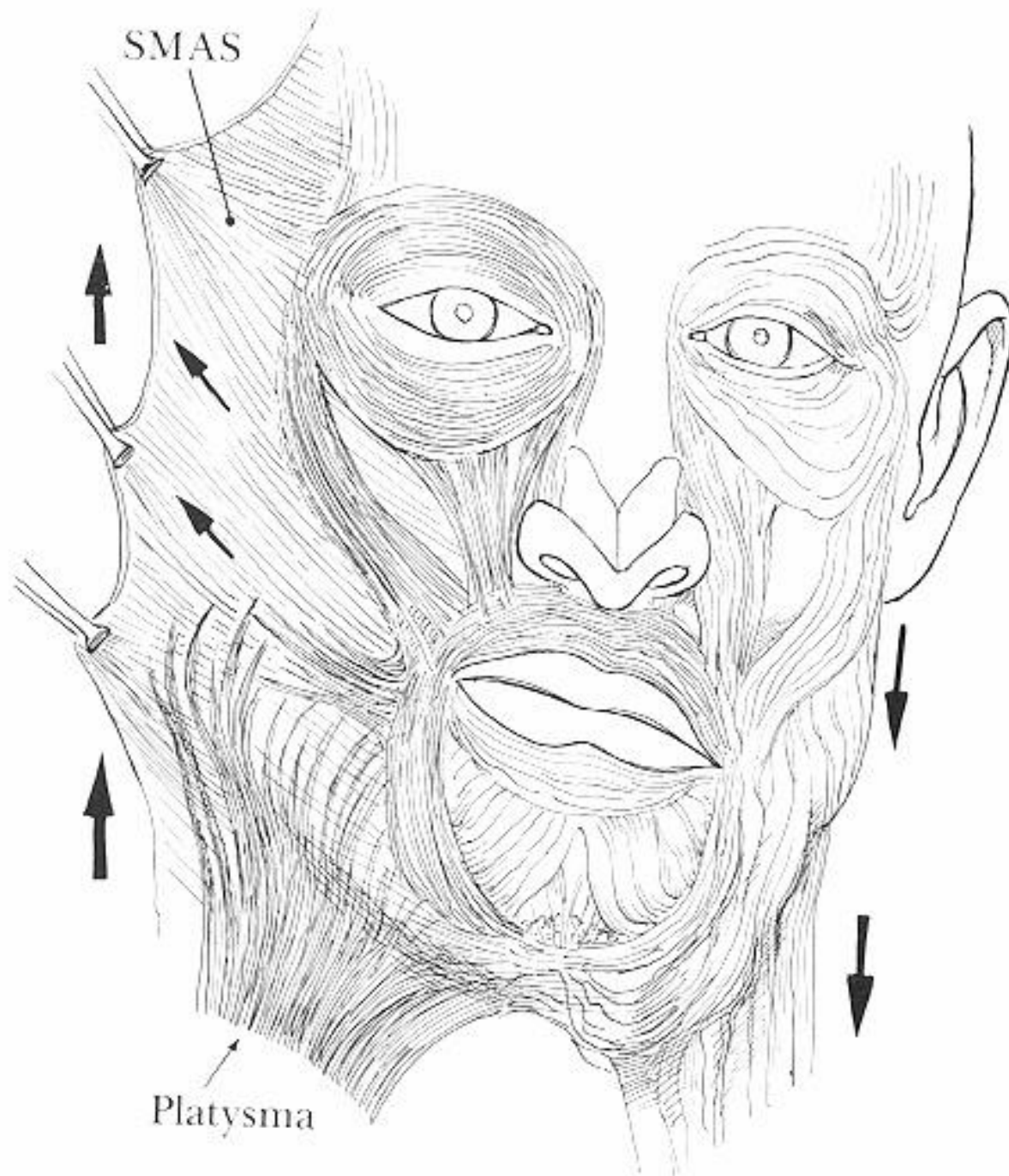
SMAS



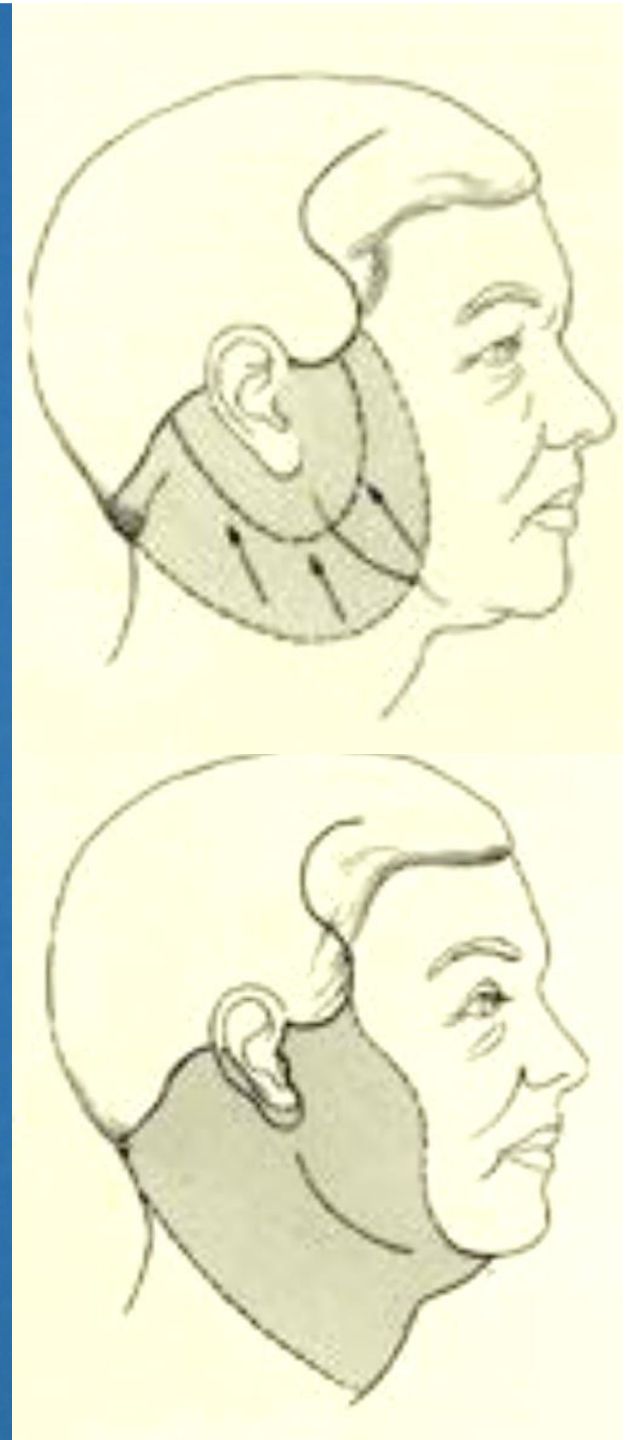
TF
TPF

VII

SMAS



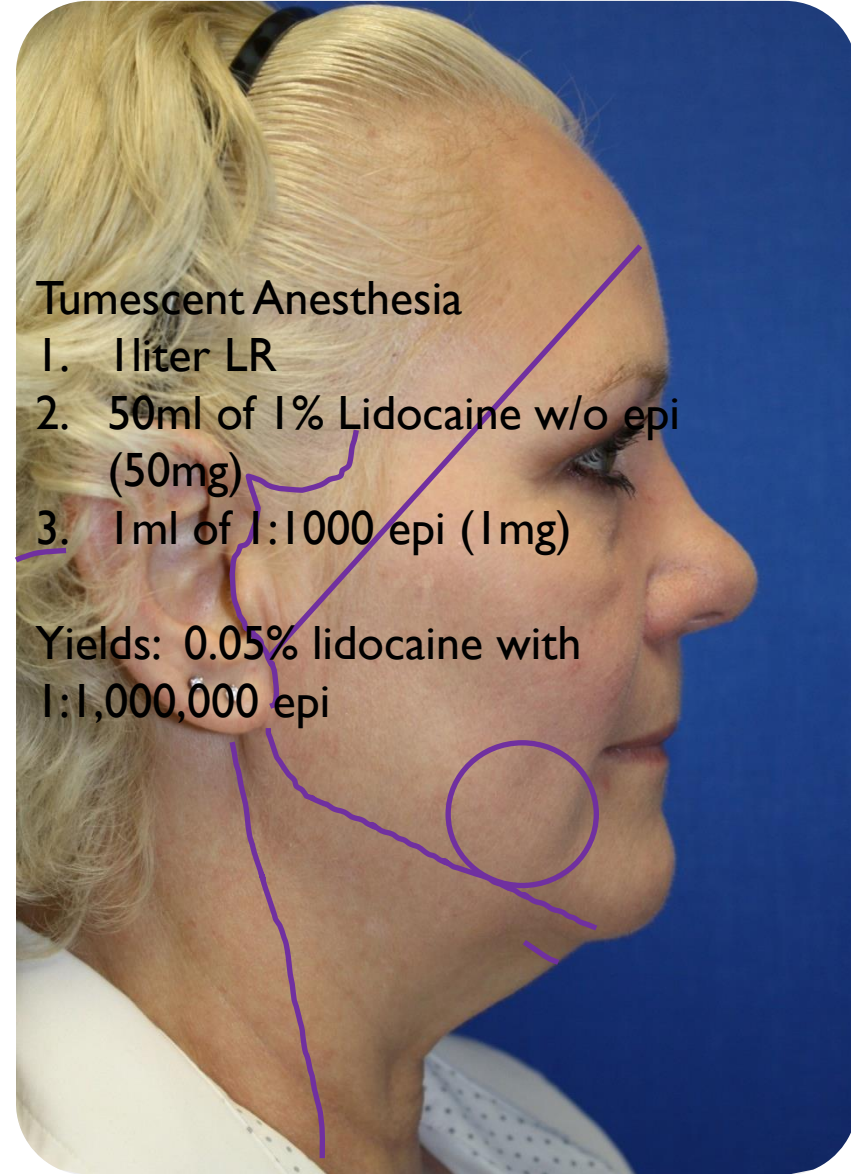
- SMAS is a single continuous layer, containing platysma, mimetic muscles of the face and the temporoparietal fascia
- The mimetic muscles & SMAS move as a single layer during facial animation
- Skin is an **elastic, distensible** layer that covers and contours over the underlying structures
- SMAS is a **sturdy, fibrous, inelastic** layer, thicker posteriorly, overlying the parotid gland, thin over the masseter
- SMAS facelift consists of two layers (skin and SMAS) which are undermined and suspended independently





Sequence

1. Consent
2. Mark the patient
3. To the OR to prep and drape
4. Tumescent anesthesia
5. Submental liposuction
6. Platysmaplasty
7. Face lift incision
8. Subcutaneous dissection
9. Skin cutbacks
10. SMAS work (plication, imbrication, SMASectomy, Bi-plane, deep, etc.)
11. Hemostasis
12. Drains?
13. Closure
14. Home

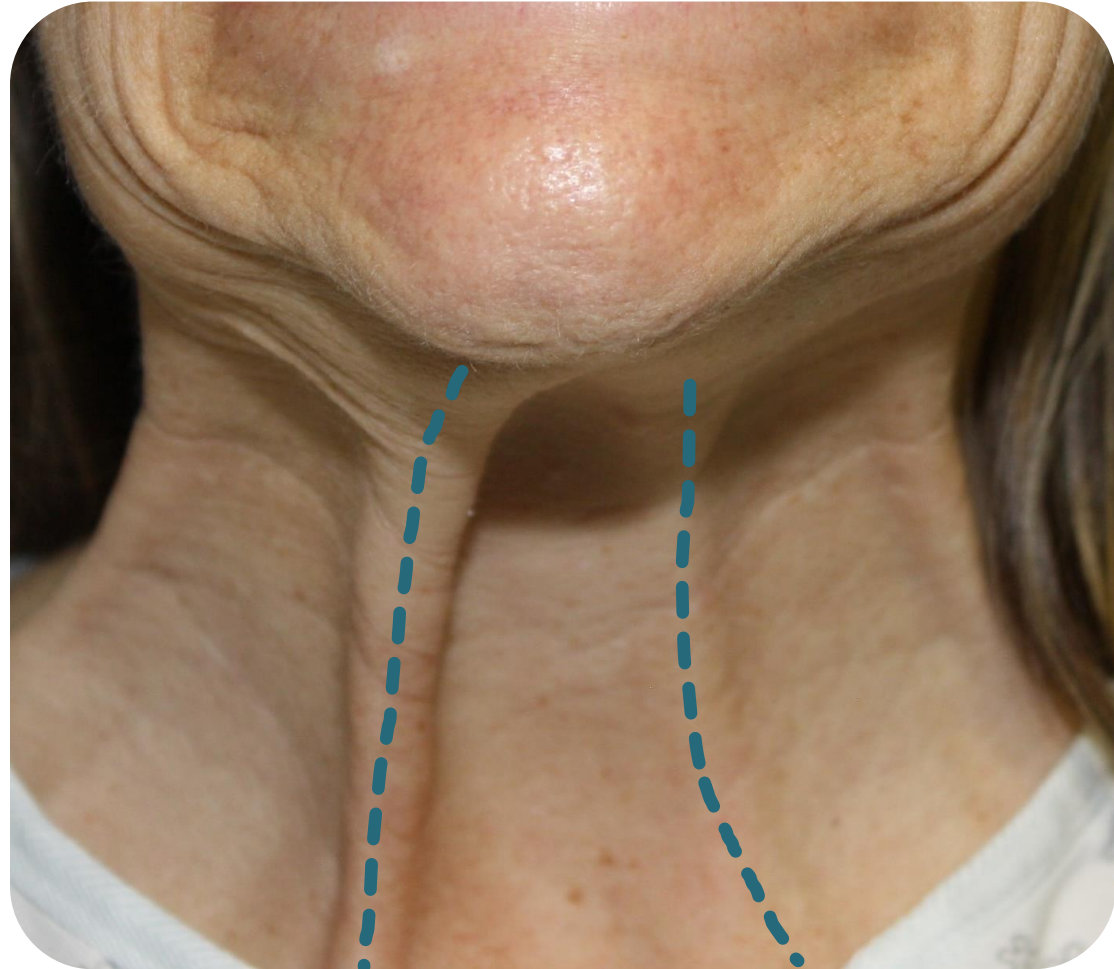
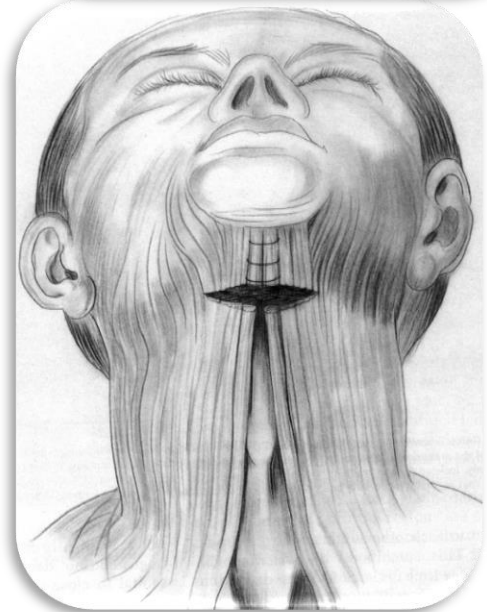
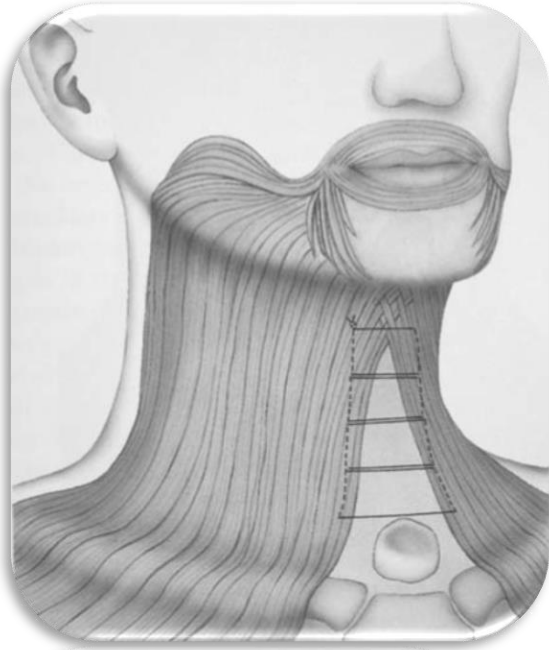


Tumescent Anesthesia

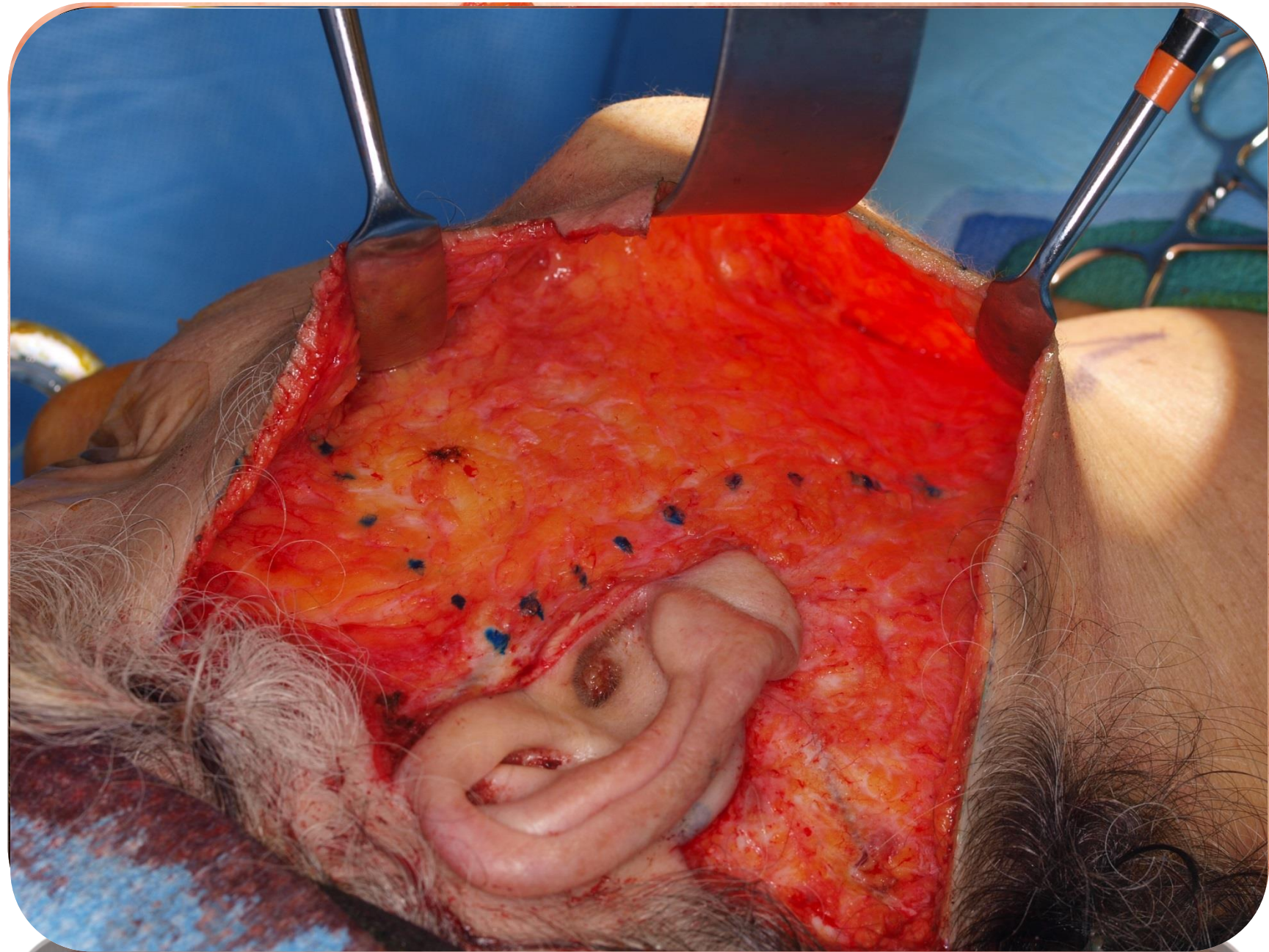
1. 1 liter LR
2. 50ml of 1% Lidocaine w/o epi (50mg)
3. 1ml of 1:1000 epi (1mg)

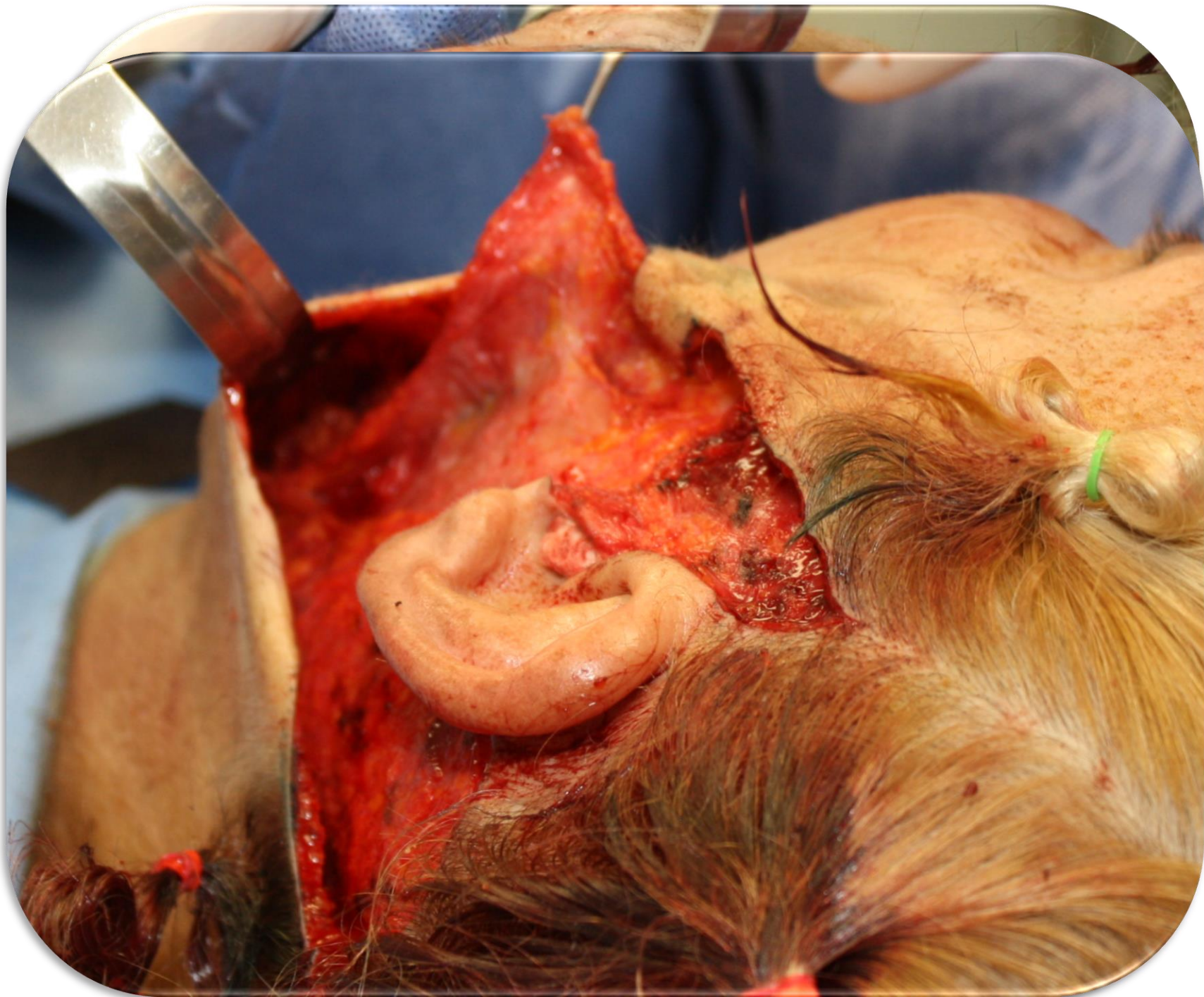
Yields: 0.05% lidocaine with
1:1,000,000 epi

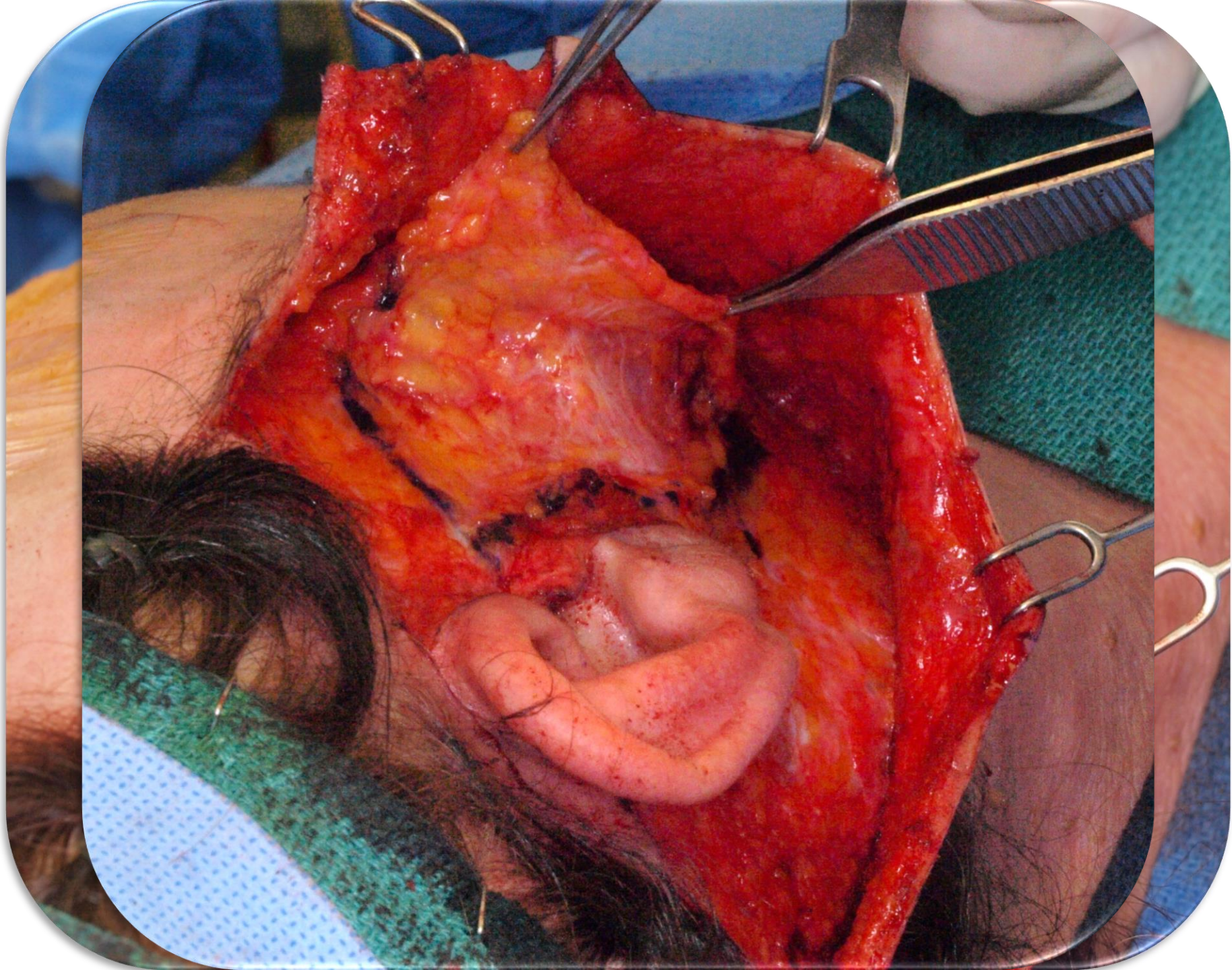
Platysmaplasty













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FACIAL COSMETIC SURGERY

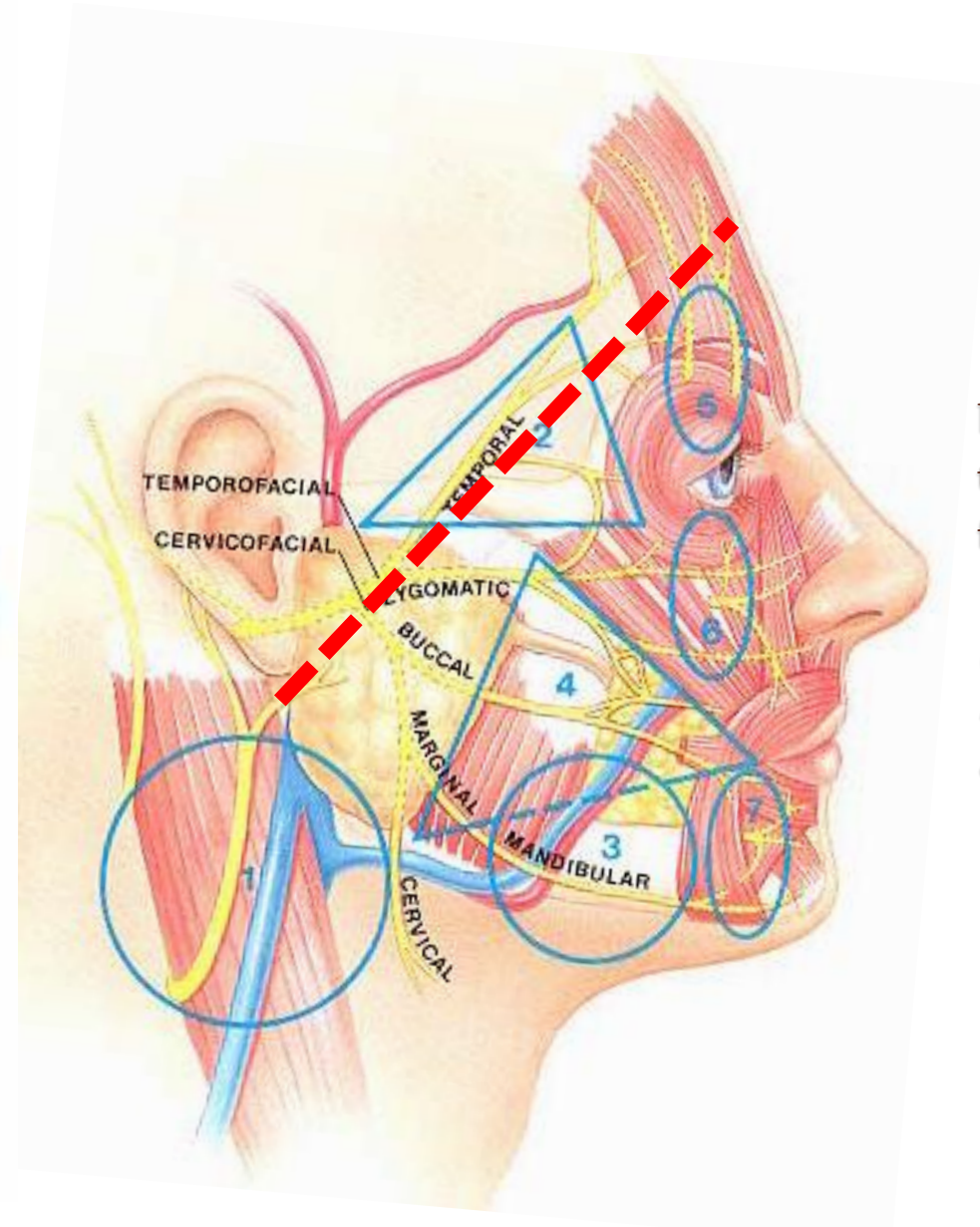
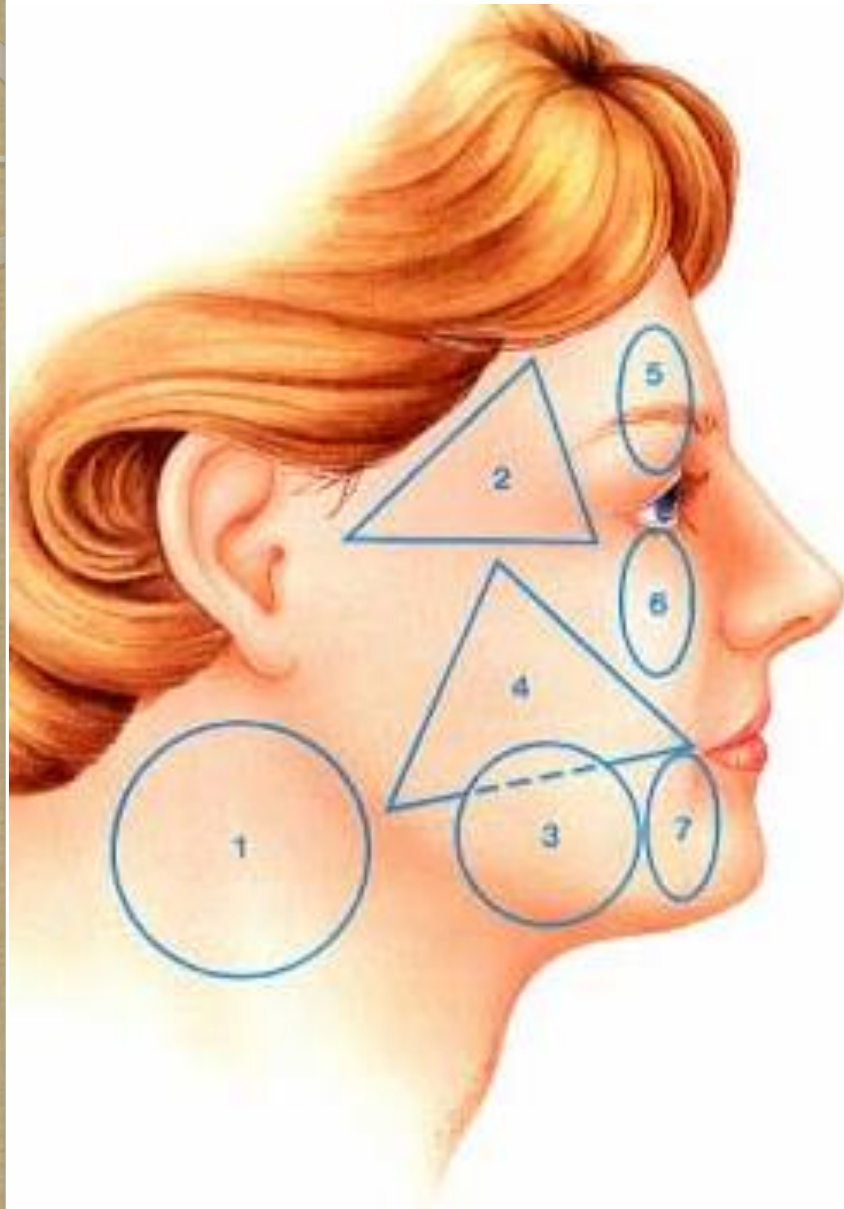


DIEPENBROCK

FACIAL COSMETIC SURGERY



Complications

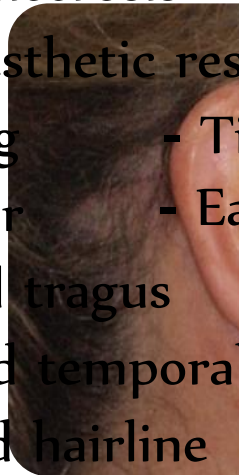


Pitanguy line defines the course of the frontal branches of VII

(ear lobule to ½ way between ear & lateral canthus)

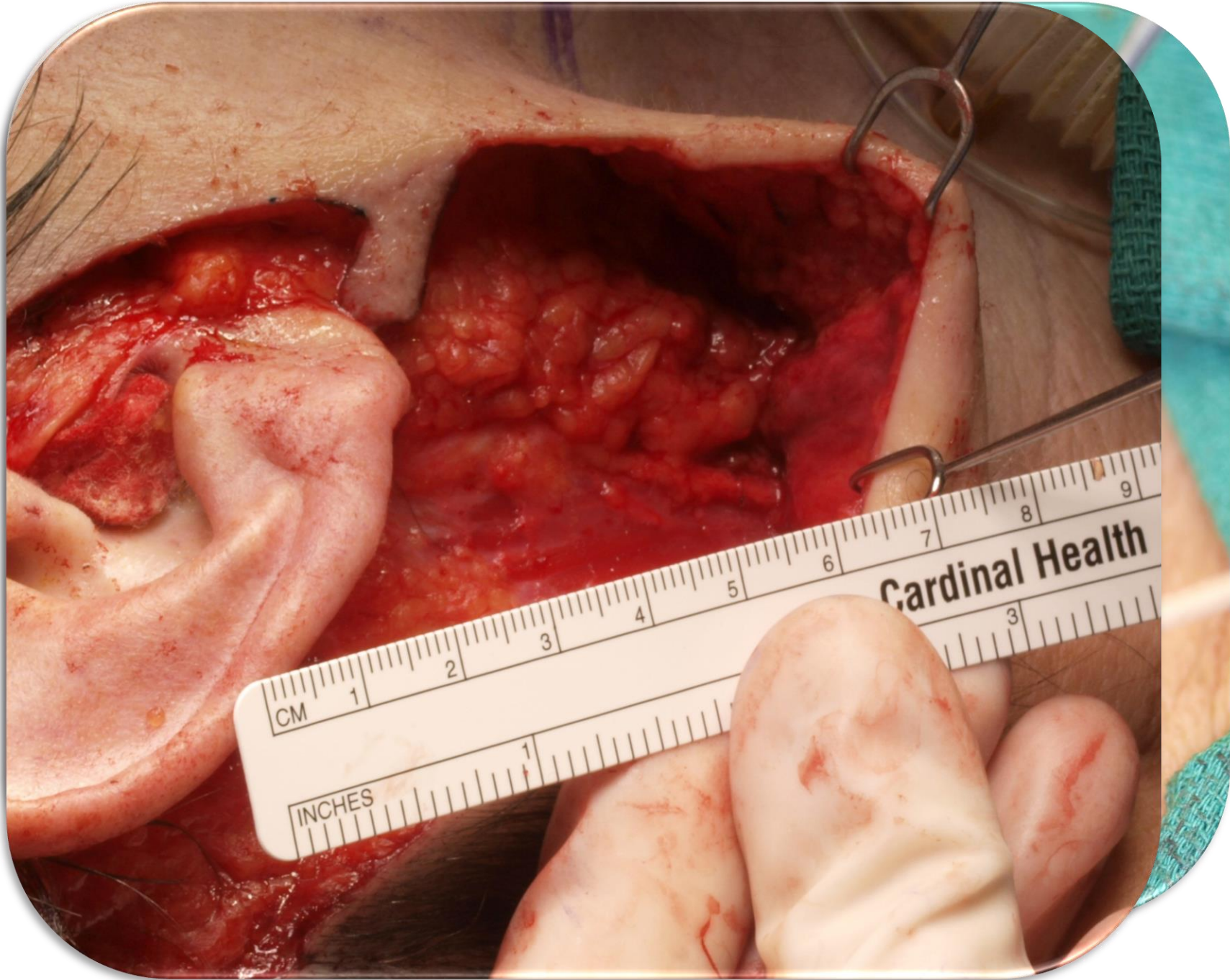
Complications

- Sensory nerve damage - Time, Reassurance, patience
- Facial nerve damage - Time, neurotoxin, facial reanimation, lawyer
- Hematoma - Drainage, pressure dressing, return to operating room
- Sialocele - drainage, pressure dressing, antisialagogues, patience
- Alopecia - Time, hair transplant
- Tissue necrosis - H₂O₂/H₂O, keep moist, nitro-paste, hyperbarics



or aesthetic res
rring - Ti
ie ear - Ea
nted tragus
vated temporal
pped hairline

council
car revision





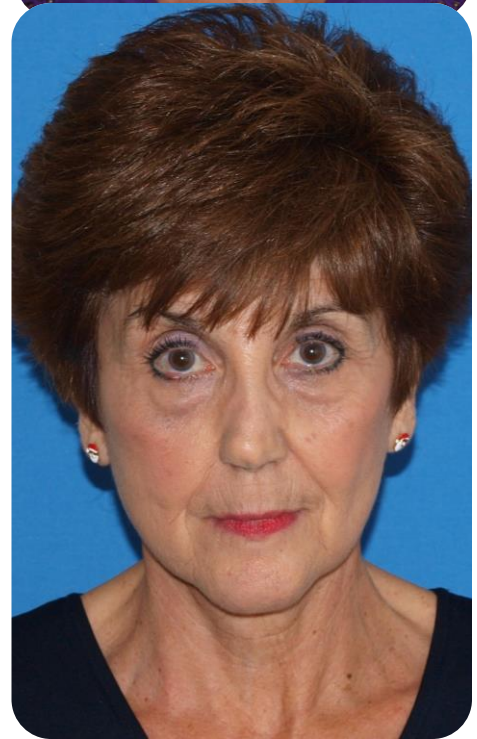
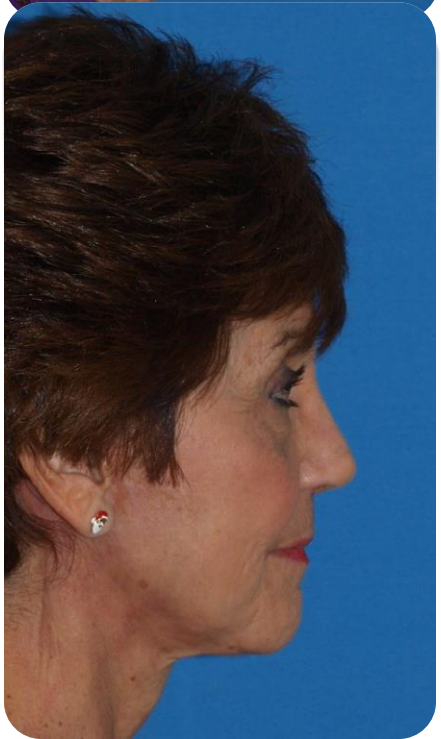
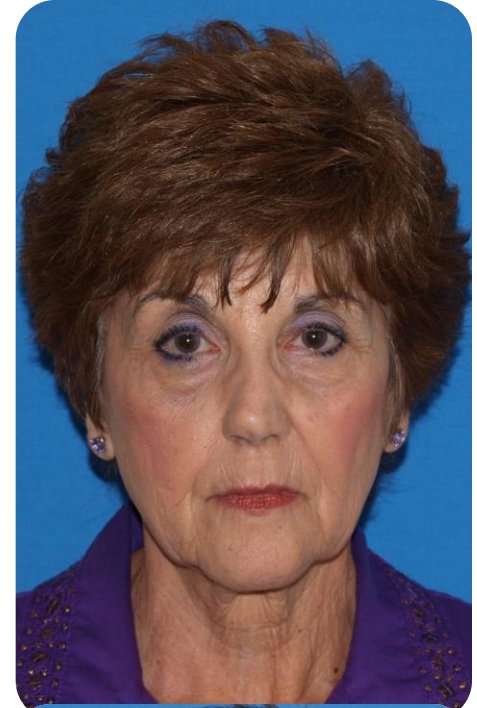
DIEPENBROCK

FACIAL COSMETIC SURGERY

*Face lift, Neck lift, Upper and Lower Blephs,
Cheek and Chin Implants*









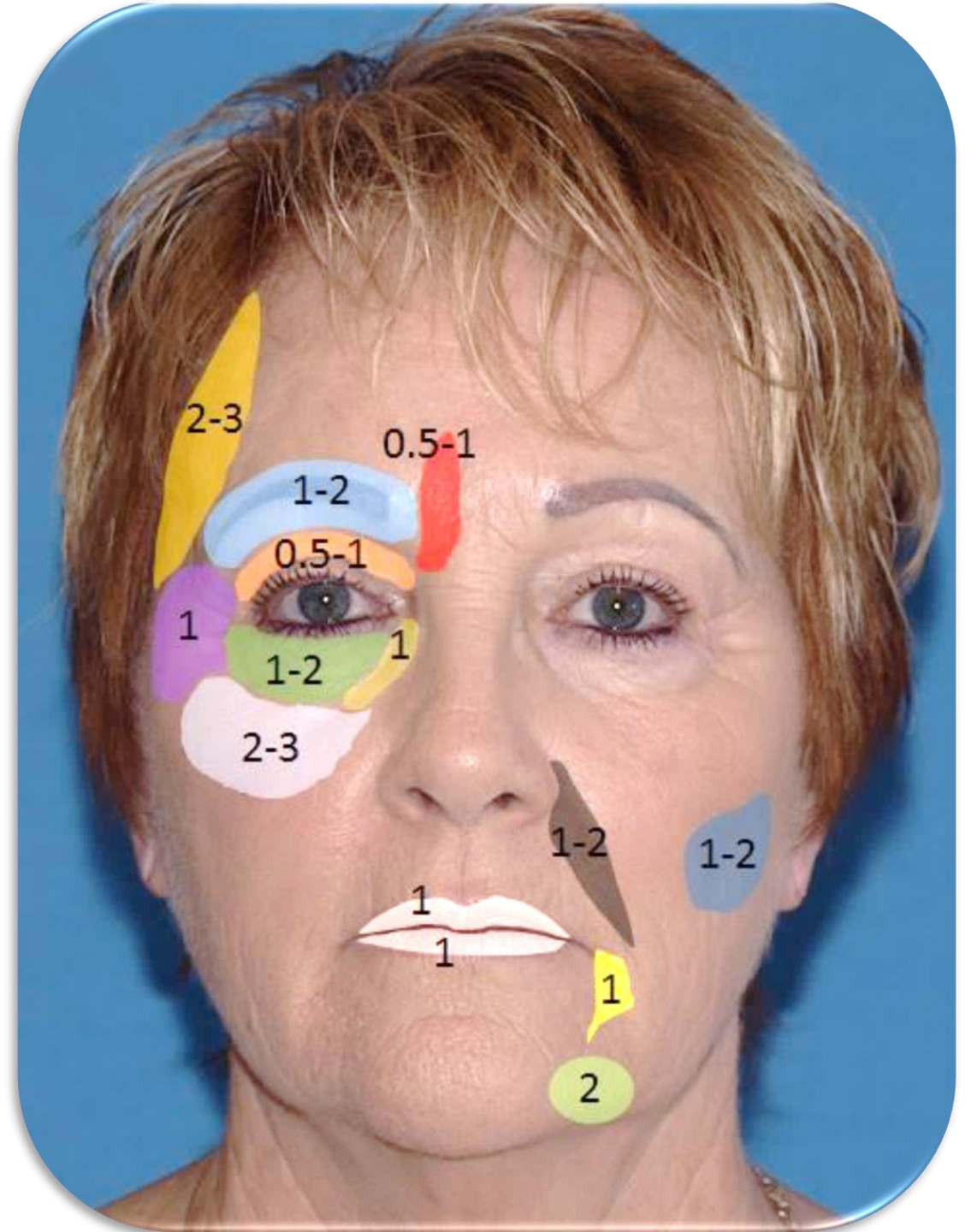
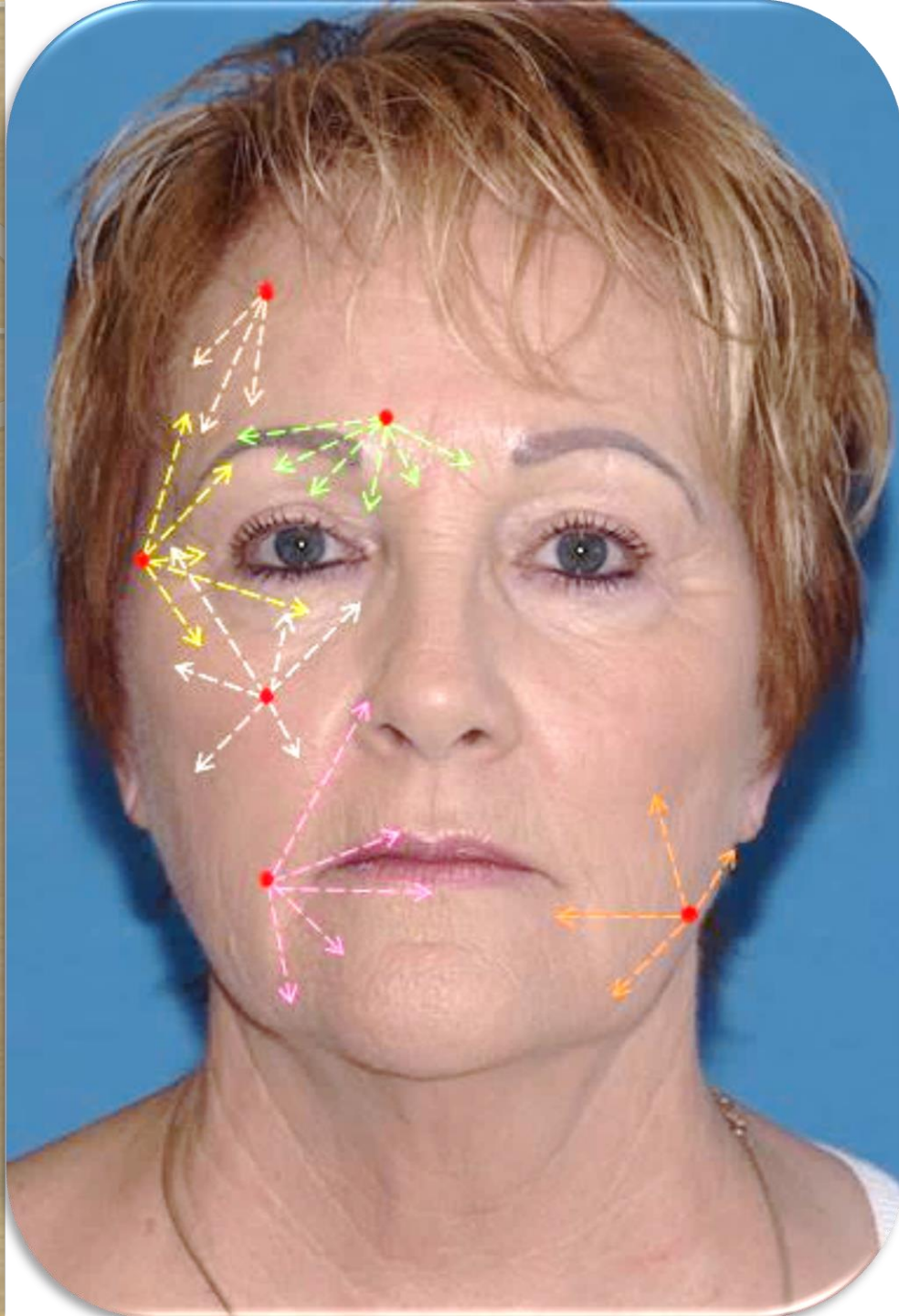
Fat Grafting

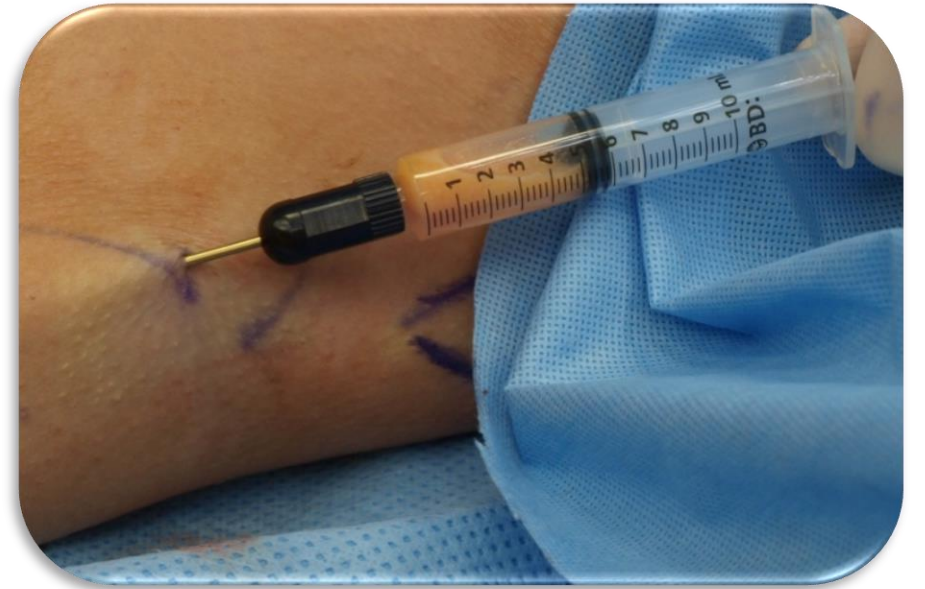


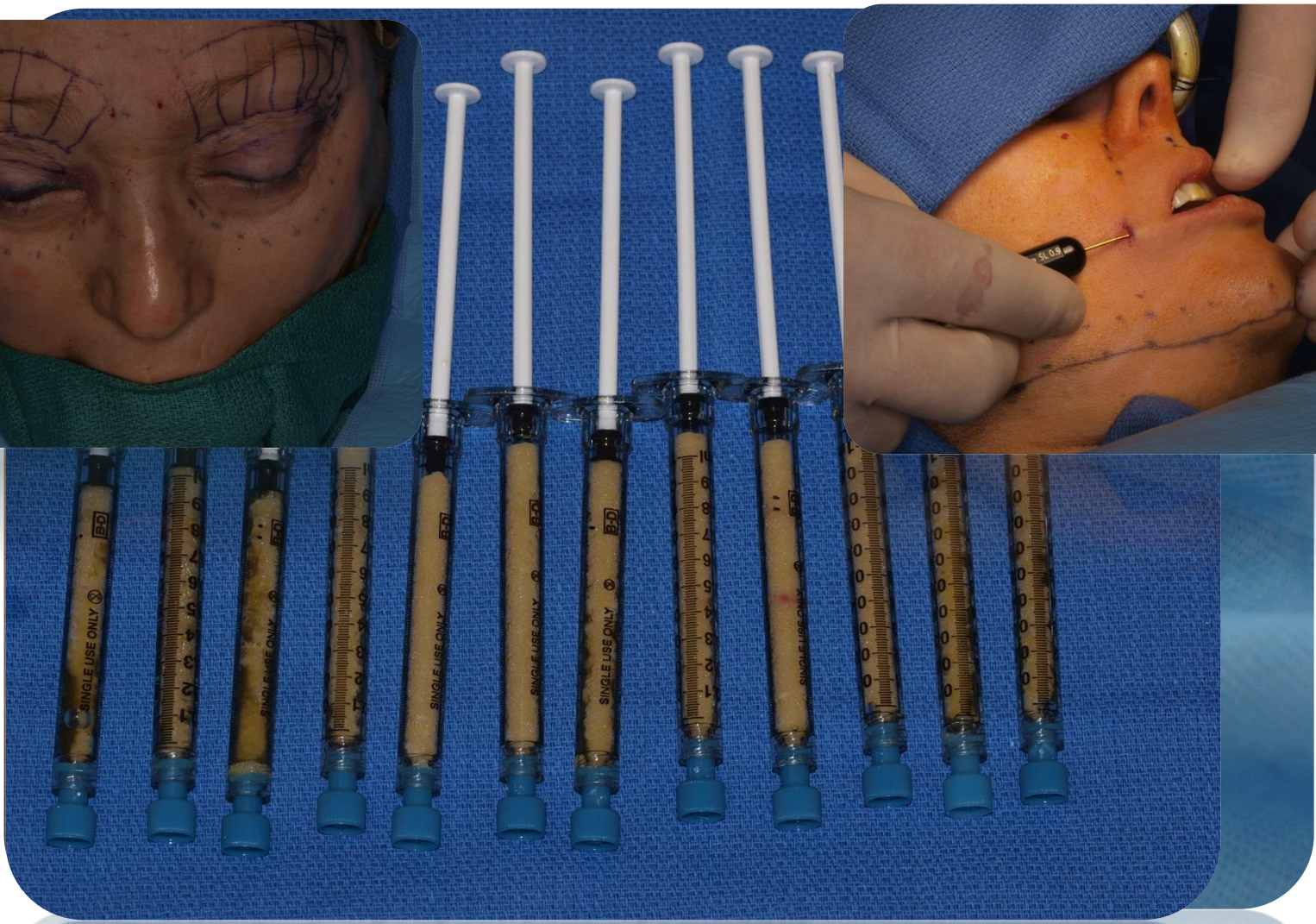
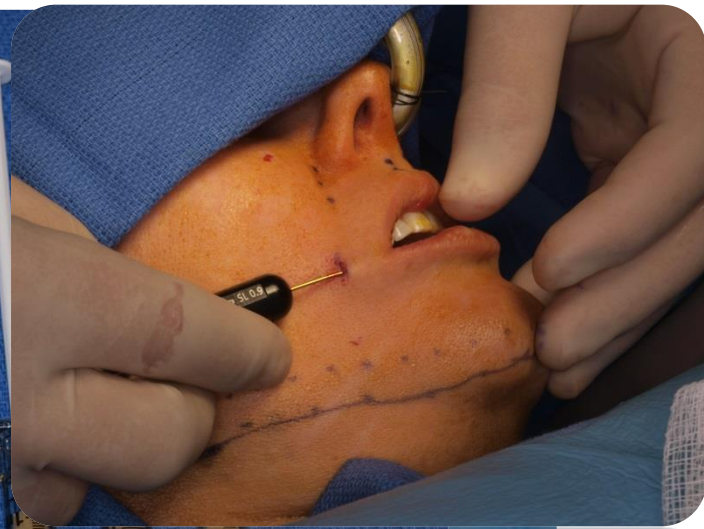
Fat Grafting Technique

1. Less manipulation the better to produce high yield adipocytes
2. Harvested from flanks, thighs, buttocks, abdomen (periumbilical)
3. Prepped/draped/local anes/Tumescent
4. Harvested with low suction and handheld syringe w/ harvest cannula
5. Fat is centrifuged or gravity separated
6. Transferred to smaller (1-5ml) syringes leaving infranate
7. Small ribbons or pearls into sub periosteum, muscular, sub-q, superficial fat layer
8. Overcorrected in cross-hatch pattern
9. Usually require multiple appointments (can be frozen up to 18m)







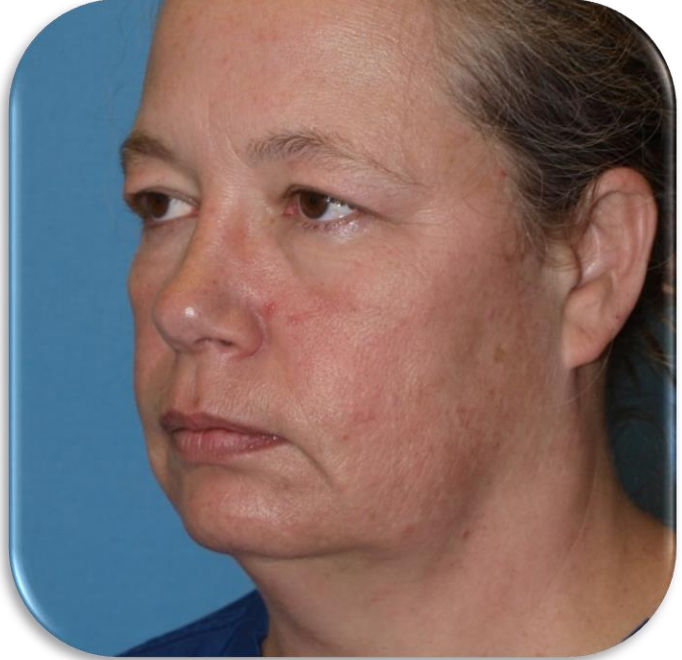


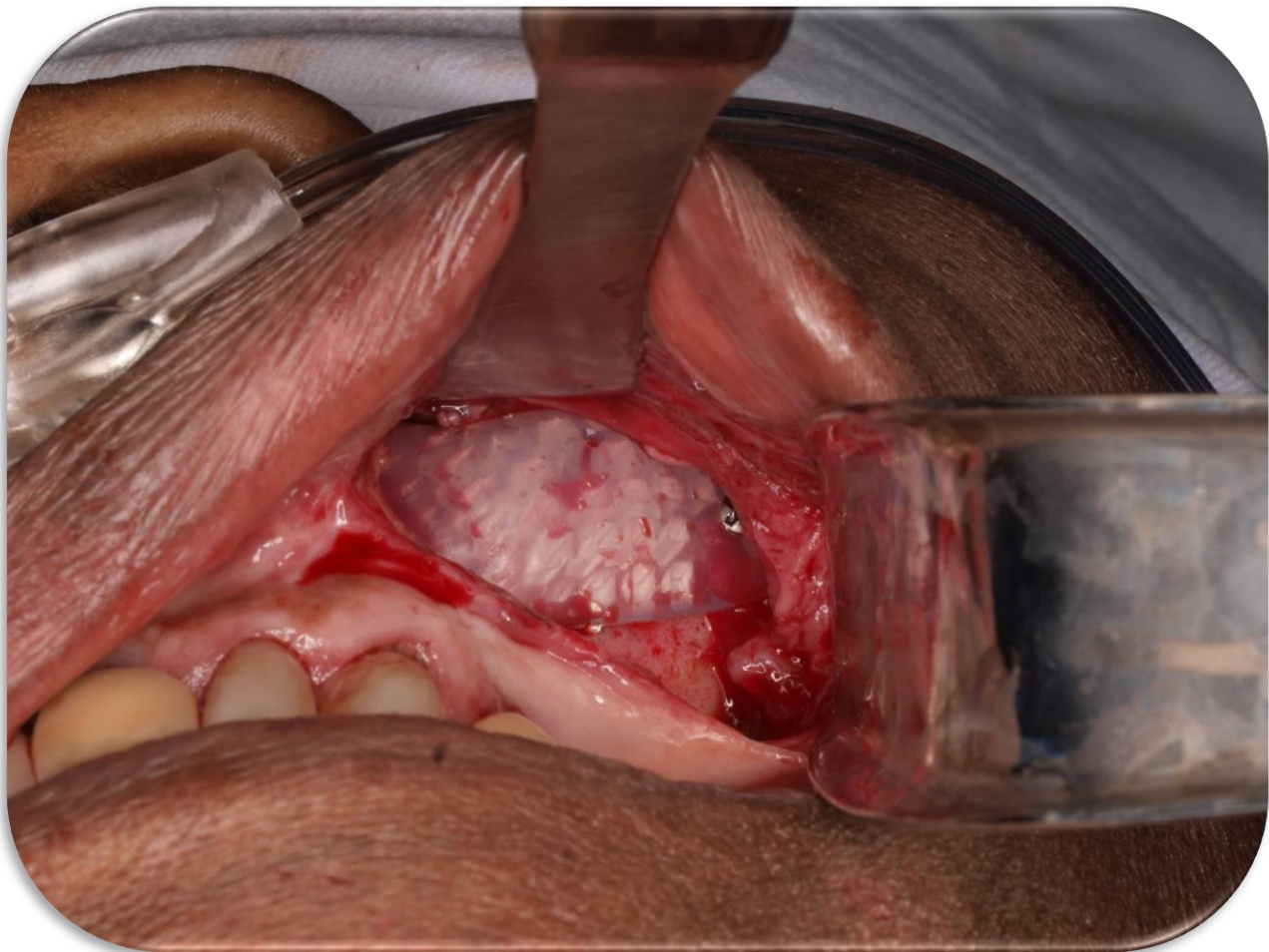


Complications

- Embolization leading to blindness, necrosis, stroke
- Resorption (debatable); 1/3 will take
- Lumpiness
- Dissipation
- Trauma at harvest site
- Poor esthetic results
- Learning curve







CASE 2



Questions?

