Cervicofacial Rhytidectomy without Notorious Scars: Experience of 29 Years

Fernando Pedroza, MD1  Luis Fernando Pedroza, MD1  Ernesto Dario Desio, MD1  Velia Elena Revelli, MD1

1 Department of Facial Plastic Surgery, CES University, La Font Clinic, Bogotá, Colombia


Abstract

Objectives  Presentation and evaluation of results of the surgical technique of cervicofacial rhytidectomy used by the senior author (F.P.), using the classification of facial aging to determine the stage of pre- and postsurgical age.

Methods  The surgical technique was used in 1,181 patients operated on in the past 29 years, starting in 1983. We analyzed retrospectively 318 patients operated on between the years 2001 and 2008, of whom 71 patients met the selection criteria. Postoperative follow-up period was from 6 months to 5 years.

Results  All patients in stage I showed clinically visible rejuvenation postoperatively. Significant improvement in facial rejuvenation in stages II and III of aging was shown, with a postoperative change of stage.

Conclusion  The technique of cervicofacial rhytidectomy with short flap, facial superficial musculoaponeurotic system (SMAS) imbrication, cervical SMAS plication, inconspicuous incisions, and postauricular z-plasty allows for successful and sustainable results over time, with short recovery time and minimal complications. The classification of facial aging pre- and postsurgery has been useful for the assessment of surgical results.

Keywords

► cervicofacial rhytidectomy
► facelift

The techniques used in cervicofacial rhytidectomy have evolved over time from resection of strips of skin and elevation and excision of excess skin to current surgical techniques with superficial musculoaponeurotic system (SMAS) plication and/or imbrication, all with the same objectives: facial rejuvenation, lack of surgical stigma, minimal complications, and durability.

Society, the economy, and public media have all influenced the evolution of cervicofacial rhytidectomy. In today’s world, competition is constantly increasing and many patients require a quick return to work and social life. This forces the surgeon to use all his or her knowledge, skills, and experience to find a technique that meets the patient’s wishes. The diagnosis of the aging face requires a thorough preoperative analysis, and the use of an effective and safe surgical technique that provides satisfactory and durable results with little or no visible scars is the objective of the rhytidectomy.

We believe that the technique used by the senior author (F.P.) meets these guidelines.

Methods

From January 2001 to December 2008, the senior author performed 318 cervicofacial rhytidectomies.

A retrospective analysis was performed on right-sided profile photographs of the patients, which indicated the degree of facial aging according to the senior author’s four signs used to determine a preoperative stage of the aging face, and a comparison was performed with 6-month postoperative photographs.

Patients were excluded if they had no postoperative photographs at 6 months after the surgery. Seventy-one patients met the inclusion criteria.

The range of postoperative follow-up was from 6 months to 5 years.
All patients were studied by performing an evaluation of the signs of facial aging, a classification used by the senior author that evaluates changes to (1) nasolabial folds, (2) labiomandibular folds, (3) curve of the jowl, and (4) submental skin angle.

**Preoperative Analysis**

We consider of most importance a thorough preoperative analysis of the patient, assessing clinical and surgical history, medications, use of acetylsalicylic acid, use of tobacco, and skin type. Photographs are important to learn the wishes of the patient and to establish the best surgical plan.

All patients who underwent a cervicofacial rhytidectomy were classified preoperatively, after studying their right-sided profile photograph. This classification allows the measurement of the degree of deterioration of the midface, lower face, and neck caused by aging. This is convenient because of its rapid implementation, and it allows for an objective pre- and postoperative assessment by classifying the aging face in degrees.

The evaluation of midface aging is performed in the right-sided profile, with the first sign of the classification being changes in the nasolabial folds and their relationship to the lateral edge of the nasal wing.

The evaluation of inferior facial third aging is done by studying changes in the labiomandibular fold (second sign of the classification) and its relation to the mandibular ridge. The curve of the jowl is evaluated (third sign of the classification), and its relation to the mandibular ridge is also used in the evaluation.

Evaluation of aging in the neck is done by measuring the angle formed by a line parallel to the Frankfurt plane passing through the gnathion and another line passing tangentially to the lower edge of the skin called the submental skin angle (fourth sign of the classification).

**Classification of Facial Aging (Used by F. Pedroza)**

**Nasolabial Fold**

- **Degree I:** Nasolabial fold does not contact the lateral margin of the nasal wing.
- **Degree II:** Nasolabial fold contacts the lateral edge of the nasal wing without exceeding it.
- **Degree III:** Nasolabial fold exceeds the lateral edge of the nasal wing.

**Labiomandibular Fold (Puppet Line)**

- **Degree I:** Labiomandibular fold does not reach the lower rim of the jaw.
- **Degree II:** Labiomandibular fold reaches the lower rim of the jaw.
- **Degree III:** Labiomandibular fold goes over the lower rim of the jaw.

**Jowls**

- **Degree I:** The jowl curve does not reach the mandibular ridge.
- **Degree II:** The jowl curve reaches the mandibular ridge without exceeding it.
- **Degree III:** The jowl curve exceeds the mandibular ridge.

**Neck**

- **Degree I:** Submental skin angle measures between 0 and 20 degrees.
- **Degree II:** Submental skin angle measures between 21 and 40 degrees.
- **Degree III:** Submental skin angle measures over 40 degrees.

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**Fig. 1** Classification of facial aging. Nasolabial fold (green), labiomandibular fold (blue), jowl curve (yellow), submental skin angle (red). Picture from Dr. Pedroza’s files.
Note: Degree I in each of the signs of facial aging corresponds to young patients without an aging face or patients with mild aging, degree II corresponds to patients with moderate aging, and degree III to patients with severe aging (►Fig. 1).

Stages of Facial Aging I, II, III
Based on this classification, overall facial aging stages I to III were established by summing the degree in each category and dividing the total by four, thus setting an average between the different degrees obtained from the

Fig. 2 Cervicofacial rhytidectomy surgical technique. (A–C) Marking and flap dissection. (D–I) Facial superficial musculoaponeurotic system (SMAS) imbrication and cervical SMAS plication. (J–L) Redundant skin resection. (M–O) Z-plasty, closure of incisions, and drains.
assessment of the patient. This overall degree is expressed in whole numbers, therefore fractional results are rounded in decimal form as follows: 0.5 or greater fractions to the higher integer, 0.49 or less to the lower integer.

Cervicofacial Rhytidectomy Surgical Technique

Marking the Patient
Using a wooden tip applicator, a mark is made with blue methylene in the supratragal indentation at the root of the helix and continues over the implantation of the ear to the midpoint of the upper ear and extends vertically 2 cm upward into the temporal area. Marking the preauricular incision continues from the supratragal indentation downward (in a male patient, the marking should continue in the pretragus wrinkle; in a female patient, it can continue behind the tragus), becoming posttragal and exiting by the subtragal indentation. In both cases, the marking continues around the implantation of the ear lobe, going up the posterior groove to a point where the ear intersects the line of the capillary implantation (equivalent to a line projected horizontally backward from the common cross of the anthelix). From here the marking goes backward on a semicircle, then it enters the scalp as it goes down parallel 1.5 cm to the implantation of the hair for 4 cm (Fig. 2A).

The zygomatic arch, the angle of the jaw, the jaw ridge, and the tip of the mastoid are also marked as references. The flap to be dissected is marked for 4 cm around the ear.

The cervical area is marked by drawing a horizontal line 2 cm long in the submental fold; the midpoint of this line lies in the facial midline. We also mark the thyroid cartilage.

Infiltration
The submental incision and the first side of the rhytidectomy are infiltrated with Xylocaine (AstraZeneca, London, UK) with epinephrine (50 mL of 1% Xylocaine plus 0.5 mL of adrenaline). Five minutes later, 3-mm incisions are performed in the marked areas: preauricular, postauricular, and submental. The subcutaneous plane is located by using a mosquito clamp, and the rhytidectomy flap is infiltrated using Klein solution (500 mL normal saline plus 0.5 mL adrenaline). Infiltration is performed only in the previously marked area, using ~ 60 mL on each side of the periauricular area, and 60 mL on the cervical area. After infiltration, a wait of at least 15 minutes is mandatory before starting the procedure.

Submental Liposuction and Platysmaplasty
In patients with a degree II or III neck aging, liposuction is performed with submental platysmaplasty as the initial part of our cervicofacial rhytidectomy technique.

In the facial rhytidectomy for patients with degree I aging, liposuction can be performed alone, without platysmaplasty.

The submental incision is 2 cm long. With the help of a 6-mm cannula, submental supraplatysmal tunnels are formed in the area marked to the level of the thyroid cartilage. Ultrasound is applied to the area followed by submental liposuction with a 6-mm cannula, whose hole opening should be oriented to the platysma muscle (Fig. 2B). The skin should feel uniform to the tact, and the area will be expanded with the help of a separator and blunt scissors, completely freeing the subcutaneous plane. With straight bayonet forceps, a subplatsymal vertical strip 1 or 2 cm wide and ~ 3 cm long is cut in the redundant muscle in the proximal platysmal midline, and the muscle edges are carefully cauterized. The platysmal edges are then sutured with Ethibond (Ethicon, Somerville, NJ) 3–0 with cross-running sutures from proximal to distal, up to 1 cm above the thyroid cartilage, and returned to the starting point (where the ends are tied up) with simple running stitching. Then, oblique cuts are made to the platysma at the level of the hyoid bone, extended laterally about 5 cm (parallel to the mandibular border), and cauterized again.

Incisions
The incision begins in the temporal area of the scalp at the midline of the upper ear, continues 2 cm upward, and then bends forward into the line of implantation of the ear, continuing as a preauricular incision. This allows us to hide the scar and prevents it from being visible, because the incision is not done in the line of implantation of the hair, nor does it continue in a straight line vertically into the preauricular area; this technique avoids injury of the temporal vessels that could be involved in the irrigation of the temporal area, which, if damaged, could produce hair loss.

The preauricular incision continues downward and enters the supratragal indentation at the root of the helix. In a female patient, it continues behind the tragus to become a posttragal incision and exits at the subtragal indentation; this way it avoids a hypertrophic and notorious scar in the preauricular area. However, if the patient is male, the incision should continue in the preauricular crease to prevent displacement of the beard over the tragus. In both cases, the incision continues around the implantation of the ear lobule (Fig. 3A).

The posterior incision is continued in the postauricular groove so it avoids any postoperative change in the ear size. Then, it bends backward at the level of the common cross of the anthelix and enters the occipital scalp area, continuing down parallel 1.5 cm to the implantation of the hair for 4 cm. We avoid making the incision in the hair implantation line, because it may cause a noticeable scar (Fig. 3B).

This way the incision is hidden almost entirely. A z-plasty is performed in the postauricular groove at the top of the incision before looping back to enter the scalp. The objective of this is to reduce the skin tension at this point, and the scar will break in the middle of its length, thus preventing it from becoming hypertrophic.

However, the development of hypertrophic scars or keloids may be due to factors inherent to the patient.

Skin Flap Dissection
Skin flap dissection should start on the most aged side by dissecting a 1-cm-wide flap in a subcutaneous plane (using Davis scissors and Bishop forceps) along the periauricular incision, beginning at the temporal area and ending at the occipitotemporal capillary implantation. Holding the skin flap with a double hook, the flap is dissected with blunt scissors up
to the previously defined limits around the ear (about 4 cm in length; ➤ Figs. 2C, 3C). Careful hemostasis is then performed.

SMAS Dissection
With Adson-Brown forceps, an oblique cut is made in the SMAS 1 cm in front of the preauricular incision and 1 cm above the jaw angle, going upward and forward with Davis scissors until reaching a point 1 cm below the zygomatic arch and 3 cm in front of the preauricular incision. The sub-SMAS tissue is dissected with blunt scissors until the anterior border of the parotid gland is reached (➤ Figs. 2D, 3D). Sub-SMAS tunnels are formed with a flat 6-mm cannula toward the nasolabial folds, the oral commissure, and the labioman-dibular folds (➤ Figs. 2E, 3E).

The preauricular SMAS flap is grasped with Adson-Brown forceps, and at the level of the top edge of the tragus, the SMAS is cut with Davis scissors for 2 to 3 cm running forward and downward parallel to the mandibular edge (➤ Fig. 3F). The excess SMAS is resected, and SMAS imbrication stitches are made with Ethibond 2–0 sutures in a posterosuperior
direction as vertical as possible sutured to the preauricular fascia (► Figs. 2F, G, and 3G).

A cervical SMAS-plication with Ethibond 2–0 sutures is performed and sutured to the mastoid fascia (four or five stitches) in a posterosuperior direction (► Figs. 2H, I, 3H).

Resection of Excess Skin
The skin flap is pulled up and backward, covering the ear. Resection begins with a stitch above the superior insertion of the ear and another stitch on the top of the postauricular incision. The postauricular excess skin is cut along the postauricular incision, down to the level of implantation of the ear lobe (► Figs. 2L). A Prolene 5–0 (Ethicon) stitch is placed at the ear lobe to avoid skin tension at this level.

Then the scalp excess above the ear in the temporal area is excised. The preauricular skin flap is pulled back and cut at the level of the supratragal incisure, placing a 5–0 Prolene stitch there. Another cut and stitch are placed over the infratragal incisure. Resection of the excess skin is made in an up-and-down direction along the preauricular incision, leaving no tension within the incision line (► Figs. 2J, 3J).

The postauricular skin flap is pulled upward and forward to preserve the continuity of the occipital hairline, resecting the redundant skin and scalp, leaving the incision line without any tension (► Figs. 2J, 3K). A z-plasty is made at the most superior point of the postauricular incision (► Figs. 2M, 3L).

The scalp in the temporal and occipital area is closed with stainless steel staples. The earlobe is fixed in a posterior and superior direction with Prolene 5–0 stitches. Several subcutaneous stitches with Vicryl (Ethicon) 1 5–0 sutures are placed in the preauricular and postauricular skin flaps (► Fig. 2N). The drains (HemoVacs [Zimmer, Warsaw, IN]) are placed in the preauricular area, introduced by the temporal incision at the scalp. Another drain is introduced by the occipital incision, and both are placed until they reach the submental area. They are fixed with Prolene 3–0 suture to the skin (► Figs. 2O, 3M).

The preauricular and postauricular incisions are closed with running intradermic 5–0 Prolene sutures, bringing one loop of the stitch out to the surface at the supratragal incisure and the other out at the superior level of the postauricular incision to facilitate easier removal. If it is necessary, simple interrupted stitches are placed to complete the closure of the incision with 6–0 Prolene sutures and then covered with Micropore (3M Health Care, St. Paul, MN) tape.

Complementary Techniques

Jowl-Preauricular Fascia Stitch
Jowl-preauricular fascia stitch is used in patients where the curve of the jowl comes within the mandibular ridge (degree II) or over it (degree III), and mainly in patients with thick skin. An Ethibond 3–0 suture is placed from the preauricular fascia to the subcutaneous tissue of the jowl, 2 cm behind the labial commissure with a Reverdin needle.

We bring the suture through the skin, and then we return it in the opposite way subcutaneously. This stitch can improve the drooping of the jowl. The skin incision is closed with 6–0 Prolene sutures (► Fig. 4).

Facial Rhytidectomy

The senior author has used the facial rhytidectomy technique in cases of facial aging degree I, when the patient is young or has had a previous rhytidectomy and does not require cervical treatment. Only a preauricular incision is made, beginning at the temporal area and finishing at the posterior side of the ear lobe. The incision does not continue posteriorly into the postauricular sulcus or the occipital scalp area.

Facial SMAS imbrication is done in an upward direction, and a jowl-preauricular fascia stitch is placed if necessary (► Fig. 4).

In our cases, we found an improvement in facial contour and rejuvenation with satisfactory and durable outcomes. We think that it is not necessary to extend the skin incision at the pretrichial temporal area as described by others authors.

With our technique (► Fig. 5), we obtain similar results to the minimal access cranial suspension (MACS)-lift technique without the possibility of a visible scar (► Fig. 6).

Results

Of 318 patients who underwent rhytidectomy surgery, 71 were analyzed retrospectively. Of these surgeries, 65 (92%) were primary and 6 (8%) secondary. Fifty-nine (83%) patients were women and 12 (17%) were men. The age range was 37 to 75 years, with an average of 56 years. Surgery was most frequently performed between the ages of 50 to 59 years, with 35 (49%) of the 71 procedures performed in this age group (► Table 1).

In this study, we used the z-test, because the variables are qualitative (categorical), allowing us to define whether there
Fig. 5  Facial rhytidectomy. (A–C) Marking preauricular and short postauricular incisions. (D–H) Skin dissection and facial superficial musculoaponeurotic system imbrication. (I–L) Jowl-preauricular fascia stitch, skin resection, incision closure, and drain.

Fig. 6  Facial rhytidectomy. (A, C) Preoperative profile and frontal pictures. (B, D) Eight-month postoperative profile and frontal pictures.
is significant improvement (►Table 2) between the proportions with 95% confidence ($\alpha = 0.05$).

We note that in degree I (for every area and stage) all the patients had clinical improvement but no change of degree, because the aging classification doesn’t have a better degree than I. For this reason, degree I patients end up having the same degree postoperatively. We see changes between pre- and postoperative photographs of these patients (►Fig. 7). For example, one patient with a submental skin angle of 19 degrees preoperatively, classified as degree I, was evaluated in the postoperative period with a submental skin angle of 10 degrees, but the patient is still classified in the same degree. Although there was a noticeable change in the angle of the neck (from 19 to 10 degrees), no change is evident in the classification (degree I pre- and postoperative). Because of this, the statistical classification cannot have a significant improvement, so for that reason, these patients are designated NA (not applicable).

Analyzing each area, we see that in degree III nasolabial folds, significant improvement is shown after the procedure, but there was no significant improvement in degree I and II, because the rhytidectomy technique has minimal effect on the midface.

In the other areas of the aging classification, the labiomandibular fold, the jowl, and the submental skin angle, there was significant improvement in preoperative degrees II and III (►Table 3).

In 24 (34%) patients with preoperative degree III labiomandibular fold, 21 (88%) patients improved with degree

| Table 1 Distribution of the patients in age and sex groups |
|-------------|-----|-----|-----|
| Age (y)     | Female | Male | Total |
| 30 to 49    | 17 (24%) | 3 (4%) | 20 (28%) |
| 50 to 59    | 28 (39%) | 7 (10%) | 35 (49%) |
| 60 or older | 14 (20%) | 2 (3%) | 16 (23%) |
| Total       | 59 (83%) | 12 (17%) | 71 (100%) |

<p>| Table 2 Evaluation of surgical results by areas (N-L fold, L-M fold, jowl, neck) and stages, according to improvement with degree change, without degree change, and with statistical significant improvement |</p>
<table>
<thead>
<tr>
<th>Evaluated area</th>
<th>Prevalence, $n$ (%)</th>
<th>Improvement with degree change, $n$ (%)</th>
<th>Improvement without degree change, $n$ (%)</th>
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</tr>
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Abbreviations: L-M, labiomandibular; NA, not applicable; N-L, nasolabial.
change, 9 (38%) to degree I and 12 (50%) to degree II. In 22 (31%) patients with preoperative degree II labiomandibular fold, 18 (82%) patients improved to degree I.

In 23 (32%) patients with preoperative degree III jowls, 20 (87%) patients improved with degree change, 9 (39%) to degree I and 11 (48%) to degree II. In 29 (41%) patients with preoperative degree II jowls, 24 (83%) patients improved to degree I.

We can observe that labiomandibular folds and jowls present similar statistical significant improvement (►Table 3).

In 25 (35%) patients with preoperative degree III submental skin angle, 24 (96%) patients improved with degree change, 18 (72%) to degree I and 6 (24%) to degree II. In 21 (30%) patients with preoperative degree II submental skin angle, 15 (71%) patients improved to degree I (►Table 3).

Relating to stage, significant improvement was observed in stages II and III. In 25 (35%) patients at preoperative stage III, 22 (88%) patients improved with stage change, 10 (40%) patients to stage I and 12 (48%) to stage II. In 27 (38%) patients at preoperative stage II, 24 (89%) patients improved to stage I (►Fig. 7; ►Table 3).
Table 3 Surgical analysis comparing pre- and postoperative results, according to the classification of aging degrees by areas (N-L fold, L-M fold, jowl, and neck) and stages, and comparing number and percentage of patients (from the total analyzed) in each degree and stage in the preoperative period, and how they change in the postoperative period

<table>
<thead>
<tr>
<th>Evaluated area</th>
<th>Preoperative, n (%)</th>
<th>Postoperative, n (%)</th>
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<td>N-L fold</td>
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<td>20 (28)</td>
<td>40 (56)</td>
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<tr>
<td>Degree II</td>
<td>33 (46)</td>
<td>24 (34)</td>
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<td>Degree III</td>
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<td>7 (10)</td>
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<tr>
<td>L-M fold</td>
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</tr>
<tr>
<td>Degree I</td>
<td>25 (35)</td>
<td>52 (73)</td>
</tr>
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<td>Degree II</td>
<td>22 (31)</td>
<td>16 (23)</td>
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<td>Degree III</td>
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<td>3 (4)</td>
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<td>Jowl</td>
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<tr>
<td>Degree I</td>
<td>19 (27)</td>
<td>52 (73)</td>
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<td>Degree III</td>
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<td>25 (35)</td>
<td>3 (4)</td>
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Abbreviations: L-M, labiomandibular; N-L, nasolabial.

Of the 71 patients evaluated, there were four types of complications: hypertrophic scars in 3 (4%) patients that were treated with triamcinolone injections; deformity of the ear lobule in 1 (1%) patient that was treated with revision surgery; seromas in 3 (4%) patients that were drained by puncture in the office; prolonged neck edema in 1 (1%) patient lasting more than 4 months, which resolved spontaneously.

The surgeries that were performed simultaneously with rhytidectomy were: endoscopic browlift in 53 (75%) patients, lower blepharoplasty in 45 (63%) patients, facial lipografting in 25 (35%) patients, upper blepharoplasty in 24 (34%) patients, rhinoplasty in 18 (25%) patients, lip augmentation in 14 (20%) patients, midface-lift in 4 (6%) patients, mentoplasty in 3 (4%) patients, and otoplasty in 2 (3%) patients, chemical peel in 1 (1%) patient.

Discussion

We have obtained satisfactory and lasting results with the implementation of the surgical technique of cervicofacial rhytidectomy used by the senior author. It’s a short flap technique with facial SMAS imbrication and cervical SMAS plication for patients with stage I to III facial aging. For stage I cases, facial rhytidectomy without cervicoplasty was used in some patients.

We can say that the rejuvenation achieved with the short dissection flap technique is similar to that of those techniques with more extended flap dissection, with the advantage of a shorter postoperative period, minimal swelling and ecchymosis, and rare complications. Limited sub-SMAS dissection doesn’t generate a postoperative lifted appearance, and sub-SMAS tunneling with a 6-mm cannula can be compared with an extended facial dissection, with the advantage of being less aggressive, so the possibility of facial nerve injury is absent. A proper design of incisions can reduce the stigmata of surgery.

The rhytidectomy is a surgery indicated to improve the lower face (labiomandibular fold and jowl) and neck mainly. When we evaluate the results with the technique used, we observe that there is significant improvement of these areas, mainly in preoperative degrees II and III.

Some rhytidectomy techniques could have benefits on the midface (nasolabial fold), as described by Adamson et al and Hamra. However, some studies by other authors show that there is no difference on midface results between techniques that use extended and limited dissection, as described by Barton, Ivy et al, and Becker and Bassis.

When analyzing our midface results (nasolabial fold), we found that there was significant improvement only in preoperative degree III patients. It could also be the result of lipografting in the nasolabial fold, a frequently used technique for the improvement of the midface, as a complement to rhytidectomy.

In younger patients or patients with secondary rhytidectomy with a degree I neck, the senior author uses the facial rhytidectomy technique and obtains very good aesthetic results without the need to perform a cervical rhytidectomy. In the facial rhytidectomy procedure, a preauricular incision is made, and facial SMAS imbrication is done without performing cervical SMAS plication, because the primary objective is facial rejuvenation only. The senior author uses a temporal incision within the scalp, 2 cm above the midline of the ear. He thinks that it is not necessary to make the incision at the pretrichial temporal area, as described in the MACS-lift technique, because it could produce noticeable scars.

Complementary surgical techniques could be used to improve other facial areas. Those include an endobrow midface-lift approach, lower blepharoplasty to improve midface, facial lipografting, fillers, and/or facial implants.

For the treatment of the neck and the submandibular area in rhytidectomy, we can use different options: submental platysmaplasty with or without liposuction, mentoplasty, or nonsurgical treatments such as the use of botulinum toxin type A.

The cervicofacial rhytidectomy technique includes submandibular ultrasound liposuction and platysmal plication at the midline through a 2-cm incision in the submental groove. In facial rhytidectomy, the submandibular liposuction is performed without platysmaplasty.
Webster et al suggest short flap rhytidectomy techniques, with skin and sub-SMAS dissection to the anterior edge of the parotid gland.21–25 This technique has the advantage of avoiding a wide dissection of the skin flap, which could present complications such as hematoma or skin flap necrosis. Because of this, we currently use the short skin flap only.

Analyzing complications with our technique, we observed that there were no facial nerve injuries (0% in our statistics), because the sub-SMAS dissection is limited, thus avoiding injury to the nerve. To avoid the formation of hematoma, it has been very useful to make a short skin incision to the nerve. To avoid the formation of hematoma, it is also useful to use drains (Hemovacs) for 36 hours.

The senior author has used this philosophy in his rhytidectomy technique for over 29 years, obtaining long-term satisfactory results.

Conclusion

Rhytidectomy techniques have continuously evolved. To do a rhytidectomy, the surgeon should discuss with the patient the different techniques and the benefits and risks of each technique to satisfy the patient’s wishes.

We believe that in stage I aging, we can achieve satisfactory rejuvenation with facial rhytidectomy only. When there is a greater cervical stage, II or III, we believe a complete cervicofacial rejuvenation with facial rhytidectomy only. When there is a greater cervical stage, II or III, we believe a complete cervicofacial rejuvenation with facial rhytidectomy only.

We recommend the use of hidden incisions in the scalp, a short skin flap, facial SMAS imbrication and cervical SMAS plication, z-plasty in the postauricular incision, placement of subcutaneous sutures below the skin flap, and the use of drains (Hemovacs) for 36 hours.

All these measures help us to achieve accurate cosmetic benefits, a natural appearance in the patient, a complication-free surgery, rapid recovery, and very successful long-term results.

Seeing the results of this technique and how it improves the involved areas in the aging process, such as the labiomandibular fold, jowl, and neck, we may recommend this technique.

We believe that the aging classification can help us to determine the stage of facial aging and evaluate the postoperative results with the surgical technique applied.

References


5 Adamson PA, Daihri R, Litner J. Midface effects of the deep-plane vs the superficial musculoaponeurotic system plication face-lift. Arch Facial Plast Surg 2007;9:9–11


