

# RAISE the bar

Modified short scar, deep plane and necklift procedures combined with fillers can recontour the face and provide volume.

Dr Sam Rizk describes his techniques

**T**he ageing face suffers from descent and loss of definition along the jaw line and cheeks. But sharp, firm features can be a key element of beauty. Older facelifts can result in a gaunt appearance, but if you go deeper in the jowl, you can elevate and reposition the dropped tissue.

Volume often needs to be added in the cheeks with fillers. Although these can keep the face looking younger for longer, fillers don't necessarily address the neck. The isolated neck lift has been growing in demand, especially in younger women who have had fillers requesting rejuvenation.

Fifteen years ago, I began doing various types of SMAS (superficial muscular aponeurotic system) lifts. I mainly performed the lateral SMASectomy and the SMAS flap, but have moved on to a modified version of the deep plane facelift.

## Deep plane

Every face is different and each requires a customised approach. As we age, the malar fat pad underneath the SMAS layer descends and loses volume. I reviewed the progression of my techniques over 4,000 lifts. Most were performed on women, with a large proportion of men. SMAS was used on 800 patients and the modified deep plane on 2750.

The short scar lift is helpful in the face, but it is limited to when you have neck laxity. You can probably get away with fillers instead of a short scar. I wasn't happy with the results of the short scar in the jaw region—I started to see pleating to get a good neck improvement. My best results were using the modified deep plane.

The original Sam Hamra deep plane facelift involves a vertical incision, lifting the orbicularis and cheek dissection. I modified the original deep plane to include a more vertical scar slightly within the temporal hairline to preserve the temporal

tufts and hide the scar.

I do not lift the orbicularis, and the cheek dissection is more limited than the original. The posterior platysma goes all the way to the mastoid periosteum. There is no separation of the deep plane from the skin, so it is lifted as a composite flap. The connection between the subcutaneous dissection in the neck and the deep plane in the face creates a thick flap, which elevates the malar fat pad into its original position.

Patients were satisfied with results from SMAS techniques but they seemed to skeletonise the face, especially with the SMASectomy. The procedure caused stretch lines and the skin became ashen—we were going under the skin and violating the sub-dermal plexus. The patients experienced more telangiectasias with the SMAS lifts, as you're lifting the SMAS layer away from the skin. For the neck, I pulled the posterior platysma all the way to the mastoid periosteum during SMAS lifts. I rarely used an extended SMAS flap—usually a short SMAS flap or a SMASectomy.

## Endotine

The Endotine ribbon has multiple tines. One of its advantages is forced distribution. It was designed to lift in areas of tines—when you lift with stitches, you have individual tension that can create lines. The ribbon distributes the tension to lift a region rather than a point. The original Endotine was long. I had to trim the ribbon to use it in the deep plane and move it about three times. You use it to lift the deep plane and secure it preauricularly.

It was originally meant for minimally invasive non-open facelifts, where you lift from the temple region or from a small auricular incision. I have never used the Endotine ribbon for these subcutaneously; I have used it only in the deep plane.

I don't have enough follow-up evidence on the Endotine to



determine if it's better than stitches. I still go back and forth using the stitch technique versus the Endotine ribbon, although I have seen no extrusion or palpability so far in the deep plane.

I initially performed submentoplasties for the platysma in the neck. I moved away from these because I noticed tiny cords that required repetitive treatments of botulinum toxin. The only time that I use submentoplasty is either in a full neck in a female, or for male patients. I find most of my male patients—because of their thick skin—tend to have more of a “turkey gobbler”, which benefits more from a submentoplasty.

I bind the platysma down to the hyoid and make a small cut to allow for the lateral pull. Boston-based plastic surgeon Dr Joel Feldman describes a complete corset platysmaplasty to the suprasternal notch. If you do a complete platysma submental binding in the middle of the neck, you cannot pull the platysma laterally. I prefer to provide a tight neck because all necks will loosen in the first year or two. Early on in my practice, I was too conservative and found that I had to retighten those necks, so now I am more aggressive with pulling the neck tight to the mastoid periosteum.

### Short scar

Dr Alan Matarasso and I have reviewed uses of the short scar facelift. This was the traditional facelift used with a temporal hairline incision. I have never used this because it repositions the temporal hairline and gives a windblown appearance. It seemed to cause too much hair misalignment in the posterior hairline.

My modification was to move it slightly within the hairline to preserve the temporal hair tufts. The short scar is a short scar posteriorly, but a longer scar anteriorly. If a patient has a deep nasolabial fold, they can probably be managed with fillers if they don't need a neck lift.

Why do a short scar where the scar is longer anteriorly and more visible? I find that my posterior hairline scar is not really an issue because I hide it well. It wasn't useful in my practice because it doesn't address the neck appropriately. One patient I treated suffered from early jowling. My short scar procedure had a longer scar anteriorly, and subcutaneous elevation from the zygomatic arch to angle of mandible. This was followed by a deep plane. I did some electro-contouring and used fibrin tissue glue—you have to apply pressure for four minutes after using the glue. I've used tissue glues in about 2,000 lifts.

Tissue glue is used to seal and it is non-toxic. There is no incidence of viral transmissions in over eight million cases and it has been used in cardiac surgery and burn patients. It's a two-step vaporisation. I prefer the seal compared with other types of glues such as PRP, because the seal is very adherent and absorbs within two weeks. A cannula is used to spray the glue 1cc per side.

I treated a thin patient with a submentoplasty and aggressive deep plane. Fat fillers in the cheeks lifted the area and helped the frontal view of the patient. The lift alone will not be enough for thin-skinned individuals—they will still need fillers. So you have to tell them that they're going to need complementary fillers in addition to the lift.

If the patient has major volume loss, you can perform a modified deep plane, aggressive liposuction and submentoplasty. You won't get a good result if you don't do an aggressive submentoplasty. The deep plane recontours the square appearance of an ageing face, lifts the malar fat pad and repositions it into the hollow cheek region.

*Dr Sam Rizk FACS is director of Manhattan Facial Plastic Surgery. W: [drsamrizk.com](http://drsamrizk.com)*



Before and after a deep plane facelift and necklift, combined with lower eyelid blepharoplasty and rhinoplasty lift