

Discussion: Updating the Concepts on Neck Lift and Lower Third of the Face

David A. Hidalgo, M.D. |
New York, N.Y.

This article, from a prestigious group, describes a large rhytidectomy series and shares important lessons learned over 40 years. It is a level of evidence V report that exhibits pros and cons of the type: a wealth of clinical experience from a single source but with a somewhat anecdotal presentation that is a bit light on data.

The approach reported is contemporary and noncontroversial. The basic tenets are as follows: patient characteristics can strongly influence results independently of the surgical effort; superficial musculoaponeurotic system (SMAS) manipulation is beneficial; it is better to open the neck more often than not; both superficial and deep fat excision in the anterior neck is important but should not be overdone; and it is best to leave the digastric muscles and submandibular glands alone. The article does not comment on incisions, regional resurfacing, or newer techniques such as facial fat grafting.

The patient illustrations show only pretragal incisions, a choice generally less popular than the retrotragal type.¹ The latter, when executed artistically, seems more reliably imperceptible, at least in women.² The authors also do not discuss short-scar postauricular incisions. This option has a clear advantage in young patients with limited cervical laxity but is acknowledged to be a less appropriate choice when laxity is more severe.³

Opinion differs today on optimal SMAS strategy. Extended SMAS dissection permits augmentation of the malar area, thereby enhancing overall facial shape beyond just treating the jowl.^{4,5} SMASectomy, in contrast, is more efficient given that less dissection is entailed, and focuses primarily on improving mandibular contour, arguably the most pressing issue in most patients.⁶ Absent good comparative studies on the subject, it probably holds that applying extended dissection to every patient means overoperating on many, and that performing an SMASectomy on every patient limits the possibilities in some. As just one

of the key elements in rhytidectomy, what is actually done may not be that critical. This notion is supported by the efficacy of simple plication in thin patients, a practice recommended in this article. In any event, the trend today seems to be moving away from dissection that begins at the level of the zygomatic arch toward midlevel SMAS treatment that includes SMASectomy, incision with SMAS overlap, and plication, similar to the authors' practice.⁷

The authors open the anterior neck in 80 percent of their patients, choosing not to dwell on the associated increase in morbidity. They felt remorse when they did not open necks they should have but do not mention disappointment when aggressively treated necks do not heal smoothly or when platysmal bands recur, which they sometimes do. Despite cogent arguments made on each side of the issue, the recommendation to open the neck most of the time likely represents the majority opinion today.^{8,9}

Although there are advocates of digastric muscle shaving and submandibular gland excision, neither option has gained wide support. This is consistent with the authors' conclusions.^{1,10,11} It makes practical sense to spend any available extra time elsewhere, such as on facial fat grafting, for example.

The authors do not discuss failure in the neck beyond anterior contour concerns. Probably the most common (and frustrating) untoward occurrence following rhytidectomy is persistent or recurrent cervical laxity. This occurs from either ineffective skin redraping in patients with strong submental skin bands or poor skin elasticity when laxity recurs at the base of the neck. Fortunately, these problems respond well to revision procedures.

The authors do not discuss total procedural time and how that may impact component procedure selection. There are myriad options available today, including newer ones such as facial fat grafting and lower eyelid fat transposition, to name just two. These add time to that required for other proce-

From the Division of Plastic Surgery, Weill Cornell Medical College.

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