The Conservative Approach To Mid-Face Elevation

Strive for improvement rather than perfection, urges this surgeon.

Richard L. Anderson, MD
Salt Lake City

COSMETIC SURGERY IS ONE OF THE ONLY medical disciplines that can make well people sick. That's why for most procedures in general, and mid-face elevation in particular, I advocate a conservative approach. In this brief article, I'll offer a few tips on how to stay out of trouble with this procedure.

Counsel patients carefully

The first step is thorough patient counseling. Most patients want the youthful "high cheekbone" appearance so revered in fashion models. I try to tone down this expectation. I tell patients that I will try to improve the mid-face sag and also smooth out any fullness or hollows under their eyes. My goal is to soften any tear trough deformities and raise the cheek and SOOF fat, to give the profile a more natural "S" shaped curve formed by concave lower eyelids and a convex cheek.

I tell patients to expect a "fresher" look, and I tell them that it will look "natural," but I warn them that they will not look 20 again. I stress that the nasolabial folds will not disappear. I also stress that I won't be able to remove most of the wrinkles in the lower lids, although I add that it is possible to improve the quality of the skin surface of the lower lids, either with a peel or with laser resurfacing. At a later date, we may also be able to reduce the depth of any "crow's feet" with BoTox injections. Overall, though, I try to moderate their expectations. Occasionally, a patient will demand perfection and wrinkle-free lower eyelid skin rather than improvement. When that happens, I suggest seeing another surgeon.

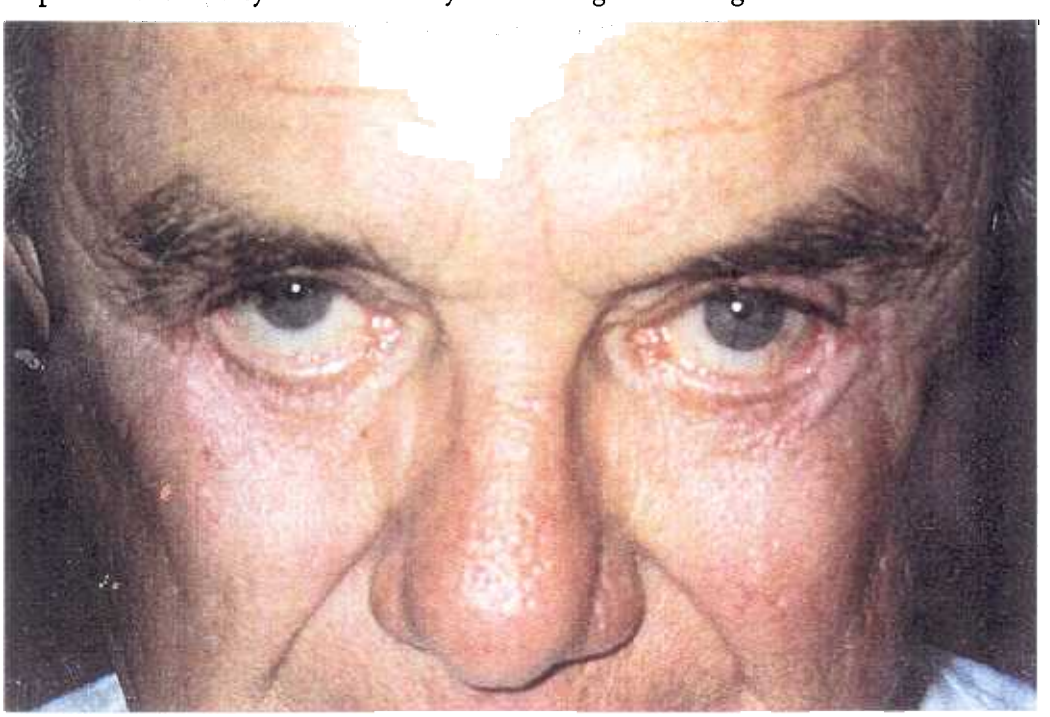

Figure 1. This patient was referred to my office for correction after anterior blepharoplasty and a mid-face elevation. An aggressive anterior blepharoplasty left him with a sad "round-eye" appearance.

Do not do an aggressive anterior blepharoplasty

Some surgeons advocate a cutaneous approach for this procedure, combining it with an aggressive anterior blepharoplasty to remove the skin from the lower lids. In my opinion, this is asking for trouble. All mid-face elevations sag somewhat over time. When this occurs and a skin removal has been done, lower lid retraction and/or ectropion is sure to follow (Fig. 1). The patient will have the classic sad round eye appearance, and ocular surface irritation. The delicate lower eyelid margin was never intended to support the heavy sagging midface.

A far better approach in my view is to perform the midface lift procedure transconjunctivally. In most older patients, I do believe in adding a modified lateral tarsal strip (fixing the lateral eyelid tarsus to the periosteum inside the orbital rim) to provide elevation of the lower eyelid and provide uplift to the lateral canthus, when indicated. This procedure alone helps lift the midface slightly and also removes some wrinkles from the lower eyelid. It also gives a pleasant uplift and happy look to the patient as opposed to the sad look created by inferior canthal displacement.

If wrinkles are present in the lower eyelids, address them with a trichloracetic acid peel or laser skin resurfacing. Recently, I've gone "back to the future" with TCA peels for lower eyelid resurfacing in most cases. Peels work just as well as laser in this area, the hyperemia doesn't last as long, the procedure is less expensive, and patients are more comfortable because no bandaging is necessary; the dead skin serves as an excellent wound cover.

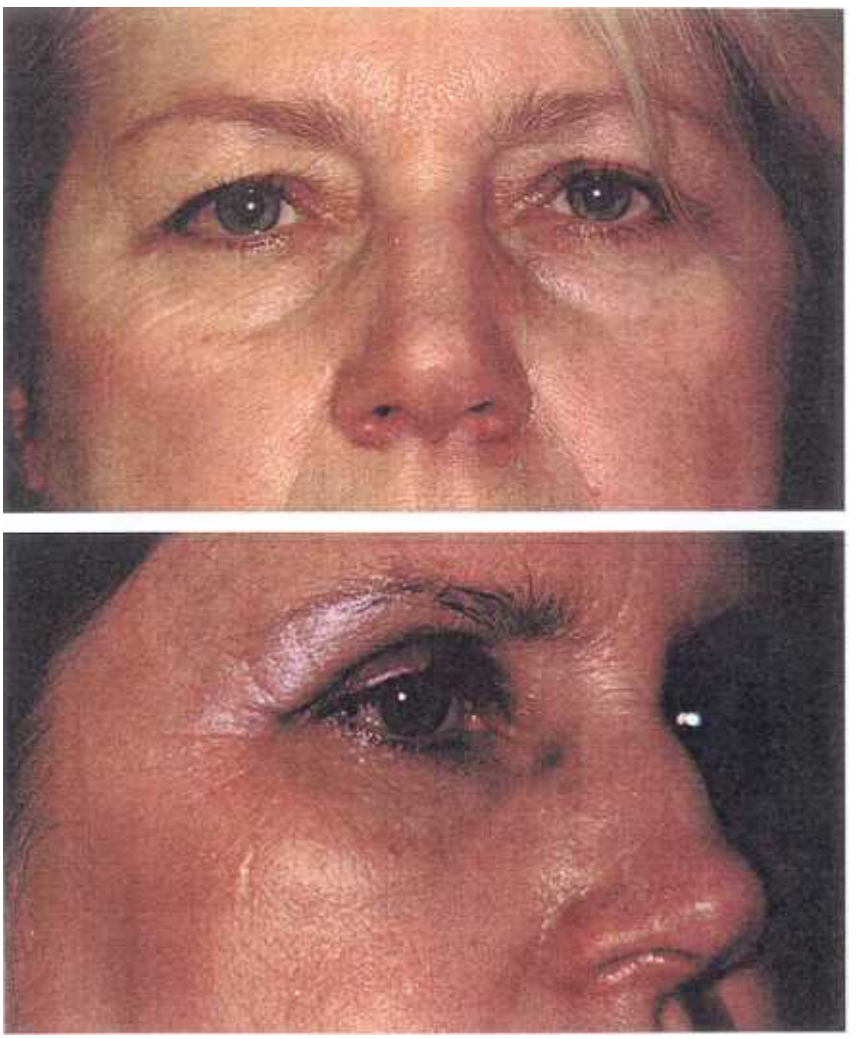

Figure 2a and 2b. A patient before and after four-lid blepharoplasty, mid facelift and peel.

When you use this combined approach, some wrinkles remain in the lower lid. But in my opinion, this is far superior to ectropion, retraction and lid lag. There is no reason to remove all the wrinkles in the lower lid; even babies exhibit these during mimetic activity.

Be conservative when removing orbital fat

A few years ago, the prevailing approach was to remove all the prolapsed orbital fat. Unfortunately, this very often resulted in a hollow-eyed, cadaverous appearance. Under most circumstances, it is still advisable to remove some orbital fat. However, I have become more conservative in fat removal. In some cases, I move the orbital fat to hollow areas such as the tear trough. I typically try to free up the orbital fat pads, trimming down their base until there is no tension, but taking care not to sever the blood supply. I then fold the fat pedicle over the orbital rim to smooth out the tear trough if present.

Choose supraperiosteal elevation

Many surgeons liberate the entire periosteum for this procedure because of the dramatic results that are sometimes possible. I used to do the same, until I realized that this method resulted in much more trauma, persistent lymphedema and retraction from scarring in some cases.

My current approach is to stay above the periosteum, and simply liberate the SOOF and cheek fat. These tissues elevate and mobilize much more easily than periosteum and it is the soft tissues rather than the periosteum that needs elevation. This approach entails much less trauma, swelling and time. The results may be slightly less dramatic, but the complications are markedly less common.

To do a mid-face elevation, I use a large Sayre periosteal elevator to bluntly separate the malar complex and SOOF fat from the periosteum, elevating rather than cutting the tissues loose. Be careful to avoid the infraorbital nerve and arteries.

Use Polygalactin sutures

Once the tissues are free, I mobilize them superiorly en bloc and suture to the periosteum.

When mid-face elevation was popularized, most surgeons including me felt it necessary to use heavy permanent sutures to maintain the elevation. In my experience, these heavier permanent sutures are sometimes palpable under the skin, and can result in granulomas and painful reactions. I have tried several different kinds of sutures, and presently use 4-0 polygalactin on a strong, small half-circle needle. This material holds the malar complex in place long enough for it to scar to the periosteum.

For this procedure, I prefer a small, half-circle P2 needle made by Ethicon. This needle facilitates working in the tight space and engaging SOOF, cheek fat and then periosteum for fixation. Avoid taking bites near the skin, as dimpling and folding will result.

Until recently, we could not adequately address mid-face sag. It was considered one of the "no-man's lands" of plastic surgery. But today, it is possible to tighten the lower lids, correct the orbital fat prolapse, and lift the cheek and SOOF fat pads simultaneously to greatly improve the mid-facial appearance. The key is to use a conservative approach. In this procedure, as with many other plastic procedures, it is much better to strive for improvement rather than perfection.

You can write to Dr. Anderson at 1002 E.S. Temple #308, Salt Lake City, UT 84102.