Neck Rejuvenation Without Face Lift

Improvement of the neck without face lift is possible through proper chin projection and adequate debulking or tightening of the submental area. For chin augmentation, the author prefers to insert a wraparound anatomic silicone implant using the “no-touch” technique. Lipoplasty with or without fat excision is often sufficient to correct the neck of patients with a minimal to moderate submental bulge and satisfactory skin tone. For patients with large fatty necks and contour problems, a full neckplasty will achieve excellent results. (Aesthetic Surg J 2005;25:285-287.)

To improve the neck without performing a face lift, it is necessary to achieve proper chin projection and to adequately debulk and/or tighten the submental area.

The preoperative examination should include evaluation of the front and side profile and the degree of chin projection. Check skin tone by the traction and rebound test, and the amount and location of fat by the pinch test. The platysma muscles should be evaluated both when relaxed and when tightened to bring out the platysma bands. The degree of prominence of the submandibular glands and the location (high or low) of the hyoid bone should also be noted. The goal of surgery should be creation of a deep, straight submental shelf that meets the vertical neck line at an acute angle (cervicomandibular angle).

**Chin Augmentation**

Proper chin projection is essential. Ideally, the chin should project approximately to a vertical line dropped down from the brow through the upper lip (assuming that there is a relatively normal brow and lip projection).

The chin implant is inserted through the external (submental) approach. The external incision provides excellent exposure and involves less interruption of lower lip musculature, better sterility, and less morbidity when compared with the intraoral approach. The pocket for the chin implant is created along the lower border of the mandible, 2 to 3 cm supraperiosteally over the midline, and subperiosteally to each side. I prefer to use the wraparound anatomic silicone implant that is inserted with the “no-touch” technique after first soaking it in Bacitracin solution. The implant is then placed in the pocket with a hemostat and tissue forceps so that the gloves do not touch the implant. One or two sutures to the midline periosteum secure the implant in the proper position just above the lower edge of the mandible.

**Lipoplasty/Fat Excision**

Lipoplasty alone is sufficient to correct the neck of patients who have a minimal to moderate submental bulge and satisfactory skin tone. The procedure is performed using a 2-mm cannula, working through a submental stab incision. In patients with a large neck bulge and fat accumulation, an additional stab incision is made under each earlobe for transverse suctioning.

After lipoplasty is complete, evaluate the submental shelf contour by using tight traction to pull the neck skin laterally. If a noticeable shelf bulge remains, further refinement is needed. Enlarge the submental incision to 2 to 3 cm and sharply excise the remaining subcutaneous fat with the aid of a fiberoptic light. Leave only a thin layer of subcutaneous fat on the underside of the skin.

**Neckplasty**

For patients with large fatty necks and contour problems that cannot be fully corrected by lipoplasty and/or subcutaneous fat removal, the full neckplasty will give excellent results. After completing lipoplasty and direct excision of the subcutaneous fat, use an insulated cutting cautery tip to incise the midline between the platysma muscles and to resect the subplatysmal fat. The fat is excised for approximately 2 cm lateral to the midline and inferiorly to the hyoid bone (Figure 1). This fat is more vascular than the subcutaneous fat, and meticulous
hemostasis is necessary when removing it from the mylohyoid muscle. After resection of the subplatysmal fat, the edges of the platysma muscle are tightly plicated inferiorly to the level of the hyoid bone with a running 4–0 nylon suture in a double layer, similar to Feldman’s corset platysmaplasty. Instead of plicating the platysma muscles below the hyoid bone, I prefer to cut them transversely for 2 cm to each side of the lowest midline plication suture at the level of the hyoid bone (Figure 2).

In most cases, platysmal plication produces an excellent result and nothing further needs to be done. However, when further definition of the neck shelf (especially the lateral neck) is needed, neck suspension sutures, as advocated by Guerrerosantos and Giampapa, will provide additional correction. To place these sutures, use scissors to make a lateral subcutaneous tunnel from the submental area to the infralobe area, and then make a small incision just behind the earlobe. Then pass a 4–0 permanent nylon suture through the midline platysma muscle plication suture line and pull it through the subcutaneous tunnel to the postauricular incision with a ten-

Figure 1. Following lipoplasty and sharp excision of the subcutaneous fat, the cutting cautery is used to excise subplatysmal fat in the dotted area.

Figure 2. Platysma muscle is plicated in a double layer of permanent sutures. Platysma muscle bands are transected just below the most inferior plication suture for approximately 2 cm to each side. Neck suspension sutures pull to each side but should not interlock in the midline.

Figure 3. A, C, E, Preoperative views of a 32-year-old woman. B, D, F, Postoperative views 6 months after neckplasty and neck suspension suture. Lipoplasty alone could not achieve desired result.
don passer. This suture catches a thick bite of the mastoid fascia. After the knot is tied, it is pushed anteriorly so it will not be palpable over the mastoid bone. A similar suture is done towards the opposite side of the neck, but I do not interlock these sutures in the midline. These sutures define the lateral neck better and can actually provide further support for the submandibular gland. Just prior to closure of the incision, spray 1 mL of Tisseell (Baxter AG, Deerfield, IL) into the submental pocket on top of the platysma muscle closure. The skin is then pressed firmly and smoothly into place and held for 3.5 minutes. The incision is closed and a surgical foam pressure dressing applied, held in place with a chin strap. The chin strap pressure dressing is maintained for 2 days postoperatively, with sutures removed at 5 days postoperatively. Figures 3 and 4 demonstrate results of this procedure.

When treating a male patient who has very loose neck skin but refuses a face lift, the T-Z-plasty as advocated by Biggs will provide an excellent correction. Elevation of the Z-plasty flaps provides excellent exposure for any necessary fat removal and/or platysma plication. The neck incisions in male patients heal nicely and have not been a cosmetic problem.

References

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