Panel Discussion

Short Scar Face Lift

Editor’s Note: My thanks to the moderator, Daniel C. Baker, MD (board-certified plastic surgeon and ASAPS member, New York, NY), and to panelists Hamid Massiha, MD (board-certified plastic surgeon and ASAPS member, Metairie, LA); Foad Nahai, MD (board-certified plastic surgeon and ASAPS member, Atlanta, GA); and Patrick Tonnard, MD (plastic surgeon, Gent, Belgium), for sharing their opinions and clinical experience.

Dr. Baker: The first patient is a 48-year-old fashion consultant who wants to correct her neck and jowl laxity (Figure 1). Although her hair is quite short, she is planning to let it grow and wear it up off her face. Many of her friends and clients have undergone face lift surgery and have significant scars behind their ears; she would like to avoid this. Dr. Massiha, how would you treat this patient?

Dr. Massiha: She has some asymmetry, and the right side of her face is smaller than the left. The asymmetry may require another procedure, such as fat grafting. She has a type 1 or 2 deformity and would be an ideal candidate for a short scar face lift.

Dr. Baker: Would you do a SMAS flap, plication, or some type of suspension technique?

Dr. Massiha: I would dissect the SMAS and platysma as one unit and pull it up. Whatever SMAS is in excess, I would remove. I would treat the left side more aggressively than the right, and maybe that would improve the asymmetry. I like using a SMAS platysma unit, but if I could not dissect the cheek part of the SMAS because it was too thin or too thick, I would create a skin flap in the upper part of the face and blend it with the SMAS platysma flap of the lower face, namely below the level of the lips inferiorly.

Dr. Baker: Dr. Nahai, the submental area seems a little full. How would you address that?

Dr. Nahai: I agree with Dr. Massiha that this woman would be a good candidate for a short scar face lift. I would concentrate as much on her lower lids as I would on her jowls; the asymmetry has already been pointed out. I see no banding in the submental area. She has skin laxity and some loss of elasticity. I rely on the vertical vector with a short scar face lift. If that improved the submental area, I would not open it. But if it appeared that the submental area still needed work, I would open it just to mobilize the skin so that it redraped better. I doubt that she has any excess subcutaneous tissue. She has no deep plane problems, just pure and simple skin excess.

Dr. Baker: When you open the submental area, do you place the incision right in the permanent crease or in a different area?

Dr. Nahai: I like to incise posterior to the crease. I do not make the incision in the crease itself. In a lipoplasty procedure, which I rarely perform in a slender person, I make the incision in the crease itself. But if I plan to explore, rearrange, and mobilize tissue, I make the incision posterior to the pre-existing crease.

Dr. Baker: Dr. Tonnard, does the asymmetry concern you? Can you correct the asymmetry in her face with a
minimal access cranial suspension (MACS) face lift (a face lift technique with a short scar, minimal access, and suspension of the soft tissues in a vertical direction)?

Dr. Tonnard: The asymmetry does not really concern me. I think it is most pronounced in her eyes. Her left eyelid seems a little bit ptotic, possibly due to a light enophthalmos. If you cover her eyes, the facial asymmetry is not that striking. I would perform a submental lipoplasty and then a simple MACS face lift with 2 suspension sutures. The way you presented this patient, especially her desire to avoid scars behind the ears, makes her ideal for a short scar face lift.

This operation, performed under local anesthesia, takes one-and-a-half hours. The patient remains in the unit for another hour, goes home, and then returns to see me the next day.

Dr. Baker: The next patient is a 60-year-old woman who wants to correct her deep nasolabial folds, jowls, and medial platysmal prominence (Figure 2). Dr. Nahai, how would you improve the nasolabial folds and midface, as well as the neck and jowls? Do you believe it is possible to accomplish this with the short-scar technique?

Dr. Nahai: It is probably possible to accomplish this with the short-scar technique, but I would recommend a full scar face lift, and I base that decision on the amount of excess skin. Judging from her frontal view, she has a lot of excess skin and a fold below her cricoid cartilage. In patients with excess skin below the cricoid or behind the sternomastoid, I can achieve a much better result, a better defined jaw line, and have less of a problem chasing a dog-ear behind the ear if I tell the patient that I will make the full incision.

Although some surgeons might choose a short scar, I would classify this patient as a “3” in Dr. Baker’s system. I would recommend the full scar with a full submental incision behind her pre-existing crease. I would divide the connections between her crease and the deep tissues, and then proceed toward the face and take down the mandibular cutaneous ligament.

Dr. Baker: It seems possible that she has significant subplatysmal excess. How would you deal with that?

Dr. Nahai: I would make that decision on the table. This is someone in whom I would definitely open the submental area, access the platysma, lift up the platysma on each side, and if I found excessive fat, I would resect it.
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**Dr. Baker:** How far would you resect the fat if it were significant? Would you go down to the mylohyoid muscle?

**Dr. Nahai:** Yes, because the only separation between the platysma and the mylohyoid is the fat and the digastric. If you proceed more laterally, you run into the gland. I do not think she would need any manipulation of her submandibular gland.

**Dr. Baker:** Would you transect the platysma?

**Dr. Nahai:** No, in her they are close enough so that I would be able to plicate the platysma. I do not think dividing the platysma would be necessary.

**Dr. Baker:** You can see her facial and auricular skin clearly. Do you prefer a tragal incision generally? What about in this patient? Do you find one more predictable than the other?

**Dr. Nahai:** Generally, I prefer the tragal incision. But this patient has a well-defined crease below the lower border of the tragus, so in her case, I would probably use a pretragal incision. The patients in Figures 3 and 4 each have a more prominent tragus, so I would use intrtragal incisions in them. My preferred method of dealing with a nasolabial fold is a lower eyelid approach. She has some upper eyelid asymmetry, and I would correct that through an upper eyelid approach.

**Dr. Baker:** Dr. Tonnard, would you consider an extended MACS lift in this patient?

**Dr. Tonnard:** The decision to perform a simple or extended MACS lift is based on its effect on the midface. The patient wants to improve her nasolabial folds, midface hollowing, and lower eyelids. What I would do first is put this patient in front of a mirror, place my fingers under the region of the mandibular angle, and pull everything upward. I would probably not get a good neck correction with this maneuver alone, especially considering the significant bands. In this patient, I believe I would need to do more than lipoplasty with suspension of the lateral part of the platysma. My preference would be to perform an anterior cervicoplasty, opening the neck at the end of the surgery after everything is lifted, and resecting the bands and, if needed, perform some subplatysmal fat resection at the midline.

**Dr. Baker:** Do you resect the subplatysmal fat down to the mylohyoid muscle?

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**Figure 2.** This 60-year-old woman is unhappy with her jowls, deep nasolabial folds, and neck cords.
Dr. Tonnard: Very seldom. I just resect what I feel is necessary. I am concerned about over-resection of subplatysmal fat that could lead to skeletonization of the neck. Medial platysmarrophy seems unphysiological to me because the medial edges of the platysma were never before at the midline position. Platysmarrophy also works against the desired lifting effect because it pulls the platysma downward. Moreover, at the end of the suspension surgery it is usually impossible to suture the bands together because they are repositioned in a cranial direction. To solve residual bands, I usually resect 1 or 1.5 cm of the bands in a sagittal direction.

Dr. Baker: Since you are trying to accomplish a significant midface elevation, do you think it would require an incision along the hairline, as opposed to an incision into the hair?

Dr. Tonnard: I always perform a prehairline incision that ends up a little higher if a midface lift is incorporated in the face lift procedure. When a vertical vector face lift is performed, which in my opinion is the most rejuvenating, the classical temporal incision into the hair cannot be used because the hairline would be raised too much, producing an obvious face lift stigma.

Dr. Baker: What are the limitations of the MACS lift in this patient? I am asking this because she presents difficulties for a short scar face lift.

Dr. Tonnard: If the results were not satisfactory at the end of the surgery, I would do a separate occipital prehairline incision for redraping any skin folds. The only indication that I see for going behind the ear is in a patient with wrinkled, sun-damaged neck skin. If you pull up this kind of skin, you get a vertical fold in the infra lobular region, but I am not sure that I would have this problem with this patient. I would tell her that, if necessary, I would make an extra incision in the retroauricular region.

Dr. Baker: Dr. Massiha, do you have any other ideas or recommendations concerning this patient?

Dr. Massiha: Basically, I agree with most of what Drs. Nahai and Tonnard said. I would perform the surgery in a vertical fashion, and I would tell her that the incision could be extended. I would start with a short scar and do whatever was needed at the end of the operation to eliminate the extra skin.

Dr. Baker: The next patient is a 58-year-old woman who has never had an attractive neck or jawline (Figure 3). In fact, she is missing all of the elements of an aesthetic-looking neck. Dr. Massiha, do you have an aesthetic ideal for how a neck should look and what you are trying to accomplish?

Dr. Massiha: Ideally, I would try to get as much distance as possible from the tip of the chin to the cervicomental angle. This patient has a small chin, and a chin implant might help to increase the length from the chin to the cervicomental angle. I would definitely place a chin implant to help increase the distance from the chin to the neck-jaw angle. On examining her, if I could feel the hyoid bone with my finger, I might consider doing a digastric muscle resection.

Dr. Baker: How do you determine whether or not to resect the digastric muscle, and how do you determine how much to resect?

Dr. Massiha: If the distance from the tip of the chin to the cervicomental angle was short, and I felt that the digastric muscle was the cause (not just the position of the hyoid bone itself), then I would resect the digastric muscle.

Dr. Baker: And how much do you resect?

Dr. Massiha: I resect it all if necessary.

Dr. Baker: Dr. Nahai, do you have an aesthetic ideal for the neck, such as certain angles and structures you would like to be visible?

Dr. Nahai: I do not like any structures to be visible. I like to see the jawline and I like a well-defined neck-jaw angle, but I don’t like a “skeletonized” look. I don’t like a heavy face on top of a thin sculptured neck. This patient does not have too much subcutaneous fat. As Dr. Massiha pointed out, most of her problem revolves around her hypoplastic mandible and the obvious lack of any neck-jaw angle. So, I agree with Dr. Massiha that she should consider a chin implant. The front view of this patient reveals wrinkled skin that is nonelastic. I would not consider her a candidate for a short scar face lift. Because she has poor-quality excess skin, I would tell her to consider a full scar in the crease behind the ear. Whether we cross into the hairline or not is a different matter. I doubt that she has any subcutaneous fat. Her problem has to do with that obtuse angle.
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**Dr. Baker:** Do you think her deformity has a lot to do with subplatysmal structures and fat?

**Dr. Nahai:** If the subplatysmal structures are the problem, I would consider procedures that would reposition the hyoid. I don’t think that just working under the skin with lipoplasty would provide the ideal neck or profile that she and I would be happy with.

**Dr. Baker:** Do you think that the digastrics and the submandibular gland are significant?

**Dr. Nahai:** I doubt if she has a submandibular gland problem. On her profile view, she has a little mole. Under that mole is the submandibular gland. I would assess this intraoperatively once I had opened her neck, keeping an open mind in relation to the anterior belly of the digastric and fascial release. I would strongly recommend that she consider a chin implant.

**Dr. Baker:** How much digastric do you resect?

**Dr. Nahai:** I have resected the entire anterior belly, and I have also done nothing more than plicate the muscles. Normally, I perform a partial resection, but if I judged that I had to remove the entire anterior belly, I would not hesitate to do so.

**Dr. Tonnard:** I think you could. With a neck like this, I think she might be happy with any improvement. I do not think she is looking for a 90-degree cervicomental angle, which would be very hard to accomplish. I completely agree with what has been said. There is a lot of skin excess in the submental area. With vertical redraping of the skin, you can get rid of a lot of skin. On the other hand, the retroauricular incision and dissection do not influence the cervicomental angle. In my experience, there is great benefit from vertical suspension and skin redraping together with a good submental lipoplasty. Usually that gives me a very reasonable result.

**Dr. Baker:** In this patient, would you make your skin incision within the temporal hair or along the temporal hairline itself?

**Dr. Tonnard:** I would definitely follow the temporal hairline. On the other hand, if I did an extended MACS lift, I would probably pro-

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*Figure 3.* This 58-year-old psychologist would like an improved jawline and a neck lift.
pose transconjunctival fat removal. Also, with vertical skin redraping, there would be skin excess in the lower eyelids, so I would need to do a lower blepharoplasty with skin resection. Because we move skin into the face, we always have to deal with some extra skin around the lower eyelids.

**Dr. Baker:** You mentioned that you thought this woman would be happy with any kind of improvement in her neck. Do you have a specific goal? If you could accomplish your ideal, what would that be?

**Dr. Tonnard:** Sitting in front of a mirror, I would show the patient what could be accomplished by pulling the platysma upward. My experience is that patients such as this are happy with any improvement. I would not open the neck because if I did, I would have to open it from mastoid to mastoid, and that would increase morbidity. If you explain it this way, most patients choose the simplest approach. They are happy to get a reasonable improvement with limited risk instead of having the whole neck opened and undergoing subplatysmal work and digastric resection, which tend to increase the complication rate.

**Dr. Nahai:** I would certainly offer her a short scar procedure. I would suggest a tragal incision because she has a prominent tragus, and I think I could blend that in nicely. The main question is how to deal with the submental area; she has very early jowl with skin laxity and some subcutaneous fat. I would recommend a short scar, and tell her that I would probably do just a little subcutaneous fat removal. The only question I have is regarding the round area on the lateral view that looks like a gland.
Dr. Baker: Dr. Massiha, what would be your approach?

Dr. Massiha: I would expect to find a submandibular gland. The simplest option would be tightening the platysma. I have used suspension sutures in the past that mask the deep structures for at least a year or two. If I was convinced that I could not give her an attractive jawline without partially resecting a small portion of this superficial lobe, then she and I would decide if that was something we wanted to do.

Dr. Baker: How would you handle her hairline? She doesn’t have much sideburn.

Dr. Massiha: I would make a prehairline incision. She has a very short hairline, so I would incise prehairline and limit the incision to the sideburn itself. I prefer to make a separate temporal incision and elevate the lateral brow. The excess is removed that way, as opposed to chasing the incision way up into the temple in the prehairline area.

Dr. Baker: Dr. Nahai, would you do an SMAS lift in this patient?

Dr. Nahai: Yes, I would. She is fairly thin. My preference is to incise the SMAS at the junction of the mobile and immobile SMAS and then pull it up. As you pointed out years ago, if you start by mobilizing the SMAS over the gland, you end up with little holes in it, and it really does not have much substance to hold sutures. Some surgeons have concerns about the nerves and whether that is the most effective point of fixation. In the midface, jowl, and perioral areas, I use the mobile SMAS rather than making the incision way behind and working my way to the mobile portion.

Dr. Baker: Dr. Massiha, would you consider plicating this patient?

Dr. Massiha: Yes, I would use the SMAS as a unit.

Dr. Baker: Do you think that the gland is something that falls with age, or do you think it is an enlarged gland? How do you analyze that particular deformity?

Dr. Massiha: My feeling is that it descends with the other tissues of the face, which can be attributed mostly to aging, and is not an enlargement.

Dr. Baker: When you address the digastric muscle, is it usually a hypertrophic muscle?

Dr. Massiha: I never have seen the digastric problem as enlargement of the muscle.

Dr. Baker: Dr. Nahai, have you had experience with hypertrophy of the digastric muscle?

Dr. Nahai: I am not sure whether it is hypertrophy, laxity, or whether with age the skin is not as tight as it was and the digastric becomes more obvious. I think it is probably the latter. With age, as we lose a little subcutaneous fat there, the skin becomes loose and the ligaments do not retain the platysma. They lose their elasticity and everything pulls away. The anterior belly of the muscle becomes more obvious, and it may be exactly the same sequence of events with the glands.

Dr. Baker: Have you had any patients complain of changes in swallowing following resection of the digastric muscle? Also, what is your incidence of submental irregularities and depressions following fairly aggressive subplatysmal treatment?

Dr. Nahai: You raise 2 important issues. First, no, I have not had anyone complain about their ability to swallow. Your second question is very significant. Any subplatysmal work that I do is in place of working superficial to the platysma. If one aggressively thins the fat and the tissues superficial to the platysma and then does the same thing between and deep to the platysma, the result is exactly what you are suggesting—a depression!

Dr. Baker: How do you assess your endpoint when you are dealing with the submental and subplatysmal areas? Do you think that the endotracheal tube affects the submental region in terms of pressure on the tongue and the muscles in the floor of the mouth, distorting the area? Could you give us some clues and helpful hints as to how to assess the ideal aesthetic results?

Dr. Nahai: I evaluate results by judging the patient’s appearance on the table. Some surgeons flex the neck, but my preference is to leave it in a neutral position or even extend it to see if I like the appearance. I also evaluate if there are skin irregularities and if I have overdone or underdone any of the thinning.

Dr. Baker: If you do your assessment and decide that you have overresected, what recourse do you have?
Dr. Nahai: Are you referring to over-resected superficial or deep tissue?

Dr. Baker: After you have finished working on the platysma (performed subplatysmal defatting down to the mylohyoid muscle, resected 90% of the anterior bellies of the digastric muscle, and redraped that skin) and the neck is in a neutral position, how would you address the problem if you find that you have a significantly concave submental region?

Dr. Nahai: Fortunately, I have not had to face that problem. I would think of replacing the volume. You cannot inject fat there. Your only option would be a dermis fat graft, or a SMAS graft. Hopefully, the patient would have sufficient tissue available for a graft. But the best option would be to wait, assess the postoperative result, and then try to correct it secondarily. If I was convinced initially that I had overdone it, I would try to correct it with some sort of composite graft.

Dr. Baker: Dr. Massiha, have you ever completed a submental dissection and then realized that you had over-resected tissue?

Dr. Massiha: Fortunately not. Theoretically, I would try to correct it right away. I might even inject some fat in that area because I would be afraid that if I waited the skin might adhere to the muscles underneath, and it would be very hard to correct. In a few patients who were secondarily referred to me, the ridge of the mandible was deficient in fat and the skin was attached to the muscle under it, and it was very difficult. I could not adequately correct the depression over the ridge of the mandible with fat injection; I had to loosen it up and then put in dermis or fat, and still it was not perfect.

Dr. Tonnard: Not really. I use a 2.5-mm cannula for the submental work if I perform lipoplasty. I have never been in a situation in which I felt I had done too much. Over-treatment is only possible if you use a cannula that is too big. I have been following the discussion about the submandibular gland with great interest. I have had one patient in the last 5 years who asked me, “Doctor, what is this lump here?” If you inform your patients honestly about the possible risks of submandibular gland surgery, most patients do not want to undergo this surgery. Moreover, there are very important structures around the submandibular gland, such as the facial nerve and a big branch of the facial artery. Moreover, if you have postoperative bleeding from the submandibular artery, this complication can transform your surgery into a life-threatening event, necessitating a tracheotomy because of difficult intubation. Quite honestly, this is beyond the scope of aesthetic surgery.

Dr. Tonnard: From the pictures it appears as if most of the problem is fat and excess skin. I would start with a submental lipoplasty, and if I wanted to treat the "witch's chin" deformity, I would definitely make an incision and dissect anteriorly, releasing the crease. A very good lipoplasty around the mandibular border would sculpt her neck and define the mandibular border—together with the vertical suspension of the SMAS and platysma and a vertical redraping of the skin.

Dr. Baker: Do you think you could get a satisfactory result with a MACS lift?

Dr. Tonnard: I think so.

Dr. Baker: Would you have to do any extended procedures?

Dr. Tonnard: If you decide to perform an extended MACS lift, you need a third suture to lift the midface. But we could get a great improvement with the 2-suture lift with submental sculpting of the fat if we wanted effects only in the lower third of the face. The decision to extend a simple MACS lift with 2 sutures to an extended MACS with 3 sutures would depend on the patient’s wish to have some effect on the midface. The decision to extend a simple MACS lift with 2 sutures to an extended MACS with 3 sutures would depend on the patient’s wish to have some effect on the midface. It looks as though she has less volume in the right lower eyelid than in the left lower eyelid. It would be up to the patient to decide...
Dr. Massiha: This woman is an ideal candidate for a short-scar face lift. I would suction the fat from the middle of the neck (the part that is protruding). I would pull the facial skin up with my hands, see how far I can lift it, and then suction below it. To avoid a mandibular border depression, I might suggest performing a buccal fat-pad resection as an ancillary procedure.

Dr. Baker: Do you perform the buccal fat-pad resection through a rhytidectomy incision or using an intraoral approach?

Dr. Massiha: I use an intraoral approach. Using anatomic landmarks, I can remove the fat pads within 5 minutes.

Dr. Nahai: No, I would recommend a short-scar procedure. This is a relatively young woman, and unless I examined her and felt that she did not have adequate skin elasticity, I think that in the submental area the skin would redrape nicely.

I would definitely open her neck to deal with her emerging "witch's chin." It is not yet full-blown. She is typical of the patient in whom I would make the incision posterior to the pre-existing crease. I divide the cutaneous connections of the crease,

Dr. Massiha: Because of more vertical lifting, and because I move the platysma and the SMAS upward together, the skin will come up nicely since it is kept attached to SMAS/platysma in most of its undersurface.

Dr. Nahai: No, I would recommend a short-scar procedure. This is a relatively young woman, and unless I examined her and felt that she did not have adequate skin elasticity, I think that in the submental area the skin would redrape nicely.

I would definitely open her neck to deal with her emerging "witch’s chin." It is not yet full-blown. She is typical of the patient in whom I would make the incision posterior to the pre-existing crease. I divide the cutaneous connections of the crease,
extending to the mandibular cutaneous ligament, which I release. And if there is cutaneous fat to deal with, the fat is deep to the platysma. A short scar face lift performed in a patient with normal skin elasticity produces a result that the patient and I would be happy with.

**Dr. Baker:** I have one last question for all 3 panelists. What do you feel is the primary value of this short scar lift? Is it specifically for young women who wear their hair pulled back, or do you feel there are other benefits? Do you think that it is more or less difficult than the classic technique?

**Dr. Tonnard:** First, the advantage of a short scar face lift is that it is a surgery that is simply shorter in duration. It saves operating time. Most of my patients, under local anesthesia, go home the same day, and the recovery time seems shorter than if I perform a complete open-neck dissection. Most of the patients resume normal social activities within 2 weeks. It is very popular.

Here in Europe the magic word is "local anesthesia." These patients are healthy; they don’t feel sick and don’t want to go to a hospital. Even patients who don’t wear their hair pulled back don’t like retroauricular scars. I have nothing against a long scar, but if it is not necessary, I prefer a short scar. It is as simple as this. I don’t think short scar face lifting is easier than the classic technique. The problem is dealing with the dog ears, and therefore you need to have good soft tissue handling.

**Dr. Massiha:** The incisions are shorter, and there is less skin dissection, less trauma, and fewer complications. The difficulty with short scar is dealing with dog ears behind the ears. In the temporal area it is very easy to get rid of the dog ears. Originally, decades and decades ago when surgeons routinely ended with a dog ear behind the ear, they extended the incision to the current “classic” postauricular and temporal areas. The difficulty for novices is that they see bunched-up skin behind the ears, become scared, and they do not want to do it again. My recommendation is to begin the procedure first with a short scar. Then at the point when there is bunched-up skin, if the surgeon cannot get rid of it, the incision can always be extended and made into a conventional incision.

**Dr. Baker:** I wish to thank the panelists for participating in this discussion.

**References**

1. Baker DC. Minimal incision rhytidectomy (short scar face lift) with lateral SMASectomy evolution and application.


Bibliography


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