EDITOR'S NOTE: My thanks to the moderator, Gustavo Colon, MD (board-certified plastic surgeon and ASAPS member, Metairie, LA); and to panelists Portia Chiou, MD (board-certified plastic surgeon, Newport Beach, CA); Onelio Garcia, Jr., MD (board-certified plastic surgeon and ASAPS member, Hialeah, FL); and Volney Pitombo, MD (board-certified plastic surgeon and ASAPS member, Rio De Janeiro, Brazil), for sharing their opinions and clinical experience.

Dr. Colon: I would like to start by posing a general question. Is there any approach that you take differently in a patient of medium complexion—whether Latino/Hispanic, Mediterranean, or another ethnicity—with regard to the incisions used for facial rejuvenation procedures? Because one of the things you must warn these patients about is that their scars may be hypertrophic.

Dr. Garcia: About 50% of my current practice is Hispanic. I am in south Florida. In the very thick, darker, or olive skinned patients that I see, I do not use hairline incisions. I always keep them behind the hairline, and I shorten the postauricular incision significantly, whenever possible. But when I cannot, because of significant extra skin, I always keep it within the hair. The problems I have seen with hypertrophic scars in these patients have been in the postauricular area.

Dr. Colon: Dr. Pitombo, what is your approach?

Dr. Pitombo: I limit the problem by limiting the incisions. In other words, I do a short scar face lift.

Dr. Colon: And Dr. Chiou?

Dr. Chiou: For my patients who have medium complexion skin, I place the scar within the hairline, if possible. Postoperatively, I start patients on active scar massage the week after their sutures are removed. In some instances, I recommend using a particular product, such as Mederma (Merz Pharmaceuticals, Greensboro, NC), which when coupled with scar massage seems to help keep scars flat.

Dr. Colon: Is there any difference in your approach to Asian patients?

Dr. Chiou: I approach Asian patients in the same way as I approach anyone with a medium complexion. Scarring is a concern, especially in the very early postoperative period. For patients at risk for hypertrophic scarring, I provide instructions in scar massage early on. There is noticeable improvement as long as patients start soon after suture removal and are followed frequently in the first several months.

Dr. Colon: Let’s look at our patient examples. The first patient (Figure 1) is a 50-year-old woman of medium complexion who simply asks, “What can you do for me to make me look better.” Dr. Garcia, how would you approach this patient?

Dr. Garcia: I would ask her to pinpoint concerns about her jowls, pronounced nasolabial folds, eyelid puffiness, and anterior neck irregularities. I would propose a rhytidectomy with SMAS elevation, which I perform in many thicker-skinned Hispanic patients.

In this patient, I would not perform the extensive submental lipectomy that I frequently perform in Hispanic patients (I usually do platysma plication in the midline...
following the submental lipectomy); this patient has very little submental fat. I would administer Botox (Allergan, Irvine, CA) injections to her glabellar area and perform upper and lower blepharoplasties. I would not do any replacement of volume in the lid, and would actually remove some of the excess periorbital fat without rearranging the fat or injecting any filler.

**Dr. Colon:** Assuming she was unhappy with her neck, how would you improve it?

**Dr. Garcia:** I would perform extensive undermining of the neck skin, which would communicate across the anterior neck. This would help address the anterior neck irregularities apparent in the lateral photo. I would follow that with platysma plication in the midline. I would then drape the skin posteriorly in the usual rhytidectomy fashion. Skin irregularities in the neck are better addressed with significant undermining.

**Dr. Colon:** Dr. Pitombo, suppose this woman had much darker skin. Would you do anything differently? How would you approach her?

**Dr. Pitombo:** I would perform a face lift with SMASectomy and plication, closed submental lipoplasty, and upper and lower blepharoplasties. I think ancillary procedures would also improve her appearance. Specifically, I would perform lip dermabrasion and nose tip surgery. Narrowing the nasal tip would give her face more harmony. If the patient had a darker skin color, I would follow the same operative plan. However, I would not perform dermabrasion, since it could cause dyschromia.

**Dr. Colon:** Dr. Chiou, if this patient complained that her midface had “dropped,” how would you approach her?

**Dr. Chiou:** She has good position of her lower eyelids, but she has lost some fullness in the midface. She would benefit from a face lift with attention to elevating the midface with SMAS plication. With her complexion, the temporal incisions should be within the hairline rather than anterior to the sideburn hairline.
Dr. Colon: Would you consider injecting fat or another substance into the nasojugal area to fill that out?

Dr. Chiou: I would consider it, but I would time the injections separately from the surgical procedure.

Dr. Colon: Would any of the panelists consider doing some type of forehead rejuvenation?

Dr. Pitombo: I think her forehead looks fairly good, and I would not do anything for it. If her forehead bothers her, some Botox would be helpful in the postoperative period.

Dr. Garcia: I might consider Botox injections to her forehead and glabellar areas.

Dr. Chiou: She has nice, well-defined upper eyelid creases and a low anterior hairline. I do not think the first priority would be to elevate her brow or to address the upper eyelids. I would focus on the lower two thirds of her face.

Dr. Colon: Dr. Chiou, Would you also consider some sort of paralytic injection to her forehead?

Dr. Chiou: Based on the photographs, she does not have many glabellar creases. What creases she has are not terribly deep. My concern is that paralytic agents added to her frontalis area would drop her brow position.

Dr. Colon: Dr. Pitombo, you commented before about her nose. I realize that her nose is a bit broad and thick. How would you improve it?

Dr. Pitombo: Reshaping the tip of her nose would make her look younger. I like a closed technique, through which I would sculpt the alar cartilage, using sutures to narrow the domes and defatting under the skin of the tip. It would make her face more attractive and make her nasal contour fit her face.

Dr. Colon: The next patient is a 50-year-old woman who is seeking facial rejuvenation (Figure 2). As you can see, she looks somewhat tired and has drooping eyelids. Dr. Chiou, what would you do to improve her appearance?

Dr. Chiou: I would like to see her in profile. However, I will make my recommendations based on the 2 photographs shown. First, as always, I would listen to the patient’s concerns. My observation is that she has a low anterior hairline and eyebrows positioned at the supraorbital rim. She has hooing of the upper eyelids and a slight tear trough definition. Her jawline is well defined with a few platysmal bands. I would focus on the upper third of her face. Primarily, she would benefit from an upper blepharoplasty with some removal of orbital fat.

Dr. Colon: How would you approach her lower eyelids and her midface area? It seems a bit hypoplastic.

Dr. Chiou: In her lower eyelid area, she has just a hint of a tear-trough deformity and may have some malar hypoplasia. Again, unless she came to the consultation inquiring about a face lift, I would not suggest it. My approach is to address the patient’s area of concern. If she specifically wanted to improve the lower eyelid area, the use of a filler for contour refinement would enhance her overall aesthetic result.

Dr. Colon: She is concerned about her beginning marionette line and the hypoplasia in her cheeks. How would you approach that?

Dr. Chiou: The downward turn at the corners of the mouth could certainly be addressed by treating the strong depressor muscles with a paralytic agent. More directly, a dermal filler may be injected to the cutaneous lower lip laterally to augment the corners of the mouth. With these minimally invasive treatments, it must be explained to the patient that she will need to return on a regular basis to maintain the optimal effect.

Dr. Colon: Dr. Garcia, how do you assess this patient’s problems?

Dr. Garcia: These are mostly upper face issues. She has a short forehead, so I would approach her with a coronal open brow lift followed by upper and lower blepharoplasties.

Dr. Colon: What do you mean by “open”? Do you mean open all the way across?

Dr. Garcia: Yes. An old-fashioned open brow lift provides excellent access and would somewhat cause the hairline to recede slightly, slightly elongating her short forehead and creating better facial harmony.

Dr. Colon: Would you make the incision in front of or behind the hairline?

Dr. Garcia: I would do it several centimeters behind the hairline. Again, the idea here, in addition to lifting the brow and improving the glabellar area, is to elongate the forehead somewhat. I would also perform a midface SMAS lift, elevating the cheek superiorly towards...
the zygomatic area. She has a relatively flat midface, and I think she would benefit significantly from SMAS elevation to improve this area. The lower face is actually nice, and she has a well defined jawline, which is why I would propose only a midface lift with upper and lower blepharoplasties, and an open coronal brow lift. I would address the anterior platysma through a submental incision.

Dr. Colon: Dr. Pitombo, if this patient is still concerned about her neck on the oblique view, especially the midline platysma band, what approach would you take?

Dr. Pitombo: This woman is a good candidate for a short scar face lift with SMASectomy and lateral platysma plication. In the submental area, I would simply excise the platysma band.

Dr. Colon: How would you all feel about the possibility of inserting cheek implants in a patient such as this who has some midface hypoplasia? Or what else might you do to lift or fill in the midface and zygomatic area?

Dr. Chiou: I would consider cheek implants, although it is not the first option I would recommend. Soft tissue augmentation to address the mild tear-trough definition may give this patient the lower periorbital improvement she seeks.

Dr. Colon: If she wanted it, and was adamant, would you consider placing a prosthesis?

Dr. Chiou: If she wanted permanent augmentation of the area, bilateral malar implants could be placed via an upper buccal sulcus approach.

Dr. Pitombo: I would treat this problem with fat grafts associated with the imbrication of the SMAS in the malar area.
Dr. Garcia: In a patient such as this, I would not perform a SMAS midface lift, photograph the patient postoperatively, and then reevaluate. I would not hesitate to use an implant at that point if she still looked significantly hypoplastic, but I don’t think I would find it necessary in this patient. To correct slight hypoplasia, I would probably use serial Sculptra (Dermik Laboratories, Berwyn, PA) injections. I do not have a long experience with Sculptra, but in the cases in which I have used it, it has shown good results in creating volume in the cheek or midface, and the volume persists for about 18 months to 2 years.

Dr. Colon: Dr. Pitombo, you brought up nasal surgery in the first patient. Again, we have a patient who has a wide nose. As part of her facial rejuvenation, would you consider performing nasal surgery in this patient?

Dr. Pitombo: No, not in this patient; the tip of her nose looks fine. It has good projection, which is important in making the face look young. The nose looks wide because she has a wide alar base. Correcting it would make her nose prettier, but it does not mean she would look younger. Again, what makes the difference in the rejuvenation process is the projection of the nasal tip.

Dr. Colon: In these particular patients, we are talking about Latino/Hispanic noses. But what about the mestizo nose? Dr. Chiou, if you saw such a patient for facial rejuvenation who had a very wide nose, would you be likely to bring up the possibility of nasal surgery?

Dr. Chiou: I would first focus on the patient’s specific request. For the patient interested in facial rejuvenation, aesthetic nasal surgery could be discussed if I thought the patient would benefit significantly in achieving a better overall appearance. Enhancing a patient’s features while maintaining a natural ethnic appearance is most desirable.

Dr. Colon: Dr. Garcia, what about you?

Dr. Garcia: This issue has come up frequently in the population I treat, especially when I review postoperative photos following facial rejuvenation procedures. I do not discuss this with the patient initially, but wait until we review the postoperative photos and then suggest nasal surgery, if appropriate. I think patients are more accepting of additional major procedures once they have had the opportunity to experience the results of their initial facial rejuvenation procedures. (The exception to this would be minor tip revisions that do not require significant bony work or fractures.) Any time you combine major nasal bone surgery or fractures with rhytidectomy/blepharoplasty procedures you significantly increase bruising and edema and adversely affect the aesthetic downtime of the rejuvenation procedures. Also, I believe the initial nasal swelling is prolonged in these combined procedures since many of the lymphatic drainage channels are already challenged by the rhytidectomy/blepharoplasty surgery.

Dr. Colon: The next patient is a 60-year-old woman from Northern Spain who has fine skin (Figure 3). She says that, while she accepts that she has aged, she does not feel as old as she looks. Dr. Pitombo, what would you suggest to her?

Dr. Pitombo: I would recommend closed liposuction of the neck, a face lift with SMASectomy, lateral platysma plication, and an open foreheadplasty.

Dr. Colon: Would you ever consider an endoscopic forehead lift?

Dr. Pitombo: No, I am not impressed with the results of the endoscopic forehead lift. In my experience, only open foreheadplasty gives reliable and lasting results. When you improve the forehead, you should also improve the upper eyelids. Although she is Spanish, this woman has a somewhat Asian appearance, and I would like her to keep that unique look. My goal would be to make her appear more rested. A foreheadplasty and upper eyelid surgery would suffice.

Dr. Colon: Dr. Garcia, how would you approach this patient?

Dr. Garcia: I would not perform an open coronal lift in a patient with a long forehead. Unlike the patient we discussed (Figure 2) in whom my approach would have been an open coronal brow lift, in this patient, I would strongly consider an endoscopic forehead lift, upper and lower blepharoplasties, and rhytidectomy with a fairly radical SMAS lift, which should improve the jowls. I would not remove the buccal fat pads or resect salivary glands. I believe the superior cheek SMAS elevation would improve the jowls significantly because a deep SMAS lift elevates the jowls.

Dr. Colon: Dr. Chiou, how would you approach her jowls? Would you consider removing her buccal fat pads?
**Panel Discussion**

**Dr. Chiou:** This patient has the potential for a very nice result, because she has fine bone structure. Along the buccal region are melolabial folds and sagging at the marionette lines. There is not an excess of tissue that would warrant resection of the buccal fat pad.

Her jowls and the lower two thirds of her face are best addressed with a face lift with SMAS plication and a submental incision to approach the platysma bands.

**Dr. Colon:** Would anyone treat the perioral area, which seems to be either sagging or protruding?

**Dr. Pitombo:** I would perform dermabrasion of the perioral area. In my experience, dermabrasion works better than laser for this kind of skin, and it has a faster recovery time.

**Dr. Colon:** Dr. Chiou, how would you approach the perioral area?

**Dr. Chiou:** In the perioral area in a woman who has lighter skin with freckles, CO₂ laser surfacing works well when executed conservatively. Patients can recover quite nicely when treated with CO₂ laser for perioral rhytids.

**Dr. Colon:** Would you consider using Botox around the perioral area to change the shape of the mouth, lift the lip, and show more dentition?

**Dr. Chiou:** I have not used Botox in the upper lip region.

**Dr. Colon:** Dr. Garcia, how would you approach the perioral area?

**Dr. Garcia:** I would use the erbium laser in the perioral area. The upper lip would benefit significantly from a filler that outlines the border and slightly plumps it up. I prefer Restylane (Medicis Pharmaceutical, Scottsdale, AZ). We use the Erbium laser very aggressively, even in the Hispanic population. We had difficulties with discoloration in these patients using the CO₂ laser. The Erbium laser is quite safe, and the discoloration issues are short lived. However, we aggressively prepare the skin before laser treatment with hydroquinone and retinol. In darker skin types, our skin preparation may begin months before the laser treatment. It also goes without saying that all these patients would use high-factor sun block.

**Dr. Colon:** If the patient came back 6 months later and complained that the corners of her mouth were still drooping, what would you consider doing?

**Dr. Garcia:** I do not have experience injecting Botox in the perioral area. Because of my lack of experience, I do not feel comfortable using paralytic agents around the lips. However, I frequently inject Restylane in this area, and the volume increase improves the lateral lips significantly.

**Dr. Colon:** Dr. Chiou, would you consider lifting the corners of the mouth?

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**Figure 3. A–C, This 60-year-old woman requested lifting of her eyelids and forehead and softening of the wrinkles around her lips.**
Dr. Chiou: I would consider lifting the corners of the mouth with a dermal filler. By injecting about .5 mL for each side at the lower lip commissure to build up the lower lip area, the corner of the mouth can be elevated from a downward to a level direction.

Dr. Colon: Dr. Pitombo, would you ever consider doing a surgical lift of the mouth or the lip?

Dr. Pitombo: No. I also prefer to use a filling agent such as Restylane to perform a nonsurgical lift.

Dr. Colon: The next patient is a man who has the “leonine facies” (Figure 4). Assume that he complained about his harsh appearance; he wants a “softer” look. Dr. Pitombo, how would you proceed?

Dr. Pitombo: This is a very difficult case. The patient has an aggressive appearance, and the surgery must make him look less aggressive. He needs a face lift and a forehead lift through an external forehead incision. I would lift his forehead using a pre-hairline incision and work on the glabella to remove the excess muscle and skin. In the malar area and midface, I would do fat grafting.

Dr. Colon: Would you consider making an incision in his brow creases?

Dr. Pitombo: Because of his darker skin, I would rather do a pre-hairline incision than a direct incision in the glabella area.

Dr. Colon: Would you approach the drooping of the brows directly or from the forehead?

Dr. Pitombo: I would approach the drooping from the forehead. I can bring the incision laterally and then lift the eyebrow; he definitely needs that.

Dr. Colon: Dr. Garcia, how would you approach his nasolabial area and his midface?

Dr. Garcia: I would tell the patient that this will be a staged surgery, because I do not think he would get a good result with anything other than direct incision in the nasolabial fold and in the glabellar area. He has some creases there that are simply not going to go away.

The first procedure would be the rhytidectomy with SMAS plication. I would then come back secondarily and perform direct excision of the nasolabial folds. I would also approach the forehead through his midforehead crease; I would not go to the hairline. I would use a direct approach, using the heavy middle crease that he has in the midforehead. I have seen that used before in men with this type of skin, and it works quite well.

At rest, he has some significant lip deficiency. I think anything done to address these low and midface areas should involve some kind of procedure to shore up his lower lip. The full face photo shows a couple of millimeters of lower lip deficiency. The patient would benefit from the use of a filler such as Restylane to increase lip volume.

Dr. Colon: Dr Chiou, if this man were human immunodeficiency virus (HIV) positive, would you consider doing anything different?

Dr. Chiou: During the preoperative consultation, I would need to find out more. He is a challenging patient, and I would want to make sure that he did not have an undiagnosed skin disorder. His neck and trunk skin seem to be normal. If he were HIV positive, the risk of bleeding with any surgical procedure would be higher. Regardless of his HIV status, this patient would be best treated in stages. His glabellar area has pronounced rugae at rest. Resection of the corrugator muscles via an upper blepharoplasty incision would relieve some of the activity in this area. Next, I would aim to reposition the forehead and heavy ptotic brows with an endoscopic brow lift.

Dr. Colon: What about the tear trough and the midface, assuming he is not HIV positive?

Dr. Chiou: He has significant cheek descent of the malar region and midface. After first improving the forehead, brow position, upper eyelids, and corrugator muscles, the lower two thirds of the patient’s face could be addressed.

This patient has lost much of the elasticity in his facial skin. The senile ectropion should be corrected. The festoons of the infraorbital region and the malar descent of thick skin are quite dramatic. The patient’s bulbous ptotic nose also contributes to his aged appearance. His lower eyelid position could be resuspended with bilateral lower eyelid canthopexy to prevent ectropion.

At yet another stage, the midface could be elevated with a face and neck lift. Remarkably, this patient does not demonstrate heavy jowling at the mandibular border.

Dr. Colon: We have not talked about his neck. If we look at his three-quarter view, you can see that he has some banding. Would you do anything to his neck?
Dr. Chiou: In contrast to the rest of his face, this patient’s neck does not show significant signs of aging. He has a few platysmal bands, which could be plicated toward the midline through a submental incision.

Dr. Colon: Dr. Garcia, Dr. Pitombo brought up the question of his nose. Would you consider doing anything to his nose if the patient were amenable?

Dr. Garcia: It is a major focal point in this particular patient. I feel very strongly about staging the procedures, especially in a patient like this. The nose would be the last thing I would do.

Dr. Colon: To me, this looks like a leonine face. Would anyone work him up for Hansen’s disease?

Dr. Chiu: Leprosy? I don’t think he has Hansen’s disease. It is exceedingly difficult to confirm the diagnosis of leprosy but it can be considered.

Dr. Colon: Let’s speak generally again for a moment. In terms of your approach to forehead surgery, at what level do you work—subcutaneous, subgaleal, or subperiosteal?

Dr. Pitombo: I perform a forehead lift on the subgaleal level.

Dr. Colon: Even if the incision is pretrichial?

Dr. Pitombo: Yes.

Dr. Colon: What about the other panelists? How would you approach the forehead?

Dr. Garcia: It depends on the patient. In this particular patient (Figure 4) I would work superficially in the subcutaneous plane because of the thick hypertrophic skin. I don’t think that even direct resection of the procerus and corrugator muscles would take care of this problem without direct skin incisions in that area, which is why I would stage the procedures. I have similar patients in whom I have come back several months later, making direct incisions into the crease area to remove some of the skin because I did not obtain satisfactory results by lifting the forehead and resecting the muscle alone. The creases are too deep, the skin is hypertrophic, and if we don’t directly incise it (same as with the melolabial folds), I do not think the result will be satisfactory. Scars have not been an issue if properly placed within the creases.

Dr. Colon: Dr. Chiou, what level would you work on in this patient?

Dr. Chiou: In a brow lift, I generally dissect subperiosteally. Again, it is not clear how this patient would respond to a subperiosteal lift. I agree with staging his procedures. The goal is to elevate the ptotic brows and also to weaken the facial muscle activity in the glabellar region. This is best done by resecting the corrugator muscles. I would be very reluctant to do direct excisions, especially since there are deep verti-
cal and horizontal grooves. Noticeable scarring is a consideration, especially with someone who has a dark complexion. Direct excision is more likely to create a new problem for this patient.

Dr. Colon: I would like to ask each one of the panelists if they have any special message for readers about facial rejuvenation in patients with medium complexions, such as Hispanic-type skin.

Dr. Garcia: After dealing with this population for 20 years, my advice is not to compromise the results by shortening the incisions when a longer one is needed. When I have tried to treat a patient who needs a standard-incision procedure by using a shorter incision, I have invariably compromised the results. I feel that scars have not been as much of an issue in this population as we tend to believe. Over the years, I have reverted back to doing what I need to do to achieve the best result. I certainly want to hide scars in the hair, but I will not shorten the incisions so much that I cannot get an adequate result.

Dr. Chiou: Be mindful of incision placement. Follow patients closely, especially when changes in scars appear. Postauricular scars demand greater attention postoperatively, because patients cannot see this area and will need close supervision of scar management.

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