Lifting Lips: 28 Years of Experience Using the Direct Excision Approach to Rejuvenating the Aging Mouth

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The mouth ages along with the face, but it is frequently ignored when performing facial rejuvenation. The authors have addressed the mouth area with direct surgical options and excisions since 1980. In using the direct approach, the tradeoff for an improved appearance at a conversational distance is a scar that is barely visible from inches away. In more than 3000 procedures, the results have been consistently good, with very few minor scar irregularities that required revision. The authors advocate performing a lip lift to elevate the central lip and a corner mouth lift to elevate the lateral lip. Although the lip and corner lift are important in shortening the long lip of aging, one of the most useful perioral procedures is the direct excision of loose skin at the lower nasolabial/marionette foldover area. The authors conclude that results of facial rejuvenation are greatly enhanced by appropriate procedures of the mouth. (Aesthetic Surg J 2009;29:83–86.)

Rejuvenation techniques employing direct excisions around the mouth have been somewhat controversial, but what has become clear is that the perioral area must be included in the surgical plan for facial rejuvenation. Ignoring any one area can create a disharmony that leaves the face looking unnatural and having an “operated” appearance. An aging mouth in a rejuvenated face still leaves the face looking old.

Our rationale in using the direct approach is the same as in all cosmetic surgery procedures. The tradeoff for an improved appearance at conversational distance is a scar that is barely visible from inches away. There are precedents for this approach. Plastic surgeons have been willing to place visible scars on the eyelids when performing blepharoplasty, on the nose when performing rhinoplasty, and on the breasts when performing augmentation and reduction. We do so because we believe that the scars are an appropriate exchange. We know that incisions distant from these sites lead to inadequate results. This also holds true for perioral rejuvenation; the area cannot be adequately rejuvenated from a distance. In the appropriate patient, we think nothing more about creating a perioral scar than an eyelid scar. As with all procedures, however, the patient must decide if the tradeoff is worth the potential result. Scars around the mouth, usually placed at natural creases, are actually less noticeable than most other scars. After performing more than 3000 of these procedures, we are more convinced than ever that the exchange is a good one.

HISTORY AND METHODS

The Lip Lift
Dr. Austin began performing the lip lift in 1980 and presented 83 cases in 1986.1 Over the past 28 years, the authors have collectively performed approximately 1200 lip lifts.2 The lip lift is performed to shorten the long lip of aging and is designed as a wavy ellipse skin excision that follows the contour of the nostril crease below the sill (Figures 1 through 4). The nostril sill itself is not violated. There is no attempt to hide the scar in the nose; the scar is well-hidden in the crease and is usually imperceptible.

The amount of skin to be excised is based on the length of the lip and the amount of incisor show. A long lip that already has incisor show should not be lifted. A lip less than 10 mm and 12 mm from nostril sill to Cupid’s bow will look too short, regardless of incisor show. Variations from this classic technique and their applications are fully described in previous articles and are beyond the scope of this review (Figure 4A).2,3

The Corner Mouth Lift
The original corner mouth lift was created in 1985 to “balance” the mouth when the lip lift exaggerated the downturned corners. The aging mouth can develop an
unhappy or even bitter appearance that cannot be adequately treated with a face- or midface lift. The goal is to achieve an appearance of serenity, much as a brow lift replaces the appearance of concern or anger with one of tranquility.

Over the past 23 years, the authors have collectively performed more than 1500 corner mouth lifts. The original technique was very effective at lifting the corners of the mouth, but left a short scar outside the vermilion border lateral to the commissure. Occasionally, the scar would be slightly depressed and noticeable (Figure 5). In 1994, we redesigned the corner mouth lift to have the resulting scar wrap around the corner of the mouth, leaving the scar at the vermilion edge (Figures 3A and 4A). This variation on the original technique is excellent when the mouth commissures require lifting, but may also leave some minor irregularity in which excess skin is wrapped around the corner of the mouth into the lateral lower lip margin.

Most commonly (90% of the time), we now perform a simple ellipse excision of skin at the lateral upper lip margin to advance the vermilion superiorly (Figures 1A and 2A). Because this does not lift the commissure, the “wrap around” technique is still used when lifting of the commissure is required. The skin excision for the corner mouth lift can be extended medially up to the peak of the Cupid’s bow without becoming visible. We caution, however, not to extend the incision to the area between the Cupid’s bow, as in a full upper lip advancement. This can leave a visible scar, an unnatural shape that is obviously surgical, and occasionally a tight banded central scar. A better choice is to perform a lip lift to elevate the central lip and a corner mouth lift to elevate the lateral lip.

**Direct Perioral Excisions**

Although the lip lift and corner lift are important in shortening the long lip of aging, one of the most useful perioral procedures is the direct excision of loose skin at the lower nasolabial/marionette foldover area (Figure 1). While a face lift can improve the lower laxity by 30% to 40%, this is frequently inadequate in providing an excellent result. In the past 8 years, we have performed more than 400 direct excisions of nasolabial and marionette folds.
folds. In contrast, the upper nasolabial area is usually improved adequately by a midface lift and fat grafting, though occasionally a full-length excision is required.

RESULTS
Using the lip lift procedure, we have had one hypertrophic scar and very few scar revisions for minor irregularities over a course of more than 1200 procedures. As noted, the original technique of the corner lift occasionally produced a visible scar that opposed natural wrinkle lines and the later techniques have rarely produced the need for scar revision. The quality of scars resulting from direct excision are usually as good as blepharoplasty scars (barely noticeable on close inspection from inches away; Figures 1C, 2C, 3C, and 4D). Our most common reoperation after direct excision is reexcision for residual looseness (<5%) secondary to inadequate resection.

Overall, our revision rate for perioral surgery is very low and is mostly related to the patient's (and surgeon’s) desire for even further improvement. Patient satisfaction is high and the procedures result in a more complete and harmonious facial rejuvenation.

DISCUSSION
Most commonly, we combine procedures of the mouth with a more extensive facial rejuvenation that may also include fat injections to thinning lips and wrin-
kles, as well as either laser or dermabrasion resurfacing (Figure 4A).

As in much of cosmetic surgery, a great deal of the success depends on patient selection, preoperative planning, and patient education. We consider the patient as the “senior partner” in the physician–patient relationship, because ultimately it is the patient who chooses which procedures, if any, are performed. The pros and cons of one particular approach versus another must always be carefully explained. In such discussions, it is often helpful to estimate the anticipated percentage of improvement. For example, a face lift might improve the looseness in the nasolabial area by 30% to 40%, but adding a direct excision might improve it by 80% to 90%, with the tradeoff of a slightly visible scar.

If the direct excision approach is not chosen initially, such procedures can be performed later if the patient feels that the initial result of rejuvenation is inadequate. In appropriate patients, these procedures can be done under local anesthesia.

In our experience, procedures of the mouth are most commonly performed in conjunction with more extensive facial rejuvenation to enhance the overall result. Rarely are they “stand alone” procedures, except in the case of younger patients who are not yet candidates for other procedures but want to enhance the appearance of the mouth.

Over the past 25 years, multiple techniques have evolved for rejuvenation of the mouth.1-11 We routinely perform these procedures and plastic surgeons can feel confident that they have stood the test of time. We believe that the lip lift, corners-of-the-mouth elevation, and related direct excision techniques that we have performed for so many years with high patient satisfaction should be considered for appropriately selected patients undergoing facial rejuvenation.

DISCLOSURES

The authors have no disclosures with respect to the contents of this article.

REFERENCES


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