Central Lip Lift as Aesthetic and Physiognomic Plastic Surgery: The Effect on Lower Facial Profile

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Abstract

Background: A central lip lift was introduced to Westerners in 1980s. However, no studies have been conducted on the facial aesthetic and physiognomic perspectives of a central lip lift in the Asian population.

Objectives: The authors presented the central lip lift as aesthetic and physiognomic treatment in Asians and explained its effect on lower facial profile.

Methods: A retrospective chart review was performed in 202 cases of Asians. The authors analyzed patient age, cause of long philtrum, purpose of the treatment, and postoperative satisfaction. The authors then performed an anthropometric assessment and a photographic analysis.

Results: The vertical disproportion of the lower face was improved after the treatment, and there was significant shortening of the philtrum length ($P < .001$) and an increase in a visible upper vermilion ($P < .001$). In Westerners, a long philtrum was mainly caused by the aging process. Aging patients (range, 40-59 years) underwent the central lip lift for upper lip rejuvenation. In contrast, in Asia, a long philtrum was primarily caused by bone retraction after an orthognathic surgery or orthodontic procedure. Young patients (range, 20-39 years old) underwent the central lip lift to correct a relatively lengthened philtrum after 2-jaw surgery. Furthermore, about half of the patients (52.0%) underwent the central lip lift for facial physiognomic improvement.

Conclusions: In today’s multiracial society, plastic surgeons planning a central lip lift in Asian patients should consider both aesthetic and physiognomic perspectives. Regardless of the aesthetic outcome, the surgeon should strive to maximize patient satisfaction.

Level of Evidence: 4

Facial physiognomy, the theory that people’s destiny may be written on their face, has emerged in South Korea as a popular trend in plastic surgery. It has been reported that some South Korean hospitals have collaborated with fortune-tellers or physiognomists, who judge human fortune from facial features.

According to facial physiognomy, a well-demarcated and symmetric philtrum and an everted upper vermilion indicate that a person has good character and will have a long, rich life. Therefore, people who have a philtrum that is too long and flattened, a congenital philtrum, or a philtrum caused by an acquired reason, such as the aging process, bone retraction after 2-jaw surgery, or another orthodontic procedure, want to reduce their philtrum. In
Asia, a central lip lift is in demand for both aesthetic and physiognomic reasons.

A central lip lift was introduced as an upper lip lift, Austin-type lip lift, or subnasal lip lift in Western countries in 1980s. However, the physiognomic perspective of a central lip lift has not been analyzed in Asia. We present the central lip lift as physiognomic plastic surgery as well as aesthetic plastic surgery for Asians.

METHODS

Study Design and Patient Population

A retrospective chart review was conducted on 202 patents of asians who underwent the central lip lift between January 2007 and April 2014. Patients who had a congenital facial deformity, oral-maxillofacial disease, an excessively short upper lip (shorter than one-ninth of the vertical facial length), a history of forming hypertrophic scars or keloids, or excessively downturned corners of the lips, were excluded from this procedure. Patients who underwent central lip lift in authors’ private clinic and who did not fall under those exclusion criteria were included for retrospective chart review of our study. Informed consent was acquired from all patients for both the treatment and the publication of photographs showing the results. The study conformed to the Declaration of Helsinki.

Before treatment, patient information, such as age, the cause of the long philtrum, and the purpose of the treatment, was recorded. Each patient’s frontal and lateral photographs were taken at a consistent distance (1.5 m) using a digital camera (DSLR D7100, Nikon, Tokyo, Japan) with the same camera setting. A standardized background and camera-mounted lighting were used for all photographs, and natural head positioning (approximating the Frankfort horizontal plane) was created by having the patient look straight ahead to a point at eye level on the wall. The subnasale, labiale superius, and stomion were marked to check the vertical disproportion of the upper lip, and both the alare of the nose and cheilion of the mouth were marked to check the horizontal asymmetry of the upper lip in the resting position.

Using these marked points, the philtrum length (the distance from the subnasale to the labiale superius) and the height of the visible upper vermilion (the distance between the labiale superius and the stomion) were measured. The amount of excision was determined by referring to these measured values, and then a preoperative design was drawn on the upper lip in the shape of a bull’s horn (Figure 1). The upper border of the excision was drawn just inferior to the columnellar base and nostril sill from one side to the other side of the lateral ala. Both lateral tips of the excision were extended to the most upper lateral point of the alar-facial groove to create a more lateral lift. The lower border of the excision was drawn based on the amount of

Figure 1. Schematic illustration demonstrating the preoperative design of a central lip lift. (Left) Preoperative illustration of the central lip lift. The authors divided the upper lip into 3 portions (a: right upper lip, b: central upper lip, c: left upper lip) and draw the preoperative design in the shape of a bull’s horn (blue zone). The position of the lower border depends on the amount of eliminated white part of the upper lip, and the amount of excision varies with the extent of horizontal asymmetry. After the surgery, 5 units of Botox (botulinum toxin A; Allergan, Inc, Irvine, CA) were injected into four points of the orbicularis oris muscle of the upper lip (1.25 units per 0.05 cc at each point) (red arrows). (Right) Postoperative illustration of the central lip lift. The incisional scar usually remains hidden under the nasolabial junction and both lateral alar-facial grooves after the surgery.
excision required. To decrease the horizontal asymmetry of the upper lip when drawing the lower border of the excision, the amount of resection was varied between the right and left upper lips. Finishing the preoperative design, the senior author (D.E.L.) showed the patient the redesigned upper lip and incisor display with a pinch test in the mirror. Finally, the patient was informed about possible complications, and any additional requirements or unrealistic expectations were identified and discussed.

The central lip lift was performed with a local anesthetic alone or with intravenous sedation by the senior author (D.E.L.) at his private clinic. For local anesthetic, 2% lidocaine, bupivacaine, 1:100,000 epinephrine, and hyaluronidase were administered, along with propofol for intravenous sedation. Before the incision was made, both nostrils were packed with gauze. The midline incision was made at the upper border of the preoperative design with a No. 11 blade, entering at the lateral alar-facial groove of the nose. (A video demonstrating the process of performing a central lip lift may be viewed at Supplementary video.) The blade was directed perpendicular to the skin and did not cross the curvature of the nostril sill into the nasal vestibule. Subsequently, an incision was made from the midline of the lower border of the nostril sill into the nasal vestibule. Along with propofol for intravenous sedation. Before the incision was made, both nostrils were packed with gauze. The midline incision was made at the upper border of the preoperative design with a No. 11 blade, entering at the lateral alar-facial groove of the nose. (A video demonstrating the process of performing a central lip lift may be viewed at Supplementary video.) The blade was directed perpendicular to the skin and did not cross the curvature of the nostril sill into the nasal vestibule. Subsequently, an incision was made from the midline of the lower border in the preoperative design to the lateral alar facial groove of the nose to meet the previously created upper border incision. To finish the incision, the senior author (D.E.L.) made a 1-piece, full-thickness, en-bloc excision of skin, subcutaneous tissue, and partial muscle layer in the shape of a bull’s horn. The amount of excision varied according to the degree of the shortening of the philtrum and the horizontal asymmetry of the upper lip. Closure was performed in layers. Typically, 4-0 polyglactin Vicryl sutures (Ethicon, Somerville, NJ) were used to close the muscle, 5-0 polyglactin Vicryl sutures (Ethicon, Somerville, NJ) were used for subcuticular closure, and 6-0 white Nylon sutures (Ailee, Busan) were used for meticulous skin approximation. Finally, the senior author (D.E.L.) injected 5 units of Botox (botulinum toxin A; Allergan, Inc, Irvine, CA) into 4 points of the orbicularis oris muscle of the upper lip (1.25 units per 0.05 mL at each point) (Figure 1). Because Botox prevented muscular movement and thus distorted the sutured incision site, the patient was not prohibited from daily actions such as smiling, laughing, and chewing after treatment.

All sutures were removed on postoperative day 7, and then the philtrum length and the height of the visible upper vermilion were remeasured. All patients had postoperative follow-up at 2 and 6 months, and standardized frontal and lateral photographs were taken. If the incisional scar appeared to be developing poorly at the 2-month follow-up, the incision site was resurfaced with a fractional CO2 laser, which was performed 3 to 5 times in 2-month intervals. At the 6-month follow-up assessment, the patients were asked if they were satisfied with both the aesthetic and physiognomic results using a 5-point scale (1 = very unsatisfied, 2 = unsatisfied, 3 = neutral, 4 = satisfied, and 5 = very satisfied). When patients were lost to postoperative follow-up at 6 months, their level of satisfaction was determined over the telephone.

**Statistical Analysis**

For our anthropometric assessment, the preoperatively and postoperatively measured philtrum length and visible upper vermilion height were assessed statistically using a paired t test with SPSS 13.0 software (SPSS, Inc, Chicago, IL) in 202 patients who underwent the central lip lift. A value of \( P < .05 \) was considered to be statistically significant. For photographic analysis of the lower facial profile in the 129 patients who had photographs more than 12 months after treatment, the ratio of the philtrum (the length from the subnasal to the labiale superius) to the height of the visible upper vermilion (the height from the labiale superius to the stomion) and the ratio of the visible upper vermilion to the visible lower vermilion (the vertical height from the stomion to the labiale inferius) were analyzed using preoperative and postoperative 12-month photographs with Adobe Photoshop 7.0 (Adobe Systems, Inc, San Jose, CA). We also analyzed the patients’ postoperative satisfaction and their characteristics such as age, cause of the long philtrum, and purpose of the treatment.

**RESULTS**

More than 90% of the 202 patients were women (184 women and 18 men), and the mean age of the patients was 30 years (range, 21-65 years). Patient demographics are analyzed in Table 1.

The mean length of the philtrum was 25.61 ± 4.83 mm preoperative and 19.87 ± 3.45 mm postoperative. The mean height of the visible upper vermilion was 3.93 ± 2.27 mm preoperative and 19.87 ± 3.45 mm postoperative. The mean ratio of the philtrum to the visible upper vermilion was 3.84 preoperative and 2.17 postoperative. The mean ratio of the visible upper vermilion to the visible lower vermilion was 0.63 preoperative and 0.80 postoperative (Table 3).

At the satisfaction assessment, 186 patients (92.1%) were satisfied with the aesthetic results, including 99 patients (49.0%) who were satisfied and 87 patients (43.0%) who were very satisfied. In addition, 175 patients (86.6%) were satisfied with the physiognomic results, including 104 patients (51.5%) who were satisfied and 71 patients (35.1%) who were very satisfied (Table 4).

The mean duration of follow-up was 25.4 months (range, 2.3-59.1 months), and 2 patients were lost to follow-up at the 6-month assessment. During the follow-up period, there were no complications such as infection, gummy smile, sad appearance deformity, hypertrophic scarring, or keloid formation.
Complications were relatively minor. There were 26 patients (12.9%) who complained of their visible scar and underwent 3 to 5 fractional CO₂ laser treatments. Two patients (0.99%) had wound dehiscence caused by hematoma and underwent revisional treatment for wound closure on postoperative day 7. Five patients (2.5%) complained of their asymmetric upper lip after treatment and underwent revisional treatment for asymmetric correction at postoperative days 7 to 13.

**DISCUSSION**

According to Becker et al., the erogtroid, also called the cutaneous upper lip, is a trapezoidal region delineated by the upper vermilion border caudally, the nasal base cephalad, and the nasolabial folds bilaterally. Located at the center of the erogtroid, the philtrum is a vertical groove that is correlated with the nose and lip and is the aesthetic unit of the upper lip. Aesthetically, the philtrum is an important structure that is related to anthropometric landmarks such as vertical facial proportion and upper incisor show. The philtrum is located in the center of the face and has a significant impact on facial expressions. For a face to be attractive, the philtrum of the upper lip is short, and the philtral columns and Cupid’s bow are prominent and symmetrical.

For many years in Western countries, a central lip lift has been recommended in the form of an upper lip lift, Austin-type lip lift, or subnasal lip lift for patients who have a long upper lip. The central lip lift involves the excision of a strip of skin and muscle from the upper lip immediately inferior to the nasolabial junction. Because the tissue void is closed, the lip rotates and lifts superiorly. The lip is raised relative to the incisor edge of the upper teeth, and the vermilion is mildly everted to a more youthful appearance.

We expanded on the upper lip lift, Austin-type lip lift, and subnasal lip lift. There are 2 differences in our operative procedure compared with the previously introduced central lip lift. First, the previous lift focused on the vertical disproportions of the upper lip, whereas our lift focused on both the vertical and horizontal disproportions of the upper lip. We divided the upper lip into 3 portions (right, central, left) and varied the amount of resection on these 3 portions according to the extent of horizontal asymmetry. Second, although the shape of a bull’s horn is similar to previously introduced designs, we drew the lateral tip of the preoperative design to

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**Table 1. Patient Demographics**

<table>
<thead>
<tr>
<th>Demographics</th>
<th>No. of Patients (n = 202)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>184</td>
<td>91.1%</td>
</tr>
<tr>
<td>Men</td>
<td>18</td>
<td>8.9%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29 years</td>
<td>92</td>
<td>45.5%</td>
</tr>
<tr>
<td>30-39 years</td>
<td>88</td>
<td>43.6%</td>
</tr>
<tr>
<td>40-49 years</td>
<td>16</td>
<td>7.9%</td>
</tr>
<tr>
<td>50-59 years</td>
<td>5</td>
<td>2.5%</td>
</tr>
<tr>
<td>&gt;59 years</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Cause of the long philtrum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital</td>
<td>51</td>
<td>25.2%</td>
</tr>
<tr>
<td>Orthognathic surgery</td>
<td>68</td>
<td>33.7%</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>55</td>
<td>27.2%</td>
</tr>
<tr>
<td>Aging processb</td>
<td>28</td>
<td>13.9%</td>
</tr>
<tr>
<td>Purpose of the operation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aesthetic improvementc</td>
<td>97</td>
<td>48.0%</td>
</tr>
<tr>
<td>Physiognomic improvement</td>
<td>17</td>
<td>8.4%</td>
</tr>
<tr>
<td>Both aesthetic and physiognomic improvement</td>
<td>88</td>
<td>43.6%</td>
</tr>
</tbody>
</table>

*a The loss of the underlying skeletal and dental support by orthognathic surgeries such as 2-jaw surgery, LeFort I osteotomy of the maxilla only, and anterior segmental osteotomy of the maxilla only. Patients who did not have an excessively long philtrum when they were young, and did not undergo orthognathic surgery or another orthodontic procedure. *Correction of a vertical long philtrum, a horizontal asymmetric philtrum, or an invaginated upper vermilion.

**Table 2. Preoperative and Postoperative Anthropometric Assessment**

<table>
<thead>
<tr>
<th>Anthropometric Measurements (n = 202)</th>
<th>Preoperative</th>
<th>Postoperative</th>
<th>P value (t test for paired samples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean length of the philtrum⁹</td>
<td>25.61 ± 4.83 mm</td>
<td>19.87 ± 3.45 mm</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Mean height of the visible upper vermilion⁹</td>
<td>3.93 ± 2.27 mm</td>
<td>6.16 ± 1.74 mm</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

⁹The distance from the subnasale to the labiale superius. ¹⁰The difference in height between the labiale superius and the stomion.

**Table 3. Preoperative and Postoperative Photographic Analysis of Lower Facial Profile**

<table>
<thead>
<tr>
<th>Vertical Proportion Indices (n = 129)</th>
<th>Preoperative</th>
<th>Postoperative</th>
<th>Ideal Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philtrum⁴/Visible upper vermilion⁶</td>
<td>3.84</td>
<td>2.17</td>
<td>2.00-2.90</td>
</tr>
<tr>
<td>Visible upper vermilion/ visible lower vermilion⁵</td>
<td>0.63</td>
<td>0.80</td>
<td>0.75-0.80</td>
</tr>
</tbody>
</table>

⁴The vertical height from the subnasale to the labiale superius ⁵The vertical height from the labiale superius to the stomion. ⁶The vertical height from the stomion to the labiale inferius.
the most upper lateral portion of the alar-facial groove for a more lateral lift. Austin reported that raising the central portion of the upper lip could make patients with downturned lip corners look sadder and called this phenomenon “sad appearance deformity.” Our laterally extended bull’s horn is designed to prevent this deformity.

In our anthropometric assessment, there was significant shortening in the philtrum length \((P < 0.001)\) and an increase in the visibility of the upper lip vermilion \((P < .001)\) after treatment. In our analysis, the mean length of the postoperative philtrum was \(19.87 \pm 3.45\) mm and the mean height of the visible upper vermilion postoperative was \(6.16 \pm 1.74\) mm. Our results are similar to the results in the study by Raphael et al.\(^{14}\) in which the ideal philtral length was 18 to 20 mm and the ideal height of the visible upper vermilion was 7 to 8 mm. In our photographic analysis of the lower facial profile after treatment, the mean ratio of the philtrum to the visible upper vermilion was 2.17, and the mean ratio of the visible upper vermilion to the visible lower vermilion was 0.80. These results are similar to the ideal ratio of the philtrum to the visible upper vermilion after treatment of 2.00-2.90, and the ideal ratio of the visible upper vermilion to the visible lower vermilion of 0.75-0.80.\(^{14,15}\) The ratio of the upper lip to the lower third of the face and the ratio of the upper lip to the lower lip were unchanged, because the central lip lift was a procedure of soft-tissue correction.

There are several aesthetic advantages of our central lip lift treatment. Primarily, our treatment makes the philtrum more distinct and the upper vermilion more everted; consequently, our treatment maintains an attractive mouth with labral harmony and a balanced facial profile. It also causes the visual optical illusion of a youthful and smaller face. Finally, our treatment decreases the horizontal asymmetry of facial soft tissue by varying the amount of resection on the right and left upper lip.

The potential complications should be discussed with patients during preoperative counseling. It is especially important to discuss the potential complications with Asian patients. Many Asian patients seek treatment quickly, with the immediate objective to improve their appearance and perhaps without much consideration for potential complications or longer-term outcomes. By showing patients the design of the upper lip in the mirror before treatment, we reviewed preoperative planning with patients not only for aesthetic satisfaction but also for physiognomic satisfaction, which could be subjective. This process is helpful both to lower the patient’s unrealistic expectations and to develop a trusting relationship with the patient. Bruising and swelling were possible complications, although these side effects typically resolve without any treatment over a period of several weeks. To prevent swelling and bruising, we mixed 0.5 cc hyalase with 5 cc of the local anesthetic solution comprised of 2.5 cc lidocaine and 2.5 cc bupivacaine. Hematoma is possible following all lip surgeries because of the very vascular nature of the lip area. Adequate coagulation with electrocauterization should be meticulously performed during the procedure; otherwise, hematoma may cause wound dehiscence when the stitches are removed on postoperative day 7. Complications, such as gummy smile, sad appearance deformity, hypertrophic scarring, and keloid formation, can be avoided by identifying patients preoperatively who have a short upper lip (shorter than one-ninth of vertical facial length), a history of forming hypertrophic scars or keloids, or excessively downturned corners of the lips. The most significant drawback of this procedure is skin scars, because this area is at risk for hypertrophic or invaginated scarring. To minimize the formation of a visible scar, we inject Botox into the

<table>
<thead>
<tr>
<th>Postoperative Satisfaction</th>
<th>No. of patients (n = 202)</th>
<th>%</th>
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<tbody>
<tr>
<td>5-point scale(^a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aesthetic results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very unsatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Unsatisfied</td>
<td>6</td>
<td>3.0%</td>
</tr>
<tr>
<td>Neutral</td>
<td>10</td>
<td>5.0%</td>
</tr>
<tr>
<td>Satisfied</td>
<td>99</td>
<td>49.0%</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>87</td>
<td>43.0%</td>
</tr>
<tr>
<td>Physiognomic results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very unsatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Unsatisfied</td>
<td>10</td>
<td>5.0%</td>
</tr>
<tr>
<td>Neutral</td>
<td>17</td>
<td>8.4%</td>
</tr>
<tr>
<td>Satisfied</td>
<td>104</td>
<td>51.5%</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>71</td>
<td>35.1%</td>
</tr>
<tr>
<td>Satisfied patients with postoperative results(^a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with both aesthetic and physiognomic results</td>
<td>161</td>
<td>79.7%</td>
</tr>
<tr>
<td>Satisfied with only aesthetic result</td>
<td>25</td>
<td>12.4%</td>
</tr>
<tr>
<td>Satisfied with only physiognomic result</td>
<td>14</td>
<td>6.9%</td>
</tr>
</tbody>
</table>

\(^a\)At the 6-month follow-up assessment, 200 patients were asked about their level of satisfaction of both aesthetic and physiognomic results using a 5-point scale (1 = very unsatisfied, 2 = unsatisfied, 3 = neutral, 4 = satisfied, and 5 = very satisfied). Two patients were lost to follow-up and asked about their level of satisfaction over the telephone." The patients who answered neutral in 5-point scale were regarded as the patients who were unsatisfied with the result.

\(^8,9\) Our laterally extended bull’s horn is designed to prevent this deformity.
The injection of Botox prevents muscular distortion of sutured incisions during the healing phase, which can result in inflammation that produces a thicker or wider scar. Scarring usually remains hidden in the nasolabial junction and alar-facial groove and can be camouflaged with makeup after removal of the stitches. However, if an undesirable incisional scar appears to be developing, the site can be resurfaced with a fractional CO2 laser.

The focus of this article is not only on the aesthetic perspective but also on the increasing physiognomic perspective in Asia. There are several differences regarding the perspective of the philtrum in the West compared with that in Asia. First, the mean age of patients and the cause of a long philtrum are different. In Western countries, the majority of patients who undergo the central lip lift are 40-59 years old. They have philtral elongation and flattening because of the aging process, which includes the loosening of fascial attachments, soft-tissue atrophy, and bone absorption (Figure 2). In contrast, the majority of patients in South Korea who undergo the central lip lift are approximately 20-39 years of age. Some of these patients have a congenitally long philtrum, and several of them have acquired a long philtrum. To be precise, the actual length of the philtrum does not change, but it appears longer because of the loss of underlying skeletal and dental support with orthognathic surgery. Patients who had a bone retraction after 2-jaw surgery or another orthodontic procedure tend to complain about a relatively lengthened philtrum and an invaginated upper vermilion. These patients think that their face becomes longer, similar

Figure 2. Preoperative (A, C) and postoperative (B, D) 12-month follow-up photographs of the central lip lift. This 52-year-old woman had an elongated and flattened philtrum caused by the aging process. She wanted to make her upper vermilion more everted and visible. The central lip lift with a 5-mm-long resection was performed. Despite 5 fractional CO2 laser treatments at 2, 4, 6, 8, and 10 months after treatment, the incisional scar still appeared to be objectionable on the 12-month follow-up photographs.
to a donkey’s face, and that they look old for their age (Figure 3).

Second, the purpose of the treatment and postoperative satisfaction between Asians and Westerners are different. For patients who exhibit a long upper lip coupled with inadequate upper incisor display in Western countries, the central lip lift is recommended. The only consideration for these patients is aesthetic: having a prettier and more youthful face. In contrast, the central lip lift has more facial physiognomic meaning than upper lip rejuvenation in South Korea. Fortune-telling and plastic surgery have been very popular in South Korea for a long time; therefore, it was inevitable that it would eventually come together with aesthetic surgery of the face. Some people believe that plastic surgery can change their fate and the direction of one’s life. In facial physiognomy, a well-demarcated symmetric philtrum and an everted upper vermilion indicate that a person has good character and will have a long, rich life. The patients who have the central lip lift expect that this treatment will bring them good fortune and a better life. In our study, more than half of the patients (52.0%) underwent the central lip lift for physiognomic improvement (Figure 4). At the 6-month follow-up assessment of satisfaction, 25 patients (12.4%) were satisfied with the aesthetic results but unsatisfied with the physiognomic results. These patients were worried that their attractive but shortened philtrum would alter their destiny negatively. Clearly, as with many Asians, many South Koreans have very high expectations for this treatment. The success or lack thereof of the treatment should not be with the surgeon alone. Regarding the physiognomic perspective,
a face with a philtrum that is too short indicates that a person will have a short life (Figure 5). Fourteen patients (6.9%) were satisfied based on the physiognomic results but were unsatisfied with the aesthetic results. Most of these patients had a congenitally long philtrum and a protruding maxilla or protruding upper incisors (buck teeth). Therefore, we recommended not only a central lip lift but also maxillary retraction surgeries or orthodontics, because there was a limit for correction of the unbalanced upper lip region with only soft-tissue correction without hard tissue correction. Nevertheless, these patients wanted to undergo only the central lip lift; therefore, we performed minimal the central lip lift with a 2 or 3 mm resection to avoid excessive exposure of the protruding upper incisors or a gummy smile. After the treatment, these patients were not satisfied with the minor change, which was not what they expected preoperatively. They made it clear that they really did desire a significant change. Of the 5 patients who had undergone revisional treatment for the correction of asymmetry, 2 patients were lost to follow-up after revisional treatment. At the 6-month follow-up assessment over the telephone, these 2 patients stated that they were not satisfied with either the aesthetic or the physiognomic results. They still complained about their asymmetric philtrum, although the outcome was objectively acceptable. At the 6-month

Figure 4. Preoperative (A, C) and postoperative (B, D) 12-month follow-up photographs of the central lip lift for physiognomic improvement. This 28-year-old woman underwent an orthodontic procedure with extraction of the first premolars by a dentist 2 years previously. She was going to meet her boyfriend’s parents for the first time, and she was worried about her physiognomic facial features of a relatively invaginated upper vermilion and a lengthened philtrum after orthodontics. She wanted an attractive upper lip both aesthetically and physiognomically, because her boyfriend’s mother believed in physiognomy. The authors performed the central lip lift with a 6-mm-long resection. After the surgery, she was happy and satisfied with both the aesthetic and physiognomic results.
follow-up, the other 3 patients answered that they were satisfied with their treatment both aesthetically and physiognomically.

In this study, neither a filler injection nor fat grafting was performed in the upper lip of the patients who underwent the central lip lift. However, for patients who feared or hated the treatment, the hyaluronic acid filler was injected into the subdermal plane of the upper lip instead of the central lip lift. The correction of the loss of lip architecture and volume with filler materials have been introduced in 1990s. The placement of a soft-tissue filler or fat graft in the position of the blunted white line and philtral columns make the upper lip and philtrum more distinct. Furthermore, the placement of a soft-tissue filler or fat graft submucosally in the body of the lip make the upper lip more everted and the upper vermilion more visible. In facial physiognomy, a well-demarcated symmetric philtrum and everted upper vermilion indicate that a person will have a long, rich life and has good character; therefore filler injection or fat grafting can also make a physiognomic improvement.

There are several limitations of our study. First, only 129 patients (63.86%) among 202 patients had photographs taken more than 12 months postoperative. Thus, the photographic analysis was performed with preoperative photographs or photographs that were taken less than 12 months postoperative in the other 73 patients. Second, the assessment of the scar problem using the standardized scar-scale was not performed, so scar outcomes were not able to be provided. Furthermore, the patients did not complete the postoperative satisfaction assessment anonymously, so bias could have been introduced. Finally, the height of the upper incisor show was not measured before and after treatment.

Figure 5. Preoperative (A, C) and postoperative (B, D) 12-month follow-up photographs of the central lip lift. This 26-year-old woman required correction of her congenital asymmetric upper lip. The authors performed the central lip lift with a 3-mm-long resection. After the surgery, she was satisfied with her more everted and attractive upper lip aesthetically. But she was worried about her shortened philtrum, which meant that she will have a short life physiognomically. She underwent hyaluronic acid filler injection on her chin for more chin prominence, after which the 12-month follow-up photographs were taken.
so we were limited in our investigation of the relationship between the central lip lift and the upper incisor show.

**CONCLUSIONS**

To understand the different perspectives in Westerners and Asians regarding the central lip lift, we analyzed the characteristics of patients in South Korea. In today’s multiracial society, it is not uncommon to meet Asian patients in America, Europe, or other countries outside Asia. Although not all Asians believe in facial physiognomy, there are many patients who strongly associate their fortune with their facial features. If a plastic surgeon plans to perform aesthetic surgery on an Asian patient, especially involving the philtrum or upper lip, the surgeon should consider not only the aesthetic perspective but also the physiognomic perspective. Regardless of the aesthetic outcome, the surgeon should strive to maximize patient satisfaction. The surgeon must strive to understand the cultural differences that exist between Westerners and Asians seeking treatment, especially the objective of the treatment and the level of change desired by the patient.

**Supplementary Material**

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