Face Lift and Lipofilling: Clinical Considerations

Sir:

We have read with great interest the article entitled "Midface Rejuvenation: A Critical Evaluation of a 7-Year Experience" by Dr. Pascali et al.[1] In the article, the authors retrospectively analyzed a series of 350 patients undergoing midface lift.

The authors reported the use of two different techniques of midface lift: in the first procedure, the flap was anchored to the deep temporal aponeurosis using a superolateral vector. In the second procedure, the flap was anchored to the lower orbital rim with a use of a superomedial vector.

The results were evaluated by subjective and objective methods using a questionnaire completed by the patients and an evaluation of preoperative and postoperative photographs by a three-member jury including a plastic surgeon, a maxillofacial surgeon, and a makeup artist.

The authors indicated high satisfaction from the perceptions of both the jury and the patients, reporting that temporal anchoring was more efficient for the treatment of malar eminence, whereas midface lift with transosseous periorbital anchoring was more efficient for the treatment of nasojugal groove.

In our surgical experience, we have used both techniques described in the article, according to the patient's particular needs and the specific defects, and have obtained an effective improvement of nasojugal groove and jowls. However, we think that in the midface lift procedure, it is useful not only to suspend the ptotic tissue using a superolateral or superomedial vector, but also to improve the posteroanterior vector to restore the facial volume in a three-dimensional fashion.[1–3]

According to the concept of the "lift-and-fill" face lift in facial rejuvenation, it is important to consider the two aspects described previously.[4] Furthermore, we prefer to realize, first, a tissue manipulation, performing a lift in differential vectors, according to facial characteristics and shape, and then to complete the procedure, filling selective compartments such as the malar area and the nasolabial fold, using autologous fat grafting, to precisely define the facial contouring.

The aging process of the face is complex, and several aspects should be taken into consideration, such as the ptosis of the soft tissues, the loss of elasticity of the skin, and the atrophy of adipose and bone tissue, especially in the malar and infraorbital area. Actually, we always combine a midface lift with fat injection to achieve complete restoration of volume and to attain complete face rejuvenation. In selected cases, characterized by severe atrophy of bone, we prefer to use silicone implants instead of fat injection because, in these patients, the advantage of bony skeletal restoration could improve the suspension of soft tissue. In conclusion, taking into account that one of the key problems in facial aging consists of volume deflation, we think that the use of fat grafting represents an important tool and should be taken into consideration in any facial rejuvenation operation.

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DISCLOSURE

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Reply: Midface Rejuvenation: A Critical Evaluation of a 7-Year Experience

Sir:

We would like to thank Dr. Idone et al. for their comments regarding our recently published article "Midface Rejuvenation: A Critical Evaluation of a 7-Year Experience." The commentary raised important questions that we will clarify in greater detail.

Regarding their interesting observation that the midface lift is used "not only to suspend the ptotic tissue using a superolateral or superomedial vector, but also to improve the posteroanterior vector to restore the facial volume in a three-dimensional fashion," we would like to emphasize an important concept. Repositioning of the whole midface flap carried out by the subperiosteal approach gives an imbricating effect with subsequent production of an anteroposterior projection of the cheek and elevation of the corner of the mouth.[1] Furthermore, the entire cheek is elevated with volumetric

enhancement producing a tridimensional restoration of the cheek.[2] This result is evident in the postoperative photographs shown in Figures 4 and 5. The final appearance of the cheeks in the photographs is entirely a result of the soft-tissue repositioning during the surgical procedure. In fact, the challenge of the midface lift is exactly that of repositioning all the soft tissues en bloc, up and backward, in a "homothetic" way, by repositioning of the volumes where they were before."[3] This preserves the original youthful proportion and identity, providing a natural appearance, which is highly appreciated by patients.[3] With regard to the second issue, where Dr. Idone et al. declare that they "prefer to realize, first, a tissue manipulation performing a lift in differential vectors, according to facial characteristics and shape," we totally agree. Therefore, we have repeatedly emphasized in the article that the choice of the traction vector is fundamental. This consequently determines which approach and technique to use, based on the patient's particular needs and the specific defects that must be corrected.[2]

With regard to using autologous fat grafting simultaneously with surgical procedures "to precisely define the facial contouring," we would like to take advantage to evidence an exclusion criterion adopted in the review. In fact, only patients in which no volume addition or injectable fillers, either simultaneously with the surgical procedures or in the postoperative period, were considered. In fact, the purpose of our work was to verify the results obtained only by repositioning of the soft tissues. Moreover, even if the midface is performed correctly, the need to also use fat grafting is notably reduced. Nevertheless, in some cases, this remains a valid technique, easy to carry out and of great effect, especially because this subperiosteal and nondissociative midface technique avoids any undermining between the face tissue layers.[3]

We routinely use fat grafting in 20 percent of patients undergoing midface procedures. Moreover, agreeing with other authors, we believe that fat grafting by injection is used to treat minor facial asymmetries or contour irregularities.[1] Fat grafting is also helpful for filling residual creases such as the nasolabial or marionette lines. Because these represent deep dermal damage, no lifting technique or laser resurfacing can completely erase them.[1]

Finally, where Dr. Idone et al. maintain that "in selected cases, characterized by severe atrophy of bone, we prefer to use silicone implant instead of fat injection," we would like to take advantage and evidence some concepts. First and foremost, we must point out that with midface lift the need for cheek implants is reduced but not eliminated. If the patient has a bone deficit, we would strongly suggest the insertion of an appropriate implant for long-term support of the face.[1] In our experience, the percentage of patients where we use the silicone implant is only 5 percent, and is limited only to cases with severe bone atrophy or those in which the patients already have a prosthetic implant.

In the remaining cases undergoing the surgical technique described in the article, it is possible to obtain good volume enhancement with tridimensional volume restoration of the cheeks.[2] Therefore, as indicated in our work, when greater increased projection of the cheekbones is requested, the flap should be anchored fairly caudally so that the periosteum will fold over itself.[2]

Furthermore, in our opinion, another important issue should be examined: the choice of using fat grafting or prosthetic implant to increase cheek volume should be carried out not only because of the different degree of bone atrophy and/or adipose tissue but in relation to an adequate evaluation of the orbital vector. When a negative orbital vector is evident, we prefer to use the silicone implant instead of fat grafting. In fact, when midface lifting is performed in a patient with a negative orbital vector, we could report a downward movement of the lower eyelid instead of the desired lifting, which is the main goal of the midface technique. In these cases, the use of a prosthetic implant, which represents a valid support for midface flap repositioning, is of fundamental importance. When we choose the implant, silicone is our preference; a great range of sizes and shapes are available today.

Of paramount importance is fixing the implant to the bone. For this purpose, we use the holes performed to the inferior orbital rim carried out for the midface procedure. Otherwise, the prosthesis implant could move, as it is situated in the area undermining the midface region, which is much greater as regards the implant itself.

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Cadaveric Study of Breast Measurements during Augmentation with Implants

Sir:

Forte et al.[1] set out to better understand how a breast implant affects nipple position and breast projection, with a view to reducing the need for revisions. These investigators conducted their study in 17 fresh female cadaveric breasts. Quite understandably, the authors were unable to place the cadavers in a standing position because of rigor mortis.[1] Recognizing this limitation, these investigators[1] chose cadavers with small breasts and minimal ptosis in an effort to avoid the influence of positional changes. In doing so, they may have underestimated the effect of recumbency on breast shape (Figs. 1 and 2).

Surprisingly, Forte et al. used only two round and two shaped implants to evaluate five implant volumes. A 310-ml, smooth, round, High Profile implant (recommended fill range, 310 to 375 ml)[2] was used to evaluate 200-, 300-, and 400-ml volumes. The authors state that a 450-ml, smooth, round, High Profile implant was used to evaluate 500- and 600-ml implant volumes.[1] However, Mentor Corporation does not manufacture a 450-ml, smooth, round, High Profile implant.[2] This company does manufacture a 450-ml Moderate Plus and a 450-ml Contour Profile Implant, but these implants have different dimensions and projection.[2] Larger implants

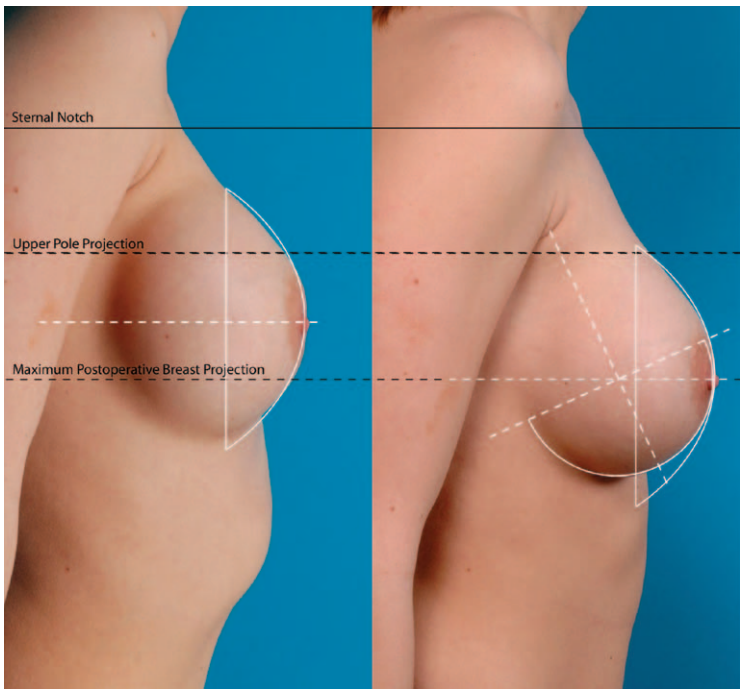

Fig. 1. This 27-year-old woman with small breasts and no ptosis underwent augmentation using 360-ml, round, smooth, saline-filled implants with a Moderate Plus profile (Mentor Corp., Santa Barbara, Calif.). Right lateral photographs were taken on the same day, 9.4 months after her breast augmentation, in both supine (*left*) and standing positions (*right*). (The *left* photograph was taken with the patient supine and then rotated 90 degrees so that she appears to be standing.) Lying down (*left*), the breast has a parabolic shape, resembling the shape of an implant lying on a flat surface. When the patient assumes a standing position (*right*), the breast settles, adopting a teardrop shape. The lower pole changes to a semicircular profile, with its axis (*oblique hatched white line*) parallel to the chest wall. The nipple level drops along with the inframammary fold and lower pole level. The shoulders and arms also drop, although the position of the torso is unchanged. The photographs have been matched for size and orientation using the Canfield Mirror 7.1.1 software (Canfield Scientific, Fairfield, N.J.)