Deep Plane Face Lift in Asian Patients

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Background: The deep plane face lift has the technical advantages of being more effective in mobilization of soft tissues of the anterior face and allowing for more direct fixation of these tissues. These attributes of the deep plane face lift make it advantageous for Asian faces.
Methods: Between January of 2021 and August of 2023, 61 Asian patients with a mean age of 52 years (range, 38 to 75 years) underwent the deep plane face lift. The authors' surgical technique and refinements in performing this procedure were demonstrated in detail. These included specific mobilization endpoints; a systemic approach to suture fixation, with each fixation suture targeting specific landmarks in the anterior face for tightening; and a systematic system of skin flap inset to ensure precise and tension-free closure. The mean follow-up was 19 months. Patient satisfaction was assessed with a targeted survey covering their appearance and quality of life.
Results: Long-term results were good. Patient satisfaction was high, with 98% reporting that they were satisfied or highly satisfied with their results. Patients reported improvement of both their appearance and quality of life after surgery. Complication rates were low and included superficial epidermolysis behind the ears ($n = 2$ [3%]), hypertrophic scarring ($n = 1$ [1.6%]), and facial nerve neurapraxia ($n = 1$ [1.6%]). There was no hematoma.
Conclusions: The deep plane face lift is a very effective face-lift technique for Asian patients. The technical refinements presented in this article allow the procedure to be performed safely and predictably. *(Plast. Reconstr. Surg.* 156: 485e, 2025.)
CLINICAL QUESTION/LEVEL OF EVIDENCE: Therapeutic, IV.

There is currently a surge of interest for surgical face lift in Asia.[1,2] Specifically, with increased awareness driven by social media, there is a growing demand for the deep plane face lift.[3,4] This is because the deep plane face lift, with its precise and extensive surgical release and more effective, direct tightening of the anterior face, is particularly effective for the wider bizygomatic projections and heavier soft tissues of the Asian face.[5] Recent advances in facial anatomy have provided a more accurate understanding of the deep plane. This has enabled us to refine our approach, making the procedure both safer and more effective. These include optimizing our deep plane dissection and surgical release endpoints and developing a more precise system of suture fixation and skin flap inset.

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PATIENTS AND METHODS

Between January of 2021 and August of 2023, 61 Asian patients with a mean age of 52 years (range, 38 to 78 years) underwent the deep plane face lift. There were 49 female and 12 male patients. Forty-two patients (69%) underwent primary face lifts, and 19 (31%) underwent revision face lifts. Patient satisfaction was assessed from 6 months after surgery. A targeted survey spanning 2 domains, which includes (1) appearance and (2) quality of life, was administered to patients. The ordinal scale ranged from dissatisfied to neutral, satisfied, and very satisfied for each parameter within a domain. An "overall satisfaction" rating based on the same ordinal scale allowed for a qualitative measure of the aesthetic outcome from the patient's perspective.

Surgical Technique

Markings are performed as shown in Figure 1. The procedure is performed under general anesthesia. The local anesthetic used is a mixture 40 cc of 1% lignocaine, 20 cc of 1% ropivacaine, 60 cc of normal saline, and 1 cc of 1:1000 adrenaline. Approximately 60 cc of local anesthetic is infiltrated per side of the face. When an anterior neck approach is planned as part of the procedure, this is performed before the face lift. The submental incision is made, and the anterior neck contouring is performed. This commonly included interplatysma fat excision, digastric shaving, digastric plication, partial submandibular gland excision, and platysma transection with corset plication. The incision is then closed, and the deep plane face lift commenced.

The face-lift skin incision is made with a no. 15 blade over most of the incision line except for the zigzag incision designed at the temporal hairline, where a no. 11 blade is used. Subcutaneous dissection is performed to reach the deep plane entry point on the face as marked preoperatively. Importantly, visualization of the posterior borders of the orbicularis oculi and platysma in the subcutaneous plane of the midcheek, lower face, and neck confirms adequacy of the subcutaneous dissection. If indicated, neck liposuction is performed at this stage. (**See Video 1 [online]**, which demonstrates skin incision and subcutaneous dissection to the deep plane entry points.)

The deep plane dissection can then proceed. (**See Video 2 [online]**, which demonstrates our deep plane dissection.) The incision is marked from the angle of the mandible to the lateral canthus. The deep plane dissection starts at the lower

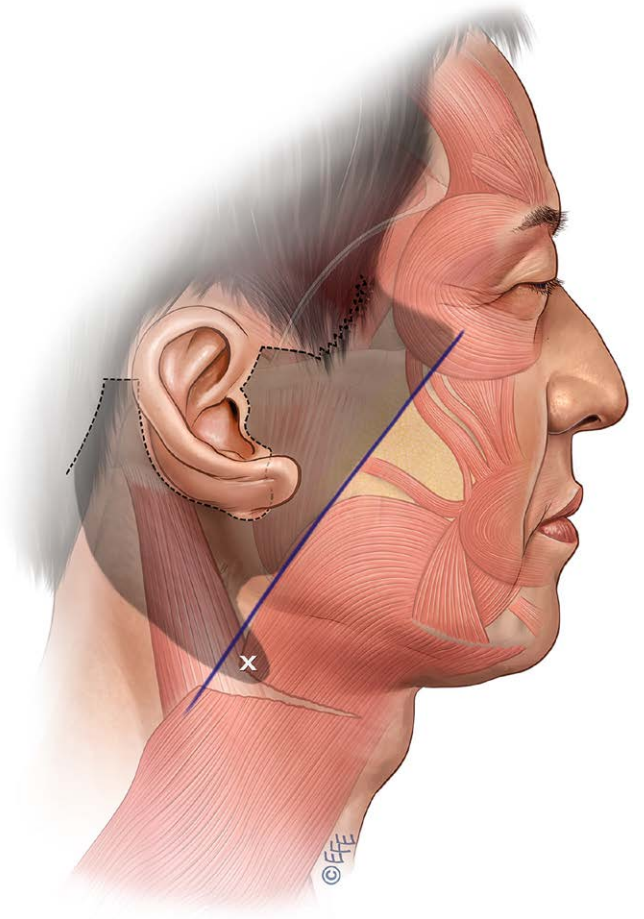

Fig. 1. The skin incisions are as shown by the *dotted line*. The *blue line* is marked on the skin, extending from the lateral canthus to the angle of the mandible and down the neck. This marking indicates the approximate location of the deep plane entry points. The *gray shading* indicates the extent of the subcutaneous dissection to reach the deep plane entry points. The location marked *X* is the key point on the neck for platysma mobilization and transection. Copyright © 2024 Levent Efe, MD. Used with permission.

premasseter space, as this is the largest and most distinct facial soft-tissue space and easiest to access. With the platysma under tension, an initial 2-cm incision at 10 mm above the angle of the mandible is made with a no. 15 blade, cutting through fibers of the platysma. The correct plane is just under the platysma and the "space" should be bluntly opened by gentle spreading of the Metzenbaum scissors. The correct entrance into the lower premasseter space is confirmed by visualization of fibers of the masseter on the floor of the space with the platysma in the roof of the space. Once the planes are correctly defined, the lower premasseter space may be completely opened to its

anterior boundary with the Trepsat dissector. The superficial musculoaponeurotic system (SMAS) incision is then extended toward to body of the zygoma, cutting the lateralmost part of the orbicularis oculi over the body of the zygoma. The middle premasseter space, located approximately 10 mm above the upper boundary of the lower premasseter space, is then opened with the same blunt dissection technique. Once the middle premasseter space is opened, it is tented upward with retractors, which places tension on the retaining ligaments that separate the lower and middle space. These retaining ligaments are sharply released near the roof of the space. The buccal fat pad is located at the anterior part of the middle premasseter space. The dissection is then shifted to the upper extent of the SMAS incision, over the body of the zygoma. With the tip of the Metzenbaum scissors aimed toward the lateral canthus, the orbicularis oculi is then bluntly elevated off the body of the zygoma. This will take the dissection into the prezygomatic space. The zygomaticus major is seen on the floor of this dissection. The prezygomatic space is opened further with blunt finger dissection, pushing the dissection toward the ipsilateral nasal ala. The next release is the zygomatic retaining ligaments, located below the prezygomatic space. Applying retractors in the prezygomatic space above and the middle premasseter spaces below, the intervening zygomatic retaining ligaments are then sharply released with tissue scissors. In releasing the zygomatic retaining ligaments, the key to preventing facial nerve injury is to stay closer to the roof of the dissection, as the facial nerve branches are still traversing deep in the floor of the dissection. The transverse facial artery is consistently encountered perforating from deep to the superficial fascia above in close association with the zygomatic retaining ligaments lateral to the zygomaticus major. This may be safely cauterized and cut. The release of the zygomatic retaining ligaments is performed to the lateral border of the zygomaticus major and then over this muscle toward the nasolabial folds. Dissecting over the zygomaticus major is safe, as the facial nerves traverse deep to the zygomaticus major. Sometimes, a small facial nerve branch may run over the zygomaticus major and will remain safe with careful release of the zygomatic ligaments closer to the roof of the dissection with the ligaments under tension. Anteriorly, the dissection limit is where the zygomatic ligaments and the key masseteric ligaments more inferiorly have been released and one can see the transitioning of the facial nerve branches from deep to superficial farther forward. The adequacy of the surgical release is confirmed by upward traction on the superficial fascia, noting the mobility of the facial soft tissues with correction of the jowl, corner of the mouth, and nasolabial folds and elevation of the lower eyelid. If indicated, buccal fat removal is performed at this stage of dissection. The buccal branch of the facial nerve runs over the capsule of the buccal fat pad. Care should be taken not to injure this nerve branch during

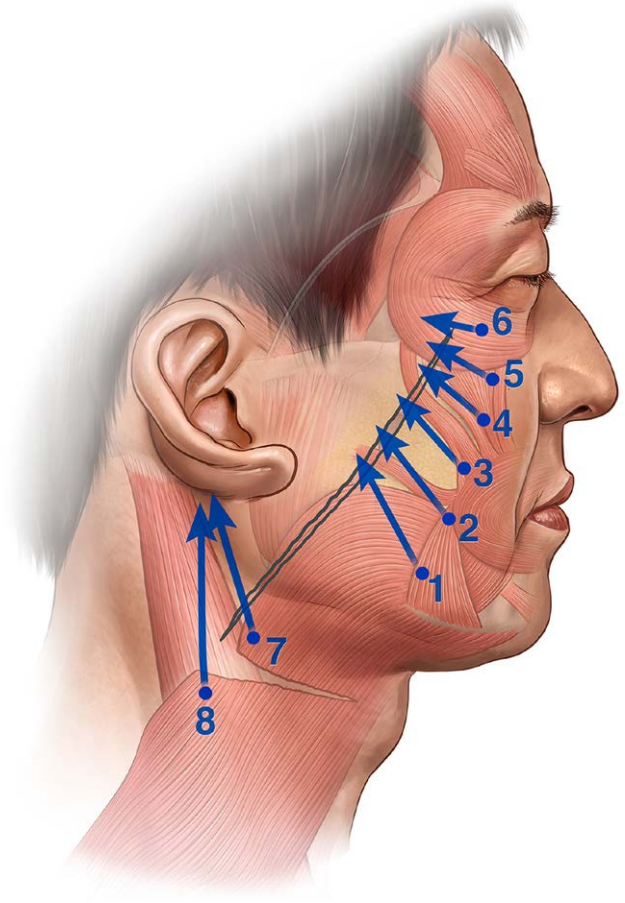

Fig. 2. Suture placement locations. Suture 1 is placed at the upper medial corner of the lower premasseter space and tightens the jawline. Suture 2 is placed at the medial part of the middle premasseter space and tightens the lower jowl. Suture 3 is placed at the superficial fascia over the buccal fat pad and tightens the upper jowl. Sutures 4 is placed medial to the lower part of the zygomaticus major and tightens the lower nasolabial fold. Suture 5 is placed medial to the upper part of the zygomaticus major and tightens the upper nasolabial fold. Suture 6 is placed at the lateral roof of the prezygomatic space and lifts the cheek. Suture 7 is placed into the upper platysma flap and tightens the submental area. Suture 8 is placed into the lower platysma flap and tightens the lower neck.

Fig. 3. A 52-year-old man presented for facial rejuvenation. He complained of deep nasolabial folds, jowling, and fullness in the buccal area. He underwent a deep (*Continued*)

buccal fat excision. The dissection then proceeds to the neck. At the key point, the posterior border of the platysma is elevated off the sternocleidomastoid by sharp release of the cervical retaining ligament. The platysma is then lifted off the deep cervical fascia with a Trepsat dissector along the upper and lower cervical spaces. The cervicomental angle suspensory ligament located between the upper and lower cervical space may be sharply released.[6] The platysma is then cut along the elevated tunnel for approximately 4 cm at the location of the key point, which corresponds to the location of the cervicomental angle suspensory ligament. This raises a superior and an inferior platysma flap for neck lift fixation.

The lifting and fixation of the composite flap are then performed. (**See Video 3 [online]**, which demonstrates face-lift flap fixation and neck lift.) Suture fixation is placed directly at the anterior face with 3-0 Ethibond sutures. This commences at the lower face, on the underside of the platysma and fixed to the platysma auricular fascia. In the lower face, a more vertical vector is used. As the fixation progress up to the zygoma, the fixation vectors transition to a more superolateral vector. In general, 6 fixation sutures are placed from the lower face to the zygoma. The specific locations of suture placement and targeted fixation endpoints are as shown in Figure 2. Multiple fixation points serve to prevent any pockets of laxity in the anteromedial face. Fixation is anchored onto the fixed SMAS slightly posterior to cut edges of the deep plane entry incision.[7] Once correct placement of the fixation sutures is achieved, the sutures are firmly tied.

The neck lift is achieved with posterior platysma suspension. With 3-0 Ethibond sutures, the superior platysma flap is anchored with a figure-of-8 technique to the mastoid fascia. The inferior platysma flap is also similarly fixed to the mastoid fascia with the same suture method. In the face, a second row of fixation is performed from the cut edge of the SMAS on superficial fascia to the fixed SMAS just anterior to the ear. This is performed with 3-0 Vicryl round-body sutures. This second row reinforces the anterior fixation and also functions to obliterate dead space. In areas where subcutaneous skin flaps are redraped, which corresponds to the prehelical area of the ear and posterior neck, the skin flaps are progressively quilted down to the deep fascia to obliterate dead space.

The skin flaps are inset and closed in a systematic manner. (**See Video 4 [online]**, which demonstrates skin flap inset closure of the deep plane face lift and facial fat grafting.) The excess skin is tailored precisely with accurate excision and inset around the ear and posterior hairline to achieve tension-free closure. Structural fat grafting is performed as needed at the end of the procedure using the Coleman technique. No drains are placed, and 3M Reston foam is applied on the lateral face and neck. A light compression dressing is then applied.

RESULTS

The mean follow-up was 19 months (range, 9 to 22 months). Of the 61 patients, 9 patients (15%) had an anterior neck approach. Ninety-eight percent (60 of 61) of patients were satisfied or highly satisfied with their results, with patients reporting improvement of both their appearance and quality of life after the surgery. Figure 3 shows the long-term results of the patient who had his procedure demonstrated in our operative videos. Figures 4 and 5 show the long-term results of 2 other patients. Complications encountered included retroauricular superficial skin epidermolysis (n = 2 [3.3%]), hypertrophic scarring of the incision [n = 1 (1.6%)], and 1 neurapraxia [n = 1 (1.6%)]. This case involved injury to the cervical branch of the facial nerve with paralysis of the ipsilateral depressor labii inferioris. This resolved completely within 8 weeks after surgery. (**See Figure, Supplemental Digital Content 1**, which shows preoperative smile [*above, left*]. Postoperatively, she developed paralysis of the right depressor labii inferioris [*above, right*] and retained the ability to pout her lower lip, indicating intact mentalis function and a functioning marginal mandibular nerve [*below, left*]. This was caused by an injury to the cervical branch of the

Fig. 3. (Continued). plane face lift, extended transconjunctival eye bag removal, and facial fat grafting. His deep plane face-lift surgery was as presented in Videos 1 through 4. In total, 38 cc of Coleman microfat was injected. Specific volumes of fat grafted into each area of the face are detailed in Video 4. (*Above*) At 2 years after surgery, he appeared profoundly rejuvenated, yet completely natural and refreshed. The cheek is lifted, the nasolabial folds and jowls are well corrected, and the jawline and neck are crisp and firm. The fat graft complemented the procedure by restoring the volume loss due to aging. (*Center*) Three-quarter views show good long-term correction of the jowl. The benefits of removal of the excessive buccal fat are evident here with significant recontouring of the buccal area, which contributes to the effectiveness of the jowl correction. (*Below*) Lateral views show that the jowl is well corrected, and the jawline is well defined. The incisions were inconspicuous.

Fig. 4. A 42-year-old woman presented with facial laxity and jowling. She had undergone energy-based devise skin tightening procedures and barb suture treatments several times. She underwent deep plane face lift and facial fat grafting. Fat grafting was used to build her jawline and angle of the mandible, in addition to grafting in the usual areas (over her maxilla, piriform and nasolabial, chin, temple, and forehead areas). In total, 36 cc of microfat was injected. (*Above*) At 18 months after surgery, the cheek was lifted, the nasolabial folds and jowls were corrected, and the jawline was more defined and oval in shape. (*Below*) The three-quarter views show the long-lasting correction of the nasolabial folds, jowl, and jawline.

facial nerve. Her depressor labii inferioris function began to recover at 4 weeks after surgery, with complete recovery observed at 8 weeks after surgery [*below, right*], ***https://links.lww.com/PRS/H969***.) There were no permanent facial nerve injuries in this series. Hypertrophic scarring was managed with early judicious use of intralesional injections of triamcinolone acetonide, 5-flurouracil, and laser therapy. (**See Figure, Supplemental Digital Content 2**, which shows a 58-year-old woman with a severe tendency for hypertrophic scarring. [*Left*] Right ear before surgery. [*Center*] Right ear incisions at 2 months after surgery, where she developed hypertrophic scarring of her face-lift incisions. A combination of high-fluence long-pulse neodymium-doped yttrium-aluminum-garnet laser [4 treatments] and intralesional injections of dilute triamcinolone [Shincort] and 5-fluorouracil [2 treatments] were used to treat the hypertrophic scarring. [*Right*] Incisions at 2 years after surgery with resolution of her hypertrophic scarring, ***https://links.lww.com/PRS/H970***.) The 2 cases of superficial skin epidermolysis healed with conservative treatment. Hematoma, sensory nerve injury, seroma, and infection were not observed. No patients required any revision surgery.

DISCUSSION

The term deep plane face lift was first introduced by Hamra.[8] In his original description, the dissection was performed under the platysma in the lower face (the premasseter spaces) and then from the lower space dissection, proceeding

Fig. 5. A 59-year-old woman presented for facial rejuvenation. She had previously undergone several energy-based device skin tightening treatments and barb sutures. A deep plane face lift, extended transconjunctival eye bag removal, facial microfat grafting, and chin implant were performed. In total, 35 cc of microfat was injected. (*Above*) At 1 year after surgery, she had good long-term correction of the nasolabial folds and jowl, a clean jawline, and well-corrected neck creases. (*Center*) Three-quarter and (b*elow*) lateral views show good correction of the jowls. The incisions from the face lift healed well, and the pretragal depression was well recreated, with no stigmata of surgery.

superiorly to release the zygomatic retaining ligaments and taking the dissection over the zygomaticus major. However, the dissection stopped there, and the cephalic extent of the dissection did not include the orbicularis oculi. Hamra reported that in the long term, his technique was not effective in lifting the cheek or correcting the nasolabial fold because, in his words, "no superior vector anchor" was available from which the cheek may be fixated.[9] He went on to include the orbicularis oculi in his face-lift, but he accessed the orbicularis oculi not from the facelift incision

but through a separate subciliary incision. Hamra called his lower eyelid approach the zygo-orbicular dissection and named this technique, which required a combination access via the face lift and lower eyelid, the composite face lift.[10] Although effective, the need for a subciliary incision with the composite face lift would necessitate more prolonged recovery and risk potentially problematic complications such as chemosis and lower eyelid malposition issues (scleral show and ectropion). Many authors have refined the original Hamra deep plane face lift by extending the deep plane dissection upward towards the lower eyelid by dissecting into the prezygomatic space, thereby including the orbicularis oculi with the face-lift flap.[11–14] This inclusion of the orbicularis oculi allows for the direct tightening of the superficial fascia of the cheek and provides the high "anchor" fixation to deliver the cheek lift and nasolabial fold correction capabilities that were missing in the classic Hamra deep plane technique. This enhanced deep plane dissection is the technique used in this article.

On a conceptual basis, the deep plane dissection is explained as dissecting through the facial soft-tissue spaces with precise release of the retaining ligaments in the interval between these spaces to achieve the desired mobilization of the superficial fascia (Fig. 6).[15–19] The microscopic anatomy of the facial soft-tissue spaces has not been conclusively demonstrated until recently.[18,20–24] In contrast to the previous conceptualization of layer 4 as being true space or "cleavage plane" at the location of the facial soft-tissue spaces, in reality, the microstructure of spaces consists of specialized deep retinacular fibers arranged in multilayered sheets that are closely stacked in a mille-feuille–like arrangement (Figs. 7 and 8). Slight gliding of these sheets relative to adjacent sheets, collectively allows for significant movement of the mimetic muscle in the superficial fascia over the deep fascia.[21] The facial nerves traversing through these spaces, are located at the deepest part of the deep fascia, at the bottom of the mille-feuille. Therefore, spaces as previously described may safely be dissected above the facial nerve branches by staying just under the mimetic muscles (ie, just under the platysma or the orbicularis oculi).[21,25] With this addendum to the understanding of the microscopic architecture of the facial soft-tissue spaces, the previous descriptions of the spaces otherwise remain accurate and correct in its locations and relations. Histologically, the retaining ligaments are dense collections of deep retinacula cutis fibers oriented more vertically to the skin,

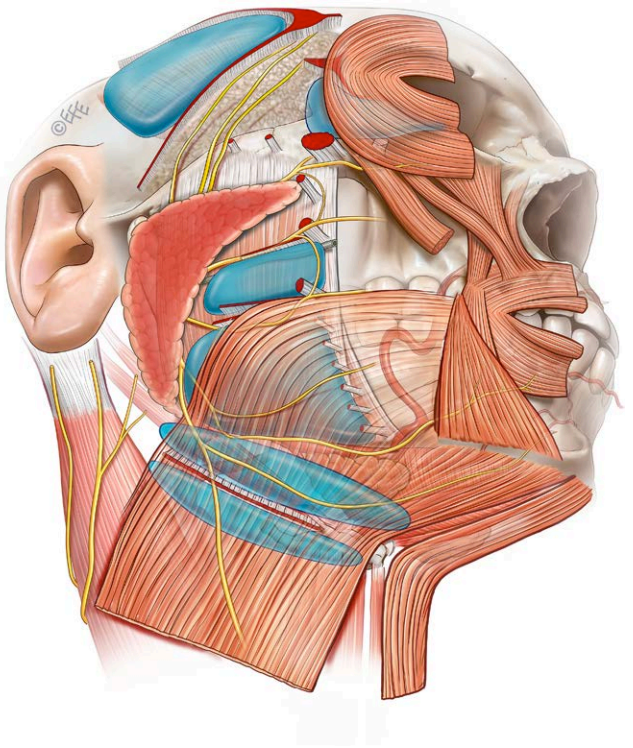

Fig. 6. This figure illustrates the surgical anatomy of the deep plane face lift. The platysma and orbicularis oculi are the key landmarks in the dissection. The facial nerve branches are located at a deeper level, in the deep fascia. Having precisely dissected the deep plane just under the platysma and the orbicularis oculi, the premasseter and prezygomatic spaces may then be retracted up, placing the zygomatic retaining ligaments that are located between the spaces under tension. The zygomatic retaining ligaments may then be safely released by dissecting closer to the top of the stretched out ligaments while the nerves remains protected closer to the floor of the dissection. In the neck, at the key point, the platysma is elevated off the sternocleidomastoid fascia by sharp release of the cervical retaining ligaments. The platysma is then safely elevated off the deep fascia by blunt dissection, releasing the cervicomental angle suspensory ligament on the underside of the platysma, located between the upper and lower cervical spaces. This deep plane dissection completely mobilizes the cheek, lower face, and neck for effective tightening of the superficial fascia. Copyright © 2024 Levent Efe, MD. Used with permission.

and they must be sharply released to allow mobilization of the superficial fascia. These retaining ligaments also serve as transition points where facial nerves pass from within the deep fascia to the underside of the superficial fascia to innervate the facial mimetic muscles. Therefore, releasing the retaining ligaments must be performed carefully under direct visualization.

The deep plane face lift is very effective in Asian patients and delivers natural and long-lasting

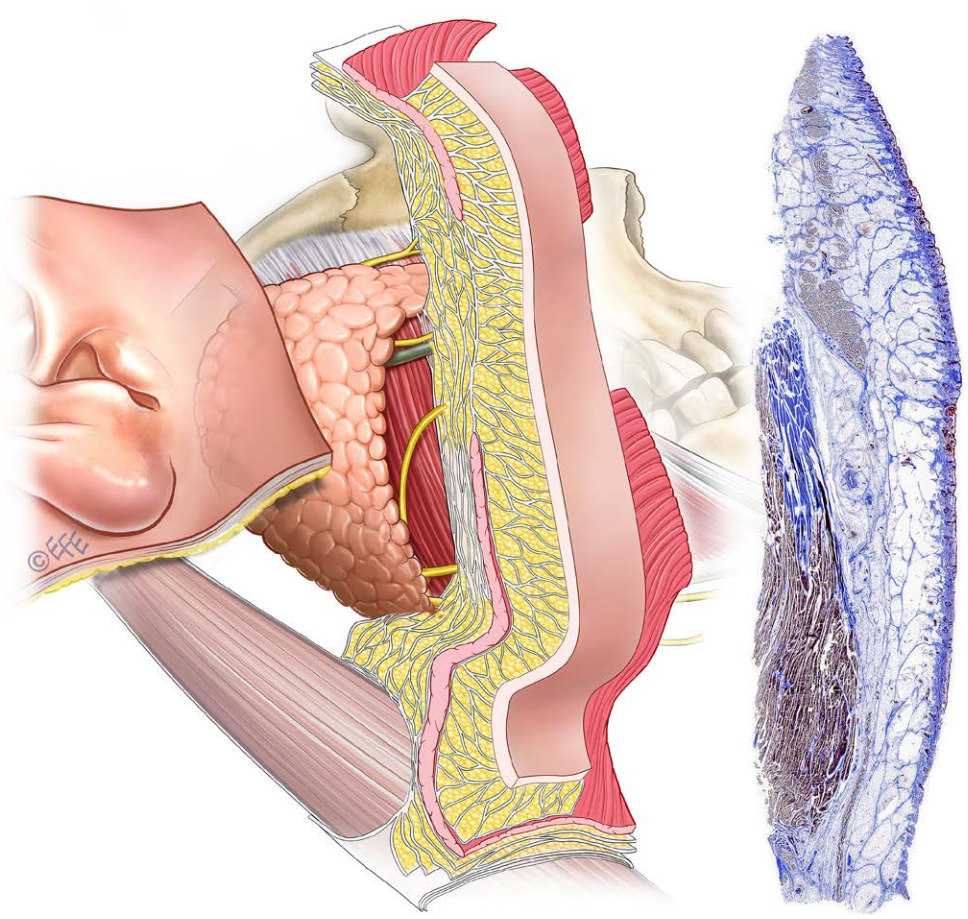

Fig. 7. Block histology showing the layered microanatomy of the facial soft tissues. In areas previously described as spaces, the deep retinacular fibers are arranged in multilamellated sheets that are parallel to the skin. This allows for the fibrous sheets to glide slightly over layers above and below it, collectively allowing the superficial fascia to glide over the deep fascia in these areas. Copyright © 2024 Levent Efe, MD. Used with permission.

aesthetic results.[2,5,26–28] The main barrier to more widespread adoption of the deep plane face-lift technique in Asian patients is the perceived higher risk of facial nerve injury.[29] With the step-by-step dissection approach explained in this article, the risk of nerve injury is minimized. The refined dissection, mobilization, fixation, and skin inset allows the surgeon to predictably harness the potential of this procedure for Asian patients. The greater tendency for hypertrophic scarring in Asian patients is a significant problem.[30] Conventional techniques that place tension on the skin closure often result in widened hypertrophic scars and pixie ear deformities. With the deep plane technique, the lifting tension is distributed across multiple points along the superficial fascia, which is securely anchored to the deep fascia. The skin flaps are quilted down with sutures, ensuring a tension-free skin closure. As demonstrated here, the incisions heal well, resulting in inconspicuous scars.

Asian facial characteristics and features differ in some respects from those of White patients. The thicker Asian skin with more robust attachments of the skin subcutaneous tissue and the mimetic muscle layers make this group of patients particularly suited for this technique that tightens the composite flap in an en bloc manner. Furthermore, the wider bizygomatic width in Asian patients mechanically blocks the transmission of the lifting effect applied from the lateral face to the nasolabial folds located in the anteromedial aspect of the face. Because of this structural feature, to effectively tighten the nasolabial folds in Asian patients, direct tightening of the anterior face, medial to the lateral prominence of the zygoma, is required. The ability to directly tighten the anterior cheek (sutures 5 and 6) therefore makes the deep plane face lift very effective in the correction of the nasolabial folds in Asian patients.

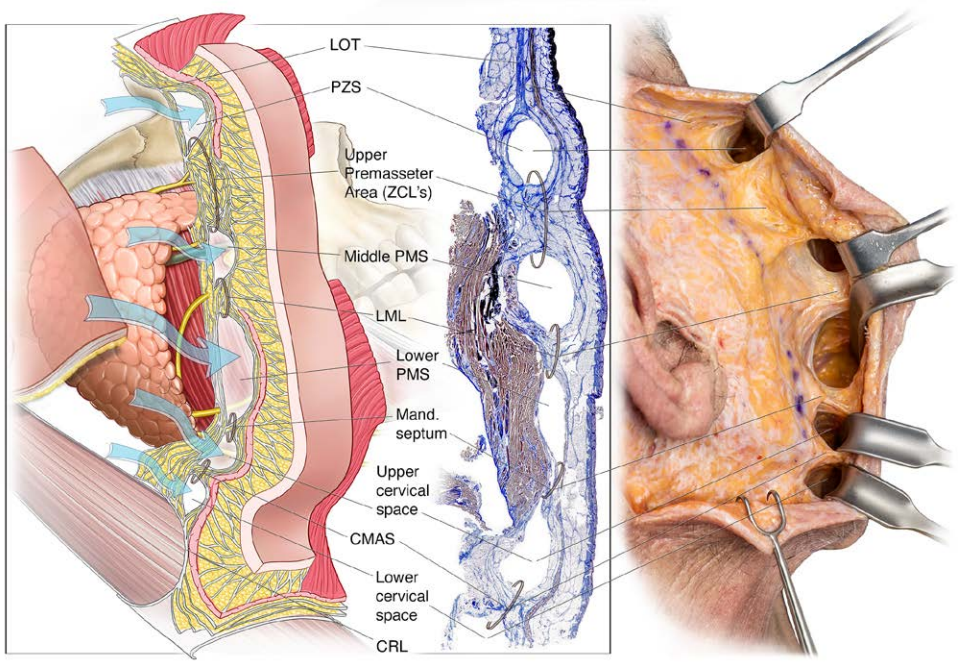

Fig. 8. This block histology shows a specimen with the facial soft-tissue spaces opened while leaving the retaining ligaments located between these spaces intact. In areas of fixation by retaining ligaments, the dense collection of deep retinacular fibers are orientated more vertically, fixating the superficial fascia at these locations. With the deep plane dissection performed just under the superficial fascia, the facial nerve branches are safe, located at a deeper level (within the deep fascia) under the protection of the deep fascia. *LOT*, lateral orbital thickening; *PZS*, prezygomatic space; *ZCL*, zygomatic ligaments; *PMC*, premasseter space; *LML*; lower mandibular ligament; *CMAS*, cervical mandibular angle suspensory ligament. Copyright © 2024 Levent Efe, MD. Used with permission.

The incidence of full obtuse necks is lower in Asian patients, with only 15% of our patients requiring an anterior neck approach. A total of 85% of patients were successfully managed with a lateral approach to the neck only. Although we perform neck liposuction in all our patients, we rarely perform face liposuction to reduce the facial fullness. In our experience, the firm tightening from the deep plane face lift can contour the lower face and jowls effectively without the need for any adjunct jowl or cheek liposuction. Asian patients also have a significantly higher incidence of masseter and parotid hypertrophy.[31,32] In patients with very enlarged masseter or parotid glands, consideration should be given to shrinking the muscle and/or glands with botulinum toxins before surgery, ideally 1 month prior. The deflation effect of this treatment on the muscle or the glands can cause more laxity in the anterior face, with worsening of the jowls. (**See Figure, Supplemental Digital Content 3**, which shows a 56-year-old woman with masseter hypertrophy who was treated with 30 units of botulinum toxin on each masseter. She is shown here at 1 month after treatment. The reduction in the bulk of the masseter results in increased laxity in the anterior face and increased prominence of the marionette lines and nasolabial folds, ***https://links.lww.com/PRS/H971***.) By reducing the bulk of the tissues over the lateral mandible, more efficient tightening of the jowl located more anteriorly can be achieved. Moreover, if patients decide not to have further botulinum toxin treatments after face lift, the re-expansion of the muscle and glands will further stretch the soft tissues in the anterior face, resulting in gradual tightening of the anterior face in the months after recovery. This enhances the face-lift results as the effects of the botulinum toxin wear off. Excessive and inferiorly herniated buccal fat is also more common in Asian patients.[33] This excess buccal fat can contribute to jowl prominence, and its conservative removal can help create a more contoured appearance. Because of the thicker soft tissues in the Asian face, conservative excision of buccal fat does not result in significant hollowing.

Many Asian patients seeking face lifts have often undergone extensive "noninvasive" facial rejuvenation treatments, including use of energy-based devices (eg, focused ultrasound, radiofrequency), barbed sutures, and filler injections. Energy-based treatments work by inducing microtrauma to stimulate scarring and tighten the skin. In patients with a history of these treatments, especially when performed repeatedly, extensive scarring of the tissue planes is often observed and should be expected, which complicates dissection. In patients who have received substantial treatments with injectables, the type, location, and quantity of injectables should be documented as accurately as possible. Small amounts of filler that are neither palpable nor lumpy can generally be left alone. However, patients who have undergone excessive injectable treatments, resulting in palpable lumps—especially in the midcheek and tear trough areas—often present with an overfilled appearance. In these patients, hyaluronic acid–based fillers should be dissolved with hyaluronidase at least 2 to 3 weeks before surgery. This helps address abnormal lumpiness and swelling caused by overfilling. Removing excessive bulk in the cheeks also eliminates physical obstructions that may hinder cheek lifting during the face-lift procedure. If left in situ, a further concern is that inflammation associated with healing after the face lift may trigger encapsulation of the filler material, making palpable lumps more prominent. In such situations, the need to dissolve the fillers after the face lift can lead to a loss of projection and early recurrence of laxity because of the deflationary effect of filler loss. Patients should be reevaluated after filler dissolution, before surgery, for photographic documentation and proper face-lift planning.

The limitations of this article include the relatively small patient cohort from a single surgeon. However, the dissection approach as presented here is safe and effective. We had 1 case of temporary paralysis of the depressor labii inferioris[34,35]; a possible cause for this is injury to the cervical branch of the facial nerve when elevating the platysma flap off the angle of the mandible. We have made a slight modification to our technique by initiating the division of the cervical retaining ligaments to mobilize the posterior platysma flap lower (approximately 2 fingerbreadths below the angle of the mandible), to clearly establish the correct deep fascial plane of dissection (keeping the nerves deep to the dissection) before progressing over the angle of the mandible (where the cervical branches are located) with the platysma elevation. With this modification, we have had no further nerve injuries.

CONCLUSIONS

The deep plane face lift is ideal for Asian patients. The surgical technique described in this article emphasizes (1) precise understanding of the three-dimensional layered anatomy of the facial soft tissues and their relationship to the course of facial nerve branches, which has enabled the development of a safe and effective deep plane dissection approach; (2) the establishment of specific mobilization endpoints; (3) a systematic approach to suture fixation, with each suture targeting specific landmarks in the anterior face for optimal tightening; and (4) a systematic approach to skin flap inset to ensure precise, tension-free closure. With this approach, safe and effective outcomes can be predictably achieved. The results are natural and long-lasting, without the stigmata associated with conventional face lifts.

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DISCLOSURE

The authors declare no conflict of interest in relation to the present work. None of the authors has a financial interest in any of the products, devices, or drugs mentioned in this article.

PATIENT CONSENT

Patients provided written informed consent for the use of their images.

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