Restoring Facial Shape in Face Lifting: The Role of Skeletal Support in Facial Analysis and Midface Soft-Tissue Repositioning (Baker Gordon Symposium Cosmetic Series)

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Summary: Aesthetic analysis in facial rejuvenation has traditionally been subordinate to technical solutions. While concerns regarding correction of facial laxity, a reduction in the depth of the nasolabial fold, and improvement of both the jowl and the jawline are worthy goals in rhytidectomy, the aesthetic concept of restoring facial shape to a more youthful appearance is equally important. Restoring facial shape in face lifting requires an understanding of how the face ages and then the formulation of a treatment plan that is individualized for the patient. Re-establishment of facial contour is significantly influenced by the re-elevation of descended facial fat through superficial musculoaponeurotic system manipulation; it can be approached through a variety of technical solutions. Underlying skeletal support affects not only the appearance of the face in youth but also how the face ages and influences the operative plan in terms of the requirements for fat repositioning. Formulating a treatment plan that is patient specific and based on the artistic goals as influenced by skeletal support is the key element for consistency in restoring facial shape in face lifting. (Plast. Reconstr. Surg. 119: 362, 2007.)

The works of Skoog1 and Mitz and Peyronie2 enlightened plastic surgeons to the possibility of repositioning descended facial fat to the anatomic position of youth, providing an alternative to skin envelope tightening to enhance contour in the aging face. The recognition that sub-superficial musculoaponeurotic system (SMAS) dissection offered a technical solution for facial rejuvenation spawned multiple anatomic studies to delineate an accurate understanding of facial soft-tissue anatomy.3–11 This later led to further investigations that more clearly defined both the anatomic and morphologic changes that occur in the aging face, leading to a plethora of technical approaches for facial rejuvenation.12–29 In reviewing the literature, good results were noted utilizing what appear to be very different technical approaches. In reality, most of these seemingly different technical procedures share a common theme that contour restoration is predominantly through the re-elevation of facial fat as opposed to skin envelope tightening. Although good results are possible through a variety of techniques, in my opinion, all techniques have advantages, disadvantages, and limitations, with the ultimate result often dependent on underlying skeletal support and the quality of facial soft tissues for a particular patient. For me, the key to consistent results in face lifting is not the particular technique utilized but rather the preoperative aesthetic analysis and how the operative plan is individualized according to the aesthetic needs of the patient.

In formulating a treatment plan, it is helpful to look at what produces surgical stigma following rhytidectomy. Perhaps it begins with the term “face lift,” a mechanical phrase suggesting that middle-aged faces become loose over time and that the surgeon’s primary goal in facial rejuvenation is to tighten relaxed facial soft tissues. Unfortunately, the surgical cause and effect of trying
to tighten a loose face too often produce a tight appearance to facial contour. This is not only unnatural but neither youthful nor rejuvenative. In my opinion, a better aesthetic concept than trying to tighten a loose face is to restore facial shape. To consistently improve facial shape in face lifting requires that the surgeon accurately understand the anatomic changes that have occurred in aging for a particular patient, appreciate the importance of underlying skeletal support in formulating the treatment plan, and incorporate his or her aesthetic vision into a surgical destination that is appropriate for the specific patient.

**CHANGES IN FACIAL SHAPE WITH AGING**

As the human face ages, facial shape changes. Morphologic facial changes are multifactorial. Some of these changes are straightforward to address, while others remain difficult technical challenges. A paradox for me has always been that facial anatomy (in terms of basic soft-tissue architecture) is essentially unchanged from youth to middle age, but facial appearance changes greatly over time and is patient specific. Although each face ages differently, there are common themes noted in all aging faces, as described below.

**Descent of Facial Fat**

As the human face ages, facial fat descends and with it facial shape changes. Typically, the youthful face is full of well-supported fat. Volumetric highlights are located within facial aesthetic subunits that have a high density of retaining ligaments (malar, preauricular, and orbital rim) and serve to fixate this volume of fat to underlying structures. Juxtaposed to the volumetric fullness (or convexity) of the malar and preauricular region is commonly a concavity within the submalar region, overlying the buccinator muscle and buccal recess. The combination of fullness in the malar region and lateral cheek associated with submalar concavity is termed the nasolabial fold and facial jowling. For me, an improvement in facial shape remains one of the primary goals in facial rejuvenation. (Reprinted from Stuzin, J. M., Baker, T. J., and Baker, T. M. Refinements in facelift: Enhanced facial contour using Vicryl mesh incorporated into SMAS fixation. *Plast. Reconstr. Surg.* 105:290, 2000.)
cavity and a well-defined mandibular border accounts for the angular, tapered appearance of the youthful face.\textsuperscript{30}

With aging, facial fat descends and facial shape changes. In middle age, as ligamentous support becomes attenuated, facial fat volumetrically becomes situated anteriorly and inferiorly in the cheek, producing a facial contour that is squarer in configuration with little differential between malar highlights and midfacial fat. As facial fat is situated inferiorly in the face, older faces appear vertically longer than young faces (Fig. 1).

**Volume Loss and Facial Deflation**

Young faces are full of well-supported facial fat. Over time, deflation of facial fat occurs and tends to be most apparent in regions of the face with a high density of retaining ligaments.\textsuperscript{31,32} For this reason, areas noted to be volumetrically full in youth (malar, preparotid, lateral and infraorbital rim, and lateral chin) become volumetrically deflated in middle age. With facial deflation, soft tissue becomes less supported and therefore appears lax. Youthful faces have a smooth blending of contour between the aesthetic subunits of the face. Middle-aged faces, secondary to both deflation and facial fat descent, develop lines of demarcation between one region of the face and another that is intuitively identified as old. As part of the aesthetic treatment plan to improve facial shape, repositioning descended soft tissue into areas of facial deflation improves shape, not only by restoring volume to the position noted in youth but also by serving to blunt the lines of demarcation that develop with aging. Volumetric addition through secondary agents such as autologous fat injection, dermal fat grafts, or other injectable soft-tissue fillers can be useful in augmenting areas of facial deflation\textsuperscript{33,34} (Fig. 2).

**Radial Expansion**

Not all facial aging is vertical. A major challenge in facial rejuvenation is the radial expansion of facial soft tissue that occurs along specific areas of the midface. In youth, the skin and underlying subcutaneous fat are densely attached to the deep facial fascia by retinacular fibers that transverse among skin, subcutaneous fat, and superficial fas-

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**Fig. 2.** (Left) Preoperative appearance of a 42-year-old patient with early facial aging resulting primarily from deflation. Note the hollowing effect along the infraorbital and lateral orbital rims and preparotid region, which are regions of high ligamentous density. (Right) Post-operative result after face and neck lift. Note that as anteriorly situated fat is brought into the upper lateral midface, it fills the areas of deflation, thereby blunting the lines of demarcation between aesthetic subunits that develop with age. Notice also the change in facial shape, which now appears more structured and supported following facial fat repositioning.
Fig. 3. (Left) Preoperative appearance of a 59-year-old man after a 90-pound weight loss from a gastric bypass procedure. Notice the significant areas of facial deflation along the infraorbital rim, lateral orbital rim, and malar region. Also notice the radial expansion of skin and fat lateral to the nasolabial fold, most marked on the right side. Not only does malar fat descend, but attenuation of the retinacular connections among skin, fat, and deep facial fascia lateral to the nasolabial line allows prolapse of soft tissue, which accentuates nasolabial prominence. (Right) Postoperatively, the areas of deflation along the infraorbital rim, lateral orbital rim, and malar region are improved, as facial fat has been repositioned into these regions. The nasolabial folds are somewhat improved after malar pad repositioning, but correction is incomplete, especially on the right. Malar pad elevation helps to flatten the prominent nasolabial fold but does little to correct radial expansion, with the skin lateral to the nasolabial line remaining prolapsed from its attachments to the facial skeleton.
cia and insert into the deep fascia and facial musculature. Over time, with prolonged animation such as smiling, the skin along the nasolabial line is forced deep to the subcutaneous fat, positioned lateral to the nasolabial fold, attenuating these retinacular attachments. Prolonged animation, therefore, forces the skin and fat lateral to the nasolabial fold to expand radially and prolapse outward from the facial skeleton, accounting for much of the nasolabial fold prominence in the aging face. Radial expansion lateral to the oral commissure and marionette line similarly accounts for some degree of jowl prominence in many middle-aged patients. Radial expansion is technically difficult to correct, because there are few surgical solutions to re-establish the retinacular attachments among skin, subcutaneous fat, and deep fascia. Because of this technical difficulty, incomplete correction in these regions is commonly noted after a face lift, despite heroic efforts at repositioning descended facial fat (Fig. 3).

Role of Skeletal Support in Formulating a Surgical Treatment Plan

Facial shape and contour are intuitively evaluated when analyzing a patient for facial rejuvenation. Often the two-dimensional considerations seen in photographs are the easiest aspects of aging to identify, and such factors as nasolabial fold depth, jowl prominence, and cervical contour become the primary objectives to improve appearance in the middle-aged face. Although these factors are certainly important considerations in treatment planning, the more subtle three-dimensional qualities of facial shape are equally important to evaluate and are greatly influenced by underlying skeletal support.

In evaluating facial shape during preoperative analysis, some of the major factors that I have found helpful to consider are as follows:

1. **Facial width, bizygomatic diameter, and malar volume.**
   The emphasis in face lifting over the last 20 years has focused on malar pad elevation.\(^6,^{12,14,15,17-20,28,29}\) While malar pad elevation and restoration of malar highlights are important factors in improving facial shape, they need to be patient specific. Many patients present preoperatively with wide faces, strong malar eminences, and large malar volume and have little evidence of malar fat descent. In these individuals, it is necessary to evaluate preoperatively the degree of malar pad elevation required to improve facial shape. While limited degrees of malar pad elevation can be helpful in patients who present with wide bizygomatic diameters, in general, if the malar volume is significantly enhanced in these types of individuals, the aesthetic effect is to make a wide face appear even wider on the frontal view postoperatively (Fig. 4).

2. **Facial length and the relative vertical heights of the lower and middle thirds of the face.** Compared with patients with wide faces, patients who present with vertical maxillary excess often have long, thin faces on the frontal view. As facial fat descends in middle age, it becomes situated anteriorly and inferiorly in the face, and the face appears even longer with age. Malar pad elevation and enhancing malar volume in these types of patients are usually beneficial. As malar volume is enhanced and bizygomatic diameter is increased, the face appears wider on the frontal view, detracting from the relatively excessive facial length (Fig. 5).

![Fig. 4.](image-url) Facial width and bizygomatic diameter reflect the underlying degree of skeletal support. Patients who exhibit a strong malar eminence and wide bizygomatic diameter often benefit from having malar highlights restored, but they usually do not require significant enhancement of malar volume (which will cause a wide face to appear wider postoperatively). Shaping considerations in these types of faces usually focus on improving the appearance of the lower two-thirds of the cheek, specifically addressing jowl fat repositioning, and creating submalar hollowing, which improves the aesthetic relationship between the malar and submalar regions.
3. **Convexity of the malar region juxtaposed with the concavity of the submalar region.** In youth, facial fat is situated overlying the malar and prepa-rotid regions. This malar fullness is juxta-posed with a concavity within the submalar region overlying the buccinator. As patients age, the relationship between the malar and submalar regions changes, and facial shape changes with it. As facial fat descends and facial deflation occurs, there is less volume overlying the malar eminence and an associated increase in fullness in the submalar re-

**Fig. 5.** Long, thin faces often benefit from an enhancement of malar volume. SMAS dissection and facial fat repositioning carried anteriorly over the zygomatic eminence allow the surgeon to restore malar volume, thereby increasing bizygomatic diameter. When malar volume is enhanced, the face appears wider, detracting from the relatively excessive facial length.
Fig. 6. This patient demonstrates that the aesthetic relationship between the malar and submalar regions has a significant effect on facial shape. Youthful faces with a tapered configuration typically exhibit a convexity or fullness in the malar region juxtaposed with submalar hollowing.

Fig. 7. Another patient with similar skeletal support photographed at age 51. In middle age, facial fat both descends and deflates, accounting for a change in the relationship between the malar and submalar regions. Typically, there is a loss of volume in the malar area associated with an increase in fullness within the submalar region, blunting the relationship noted in youth. Facial shape becomes less tapered and squarer in configuration, with less differential in highlights between the malar eminence and the submalar fat.
Fig. 8. (Left) Preoperative appearance. Note that facial shape is oval, secondary to malar deflation associated with an increase in submalar fullness. (Right) Postoperatively, following malar pad elevation, malar volume is enhanced in association with a restoration of submalar concavity, producing a more angular appearance to facial shape.

Fig. 9. (Left) Preoperatively, this patient shows a similar blunting of the relationship between the malar and submalar regions. (Right) Postoperative appearance. Enhancing malar volume (and bizygomatic diameter) and restoring the concavity within the submalar region make the face appear more angular, as well as vertically shorter.
modified with time, there is a loss of the angular, tapered configuration in shape noted in youth, and middle-aged faces often appear oval. With greater facial fat descent and an increase in submalar fullness, older faces appear square (Figs. 6 and 7). Preoperatively, an evaluation of the relationship between the malar and submalar regions on the frontal view, for me, is an essential component of aesthetic treatment planning. For many patients, a restoration of this relationship by increasing malar highlights and malar volume, in association with a restoration of concavity in the submalar region, becomes a central component in improving facial shape (Figs. 8 and 9).

**THE VERTICAL HEIGHT OF THE MANDIBULAR RAMUS AND THE HORIZONTAL LENGTH OF THE MANDIBULAR BODY**

The vertical height of the mandibular ramus and the horizontal length of the mandibular body provide skeletal support for the lower two-thirds of the face. Patients who present with a normal mandibular ramus height, as well as an adequate horizontal length of the mandibular body, usually have excellent skeletal support for soft-tissue repositioning and are, therefore, less of a surgical challenge. In contradistinction, patients with a short mandibular ramus, an open mandibular plane angle, and a short mandibular body typically have poor skeletal support for midface and perioral soft-tissue repositioning. These patients are a greater surgical challenge in restoring facial shape and often benefit from volumetric augmentation, either alloplastic or autogenous, to enhance skeletal support (Fig. 10).

**TECHNICAL CONSIDERATIONS: PREOPERATIVE PLANNING**

My experience in face lifting has centered on utilizing an extended SMAS technique\(^1\) to reposition descended midfacial fat superiorly to the anatomic position of youth. The incision design

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Fig. 10. (*Left*) The underlying skeletal support from the mandible has a significant effect on the surgeon’s ability to restore facial shape. Patients with a normal height to the mandibular ramus and a long mandibular body are favorable surgical candidates, as there is significant skeletal support to aid in shaping through facial fat repositioning. (*Right*) In patients with a retrusive mandible, a short mandibular ramus associated with an open mandibular plane angle, there is less skeletal support to aid in facial shaping. These patients represent a greater surgical challenge and often benefit from volumetric augmentation.
for this dissection is essentially an extension of a standard SMAS dissection anteriorly and superiorly into the malar region, to allow access for the release of the zygomatic, upper masseteric, and parotidocutaneous ligaments. Repositioned facial fat, in any subSMAS procedure, ends up being located where it is sutured. For this reason, the incision design I utilize allows the versatility to reposition fat along the infraorbital rim, lateral orbital rim, malar eminence, and preparotid regions, depending on the aesthetic needs of the patient (Fig. 11). Variations in extended SMAS incision design, in terms of the superior and medial malar extent of the SMAS dissection, provide the surgeon with aesthetic versatility in terms of restoration of malar volume and facial width.

The biomechanics of SMAS repositioning have previously been described and are influenced by the degree of release, the vector of fat repositioning, and how the superficial fascia is fixated. As postoperative contour is dependent on each of these factors, preoperative planning needs to be patient specific in terms of the degree of SMAS release required, the vectors in which facial fat are repositioned, and the location and method for SMAS fixation.

**RELEASE**

The incision design of an extended SMAS dissection allows for complete release of the SMAS from its underlying retaining ligamentous attachment in the lateral midface. As surgeons, there is a tendency to believe that a greater degree of SMAS dissection equates with a better result, but this has not been my experience. Rather, precision in the degree of SMAS dissection and its release from the retaining ligaments as dictated by the aesthetic needs of a patient increases surgical control and consistency while minimizing morbidity. How much to release the SMAS, and how high and anterior to carry the SMAS dissection, needs to be decided preoperatively. In patients who present with adequate malar volume, wide bizygomatic diameter, and little evidence of malar pad descent, it is usually unnecessary to carry the SMAS dissection medial to the lateral orbital rim (although I usually carry the dissection high within the malar eminence to allow fat repositioning along the infraorbital and lateral orbital rims). Most commonly, these patients require only a restoration of malar highlight and not significant anterior malar volume enhancement. Limiting the SMAS dissection to the lateral aspect of the malar eminence will not increase facial width on the frontal view. Typically, the shaping considerations for these patients are focused on reducing fullness in the submalar region. SubSMAS dissection along the lateral aspect of the zygomatic eminence provides exposure to the juxtaposed masseteric ligaments, allowing the submalar fat to be repositioned superiorly along the concavity of the underlying buccinator, thereby restoring submalar hollowing (Fig. 12).

Vertically long faces often benefit from carrying the malar portion of the extended SMAS dissection anteriorly, medial to the lateral orbital rim, so that malar volume restoration is performed along the anterior aspect of the zygomatic eminence. Carrying the SMAS dissection more medially allows the surgeon to enhance malar volume and restore malar highlights anteriorly over the zygomatic eminence, thereby increasing facial width on the frontal view (Fig. 13).

**VECTORS OF FAT ELEVATION: FACIAL ASYMMETRY**

All patients exhibit some degree of facial asymmetry.Commonly, one side of the face is vertically

![Fig. 11. The incision design for the extended SMAS dissection is an extension of a standard lateral SMAS dissection. The malar aspect of the dissection allows for the repositioning of facial fat along the infraorbital and lateral orbital rims, as well as the restoration of malar volume. The SMAS dissection just lateral to the zygomatic eminence provides access to the masseteric ligaments to allow jowl fat elevation and restoration of submalar hollowing. The dissection laterally in the cheek frees the SMAS from the parotid, providing for repositioning of the descended platysma, thereby improving mandibular border contour.](image-url)
longer, and the short side of the face is usually wider than the long side. Malar highlights are typically more superiorly located on the long side of the face, and with age, facial fat tends to descend in a more vertical direction on the long side. As facial asymmetry and facial skeletal configuration are asymmetric in most individuals, it follows that the vectors of fat elevation (SMAS repositioning) should be specific for the right and the left sides of the face.

The vector in which the SMAS is repositioned has a significant effect on the location and volume of elevated facial fat, thereby influencing facial shape. Decisions regarding the direction of SMAS vectoring for the right and left sides of the face are best determined preoperatively, as it is very difficult to make aesthetic vector judgments intraoperatively with the patient recumbent.

SMAS vectors influence postoperative facial shape. Vertical SMAS repositioning typically provides a larger amount of fat for malar eminence enhancement, as well as allowing for a reduction in fullness within the submalar region as fat is forced vertically along the concavity of the buccinator. For this reason, vertical SMAS vectors are often indicated to reshape round, full faces, allowing them to appear more tapered and thinner postoperatively (Fig. 14). If the SMAS is vectored more obliquely, less fat volume is brought into the malar region and a greater volume of fat is repositioned into the submalar region. Oblique SMAS repositioning is helpful, therefore, in elderly patients who appear gaunt over the buccal recess, as it allows the surgeon to volumetrically enhance the submalar region (Fig. 15).

**SMAS FIXATION**

In a two-layer SMAS-type face lift, the tension of contouring is placed on the superficial fascia rather than the skin envelope. For this reason, the fascial quality and tensile strength of the superficial fascia have an influence on both the longevity of the result and the volume of fat that can be repositioned intraoperatively and maintained postoperatively. In other words, soft-tissue quality influences long-term contour and is the primary reason why face lifts in young patients are more predictable.
Fig. 13. Faces that are dominated more by their facial length (especially the lower third of the face) usually benefit from malar volume restoration. Enhancement of malar volume requires that the SMAS dissection be carried toward the anterior aspect of the zygomatic eminence, such that malar volume is increased in this region.

Fig. 14. Vectors of SMAS elevation have a significant effect on facial shape. Vertical repositioning of the SMAS allows the surgeon to enhance malar volume and reduce fullness within the submalar region, as fat is forced up along the concavity of the buccinator. Restoration of submalar hollowing through SMAS vectoring is useful in contouring full faces, making them appear thinner postoperatively. In this patient, a small amount of jowl defatting through needle aspiration was also performed.
In an effort to improve fascial quality in a SMAS-type face lift, for the last 10 years I have incorporated Vicryl mesh into the SMAS fixation. It is my observation that incorporating Vicryl mesh into SMAS fixation not only improves the longevity of these procedures but provides the surgeon with greater aesthetic control in terms of restoring facial shape. Incorporating the Vicryl mesh allows the surgeon to secure the SMAS under greater tension (while preventing the sutures from “cheese-wiring” through the SMAS), which allows the surgeon to reposition a greater volume of fat into specific regions of the midface. Greater control in fixating repositioned fat provides greater control in restoring facial shape (Fig. 16).

If malar volume requires enhancement, once the SMAS is initially fixated, adding a few more sutures between the SMAS flap and the periosteum of the malar eminence allows the surgeon to imbricate more malar fat superiorly over the zygoma, thereby increasing malar volume. Essentially, this type of stacking fixation imbricates malar fat onto both mesh and zygomatic eminence, aesthetically resulting in an increase in bizygomatic diameter.

If the predominant aesthetic problem is to reduce fullness within the submalar region, SMAS release of the upper masseteric ligaments and vertically vectoring the SMAS tend to increase submalar hollowing. Adding fixation sutures just lateral to the malar eminence also accentuates submalar concavity. This method of SMAS vectoring and fixation is useful in shaping round, full faces without having to overly rely on the removal of facial fat to improve facial shape.

Suturing in the preauricular region repositions descended platysma muscle superiorly over the mandibular border, thereby accentuating mandibular border and cervical contour. Adding sutures into the SMAS fixation along the preauricular region is also useful in providing volumetric enhancement laterally in the cheek, improving an aesthetic subunit that typically deflates with age.

AESTHETIC EFFECT OF STRONG VERTICAL SKIN TENSION ON FACIAL SHAPE

Strong, vertical shifting of the cervicofacial flap has traditionally been a maneuver utilized in many face lift techniques. While skin envelope tightening can produce a dramatic effect in terms of the improvement of facial laxity, the aesthetic effects of vertical skin shift on facial shape have been poorly delineated. Specifically, when skin is shifted in a

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**Fig. 15.** This patient exhibits asymmetry in the submalar region preoperatively. Notice that she appears hollow and concave on the right, while she is fuller on the left side. For this reason, the SMAS was vectored obliquely on the right to volumetrically enhance the submalar region, while it was vertically vectored on the left side to restore submalar hollowing and balance the two sides of her face.
cephalad direction, the effect of skin tension commonly produces a depression or flatness in the preauricular region, an area that typically deflates with aging (Fig. 17). If the preauricular region remains deflated despite fat repositioning, vertical skin vectoring will further depress and flatten this region. In my opinion, vertical skin shift all too often produces an unnatural tightness to facial shape, producing the typical stigma associated with rhytidectomy. If the surgeon has been successful in enhancing contour through repositioning descended platysma superiorly over the mandibular border, thereby improving mandibular border contour.

**CONCLUSIONS**

Thirty years after the milestone work of Mitz and Peyronie,² plastic surgeons continue to struggle in their quest for a perfect solution to rejuvenate the aging face. Over this time period, the surgical spectrum has swung from wide skin and SMAS dissection to short-scar face lifts with imbrication or SMAS resection, in an attempt to limit morbidity while improving consistency in results.²³,³⁶

In my opinion, surgical rejuvenation of the aging face suffers not from inadequate technical solutions but rather from the absence of a uniform method of preoperative analysis. Unlike rhinoplasty, in which preoperative analysis is defined by angles and measurements of length and projection, aging faces vary greatly in terms of skeletal support, volume of fat, fascial quality, and skin quality. The variability of facial shape from patient to patient, as well as how individual patients age, makes a uniform system of analysis difficult. Artistic vision and artistic goals, as to what will aesthetically improve for a particular patient, are also surgeon specific.

From my perspective, independent of technique, the primary goal in face lifting is to improve facial appearance while minimizing signs that a surgical procedure has been performed. Understanding the nuances of superficial fascia repositioning (repositioning facial fat), whether it be utilizing imbrication, SMAS resection, or formal

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**Fig. 16.** Fixation of the superficial fascia affects facial shape. The advantage of incorporating Vicryl mesh into the SMAS fixation is that it provides the surgeon with greater control in determining the position and volume of repositioned fat. Suturing in specific areas along the SMAS incision affects volume for a particular region. Adding sutures in the malar region allows the surgeon to bring a greater amount of malar fat onto the zygomatic eminence, thereby enhancing malar volume. Adding sutures in the region just lateral to the zygomatic eminence forces cheek fat superiorly along the concavity of the buccinator, thereby reducing submalar fullness. Sutures placed in the preauricular region force descended platysma superiorly over the mandibular border, thereby improving mandibular border contour.

**Fig. 17.** The aesthetic consequences of vertical redraping of the cervicofacial skin flap are much different from those for vertical SMAS redraping. Strong vertical shift of the skin flap not only produces temporal hairline distortion but accentuates flatness in the preauricular region (which typically deflates with age). Lateral flatness can produce a tight, unnatural appearance all too commonly associated with patients having undergone a rhytidectomy.
SMAS flap elevation, provides the surgeon with only a mechanism to restore facial shape. What is critical to the end result is preoperative analysis and accurately delineating the aesthetic goals before surgery. Formulating a treatment plan to restore facial shape that is patient specific and based on the volumetric requirements as influenced by underlying skeletal support is the key element to increasing consistency in face lifting. The technical solution thereby becomes subservient to the aesthetic destination. Good surgeons can get good results through a variety of techniques as long as there is an understanding of how to vary technique according to the aesthetic needs of the patient.

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DISCLOSURE
The author has no financial interests in any of the products, devices, or drugs mentioned in this article.

REFERENCES
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