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<p>In this article, which focuses on concepts rather than techniques, the author emphasizes that the best predictor of a good facelift outcome is an already attractive face that has good enough tissue quality to maintain a result past the swelling stage. The author notes that too often, surgeons gravitate toward a particular facial support technique and use it all the time, to often unsatisfactory results. He singles out different areas (the brows, the tear trough, the cheeks, and so forth) and shows how the addition of volume may give results better than traditional methods. As he points out, a less limited and ritualistic approach to the face seems to be how cosmetic surgery is evolving; all factors that might make a face better are reasonable to entertain.</p>	
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<p>Endoscopic forehead rejuvenation has several advantages over traditional open techniques. First, large incisional scars are avoided. Second, the chances of forehead elongation are less. However, the technique requires a significant learning curve for best results. Suboptimal results may occur and are typically due to under-resection or uneven resection of the glabellar musculature, overdissection of the</p>	

medial periosteum, and under or overcorrection when repositioning of the lateral brow. This article reviews the pertinent anatomy and techniques for endoscopic forehead rejuvenation, and describes the authors' technique for more consistent, predictable results.

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**Closed, Nonendoscopic, Small-Incision Forehead Lift** **363**

Timothy J. Marten

As endoscopic techniques made inroads into surgery, one of the first procedures they were adapted to by plastic surgeons was the forehead lift. The "closed" forehead lift procedure has since achieved wide acceptance and exists as a viable alternative to open procedures for many patients. Experience has shown, however, that it is not necessary to use an endoscope to mobilize and release the forehead and modify the corrugator supercilii muscles in "closed" procedures if the anatomy is understood, the operation is appropriately planned, and the corrugator muscles are modified using a transpalpebral approach. In addition, transpalpebral corrugator myectomy, when used in conjunction with closed mobilization and resuspension of the forehead, provides not only a scheme for the performance of closed forehead-plasty without the need for an endoscope, but a method by which medial brow elevation can be minimized or avoided. This may, indeed, be one the procedure's most important advantages over the endoscopic technique.

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Henrique P.L. Cintra and Filipe V. Basile

The combined-access brow lift described in this article is a limited-incision technique that can provide a cosmetic effect comparable to that produced by the coronal incision technique. It also allows safe direct visualization of anatomic structures comparable to that allowed by the endoscopic-assisted technique, but because it requires no endoscopic instrumentation, it is less expensive and takes less time to learn.

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**Surgical Anatomy of the Midcheek: Facial Layers, Spaces, and the Midcheek Segments** **395**

Bryan C. Mendelson and Steven R. Jacobson

This article describes the surgical anatomy of the midcheek. The article's key points: (1) Structurally, the midcheek is formed by the convergence of three components: the lid-cheek segment, the malar segment, and the nasolabial segment. (2) The midcheek skeleton provides the attachment for the muscles and ligaments of both the lower lid and the upper lip. (3) The midcheek contains proportionally more spaces and fewer ligaments than other parts of the face. (4) Each midcheek segment overlies a specific facial space. (5) The lid-cheek contour transition does not have a fixed relationship to the inferior orbital rim. (6) The youthful lid-cheek transition is above

the orbital rim and the aged is below the rim. (7) Facial nerve branches course in predictable locations.

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**Personal Approach to the Aging Lower Lid and Face** **407**

Gordon H. Sasaki

This article presents the author's personal approach to the lower lid and midface. The approach is based on a systematic process of determining which combination of surgical procedures can optimally address the patient's concerns and correct the anatomic findings. In most faces, there is an opportunity for both suspension and tightening of ptotic structures and also provision for volumetric filling and shifting of tissues. Our present algorithms for lower lid and face rejuvenation will likely change with a better understanding of the aging processes and the development of more effective, safer, and longer-lasting procedures to meet the individualized age-appropriate needs of patients.

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**The Magic of Mid-Face Three-Dimensional Contour Alterations Combining Alloplastic and Soft Tissue Suspension Technologies** **419**

Edward O. Terino and Michael Edward

Recent advances in the technology of implant designs and shapes, as well as improved understanding of the principles of facial aesthetics, give the plastic surgeon, for the first time, tools to precisely and permanently change faces in specific areas and with minimum morbidity. Cosmetic facial surgeons must learn and understand the zonal anatomy of the malar-midface region to be prepared for growing patient demands regarding analysis and alteration of facial cheek contours. This article describes and illustrates contemporary technology that uses alloplastic implants throughout the face. Three-dimensional changes in facial form and shape using alloplastic augmentation techniques are essential for creating aesthetic beauty and are the "final chapter" of the development of cosmetic facial surgery.

**Barbed Sutures for Aesthetic Facial Plastic Surgery: Indications and Techniques** **451**

Malcolm D. Paul

This article describes the indications and techniques related to the use of barbed sutures in facial aesthetic plastic surgery. The principle applications for barbed sutures in facial aesthetic plastic surgery are those involving lifts of the brow, midface, and the lower face and neck. Usually all three areas require surgical maneuvers to create a harmonious rejuvenation. Regardless of where in the face bidirectional barbed sutures are planned, five essential steps are needed: (1) making the incision or incisions, (2) dissecting soft tissue, (3) proximal anchoring, (4) deploying threads, and (5) molding soft tissue.

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