



Operations That Refresh, Rejuvenate and Improve Facial Appearance

**Written and Illustrated
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Facelift/Necklift

Facelifts reduce the amount of loose tissue and wrinkling on the face and neck. At the Flowers Clinic, we routinely and additionally tighten the deep layers-known as *SMAS* in the cheeks and the platysma muscle in the neck. Many practitioners ignore the support and holding value of these deeper structures, which diminish stress on the skin and give a higher quality of result with better scarring and greater longevity. Often we combine a separate enhancing procedure called the mid cheek lift, done at the level of the bone lining. Facelifts commonly lift both the face and the neck, but modified versions may target only one of those areas. At the Flowers Clinic one or more smaller adjunctive procedures commonly accompany the face lift – boosting the outcome to a higher level of excellence. This includes turning up the corners of the mouths (Anguloplasty), enhancing the lips and lip projection, shortening often the upper lip, resurfacing the lines around the mouth, improving the chin and jaw line, and filling in or even (on occasion) “cutting out” deep creases which angle downward from the nose to just beyond the corners of the mouth. Fat harvested from beneath the chin (or elsewhere) serves as an excellent “filler” for cheeks, groves, and depressions. Other times another suitable filler works best for creases and depressions.

Other adjunctive procedures refresh the eyes, remove bags, restore the youthful eye lift, lift the forehead, remove frown lines, lift or build up the cheek. At the Flowers Clinic the most up-to-date techniques combine with skill, experience, artistry and creativity to give results far better than that anticipated from a mere facelift, no matter how well it is done and well beyond the results. Here at the Flowers clinic we like to prioritize procedures for you and patients often notice the facelift as low on the Flowers clinic list of priorities for you, meaning there are less expensive operations, which are more important for the best outcome. Then, again, a facelift may be first on the list. If elected, it will be done with artistic skill and the benefit of a huge experience with this type of surgery.

With artistry and experience our chief surgeon seeks out the simplest and least expensive operations custom designed to give the most awesome and positive result possible, deleting conserving unnecessary expenditures for operations that offer little to no improvement. All of these extra procedures are in addition or instead of the skin tightening procedure commonly done in the past. This makes the expanded facelift more tedious and time consuming, but also more beneficial and longer lasting. Often our twenty first century expanded version lifts the tissues together with the bone lining over the cheekbone. This is a subperiosteal or mid-face lift.

The facelift is done an incision running just beneath the sideburns, along the edge of the ear, around the earlobe, up the back side of the ear, across to the hairline behind the ear, and then into the hairline behind the ear, across to the hairline behind the ear, and then into the hairline behind the ear, or sometimes down along the hairline, depending on the hair growth pattern. Incisions sometimes extend the scalp after surgery. The only hair shaving is a little path where the “cuts” occur. Most, if not all, of that hairless scalp is removed. In a person who has had previous facelifts, it may be best to put the new scars in front of the hairline. When poorly designed previous facelifts have removed the sideburns, it is desirable to transplant any hair removal into the bald sideburn area, restoring a normal hairline.

We lift the skin and attached tissues off the face and neck through the described incisions, then pull backward and upward, remove excess, and anchor the skin in its new, tighter position. Deep to the skin lift, independent tightening procedures to the deep layers of the face provide additional support. Fat content may also be altered.

It is important to have a good understanding of what facelift can and cannot accomplish. Putting your hands on your cheeks and forcefully pulling back and up makes dramatic changes. This amount of change cannot possibly be reproduced surgically on more than a temporary basis. The body will always loosen tissues until they reach a comfortable level of relaxation. With turning the head and moving the mouth, stretching is inevitable. A more realistic estimation of what is possible on a long-term basis can be simulated by pulling the skin taut, then allowing it to return halfway between the stretched position and a relaxed position. If that amount of improvement seems worthwhile, the facelift is likely to be meaningful on a long-term basis.

We don't really know whether a lift done prior to obvious relaxation does anything significant to defer or postpone loose skin and wrinkle formation. My opinion is that it does not. Therefore, the visible improvement obtained should be sufficient to counterbalance any scars, sideburn modification, or other side effects of surgery. If significant improvement is unlikely, it is best to forgo the operation.

There are other misconceptions about what a facelift can accomplish. Although it certainly can roll years back, it cannot stop the aging process. How long the effects of facelift endure depends on the rate at which any given person's skin is aging and the associated procedures chosen. Within a given person, the rate of aging may be faster or slower at certain times without obvious reasons. But so far, skin always continues to age. Because of this, many who enjoy the benefits of one facelift often return for a second one. No limit exists on the number of times such an operation is possible. Such lifts, however, should be strategically placed for optimal benefit and minimal inconvenience, risk, and expense.

Another thing to clearly understand is that facelift itself does not remove the deeply etched lines in the face, especially the ones on the forehead, cheeks and lower lids, extending onto the cheeks. Nor does it totally eliminate the crease at the junction of the mouth region and the cheek. It does nothing for vertical lines radiating out from the mouth. These deeply etched lines, together with facial blemishes, can, however, be reduced and improved by tightening the lateral tissues near the eyes, or by excision, abrasion, chemical peel, laser "resurfacing" and occasionally by injections or the placement of Gortex threads within the deep wrinkles. Sometimes lipo-injections of your own fat are additionally helpful. All of these possibilities are discussed under "Associated Operations". Furthermore, a facelift does not change the basic texture of leathery or weather-beaten skin. Nor does it change or eliminate blemishes and pigmented areas. Other types of treatment help in these areas.

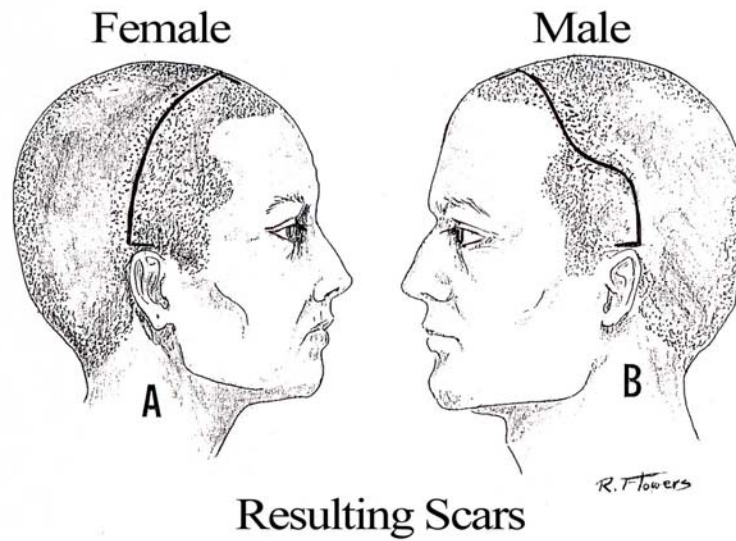
Heavy, chubby, well-padded, or outright fat cheeks lend themselves less to good results from face-lifting than do less unwieldy tissues. It is true that fat can be removed in conjunction with a facelift, but it is better to diet away as much of the excess as possible prior to surgery. Then you will be rewarded more generously for your inconvenience and expense. It is inadvisable to lose a lot of weight after a facelift for it encourages and speeds the process of skin relaxation and sagging. The following operations often accompany facelift at the same time or in close proximity. They also may be done independently.

Corono-Canthopexy

This operation is actually a combination of two well-established procedures, done with great frequency in my clinic over the last 25 years. Together they are commonly the most refreshing and rejuvenating operation in plastic surgery. Often they will be recommended to accompany facelift, or they may be recommended instead of facelift. The cleaning up and youthening of the eye region commonly sought in eyelid surgery (blepharoplasty) is much more likely to be found in this combination, especially when combined with mid cheek lift (see page 15), and lower lid surgery. Frequently, the coronal-canthopexy is required as a prerequisite to blepharoplasty in order to secure the brow in proper position, and provide tone and lift to the often atonic and drooping lower lid. Discussion of the two key components – coronal lift and canthopexy – follows in the next several sections, as does a discussion of mid cheek lifting. The reason coronal lift and canthopexy accompany each other is that lifting the lower lid (canthopexy) causes crowding when the brow is not lifted. Secondly, the coronal gives beautiful access to the rim of the eye socket in a way that facilitates the best possible lift to the outer corner of the eye and to lower lid correction, which of course is the part known as canthopexy. Canthopexy requires only a short incision beneath the outer corner of the eye. The incision is longer when combined with lower lid blepharoplasty. The “coronal” part requires a larger incision. Please read on.

Coronal Scars

Significant areas of hair loss, skin loss, or numbness are possible complications, but have not occurred (at the time of this re-editing in 2006) to any significant degree in any patient operated on at this facility or elsewhere by Dr. Flowers. Scars have been markedly improved by moving them posteriorly as mentioned, and shown earlier.



Periosteal Flaps

A wonderful aid in correcting very low positioned eyebrows as well as marked brow asymmetry is the periosteal flap operation. A small piece of bone lining is drawn into an incision within the substance of the eyebrow. This allows adjustment of the eyebrow level anytime within two weeks after surgery. Rarely are the scars detectable, but once in a while a little indentation may necessitate a simple three to five minute minor adjustment.

The Corrugator Frown

The “corrugator” frown and associated deep furrows between the eyes require special handling. Sometimes the furrowed skin lends itself to direct excision, but the preferred method is to surgically remove the corrugator muscles, which cause the frown, leaving no scar at all on the forehead. Muscle removal is far better in all except some patients prefer to have Botulism toxin (Botox), injected into the muscles for the temporary way paralyze the muscles for approximately six months. We offer Botox injections at The Flowers Clinic, but we believe that muscle excision is a more permanent solution. The only scars present are the ones from the coronal lift, i.e., within the hairline or the modified scar location for male type balding. With direct incision cuts may be located at the site of the frown “grooves”.

Eyelid incisions are occasionally used to attempt removal of frown muscles. This is much less effective than the coronal incision. Frown muscles are routinely removed when performing a coronal. Total frown muscle removal is not always desirable. Sometimes a tiny crease remains between the brows, as does some ability to generate a frown. Although the removal of these muscles is typically helpful, it is not a guarantee that very deep frown lines will totally and absolutely disappear. (The frown lines always fade as the activity of the muscle and the frown definitively decreases. Deeper creases may take months to years to maximally disappear.)

Nerves supplying sensation to the scalp and forehead are in frequently injured in the process of removing these muscles. This means that in our experience at The Flowers Clinic there may be temporary, but rarely permanent, numbness on a portion of the forehead and scalp. There is commonly some early numbness beneath the skin deep in the forehead at the level of the bone lining, and in a small area right at the top of the head.

Bone Contouring Via Coronal Incision

Sometimes the bony eye socket encroaches on the upper eyelid in the outer aspect. This excess as well as that which sometimes causes forward protrusion of some orbital rims is easily reduced through the open wound approach.

Canthopexy

When lower lids are lax having poor tone and support (as it usually is in people requesting eyelid surgery) A canthopexy or canthoplasty is advisable. Lid strength and tone must be restored prior to doing a lower blepharoplasty. This is to counteract the tendency of the lids to pull down after surgery.

Commonly, tiny drill holes are made in the bony rim of the eye socket to tighten eyelid support. Other times, the supporting sutures are secured to the lining of the bone only. Both types of support restrict eye opening for one to several days, cause extra swelling, and give the eyes an exaggerated tilt for a period of time after surgery. Asymmetry related to the canthopexy is not uncommon in the early weeks after surgery. Yet, it is unlikely for inequality to persist. Should it do so, a surgical modification designed to restore symmetry would be in order. Even maximum attentiveness to detail at the time of surgery does not prevent asymmetry from occurring in the usual patient. It may even be anticipated when one lid is corrected more by design than the other side, as in repairs for pre-existing deformities. The droopier side must have “extra” overcorrection to end up with maximum symmetry and normalcy in the end.

Realize also that canthopexy can interfere with normal full forceful closure of the eyelids at sleep during the early post-op phase. Because of this, ointments must be used at bedtime, at least for the first few weeks after surgery. If dryness or small surface defects develop, seek prompt medical or ophthalmological attention. Certainly let your surgeon know. The symptoms of this are pain, light sensitivity, and lots of tearing.

Blepharoplasty

Often some type of eyelid surgery (blepharoplasty) accompanies the facelift operation. Most commonly it involves either removing excess skin from the upper eyelids or lower eyelids (together with any superfluous muscle). Instead of skin removal, the lid crease may be deepened – conserving the skin while lifting the lid fold. This involves restoring and tightening connections between the eyelid skin and the eye opening muscles, which have stretched out over the years. Protruding fat from the upper and lower lids often requires either removal or restraining. On the lower eyelid, we lift up skin or/and muscle, re-drape it, and trim the excess. This almost always requires a canthopexy to restore lower eyelid tone and support, thereby preventing deformity.

Infrequently, the lower lid scars may be placed at the junction of the eyelid and cheek skin. This varies in accordance with the amount of excess skin to be removed and the tone of the lid. When there is no excess skin to remove, only protruding fat, the best location for the incision is inside

Usual location of scars

In Caucasians, as well as most Orientals over 30, the most effective operation commonly demands an accompanying forehead lift, or creation (or recreation) of neat and precise upper lids folds by anchoring eyelid skin to deeper structures. This method gives a crisp, more stylized and deeper set lid fold, which remains neat and youthful longer than the traditional upper lid operation. The seventy-five-year-old operation, still performed by the majority of plastic surgeons, involves only removal of skin and some muscle. It produces less swelling and bruising than the newer and more difficult operation. The significant difference is the quality of long-term results. Though the newer one may make you look worse early after surgery, try to realize that this is necessary for long-term benefits. The reason most surgeons continue the old operation is their unfamiliarity with the advanced, more time consuming updated techniques. However, in the unusual patient, a small excision sometimes is enough for a good result. That would be in the group of people who have satisfactory resting position of the brows – without flexing the forehead muscle.

More commonly the improvement sought after in both upper and lower lids best occurs with the coronocanthopexy, a combination of forehead – brow elevation and lower lid–outer–corner-of-the-eye lifting. Many patients require this and together with the eyelid operations. The better surgeons are doing less and less eyelid surgery without a brow positioning operation and some type of canthopexy for lower lid support.

All of the many different eyelid operations vary in length of operating time and complexity. One factor responsible is the variation in amount of bulging fat. Sometimes we remove it. Other times we contain it by tightening its restraining wall. Bruising and swelling are in proportion to work done, accompanying adjunctive procedures, quantity of fat removed, predisposition to bruising, and proper dietary preparations for surgery. Bruising is commonly worse when the incision is inside of the lower eyelid rather than on the skin.

Eyelid operations are often independent procedures. Occasionally just the upper lids or only the lower lids need surgery. Sometimes only fat is removed. Commonly a forehead (coronal lift or a frontal lift) or even a simple brow lift (the removal of forehead skin at the margin of the brow or higher on the forehead) or a periosteal flap via an upper lid skin incision to raise and reposition the eyebrows suffices and does away with the need for upper lid surgery. A combination operation mentioned earlier and recommended to enhance and improve the overall outcome is the corono-canthopexy, frontal lift combined with canthopexy (a lower lid and outer corner lift which restores tone, tilt, and a youthful almond shape to the lower lids and aperture). Often the two-in-one procedure makes skin removal and/or invagination unnecessary – and provides beautiful restoration by itself, something blepharoplasty rarely does unless corono-canthopexy accompanies.

Tear Trough Implants - (Suborbital Malar Implants)

Another increasingly common combined operation is inserting “suborbital malar” or “tear trough” implants to fill up the deep grooves beneath the eyes, which commonly angle diagonally down and across the cheek. This bothersome groove will not be solved by a blepharoplasty or eyelid “lift” or “tuck” operation alone. Neither is it likely to be remedied by fat relocation or grafting.

Possible Problems Associated with Eyelid Surgery

Although good results are hoped for, some inconveniences occur as well as the occasional but infrequent complication. Other problems have been reported after operations around the eyes that we have never experienced, such as loss of vision. Excessive swelling, tearing, irritation and dryness, and failure of the lids to close completely are common symptoms early after surgery, but usually disappear as the post operative period progresses. In unusual situations such a problem might persist or worsen. Problems are of course more common in patients who underwent previous lid surgery, especially when too much skin was removed. We have many such patients referred for correction. Usually we can help a lot but after care of the eye can be especially difficult in these patients requiring frequent rechecks and ophthalmological (eye specialist) support.

Two weeks or more must pass for swelling of the conjunctiva or lining of the eye to totally disappear. In extensive surgery it sometimes persists longer. Sometimes corneal surface defects result for which ophthalmological consultation is maybe required. The use of bedtime ointment (as directed) and daytime drops is important to help prevent this from happening.

Some downward pull of the lower lids is to be expected during the first six to eight weeks after surgery, occasionally exposing more “eye-white” than before the operation. This is preventable in all except the rarest instances by a good canthopexy or lid support procedure, a proper design for skin removal and removal of any collected blood within the incision. Time, assisted by appropriate massage, usually remedies any downward pull. Rarely, even with canthopexy, the lower lids may be permanently lowered after surgery. A lower posture is a common occurrence when weak lids are not supported with canthopexy, but our routine use of canthopexy support seems to have totally solved this problem, making such an occurrence a very rare happening in this facility. When blood accumulation and/or excessive bruising are present in the lower lids, a highly abnormal amount of scarring with downward pull of the lids may occur. Proper design for skin removal combined with support of weak or drooping lower lids with canthopexy (and blood removal when present) prevents this complication in all but the most unusual situation. Whenever the condition does occur know that it improves with time and massage. In extremely rare instances, additional surgery may be necessary to improve a persisting problem from a complication.

A bizarre, poorly understood, extremely rare occurrence after some lid surgery is visual deterioration and/or blindness. The causes are often unclear, but we feel you should know that such reports exist in medical literature. In the thousands of eyelid operations done at The Flowers Clinic, prior to the 2006 writing of this procedure, no visual loss or deterioration ever occurred. Human aging is always associated with dramatic reduction in tear production. This results in progressive dry eye symptoms, worse in some than in others. Prominent eyes and eyes with more white showing inevitably have more dry eye symptoms and pathology than those without. Surgery can aggravate preexisting dry eyes and can bring to the “surface” a dry eye condition that had not previously progressed to the point of being symptomatic.

Laser “Resurfacing”

Laser resurfacing of eyelids – is helpful, as are chemical peels and dermabrasion. Blemishes of the skin also respond favorably in selected patients. But laser, like chemical peel and every other type of burn shortens the skin on the lower lids and commonly results in a lowered posture of the lower lids – sometimes severe. It may so shorten the upper lids that closure is impossible, especially on eyelids that have been previously operated. Know also that areas treated with laser have prolonged periods of discoloration and may be up permanently darker or lighter than adjacent skin, depending on skin type.

Coronal Lift, Brow lift, or Forehead Lift

Commonly there is so much scalp and forehead relaxation that the eyebrow either hangs over the bony rim of the eye socket or is kept from doing so by constant contraction of forehead muscles. Sometimes the brow’s lower position is congenital or developmental. This makes additional stretching that comes with aging even more problematic. Restoring the eyebrow to a normal location and contour without having to contract the forehead muscles is critical to cleaning up the upper lid and restoring a fresh and youthful look to the upper part of the face. When upper eyelid skin is removed in patients who continuously raise their brows (in order to have unobstructed comfortable vision), the eyebrows will invariably drop to a lower level after surgery.

The reason for this is that the overworked forehead muscle from is able to relax at least partially, which drops the brow, but still allows the patient to see – so it does just that. This results in a lower position of the eyebrow and an exaggeration of the frown between the brows. This frown had been lessened or eliminated by the forehead muscle pulling on the frown as it raises the eyebrow. The result of the dropped brow and more prominent “frown” is an older more tired appearance with the patient looking angry as well. It is to prevent this sort of outcome of this “lift” is a brow which may not be positioned any higher after surgery, only shaped nicer – with the devastating post-blepharoplasty “drop” having been checked or prevented (at the time that the frown is reduced or eliminated).

Most of our brow lifts occur through the coronal approach across the top of the head or a modification thereof. The common modification is for male type balding (which also occurs in some women). Other brow lift operations involve hair margin incisions or removal of skin from just above the eyebrow, leaving a scar reaching out toward the temple hair. These latter techniques are rare at Plastic Surgery Center of the Pacific, but common elsewhere. Some surgeons are exploring the effectiveness of an endoscopic approach to brow lifting. So far this operation has not measured up to what we routinely accomplish with the traditional operation. Complications are more common with endoscopic.

Sometimes deep creases running across the forehead suggest a mid-forehead location for scars, but the transverse lines in which the scars are “hidden” disappear when that person no longer has to flex the forehead muscles for unobstructed vision. The relaxed forehead leaves the mid forehead scar totally exposed and undisguised.

You are not required to accept these helpful brow elevation procedures. You should know however, that the most common error in surgery is the attempt to solve a forehead-brow problem by removing skin from the eyelids. It simply does not work and serves only to worsen appearance. Please realize that operations are recommended only when it is felt that they are necessary in order to have the result you desire.

A common forehead lift variation (Mentioned above adjusts to the patient with a balding pattern – where the hair recedes in the temples. This condition is more frequent in men but also occurs in women. For these persons incisions are well behind the hair centrally, at the hair margin in the temple receding area and well back in to hair again in the lateral forehead and above ears. This actually decreases the height of the balding temple and forehead skin. Another option is transplanting some of the individuals hair removed to the area in front of the temple hair margin scar. This shortens the balding area even more.

Careful considerations of benefits are always weighed against the presence of visible scars. Coronal lift scars are carefully concealed by hair, but forehead incisions leave the patient with permanent scars in a prominent location. Such prominent scars often pose a problem, even with makeup, for many months after surgery – sometimes permanently – especially in sebaceous or porous skin. That is why these suboptimal incisions are elected infrequently at this facility.

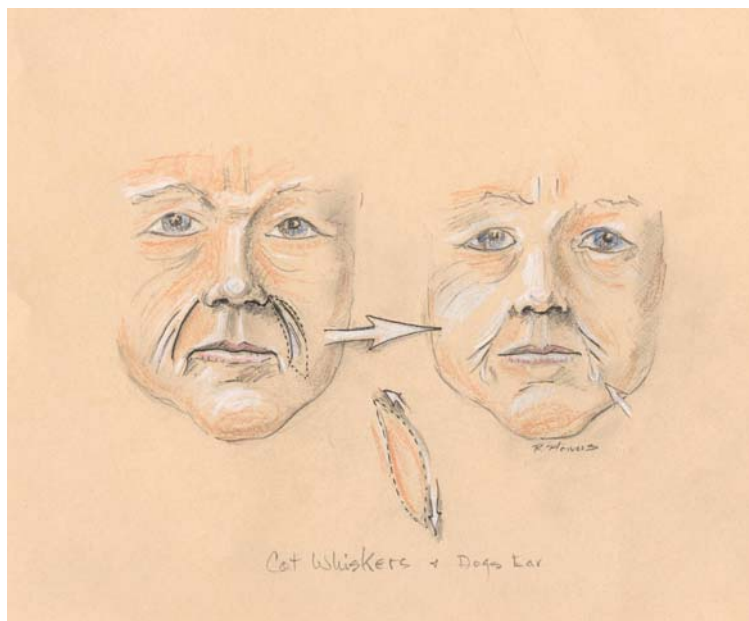
Remember, scars vary greatly from person to person, and scars associated with the brow lift may be more bothersome to some people than others. Our newer coronal type scars are rarely visible since they were moved backwards to the point where all the hair grows in the same direction. Scars on the open forehead are generally more difficult to conceal than the ones associated with a facelift, coronal, or a blepharoplasty, especially in the early post-operative period.

Endoscopic Surgery to the forehead and to the face

A number of doctors are pushing forehead surgery using long “endoscopes” and other very expensive and cumbersome equipment. A few have been able to show early good results. In general, the final outcome is far less desirable than the operation preferred at Plastic Surgery Center of the Pacific. Our open technique has less complications and a far better and longer lasting final appearance.

Nasolabial Fold Resection

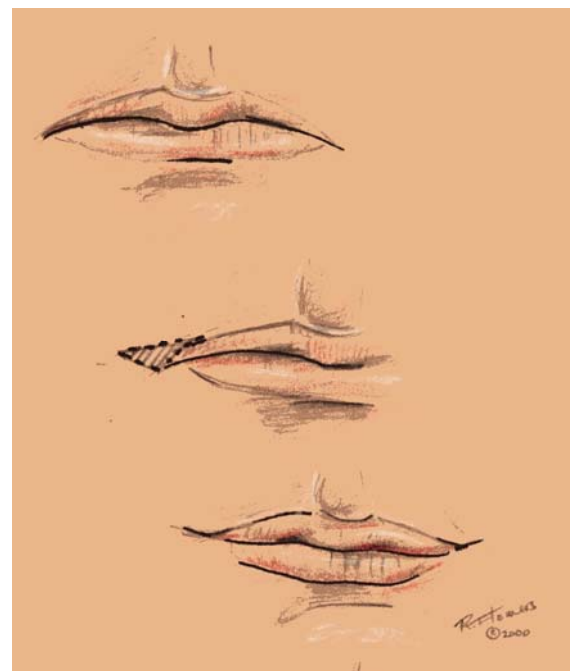
The cheek crease, sometimes with fatty overhang which goes from outside the corner of the mouth to the side of the nose is often so prominent and deep that it resists adequate improvement with facelift alone – even with currently popular deep plane lifts, that we do routinely. We therefore choose for those patients’ skin, or/and fat direct excisions in the region of the crease. This does leave a scar but those scars are usually minimally apparent and disappear into a natural smile line. Sometimes the required correction makes the scar extend beyond the natural smile line. Sometimes the required correction makes the scar extend beyond the natural crease line. We will show patients the extent of theirs before surgery. Whether short or long; nasolabial excisions do wonders in correcting the down-turned mouth, and sometimes can substitute for facelift. Occasionally these nasolabial excisions are combined with a facelift. (The scars commonly need concealing make-up from the third to the tenth week after surgery.) This problematic period of thickened, tightened scar can be reduced or eliminated if you follow the exercises prescribed for the early weeks after surgery.



Lip Enhancement: creates fuller lips (the vermillion or pink port) and malses the margin project (“pucker”) in a more youthful fashion.

Lips diminish in size and fullness as we age. Restoring them to their youthful fullness is a major part of “rejuvenation” surgery. It also softens a severe or “hard,” appearance. It adds “good looks” to a man and beauty to a woman. One’s own fat, Hydroxyappetite, Gortex, silicone, alloderm, and Bioplastique all offer help. My preference is a person’s own fat or one of the newer tissue fillers injected into the lips, but I occasionally select other methods, or use them to supplement. Filling out the lips helps remove any wrinkles that radiate out from their margin.

Valentine Anguloplasty



This is a tiny operation at the far lateral extent of the upper lip, near the *angle* of the mouth that lifts the downward turn at the mouth's outer corners. This does wonders to correct that unfortunate grumpy – saddened look that commonly appears in the late twenties or early thirties and gets worse with progressing years. Its name is taken from the small lopsided valentine excision shown in the illustration. Sometimes a little fat removal or fat injections, just beneath the corner, are necessary for the best result. Occasionally, an additional excision accompanies running up toward the side of the nose within the natural groove. It is common for one or more other small procedures to accompany valentine anguloplasty such as injection of fat or some other type filler into the lip and/or lip line, peel or resurfacing of the lip, chin augmentation, or shortening the distance between the upper lip and the bottom of the nose.

Lip Wrinkle Resurfacing: Reduces or eliminates lip wrinkles. Length of procedure: 10-30 minutes. What to expect: tender oozy lips for 2 days, then “crusty” lips for the remainder of the 1st week. All crust are usually off by the 8th or 9th day. Recovery: back to full socialization by the 10th to 14th day. Lips may be pink for several weeks afterwards, requiring coverup makeup.

Lines radiating out from the lips suggest an aging face. It is important to treat these lines for maximal facial rejuvenation. Our favorite method, and the one most used is the chemical peel, which creates a partial thickness burn. Some lips benefit nicely from laser treatment but the recovery is longer, and the result seldom as good. Another way is to abrade or sand the area with a high-speed rotary diamond cylinder. Sometimes a combined peeling/Sanding approach – possibly with laser later on – is also effective. All methods make the lips raw and oozy after which a crust forms and remains from 7 to 9 days. With laser, the discoloration can be prolonged lasting up to three months or more. Sometimes more than one abrasion, peel, or laser treatment is necessary for maximal improvement. There is no limitation on the number of treatments. Each one usually improves the condition—sometimes more than expected and sometimes less. Often one treatment totally removes the wrinkles.

The methods that injure the skin deep enough to eliminate deep wrinkles, results in some pigment disruption. In spite of this, most all patients find the result well worth the loss – or increase – in skin pigmentation.

Another method of treatment is injection of fat or some other appropriate filler into these tiny lines, or into individual wrinkles. Gortex gets “mixed reviews” for improvement. Collagen treatment is vastly overrated. The big problem with collagen is lack of permanency and the need for repeated treatments. Another problem is occasional allergic reactions. Fat injection, threading Gortex suture or other tissue fillers in the wrinkles offer more probability of long-term success than collagen. Silicone for injection is no longer DEA approved for injection in the U.S.A.

Full Facial Peel and/or Abrasion and Minor or Maintenance Peels

Subsequent to your facelift, it may be beneficial to undergo a chemical peel or dermabrasion or laser resurfacing of the entire face. Focused light or laser treatment to blemishes can be extremely helpful. Selected techniques can deal effectively with finely etched lines, small blemishes, and certain pigmentation irregularities; all result in the removal of outer skin layers. Retin-A and sometimes skin bleaches are often recommended to precede the treatment. Commonly, the treated areas are permanently lighter in color than untreated surrounding areas except in pigmentation-prone patients. These people are helped immensely by bleaches used before and after the treatment. Often the dark pigmentation doesn't occur. Other possible complications are scarring, keloid formation, and thinning of the skin that allows tiny vessels to show through.

The peel and the abrasion treatments require one to two weeks for crusts to come off. Then for an additional period of two to three weeks, the skin is pink and swollen. Pigmentation irregularities usually diminish over the ensuing months. Sun exposure should be avoided for six months after peels and abrasions except where only localized areas such as the lips are treated. Sun block with a Sun Protection Factor (SPF) of 15 or higher is helpful and strongly recommended anytime you are out of doors.

Laser “resurfacing” with newer type instruments has gained popularity as a method of treatment. Newer instruments are constantly appearing on the market.

Fat Removal

Removal of fat can be very helpful in conjunction with other facial surgery to improve appearance in the neck, beneath the chin and/or jaw, in the jowl region, in the fatty folds extending from the side of the nose down the cheeks just beyond the corners of the mouth (nasolabial folds) and in the folds at the outer corners of the mouth (marionette folds), which add to a down-turned, saddened appearance. For facial fat and jowls, no visible incisions are required. For the area beneath the chin and jaw, one tiny incision is necessary. This fat removal increases surgery time and raises to a minimal degree the risks of nerve injury and surface irregularities, but significantly improves the result. It is possible to injure the motor to the lower lip causing paralysis. As of 2005, we have not experienced any such complication at The Flowers Clinic.

Fat Pads of Bichat

Deep within the cheeks is a sizable accumulation of fat – named for Dr. Bichat. Its reduction gives definition to facial features and emphasizes existing cheekbones often obscured by excessive “baby fat” or “chubby” cheeks. Tiny incisions in the cheek opposite the second molar allow removal of this fat. It is important to be conservative in this removal in order to prevent deeply hollowed cheeks later in life.

Genioplasty (Chin Augmentation)

An important effect of the facelift is an improvement of the jaw line and profile. When the chin is weak, the benefit of the facelift is minimized. With the weak chin the lower facial skin is not filled out and there is an exaggerated abundance of loose skin and subcutaneous fat. To overcome this, a chin enhancement (genioplasty) is extremely effective. In the simplest and most common technique a custom contoured piece of silicone is placed in front of the anterior portion of the jawbone. The scar to accomplish this is usually inside the mouth between the lip and lower teeth.

Complication rates of this operation are extremely low in our hands. The possibilities, however, include infection (which would necessitate removal), possible late extrusion, and erosion of the bony surface of the mandible, numbness of the lower lip, weakness of the lip muscles, asymmetry, and pain. In the many, many cases done here, we have only one implant removed because of infection. It was replaced several months later and continues to do well many years later. Many hundreds of these operations have been done at The Flowers Clinic over the last 25 years without complications of any sort.

Hair Transplant

Often there is some type of balding in men but also in 15 to 20% of women. If forehead lifting involves some scalp removal, the hair can of course be replaced with micrografts – one or two follicles at a time. Of course hair transplants are also possible without coronal lifting type procedures – often in combination with other type operations. Two special situations calling for hair transplants are described on page 8. Please refer to that section.

Rhinoplasty

Often some modification of the nose helps achieve the end goal of facial rejuvenation. This may be elevation of the tip, opening of the angle between the nose and the upper lip with a small implant or a slight hump removal. If the nose operation is likely to be complex, especially if difficult internal work is necessary, separate surgery may be required. Elevating the tip of the nose, opening the angle between nose and lip, eliminating a hump or refining a thick or somewhat bulbous tip are sometimes the single most important step in rejuvenating a face. If done as a separated operation, it may precede or follow your facelift. At the same time it allows bruising and healing phases to be superimposed – thereby shortening the total convalescence of two separate operations. A splint may remain on the nose for one to five days – rarely more.

In nose surgery, the planned result anticipates normal tissue reactions and healing processes. Deviation from the expected course of healing can, of course, interfere with desired results. This means that desired and anticipated results can't be guaranteed. The actual surgery is not painful, nor has pain been reported after surgery by our operated patients, except when the nose is squeezed, or otherwise challenged.

SMAS Repair & Platysmaplasty

Once the skin of the face and neck is elevated, it is possible to lift and tighten the SMAS, which is the deep support system in the cheeks. This repair is done in continuity with the repair of sagging neck muscles. These two adjunctive procedures are routine companions to first time facelifts at The Flowers Clinic. The muscle fibers are tightened and redirected to help create, rather than work against, a nice, clean neckline.

Mid Cheek Lift (Subperiosteal)

Often a deep level lift in the mid cheek region is chosen instead of, or in addition to, the more traditional facelift. This is commonly done in association with a lower lid lifting procedure, including canthopexy (corner lift or tightening). This operation is very effective in rejuvenating the sagging mid cheek – lower eyelid region. It involves lifting the cheek tissues together with the lining of the bone (periosteum), and then advancing it upwards and outwards, securing it with a suture into the bone, holding it in position until the periosteum and bone reunite. This adds fullness to the cheek region and does a lot more to correct a tired, aging look than is achievable with a facelift.

Early on after surgery there is commonly a visible dimple in the tuft of the cheek caused by the absorbable suture securing the lifted cheek mass to the bone. This resolves spontaneously in most all instances.

Ear Lobe Reduction & Ear Set Backs

Large and/or wrinkly ear lobules are often reduced at the time of facelift surgery. Repairs of prominent ears that “just out” can occur with facelift, but is best done as a separate surgical event. It can safely accompany other adjunctive procedures.

Cheek or Malar Implants

When the cheek mound is deficient, it is possible to place silicone implants against the bone increasing the prominence of the “cheek-bones”. The use of a solid silicone implant is far superior to most other types of tissue augmentation – such as injection of fat or the many other materials in our opinion and experience currently available as soft tissue substitute. A modified cheek implant for deep grooves beneath the eyes is also extremely successful. (See Tear Trough or suborbital malar implant on page.) Incisions beneath the eyelashes, incisions inside the eyelid, and incisions within the mouth give access for implant placement. (Also see section on complications, especially paragraph 15.)

General Statement about Complications

It should be appreciated that all anesthesia and surgery represents some risk to life, health, and well-being. Reactions to medications or anesthetics could have grave consequences. However for anyone in reasonably good health, the risk is minimal. It is, nevertheless, impossible to assure any patient that complication, either of minimal or of major significance, will not occur. We can assure you that your surgery will be expertly carried out and that our best effort will be made to provide the highest level of outpatient care possible for you.

Although the incidence of complications at this facility has been extremely low, there remains the remote possibility of a myriad of complications all of which cannot possibly be given here. Many have already been mentioned – especially with the adjunctive procedures. The following are specifically related to the face/neck lift operation proper and to the use of implants. We have tried to include the ones which we know to have occurred (most at facilities other than ours) and which would be most significant.

1) Skin loss: When the skin is lifted and stretched, as in a facelift, parts of it may fail to survive. It is not uncommon to have a tiny area of skin loss behind the ear where the skin is thin and remote from its source of blood supply. Indeed it has been said by many who teach in plastic surgery that unless a surgeon has small amount of skin loss from time to time, the skin is not being pulled sufficiently tight. What such loss means to a patient is that incisions do not heal as quickly as normal and also that there can be a resulting scar which may be more prominent than normally expected.

Larger areas of skin loss can occur, but very infrequently, leaving encrusted areas that ultimately become ulcerated. Such areas prolong the healing process and may also lead to additional scarring. Cases have been reported where such ulceration extends onto the neck or cheek, thereby requiring treatment with skin grafts. Additional scarring and possible deformity would result in these rare situations. Subsequent revision can minimize such deformities if it occurs.

It is essential that a person having a facelift stop smoking at least one week before and for at least two weeks after surgery to prevent skin loss, for we know now that most all skin loss patients are smokers. We also know smokers to have an incidence of skin loss twenty times greater than non-smokers. The longer before surgery that you stop, the better the chances for a perfect uncomplicated convalescence! You must not resume until at least three weeks after your facelift.

2) Nerve injury: Face-lifting separates the skin from the underlying nerves. This produces numbness of the cheeks, which persists for three to six months before the return of normal sensation. Rarely it may take a year or more for sensation to come back to normal in the cheeks. Extremely unusual cases have been reported where normal sensation never totally returned.

Men are often annoyed by loss or alteration of sensation in the post-operative period because of their need to shave. A more significant type of nerve injury has occurred on rare occasions. In this type, there may be temporary or permanent loss of function (paralysis) of the muscles responsible for facial expression. Such injury would cause significant facial asymmetry – especially on smiling. The forehead, the upper lip, and the lower lip are areas, which could be involved, significantly altering the smile or interfering with the raised brow and blink reflex on the affected side. These possibilities exist after such operations as coronal lifts, mid-cheek lifts, implants to cheeks and chin, liposuction to the face and neck, and removal of the cheek fat pads. They are acknowledged throughout our specialty as possibilities.

3) Poor scars: Scarring varies from person to person even when identical techniques are used. All scars go through a period of being red and thickened. Sometimes this lasts many months or years. Rarely, keloid develops (permanently thick, raised, red scars which may continue to grow). Normal scars go through the red phase and then become minimally apparent. Know that your incisions will be placed in the most optimal areas for both concealment and favorable scar formation, and that they will be handled by the most modern techniques known to produce the best scars possible. Superficial skin shedding after face lifting can cause pigmentation changes, especially behind the ear, which, like scars, can also be undesirable. Typically – this causes a lighter than normal area. In dark skin people the pigmentation may be increased, making the skin darker.

4) Hair loss: Tightness of the scalp may lead to exaggerated hair turnover in the early healing phase. Expect this to return to normal after the skin relaxes a bit. Some permanent loss, especially around the scar, is a rare companion of the operation and would probably represent an area of infection. Rarely small or larger areas of alopecia occur resembling that which dermatologists see as a side effect of stress or other causes.

Sideburns are commonly raised or eliminated by the lifting process, but not in our version. By putting the scar beneath the sideburns, they are preserved and this “telltale” sign of a “facelift” is avoided. People with very long sideburns do not require these special incisions. Theirs will not be eliminated by the lifting process. But subsequent facelifts would best be done in front of the sideburns and hair margin.

5) The ears: The ears occupy center-stage in the lifting process and may be slightly altered in their position relative to other facial structures. The ear lobule is especially vulnerable. Every effort will be made to keep the ears normal in appearance, although some alteration may occur. Sometimes there is a little downward traction on the ear lobule. At our clinic we are very attentive to factors that normally prevent this from occurring. Indeed, we commonly correct pulled down ear lobes from surgery done somewhere else, but rarely our own.

6) Facial asymmetry: Very few faces are symmetrical before surgery. After surgery, the typical patient scrutinizes appearance in greater detail than before surgery, noticing asymmetries that were unnoticed before surgery. It is very unusual for patients to have any true increase in asymmetry as a result of face lifting, but it is a possibility.

7) Pain: Pain is extremely unusual among our patients after face lifting, but some may occur. If ear pain beneath the bandage is more than a slight discomfort, a bandage change may be indicated. Occasionally areas tender to touch in the face or neck stay that way for some time after surgery. Most patients feel only pressure and tightness after face lifting and the adjunctive companion surgery. This is also true with most of the adjunctive procedures. It is only with chin augmentation that we occasionally have the complaint of “pain”. This is short lasting and only occurs in one out of fifteen.

One type of pain can be troublesome – and sometimes long lasting. This occurs after a nerve in the neck gets injured. This rarely is a problem.

8) Infection. Fortunately infection is a rare complication, but when it happens it can get serious and could cause skin loss, scarring, and hair loss. Antibiotics are prescribed prophylactically to keep the risk of infection as low as possible. Thorough hair cleansing before surgery helps prevent infection. Plan on a vigorous hair shampoo the night before and the morning of surgery – before you come to the clinic.

9) Hematoma. Bleeding beneath the skin flaps in the early hours or days after surgery can pose a problem and may require a return trip to the operating room. It can cause extreme and/or prolonged bruising and could set the stage for skin loss. Small accumulations of blood in the cheeks or neck can cause areas of post-operative lumpiness, which may persist for a number of months. Bleeding is more likely in patients with high blood pressure, or patients who took aspirin or other “forbidden” products before surgery.

10) Suture extrusion. Occasionally buried sutures work their way to the skin surface and require removal, normally they dissolve before this can happen. This is an occasional inconvenience, which has no other significance.

11) Facelifts in males require relocating hair-bearing skin to normally hairless areas, like in back of, below, and just in front of the ear lobe. Hairs in these areas become a little more challenging to shave than the usual areas. We minimize this problem by trimming off the hair “bulbs” from underneath. Electrolysis can remove any remaining offensive hair follicles that remain.

Operations in beard-bearing areas produce incisions, which often get “oozy” because of the chemical irritation from the oil glands that lubricate the hair follicles. This is not infection, but may look like it, and may also result in less optimal wound healing and scar formation than in normal or non-hairy bearing skin. The same may be said for incisions in acne-prone or acne-scarred skin. Skin excisions in areas of thick oily skin typically result in less than hoped for quality to the scars.

12) Paresthesia. Unusual sensations in the cheeks and forehead are common during the healing period a feeling returns. This is similar to what we experience when a foot or a leg goes to sleep and starts to wake up.

13) Tightness. The amount of tightening accomplished with face-lifting surgery sometimes makes it a little bit of a “struggle” to turn the head side to side during the first few months after a facelift. Relaxation is inevitable.

14) Rapid skin relaxation. Sometimes the rate of lift relaxation after an operation is surprisingly rapid. This does not mean that something went wrong with surgery or that it was done poorly. Such failure of long-term good result in heavy or obsess faces is common. It is much less likely in thin faces. Even then it does not mean something was deficient from the operation. It represents different characteristics of different people. Rapid relaxation is more prone to occur in people with exceptionally long jaws, or with lots of sun exposure. It is most common in smokers, heavy drinkers and in people with a lot of stress. People do age at different rates and even that varies during different periods within one person's life span.

15) Facial implants and grafts. Both foreign material implant and grafts of your own cartilage, bone, and soft tissue have the capability of becoming infected. Signs are increasing swelling, redness, pain, and increased heat. An infected implant usually requires prompt removal, allowing time for healing after which the implant can be replaced. If infection goes untreated the implant can work its way through the skin and leave scarring. Implant and/or graft placement can result in injury to nerves supplying sensation or injury to nerves responsible for muscle movement. Rarely do our implants displace and it is hardly ever that their edges are visible. Forehead implants have greater detectability than other implants used about the head and face. Immune disorder caused by solid implants probably doesn't exist, but nevertheless we mention it as a "possibility". At this writing, there has been no documentation of any connection between a solid implant and immune disorder. Our infection rate for implants (at the time of writing) is approximately one per thousand. Infection rates using your own tissue are somewhat higher but still very low.

About the Surgery

Surgery usually involves a general anesthetic and local anesthesia, which is used to minimize the amount of general anesthesia necessary. You will be unaware of any discomfort during the operation. In most instances a skilled anesthesia professional is on board to assist in making your operation maximally safe and maximally comfortable. Short simple operations, your surgeon and nursing staff may administer the medications.

Preparing for Surgery

It is important for you to be in the best possible physical and psychological condition for your surgical adventure. Four weeks prior to surgery, discontinue the use of all aspirin-containing medication as well as any medication containing ibuprofen. No other anti-inflammatory agent should be taken without your surgeon's specific approval. Also stop vitamin E. Multi-vitamins should be stopped well in advance of the operation to counteract extra blood vessels stimulated by vitamin B complex. Also most "multi-vitamins" contain vitamin E. Black fungus and black or shitake mushrooms must not be eaten within two weeks pre- and two weeks post-operatively. Stop taking all herbal preparations, shark cartilage, etc... and other health supplements or naturopathic remedies. Take no "over-the-counter" medication or cold preparations without getting the pharmacist to assure you it contains no aspirin or ibuprofen. Most of the substances listed are all powerful "blood thinners" and turn you into a "free bleeder" at the time of surgery.

Cigarette smoking as well as marijuana use must be stopped to allow an easier anesthetic and a recovery without complications. Cigarette smoking just before or within three weeks after a facelift often cause face and neck skin to die, leading to marked prolongation of healing and a lot of scar deformity. Eliminate all recreational drugs well in advance of surgery.

Alcohol consumption is best stopped or markedly reduced in order for the liver to be in optimal condition to manufacture the building blocks necessary for healing and cessation of bleeding. Furthermore, we strongly recommend that you avoid alcohol intake for several days preferably several weeks, prior to surgery. If you are accustomed to drinking alcohol everyday, please discuss this with us. Special arrangements will be made to accommodate your health needs.

If you take high blood pressure or diabetes medication discuss it with your surgeon. We will generally wish to continue the medicine during and after surgery.

It is your responsibility to make us aware of any significant health condition, which you have. Let us know all the medications you take or have recently taken, including herbal remedies and naturopathic preparations. Some certain ingredients profoundly affect the heart and blood clotting capabilities.

Remember a good result requires the three important ingredients: 1) Good surgical care, 2) Good patient cooperation (following instructions), and 3) Mother Nature's blessing. We will provide the first. You are responsible for the second. When we do our parts together, we best assure Mother Nature's cooperation.

The Trip Home

After surgery, you will remain in the recovery room for two to three hours or until we feel that you are ready to transfer to your extended care facility (sometimes the hospital or home in certain instances). We will only discharge you into the care of a responsible adult and will not allow you to travel home alone by taxi after receiving any medications for pain and/or sedation.

Make care arrangements in advance of facelift and other large operation, making sure someone is with you during the first two or three nights after your operation unless scheduled for one of our care facilities. When suitable arrangements have not been made, we will admit you to the hospital for safety and competent overnight nursing care. This should become expensive if not carefully planned in advance.

Usually we prefer that you go to the hospital for at least the first night of aftercare. It's possible that we could decide the hospital is advisable, even though you had planned to go home. We always reserve the right to change plans and admit you if we feel it important for your well being. Such changes of plan are rare, but if it happens, you will be responsible for all hospital charges.

A car with a back seat large enough for reclining is desirable when you travel home after surgery. Occasionally a person may be a little dizzy and nauseated after discharge. Because of this, the option of reclining is not only important, it is essential. We can arrange medical transportation for your trip home if necessary.

Post-operative Visits

Plan to return to our office for a number of post-operative visits, beginning with the first day after surgery. On these visits, it is not always necessary for your surgeon to see you. On some visits, for instance, the nurse or fellow may need only to remove sutures. If they feel that the surgeon should see you, he will of course.

Many visits will be brief. The point is to make sure that you are healing properly. It is a good idea to jot down questions you wish to be answered at that time. The cost of all post-operative visits is included in the surgical fee. Necessary parking will be validated.

Photography

We will take photographs of your face before and after surgery. These become an essential part of your medical record. It is interesting to refer back to these photographs for evaluation of progress and improvement. Post-operative pictures will be taken at appropriate points after surgery. They will not be shown to other patients without your consent.

Activity

Each person's response to surgery varies – in the amount of swelling and bruising, as well as the amount of general difficulty in the post-operative period. The first three days are the worst. During this time, your head may be in a football helmet type bandage and your eyes will most likely be bandaged the first night after eyelid surgery.

From the third to the seventh day, swelling is still “generous” and bruising may be considerable.

The worst thing you could do is to take pain medication and sleeping pills in an attempt to sleep through until you are better. Never take more than one sleeping pill per twenty-four hours. If you sleep during the day, you'll be awake all night. Either sit up in bed or in a chair during the day or keep your head up 30 degrees always with the chin and jaw raised.

After ten days you may resume normal posture. Starting the day after surgery be up and about in gentle walking from time to time.

Surgical Depression

Four to six days after a long operation, it is common to experience one to three days of depression. This depression is both chemical and normal. It happens when your body uses up its supply of stress hormones, a natural substance that keeps you “feeling” good through bad times. This usually happens when the patient is sufficiently better and can look in a mirror – but before the patient really starts looking good, and before swelling has gone down. Often it creates a feeling like the world has been pulled out from under you, and as if you will never be “okay” again. Know that this is natural, and goes away in one or two – sometimes three days.

A week after surgery, you are encouraged to go on little excursions, for walks, or to the grocery store. If convalescence is normal, you may feel comfortable attending social events after one to three weeks depending on what was done. Appearance at the time may be near normal, but there will undoubtedly be residual swelling.

Make-Up

Purchase some cover-up make-up that matches your skin color before surgery. This is very helpful when there is bruising. Having it “on hand” gets you out and about much sooner.

Your cheeks will remain puffy for two to three months after surgery in lessening degrees. A tiny bit of swelling persists in operating areas for two to three years in diminishing amounts, but it does not interfere significantly with appearance.

Mild exercise may be resumed after ten days, although you should not allow your head to be in a dependent position until at least one month post-operatively.

Exposure to Sun

During the first three or four months after surgery, exposure to sunlight should be avoided or minimized. If you must be in the sun, apply absolute sun block to the nose and sunscreen with a Sun Protection Factor (SPF) of 35 or higher to the rest of the face. Severe sunburn could result in permanent scarring or discoloration. Should sun burning occur, your face might stay red for many months in a way most bothersome and unattractive. The nose is extremely vulnerable to this after surgery.

Hot and Cold

Ice water packs may help prevent swelling about the eyes during the first 36 hours after surgery. Doing it longer slows down recovery. Heat should not be applied for at least ten days to two weeks. Don't apply heat to lifted cheeks and neck for at least a month. Never put ice directly on the skin of an operated area. Heat is especially dangerous because sensation may be reduced and the application may be hotter than suspected.

Returning to work

Many patients can return to work a week or more after surgery. However, with a full complement of associated procedures such as blepharoplasty, coronal lift, suborbital malar implants, lip peel, etc., most patients do not elect to return to work until two or three weeks after surgery.

Costs

In addition to charges, which have been made to you for the operation, anesthesia, operating room, and recovery room, there will be additional costs for prescriptions, blood work, urinalysis, EKG, and a chest x-ray when required. Often pre-operative evaluations with a treadmill test, performed by an internal medicine specialist, will be required.

In the event of complications such as severe infection or other events requiring additional work in the early post-operative period, no additional fee will be charged provided Dr. Flowers is able to provide the required care. However, the expenses of operating room and anesthesia will be charged additionally just as if the surgery were done in the hospital. You will be expected to pay the costs of hospitalization or other medical consultants if required. Should you, for any reason, elect care by another surgeon, you must pay for that care yourself.

Warranty

All faces differ and so do the results after surgery.

The only warranty offered is that your surgeon will put forth his very best effort to achieve the best possible results. No further guarantee can be made. It should further be understood that fees paid are for the performance of an operation and NOT for a guaranteed or hoped for result, nor for an improvement, which will last indefinitely. It is possible that a modification of your operation may be required at some point in the future.

Finally

The information contained herein is extensive but by no means complete. It is intended to re-emphasize many of the points discussed during your initial consultation and to provide documentation, which you may find convenient to refer to.