

The Pinch Face Lift: A Safe and Effective Variation on a Theme

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Despite the intervening 100 years, the essential goals of the face lift have changed little since its beginnings. Surgeons have always striven to rejuvenate the face by removing the aged and excess skin at the cheek and neck. Naturally, time has proffered significant advances that have facilitated our reaching these goals. We are now able to manipulate more of the face and its features and tissues in far more nuanced (and not so nuanced) ways. We have truly come a long way: from removing extra skin through simple lenticular preauricular excisions to lifting brows, adjusting the cant of the lateral canthus, erasing wrinkles, and reconstituting volume and shape--all through good-quality, hidden scars. Although the goals may be similar, the many techniques available to accomplish them underline a confounding truth: we clearly do not have a consensus on how to get there from here. In general it is a reasonable surgical maxim, particularly in plastic surgery, that there can and should be many roads to Rome. However, to honestly assess these alternatives, we must use consistent criteria to measure the outcomes.

Which aesthetic benchmarks should define a face-lift result as optimal? The answer to this should include the goals of the largest number of techniques and erasure of the primary stigmata of aging, such as the ptotic midface, redundant cheek skin and deepened nasolabial folds, jowl and marionette grooves, and excess skin, bands, and fat in the neck. In addition,

after achieving these goals, the patient must be left with only inconspicuous scars.

This article presents a variation of the SMASectomy technique that has proven to be a safer, less-invasive technique that delivers an effective, long-lasting, natural-looking correction of the cheek, neck, and jawl.

During the past 10 years, the pinch face lift without a direct neckplasty has replaced the traditional, more limited SMASectomy with direct neckplasty. The results of more than 50 cases have been evaluated, ranging from 1 to 7 years of follow-up.

Evolution of the Pinch Face Lift

Baker's advancement of the lateral SMASectomy face lift has been repeatedly validated as a viable face lift technique.¹ The primary raison d'être of the SMASectomy technique is the creative concept that redundant tissue need not be mobilized extensively to be tightened adequately. The benefits of this are obvious and numerous: There is no need for a potentially risky dissection in and around the facial nerves, and the surgery is more efficient with less postoperative swelling and bruising. In addition, the SMASectomy may be carried as high as necessary to accomplish a proper lift of the midface/malar anatomy. For the care of the submental fat and platysma bands, the neck is most often opened through a separate submental incision.

But there are issues even with this approach. The necessary neck dissection adds surgical time and potential morbidity, particularly from neck hematomas. In addition, the midline muscle repair could defeat the opposing vector of force in the postauricular/neck SMAS tightening and encourage early

or late reappearance of bands. Instead, the less-invasive approach described here eliminates the need for submental reconstruction. That is, by extending the lateral neck dissection and SMAS repair as inferiorly as necessary, the neck dissection can be avoided altogether. It is for these reasons that the pinch face lift was designed.

Logic Behind the Pinch Face Lift

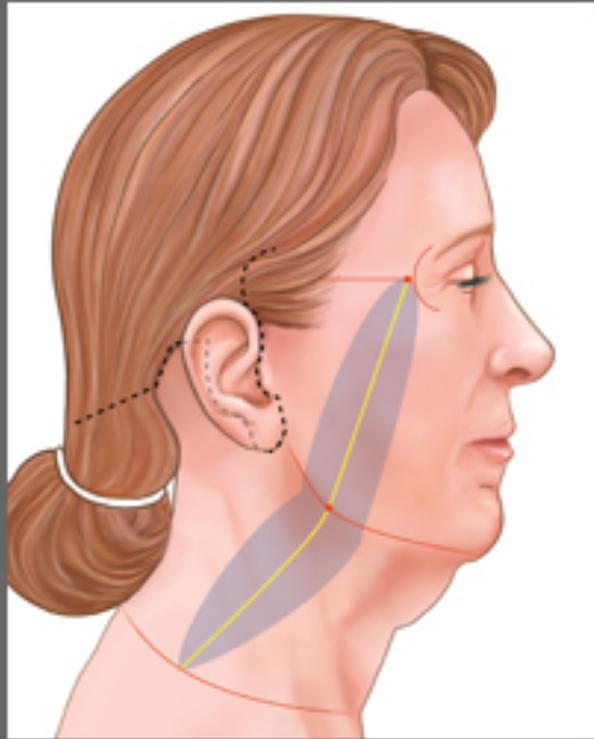
The principles of this approach include the following:

- The SMAS does not necessarily have to be undermined or mobilized to tighten it. A formal, direct neck dissection/repair may be avoided, and skin undermining can be restricted to only what is needed to expose the SMASectomy site. This principle can be proven preoperatively by translating the excess skin with finger distraction, which allows full correction of the neck, jowl, and cheek to be visualized. In my experience, this effect can be seen regardless of the active or passive nature of the platysmal bands, and patients themselves often demonstrate it during examinations when describing the effects they desire.
- As Baker¹ mentioned, the goal of SMAS tightening, whether by plication or imbrication, should be to remove excess tissue, mobilize the SMAS, and suture its lateral margin to the immobile SMAS. To determine the presence and extent of SMAS laxity, the surgeon can test the tissue between two forceps.
- To correct the neck fully from the posterior approach, the lower neck dissection must be taken as far laterally as one would anteriorly (a distance that is not normally traversed with the traditional technique). In other words,

the lateral inferior tissues must be exposed at least as far as, if not below, the inferior margin of the anterior platysma bands. Not only is platysma redundancy fully addressed using this method, but a more comprehensive redraping of the neck skin to the clavicle is often achieved.

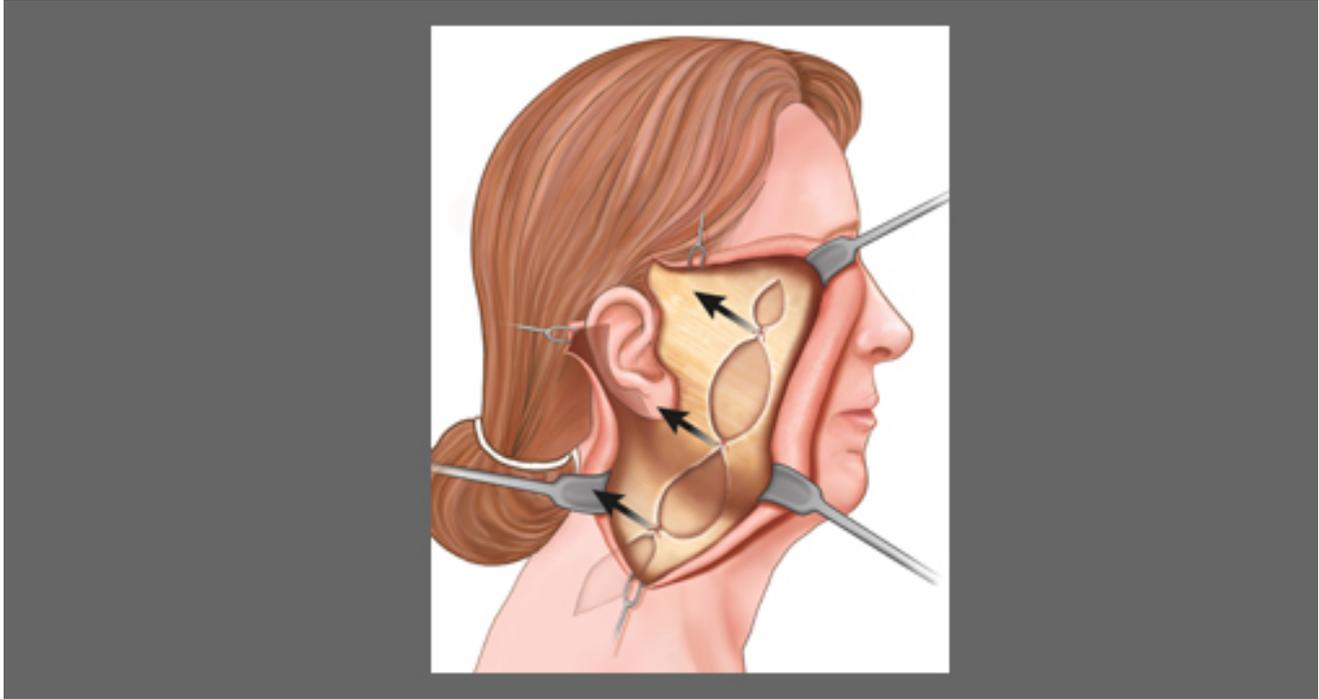
- To correct cheek ptosis, the dissection must extend more superiorly above the zygomatic arch. Then the malar tissues may be lifted with a high SMASectomy, as promoted by Dr. Barton.²
- The prospective SMASectomy is designed similar to a hockey-stick shape, paralleling the nasolabial and marionette folds and then turning more posterolaterally to match the cant of the platysma bands ([Fig. 1](#)). The vector of the SMAS repair can be more or less oblique to the vertical, as needed.
- The SMAS treatment may be either with an imbrication or a plication, its primary purpose being simply to tighten the investing girdle, which can be taken in more or less as needed to better define the underlying soft tissue and bony anatomy. Generally, imbrication is chosen for most patients, but plication may be used for thinner or secondary face-lift patients. Because the skin elevation is intentionally modest, a wider and tighter SMAS repair must be conducted to attain as full a correction as possible. This SMAS reconstruction may cover an area as much as 6 cm wide ([Fig. 2](#)).
- The skin is redraped under no tension, in a deliberately less-oblique and more-natural vector than the underlying SMAS repair, particularly in the area of the cheek ([Fig. 3](#)).

- If necessary, liposuction of the neck may be accomplished through a submental stab incision, and of the jowl through the open facial wound itself.



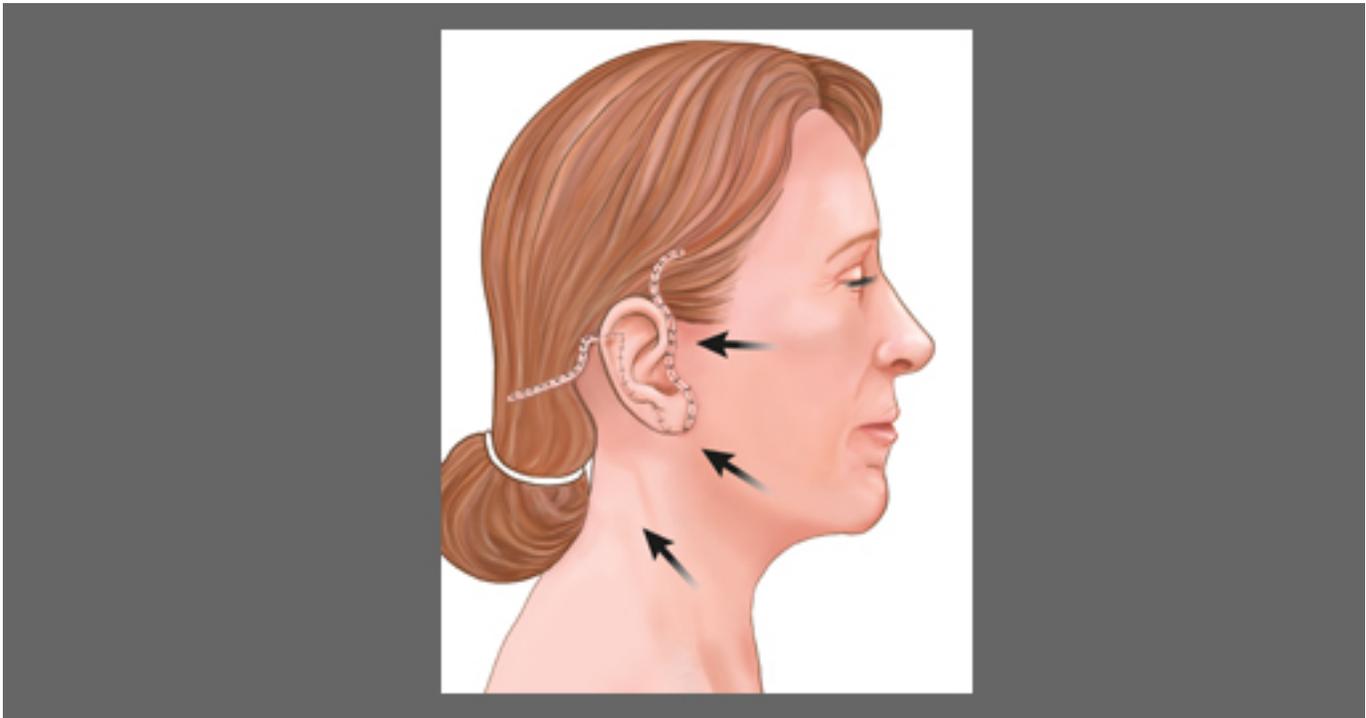
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Fig. 1 Incision placement and SMASectomy design. The postauricular incision is higher and more hidden, and a hairline jog is included for lower neck access. Notice the width of the SMASectomy boundaries and that they extend from high on the cheek to low in the neck. The red dots indicate where the initial key tacking sutures will be placed to gauge tension and adequacy of the SMASectomy.



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Fig. 2, The reserved extent of skin elevation and wider SMAS repair.



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Fig. 3 The vectors of skin closure. Notice the more horizontal, natural closing vector at the level of the cheek.

Results

Results have been followed from 1 to 7 years postoperatively. Early results reveal much less swelling and swifter recovery (see [Fig. 4](#)). Most important, because of the conservative skin undermining and tightening in comfortable vectors, results are natural looking. Longer-term results are stable with about a 5% recurrence rate of usually very modest and acceptable neck bands. However, if necessary, these bands can be corrected relatively easily, under local anesthesia, by either excision or plication. There have been no motor nerve injuries, skin sloughs, or areas of poor scarring.

Patient Examples

This 70-year-old woman presented for repair of a significant cheek and neck deformity. She is shown preoperatively and at 7 days following a pinch face lift ([Fig. 4, A and B](#)). Notice that she has a natural, full correction with minimal swelling and bruising. Notice also that no central neckplasty was performed.

This 59-year-old woman underwent the pinch face lift (no direct neckplasty) with an upper and lower blepharoplasty. She is shown preoperatively and 1 year postoperatively with a comfortable, natural-looking result ([Fig. 5, A and B](#)).

This 54-year-old woman underwent upper and lower blepharoplasties with the pinch face lift. She is shown preoperatively and 3 years postoperatively with a stable, natural result ([Fig. 6, A and B](#)).



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Fig. 4 This 70-year-old woman presented for repair of a significant cheek and neck deformity. She is shown, A, preoperatively and, B, at 7 days following a pinch face lift. Notice that she has a natural, full correction with minimal swelling and bruising. Notice also that no central neckplasty was performed.



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Fig. 5 This 59-year-old woman underwent the pinch face lift (no direct neckplasty) with an upper and lower blepharoplasty. She is shown, A, preoperatively, and, B, 1 year postoperatively with a comfortable, natural-looking result.



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Fig. 6 This 54-year-old woman underwent upper and lower blepharoplasties with the pinch face lift. She is shown, A, preoperatively, and, B, 3 years postoperatively with a stable, natural result.

Conclusion

The essence of the pinch face lift is the power of a pinch SMASectomy that is higher, lower, wider, and tighter and eliminates the need for a direct neckplasty. A very natural result is realized, with a more complete neck repair fully to the chest, as well as an effective correction of the midface cheek and jowl. Additionally, patients enjoy a swift recovery, with little risk of skin ischemia and predictably better scars.

References

- Baker D. [Rhytidectomy with lateral SMASectomy](#). Facial Plast Surg 16:209-213, 2000.
- Barton FE Jr. [The "high SMAS" face lift technique](#). Aesthet Surg J 22:481-486, 2002.