

# COSMETIC FACIAL SURGERY

# COSMETIC FACIAL SURGERY

Second Edition

JOE NIAMTU, III, DMD

PRIVATE PRACTICE

COSMETIC FACIAL SURGERY

RICHMOND, VIRGINIA

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# FEATURES AND ORGANIZATION

## Key Features

- **Comprehensive** step-by-step contemporary procedures of the face and neck
- **Accessible, easy-to-grasp, first-person narrative** teaches concepts based on real cases and experiences, making the surgical procedures tangible and easy to understand
- **Over 3000 illustrations** including an extensive number of drawings and before and after photographs help clarify important concepts and techniques and show the dramatic results that can be achieved
- **Videos** showing the author performing the procedures discussed in the book bring the surgeries to life

## Organization

**Chapter 1: The Aging Face**—addresses the intrinsic and extrinsic aging changes of the aging face.

**Chapter 2: Evaluation of the Cosmetic Facial Surgery Patient: The Art of the Consult and the Office Patient Experience**—describes keys to successful consultation including patient communication, choosing the right patient, and how to say “no”; the preoperative appointment, the day of surgery, and post-surgery follow-up.

**Chapter 3: Facelift (Cervicofacial Rhytidectomy)**—addresses the history of facelift surgery, facelift anatomy, patient selection, determining status for potential cosmetic facial surgery, preoperative consultation work-up, facility, instrumentation, the day of the surgery, anesthetic considerations, facelift procedure, SMAS techniques, postoperative care, short scar/weekend facelift, simultaneous laser skin resurfacing, concomitant or ancillary procedures, revision facelift surgery, complications and their prevention, post-surgical revision, and the informed consent procedure.

**Chapter 4: Brow and Forehead Lift: Form, Function, and Evaluation**—detailed evaluation, treatment, and complications of open (transfollicular subcutaneous) and endoscopic brow and forehead lift techniques, with the relative indications for each procedure.

**Chapter 5: Cosmetic Blepharoplasty**—looks at orbital anatomy, aging conditions of the eyelids and periorbital areas, diagnosis and patient selection, treatment planning, preoperative marking, surgical preparation and anesthesia, instrumentation, upper-eyelid incision, lower-eyelid blepharoplasty, alternative treatments, Asian blepharoplasty, canthopexy techniques, and complications.

**Chapter 6: Rhinoplasty**—covers contemporary rhinoplasty topics, including anatomy, examination and consultation, treatment planning, external versus endonasal technique, incision and grafting options, open and closed rhinoplasty, and complication recognition and management.

**Chapter 7: Facial Implants**—looks at midface cheek, chin, mandibular angle, temporal and custom facial implants, including implant selection, preoperative planning, surgical placement, postoperative care, and complications.

**Chapter 8: Cosmetic Otoplasty and Related Cosmetic Ear Surgery**—addresses ear deformities and the two techniques that can be applied to the most common ear deformities, the Davis and Mustardé procedures, and also looks at earlobe reduction, the repair of torn and gauged earlobes, complications in earlobe repair, and keloid excision.

**Chapter 9: Neuromodulators (Neurotoxins)**—looks at botulinum toxin A, including its history, physiology, clinical usage, and contemporary clinical usage of all common treatments in the upper, mid, and lower face and neck, as well as ancillary uses for hyperhidrosis, migraine headache, TMJ, and myofascial pain disorders.

**Chapter 10: Injectable Fillers: Lip Augmentation, Lip Reduction, and Lip Lift**—looks at contemporary injectable facial fillers, including their composition, indications and use in the upper, mid and lower face and related anatomic structures such as lips, folds, brow, teartrough, cheek, nose, and jowl with related local anesthesia techniques. Also details recognition and treatment of complications including intravascular injection, filler reversal with hyaluronidase, infection, and granulomas.

**Chapter 11: Cosmetic Lip Surgery: Lip Anatomy and Histology**—looks at cosmetic surgical lip techniques including subnasal lip lift and lip reduction including diagnosis, treatment options, and complications.

**Chapter 12: Lifetime Skincare**—looks at the anatomy and histology of healthy and aging skin and details products and treatments to reverse aging and maintain youthful skin.

**Chapter 13: Laser Skin Resurfacing**—looks at traditional and fractional laser skin resurfacing and details patient selection, treatment options of light, medium, and aggressive techniques, pre- and

postoperative care, and recognition and treatment of resurfacing complications.

**Chapter 14: Chemical Peel**—details the art and science of chemical peeling including patient selection, pre-treatment, treatment, post-treatment, and recognition and treatment of complications.

## Videos

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### Chapter 3

#### Facelift (Cervicofacial Rhytidectomy)

- Avoiding facelift problems
- Short-scar facelift (Parts 1 and 2)
- Comprehensive facelift (Parts 1–3)

### Chapter 4

#### Brow and Forehead Lift

- Endoscopic brow and forehead lift (Parts 1–3)
- Transfollicular, subcutaneous brow and forehead lift
- Transfollicular, subcutaneous brow and forehead lift (revision surgery)

### Chapter 5

#### Cosmetic Blepharoplasty

- Upper and lower CO<sub>2</sub> laser-assisted blepharoplasty
- Subciliary lower blepharoplasty
- Ellman radiowave upper blepharoplasty

### Chapter 6

#### Rhinoplasty

- Open rhinoplasty

### Chapter 7

#### Facial Implants

- Extra-large submalar implant placement
- Submental placement of silicone chin implant
- Intraoral silicone chin implant placement
- Mandibular angle implant placement
- Temple implant placement

### Chapter 8

#### Cosmetic Otoplasty and Related Cosmetic Ear Surgery

- Davis and Mustardé otoplasty
- Earlobe repair

### Chapter 9

#### Neuromodulators (Neurotoxins)

- Botox marking and three areas
- Botox to DAO, mentalis, platysma, and upper face
- Botox to glabella, bunny lines, and lateral canthus

**Chapter 15: Management of Cervicofacial Fat**—details the nuances of face and neck fat including anatomy and treatment options such as cervicofacial liposuction, buccal fat pad reduction, fat transfer techniques, and submentoplasty.

Botox to gummy smile

Botox to lipstick lines

Botox touchup for “Spock brow”

Dysport marking and three areas of injection

Dysport injection to masseter muscles

Reconstitution of Botox, Xeomin, and Dysport

### Chapter 10

#### Injectable Fillers

Botox and filler injection to glabella

Filler rhinoplasty and chin augmentation

Filler rhinoplasty

Radiesse to nasolabial folds

Restylane filler to upper and lower lips

Restylane injection to nasolabial folds

Voluma injection to cheektrough and nasolabial folds

### Chapter 11

#### Cosmetic Lip Surgery

Subnasal lip lift

Lip-reduction surgery

Permalip silicone lip implant

### Chapter 13

#### Laser Skin Resurfacing

Aggressive CO<sub>2</sub> and Active FX laser

CO<sub>2</sub> Lite and Active FX to neck

CO<sub>2</sub> Lite over facelift

Deep FX CO<sub>2</sub> laser to scar on patient with pigmented skin

Iridex 940 laser to facial telangiectasias

### Chapter 14

#### Chemical Peel

TCA peel

### Chapter 15

#### Management of Cervicofacial Fat

Facial liposuction, buccal fat reduction, and submentoplasty

Fat transfer to face

## Bonus Videos

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Ellman removal of large mole upper lip

Ellman removal of multiple lesions

Iridex 940 laser to vascular lip lesion

Vascular laser to lower lip vascular lesion

# PREFACE

Writing a comprehensive cosmetic facial surgery textbook for the world's largest medical publisher is a once in a lifetime opportunity and my first edition was truly that. When asked to write a second edition 5 years later, by the plastic surgery department of Elsevier, I realized that I had a "twice in a lifetime opportunity" and jumped at the chance. It did not take long to remember how hard it was to write this text the first time. In the last edition, I wrote hundreds of thousands of words and produced 3000 pictures. Now that I am back into the writing mode, it makes me wonder how I did it the first time!

This second edition is different from the first edition in numerous ways. First of all, most of my chapters have been totally rewritten and new pictures have been used. This, in essence, is truly like writing an entirely new text and this has been my goal. The reason to write a second edition of a text is multifactorial and includes: new advances in the field, increased knowledge by the author(s), and updated descriptions and images that were not present in the first edition. There is no reason to write a second edition of a text that is just a warmed-over copy of the first edition. I can personally guarantee this is primarily new content throughout. I personally wrote 13 of the 15 chapters and thank my dear friends Angelo Cuzalina, MD, and Suzan Obagi, MD, for their chapter contributions as well as my other friends who are leaders in their respective specialties for their commentaries. One of the goals of this edition was to include more author and specialty diversity and I am happy to have some of the best and well-known surgeons in the world as contributors to this text. The specialties included in this author list include: plastic surgery, facial plastic surgery, oculo-plastic surgery, oral and maxillofacial surgery, and dermatology, which mirrors the primary specialties involved in contemporary cosmetic surgery.

The other main goal of this text was to continue the picture-rich, step-by-step descriptions of the various cosmetic procedures. I am very proud of how this book has turned out and what went into it. I began the rewrite with the facelift chapter, which itself took 4 months to complete. This chapter has over 60,000 words and 400 new images and at the risk of sounding boastful, I have never seen a more photographically comprehensive facelift chapter in any textbook, and I am proud of this effort. My total commitment involved almost 12 months of typing and creating pictures and videos.

Honesty is required from all authors and I have put forth great effort to make this book relevant to mainstream cosmetic facial surgery. It is impossible to describe every single way to perform each operation and I have attempted to describe "best practices" that are safe and effective and used by experts. This does not imply

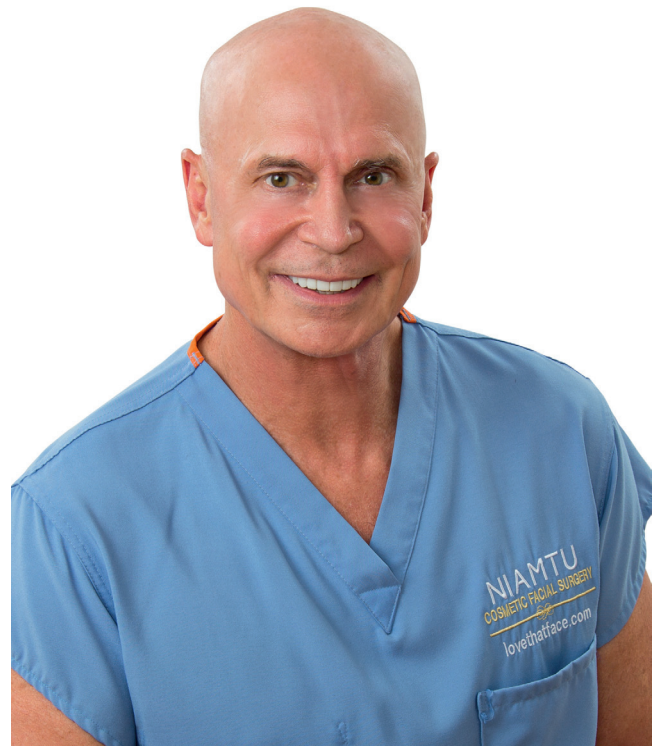
that my way is the only way or that some of my opinions cannot be disputed. The procedures described and the detail included are a result of 30 years of facial surgery practice and analyses of thousands of procedures to find the safest methods with the most predictable outcomes.

Another of my goals for this text is to make it applicable for all levels of surgeons. For residents and novice surgeons my aim is for this book to be a guide that can coach them through all the steps of diagnosis, surgery, and complication management for safe surgery with predictable outcomes. For intermediate and advanced surgeons, my aim is that it will serve as a refresher, reference book, and hopefully, introduce new contemporary techniques.

I have put my heart into the fabric of this textbook and want it to represent my life's work and commitment to cosmetic facial surgery. To that end, I want to thank my numerous contributors for their expert commentary and writing.

I hope this text becomes worn and tattered from your continual reference and that it assists you in the wonderful journey of cosmetic facial surgery.

*Always be a teacher, always be a student.*  
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Chapter 7 Facial Implants

Chapter 8 Cosmetic Otoplasty and Related Cosmetic Ear  
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Chapter 9 Neuromodulators (Neurotoxins)

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*The views expressed in this material are those  
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# DEDICATION

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This second edition is dedicated to my wife April, for her unwavering support in the time it took to author this text, and to my sons Joey and Evan who, because of their disabilities, will never speak a single word, but have taught us volumes about love and life.

# The Aging Face

Joe Niamtu, III

Numerous times a day the average cosmetic surgeon will deal with patients who are unhappy with their aging. I tell these patients that “aging is a privilege denied to many.” What is equally important is how the patient is “handling” their aging. A 60-year-old patient who wants to look 30 is unreasonable, while a 60-year-old patient who wants to look as good as they can for 60, is very reasonable. A big part in a surgeon having good outcomes is picking the right patients. Cosmetic facial surgery is very popular in our culture and body dysmorphic disorder (BDD) is very prevalent. A normal and balanced cosmetic surgery patient can be a pleasure to work with. However, a patient with BDD can be a nightmare both clinically and legally. This type of patient cannot accept aging and their entire psyche revolves around narcissism and pathologic body image and wellbeing. Acquiring the ability to avoid this type of patient is a true skill.

Aging is a physiologic process of the body in the response to the passage of time. Since the beginning of time, people have sought treatments to retard or reverse aging, to no avail. Aging can be accelerated by both intrinsic and extrinsic factors and it cannot be stopped or reversed, but its effects can be mitigated.

It is imperative that cosmetic surgeons fully understand the pathophysiology of aging, and educating patients about aging helps them appreciate the process and basis for rejuvenation. Although we do know much about aging, in reality, we know relatively little. Most textbook descriptions of facial aging are very mechanical and relate to loss of volume and support. Although these are factors and important to aging reversal through cosmetic surgery, there are many other intrinsic factors that make aging happen.

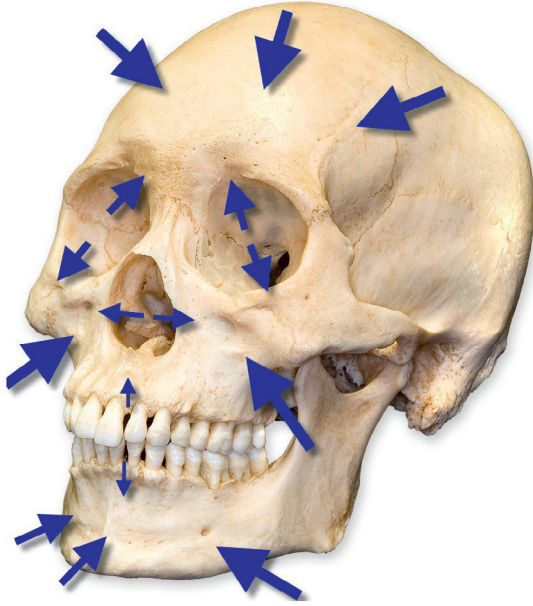
As most cosmetic facial surgery patients are female, the nuances of metabolic aging influences are significant. Menopause produces decreased estrogen levels with elevated androgen levels, which contribute to epidermal and dermal changes. The decrease in basal metabolic rates (in men and women) facilitates weight gain and fat distribution in unwanted places such as thighs, abdomen, hip, buttocks, face, and neck. Add the ravages of childbearing to the skin and muscle and it is easy to understand the aging process in females. Subcutaneous fat also decreases, which affects the support of the skin. The face and neck are rich in glandular structures, which are less frequently discussed in volume loss but are probably moderate contributors. Skeletal muscles can undergo 50% atrophy

with aging, and osteoporosis plays a key role in bone resorption, as the majority of women in their fifth decade are osteoporotic. Osteoporotic changes also occur in males and in both sexes contribute to facial skeletal and dental resorption. As the facial skeleton shrinks, even more soft tissue support is lost (Fig. 1.1). Bone in the aging face is more prone to resorption in specific areas such as the orbital rims, maxilla and piriform region and anterior mandibular and pre-jowl regions (Fig. 1.2). In addition to this, ligamentous attachments from bone to soft tissue tether the overlying soft tissue and contribute to hollowing when bone loss drags down the soft tissue anatomy.

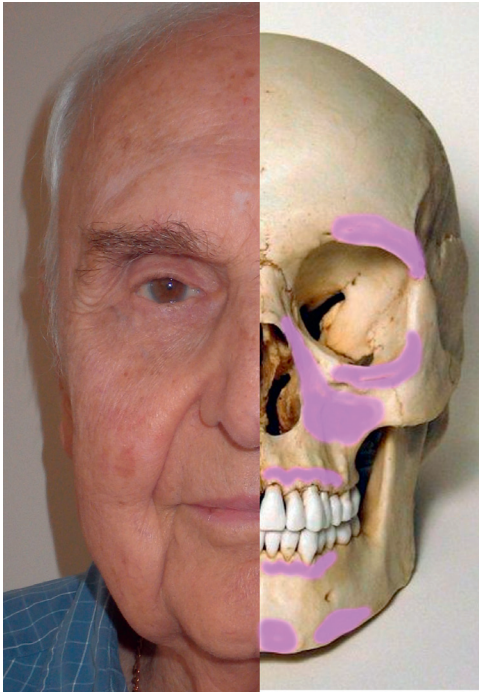
One unique factor to facial aging is that in most cultures the face is exposed. Clothes can masquerade somatic aging but the face, neck, and hands give it all away.

As with all other theories or processes, surgeons and anatomists argue about what exactly happens during aging. While most surgeons agree that atrophy, ligamentous laxity, and ptosis are causative factors, others argue against this. It is universally agreed, however, that aging is a gradual process of structural weakening and its clinical effects begin in the third decade and progress throughout an individual's lifetime. Aging is basically a process of deflation similar in the transition from the grape to the raisin (Fig. 1.3).

Babies and toddlers have full rounded faces with full convex contours. This is, in part, from the small skeleton supporting the generous fat compartments in infancy. Adolescence includes rapid but disharmonious growth of bone, cartilage, muscle, and fat, which produces a sometimes awkward appearance in the preteen years. Through the teen years, puberty produces secondary sexual characteristics including rapid growth phases, which produce hereditary but predictable and distinguishable facial changes. Middle age brings the onset of aging changes that progress until death (see below). The cycle of aging is such that infants have large orbits and smaller maxillae, which make their midfacial characteristics resemble an aged person. As the midfacial skeleton grows, the infant takes on the midface of youth. Continued aging produces widening of the orbits and maxillary and piriform resorption, which makes the aged person resemble an infant. Truly the cycle of life. While some parts of the facial skeleton resorb with age, some areas such as the mandible enlarge, underlining the multifactorial and dynamic changes that contribute to the aging facial skeleton.



**Fig. 1.1** Bone resorption accounts for many aging changes. The arrows show regions that commonly atrophy thus affecting overlying soft tissue anatomy.



**Fig. 1.2** Comparing the osseous skeletal changes with overlying soft tissue aging. The loss of support of the soft tissue contributes to the volume loss of aging and is common in the shaded regions of the facial skeleton.

The youthful face is tapered like an upside down egg, due to the distinct volume and tight tissue retention (Fig. 1.4A). The aging face is more of a reverse taper, similar to a right-side up egg, due to the descent of volume and fat compartment changes (Fig. 1.4B).

Aging changes are not only from volume loss and support changes but also due to intrinsic and extrinsic factors (Box 1.1). It is interesting that biologic aging can sometimes exceed chronologic aging, and we all know 45-year-olds who look 60 or the inverse.



**Fig. 1.3** The grape transforming to a raisin symbolizes skin aging and the loss of volume in facial aging over a lifetime. Intrinsic factors and extrinsic factors such as lifestyle choices can accelerate the process.

### Box 1.1 Comprehensive aging factors

#### Intrinsic aging factors

Cellular senescence  
Decreased proliferative capacity  
Decreased cellular DNA repair capacity  
Chromosomal abnormalities  
Hormone reductions  
Gene mutation  
Hard, soft, and dental structure loss

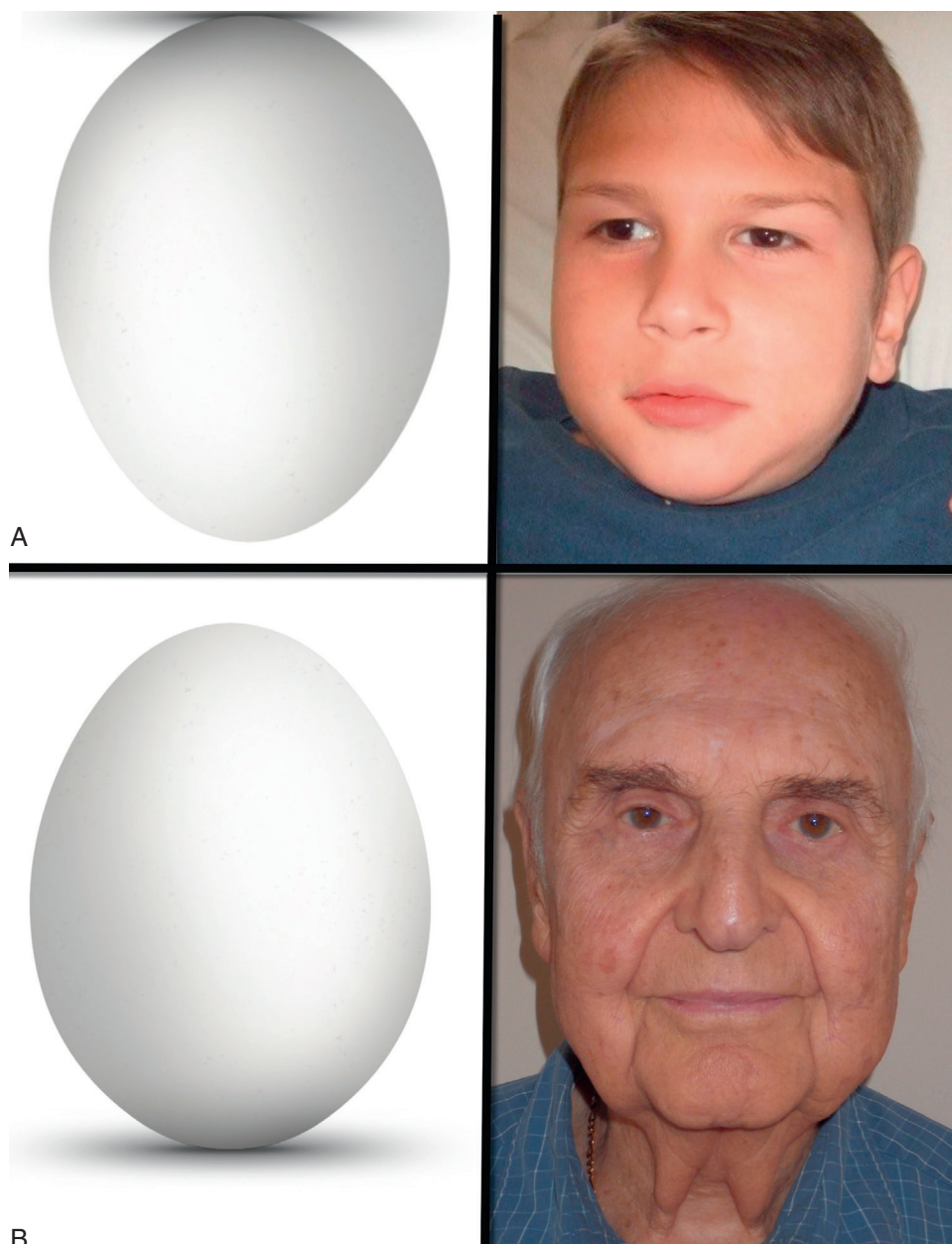
#### Extrinsic aging factors

Ultraviolet radiation  
Environmental factors (ozone, etc.)  
Tobacco use  
Ethanol abuse  
Gravitational effects  
Elasticity changes  
Emotional stress

Fig. 1.5A shows a career truck driver with obvious accelerated actinic damage on the driver's side that is exposed to more sun and wind and Fig. 1.5B shows a 65-year-old female with both hereditary and acquired aging (intrinsic and extrinsic).

Lifestyle and hereditary factors are significant contributors to the aging equation. Some aging factors are controllable, while others are not. Studies of monozygotic twins have revealed that aging is affected greatly by environmental and lifestyle factors, as measured by physical appearance. The factors that exert the greatest influence seem to be substance or alcohol abuse, sun exposure, and emotional distress. These aging changes are shown with supporting images in the various procedure chapters. An excellent description of cutaneous aging is presented in Chapter 12.

In the first textbook I wrote, Dr. Tom Faerber contributed a chapter on facial aging and performed an interesting study where he obtained computed tomography (CT) scans on his 9-year-old daughter, 42-year-old wife, and 75-year-old mother-in-law, to compare aging changes. Of particular note is that the youthful face



**Fig. 1.4** The youthful face is the shape of an upside down egg as the majority of the volume is in the midface with a tapering lower face (A), while the aging face has volume loss and descent of tissues with loss of the taper. This inverses the facial volume with the fullness on the lower face and jawline like a right-side up egg (B).

is convex, while the aging face is concave due to fat atrophy, muscle atrophy, gravitational and ptotic changes (Figs. 1.6–1.8). A pattern of muscle atrophy was demonstrated in the masseter and buccinators muscles in the oldest family member. The parotid gland maintained its volume, whereas the surrounding perimuscular and subcutaneous fat showed atrophy. Fat and muscle atrophy in the temporal, buccal, and malar regions were also seen and contribute to the concavities in those regions that develop with age, as evidenced in the progressive CT scans. This is evidence-based data that shows facial aging transformations from convex to concave. Although osseous volume loss is a big component of midfacial aging, some studies show osseous volume increases in the lower face.

## Regional Facial Aging

The most logical means of addressing facial aging and rejuvenation is to start at the top and work downward in an orderly progression during the consultation, and discuss the diagnosis and treatment of each unit.

### Skin

The most plentiful facial tissue is skin. The facial skin, like the exposed hands, rarely gets respite from the ravaging effects of the environment. Photodamage from sun exposure is especially harmful and, coupled with extrinsic factors such as smoking, can accelerate the effects of aging.



**Fig. 1.5** (A) This career truck driver exhibits advanced aging on the left side of his face that corresponds with the increased exposure from sun and wind on the driver's side of his truck. (B) This patient has severe wrinkling, which she says runs in her family. She is also a long-time smoker and sun enthusiast.

*Photodamage* describes aging changes of the skin from chronic ultraviolet (UV) light exposure. Cumulative photodamage can be seen in almost every patient by comparing the sun-exposed and sun-protected areas of skin. The most obvious clinical cutaneous aging changes include markedly increased skin roughness, mottled hyperpigmentation, loss of elasticity, wrinkling, and sallowness.

*Genetic contributions* to skin aging result in numerous biochemical, histologic, and physiologic changes. These changes include a reduction of vascularity, increased dermal/epidermal thickness, collagen changes, proteoglycan and dermal cellularity, and loss of elastic fibers.

Photoaging causes functional and anatomic modifications in the exposed regions. Ultraviolet B (UVB) radiation produces direct damage on the DNA of skin cells and also modulates the activity of cytokines and adhesion molecules. Ultraviolet A (UVA) radiation initiates the formation of reactive oxygen species (ROS), which also damages nuclear and mitochondrial DNA and activates matrix metalloproteinases (MMPs).

### Box 1.2 Pathologic changes of photodamaged skin

- Thickened more basket-woven stratum corneum
- Thinner more atrophic epidermis
- Epidermal atypia
- Irregular melanin dispersion in the epidermis
- Decreased glycosaminoglycans in the dermis
- Abnormal-appearing elastic fibers in the dermis

Histologically, the effects of skin photoaging include epidermal thickening, keratinocyte atypia, loss of polarity, and increased melanogenesis (Box 1.2 and Fig. 1.9). A fragmented and disorganized dermal fibrillar network is present and forms amorphous groups. Collagenous changes occur in the appearance of fragmented collagen fibrils, senescent fibroblasts, loss of function of glycosaminoglycans, and alterations in the cutaneous microvasculature.

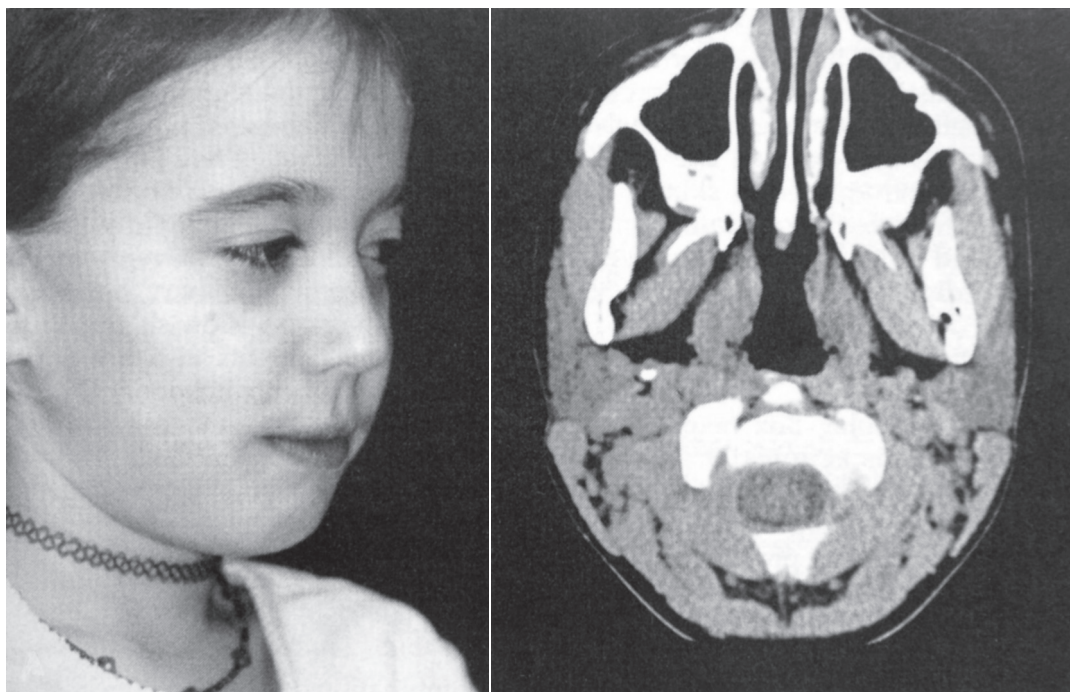
Contributing to exogenous skin aging is the decrease in skin functions that occur with age. These include decreases in cell replacement, injury response, barrier function, sensory perception, immune and vascular responsiveness, thermoregulation, sweat production, sebum production, and vitamin D production. The dermis is thicker on areas of the face that are less mobile (e.g., forehead and nose) and thinner on areas of the face with increased movement (e.g., lower eyelids).

## Upper Facial Aging

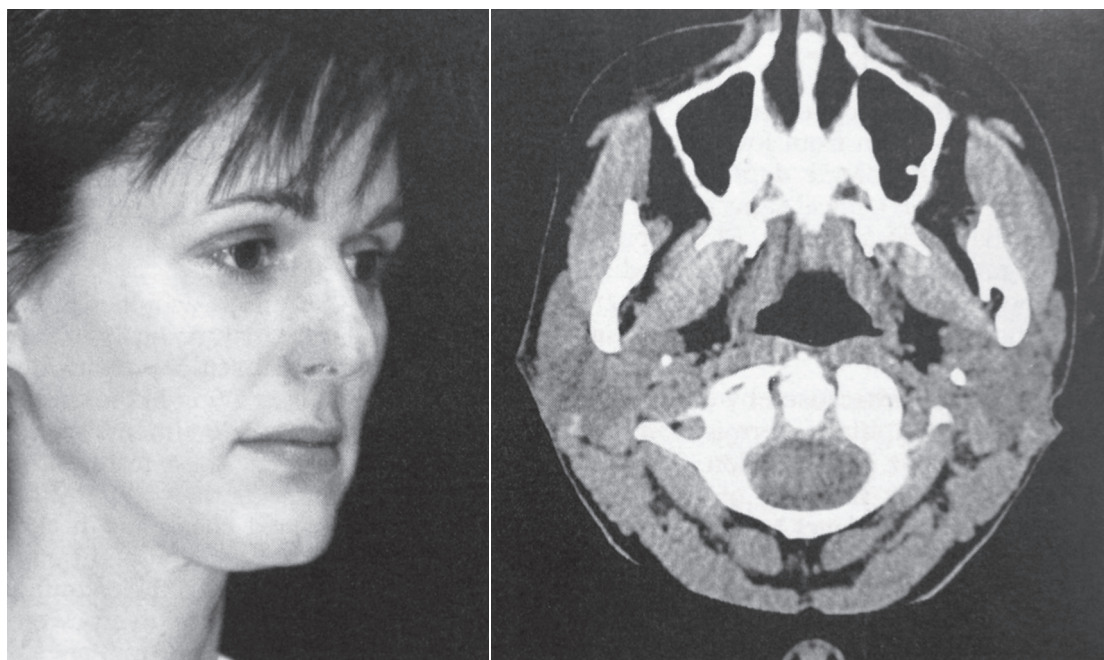
### Hair

Aging in the scalp manifests as the pigment changes of graying, thinning, hair shaft fragility, pattern baldness, and recession. These changes are largely genetically controlled and less at the mercy of the environment compared with the skin. Additionally, "hair aging" is less of an indicator of age, as some 20-year-olds lose their hair, while some 70-year-olds have a full head of thick hair.

The aging scalp is treated surgically with follicular grafts, flaps, etc. More recently, robotic-assisted transplantation has become popular and is eliminating the need for large occipital scalp scars from harvest. The medical treatment of hair loss, although in its infancy, may overcome surgical treatments in the lifetime of many of the readers of this text. Bimatoprost (Latisse, Allergan Inc., Irvine, CA) is a glaucoma medication that has been scientifically shown to make eyelashes thicker, darker, and longer, and at the time of this writing, is in clinical trials for scalp hair growth. Minoxidil is a topical alopecia treatment drug that produces vasodilation of the hair follicle. Patients taking this drug for blood pressure developed increased hair growth as a side-effect and this was eventually accepted by the Food and Drug Administration (FDA) for pattern baldness. Finasteride is a medication taken in tablet form originally used to treat benign prostatic hypertrophy. It is a 5- $\alpha$ -reductase inhibitor, which blocks the conversion of testosterone to dihydrotestosterone, the latter being toxic to hair. This drug is FDA approved for male pattern baldness only and causes birth defects in pregnant females.



**Fig. 1.6** The facial anatomy of a 9-year-old female (+CT scan).



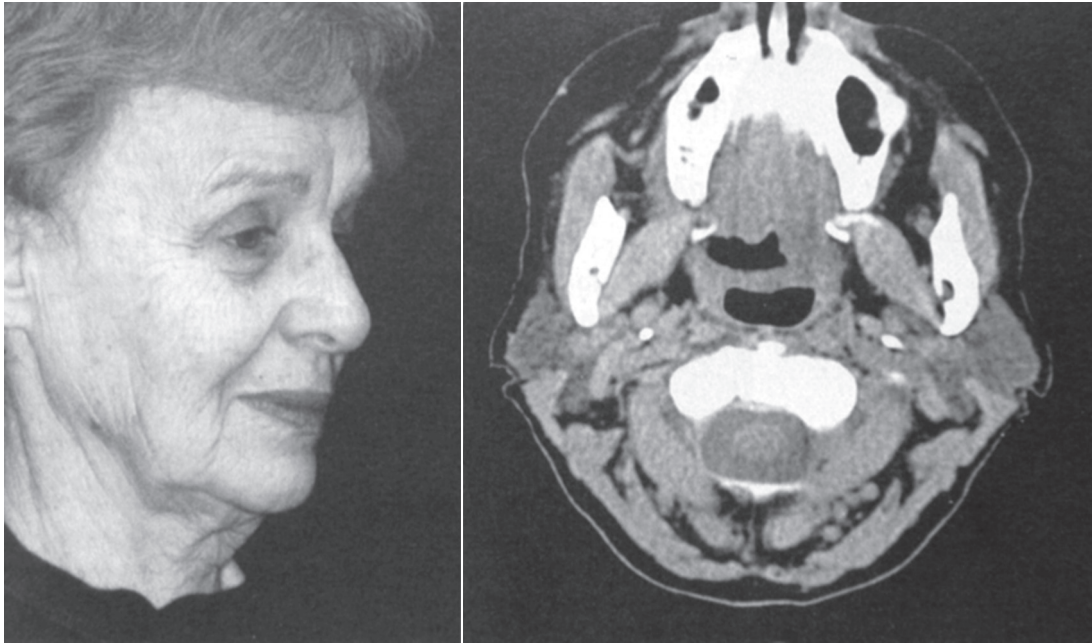
**Fig. 1.7** The facial anatomy of a 42-year-old female (+CT scan).

## Forehead and Brow

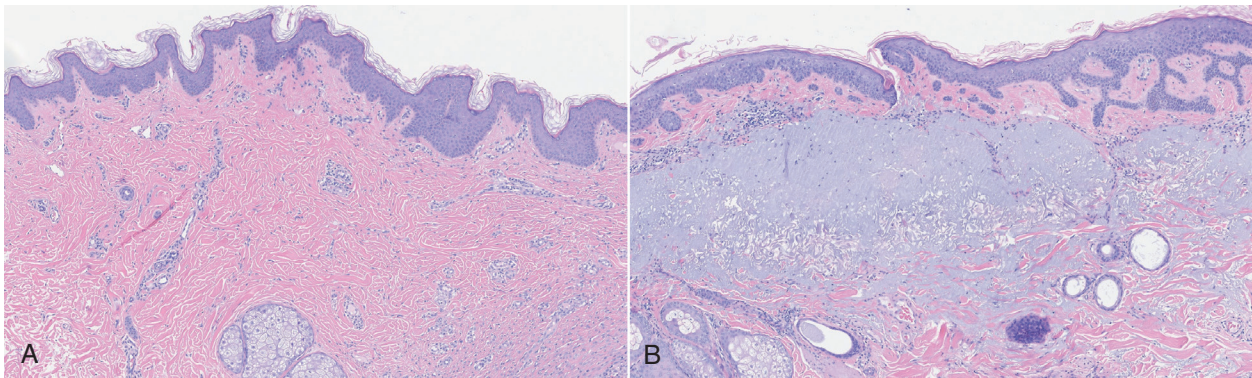
Younger people have smooth foreheads. Photodamage with the resultant skin changes, tissue ptosis, osseous changes, and gravity contribute to brow and forehead changes.

Although some people, even in youth, never have elevated or arched brows, many do. Most youthful females have brows that arch at the junction of the central and lateral brow (which corresponds to the lateral pupillary limbus). The youthful male brow lies

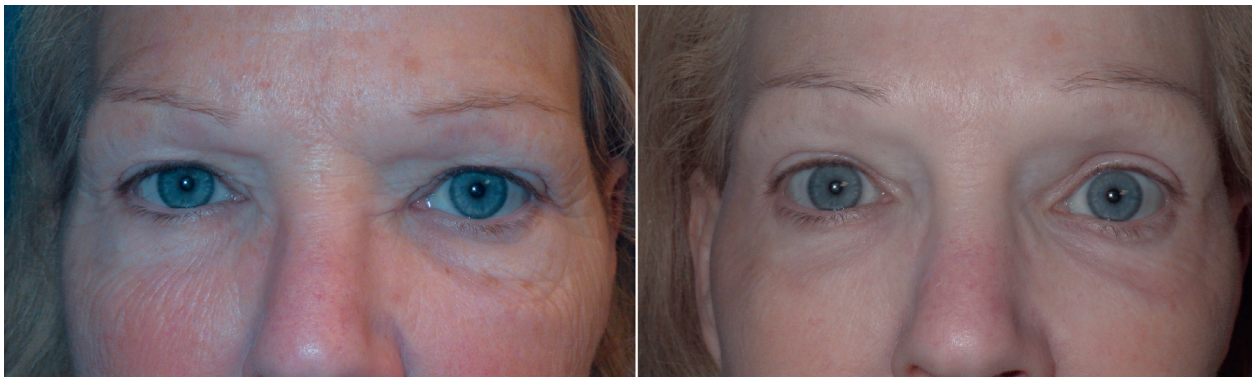
at or slightly above the superior orbital rim. Due to the aging changes, coupled with the atrophic changes in the brow fat and upper periorbital complex, the brows descend in many people. This manifests as lateral hooding and or generalized ptosis, which gives the appearance of smaller eyes (Fig. 1.10). In severe cases, the eyebrow sits on the lashes. A ptotic brow associated with the upper periorbital changes produces a sad and tired appearance. Due to this, many females go through their waking hours subconsciously raising their brows, which further compounds the problem



**Fig. 1.8** The facial anatomy of a 75-year-old female (+CT scan).



**Fig. 1.9** (A) Hematoxylin and eosin stain (H&E) of healthy skin showing normal stratum corneum, normal epidermal thickness, no atypical epidermal cells, normal rete ridges, healthy collagen bundles. (B) H&E of photodamaged skin showing thinning of the epidermis, flattening of the rete ridges, and solar elastosis in the dermis. (Courtesy of Dr. Jonhan Ho, Assistant Professor, University of Pittsburgh Medical Center.)



**Fig. 1.10** A patient with brow and upper-lid changes before and after subcutaneous browlift.

of flexed muscles and brow skin wrinkling. Any surgeon who performs browlift surgery can attest to the difficulty of getting some females to relax their brow for a preoperative photograph, or when looking in a mirror.

The treatment for brow and forehead ptosis is endoscopic or open brow techniques. Unfortunately, many patients who are candidates for a browlift end up with blepharoplasty. This can worsen the aging sign by further pulling down of the brow. The correct diagnosis of brow and forehead ptosis is paramount in aesthetic rejuvenation. Surgeons who perform blepharoplasty but not browlifting have an ethical responsibility to refer potential browlift patients for consultation with a surgeon experienced in browlifting, for fair and accurate diagnosis.

The frontalis is the only elevator of the brow and is opposed by numerous depressor muscles, including the procerus, corrugator supercilii, orbicularis, and depressor supercilii. Wrinkles in the skin run 90 degrees to the underlying muscles, so continual flexing of the frontalis muscles creates horizontal forehead rhytids. Popular parlance refers to the vertical glabellar rhytids as the “11” if two furrows, or a “111” if three furrows. Treatment of glabellar rhytids includes injectable neuromodulators, injectable fillers, radiofrequency nerve ablation, laser skin resurfacing, and muscle disruption with concomitant browlift.

## Upper Eyelids

The upper lids are inseparable from brow and forehead aging, as the ptotic brow enhances upper-lid skin redundancy. The upper-eyelid skin is extremely thin, and aging and photodamage lead to the redundant and crinkly looking skin, known as *dermatochalasis*. Due to the weakening of the orbital septum, the upper periorbital fat protrudes and produces aged contours. In some patients, the lacrimal gland becomes ptotic and can obstruct the upper-eyelid sulcus. Laxity in the orbicularis retaining ligaments in both the upper and lower eyelids also contributes to this process. The youthful eyelid consists of a slight upward slope from medial to lateral and weakening of the lateral canthal support produces a downward slant of the eyes. Fig. 1.9 shows upper-eyelid aging changes. The continual flexing of the orbicularis oculi muscle causes lateral canthal (crow’s feet wrinkles), which also contribute to upper facial aging. The skin wrinkles are horizontal to the circular underlying muscle.

The treatment of upper-eyelid aging includes blepharoplasty, brow and forehead lifting, and skin resurfacing.

## Midfacial Aging

### Lower Eyelids

The lower-eyelid complex is one of the biggest contributors to facial aging. The same skin and fat changes discussed in the upper lid apply to the lower lids. Also, the medial and lateral canthal tendinous attachments become weakened and contribute to lower-lid laxity. This can manifest in increased scleral show and lateral canthal rounding. The sum of these changes, coupled with fat protrusion, gives patients a tired and aged appearance. The protruding lower-lid fat compartments can cast a shadow (especially in overhead lighting) that patients often mistake for “dark circles”



**Fig. 1.11** Dermatochalasis and fat protrusion through a weakened orbital septum produce an aged and tired appearance of fat bags. This patient was treated with transconjunctival blepharoplasty and periorbital laser skin resurfacing.

though it is not a result of pigmentation. True pigmentation changes can occur from actinic damage, hemosiderin deposition, or are hereditary.

The upper face frequently presents with aging changes before the lower face and it is common for younger patients to present for cosmetic consultation for their “tired look” (Fig. 1.11). Most patients need eyelid surgery at a younger age than facelift surgery.

The nasojugal groove is the depression that represents the transition between the lower lid, malar fat pad, and lateral nose. The lower-lid aging changes and the descent of the malar fat pad expose the bony inferior orbital rim and accentuate the nasojugal groove, which is also called the *tear trough deformity*. The tear trough can be treated with injectable fillers, fat, and lower-lid fat transposition. Laser skin resurfacing or chemical peeling can also improve this region. Tear trough silicone implants are a less frequent option.

## Cheeks

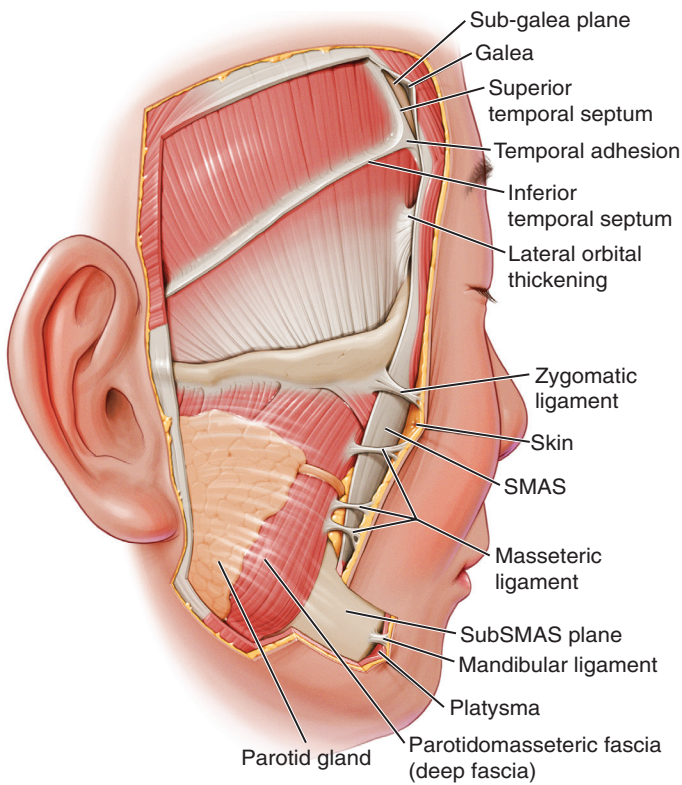
The cheeks are the foundation of the midface and basically are composed of the malar fat pads. In youth, the malar fat pads are full and in a superior and somewhat lateral position. With aging, the fat undergoes atrophy and the malar fat pad becomes ptotic with underlying osseous resorption (Fig. 1.12).

In youth, the skin is held taut over the bone by several types of retaining ligaments. The taxonomy of these connective tissue structures varies. Some anatomists describe “osteocutaneous” ligaments that represent fibrous bands with osseous (periosteal) origins and dermal insertions. The zygomatic and mandibular retaining ligaments are representative of “true” osteocutaneous retaining ligaments. The masseteric ligaments attach from muscle to dermis.





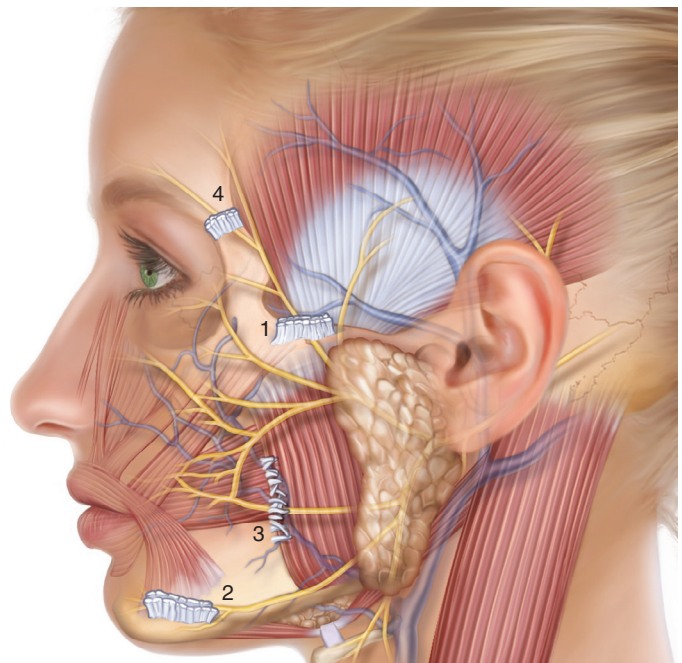
**Fig. 1.12** (A) The position of the youthful malar fat pad. (B) The author's 8-year-old son; (C) the author at 56 years of age; and (D) the author's father at 83 years of age. Progressive hard and soft tissue atrophy, ptosis and volumetric aging changes are evident and predictable across a family tree.



**Fig. 1.13** The true ligaments and other connective tissue connections that support and stabilize the soft tissues of the face. SMAS, the superficial muscular aponeurotic system.

An additional support system is formed by the coalescence of the superficial and deep fasciae and referred to as *septae* and *adhesions*. These “soft tissue to soft tissue” retaining structures occur in the temple and lateral orbit. All of these structures lend support against gravitational forces (Fig. 1.13).

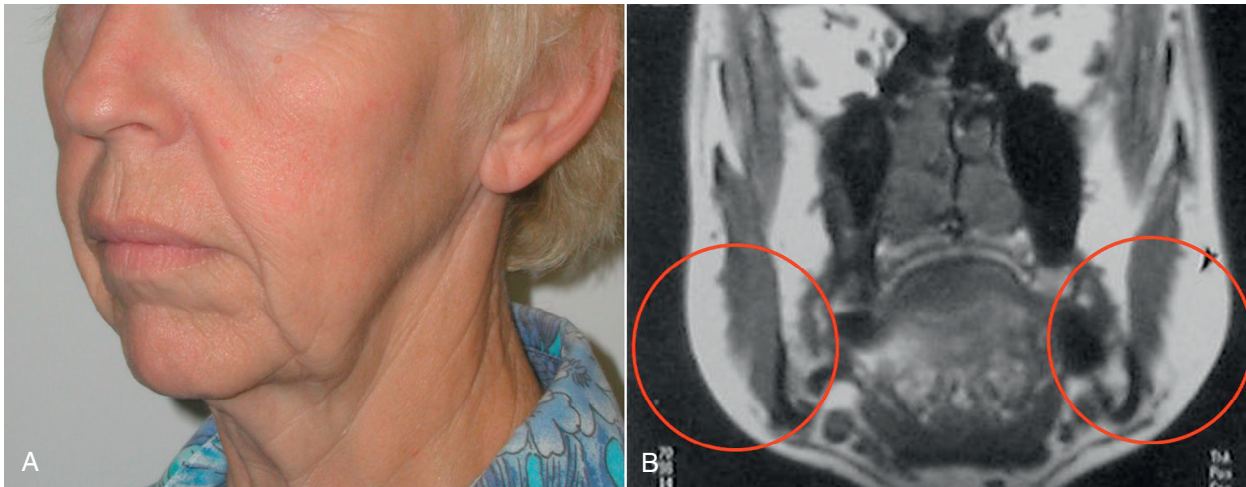
It is of note that, clinically, the zygomatic and mandibular ligaments must be transected to truly free up the subcutaneous plane from the deeper planes during facelift surgery (Fig. 1.14). The zygomatic ligaments are also referred to as *McGregor's patch* and represent a resistant region of dissection in the cheek. This is a vascular area, which is also referred to as the “bloody gulch.”



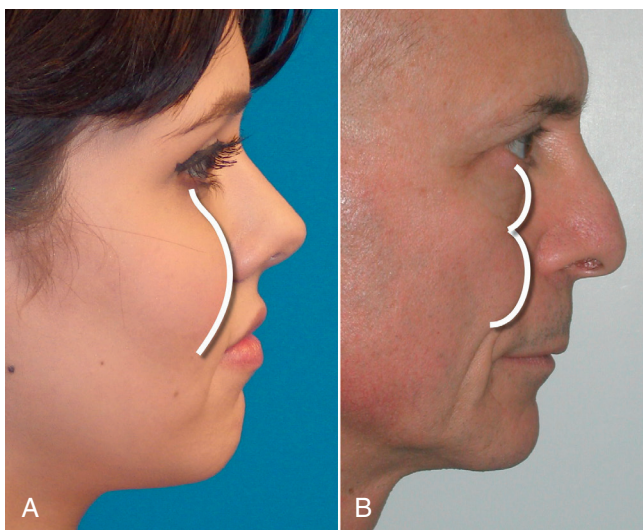
**Fig. 1.14** A representation of facial ligaments. The osteocutaneous retaining ligaments, such as the zygomatic (1) and mandibular (2), originate on bone and insert on dermis. Cutaneous ligaments such as the masseteric retaining ligament (3) and the parotid retaining ligament (4) are thickenings of connective tissue that join deeper soft-tissue structures to the dermis. Collectively, these ligaments support the facial structures and may be violated during facelift dissection.

Weakening of the all of the aforementioned ligaments also contributes to tissue descent, including the malar fat pads and buccal fat pads. In essence, the cheeks become the jowls (Fig. 1.15). These volumetric and gravitational midface changes, coupled with photodamage, loss of tooth structure, and skeletal changes, all contribute to the drawn, gaunt, or hollow midface.

A youthful lower-lid and cheek complex has a single convexity configuration. The aging midface, due to the protrusion of lower-lid fat and cheek ptosis develops a dual convexity configuration (Fig. 1.16). Midface aging is treated with facial implants, injectable fillers and fat, midface lifting procedures, and skin resurfacing.



**Fig. 1.15** (A) The jowling and lower facial changes seen in the seventh decade. (B) An MRI scan shows the accumulation of fat in the jowl area.



**Fig. 1.16** (A) A youthful profile has a single convexity configuration, while (B) the aging face due to midfacial and lower-lid senescent changes has a double convexity configuration.

## Nasolabial Folds

The nasolabial fold is a very unique structure as it is one of the earliest signs of aging and is disdained by most people early on in their life. It is also a very unusual structure, as it is absent at birth, present at death, and diminished with facial nerve damage. There is a saying in cosmetic surgery that despite all technology and advances, the nasolabial fold “remains undefeated.”

The aforementioned midfacial changes and related ptosis produce a deepening of the nasolabial folds. Maxillary skeletal regression and loss of dental vertical dimension are also contributors. The dermal muscle insertions of the levator labii superioris, zygomatic major/minor, and the risorius cross the superficial muscular aponeurotic system (SMAS) to form the nasolabial fold. The nasolabial fold is also formed by the muscular SMAS (modiolus) and the nonmuscular SMAS (subcutaneous tissue and fat). A

muscular and tonic modiolus and SMAS supports the nasolabial fold in youth. The SMAS also supports the buccal fat pad and holds it in place, which prevents forward protrusion that contributes to a deep (concave) nasolabial fold. The loss of muscle tone of the modiolus and SMAS with the resultant ptosis contribute to the deepening of the nasolabial fold with aging. This, along with the overlying fat and dermal atrophy and osseous resorption, contribute to the gradual deepening of the nasolabial fold over time. With the weakening of the cheek-retaining ligament system, the malar tissues become ptotic, but fat cannot “cross” the nasolabial fold due to the dense fascia to dermis adherence within the fold. This bunched up tissue lies lateral to the fold, making it deeper.

## Nasal Aging

The youthful nose possesses a well-defined dorsum, a well-defined tip with good projection and a nasolabial angle of 90–110 degrees. The aging nose undergoes a gradual ptosis for numerous reasons, including the weakening of the junction of the nasal bone and cartilage interface, which results in nasal tip droop. Laxity of the supporting intercartilaginous fibers, fat atrophy in the upper lip, as well as alveolar and perinasal bone loss, contribute to nasal ptosis. As the soft tissue atrophies in the region of the anterior nasal spine, the medial crura footplates become retrodisplaced. Ptosis also occurs as the relationship of the upper and lower cartilages weakens over time with a gradual dehiscence of supporting ligamentous structures. Age-related changes in the nose are usually related to overgrowth of the nasal tip cartilage or skin. Any change than disrupts the proper proportions of the nose can affect its appearance. Cartilage makes up the lower-half of the nose and the lower-third is prone to enlargement with age. The two lateral crus of the lower lateral cartilages are the main contributors to the classic bulbous nasal tip that enlarges over time. Cartilage enlargement cannot only make the nasal tip bigger, but can also cause it to grow in a downward (ptotic nasal tip) direction. The loss of teeth with aging, along with nasal tip enlargement or ptosis, can create the appearance of the nose touching the chin.

Swelling or growth of the sebaceous glands on the nasal skin can also occur with age, but is more commonly associated with excess alcohol consumption. WC Fields had the classic example of sebaceous hyperplasia or *rhinophyma*, where skin in the nasal tip enlarges and becomes red and lumpy because of the overgrowth of sebaceous glands below the surface. Enlargement of the nose, whether from skin, cartilage, or bone, can be treated by rhinoplasty and rhinophyma is treated with laser or radiowave ablation. Nasal airflow patterns are also altered with aging.

## Ears

The external ear reaches 85% of growth by 3 years of age and is fully grown by 7–8 years of age. The earlobes become wrinkled, lose volume, and appear to enlarge in some patients. Continued growth of the external ear is controversial. The aging ear is treated with skin resurfacing, earlobe reduction, and filler injection to volumize senescent lobules.

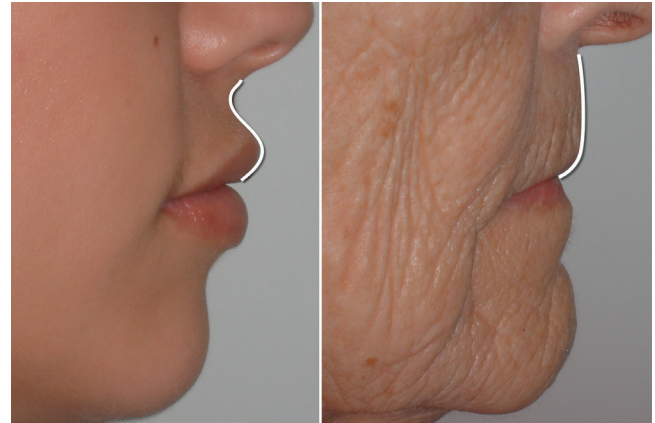
## Lower Face

### Perioral Region

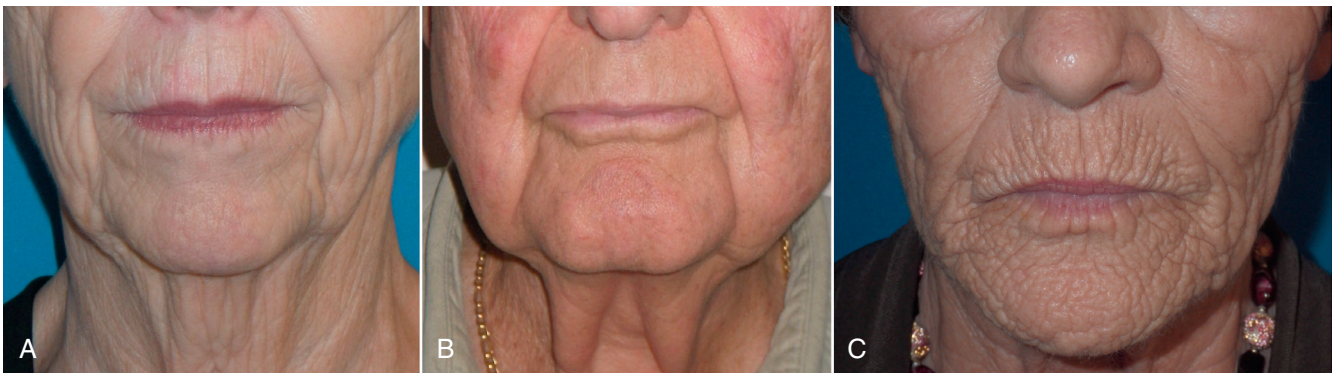
Perioral aging is a significant contributor to looking “old.” The corners of the mouth turn downward from cheek ptosis and loss or dental vertical dimension as well as soft changes in the lips. Prominent buccolabial folds (marionette lines or drool lines) develop lateral to the oral commissures. The lips become thin from fat and muscle atrophy and the vermilion border diminishes. Vertical upper and lower lip rhytids develop, especially in females. The loss of muscle tone and atrophy of the lip elevators, depressors and modiolus allow this “sling”-like anatomy to weaken and produce generalized loss of lip support. The youthful upper lip is shorter, fuller and curvaceous while the senescent lip becomes elongated and flat (Fig. 1.17). The mentalis muscle, which is partially responsible for lip competence, is subject to ptosis and atrophy, producing changes in the lower lip and chin. Skeletal maxillary and mandibular bone and alveolar resorption and the loss of dental structure are also strong contributors to the aging perioral region (Fig. 1.18).

## Jowls

As described in Chapter 3, a series of ligaments keep the facial tissues taut in youth and the laxity associated with aging allow cheek and jowl ptosis (Fig. 1.19). In youth, a tight well-defined mandibular border is present. With aging, the combination of ligamentous laxity from the masseteric cutaneous and mandibular ligaments, photodamage, midface descent, and weight gain, obscures the mandibular definition. Jowling is a result of ptotic fat compartments, as well as the buccal fat descent and the overlying skin changes. Superior and inferior jowl fat compartment position change is seen in patients with ptotic jowls, suggesting a shift of volume inferiorly. Dehiscence of the mandibular septum allows fat to flow across the mandibular border into the submandibular fat compartment. In addition, dermal muscular attachments are weak in the cheek, mandibular angle, and neck, which also contributes to cheek, jowl, and neck aging. Buccal fat is separate from jowl fat. Jowl fat is separate from the submandibular fat by a “septum” of connective tissue adherent to the mandibular body. Jowling is treated with SMAS facelift, liposuction, and skin resurfacing procedures.



**Fig. 1.17** The youthful lip is shorter, curvaceous and volumized, while the senescent lip is elongated and has loss of volume and shape.



**Fig. 1.18** Perioral aging changes seen in an 80-year-old (A) woman and (B) man. The cumulative effects of skin damage, bone loss, dental changes, and gravitational and atrophic changes produce loss of lip tissue with accentuated folds and jowls. (C) Severe aging changes that involve heredity, actinic damage, and smoking.



**Fig. 1.19** Jowl formation is a result of weakening of the mandibular septum and the shifting of fat in the lower face as well as generalized soft tissue ptosis.



**Fig. 1.20** A patient with senescent and ptotic chin aging before and after facelift with chin implant. The chin implant serves to provide a new scaffold support as the tightened skin is redraped to provide a more youthful profile.

## Chin

The chin and submental area undergo significant aging changes. Because of skin changes, fat atrophy, muscle atrophy, dental changes, and contributing submental anatomy, the chin can become quite ptotic, especially in females. Generalized weight gain with aging also decreases the definition of the chin. A “witches chin” is a term describing chin ptosis with soft tissue excess in females (Fig. 1.20). Loss of tone of the mentalis dermal insertions also contributes to chin aging. Chin aging is treated with chin implants, lifting procedures, injectable fillers, and submentoplasty.

## Submental Region

The submental region is well-defined in most young people and numerous changes occur throughout life. Generalized fat deposition with changes in the hyoid structure and muscular support can affect youthful submental sling. This produces a loss of definition of the cervicomental angle, fat deposition, and loss of chin definition with generalized fullness of the submental region (Fig. 1.21). Rejuvenation of this region is accomplished with chin implants, submentoplasty, liposuction, platysmaplasty, and facelift.



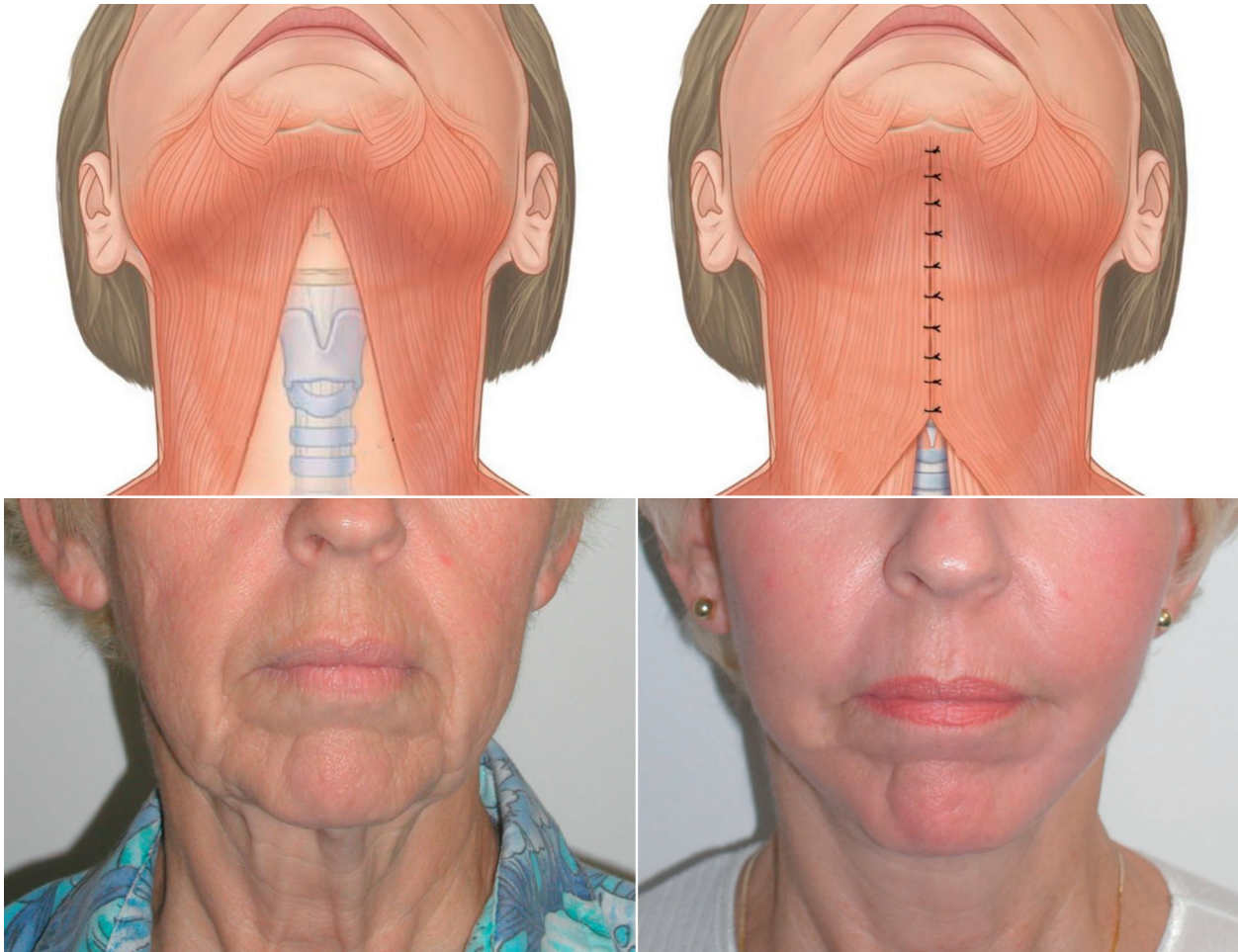
**Fig. 1.21** A Hollywood “fat suit prosthesis” used to make actors appear fatter and older. The augmented regions correspond to aging and weight gain with face and neck fat deposition.

## Neck

“I hate my neck” are words that cosmetic facial surgeons hear on a daily basis. There is no more demoralizing feature to aging patients than excess and floppy neck skin. Platysmal banding begins in the late fourth decade and results in two separate cord-like structures from the mandibular border extending down the neck (Fig. 1.22). The appearance of platysmal bands and neck fat is associated with dehiscence of fascia. Generalized weight gain and fat deposition can obscure the definition of the jaw. The aging neck skin and thin platysma muscle often appear to represent a single unit, although they are separate layers. Sagging skin is also a strong contributor to the aging neck and this laxity is very evident during a facelift procedure (Fig. 1.23).

Treatment options in the neck are very limited and other than rhytidectomy (sometimes isolated platysmaplasty and submentoplasty), very few rejuvenation options exist. Newer technologies such as suture suspension procedure and skin tightening with radiowaves, ultrasound waves, or dermal heating have been disappointing in improvement of excess neck skin.

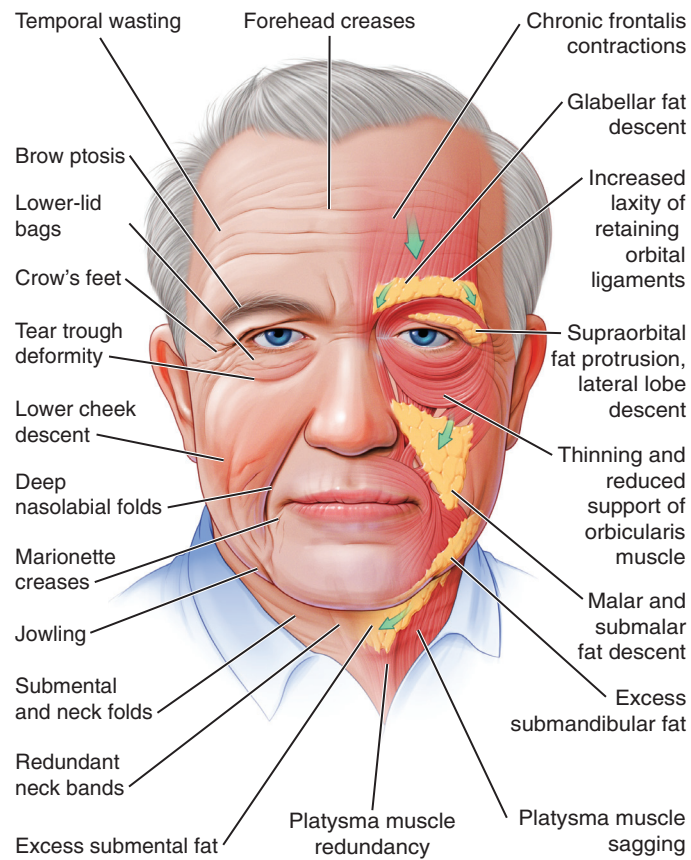
Fig. 1.24 summarizes many of the soft tissue cervicofacial aging changes.



**Fig. 1.22** Platysma dehiscence with related neck banding and the improvement with platysmaplasty during facelift.



**Fig. 1.23** The extreme amount of skin excess that is repositioned and removed during rhytidectomy, underlining the contribution of skin excess to lower facial aging. The arrows point to excess neck skin after platysmaplasty, which translates into pre- and postauricular excess to be removed.



**Fig. 1.24** A summary of the soft tissue changes described in this chapter.

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# Evaluation of the Cosmetic Facial Surgery Patient

## The Art of the Consult and the Office Patient Experience

Joe Niamtu, III

Cosmetic surgery is a very unique specialty as it is, for the most part, totally elective. No one *needs* cosmetic facial surgery and very few surgeons begin their journey as “strictly cosmetic surgeons.” A total cosmetic surgery practice is rare as many “cosmetic surgeons” perform other procedures based on their background training. For instance: plastic surgeons may also cover burns, trauma and reconstruction; facial plastic surgeons may cover ENT procedures and skin cancer; oral and maxillofacial surgeons may cover implants and wisdom teeth; dermatologists may cover acne and general dermatology; ophthalmologists may cover cataracts and corneal surgery, etc. Some practitioners enjoy the mix and others only perform the non-cosmetic procedures because they are asked to. If a surgeon is interested in transitioning to a totally cosmetic surgery practice, he or she will eventually drop the ancillary procedures and progress to total cosmetics. I, personally, have limited my practice to cosmetic facial surgery since 2004, and there are certainly pluses and minuses to this. First, I love cosmetic facial surgery, it is my passion and I love going to work; so for me, this specialization has been awesome. The only downside is that shifts in the economy can affect “luxury” purchases, which include cosmetic surgery. Other surgeons will list negatives as having to deal with the sometimes fickle, unpredictable, body dysmorphic, demanding, litigious, and elective patients, and those with unrealistic expectations.

The cosmetic surgery patient is truly different to many of the patients presenting in residency or in a specialty practice. The biggest difference is that these are elective patients seeking an upper-class luxury. When treating a patient for trauma or malignancy, they are most frequently grateful for your skills. Cosmetic surgery patients, on the other hand, are totally elective and paying a lot of money for services they do not actually need. Fortunately, the vast majority of these patients have a positive outcome and are happy with their treatment. Many cosmetic surgery patients may also have significant biopsychosocial implications that complicate normal interaction. Some of these patients have unrealistic expectations, some are body dysmorphic, and some are undergoing surgery for the wrong reasons. In these cases, they may be unhappy with a perfectly acceptable surgical result, and this is when

things can get problematic. One of the best ways to become a great cosmetic surgeon is to choose the right patients. This is a skill that usually takes decades to master and will be addressed later in this chapter.

There is no more important aspect of the cosmetic surgery experience than the initial patient consult. As they say, you never get a second chance to make a first impression, and the first impression occurs when the patient phones the office to make an appointment. Unfortunately, this is when a lot of patients are lost. Having personable, friendly, energetic staff answering the phone can be one of your best referral sources. Patients often tell me they actually saw three or four other surgeons, but the professionalism and attitude of my staff persuaded them to come to my office. Many barriers between the initial phone call and the operating room can be eliminated by an astute front-desk person. A compassionate receptionist can alleviate many patient apprehensions and get the client into the office. I call this staff member “the patient representative.”

An exceptional patient service representative knows how to “answer the phone with a smile” and make patients feel comfortable. The first question they ask is the caller’s name, then they use it frequently throughout the conversation, as people often like to hear their own name. A great front-desk person can convert a question into a consult. If a patient calls to inquire “How much do you charge for Botox?” a poor employee will tell them “\$11” and the conversation is over. An exceptional employee will ask the patient their name. The patient answers “Anne.” “Thanks for calling Anne. Have you ever had Botox before? Did you know Dr. Niamtu is one of the top Botox providers in the country and he teaches neurotoxin techniques to other surgeons? He also uses special techniques to make the procedure painless. Can we make you an evaluation appointment?”

This great patient service representative has now converted a patient with a question into a patient with an appointment. Great patient service reps are priceless and poor ones can run your business into the ground. Uncourteous staff has been shown to be one of the biggest contributors to patients switching doctors (16% due to procedure dissatisfaction; 68% switch because of



uncourteous staff! Results from the 1995 American Society for Quality Survey).

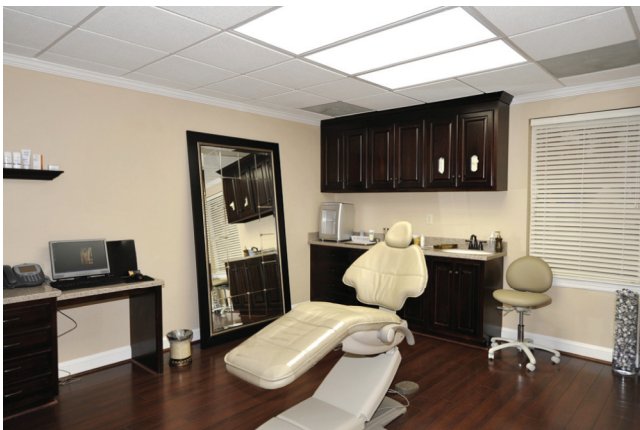
Our patient representatives are familiar with every procedure we perform and can discuss them accurately with prospective patients. We make all receptionists spend time in the operating room observing procedures and we also cross-train all our surgical assistants to answer the phones and make appointments. This cross-training allows all employees to appreciate the work of their peers and also means that they can fill in easily.

## The Physical Plant

If you perform cosmetic surgery, you have to have an office that is as nice as your biggest competitor. I say this because it is common for cosmetic surgery patients to seek multiple consultations. They are likely to see your competitors and if their office grossly outshines yours, you are already at a disadvantage. Having said that, a poor surgeon with a great office will not succeed, but cleanliness and presentation can go a long way. Always remember, these are elective patients seeking upper-class luxury surgery. They shop at high-end stores, stay at high-end hotels, and go on high-end vacations. They are used to being pampered and being in nice surroundings (Figs. 2.1, 2.2). The cosmetic surgery office needs to be set up with this in mind. Many of my patients are middle-class or



**Fig. 2.1** The reception room of Dr. Angelo Cuzalina of Tulsa Surgical Arts is efficient and elegant.



**Fig. 2.2** An exam room in the author's office.

blue collar, but they are spending outside of their means and expect the same environment as do the wealthier patients.

The cosmetic surgery office should be clean, pleasant, and in most practices, decorated to accommodate females, since the majority of cosmetic patients are women. Consider your experience at a very high-class hotel and try to duplicate that in your business. "Concierge care" is a new buzzword, but most successful practices have known these secrets for centuries. The entire goal is to get the patient's attention; for them to come and go with positive impressions. They have to realize that you are special and "do it differently." A patient greeter, providing drinks and snacks, assisting patients with paperwork, and having educational material available for perusal, underline your commitment to patient service. Conveniences such as computers or iPads and wireless connection are all amenities appreciated by patients.

If you are looking for a model of what to do, look at Las Vegas casinos. They know how to treat their high-rollers to keep them coming back. Cosmetic surgery patients are also high-rollers and successful practices know how to make them feel special. They have beautiful furnishings, great smells, comfortable temperature, extremely friendly staff, and everything is clean and bright. If you can make your patients feel special, you will succeed.

The surgeon and/or staff should regularly sit in the reception room and observe all the senses. Does everything look good, smell good, and sound good? Are the magazines current? Is the space spotless? Occasionally, our administrator has a "secret shopper" that none of us know about, who comes into the office to evaluate the entire experience. This can be very eye-opening, as we sometimes fail to see the negative things that are around us. Fish cannot see water because they are in it! Many practice management specialists say that there should be no magazines in the office, only promotional material about services offered. Personally, I think that patients need some diversion. Every one of them has looked at the website and marketing literature before getting here. Sometimes, it is nice just to chill and not feel you are getting "sold" at every angle. First time cosmetic patients are usually nervous, so I want them as relaxed as possible. They can use our computers, watch TV, or read a variety of magazines, as well as have drinks and snacks, which about 99% do.

One of the goals of a well-run office is to not make people wait for long periods. In my office, we have five evaluation and treatment rooms and a relatively small reception room. My goal is to get the patients out of the reception room and into an evaluation room as soon as possible. If you can break up the experience and keep the patient busy, their wait seems shorter. Once they get into the evaluation room, they have the company of a staff member, and also can watch TV or review our website, while waiting for the surgeon. We have 15 high-quality widescreen TVs in our office, and use them for many purposes, including recreation, patient education, anesthesia monitoring, and teaching.

## Office Accreditation

In the 1970s, an uncomplicated facelift required a 4.5-day hospital stay. There have been huge paradigm shifts in hospital stays for all surgical procedures and, currently, most cosmetic surgery is not

performed in a hospital environment. There are numerous reasons for this including exorbitant hospital costs, presence of nosocomial infections, lack of insurance coverage for cosmetic surgery, having cases bumped by emergencies or other surgeons running behind, and lack of privacy for elective cosmetic procedures.

Having a fully accredited surgery center in one's office offsets the need to operate in a hospital and all the negatives associated with it.

- It gives the surgeon total control of his or her operating environment.
- There are no other surgeons to run late or bump your case.
- The surgery is much more cost-effective compared with hospitals.
- Safety is usually enhanced due to the fact that the same people do the same job every day, which eliminates shift changes and related problems.
- There is no worry about infections from other patients.
- Since cosmetic procedures are usually very personal and discrete, patients can come and go without exposure to the employees that work in a hospital environment.
- Small offices usually have one or two anesthesia providers that work on a continual basis and this prevents surprises that can occur with random anesthesia providers.
- Convenience for the doctor, staff, and patient is unparalleled. I used to spend a lot of time driving back and forth from the hospital and now my operating room is just several steps away.

Office accreditation is not a panacea and has relative drawbacks. First, the surgeon is the captain of the ship and responsibility falls on his or her shoulders. If an emergency occurs in the hospital environment, there are dozens of trained personnel immediately available. In your office, it is you and your staff. For this reason, the surgeon must use discretion as to which cases are not suitable for the office surgery center. I never take a chance and I cancel cases 5–6 times per year because the patient has a medical condition that may put them at risk. A big part of having a good reputation and being safe has to do with picking the right patients. Never take a chance with a patient's health.

One of the best things I have ever done in my professional career was to have my office and surgery center accredited. I have hundreds of colleagues who agree. Many surgeons are hesitant to pursue this because of the perceived extra work and expense, and many surgeons mistakenly believe they have to physically rebuild their facility. In reality, bona fide accreditation is attainable for the average practitioner and facility, if the surgeon and staff are willing to meet the requirements. The biggest misconception is that accreditation is a bricks and mortar undertaking, when in reality it is more about policies and governance.

The basis of accreditation is to ensure a safe, efficient, and accountable facility to better serve patients, surgeons, and staff by meeting or exceeding nationally recognized standards. In effect, you are making your office function as a small hospital. It is a lot of work, mostly paperwork, and is not something to be undertaken casually, but it unequivocally will make you a better and safer surgeon with a better and safer staff, facility, and patient experience.

The most common organizations for outpatient, office ambulatory surgery center accreditation are: Accreditation Association for Ambulatory Health Care ([www.AAAHC.org](http://www.AAAHC.org)); Joint Commission on Accreditation of Healthcare Organizations ([www.jointcommission.org](http://www.jointcommission.org)); and the American Association for Accreditation of Ambulatory Surgery Facilities ([www.AAAASF.org](http://www.AAAASF.org)).

Some examples of changes to routine office protocols include the requirement to dictate all surgical operation reports; quality review studies for sterilization; malignant hyperthermia rehearsal; infection prevention and reporting; studies for patient waiting times; peer chart review; impaired physician; and operating room (OR) fire rehearsals and credentialing all users of the operating facility. This is all very paperwork intense. Trying to become accredited on your own can be a task of awesome proportions. I highly recommend that any practice interested in becoming accredited seeks the services of professional accreditation consultants. It is not expensive and they coach the office and staff through every step of the way, including a mock accreditation site visit. I can speak from experience that the consultant route is a good choice. Finally, one drawback to accreditation is the fallacy that the surgeon must do all the work. In actuality, the staff does 90% of the work and record-keeping and the surgeon is the team leader. Having one nurse or exceptional employee to handle all the accreditation work makes this task very straightforward. Since accreditation comes in 3-year cycles with office inspections, having a stable employee that will be there for a long time is preferable.

## Cosmetic Surgery Staffing

I have always said that a surgeon can be no better than the sum of their staff. In elective surgery, there is no doubt that great staff will enhance the patient experience and a poor or apathetic staff will drive patients away. Choosing the correct staff is never happenstance. Cosmetic surgery is very different than many specialties, as discussed earlier. You need staff who understand and relate to the biopsychosocial needs of the clientele. My best cosmetic coordinators were not trained in surgery but rather worked at high-end women's stores. They know how to talk to and sell to upper-class females. Some of my best front-desk representatives previously worked at hotels or travel agencies and are used to catering to people with elective money to spend that value exceptional service.

When it comes to building a great staff, the word TEAM says it all. We have a cosmetic team in my office and we all represent exceptional patient service with optimal safety and predictable and reproducible outcomes. Any winning cosmetic team, as in any sport, takes hours and hours of practice and working together. Each "player" must have a distinct job description and also understand the job of other team members. When you have this, you can achieve synergy. This is when the total is greater than the sum of the parts. You build a great team with everyone on the same page and success is greatly simplified. This entire text could deal with staffing but needless to say, we want team players that are "win/win" people. They represent health and beauty and should look the part. They should smile, radiate happiness, warmth, and compassion, and should be able to make conversation with anyone



**Fig. 2.3** Consistent branding is important in conveying the team concept.



**Fig. 2.4** Consistent branding also should extend to promotional items used in the practice.

anytime. In interviews I look for bubbly conversationalists with a great smile. Their demeanor is much more important than their job experience. I want to hire a “people” person. The job of my staff is to make me look good and they do an excellent job. Germane to the team concept is consistent use of logos, trademarks, pictures, etc., for all office and marketing materials. This includes printed materials (Fig. 2.3), promotional items (Fig. 2.4), and scrub logos.

## The Art of the Consult

Cosmetic surgery is my passion and I love to operate. If we could all go to our offices and simply operate, life would be perfect, but to have surgery, you must have consultations. The cosmetic



**Fig. 2.5** A bubbly conversationalist is a great attribute for the cosmetic coordinator. The ability to interact, relax, and bond with the prospective patient is extremely important.

consultation is usually the first face-to-face meeting with the cosmetic team and the surgeon. It is an extremely important appointment and many patients will see multiple providers, so making the best impression is paramount. Since most consultations begin on the phone, the front-desk patient representative can be a great adjunct. They can set the stage for great patient service, explain what will happen at the consult, and get some information in advance from the patient.

From the time the patient drives onto your parking lot they must be impressed. Are you easy to find? Is it easy to park? Are the grounds and building clean and classy? All of these small elements serve to add up to a final analysis and choice on the part of the patient.

When the patient walks in our door, they are greeted personally and our staff signs them in and serves them snacks and/or drinks (almost everyone wants some), and makes small talk. If we are running behind, the patients are informed and kept up-to-date. A new consult patient should not be made to wait; it sends a very bad signal, so it is important to schedule new patients at the predictable times when the office is not expected to run over.

The patient should be escorted from the lobby to the consult room by the person who will be assisting the doctor at the consult. Furthermore, this person should accompany the same patient throughout their entire surgical experience, and this one-on-one bonding is extremely powerful at building relationships.

The cosmetic coordinator takes the patient to the consult room to begin the process. This room should be the fanciest one in your office and should have a comfortable temperature and smell pleasant. Aromatherapy is a powerful stimulation of the senses. The first order at hand is for the cosmetic coordinator to bond with the patient by making small talk and helping them relax (Fig. 2.5).

If the patient is serious about having a large procedure or is considering multiple procedures, it is frequently helpful to have their spouse at the consult. The spouse (usually the husband/partner) may have considerable concerns about the need for surgery, the finances, and other questions.

For many patients, meeting a new doctor makes them very nervous. With cosmetic patients, they not only have to meet a stranger, but they have to tell them about, and show them, their



**Fig. 2.6** Patients love to see good things about their doctors and in turn they frequently brag about them. Showcasing accolades and community service is great, free marketing.

biggest physical insecurities. Many patients have problems with aging and do not cope well. This apprehension can lead to a patient who is literally perspiring by the time the doctor examines them. It is very important for the staff to relax the patient and to compliment the surgeon. They can make you look good without sounding arrogant. People want to know that they are seeing a compassionate, experienced, and popular surgeon, and your staff can really help with this.

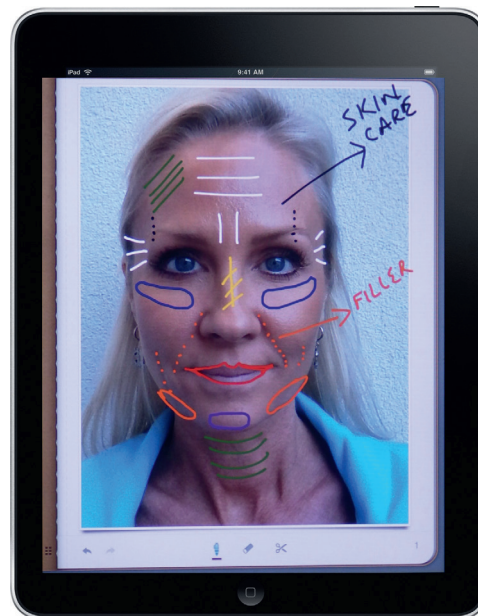
The cosmetic coordinator also asks the patient what it is they wish to discuss and she can make cursory suggestions, such as, “I believe Dr. Niamtu will want to discuss eyelid surgery, cheek implants, and facelift with you.” She then displays our website on the widescreen TV and goes through specific procedure pages to discuss what we do and how we do it. She then shows the patient before-and-after pictures of relative cases. This interaction is important, as it gives the patient an idea of what the doctor will discuss and also provides them with information on the procedures and this can shorten the surgeon’s consultation time. Having awards, publications, charity involvement, and similar accolades in plain view can be useful for patients (Fig. 2.6).

## Meeting the Surgeon

After the staff “pre-consult” the surgeon is called into the room and introduced. This initial meeting can make or break the patient’s decision. I always shake hands with the patient and introduce myself by my first name. I believe friendly communicative contact puts patients at ease and subliminally enhances the doctor–patient relationship. A show of personal warmth, an unhurried attitude, and some small talk with the patient before getting to the cosmetic problems will be time well spent.

Most of our patients register online and are asked to bring a list of cosmetic facial concerns to the first appointment. Nervous patients often forget to ask key questions. Patients are also frequently asked to bring in younger pictures of themselves to see what they considered their strong or weak points and how they have aged.

The most important instrument used in the consult is a hand mirror. I ask patients to tell me what bothers them or what they



**Fig. 2.7** Digital applications and tablet computers are very useful adjuncts to enhance the evaluation.

would like to change and to show me in the mirror. At this point, I always begin with a compliment such as, “You have a great jawline” or whatever positive feature you can start the conversation with. Since you are going to be discussing negatives, it is best to begin with a positive. Occasionally a patient will say, “Doctor, what do you think I need?” The novice surgeon should never fall into that trap. It is imperative that the patient takes ownership of what bothers them or what they would like to change. A patient who cannot communicate their cosmetic problems may have other underlying problems. Some patients are embarrassed to discuss the topic and need some prodding. The other problem with answering this question is that the surgeon may suggest a problem that the patient has not seen and thus offend the patient.

Some practice management experts say that you should not hand a woman a mirror, as it is offensive to make her look at her flaws. An alternative to using a mirror is to take several pictures of the patient just before the consult and project those images on the widescreen monitor. This can have great impact when showing patients their aging changes. Also giving the patient a copy of the pictures to take home can go a long way in having them realize their aging problems, especially in the lateral view, which no patient likes to see. A more digital means of avoiding the mirror is to use an iPad to take front, three-quarter, and side views, and to share them with the patient. Using a free app such as Penultimate ([www.evernote](http://www.evernote)) allows the surgeon to write or draw on the photograph and this can also be e-mailed, texted to the patient, or printed (Fig. 2.7). This allows the patient to leave with notes and drawings.

Although I developed one of the original digital imaging systems in the 1990s, I am not a fan of surgical predictions. First, they are time-consuming and the doctor or staff plays around with digital surgery, which can waste precious patient time. At one time the cool factor of digital imaging would help promote a doctor or sell



**Fig. 2.8** The surgeon and staff should work together in consultation, which helps reinforce the fact that you are a team and that you value the knowledge and experience of your staff.

a case, but today I feel that it is blasé. Second, this is simply a digital cartoon. You can make any patient look like anyone. The accuracy is often suspect and can also give the patient false hope of what to expect. Having said this, I have friends who take great delight in surgical predictions and feel they truly enhance their consults.

The best way to discuss cosmetic deficiencies is to make the consult an educational experience. I explain to the patient that I am going to discuss their entire head and neck in terms of diagnosis and potential treatments, and that this does not mean I feel they need all the discussed procedures but they are possible options. The most orderly means of systematically discussing facial aging and potential treatment is to explain to the patient that the face is divided into thirds, and we will discuss the upper-, middle-, and lower-third and then discuss the skin as a separate unit. During this discussion, the surgeon should never assume, for example, that the patient understands the difference between brow aging and eyelid aging. Always stay elementary when explaining diagnosis and treatment. Many patients have never heard of cheek implants or understand what a browlift or facelift does. If patients are put off by discussion of multiple procedures, and if I sense the conversation going that way, I consider this patient more conservative and stay closer to their main concerns. As I talk to the patient, I include my cosmetic coordinator in the discussion. I may say, “Mrs. Smith, I think you are a great candidate for laser skin resurfacing. Don’t you agree, Ginger?” (Fig. 2.8). This adds a third opinion to the discussion, puts the patient at ease, and reinforces my diagnosis. My assistant is continually recording bullet points of the consultation discussion and prepares a form to give to the patient when they leave that lists the discussed procedures and their respective fees.

I prefer to do my cosmetic facial consults in a high-end dental chair that can also double as a treatment platform for injectables or minor procedures. In almost every consult, I recline the chair and have the patient elevate their chin and look into the hand mirror (Fig. 2.9). This takes gravity out of the equation and provides a surprisingly accurate estimation for facelift, browlift, or cheek implants. This goes a long way to help the patient understand and preview a potential result.

A very important concept is not to assume that any patient has an appreciation as to what any procedure is or does. We do surgery every day but they may have it only once in their life. It is



**Fig. 2.9** A contemporary dental chair is comfortable for consults and useful for showing patients approximate results for various procedures such as facelifts, browlifts, and cheek implants. They also are very adjustable for injectables and postoperative visits.



**Fig. 2.10** Using my website on a widescreen TV has been the most efficient way for me and my staff to truly educate the patient at consultation.

our job to clearly define the correct diagnosis, and explain in an elementary way what procedures are available and what each one will and will not do. The more “props” you have on hand, the easier it is to convey how procedures are performed. In this digital age, the standard for consultations includes animations, videos, and photos. The best place for me to get all of this is from my own website. Our standard protocol is to have the cosmetic coordinator open our website on a widescreen TV in the consult room (Fig. 2.10). The staff member then reviews the procedures that the patient is interested in. While on the web page, they can view and discuss procedural examples, animations, surgical videos, and thousands of before-and-after images. The consult should be an educational experience and this is the best way to do it.

The best way to perform a consultation is to tell the patient that “today we are going to do a full exam and discuss what aging changes you have and what nonsurgical and surgical options are available.”

I further explain that, “cosmetic surgery is totally elective and just because I point out some aging or discuss a procedure, it does not mean that you need or want that procedure.”

It is very important for the staff and surgeon not to appear “pushy” in terms of having surgery. No patient likes a high-pressure sales pitch and there are many aggressive offices out there that push too hard and it is very apparent to the patient. I make a point of telling the patient that I really do not mind what they have done. I love doing surgery and if the procedure is good for the patient it is good for me. I may make suggestions, but if I see that a patient is very conservative or resistant to multiple procedures, I immediately back away from discussing a comprehensive treatment plan. Of utmost importance is to address the patient’s primary concern first. If a patient presents and says, “I hate my neck,” then you do not want to begin the conversation about their eyelids. Stay focused on what is important to the patient; after their major concern is thoroughly discussed, other areas can be addressed. As stated above, patients are frequently nervous and the office has a lot of information to present, so it is not hard to confuse the patient or skip over important details. The best way to avoid this is to do the same thing in the same order at every consult.

After introducing myself and making some small talk, I get down to business. I either say “My staff says you are interested in a facelift.” Or I ask the patient “What are we discussing today?” Both of these set the stage for the patient to begin dialogue. Sometimes they are less forthcoming because they are nervous, embarrassed, or not good communicators. At times like this, I say “When you look in the mirror, what bothers you the most?” I frequently use myself as an example, saying “When I look in the mirror, I see a big bald head, so I would love to have hair.” That usually brings out a giggle and then they relax and tell me what bothers them. Personally, as I have gotten older and now have some early jowling and neck skin, I can use myself as a model to discuss aging and this helps the conversation because I “feel their pain!” Once I address the main problem, I tell the patient we are going to do an educational aging analysis in a specific order, addressing four distinct areas. The areas to be discussed are the upper face, the middle face, the lower face, and the skin. I then repeat that list to make sure they understand the order (Fig. 2.11).

While the patient looks in the mirror or at a picture, I point out aging problems in the following areas:

- Brow and forehead complex
- Upper lids
- Lower eyelids
- Cheeks/nose
- Lower face and neck
- Skin.

After I discuss each area I present nonsurgical and surgical options and my staff records the procedures and the appropriate fee. Once we have discussed all the above areas, I tell the patient that we are building their “cosmetic menu” and that every patient has a different menu and that some patients “order” everything on the menu and others may only “order” one item. I reinforce that they should only consider procedures that are important to them and not let our list influence their decisions. By this time, we have also discussed their health history, recovery window, and budget.



**Fig. 2.11** I refer to this diagram to explain to the patients the areas we will evaluate.

My average patient is a candidate for “3 Ls” and a “C,” which translates to lift, lids, laser, and cheeks. These are the most commonly combined cosmetic procedures in my practice.

At this point, I tell the patient that I have done all the talking and I ask them for their input and I sit back and listen. I review their “menu” and tell them that I will leave them and my cosmetic coordinator to discuss further details (finances, scheduling, etc.). Before leaving the room, I personally hand each patient my business card with my personal cell phone and e-mail. Most patients are quite surprised by this, as many doctors hide from their patients. I tell my patients that if they cannot call their surgeon, then they have the wrong surgeon. This availability has a large impact on patients choosing their surgeon. I shake the patient’s hand, thank them for coming, ask them how they heard about our office and one more time ask them if there any further questions. The average time for the consult is 45–60 min and the actual face time with me is about 20 min.

Although for years I never charged for consults, as we have gotten more and more busy, I have instituted a small consult fee. This has eliminated a lot of “tire kickers” or patients who were just curious but not serious about having cosmetic surgery, and has greatly improved our schedule to concentrate on the more serious patients.

When I leave the room, the coordinator sits back down and continues the conversation with the patient to discuss finances, offer literature about payment plans, and to give the patient a professionally made pre-surgery package that has information about our office, our doctor, and the pre-surgical experience (Fig. 2.12).

We encourage patients to carefully study our website – a great educational tool – in relation to their anticipated procedures. Serious patients are given information about required preoperative history and physical and lab tests, so they can begin planning. Roughly one-third of patients already have their minds made up that they are going to book a surgery. Before the patient leaves

the consult room, we also ask about their skin care regimens and many patients will show interest and purchase products at that appointment (Fig. 2.13). Finally, when a new patient leaves our office we want them to remember us. We give all new surgical consults a gift bag with small logo gifts, office brochures, and product information.

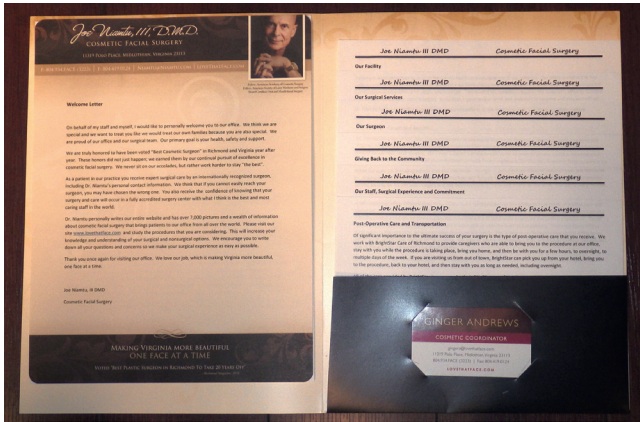
Before the patient leaves the office, the cosmetic coordinator gives them a tour of our surgical facility. We discuss all the attributes of having a fully accredited surgery center and explain to them that all of our facilities, equipment, procedures, and emergency equipment are the same as in local hospitals (Fig. 2.14).

That same day, we send a follow-up personal notecard thanking the patient for coming to the office, and inviting them to contact us with any further questions. If we do not hear back from the patient in 6–8 weeks, a “tickle” letter goes out reminding them we are at their service for questions or concerns and the staff member

that sat in the evaluation calls the patient to see if there are any questions that she may answer.

## Patient Screening

Patient screening has a lot to do with the success of the case. A patient with a positive attitude and realistic goals and expectations can make the cosmetic facial surgery transformation sheer joy. A patient who does not understand the procedure, is uncooperative, or has unrealistic goals and expectations can present profound clinical and legal challenges. A frequently quoted sentence is that, “1% of your patients will cause 99% of your problems” and it is true! The key to having happiness and balance in one’s professional life is to be able to “weed” out the patients who will be problematic. The surgeon and staff must be continually on the lookout for patients who exhibit “red flags” for potential problems. The best



**Fig. 2.12** A portion of our pre-surgical packet that the patient receives at the end of their consultation appointment.



**Fig. 2.13** Many patients want to jump-start their treatment and have an immediate interest in skin care. The author’s skin care suite is shown.



**Fig. 2.14** Patients feel very confident when they see a modern, safe, and well-equipped facility. Giving them a personal tour allows the surgeon to show their commitment to excellence. One of the author’s operating suites (A) and post-anesthetic suites (B) are shown.

reason for a patient to have cosmetic surgery is to look as good as they can for their age. When I hear this, I know I have a potentially great patient. Patients who are trying to look like someone else, trying to get a job promotion, or trying to save a relationship may be poor surgical choices. Problematic patients include those shown in [Box 2.1](#).

The Internet is a wonderful thing, which has changed my practice from local to international cosmetic facial surgery. Although I am honored to accept out-of-town patients, the Internet also brings some uniquely problematic ones. I meet young patients who request cosmetic procedures generally performed on much older patients, and patients who are heavily involved with “Internet cosmetic surgery,” such as cosmetic surgery bulletin boards and

### Box 2.1 Potential “red flags” for having cosmetic surgery

Surgeons should proceed with caution with patients who:

- demand guaranteed results
- the surgeon or staff do not like
- exhibit body dysmorphic disorder or psychiatric conditions
- want to look like a celebrity
- want to look “young” or “take 20 years off”
- are overly narcissistic or immature
- are unfriendly or impersonal
- do not make eye contact
- do not listen and do all the talking
- do not “get it” and ask the same questions over and over
- are too busy or important for surgery
- do not want any pictures taken or demand unusual anonymity
- are not telling spouse or family about their surgery or true extent of their procedures
- berate previous surgeons and compliment you
- cannot decide on a surgical plan
- are overly impulsive, and want to book surgery immediately
- have unrealistic expectations
- know more about the procedure than the surgeon
- request specific operative techniques
- are obsessed with online cosmetic surgery patient sites
- are addicted to cosmetic surgery
- are over-reacting to small flaws or minor aging
- complain about or want to negotiate fees
- want surgery for the wrong reasons, such as a job promotion or pending divorce
- have a resistant spouse
- have consulted with “all the leading specialists”
- cannot stop physical activity or exercise
- refuse caregivers
- send too many e-mail questions
- cannot really afford the surgery
- have transportation problems
- will not come to the office for consults
- are nice to the doctor but rude to the staff

websites. Also potentially problematic are younger patients who have already had numerous cosmetic procedures, despite their age. Some of these patients are clearly addicted to cosmetic surgery, and many have body dysmorphic disorder (BDD). They are seeking rejuvenation for the wrong reasons, and once you operate on them, you “own” their result. If they are unhappy, which they have a strong potential to be, they may retaliate in ways that put your practice at risk. Younger Internet male patients can be a specific problem, especially those that forward pictures of male models they want to emulate. Much has been written about SIMON, which is an acronym for Single Immature Male Overly Narcissistic. These younger patients are very Internet savvy and if they have an outcome that they are not happy with, they can assassinate you on doctor rating sites.

One of the hardest things, especially for novice practitioners who are not busy, is to say “No” to a patient who is sitting in front of you, wants surgery, and can pay for it. Use caution and common sense in patient selection. All a surgeon has to say is, “I don’t think I can achieve your goals and make you happy.” Following this practice can save you from very stressful and unhappy experiences. Much is written about having questionable patients see a psychiatrist before accepting their case. Personally, I never do this. First of all, if I am worried enough about a patient’s psychological status to have them evaluated, I already do not think they are a good fit for my practice. Second, this can be very offensive to a patient. Good cosmetic surgeons know how to say no, and do it frequently. Remember, having good and predictable outcomes and a great reputation has a lot to do with operating on the right patients.

## Preoperative Appointment

When patients call to schedule a surgical appointment, they are required to pay a nonrefundable deposit. This screens out insincere patients and prevents broken surgical appointments. The preoperative appointment is scheduled at least 2 weeks before the surgery date. At this appointment, we conduct the informed consent process, make sure proper labs, history and physical exam, and anesthesia information are in order, and one more time explain the procedure and options. A lot of time can be saved and repetition minimized by having patients review consents and postoperative instructions online prior to this appointment. It can be a very unnerving experience for the patient signing four or five informed consents and this gives many patients cold feet. I tell them they will be worried after reading the things that can possibly go wrong, and I explain that serious complications are very rare. I reassure them that this is what I do for a living every day, and not something I just dabble in. I further explain that statistically speaking, driving to the office is probably much more dangerous than having surgery and anesthesia.

At this appointment the remainder of the surgical and anesthetic fee is due. Many surgeons bill for the anesthesia and pass this on to the anesthesiologist. Although there is nothing wrong with this, it appears on the surgical bottom line and makes your surgical fees appear higher. By having the anesthesiologist bill separately for their services, the actual surgical fee is not distorted.





**Fig. 2.15** A photographic background on the back of each door enables the taking of professional and controlled pictures in any room, and negates the need and congestion of a centralized photographic suite.

We require that the patient's caregiver be present at this appointment. The first 20–30 min of the preoperative appointment are spent with the surgical coordinator or surgical nurse. They go over all of the consents and surgical details, as well as the postoperative instructions. Again, the caregiver must really understand their upcoming role. At this point, I enter the room and review all the information and questions or concerns. I also perform and document a formal physical exam. I cannot stress the importance of accurate documentation at this appointment. Any problems, asymmetries, abnormal anatomy, etc., need to be documented at this time and the patient informed. “Before” pictures are taken in full makeup and without makeup at this appointment (Fig. 2.15). Patients are given their prescriptions, preoperative instructions, surgical and postoperative instructions. Out-of-town patients or those without caregivers are offered the option of private-duty assistants or nurses and transportation if needed.

## The Day of Surgery

The patient arrives at the office NPO and changes into a hospital gown. It is very important to give these patients a warm robe and to keep them out of the hustle and bustle of the office. Nervous patients in skimpy gowns in cold rooms with a lot of activity is not the environment you want. Remember we do this every day and can be immune to the comfort and privacy required.

In our practice, the anesthesiologist meets with the patient that morning before surgery. If there are any significant medical or anesthetic concerns, a meeting would have been scheduled several weeks before, but for routine cases on healthy patients the anesthesia evaluation is performed the morning of the surgery. I also meet with the patient and caregiver to make sure there are no last minute questions or concerns. I always maintain an upbeat attitude



**Fig. 2.16** An official timeout is taken to ensure that the entire staff is aware of procedures, surgical sites, and patient history.

and tell the patient I am very excited to be their surgeon and everything will be fine. I then mark the patient with a surgical marker for the specific procedures.

## The Intraoperative Period

The intraoperative period is very busy and this is when mistakes can happen. The room is kept warm and quiet during the anesthetic induction. The very first thing that is done when the surgeon enters the operating suite is a formal timeout. A standardized form is projected on to the widescreen in the room and all personnel in the room stop and the circulating nurse reviews the patient, their medical history, allergies, specific surgical sites, and proposed procedures (Fig. 2.16). I also personally mark the patient's cricothyroid ligament in the rare event an emergency airway would be required during the case. In 30 years this has not happened, but it is a preventive intervention.

Every surgeon and staff member should understand the stressful situation of waiting for a loved one who is having surgery. This is the time that family frets, and they need be updated and reassured. We encourage our relatives or caregivers not to stay in the office, but if they desire to, we keep them in a segregated small family waiting room that is stocked with beverages and snacks and has a large-screen TV and Internet access. The circulator also personally updates the family or caregiver in the middle of the case to let them know everything is going well.

## The Post-Surgical Period

After the surgical procedure is completed, the patient is transferred to the post-anesthesia suite. This is also a vulnerable time for medical mistakes, as a lot of things are going on. The operating room is being cleaned, instruments being washed, and preparations made to see afternoon patients. It is imperative that a qualified dedicated staff member stay by the side of the patient and monitor their vital signs until they leave the office (Fig. 2.17). Many tragic stories exist about unattended or poorly attended recovery patients. After the patient is coherent, the caregiver is brought back to the recovery suite. It is important that they have been prepared to see their spouse or family member bruised, battered, bleeding, and burnt. You do not want to have a fainting caregiver, they need to be strong for the patient.



**Fig. 2.17** The recovery period is a critical time for patient safety and staff communications. Proper monitoring and staff is essential.

Ambulatory outpatient anesthesia recovery is very different from a hospital post-anesthesia unit with an entire shift of nurses attending. It is imperative that no patient is ever discharged without proper stability of vital signs and mentation. A recovery scale must be used and documented. A caregiver that has been properly instructed previously is a huge asset for patient management. The caregiver is given my cell phone and are asked to call me later that evening. Germane to this conversation is to be prepared in the event that the patient has a post-surgical hematoma or complication. The office has to have an emergency plan for “return to OR.” You will need available staff, clean instruments, anesthesia support, and medications. If you are not prepared for this, you are putting your patient and yourself at risk. Be prepared!

## Patient Recovery and Biopsychosocial Implications

Getting a patient “in the door,” completing the preoperative phase, and finishing the surgery are generally considered to be the bulk of the surgical experience. As every surgeon is aware, this is often only the beginning and sometimes the recovery process is the most complex of the entire doctor–patient experience. While some patients understand, are prepared, and breeze through their recovery, others are ill-prepared, misinformed, and struggle to maintain the normal balance of life. In extreme cases, these patients may require psychological assistance or other intervention to prevent mental decompensation. Patients with a straightforward, uncomplicated recovery are a pleasure and patients who become entwined in a web of complicating physical and mental factors can literally suck the energy and spirit out of the surgeon, staff, and the patient’s family.

Why do some patients do so much better than others in healing and recovery, accepting the temporary disability, and returning to normal life than others? There is no single answer other than the complexities of unique constitutions for every individual. I would bet if one could follow a complex recovery patient through their life before and after surgery, you would see these complexities

extend into other psychosocial aspects of the patient’s life. This may include trouble with intrapersonal relationships, manipulating spouses, problems interacting with their children’s teachers or neighbors, and other similar situations that categorize individuals as “high maintenance.” These individuals may create an accelerated problematic environment, having problems, symptoms, and reactions that are beyond the mean for an average patient for the given procedure. Suddenly, their cosmetic recovery becomes abominable. The patient may wallow in self-pity, or experience unimaginable pain. They may fear that something is terribly wrong or become totally physically incapacitated, unable to sleep, eat, or drink. Some patients simply do not handle pain, swelling, or recovery very well, although they are totally normal before and after they heal. Other patients, however, may exhibit intentional problems in an effort to extract pity from doctor and/or family, manipulate relationships, and induce retribution. A good example of this dichotomy is a patient A, who undergoes facelift, blepharoplasty, full face laser, and cheek implants. She recovers quickly in the office surgery center, goes home and presents the following morning and is bruised and swollen, but smiling and joking about her appearance. She is sipping on orange juice and eating snacks from the waiting room. Her husband is supportive and has been a good caregiver. Patient A has a positive attitude and wants to make sure she does all she can do to hasten her recovery. Patient B is the same age with the same frame, health, etc., and has the exact same procedures as patient A. Patient B is crying in pain immediately upon anesthesia recovery and begs for pain medicine. She is worried that she may not have enough pain medicine from her preoperative prescription. She stays in recovery twice as long as normal for her procedure. Her husband begins calling the office soon after they arrive home that she has uncontrollable pain, and she is crying in the background. Her husband is confused because she told him that she was get just getting a little tune-up. The surgeon’s cell phone rings numerous times during the night as the patient is still in pain and does not know how to perform her recovery care, despite having been given comprehensive instructions and handouts a week before. Patient B presents the next morning for follow-up and cannot get out of the car without assistance. They ask for an emesis basin and ask for the room lights to be turned off. She has the demeanor of a multisystem trauma patient and will not make eye contact or engage in discussion. She still complains of severe pain and is sorry she had the procedure and states that we did not tell her it would “be like this.”

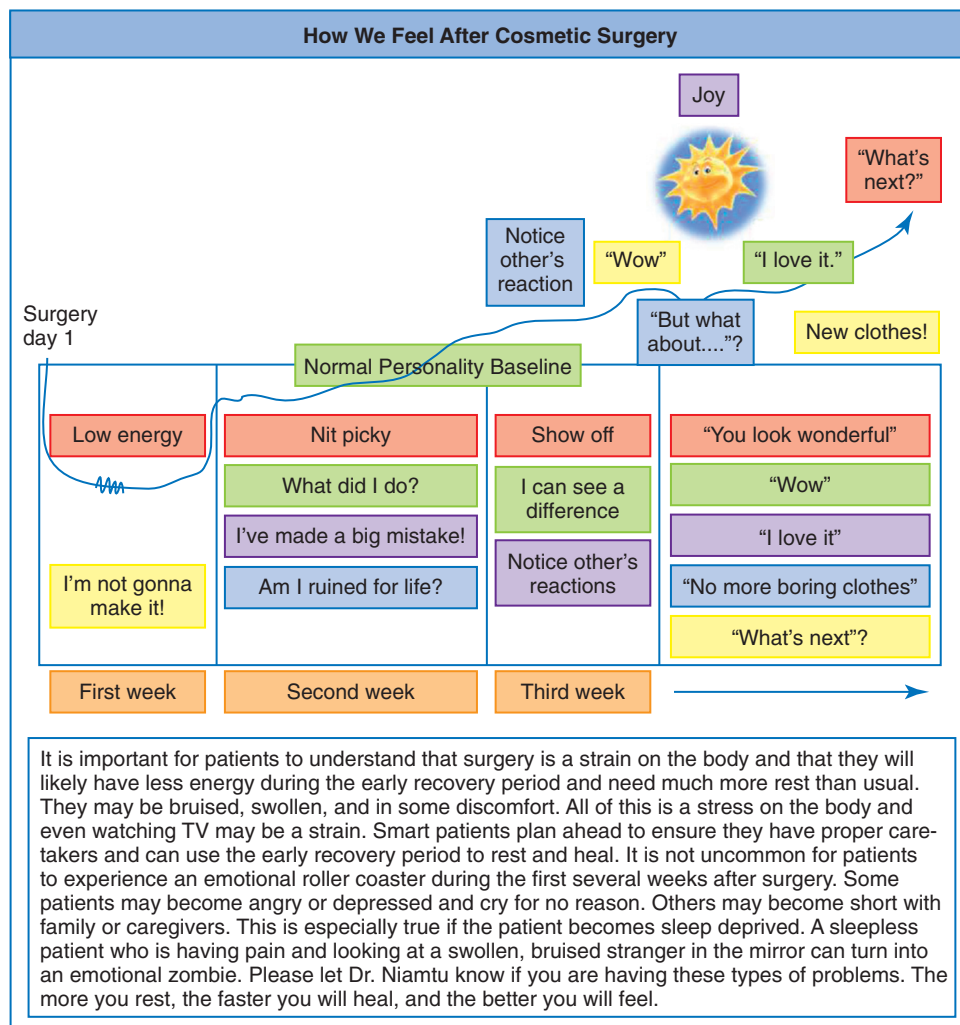
The differences between patient A and B are notable. Patient A makes surgery fun, Patient B makes the surgeon wonder why he or she chose this profession. Not every patient who acts like patient B has psychological problems; some patients are merely fragile and have lower pain thresholds. More often than not, however, a distinct pattern is seen in the B type of patient. Sometimes the surgeon and staff can settle the patient down and get them back on track. Other times it may require some TLC and the surgeon explaining to the patient that what she is experiencing can happen, and the doctor and staff will support her. Some patients need increased pain control and sleep medications. The mix of pain, swelling, sleep deprivation, and fear can put some patients into an acute psychosis. Even strong and “normal”

patients can become emotional, especially females who may have spontaneous crying episodes, and when asked what is wrong, they honestly say “I don’t know.” Emotions can sometimes run rampant with the combination of surgery, swelling, bruising, and medications. Males are not exempt from such behavior. To combat the problematic patient, I spend significant time in the preoperative consultation discussing the good, bad, and ugly aspects of recovery with the patient. I tell them (as does my staff) that they probably won’t like me for several days and that they may ride an emotional roller coaster in the immediate and sometimes extended recovery period. I also provide them with graphics that discuss the various predictable (and sometimes unpredictable) stages of recovery. I have seen facsimiles of these charts around for years and I am unaware of the original author. I made significant modifications to this idea and present them in the online graphics (Figs. 2.18–2.23).

## Dealing With the Unhappy Patient

Most of this chapter has been about making patients happy, but every cosmetic surgeon will have unhappy patients from time to

time. This may be because of a complication, unanticipated outcome, or a patient who simply had unrealistic expectations. A mad or unhappy patient can upset your world from several aspects. First, most cosmetic surgeons truly care about their patients, outcomes, and reputation and take it personally when things do not go well. Second, elective cosmetic surgery is fertile ground for lawsuits. Even though the vast majority of lawsuits are won by the doctor, it can be a humiliating, time-consuming, expensive, and stressful ordeal. The best way to stay out of a lawsuit is to make every aspect of the patient experience protect the practice. Poor documentation is one of the frequent conditions that leads to suits. Although it is time-consuming, accurate documentation is imperative and this is where your staff can really assist. Your informed consent process should be very broad and these documents should be dynamic. By that, I mean that informed consent forms need to be continually updated to protect the practice. Each time you feel that your consent has everything covered, some patient finds a new way to complain and say they were not aware of a given situation. Updating your consents helps protect you. You literally need to go out of your way to think of the most unusual situations that could arise and reflect them in your consents. As stated numerous times in this chapter, if you or your staff see “red flags” with a given patient, do not operate on them.



**Fig. 2.18** The various phases that patients experience after cosmetic surgery.