In essence, the article published in 1998 described a technique for performing a platysmaplasty in conjunction with suction lipectomy of the submental area through a 2.5-cm submental incision to treat the "heavy" neck or the neck with an oblique cervicomandibular angle without using periauricular skin incisions. I reported my results of 56 patients treated between 1981 and 1997. As this relatively small number of patients over a 16-year period suggests, the technique was applied selectively. The long-term effectiveness of this technique in appropriate candidates has been good, considering its limitations (Figs. 1 and 2). One limitation is the patient who has more than mild jowl formation. The technique is performed best for the patient without jowl formation, as illustrated by the patient in Figure 1. The inability to adequately treat a jowl with this approach is illustrated by the patient in Figure 2.

Another limitation of the technique is inelastic neck skin. The technique is not appropriate for the patient with atrophic, sun-damaged skin, which does not contract well over remodeled submental fat and platysma muscle.

I continue to use this procedure as it was described in 1998 except for two modifications. The first change in technique was in my method of neck flap dissection and elevation. For the first 56 patients, I used hydrostatic expansion of the submental and anterior neck subcutaneous fat with 200 cc of saline injected after placement of an infiltration block using 0.25% lidocaine. I wanted to leave an adequate layer of fat on the elevated skin flap, and I felt at the time that saline-expanded fat could be more easily dissected to leave a smooth, 5- to 6-mm layer of intact fat under the skin flap. However, a 5- to 6-mm thickness of saline-expanded fat was not thick enough in some patients. I learned that postoperative neck skin looked smoother and softer if more subcutaneous fat was left under the skin flap, and I found that could be judged best without the hydrostatic expansion of the fat. Although the saline-expanded fat did make dissection easier, its fluid content occasionally misled me into thinking that I was leaving more fat than was actually the case. Although I still remove excess fat from the submental area both above and under the platysma muscle, I now leave at least 7 to 8 mm of unexpanded fat under the skin flap there. Except for obese individuals, I rarely remove any fat at all from under the anterior neck skin, because aggressive fat removal over the anterior neck may give the postoperative patient a skeletonized appearance, especially the patient with marginal skin tone.

The second change in technique I made relates to the platysma muscle plication step of the procedure. In the original article, transection of the platysma muscle at the level of the thyroid cartilage was performed routinely, because it allowed the muscle to slide cephalad and create a better defined cervicomandibular angle. However, this muscle transection at the most distant point from the submental skin incision was frequently associated with troublesome bleeding during surgery, and I believe that muscle transection was associated with most of the cases of postoperative hematoma formation I experienced. I now usually omit

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FIG. 1. This female patient was 55 years old when she underwent a limited incision submental lipectomy and platysmaplasty and a limited incision foreheadplasty (performed with bilateral 4.5-cm temporal scalp incisions and upper blepharoplasty incisions). She is shown preoperatively (left), 1 year postoperatively (center), and 5 years postoperatively (right). At 1 year, the patient had an improved cervicomandibular angle and her elevated eyebrow position was stable. Between the fourth and fifth postoperative years, she began to show some mild submental skin redundancy. Her eyebrow position remained stable. Because her midface had aged much less than her lower or upper face, the patient represents an excellent candidate for this combined limited incision approach, which eliminates periauricular incisions.

FIG. 2. This female patient was 52 years old when she underwent the limited incision submental lipectomy and platysmaplasty in conjunction with the placement of a small chin implant. She is shown preoperatively (left), 3 years postoperatively (center), and 10 years postoperatively (right). The improvement in her cervicomandibular angle persisted over the 10-year period. Note that her jowl, present preoperatively, remains. Liposuction cannot adequately correct the heavy jowl seen here, because the redundant platysma muscle component in the jowl must be addressed from a cheek flap approach.
The incision of the platysma muscle, because I found that approximation of the medial platysma muscle edges alone can create an adequately acute cervicomandibular angle in most patients who have normal mandibular body length. If a more acute cervicomandibular angle is desired, it can be obtained by additional plication of the submental platysma, as shown in Figure 3. This submental platysma plication technique also has been useful for supporting a large submaxillary salivary gland.

For the patient with a short mandible and a large larynx, transection of the platysma muscle still provides the best cervicomandibular angle. In those cases, the medial edge of each platysma muscle is transected for approximately 50 percent of each muscle’s width. This is performed just below the level of the larynx in female patients and just at the superior margin of the thyroid cartilage in male patients. The lower transection level for the female patient softens the laryngeal prominence with the platysma muscle coverage.

Today, I am even more selective about the patients to whom I recommend this approach. The ideal patient has thick, elastic neck skin, which is tented forward by platysma muscle bands covered by at least some excess submental fat. These ideal candidates for this limited incision approach include not only younger men and women but also older patients with good residual skin tone. Many older male patients with their typically thicker neck skin are good surgical candidates.

Do not use this procedure on the patient with thin, wrinkled neck skin and minimal subcutaneous fat. For these patients, the oblique cervicomandibular angle can be improved, but the postoperative skin texture is often unacceptable cosmetically. This type of patient should have periauricular incisions for transposition of the neck skin in conjunction with a cheek flap.

Over the years since 1998, I have used this procedure with greater frequency, because more patients today want minimal incision facial cosmetic surgery. Other surgeons also have begun to adopt this approach. By July of 2003, I had treated 136 patients with this technique. I often combine the limited incision submental lipectomy and platysmaplasty with a limited incision foreheadplasty (performed with bilateral 4.5-cm temporal scalp incisions and upper blepharoplasty incisions) plus a blepharoplasty for the patient who presents with minimal midface aging and no jowl formation, as shown in Figure 1. An occasional aged patient who will not accept a “full” face lift or periauricular incisions can often obtain good aesthetic improvement with little visible scarring (Fig. 4). Appropriate candidates for the limited submental incision approach to the heavy neck will constitute a small percentage of surgical cases, but these individuals may become the most appreciative patients.

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Fig. 4. This patient, who might be considered a marginal candidate, underwent the limited submental platysmaplasty and lipoplasty technique at the age of 69. Periauricular incisions or a “full” face lift was refused. She is shown preoperatively (left), 8 months postoperatively (center), and 2 years postoperatively (right). One year after the limited incision submental lipectomy and platysmaplasty, she underwent the limited incision foreheadplasty, upper blepharoplasty, and full-face laser planing procedures. She accomplished this result with only submental, temporal scalp, and blepharoplasty incisions.