

The Deep-Plane Approach to Neck Rejuvenation

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KEYWORDS

- Neck rejuvenation • Deep plane • Facelift • Rhytidectomy • Neck lift • Aging face
- Platysma muscle

KEY POINTS

- Neck changes are often the motivator for seeking treatment of the aging face.
- The platysma muscle/superficial muscular aponeurotic system/galea are the continuous superficial cervical fascia, encompassing most of the facial and neck fat. This superficial soft-tissue envelope is poorly anchored to the face and neck.
- Facial aging is mainly due to gravity's long-term effects on the superficial soft-tissue envelope, with more subtle effects on the deeper structural compartments, manifesting in soft-tissue redundancy throughout the face and neck.
- The deep cervical fascia binds the structural aspects of the face and neck, and covers the facial nerve and buccal fat pad.
- The deep plane is the embryologic cleavage plane between these fascial layers and is the logical place for midfacial dissection, which allows access to the buccal fat pad for treatment of jowling.
- Soft-tissue mobilization is maximized in deep-plane midface dissections. Because the superficial soft-tissue envelope is continuous from the midface to the neck, this technique creates the best opportunity for reestablishing proper neck contour.
- Flap advancement creates tension only at the fascia level and is the optimal technique for revision rhytidectomy.
- The lack of skin tension in the deep-plane advancement flap allows natural, long-lasting outcomes, and is resistant to complications.



A video of a complete extended deep-plane midface lift with platysma tightening accompanies the article.

INTRODUCTION

Change in neck contour is the most common complaint that motivates a potential patient to consider a rhytidectomy. Patients desire a youthful appearance, bolstered by a well-defined neck and clear jawline. Of all facial changes associated with aging, loss of neck contour and jawline are most often associated with advanced aging.

The principal goals in neck rejuvenation, which were defined by Ellenbogen and Karlin¹ in 1980, include creating a distinct mandibular border, subhyoid depression, thyroid bulge, a distinct border to the sternocleidomastoid muscle, and a cervicomenthal angle of 105° to 120°. Whereas the primary and often sole cause of blunted neck contour in younger patients is excess fat deposition, this

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