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The Open Brow Lift Revisited

by Joseph Niamtu, III, DMD

The trichophytic mini open lift may seem old-fashioned, but it has its advantages

The trichophytic mini open lift is not new; it was described by Dr. Richard Placik in the 1970s. However, it seems to be making a comeback in recent years. The technique involves making small incisions along the hairline, which are closed with sutures. This allows for a more natural appearance and avoids the potential for scarring that can occur with traditional brow lifts.

While the trichophytic mini open lift is not a quick procedure, it is a great option for patients who are concerned about scarring. It is also a good option for patients who have very thick hair, as the incisions along the hairline are less visible. Overall, the trichophytic mini open lift is a great option for those looking for a more natural and permanent brow lift solution.
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The trigichropic Procedure

The cren of this technique is a subcutaneous dissection using an extreme reverse bevel on both flaps and an incision made several millimeters behind the hairline. By incorporating the extreme bevel, the hair follicles can regrow through the scar, making it virtually imperceptible after several months. Although this technique can be performed with local anesthesia, I usually use intravenous sedation because I frequently combine the brow lift with other head and neck procedures.

The patient is prepped and draped in the usual manner for aesthetic facial procedures. Standard tarsorrhaphy anesthetic solution is infiltrated over the entire forehead from several centimeters above the hairline to the orbital rims. In addition, 2% lidocaine with 1 part per 100,000 epinephrine is injected at the proposed incision line.

Examination of the hairline shows a secondary line, where the thinner hairs begin to feather out to a lower density. This is usually 3–4 mm posterior to the most inferior hairs and corresponds to the desirable incision site (Figure 1A). Because this technique is subcutaneous, there is no need to dissect inferior to the orbital rims or to the lateral orbital rims.

When I am asked how far to dissect in this technique, my answer is “until the brows are adequately elevated.” This can be observed directly, and it usually does not require excessive inferior or lateral dissection. The lateral extent of the dissection is just past the junction of the middle and lateral one third of the brow—in other words, just past the area of desired maximum elevation. Similarly, the inferior dissection is continued to the orbital rim but is stopped when enough subcutaneous dissection is achieved to adequately elevate the brow.

After an appropriate delay for the vasorumitators to take effect, the incision is made. A number 11 blade is used to make an extreme reverse bevel undulating incision in the subcutaneous plane (Figure 1B). With an extreme reverse bevel, the scalp is held at a 5–10° angle above horizontal.

My experience has shown me that making smaller undulations produces a superior scar, as opposed to using larger “saw teeth.” After the incision, a small spatulate liposuction cannula is used (without a suction source) to retract the subcutaneous flap. This greatly facilitates the dissection of this sometimes delicate flap. After pretunneling, a facelift scissors—or sometimes an index finger—is used to continue the dissection to the desired limits (Figure 2).

Rethink the Resection

When the dissection has reached the point where the brows are adequately released, the brow depressors can be disrupted. For surgeons who are accustomed to performing corrugator resection from a subperiosteal view, some rethinking is necessary. With the subcutaneous dissection, the depressors are being viewed from above instead of from below. Care is used to avoid sensory nerve damage. Figure 3 shows the corrugator supercilii muscles incised within the groove.

When the release is deemed appropriate, the assistant elevates the scalp forward from the vertex (to prevent the incision from gaping), the amount of excess skin is determined, and cutbacks are made. In general, 15–20 mm of skin is excised at the peak area of brow elevation. Less skin is cut back in the midline, which provides desirable flattening and nasal-bridge elevation and narrowing.

It is imperative not to over-resect skin in the midline. After the cutbacks are made, the flap is anchored with three sutures or staples to bear and evenly distribute the tension (Figure 4A). Using the same extreme reverse bevel incision, the distal flap is trimmed to match the proximal reverse bevel. Although it may seem difficult to line up the cutbackstomatch each other, it is actually quite simple, and they fall into place with little effort. Figure 4B shows the distal flap being trimmed. After the excess skin is trimmed, subcutaneous 4-0 interrupted polyglycolic acid sutures are placed, followed by a running 6-0 nylon suture (Figure 5). The sutures and staples are left in place for 10 days. The hair is washed with sterile

Figure 1: The undulating incision is marked at the change of follicular density several millimeters posterior to the hairline. Vertical lines are made at the desired area of maximum elevation. B: An extreme reverse bevel incision is made in the subcutaneous plane.

Figure 2: The subcutaneous dissection is facilitated with facelift scissors. B: The liposuction flap is elevated, revealing the underlying frontal muscles, based on the usual criterion degree of aging, combination with other procedures, available recovery time, and finances. For patients who already have high hairlines or bulk at calvarial fixation techniques, the trigichropic option has been well-received. Although I frequently resect the entire brow and a facelift flap, I have not yet performed simultaneous carbon dioxide laser resection on the thin lipocutaneous flap of the trigichropic open mini brow lift, but I believe that this procedure can be performed at low fluence.

Figure 3: The brow depressors are disrupted under direct view.

Figure 4: A. Three sutures anchor the flap to bear and evenly distribute the tension. B: Vertical lines are made at the desired area of maximum elevation. B: An extreme reverse bevel incision is made in the flap.

Figure 5: The final closure consists of staples, subcutaneous 4-0 polyglycolic acid sutures, and a running 6-0 nylon suture.
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Before & After

This 55-year-old patient is shown before and 6 months after a microphophyle mini-open brow and forehead lift.

Before & After

This 49-year-old patient is shown before and 6 months after a microphophyle mini-open brow and forehead lift.

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