

Techniques for Creating Inconspicuous Face-lift Scars

Avoiding Visible Incisions and Loss of Temporal Hair

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Patients seeking rhytidectomy desire an improved neckline, jawline, and midface, but rarely at the price of signs that betray a face-lift, namely, visible incisions. We describe our face-lift incisional planning and the rationale behind specific surgical maneuvers for preventing unwanted sequelae. The telltale signs of poorly placed incisions include temporal hair loss, conspicuous scars, an unnatural appearance to the tragus, and a posterior hairline distortion. Special considerations are given to the male patient and to the salvage of readily visible incision lines from previous surgery.

Arch Facial Plast Surg. 2003;5:325-333

Much of the recent literature on rhytidectomy describes techniques for improving the quality of the face-lift, eg, to achieve a tighter neckline, decreased jowling, a longer-lasting lift, or more satisfactory midface results. What is patently missing from these articles, however, is attention to incision placement to avoid visible incision lines. Patients want an improved neckline, jawline, and midface, but rarely at the price of visible incision lines, those obvious signs of a face-lift. Most before-and-after pictures in articles on face-lift show the neck and the jawline, but rarely close views of the hairline. To the contrary, in most pictures, the hair is covering the areas of the incisions. In our practice, patients are routinely shown close-up photographs of the postoperative incisions. Prospective patients should be wary of surgeons who fail to show their results with pictures of patients wearing their hair up.

A review of patients in the senior author's private practice who have had face-lifts elsewhere showed a broad nonacceptance of the incisional results. One of the most resented consequences of badly placed incisions is the loss of the temporal tuft or sideburn hair. No salvage face-lift procedure can improve this complication, which is remedied by hair flaps or follicular-unit transplantation. Other scars can almost always be improved with a secondary face-lift, but, in some instances,

they remain for life. We would like to coin the phrases "face-lift cripples," or "hairline cripples," for individuals who, because of a face-lift, can no longer wear their hair up, but must always wear it down to hide conspicuous incisions.

This article outlines a safe method for face-lift incisions that, without compromising the results of the lift itself, preserves the hair tufts, maintains well-concealed incisions, and allows patients to wear their hair in any style after healing. In addition to temporal hair loss, other telltale signs of a poor face-lift include visible preauricular incision lines, an unnatural appearance to the tragus, loss of earlobe definition with a pixie-ear configuration, migrating postauricular incisions, postauricular webbing or hypertrophy, a posterior hairline distortion, and visible posterior hairline incisions lines. We will examine reasons why unacceptable face-lift incision lines occur. Careful attention to preoperative incisional planning, meticulous intraoperative technique and suturing, and timely and detailed postoperative care are essential to inconspicuous incision lines. This article initially focuses on the female patient. Techniques specifically designed for the male patient are described at the end, along with techniques for the amelioration of unacceptable incision lines from a previous face-lift.

OUR TECHNIQUE

Markings are first applied to the patient in a sitting position, which enables an accu-

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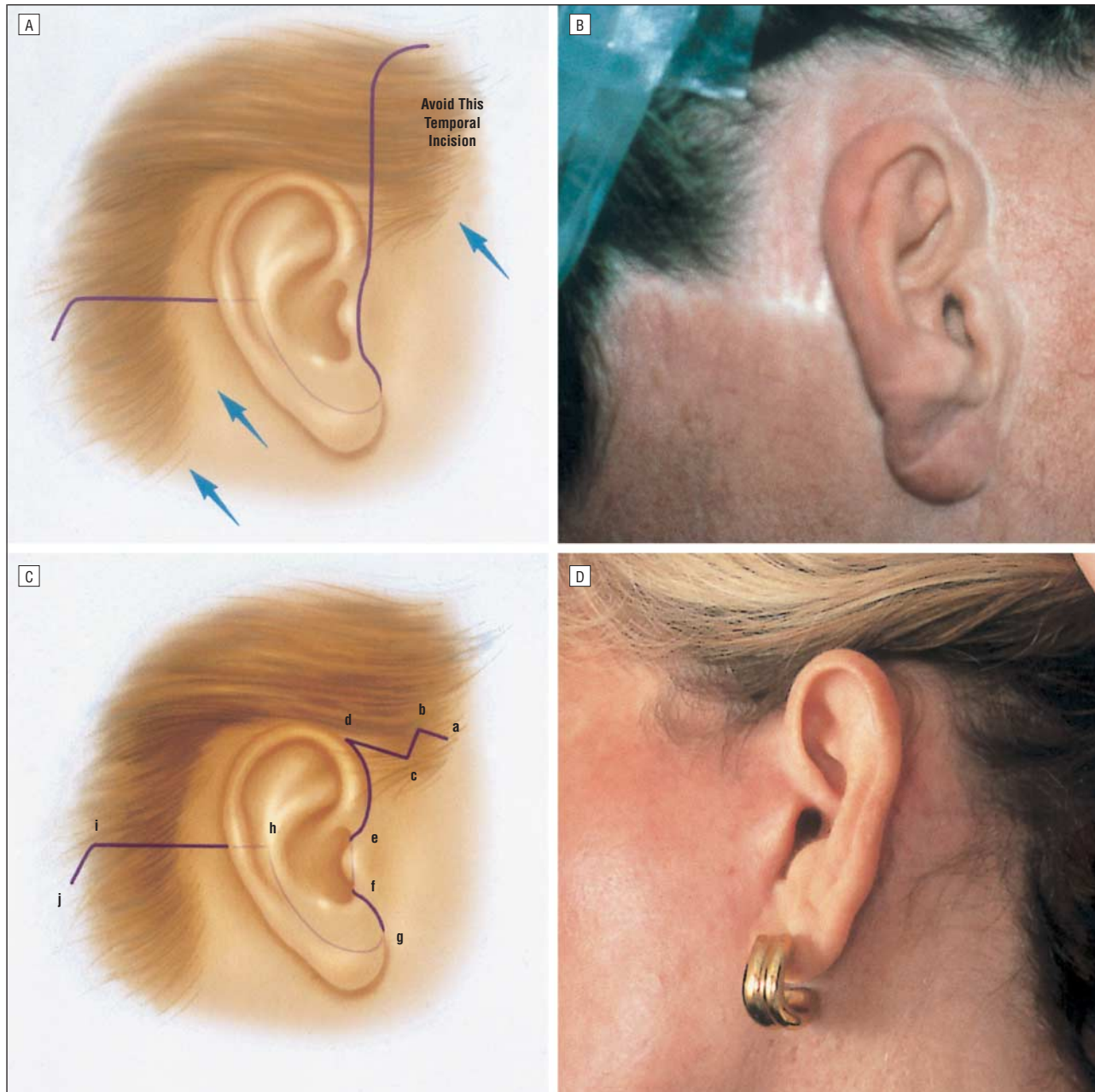


Figure 1. A, Schema of a typical female face-lift incision performed elsewhere; the temporal portion of this incision should be avoided in women because skin excision after a posterosuperior pull leads to loss of the temporal hair tuft by advancing non-hair-bearing skin into the temporal region. B, Temporal hair loss and readily visible preauricular incision secondary to poor placement of incisions; this “face-lift cripple” is unlikely to be able to wear her hair up. C, Schema of our incision with various segments labeled. D, Postoperative result of a typical patient with our incision. There is no temporal tuft hair loss. The preauricular incision is well concealed, partially behind the tragus; it has a natural contour with a pretragal sulcus. The postauricular incision is not readily visible and there is a natural hairline with no distortion.

rate determination of the gravitational forces of aging. Once in the operating room, after general anesthesia is achieved, the patient’s hair is trimmed around the incision marks. It is important to be thorough, as hair is easily trapped in the suture lines, which may pose problems later. Hair detangler is sprayed and the hair is pulled away from the incision marks with rubber bands. Clear sticky drapes are then placed to maintain the hair out of the surgical field.

FACE-LIFT IN WOMEN

Descriptions of many of the classic face-lifts include a vertical, preauricular incision that enters the temporal scalp

posteriorly to the sideburn hair, and then angles forward in a curvilinear fashion (**Figure 1A**). The redraping and/or pull of the anterior facial skin in a posterosuperior direction advances the lower cheek skin into the temporal sideburn, which creates an area of hair loss. The textbook examples show the preoperatively planned incisions, but do not show the typical postoperative appearance (Figure 1B). As most women do not have long sideburn hair, posterosuperior advancement of the non-hair-bearing cheek skin causes temporal alopecia.¹

In cases of excessive facial skin laxity a large amount of skin is removed, which results in a greater loss of temporal hair. The possible advantage of extending the ver-

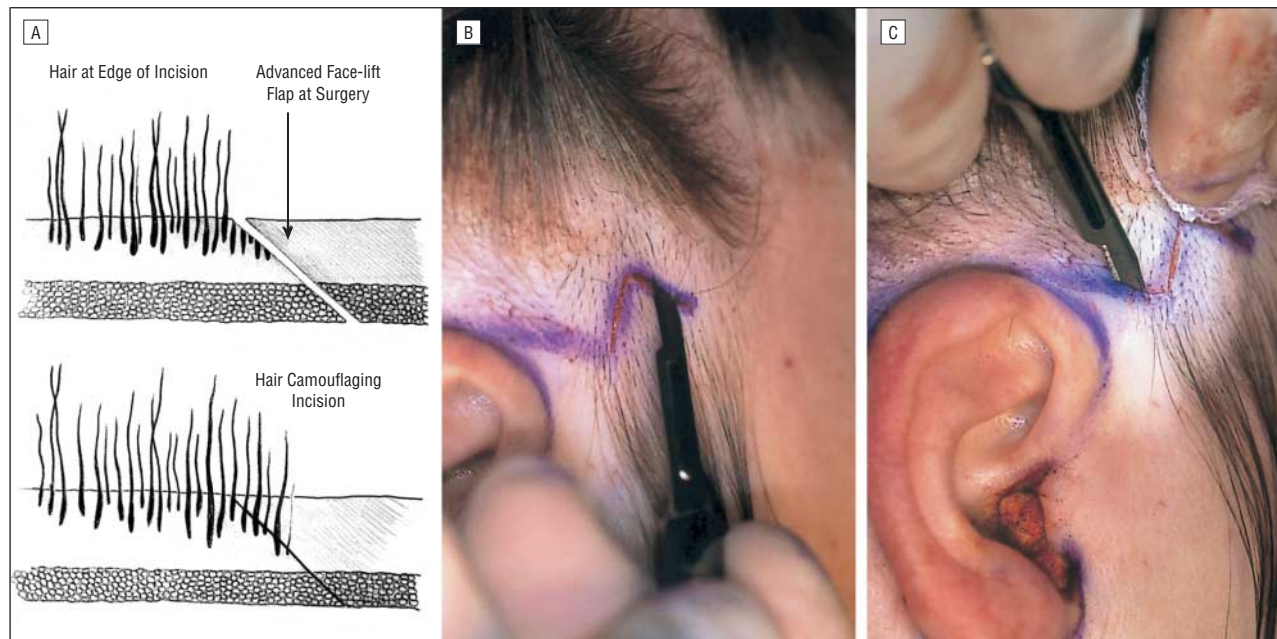


Figure 2. A, One of the options in the temporal incision is to bevel the knife blade perpendicular to the hair shafts; this allows the hair to grow through the advanced skin flap, as depicted here in the schema. The other option is to bevel the blade parallel to the hair shafts; this incision is usually done if the surgeon expects to have a sufficient sideburn tuft inferiorly to the incision even after excision of excess skin. Both techniques may be used in different segments of the temporal incision. Beveling parallel to the follicles is always done in the occipital incision. B, Intraoperative view of the temporal incision parallel to hair shafts to preserve the hair follicles. There will be some hair remaining on the inferior skin flap even after excision of excess skin. C, Intraoperative view of incision beveled perpendicular to the hair follicles. Here, the goal is for the hair of the superior skin to grow through the inferior non-hair-bearing skin flap after redraping.

tical incision superiorly into the hairline is to achieve a greater pull in the temporal area without performing a forehead lift. However, any advantage of this approach is nullified by the loss of the temporal hair tuft.

The incision begins in the temporal region and is designed to preserve the temporal hair tuft (see Figure 1C for details). We advocate a lower incision horizontally across the hairline tuft, no higher than the level of the supra-auricular crease (segment c-d). As it extends horizontally, this incision has a vertical limb (segment b-c) and then an anteroinferior limb (segment a-b) to accommodate any excessive skin reduction and prevent tissue coning. To avoid visibility of this incision, the angle of the first horizontal portion closest to the ear is designed to cut across the hair follicles; thus, if there is no hair below this line, the hair follicles above will grow through the advanced lower facial skin flap and hide the scar. In other words, this portion of the incision (segment c-d) is beveled across the hair follicles. Conversely, if hair remaining inferiorly to the incision would abut on this area, the incision is made parallel to the hair follicles (**Figure 2**). This is rare, however, because of the usual shortness of the hair sideburn tuft in women. The more anterior vertical tuft (segment b-c) and then horizontal limb (segment a-b) are carried out parallel to the hair follicles to avoid alopecia. For each segment of this incision, attention must be paid to the direction of beveling (Figure 2). The exact length and placement of these temporal incisions may vary slightly according to the preoperative height and width of the sideburn and temporal hair tuft in this area.²

The preauricular incision is the next problematic area. When placed anteriorly to the tragus, a long visible vertical line is noticeable. One of the rationales for scar revision surgery is to break up a straight line, so that the eye

cannot follow it. A totally preauricular face-lift incision extends for at least 3 cm in most individuals, which makes it noticeable. Our method attempts to camouflage the preauricular incision by first following the natural curve of the helix in the superior segment. A retrotragal incision of at least 4 to 5 mm (segment e-f) is made deep into the external auditory meatus from the edge of the tragus. This incision is often more visible if made more anteriorly or closer to the edge of the tragus. When raising the skin flap over the tragus, the perichondrium is left intact over the cartilage to preserve its blood supply and maintain its natural shape.

Figure 3A shows the V-shaped wedge of tissue excised at the supra-auricular crease, which facilitates placement of a 1/4-inch Penrose drain and pulls the hair-bearing skin inferiorly. The curving allows for a more natural appearance than a vertical incision. The Penrose drain provides an additional site where any fluid accumulated under the flaps can be expressed, therefore decreasing bruising and edema. This site provides drainage for the temporal and superior preauricular areas not directly accessible by the Blake drain, which serves the more inferior portions of the flap. The incision descends inferiorly toward the ear lobule and is carried out around the lobule in women; it then extends parallel to the postauricular sulcus (several millimeters onto the posterior concha itself to account for the migration of the incision posteriorly with time) to about the level of the superior external auditory canal; then posteriorly for 5 cm; and finally obliquely for 1 cm to account for any tissue coning.

Before entering the postauricular skin itself, it is most important to look at the natural oblique continuity of the postauricular hairline. If the ear is shaped with an helical prominence superiorly, the incision is carried slightly more

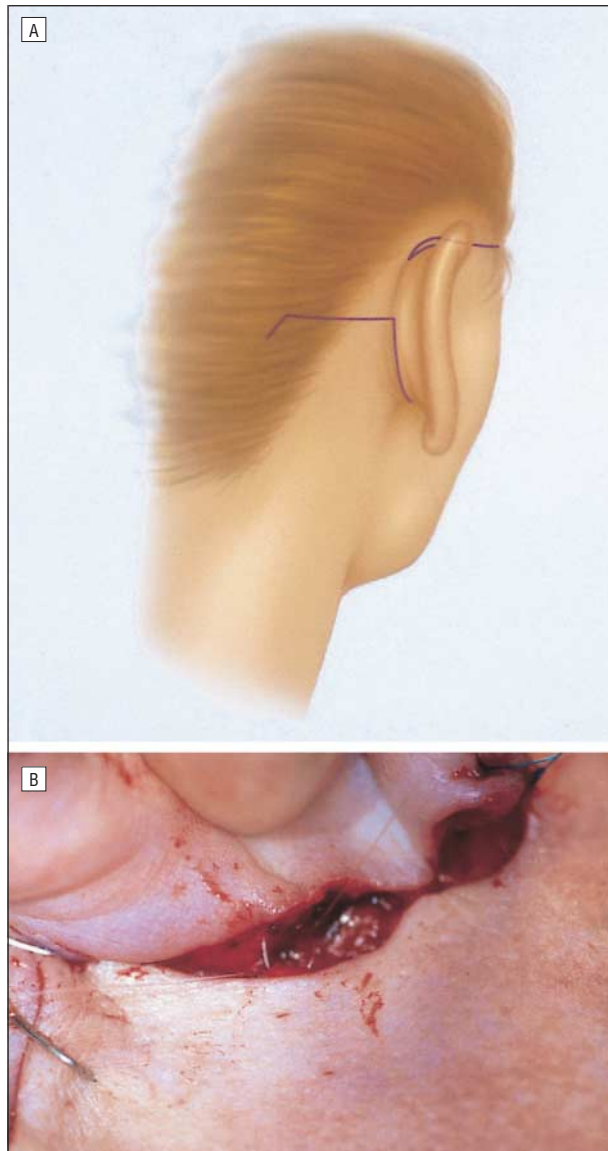


Figure 3. A, Posterior view of the incision. B, Intraoperative photograph of a deep 5-0 polydioxanone suture in the postauricular sulcus closure. The stitch not only approximates the skin edges subcutaneously, but also secures the overlying skin and dermis to the underlying soft tissue exactly in the sulcus itself. This obliterates the dead space, and it also prevents possible migration of the incision posteriorly to a more visible location.

superiorly onto the concha. The distance between the hairline and the ear is variable not only from patient to patient, but often from one side to the other in the same patient. The horizontal portion of this incision crossing the hairline is beveled parallel to the hair follicles to prevent alopecia. Most of the incision is in the hair-bearing area, and its only visible portion is between the postauricular hairline and the conchal sulcus.

The principle of skin redraping must be followed in a face-lift rather than that of placing tension on the skin. If redraping the skin over the tragus is performed with excessive tension, the tragus will be pulled forward and the external auditory meatus will be abnormally open; it may also give retrotragal incisions a surgical appearance. We provide extra skin in this area, and would rather have it bunch up at the incision site at the time of surgery than be short of it, as the redundant skin usually evens out to

appear natural (**Figure 4**). Whether deep-plane face-lift or any of the various superficial musculoaponeurotic system (SMAS) techniques is performed, we prefer that the tension of a face-lift be placed on the deeper layers than on the skin itself. In our repertoire, skin-only face-lifts can only lead to widened and visible scars and nonlasting results, and therefore cannot take place without resuspension of the SMAS layers.

The postauricular incision is made several millimeters onto the posterior surface of the conchal bowl (Figure 3A). If the initial incision is made in the sulcus itself, the scar is much more visible. Perkins³ agrees with this, and also makes this incision above the sulcus to avoid the settling of the scar on the visible mastoid area.

The posterior portion (segment h-i) does not extend along the hairline where it would be visible. Rather, it extends straight posteriorly into the hair-bearing portion of the postauricular scalp to properly realign the hairline and avoid visibility (Figure 1C).

Another problem often occurs in classic face-lifts when, like the preauricular skin, the postauricular skin is pulled in a posterosuperior direction (**Figure 5**). Here too hair is lost, and a hairline distortion (“step-off” configuration) is common postauricularly where normal non-hair-bearing skin replaces the scalp hair. We advocate an anterior or purely superiorly oriented redraping to recreate the normal, preoperative hairline (Figure 5A). The horizontal, posterior incision into the hair-bearing scalp is done high enough to allow for a sufficient amount of hair below the incision. Thus, when some of the skin and scalp with hair is removed, there is still enough hair inferiorly to camouflage the incision.

The next area that can be a telltale sign of a face-lift is the earlobe. If too much skin is excised at the earlobe, or if there is excessive tension on it, the earlobe fails to retain its own definition and appears attached to the face—in what has been described as a pixie-ear or satyr-ear configuration (**Figure 6A**). This can be avoided by incising the flap prior to SMAS dissection or placement of suspension sutures. A further precaution to prevent tethering is the use of a polypropylene mattress suture at the cut edge of the ear lobule secured to the underlying tissue (Figure 6B). This was described by Clyde Litton (oral communication, 1986).

Although excessive tension placed on any incision causes widened and hypertrophic scarring, some surgeons believe that such tension can be placed in the postauricular area because it is not usually very visible. We would again encourage minimal tension for postauricular incision lines, especially since they migrate posteriorly. Incision lines also show when sutures are left in place too long, and tissue tracking occurs when the epithelium travels down along the suture line (Figure 5E). “Railroad tracking” is common when sutures are left longer than 5 or 6 days; skin staples have been used to avoid railroad tracking but they, too, leave permanent marks if they are left in place too long or if they hold skin under tension.

In addition to the polypropylene tacking sutures, the incision is closed in several segments using running, locking 5-0 plain gut sutures. The V-shaped excision in the supra-auricular crease, however, is closed with a running, locking 5-0 polypropylene suture to enable placement of the Penrose drain (we also use a 15F Blake drain)

on each side through a separate stab incision to drain the inferior portions of the flap). All drains are removed the first postoperative day. We find that 5-0 plain gut sutures; provide sufficient tensile strength and provoke some inflammatory tissue response, which results in less suture tracking. A running, locking suture provides hemostasis and an airtight flap closure that allows the suction drains to function more effectively. It also permits the surgeon to loosen the suture prior to complete removal a few days later. Staples are placed in the postauricular incision (Figure 1C, segments hi and ij) and occasionally in the temporal area if the hair is not too thin.

Timely removal of sutures under magnification is imperative for inconspicuous incisions. Because the preauricular area is the most noticeable, we loosen our superior preauricular incision on the third or fourth postoperative day, and remove all of the plain gut sutures on the fifth day at the latest. The individual polypropylene tacking sutures at the superior helix, as well as the one above and the one below the tragus, and the one at the ear lobule, usually remain in place for up to 1 week to maintain good approximation and avoid railroad tracking in the preauricular area. The sutures around the lobule are usually removed on the fifth postoperative day, but the sutures of the retroragral incision into the ear canal rarely need to be removed. First, the incision is hidden; and because ointment is used over this area, the sutures usually dissolve on their own. The same applies to any other incisions within the hair where tissue tracking would not be noticeable. The postauricular sutures and any staples that are in the non-hair-bearing areas are removed by the fifth postoperative day. Those within the scalp are sometimes left for 7 to 14 days. It is often difficult to see plain sutures, especially in fair-haired individuals; therefore, removal under magnification is often necessary. Patients must be followed up because of the risk of ingrown hairs where hair-bearing areas have been approximated to non-hair-bearing areas or to hair-bearing areas. Ingrown hairs may serve as a nidus for infection and inflammation, and cause thickened scars.

MALE FACE-LIFT CONSIDERATIONS

Male face-lift incisions deserve special consideration, as they must accommodate the beard and the sideburn. Because the male sideburn blends into the beard, rarely is loss of the temporal tuft a problem. Therefore, a curving vertical incision into the post-tuft scalp is permissible in most men (**Figure 7**). However, if a large amount of skin must be removed, the most anterior extent of the beard, especially in the temporal area, may be pulled back significantly. In such cases, where the sideburn could be noticeably narrowed or even disappear, a horizontal sideburn incision might be considered.

When one makes a posttragal incision, the beard may be pulled onto the tragus and oppose the anterior lobule and the region just anterior to the root of the helix. Because most men do not wish to shave this area on the tragus and because a clear, non-hair-bearing preauricular space is more evident, most surgeons make a vertical preauricular incision in front of the tragus and preoperatively tell the patient that the vertical limb will be visible (Figure 7). However, in our practice, we have noted that

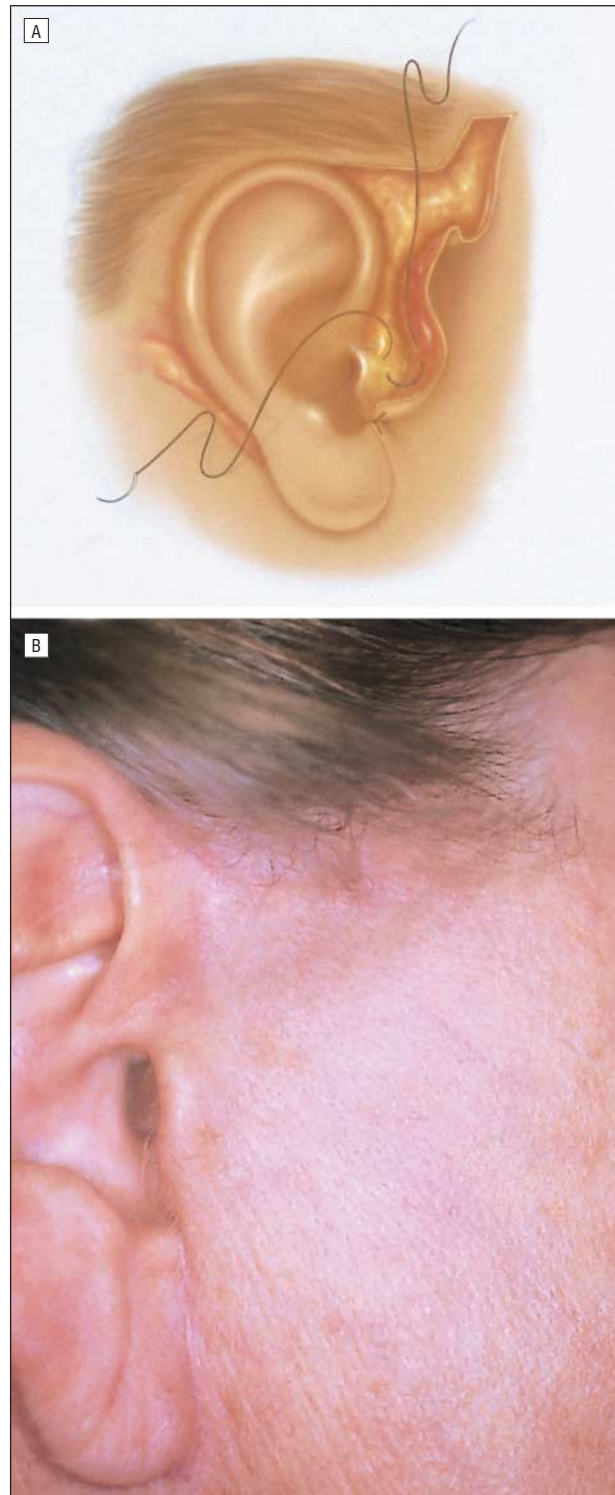


Figure 4. A, A deep 5-0 polydioxanone suture is placed through the deep dermis of the pretragal skin and secured to the underlying subcutaneous tissue prior to skin closure. This re-creates the natural pretragal sulcus and also counteracts any anterior pull on the tragus. B, Postoperative appearance showing a natural-appearing tragus. Note the preauricular sulcus and gentle posterior curve to the posterior edge; there is no lateralization or anterior pull.

an increasing number of male patients would much rather have a retroragral incision, shave this hair, and have a less noticeable incision. In patients in whom we perform a retroragral incision, we attempt to inactivate the hair follicles that will abut on the tragus or the immediate pre-

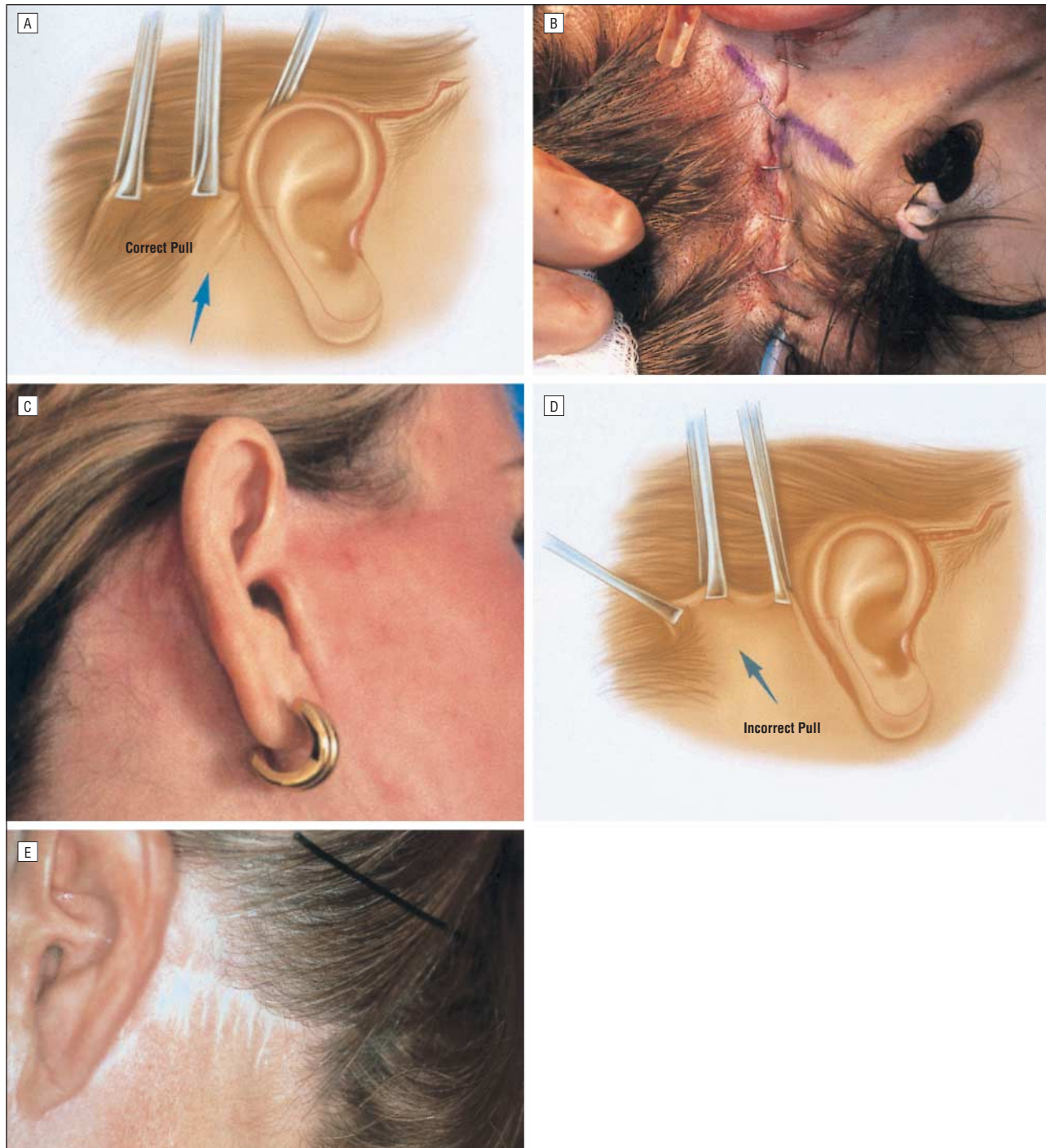


Figure 5. A, The secret to making a postauricular incision inconspicuous is in the redraping of the postauricular skin after any of the needed superficial musculoaponeurotic system techniques have been used. The correct, anterosuperior pull direction on the posterior skin flap properly realigns the posterior hairline. After redraping, some skin excision of the superior portion of the posterior skin flap is necessary; skin excision is also necessary in the postauricular sulcus. B, Intraoperative view of properly aligned posterior hairline on the right side. The surgical marking along the hairline is made before any incisions, and it is used to realign the hairline after flap advancement and skin excision. C, Postoperative view with properly aligned hairline. D, Incorrect orientation of pull in a posterosuperior direction. E, Postoperative view with a “step-off” hairline distortion, a migrated postauricular scar, and suture tracking. Some surgeons try to avoid this step-off by making an incision right along the postauricular hairline edge itself, but this incision can become hypertrophic or stretched and, therefore, visible when the patient wears her hair up.

auricular area by severing the follicles from the undersurface of the flap with fine scissors prior to suturing, and/or by using the cautery unit on the hair follicle bulbs. Electrolysis can be later performed for persistent hairs.

In most cases, the incision around the lobule is not made exactly in the sulcus, but slightly anteriorly. This

leaves a tuft of non-hair-bearing skin, and prevents hair-bearing skin from being pulled into the lobule sulcus. As noted, this incision can be replaced by an incision in the sulcus, with an attempt to destroy the hair follicles.

Most candidates for a male face-lift being in the aging population have already noted an increase in tragal

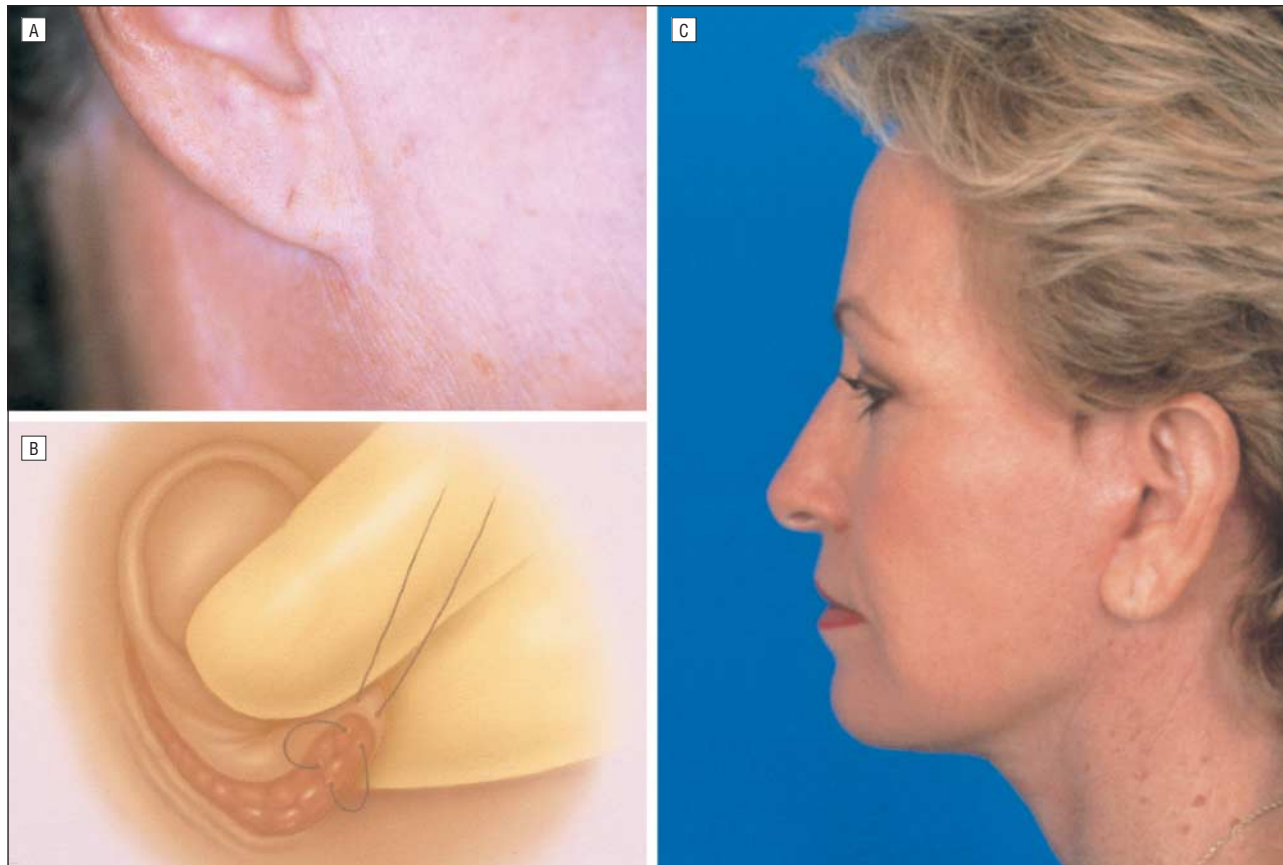


Figure 6. A, Pixie ear or satyr ear deformity caused by excessive skin excision or tension at the earlobe. This can be avoided by incising the flap prior to dissection of the superficial musculoaponeurotic system or placement of suspension sutures. At this step, the surgeon can easily estimate the distance of the insertion of the lobule onto the facial skin. One then avoids excision of any more skin in this area after the suspension is accomplished unless there is gross skin excess. B, To further prevent tethering of the lobule, a mattress stitch with 5-0 polypropylene is placed at the free cut edge of the lobule and secured to the underlying tissues (Clyde Litton, oral communication, 1986). C, Photograph of a natural-appearing earlobe.

and ear canal hair. They often state that they are used to trimming that hair on an almost daily basis, and would not object to trimming any hair growing from the retrotragal incision. We carry out a very thorough discussion with men on this subject so that they may decide which incision they would prefer. All men, no matter what incision is used, must be warned that neck beard will be pulled postauricularly when skin is removed, and that they will need to shave this area posteriorly. Obviously, the more skin is removed, the more posteriorly and superiorly the beard will be redraped.

SALVAGE FOR POOR FACE-LIFT INCISIONS

Unfortunately, some of the visible incisions due to too much tension cannot be immediately repaired or camouflaged. When skin has loosened sufficiently to permit another face-lift, care should be taken with the placement of the new incision so that the scar will be excised with the excess skin. For instance, in the preauricular area, the new incision should be placed posteriorly to the scar. With posterosuperior advancement of the skin flap, the scar is removed along with the redundant skin.

On the other hand, loss of hair can be remedied soon after an unsuccessful face-lift. Usually after 3 to 4 months, the surgeon is assured that a telogen phenomenon is not

occurring, ie, that the hair follicles are not in a state of shock from the new tension, and reimplantation can proceed. With microfollicular-unit hair transplantation, several hundred plugs can be placed in one temporal sideburn tuft alone (**Figure 8**). Usually, 2 sessions are necessary to achieve full natural density and thickness in this area. The grafts are placed to orient the hair shafts in the natural direction. Hair transplantation can also be used for postauricular incision lines placed right along the hairline. Areas of alopecia appearing within the posterior scalp or the temporal area, again often secondary to excess tension, can usually be excised by incisions that parallel the hair follicles and then reapproximated. One should wait until enough skin laxity has returned to avoid cicatricial alopecia.

Keloids could present an unacceptable cosmetic complication after any surgery, but especially after a face-lift; thus, careful preoperative questioning should ascertain whether the patient is keloid prone. Hypertrophic scars may occur in the postauricular incision lines either in the sulcus, in a non-hair-bearing area, or at the lobule. They can be injected with triamcinolone acetonide, beginning at a concentration of 10 mg/mL; the concentration can be increased up to 40 mg/mL, depending on the response to the steroid and the thickness of the hypertrophic scar. If repeated injections, usually administered every 6 weeks, are ineffective, one can consider reexcision.

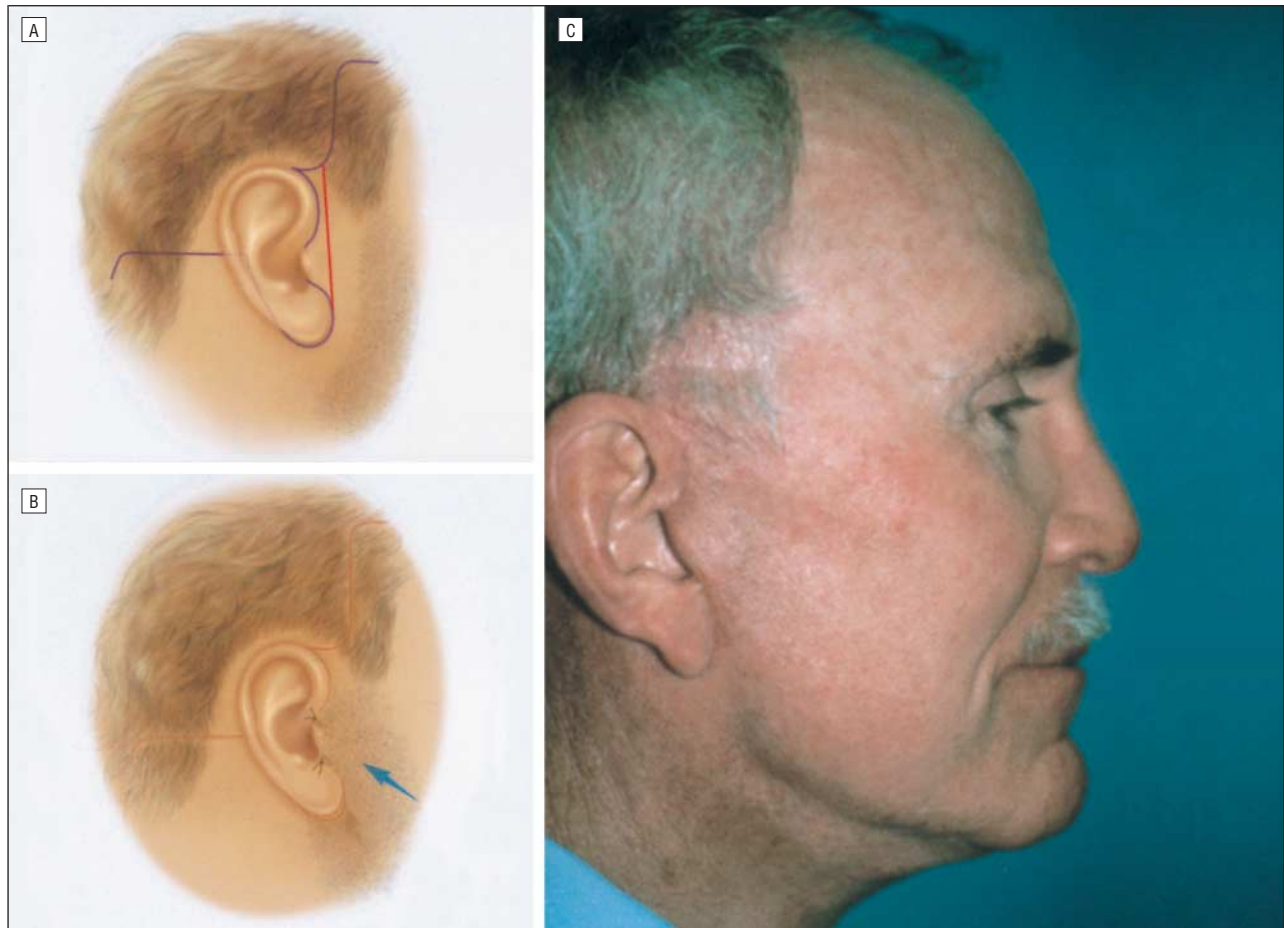


Figure 7. A, Schema of 2 possibilities for the male face-lift incision. The temporal incision varies from the female version. B, Schema of the retrotragal male incision after skin excision and posterosuperior flap advancement. The hair-bearing skin has been pulled onto the tragus. Two polypropylene stay sutures are placed at the superior and inferior margins of the tragus. Also, a cuff of non-hair-bearing skin is left around the lobule and the postauricular incision is placed in the sulcus and not onto the posterior concha itself, as in women. These maneuvers are an attempt to prevent men from having to shave in these areas. C, Postoperative result of a male retrotragal incision (the patient had just removed his eyeglasses, which left an indentation; there is no hair loss in this area).

COMMENT

This technique has been used successfully in more than 500 consecutive face-lifts. Most other articles concentrate on only one issue, whether it be the preauricular regions, the prevention of temporal alopecia, or the postauricular hairline. We have attempted to address and integrate all issues into a single, all-encompassing method.

Regarding the placement of the preauricular incision, Becker⁴ agrees that the posttragal incision yields improved cosmesis. In his study, 4 surgeons compared postoperative close-up photographs, taken at least 6 months after surgery, of 18 women who had received pretragal incisions with 18 photographs of women who had received posterior tragal edge incisions. The incisions rated to have a superior result for a natural-appearing tragus shared 3 specific properties, which our technique includes: presence of a pretragal sulcus, maintenance of a gentle posterior curve in the center, and prevention of lateral and anterior deflection.

Other techniques have been described to prevent temporal alopecia. Brennan et al⁵ categorize the preauricular hair tuft into 3 types according to its level in the vertical dimension. In type 1, the tuft is located superiorly at the supra-auricular crease, and a pretrichial temporal incision is made

with a V-Y advancement of hair-bearing skin into the incision. In type 2, the tuft is in an intermediate position and a horizontal incision only is made at the inferior edge of the tuft. In type 3, the tuft is in a low position and the incision is made within the hair. These authors also describe a novel, anteriorly based transposition flap of hair-bearing skin, with primary closure of the donor site to correct iatrogenic temporal alopecia. We agree with the ensuing discussion by Barrera⁶ that micrografts allow for a more exact replication of the natural hairline and better control of the natural inferior direction of hair growth.

Knize⁷ described a similar wedgelike excision of non-hair-bearing skin between the temporal hairline and the superior pole of the ear. This skin removal allows transposition of the temporal hairline down to the level of the superior pole of the ear and prevents the temporal hairline from migrating superiorly. To address the posterior scar, Little⁸ advocates what he terms the “omega incision” to conceal the scar and maintain the natural posterior hairline. However, drawbacks include significant dissection of the posterior scalp, additional operative time with increased expense to the patient, increased risk of hematoma formation, and increased risk of sensory nerve damage of the posterior scalp. Our technique avoids these disadvantages while achieving the same goals.

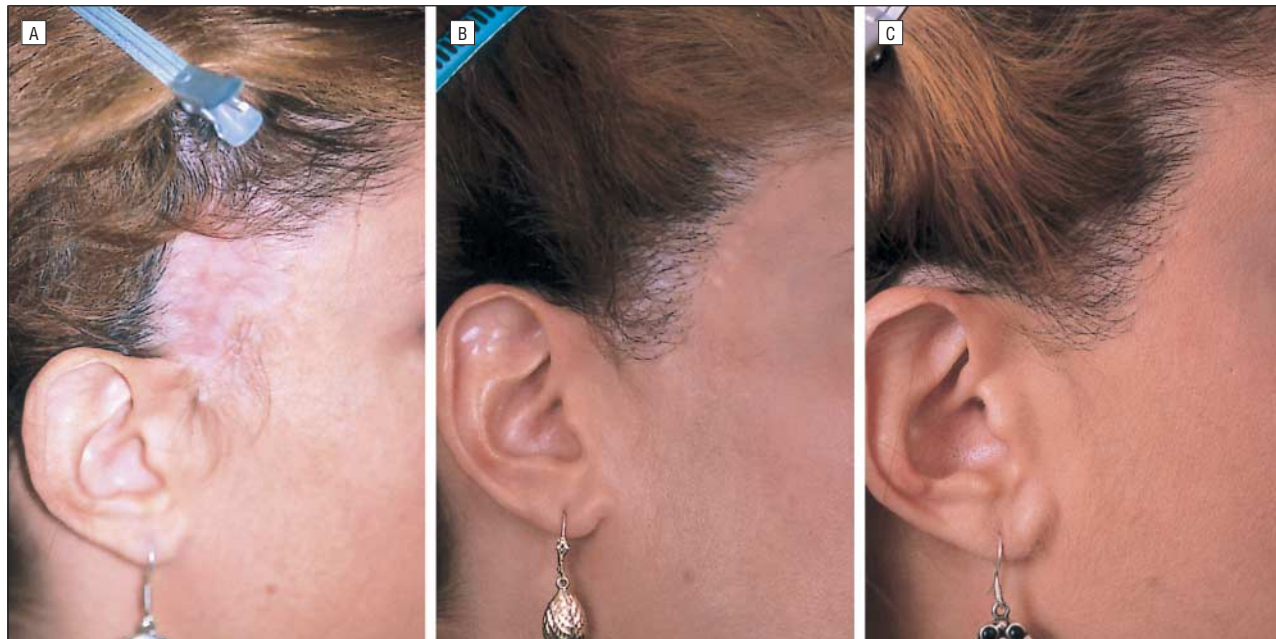


Figure 8. A, Preoperative photograph of a patient who has temporal alopecia secondary to scarring. B, Postoperative result following tissue expansion, scalp advancement, excision of scars, and microfollicular-unit hair transplantation. This photograph was taken 7 months after the patient received 160 micrografts to the right temporal scalp in one session. C, Postoperative result 17 months after a second transplantation session of 147 micrografts.

Camirand and Doucet⁹ compared the degrees of visibility, linearity, and hypopigmentation, and the amount of hair at the incision line, obtained with incisions parallel to the hair shafts and incisions perpendicular to the hair shafts. They reported that, according to the subjective evaluation of a group of 30 patients, the perpendicular incision healed better in 95% of these patients. In the temporal area, the authors performed micro W incisions inside the hairline, with linear excision of excess skin from the distal flap. In our experience, beveling depends on the location of the incision, and the surgeon must first determine if hair-bearing skin will be on both sides of the incision. Thus, in our practice, there are indications for both.

Regarding face-lifts in men, some authors prefer either pretragal or retrotragal incisions. Cremone et al¹⁰ favor retrotragal incisions and described in 1982 their technique for cauterization and removal of hair shafts from the immediate preauricular skin to maintain an area of non-hair-bearing skin. This technique is similar to what is described here; however, we have found that despite these efforts, sometimes the hair is not permanently removed. Botta¹¹ describes a continuous temporal incision and a lower blepharoplasty incision. He claims that this incision provides an advantage in rotation of the flap, leaves the preauricular non-hair-bearing skin undisturbed, and does not elevate the temporal hairline (he makes a pretragal incision usually at the hairline). The trade-off is a visible scar in the temporal area, which he reports to heal exceptionally well.

In summary, we believe that, to achieve attractive neck, jaw, and cheek lines, the face-lift surgeon must not only pay careful attention to the technique of the face-lift, but also take extreme care to ensure that face-lift incisions are as invisible as possible and that no hairlines are altered to the point of making loss of hair apparent. We know patients who, because of previous face-lifts with loss of hair, have avoided further face-lift surgery for fear that

they should lose even more hair—these are the “face-lift cripples.” Patients should be wary of surgeons who do not show them close-up photographs of postoperative incision lines in patients wearing their hair up. It seems incongruous that a surgeon would attempt a rejuvenation procedure to make someone appear younger and better rested, but leave visible incision lines telling everyone that surgery has been performed, thus negating any benefits from the lift.

Accepted for publication February 26, 2003.

This work was originally presented at the Aging Face Course, Indianapolis, Ind, October 16-19, 1997.

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