Midface Lift: General Considerations and How I Do It

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Guy G. Massry

The endoscopic midface lift is a great volumizing procedure, but a poor lifting procedure:

- It can be done with or without browlift.
- Standard temporal posthairline incisions—like browlift.
- Dissect over white glistening surface of the deep temporal fascia (DTF) to the lateral canthus.
- Stay subperiosteal over the zygomatic arch. Dissect over the medial third of the arch to reduce incidence of damage to the fascial nerve branch.
- Avoid sacrificing the sentinel vein (potential arborization of new vessels—lower lids).
- This can all be done blindly in most patients. It helps to use a bimanual technique (one hand guiding the elevator, the other applying external guidance over the arch), especially when there is thick tissue or in redo cases.
- Advance the elevator while feeling and guiding with the other hand over the skin. Make sure the tip of the elevator rubs on the bone to stay subperiosteal. When entering, the midface will feel a "pop." Advance radially over the face of the maxilla.
- Place a 4×4 gauze deeply into the temporal pocket for pressure induced hemostasis before continuing with oral dissection. This also elevates tissue over the zygoma so that there is less chance of entering the wrong plane when connecting subperiosteal maxillary dissection with temporal pocket.
- Infiltrate the gingivobuccal sulcus with the same 1 % anesthetic.
- Make a small 1/2-in. vertical incision over the second premolar (in line with the infraorbital nerve).
- Use a small, hooked retractor (army/navy) to elevate all tissue off of the maxilla and begin subperiosteal dissection.
- Dissect all the way to the arcus marginalis of orbital rim—around infraorbital neurovascular bundle. Visualize the infraorbital foramen and nerve. I use a small Freer elevator medial to the nerve to get to the arcus and then release it. Temporal to the nerve, I use any one of a number of larger elevators to release arcus to canthus.
- At canthus, I connect to temporal pocket subperiosteally.
- It is important to continue dissection over zygoma to insertion of masseter muscle (visualize origin of fibers). This is necessary for proper mobilization.
- Equally as important is lysing the arcus marginalis. This breaks the fixed attachments

G.G. Massry, MD
Beverly Hills Ophthalmic Plastic
and Reconstructive Surgery, Beverly Hills, CA, USA

Department of Ophthalmology, USC Keck School
of Medicine, Los Angeles, CA, USA
e-mail: gmassry@drmassry.com

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and allows elevation. If this is not done, we will only achieve the tissue-folding effect and volume augmentation. Also, if this is not done, the tear trough may become deeper.

- Place a long $1^1/_2$-in. 25-gauge needle at the suture placement site from the skin to subperiosteal space. The higher the placement, the more lift achieved—the lower, the more volume (differences are dramatic).
- Engage tissue at the suture demarcation site (get a good bite). I use a long tonsil through the temporal pocket to the gingivobuccal opening to engage the suture (grab ends of suture) and pull it through.
- Retract the temporal wound and secure suture (double bite) to DTF as low as you can. I cinch up in a slip knot. I then check the midface volume and lift and adjust as necessary before securing a knot.
- I then use a tonsil to guide a 10-French drain from temple to mouth and fix it with externalized suture.
- Irrigate the temple wound to mouth with antibiotic/saline solution and then the mouth with the same.