



Subplatysmal Necklift: A Retrospective Analysis of 504 Patients

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Abstract

Background: Improvement of neck contour is a primary goal of patients who seek rejuvenation of the face and neck. Subplatysmal structures, including fat, the digastric muscle, and the submandibular salivary glands (SMSGs), may contribute to the appearance of a disproportionately large neck.

Objectives: The authors sought to evaluate the safety, effectiveness, and predictability of necklift combined with reshaping and repositioning of the subplatysmal structures.

Methods: The records of 504 patients were reviewed retrospectively. Surgical maneuvers for subplatysmal necklift were described comprehensively and supplemented with videos. The subplatysmal anatomy was detailed by means of 2 cadaver dissections.

Results: A total of 430 patients (85.3%) underwent subplatysmal necklift. The most commonly treated structures were fat (423 patients [83.9%]), the SMSGs (307 patients [60.9%]), and the digastric muscle (91 patients [18.1%]). The most common complications were weakness of the lower lip depressor (29 patients [5.7%]), followed by sialoma of the parotid gland (10 patients [2%]). No patients experienced subplatysmal hematoma.

Conclusions: Subplatysmal necklift is a safe, effective, and reliable option for patients who desire improved cervical contour.

Level of Evidence: 4



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Patients who seek facial rejuvenation frequently indicate improvement of neck contour as a primary goal of treatment.^{1–4} Patients often regard neck sagginess as exclusively attributable to skin flaccidity. However, a saggy appearance of the neck usually results from imbalances in the volumes and positions of the subplatysmal structures, including fat, the digastric muscle, the submandibular salivary glands (SMSGs), the mylohyoid muscle, and the hyoid.^{5–7}

Castro et al⁸ advocated against aesthetic surgery of the subplatysmal region, citing potential complications such as fluid accumulation (blood, serum, and/or saliva) and damage to the marginal mandibular nerve or the cervical branch of the facial nerve.

Surgical procedures to treat structures deep within the neck have been refined by many surgeons in an effort to develop safe, straightforward, and reproducible methods.^{2,3,5–7,9,10} We previously described surgical maneuvers to avoid complications in patients who undergo

necklift with partial resection of the SMSGs.¹¹ Herein, we provide an update of our experience with subplatysmal necklift and describe a novel strategy for repositioning the hyoid.

METHODS

The records of 504 consecutive patients (461 women [91.5%], 43 men [8.5%]) who underwent necklift performed by the same team of surgeons and anesthesiologists

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