PREOPERATIVE DIAGNOSES:,1. Eyebrow ptosis.,2. Dermatochalasia of upper and lower eyelids with tear trough deformity of the lower eyelid.,3. Cervical facial aging with submental lipodystrophy.,OPERATION:,1. Hairline biplanar temporal browlift.,2. Quadrilateral blepharoplasty with lateral canthopexy with arcus marginalis release and fat transposition over inferior orbital rim to lower eyelid.,3. Cervical facial rhytidectomy with purse-string SMAS elevation with submental lipectomy.,ASSISTANT: ,None.,ANESTHESIA: , General endotracheal anesthesia.,PROCEDURE: , The patient was placed in a supine position and prepped with general endotracheal anesthesia. Local infiltration anesthesia with 1% Xylocaine and 1:100,000 epinephrine was infiltrated in upper and lower eyelids.,Markings were made and fusiform ellipse of skin was resected from the upper eyelid. The lower limb of the fusiform ellipse was at the superior palpebral fold. A 9 mm of upper eyelid skin was resected at the widest portion of the lips, which extended from medial canthal area to the lateral orbital rim. This was performed bilaterally and symmetrically and the skin was removed. Incision was made through the pretarsal orbicularis with small amount of fat being removed from the medial and middle fat pocket. An incision was made over the superior orbital rim. Subperiosteal dissection was performed over the forehead. The dissection proceeded medially. The corrugator and procerus muscles were carefully dissected from the supratrochlear nerves on both right and left side and cauterized.,Hemostasis was achieved with electrocautery in

this fashion. A 4-cm incision was made, and the forehead at the hairline, subcutaneous dissection was performed and extended over the frontalis muscle for approximately 4 cm. A subperiosteal dissection was performed after the fibers of the frontalis muscle were separated and subperiosteal dissection from the forehead lead the subperiosteal dissection from the upper eyelid. The incision was made in the lower lid just beneath the lashline. Subcutaneous dissection was performed over the pretarsal and preseptal muscle. Dissection was then proceeded down to the inferior orbital rim. The arcus marginalis was released and the lower eyelid fat was teased over the inferior orbital rim and sutured to the suborbicularis oculi fat and periosteum, which was separated from the inferior orbital rim. The orbital fat was sutured to the suborbicularis oculi fat with multiple preplaced sutures of 5-0 Vicryl on a P2 needle. The upper eyelid incision was closed with a running subcuticular 6-0 Prolene suture bilaterally. The forehead was then elevated, and the nonhairbearing forehead skin was resected 1.5 cm wide raising the tail of the eyebrow. The head of the eyebrow was felt to be elevated by the antagonistic frontalis muscle now that the accessory muscles specifically the corrugator and procerus and depressor supercilii were released and divided.,A lateral canthopexy was performed with 5-0 Prolene suture on a C1 double-arm tapered needle being passed from the lateral commissure of the eyelid to the small stab incision being passed to the medial superior orbital rim and sutured to tighten the lower lid. The distal lateral resection of excessive lower eyelid skin was

reduced at risk of eyelid malposition. The lower lid incision was closed after the redundancy of skin measuring approximately 3 mm was resected on both sides. Closure was performed with interrupted 6-0 silk suture for the lower lid. The eyebrow hairline brow lift was closed with interrupted 4-0 PDS suture, deep subcutaneous tissue, and dermis, and the skin closed with a running 5-0 Prolene suture.,Attention then was directed to the cervical facial rhytidectomy and purse-string SMAS elevation with submental lipectomy. Incisions were made in preauricular area, postauricular area, mastoid and occipital area. Subcutaneous dissection was performed to the nasolabial fold and cheek and extending across the neck in the midline. Submental lipectomy was performed through the incision in the submental crease. Fat was directly removed from the fascia.,Hemostasis was achieved with electrocautery. A SMAS elevation was performed with a purse-string suture of 2-0 PDS suture from temporalis fascia in front of the ear extending beneath the mandible and then brought back up to be sutured to the temporalis fascia. This was performed bilaterally and symmetrically. Hemostasis was achieved with electrocautery. The cheek flap was brought back posteriorly and the cervical flap posteriorly and superiorly with redundant skin on the right massaged and closed. The skin of the cheek and neck were resected which was redundant after the ***** posteriorly and superiorly in the neck and transversely in the cheek.,Closure was performed with interrupted 3-0 and 4-0 PDS suture of deep subcutaneous tissue and dermis of the skin was closed with a

running 5-0 Prolene suture. Drains were placed prior to final closure. A 7-mm flat Jackson-Pratt was then secured with 3-0 silk suture. Dressing consisting of fluffs and Kerlix and a 4-inch Ace were applied to support mildly compressive dressing. Scleral eye protectors were removed. Maxitrol eye ointment was placed followed by Swiss therapy eye pads. The patient tolerated the procedure well, and she returned to recovery room in satisfactory condition with Foley catheter and Pneumatic compression stockings, TED hose, two Jackson-Pratt drains, and an IV.