PREOPERATIVE DIAGNOSES:,1. Request for cosmetic surgery.,2. Facial asymmetry following motor vehicle accident.,POSTOPERATIVE DIAGNOSES:,1. Request for cosmetic surgery.,2. Facial asymmetry following motor vehicle accident.,PROCEDURES:,1. Endoscopic subperiosteal midface lift using the endotine midface suspension device.,2. Transconjunctival lower lid blepharoplasty with removal of a portion of the medial and middle fat pad.,ANESTHESIA: , General via endotracheal tube.,INDICATIONS FOR OPERATION: , The patient is a 28-year-old country and western performer who was involved in a motor vehicle accident over a year ago. Since that time, she is felt to have facial asymmetry, which is apparent in publicity photographs for her record promotions. She had requested a procedure to bring about further facial asymmetry. She was seen preoperatively by psychiatrist specializing in body dysmorphic disorder as well as analysis of the patient's requesting cosmetic surgery and was felt to be a psychiatrically good candidate. She did have facial asymmetry with the bit of more fullness in higher cheekbone on the right as compared to the left. Preoperative workup including CT scan failed to show any skeletal trauma. The patient was counseled with regard to the risks, benefits, alternatives, and complications of the postsurgical procedure including but not limited to bleeding, infection, unacceptable cosmetic appearance, numbness of the face, change in sensation of the face, facial nerve paralysis, need for further surgery, need for revision, hair loss, etc., and informed consent was obtained.,PROCEDURE:, The

patient was taken to the operating room, placed in supine position after having been marked in the upright position while awake. General endotracheal anesthesia was induced with a #6 endotracheal tube. All appropriate measures were taken to preserve the vocal cords in a professional singer. Local anesthesia consisting of 5/6th 1% lidocaine with 1:100,000 units of epinephrine in 1/6th 0.25% Marcaine was mixed and then injected in a regional field block fashion in the subperiosteal plane via the gingivobuccal sulcus injection on either side as well as into the temporal fossa at the level of the true temporal fascia. The upper eyelids were injected with 1 cc of 1% Xylocaine with 1:100,000 units of epinephrine. Adequate time for vasoconstriction and anesthesia was allowed to be obtained. The patient was prepped and draped in the usual sterile fashion. A 4-0 silk suture was placed in the right lower lid. For traction, it was brought anteriorly. The conjunctiva was incised with the needle tip Bovie with Jaeger lid plate protecting the cornea and globe. A Q-Tip was then used to separate the orbicularis oculi muscle from the fat pad beneath and carried down to the bone. The middle and medial fat pads were identified and a small amount of fat was removed from each to take care of the pseudofat herniation, which was present. The inferior oblique muscle was identified, preserved, and protected throughout the procedure. The transconjunctival incision was then closed with buried knots of 6-0 fast absorbing gut. Contralateral side was treated in similar fashion with like results and throughout the procedure. Lacri-Lube was in the eyes in order to maintain hydration.

Attention was next turned to the midface, where a temporal incision was made parallel to the nasojugal folds. Dissection was carried out with the hemostat down to the true temporal fascia and the endoscopic temporal dissection dissector was used to elevate the true temporal fascia. A 30-degree endoscope was used to visualize the fat pads, so that we knew we are in the proper plane. Subperiosteal dissection was carried out over the zygomatic arch and Whitnall's tubercle and the temporal dissection was completed.,Next, bilateral gingivobuccal sulcus incisions were made and a Joseph elevator was used to elevate the periosteum of the midface and anterior face of the maxilla from the tendon of the masseter muscle up to Whitnall's tubercle. The two dissection planes within joint in the subperiosteal fashion and dissection proceeded laterally out to the zygomatic neurovascular bundle. It was bipolar electrocauteried and the tunnel was further dissected free and opened. The endotine 4.5 soft tissue suspension device was then inserted through the temporal incision, brought down into the subperiosteal midface plane of dissection. The guard was removed and the suspension spikes were engaged into the soft tissues. The spikes were elevated superiorly such that a symmetrical midface elevation was carried out bilaterally. The endotine device was then secured to the true temporal fascia with three sutures of 3-0 PDS suture. Contralateral side was treated in similar fashion with like results in order to achieve facial symmetry and symmetry was obtained. The gingivobuccal sulcus incisions were closed with interrupted 4-0 chromic and

the scalp incision was closed with staples. The sterile dressing was applied. The patient was awakened in the operating room and taken to the recovery room in good condition.