# Surgical or non-surgical? Knowing when to use the knife

Mr Adrian Richards outlines the invasive and non-invasive options for facial aesthetic treatments

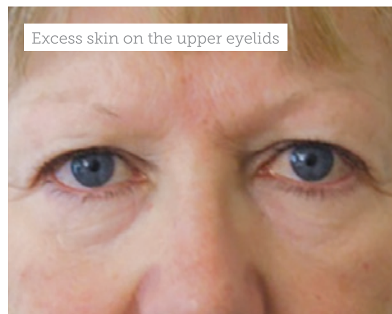
**As Abraham Maslow said in 1966: "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail."** In other words – if all you can do is surgery, it's tempting to decide that every patient needs a surgical solution. Likewise if your focus is non-surgical treatments, these tend to be considered the Holy Grail. But to achieve the best aesthetic results for our patients, we need to have an understanding of all the tools available to us. My background, as clinical director of Aurora Clinics, is in plastic surgery; I came relatively late to non-surgical treatments. And many of my esteemed plastic surgery colleagues still know little about non-surgical treatments, despite having well-established facial plastic surgery practices. In this article, I will endeavour to present the best surgical and non-surgical options for each facial area. Hopefully this outline of treatment options may help you when it comes to deciding on the best treatment for your next patient. For simplicity, I will start at the top.

## THE SCALP

Few of us treat the scalp, but hair thinning, baldness and grey hair can be extremely ageing. Treatments for thinning hair can be non-surgical or surgical. Non-surgical options include Regaine, a topical treatment containing minoxidil that stimulates blood flow to the hair follicles, increasing follicular size and the diameter of the hair shaft. Surgical options include hair transplants, which involve removing a sample of donor hair (usually from the nape of the neck, but newer techniques also use body hair), isolating the hair follicles and re-implanting where hair is thinnest.
Scalp treatments are usually performed in specialist clinics but companies such as Parkwood Clinic in Harley Street will provide a visiting service to your clinic. Even if you choose not to offer these treatments, it's still useful to have the details of a reputable treatment centre to suggest to your clients.

## THE FOREHEAD AND GLABELLAR

In this area, non-surgical treatments are the undisputed king. Whenever I train Cosmetic Courses delegates, I encourage them to analyse the four factors of facial ageing in their clients: active lines, gravitation changes, volume loss and skin quality. Children and young adults have temporary lines on their foreheads and glabellar when they raise their eyebrows and frown, but in their late 20s and 30s these lines become ingrained and are present at rest.
As these are active lines, caused by contraction of the underlying muscles, they are best treated with muscle relaxing injections. Although botulinum toxin injections are best in this area, there are surgical options–the most common being division of the procerus and corrugators surgically.
Access to these muscles is either from above, via scalp incisions during a brow lift, or from below during an upper blepharoplasty. Surgery has the advantage of providing a permanent relaxation of these muscles, but in the vast majority of cases muscle relaxing injections offer the safest and most convenient option.



Excess skin on the upper eyelids

## THE BROW AND UPPER EYES

Surgical treatments tend to dominate in this region. In my opinion there are no effective long-term, non-surgical solutions to lowering of the eyebrows, or removal of excess skin and fat in the upper eyelid. This is where surgery comes into its own. The brow can be lifted surgically, which is either performed endoscopically (typically through five incisions in the scalp), or by an open technique, which uses an incision in the hairline stretching from ear to ear. In both techniques the forehead is freed from its underlying attachments, allowing the surgeon to elevate the brow.
A variety of fixation techniques are used but the outcome is that the eyebrow sits in a higher position. But brow lifts don't suit every face, and many faces with low brows – Cindy Crawford is a famous example – are also considered very attractive. When considering brow lift surgery it is important to analyse every case in detail. Just because it is possible to elevate the brow, it doesn't mean it's appropriate for everyone. When the brows drop with age, it can also contribute to the development of excess skin in the upper eyelid. Some

people, however, have excess skin in the upper eyelid without significant brow ptosis.
The eyeball is supported in the eye socket by fat pads. These fat pads can herniate forwards, producing bulges in the eyelids. In the upper eyelid this occurs most commonly in the medial compartment towards the inner side of the eyelid. I challenge you to look in detail at the upper eyelids of the patients you see in the next week. Do they have a low brow position? Are their eyebrows in their natural position or have they been shaped? Do they have excess skin on their upper eyelids, and do they have a bulge on the inner aspect from fat herniation? Look particularly carefully at any Asian patients–in most cases they do not have a defined upper eyelid crease due to different locations of muscle attachment. Asian blepharoplasty, producing a European type fold in the upper eyelid, is one of the most common operations in the Far East, although it is seldom performed in the UK. Often the solution to excess skin and fat in the upper eyelid is an upper blepharoplasty. This is performed, most commonly, as a local anaesthetic procedure taking less than an hour. If asked, I tell my patients that if there's one cosmetic surgery procedure they should consider, it's an upper blepharoplasty–it is a relatively simple procedure with reliable long-term results. It brightens the eyes, makes it easier to apply make-up, and can increase the patient's field of vision.

## THE LOWER EYES

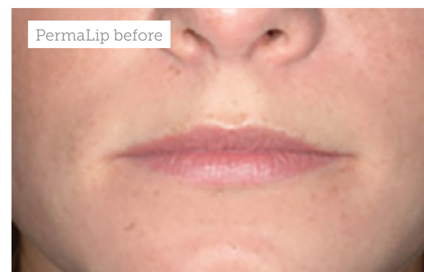
Who wins in this area? In my opinion, overall honours should be shared. Surgery is better for the more severe conditions, whilst non-surgical options are great for milder issues. When looking at the lower eyelids, look for skin excess, prolapse and herniation of the fat pads and conduct the 'snap test'. Skin excess results in folds of skin bordered by wrinkles.
The four fat pads of the lower eyelid can move forward and produce puffiness, and the eyelid becomes looser with age. Assess the tension in the lower lid with the snap test.
Gently pull the eyelid away from the eyeball — it should snap back firmly. If there's any lag in it snapping back, be careful not to weaken the orbicularis oculi muscle of the lower lid with Botox injections. This can further weaken the eyelid and cause it to lie away from the eyeball, a condition known as ectropion.
Lower blepharoplasty can be performed via an incision inside the eyelid (trans-conjuctival blepharoplasty) or via an incision just below the eyelashes. In both techniques the fat pads that produce puffiness can be reduced. The advantage of the trans-conjuctival approach is that there is no external scar; the disadvantage is that it's not possible to remove excess skin from the lower eyelid. If this is required, skin tightening in most cases is achieved with a chemical peel. Non-surgical solutions to the lower eyelids tend to focus on rejuvenating and tightening the skin.
I avoid dermal filler treatment to the tear troughs. Although it works well in the majority of cases, I have seen too many cases of long-term, often untreatable swelling to advocate this treatment.

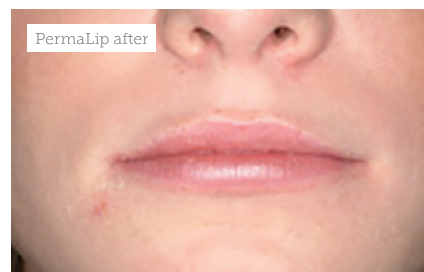
## THE CHEEKS

My vote goes to non-surgical treatments for this area. Cheek implants are often inserted from inside the mouth without external scars. They offer a more permanent solution to volume loss in the cheeks but they are prone to rotation and displacement and to insert, they require an operation. For these reasons, I prefer the new generation of dermal fillers designed for deeper placement. They offer safety and reliability without the need for an operation. The only downside being that they need repeating.

## AROUND THE MOUTH

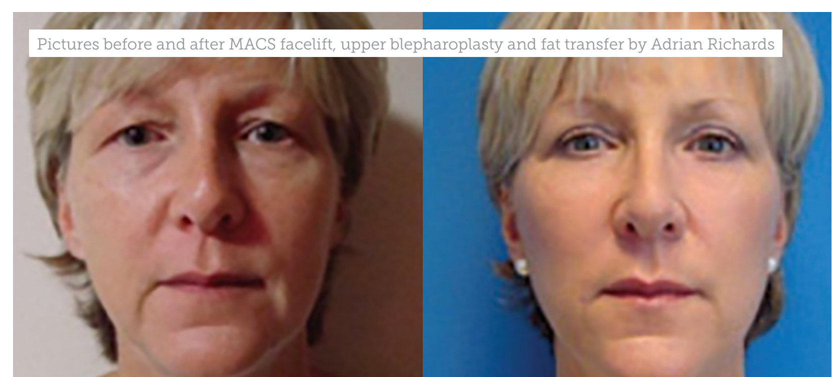
Both surgical and non-surgical treatments share equal merit in the peri-oral region. For treatment of the naso-labial folds, upper lip lines and marionette areas, only re-volumising treatments will do. In my opinion, facelifts do not reliably lift and soften the naso-labial folds. So what do we use to re-volumise this area? If you're a surgeon often the answer is fat. If you're not a surgeon, it is likely to be dermal fillers. Both offer reliable correction of age-related volume loss in these areas.
Most surgeons now offer fat transfer as part of a facelift procedure. If the patient is asleep it makes sense to harvest fat from the lower body and use it to restore lost volume in the face. If the patient is awake and fat is not easily accessible, dermal fillers are the logical choice. But beware – fat cells maintain the identity of the area they were removed from and will behave like them. So if the fat cells came from the abdomen and are programmed for fat storage, they will enlarge their new home if the patient gains weight.


PermaLip before


PermaLip after

## THE LIPS

This must be a draw. Traditional surgical options for lip enhancement have been limited but there's now a new implant available - PermaLip.
This offers permanent, reliable, adjustable lip augmentation with a simple procedure. It is performed under local anaesthetic and takes approximately 30 minutes. The procedure is well tolerated by patients who, in most cases, say it was better than going to the dentist. The down side of PermaLip is that it requires a degree of surgical training and the use of local anaesthetic. For this reason dermal fillers offer a safe alternative, with the only disadvantage being that they again need to be repeated regularly.


Pictures before and after MACS facelift, upper blepharoplasty and fat transfer by Adrian Richards

## THE JOWLS

Surgery can be said to win overall in this category, although in the early stages non-surgical treatments can be very effective. Selective re-volumising of the face when combined with reduction in the downward pull on the jowls, from the platysma in the neck, can reverse early jowl formation. For more advanced jowling, however, it is my opinion only surgery will suffice. For patients with skin laxity of the neck, particularly centrally, a facelift and neck lift is the ideal option. For anyone in the 40-55 year-old bracket without significant neck laxity, a MACS facelift is a great option.

## THE NECK

A neck is often the best place to look to ascertain a person's age. The main issues with the neck are loss of skin tone, excess skin folds and a build-up of sub-cutaneous fat.
The best solutions to each these, in turn, are non-surgical skin resurfacing or tightening to improve skin tone, and fat dissolving or removing treatments to refine the contour of the neck. Loose neck skin and bands are caused by a combination of gravity and the downward pull of the platysma muscle.
This also contributes to jowl formation. Selective injections of botulinum into the platysmal bands or below the angle of the jaw (referred to as the 'Nefertiti lift'), can be effective in cases of mild skin excess. In my opinion, surgery is the best option for true skin excess in the neck.
So what are the surgical options for a neck lift? Essentially an incision is made behind the ear in the hairline and in the natural fold in front of the ear. The platysma muscle is identified and lifted into its youthful position, with sutures tightening and lifting the skin of the neck. To achieve a really youthful neck contour some surgeons recommend a central platysmaplasty. This involves stitching the medial borders of the platysma together via an incision under the chin as well as lifting it laterally. We explain to patients that if they imagine their platysma was a curtain, pulling it from one side without securing it in the middle would not flatten it.
Securing it in the middle and then lifting it from the side would however produce a firm, youthful tightening.

## CONCLUSION

To provide the best possible results for our patients, it is vital to have an understanding of all the options for each issue, and continued education is crucial for this. It's important that we continue to learn from each other; I would encourage those whose focus is on non-surgical treatments to spend time in clinics and theatres with a plastic surgeon. In turn, and as part of their revalidation and ongoing training, all our surgeons at Aurora undergo regular refresher courses on the latest developments in the non-surgical field.
Communication, continuous learning, and the humility to realise that yours is not the only way, is truly the best way to treat our patients.

**Mr Adrian Richards** is a consultant plastic and cosmetic surgeon who has specialised in aesthetics for more than 15 years. He is the clinical director and founder of nationwide cosmetic surgery group Aurora Clinics, as well as training provider Cosmetic Courses, which offers aesthetic training to medical professionals.

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