Facial contouring

Restoration of facial contouring and enhancement are the primary goals of patients desiring to roll back the years. **Dr Raina Zarb Adami** discusses the anatomy of beauty, causes of ageing, and how she helps her patients look younger

When discussing facial contouring, revolumisation immediately springs to mind or, "liquid facelift" is often mentioned. I find this term a little restrictive because, while youth is a significant player in appearance and beauty, many other contributors exist.

Symmetry is commonly recognised as one. When the left side of the face mirrors the right, this tends to be perceived as more beautiful. We find this in most classical beauties. However, we know that many people who are considered beautiful are not symmetrical at all.

Proportion has been defined in many ways. We have heard about the face being divided into vertical fifths, where one-fifth is ideally the width of an eye, and in the ideal face, these are all equal. Horizontal lines divide the ideal face is divided into equal thirds. These thirds lie between the hairline and the glabella, the glabella and the subnasale, and the subnasale and the menton.

Nature has demonstrated beauty in the golden ratio of 1:1.618. For example, the width of the base of the nose to the width of the mouth, the width of the face to the length of the face, and the thickness of the upper lip to the thickness of the lower lip. In the ideal face, these all follow this ratio, and this is seen even in the length of the bones of the hand.

The ratio of the length of the distal phalanx to the middle phalanx follows phi, and so on up to the metacarpals. We see it in seashells and in many other things in nature, and in architecture. An American surgeon, Marquardt, put these lines into a facial mask. The classical beauties of today and in days gone by all fit this mask.

The lines of the face are also notable. Our eyes fall naturally onto smooth lines, and so a smooth jaw line is considered more attractive than one made irregular by the presence of jowls. If you look at a patient's profile, a straight line between the glabella, the subnasale, and the menton is considered attractive as well. Of course, the texture and condition of the skin are important, too.


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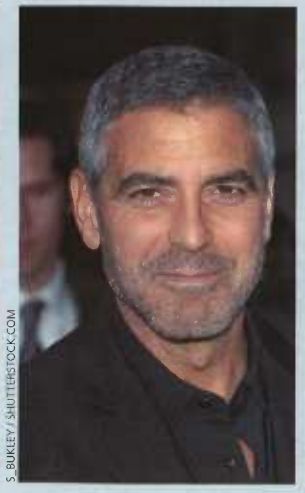
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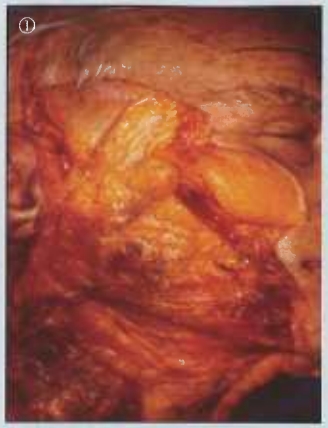
Certain imperfections add to the allure of stars, such as Cindy Crawford's mole. Angelina Jolie has a beautiful Ogee curve and rather full lips. George Clooney's prominent jaw is considered classically handsome for men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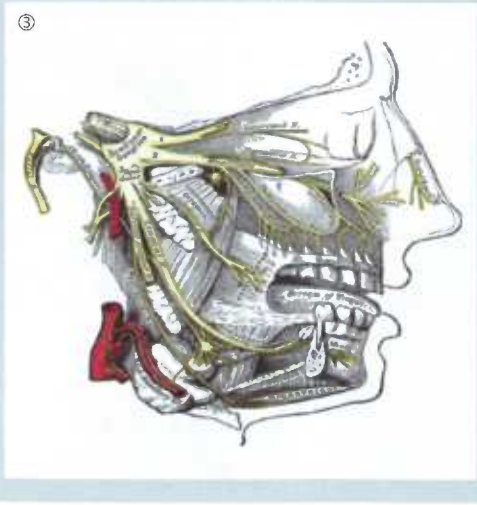
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①The descent of the malar fat pad is a gradual process that results in the formation of naso-labial folds, which leads to down-turning corners of the mouth and the formation of marionette lines and eventually jowls
②After marking the orbital rim, the next structure to consider is the infraorbital nerve. Identify it and mark it. You don't want to prang that nerve or inject product next to, or worse still, into it, because it will cause the patient a sharp pain that might persist
③Blood supply to the face

Most of these factors apply to men and women and women alike, but some key properties differ, especially in youth. In a man, it is considered more acceptable to look older. The "silver fox" is still considered attractive. In a woman, large eyes, high cheekbones with a corresponding narrow jaw with a curvaceous sigmoid Ogee curve, a smooth jawline, and a baby face are considered contributors to beauty.

In women, there is some beauty to be found in certain imperfections, such as Cindy Crawford's mole. That was her major selling point. Fuller lips come across to people as being a warmer person, therefore more approachable and, in turn, more attractive.

Angelina Jolie has a beautiful Ogee curve and rather full lips. What she has, which is not considered feminine, but nobody would say she's unattractive, is her prominent jawline. Marilyn Monroe, as well, has a rather long face with a beauty spot, and Kate Moss has the typical baby face. She has a high forehead with large eyes, prominent cheekbones and thick lips.

Narrower facial shape

Men, on the other hand, tend to have a narrower facial shape with fuller and more symmetrical lips, the upper half of the face being broader in relation to the lower, with higher cheekbones and a prominent lower jaw. A prominent chin in a man is considered more masculine, and a full head of hair, if a man has a full head of hair, is considered to be more attractive.

This is, of course, completely subjective. There are no rights or wrongs, but for us, as the medical practitioners, we have a few rules to go by to help a guide a patient to achieve an improvement in facial appearance.

Some of the men considered attractive include George Clooney, who claims he has not had any interventions. We know he does have a few wrinkles, and there was speculation he might play Simon Cowell in a film. Apparently Simon Cowell said: "If he's going to play me, he needs loads of Botox."

When we speak to and see people, we rarely just see them front on; we have to appreciate them from the oblique and lateral view. The oblique view is often the most important and is the biggest giveaway of a person's age. This is because of the curve formed by the zygomatic prominence.

The Ogee curve is the curve seen on an oblique photo formed by the lateral margin of the superior orbital rim, the eye socket, the malar prominence, and the rest of the cheek. The curvier this is, the more attractive this is considered. The inferior part of the curve tends to be more of a straight line. As we grow older, this curve tends to flatten.

What detracts from beauty, or why do we become less attractive as we grow older? Major components are muscular hyperactivity and volume loss. Up to the age of 25, our dermis has produced all the hyaluronic acid, collagen, and elastin it will ever produce. After that, we are just drawing from a bank. As we grow older, the dermis thins out and facial volume diminishes. We also use our elevator and the depressor muscles

more—dynamic lines morph into static rhytids.

One of the biggest telling factors is the malar fat pad. When we were medical students, we never gave much importance to this adipose tissue. As the years take their toll and we study the science of aesthetics, we find that it is the root of most of our patients' grief.

The malar fat pad has two components: a superficial and a deep component. The deep component is fixed and doesn't migrate with age. However, the superficial component descends with age.

As the malar fat pad descends, the naso-jugal fold (commonly known as the tear trough) makes it debut. This leads to the formation of naso-labial folds taking with them the oral commissures, thus leading to down-turning corners of the mouth. In younger people, oral commissures curve upwards slightly, slowly descending with time. This leads to the formation of shadows called the marionette lines, and eventually jowls.

This is, of course, a gradual process, but it is all related to the descent of the malar fat pad. This process can be accelerated by smoking and by sudden weight loss. Very often we see skeletonisation in people who have lost weight suddenly due to diet, exercise or both.

Often, the bodies of runners and people who have dieted look brilliant, but their face gives their age away because they have a sudden, gaunt appearance. This is the same with people taking anti-retroviral medication. This is the reason cheek fillers became so popular, when people on these medications were stigmatised because they were losing this fat due to lipodystrophy. Suddenly, they could be identified as HIV-positive patients.

When it comes to marking the cheeks for rejuvenation or augmentation, we must remember the appearance of a cheek depends on many things—not just the malar fat pad. There is the underlying bony structure, the parotid gland, the musculature, especially the muscle mass of the masseter, and the overlying skin. However, there is little we can do to many of these anatomical components, but we can restore volume, or introduce it where it is needed to augment appearance, such as those with relatively narrow faces, perhaps due to elongation of the maxilla.

It is imperative to warn patients of the possibility of bruising. We avoid bruising the patient by keeping in mind the patient's anatomy. The most important structures to consider are the facial artery, which is the fourth branch of the external carotid artery coming up superficially and anterior to the masseter. This artery takes a tortuous path, so it's not always easy to predict its exact location.

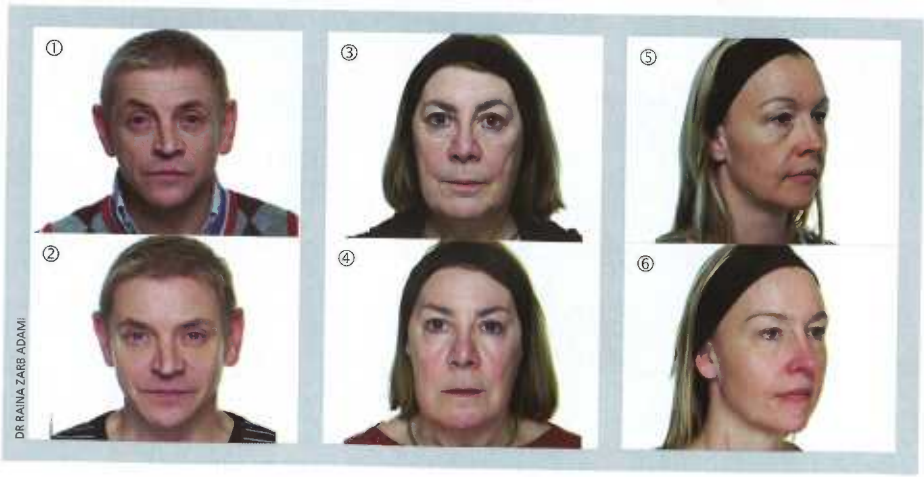
In rather thin patients, the pulsation is palpable. It takes a path towards the angle of the mouth, giving off the inferior labial and superior labial arteries, coursing up towards the corner of the nose, and ending up as the angular artery next to the medial canthus of the eye. The veins follow a more direct course and are more lateral.

Inadvertent intra-arterial injection may result in embolism and block off the end artery, causing necrosis to the structures supplied by that artery. Aspiration before injection is wise.

There are various ways to mark the patient. I tend to start with the inferior orbital rim, as a superior margin. Injecting above it, is likely to cause a Tyndall effect and give the patient prominent bulges under the eyes.

After marking the orbital rim, the next structure to consider is the infraorbital nerve. In many people, you can just palpate along the inferior orbital rim and feel the notch. In patients where you can't feel that, just tap along and ask them when an altered sensation is felt. It usually resembles a tingling sensation radiating to the upper molars. Identify it and mark it. You don't want to prang that nerve or inject product next to, or worse still, into it, because it will cause the patient a sharp pain that might persist.

Hinderer's line is a line drawn from the lateral canthus to the oral commissure. We aim to avoid injecting medial to that line. The next line you draw is Frankfort's horizontal line, a horizontal line from the superior aspect of the tra- *continued on page 44* ▶



① and ② A patient lost much weight and looked gaunt. I injected 2mm of Juvéderm Voluma on both sides of the cheeks and a little Juvéderm 4 into the nasolabial folds and added some toxin
③ and ④ One patient had sworn against surgery and said she wanted only subtle results. I used Voluma in the cheeks and jowl area and Juvéderm 4 in the nasolabial folds
⑤ and ⑥ I injected this patient with Juvéderm Voluma with lidocaine into the malar area and just underneath. I used a bolus technique onto the cheekbone with a little fanning underneath. All she needed was 1mm on each side

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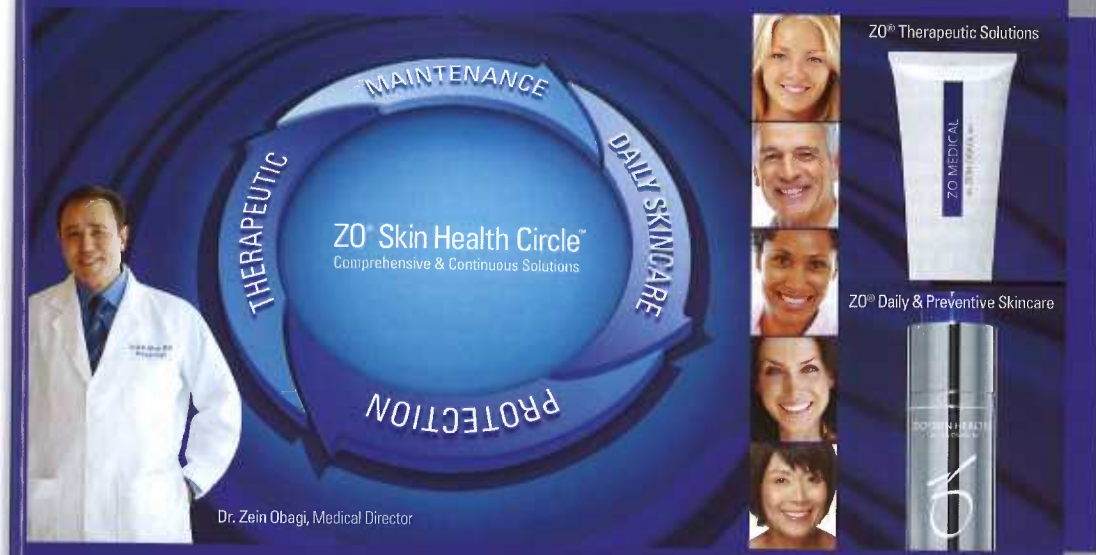

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gus of the ear going through the inferior orbital rim. Generally, in most people, it ends up just above the nasal ala. We don't want to inject above this line because, when a patient opens her eyes, she wants to see what's in front of her. She doesn't want to see cheeks.

> We don't want to inject above Frankfort's horizontal line because, when a patient opens her eyes, she wants to see what is in front of her

Case studies

Typical patients I have treated (page 42) include Amanda, a 43-year-old mother of four, who I injected with Juvéderm Voluma with lidocaine into the malar area and just underneath. I used a bolus technique onto the cheekbone with a little fanning underneath. She was not too far gone, and all she needed was 1mm on each side, which has caused a big improvement in the nasojugal area, nasolabial folds and in the marionette lines. A hint of a jowl remained, but I didn't think she needed any further intervention.

Another patient, Mark, turned 50 recently, and decided to lose much weight. He did so successfully, but at the expense of looking rather gaunt. He told me that people were asking him whether he was ill instead of telling him he looked fabulous and healthy, because he had the body he always wanted. I injected Mark with 2mm on both sides of the cheeks with Juvéderm Voluma, but I put a little Juvéderm 4 into the nasolabial folds and some toxin as well.

I first treated the cheek volume and then observed the rest of the face. When treating the cheek area, which is often the cause of problems further down the face, you often see an improvement in the lower face. If needs be, I add other products afterwards. I've always found that, when I'm treating the face with dermal fillers, I start from the top and tackle the problem first.

Another patient, Sarah, was an ideal candidate for a surgical facelift and not so much for nonsurgical intervention, but she has sworn against surgery. However, if there is more than an inch to grab between your thumb and index finger in the jowl area, you cannot perform miracles with dermal fillers alone, and it's very important that patients do understand this.

Nevertheless, she was pleased with her treatment. She said she wanted only subtle results, and she got more than that, but she was pleased. I used Voluma in the cheeks and jowl area and Juvéderm 4 in the nasolabial folds.

Dr Raina Zarb Adami is a cosmetic doctor and the medical director of Aesthetic Virtue, with clinics in Harley Street, Knightsbridge and Malta. She is also the director of the Academy of Aesthetic Excellence, which provides courses in aesthetic medicine for medical professionals

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