I appreciate this opportunity to discuss the article by Drs Lawson and Naidu. The authors are presenting a retrospective study and a reflective assessment of the male facelifts they performed.

Previous series on male facelift surgery stressed personal techniques without in-depth analysis of long-term results and variables encountered in the male patient. Since male facelift surgery has become a more common procedure, the literature on facial plastic surgery is in need of articles that stress the experiences and results of this surgery.

Lawson and Naidu stress the main differences in the cervicofacial skin between men and women. These differences should be kept in mind during the surgical planning of facelift surgery. Variations in the placement of the incision depending on different presenting clinical features is essential in a male facelift.

Hair distribution in the temple and preauricular and postauricular areas should be carefully analyzed. The hair distribution in the temple region in male patients presenting for facelift surgery can be divided into three groups: full growth of hair with mild temporal hairline recession, full growth of hair with moderate-to-severe recession of the temporal hairline, and thinned hair with or without hairline recession. For the male patient who presents with a full growth of hair, the incision can be extended to the temple region. In the remaining two groups, the incision is usually varied, avoiding extension to the temple region. Usually, a horizontal incision is made at the inferior aspect of the temporal hairline. This type of incision is sometimes also preferred in long-term smokers who have a higher chance of skin necrosis at sites of maximal tension. Posterior displacement of the temporal hairline should be avoided in patients with preexisting temporal recession. It is also essential to avoid temple incisions and to protect the superficial temporal artery in patients with frontal hairline recession for whom a hair-bearing scalp rotation flap is anticipated in the future. The authors avoid connecting the temple incision with the lateral extensions of browlift or blepharoplasty incisions. Although this technique provides an increased mechanical advantage in rotation and elevation of the cheek flap, scarring in that region should be avoided.
The location of the preauricular incision determines the eventual position of the sideburn in relation to the helix and tragus, the width of the sideburn, and the visibility of the scar. The authors stress the importance of placing this incision in "a natural skin fold slightly anterior to the tragus so that a small rim of non-hair-bearing skin is preserved." Incisions designed to leave a wide strip of preauricular non-hair-bearing skin will narrow the sideburn when the flap is pulled back and might result in a more conspicuous scar, especially in pigmented patients. In patients with a thin beard where the line of demarcation between hair-bearing and non-hair-bearing skin is not prominent, we tend to use a posttragal incision.

In the area of the earlobe attachment, a cuff of non-hair-bearing skin (2 mm wide) is kept to make shaving in this area easier. Epilation of the hair follicles is a technique that is recommended for some patients, especially those with hair growing around the tragal and postauricular areas.

The high incidence of ancillary procedures (blepharoplasty and browplasty) required in men, in addition to the facelift, reflects the fact that this surgery corrects only part of the changes associated with aging. Although facial scars are to be avoided in facial rejuvenation surgery, treatment of severely prominent melolabial folds might require direct excision.

The platysma muscle is generally thicker in males and should be adequately addressed to improve definition of the anterior aspect of the neck and long-term results, eliminating in most patients the need for excision of the anterior aspect of the skin on the neck. Direct skin excision remains to be indicated in male patients with a severe redundancy of skin on the anterior aspect of the neck (Figure), persistent deformity in spite of wide neck undermining, anterior platysmal plication and tightening of the skin on the neck, and in patients with "turkey gobbler" deformity who would not accept preauricular scarring. Only 6% of the patients in this series underwent anterior platysmal surgery. Although this number cannot be compared with other series, I find the need for anterior platysmal surgery higher in my group of patients.

The increased incidence of hematoma in male patients (8.9% in three collective series) is primarily due to increased blood supply to the skin and continues to occur in spite of placement of suction drains for a period of at least 24 hours. The negative effect of hematoma on skin flap viability should be eliminated without delay. Skin sloughs cause permanent scars that are more visible in men than women.

The article by Lawson and Naidu deals with an important topic that requires a greater attention from us in analyzing its differences and long-term results. Lawson and Naidu have nicely emphasized and analyzed the important principles and conclusions that are essential in our planning of facelift surgery in men.

NABIL S. FULEIHAN, MD
Boston, Mass

References