

The Use of the Temporal Fascia Flaps in Rhytidectomies

Videoendoscopic Approach - Previous Note

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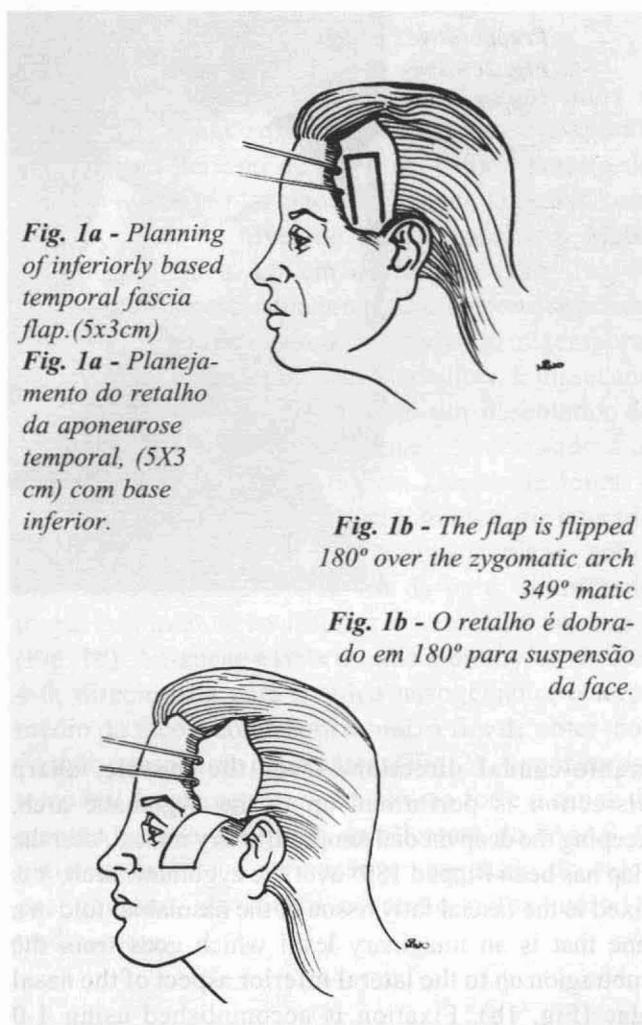
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The nasolabial fold frequently is a difficult correction in face-lifting procedures. Anatomical studies have demonstrated the fascia-fatty layer and skin of the cheek mass as the primary ptotic element responsible for facial aging. Suspension at the nasolabial folds with bilateral temporal fascia flaps as an ancillary procedure in standard face lifts, in our experience, has produced lasting and beneficial alterations of the nasal labial fold ptosis. We have now attempted to use bilateral temporal fascia flaps using endoscopy in patients who did not require skin excision or did not desire a preauricular incision. Sixty-three patients have been submitted to face lifts plus temporalis fascia flaps procedures in the last one and half years. The flaps is planned to be of rectangular shape, inferiorly based on the zygomatic arch. The flap usually measures 2.5 to 3 cm in width (Fig. 1a). The superior incision connects the lateral and medial edges of the flap, and is situated slightly above the muscle origin at the superior temporal line. Using a periosteum elevator, the flap is undermined in a



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Fig. 2a -
Preoperative; facial corrugations.

Fig. 2a - Pré-operatório; rugas faciais.



Fig. 2b - Post-operative.

Fig. 2b - Pós-operatório.

Fig. 2c -
Preoperative.

Fig. 2c - Pré-operatório.



Fig. 2d - Post-operative.

Fig. 2d - Pós-operatório.



cranio-caudal direction. Over the muscle, sharp dissection is performed up to the zygomatic arch, keeping the deep medial temporal artery intact. After the flap has been flipped 180° over the zygomatic arch, it is fixed to the fascial fatty tissue of the nasolabial fold in a line that is an imaginary level which goes from the subtragion up to the lateral inferior aspect of the nasal alae (Fig. 1b). Fixation is accomplished using 4-0

nylon sutures, spreading the flap in its entirety with the objective to obtain fixation and suspension of the middle third of the face, the nasolabial fold and the mouth commissures (Fig. 2). The temporal fascia flap is a strong anatomic structure and is able to maintain a definite plication to the SMAS. The main gain is the fixation and correction of the nasolabial fold, a solution difficult to obtain while using the traditional methods.