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removing muscles and even part of the salivary glands, can produce a very sharp neck but again at the cost of an increased downtime and complication rate.

The ideal operation should be relatively straightforward to carry out and relatively easy for the patient to tolerate and return to normal activities within a few weeks. In addition it is desirable for patients to be able to recognise themselves and look refreshed and natural. I often think that facelifts are less about reversing the chronological age but more about improving the femininity and shape of a female face.

Male facelifts are subtly different but just as important to have a natural non-stigmatic result which means that modifications of scar design are employed.

The benefits of the experience of the last 20 years are that experienced surgeons can choose from a variety of techniques that are designed specifically for each individual patient. Using this principle I would still say that in my practice over 80-85% of patients will undergo a SMAS lift with some liposuction to the fat in the neck. The SMAS procedure will usually be a plication without removing any SMAS particularly if the face is thin although with a fatter face some SMAS may be removed. Although I often use some fat transfer I am generally very cautious

in reflatting the face with large volumes of fat. Although this can produce a full youthful volume it is often a very significant change in the patient's appearance which can be more than they would want. In my practice at the moment I will often use a little fat to augment the chin by a few millimetres and to help to clean the line of the jaw. I will also sometimes make the cheekbones look a little larger. However I rarely use more than 5-10 ml of fat at the same time as a facelift.

Scars have also changed in the sense that we now try to keep the scars to the smallest length possible. However I do think that it is important not to carry out a short scar facelift when there is a lot of excess skin in the neck or this can result in bunching of the scar behind the ear which takes a long time to settle down.

Lastly I am still a great advocate of gentle balancing lateral brow lifts for many patients who have facelifts as the overall effect is greatly enhanced by having balance throughout the face. The lateral brow lift is now a much smaller procedure than it used to be and I never remove muscles from in between the eyebrows.

Modern facelifting requires a great deal of experience in knowing what kind of results will be achieved by different gestures. Essentially it is always important to remember that a patient

has a social, personal and professional life to return to and facelifts which are significant procedures need to be tailored to minimise the downtime. In this respect patients also have a responsibility to eat well and to avoid smoking and alcohol and dietary supplements that include active ingredients that impact on blood clotting.

A facelift only affects structural changes in the face caused by gravity. It is extremely important to take a holistic view about rejuvenation and to include skin care in the overall treatment. This often means a careful skin assessment prior to surgery and some tailored treatment either with antioxidants, gentle exfoliative treatments and pigment regulation. If we have learned anything over the last 25 years it is that an integrated holistic approach with the minimal surgical gesture possible is our aim. Strangely we have almost come full circle since the 70s in terms of the degree of surgery that is being carried out but with a much greater level of sophistication.

It is always difficult to know what the future holds and whether there will be further advances in surgical facial rejuvenation. My feeling is that most of the advances will be adjuvant treatments which improve skin quality and also help to maintain the results of surgery, either with some form of internal suture techniques or some form of externally applied energy that

will maintain collagen production in the face. The rate of change is accelerating and the future is exciting.

Norman Waterhouse graduated from Birmingham University in 1978. His early surgical training took place in Cambridge and Bristol and in 1982 he became a Fellow of the Royal College of Surgeons of England and the Royal College of Surgeons of Glasgow. His higher surgical training in Plastic Surgery was carried out in Bristol and London as well as periods spent at specialist centres in Bordeaux, Tokyo and Adelaide. In 1988 he gained the Specialist Fellowship in Plastic Surgery FRCS(Plast).

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