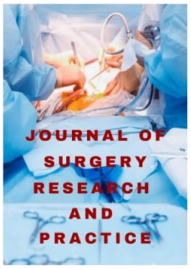

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Case Report

The U-Lift: A Hybrid Limited-Incision Deep Plane Facelift Integrating Superficial Musculoaponeurotic System (SMAS) Suspension Through U-Shaped Periauricular Access

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Abstract

Background: The evolution of facelift techniques reflects the ongoing search for natural, durable and reproducible facial rejuvenation. While deep-plane and extended- Superficial Musculoaponeurotic System (SMAS) approaches offer comprehensive results, they require wide dissection and recovery. Conversely, short-scar and mini-lift techniques minimize incisions but may lack true deep support.

Objective: To describe the U-Lift, a hybrid technique combining limited periauricular access with deep-plane dissection and SMAS fixation.

Methods: A U-shaped incision around the ear allows elevation to the pre-parotideal fascia. Three main PDS 3-0 fixation sutures are placed at the lower conchal, preauricular and postauricular points. Complementary 4-0 Polydioxanone Suture (PDS) close the deep layer and a continuous 5-0 mononylon suture closes the skin. Results: The technique provides effective lower face and cervical rejuvenation through minimal incisions, with low morbidity and rapid recovery.

Conclusion: The U-Lift achieves natural rejuvenation by integrating true SMAS suspension with short-scar access, bridging the gap between mini and deep-plane facelifts.

Keywords: Superficial Musculoaponeurotic System (SMAS); Deep-Plane Facelifts; U-Lift

Introduction

Facelift surgery has evolved through more than a century of innovation, from the early subcutaneous lifts of Passot to the deep-plane dissections described by Hamra [1,2]. The search for techniques that balance minimal invasiveness with long-lasting rejuvenation continues. While traditional short-scar or MACS lifts reduce incision length and morbidity, they may fail to reposition the deeper facial structures adequately. The U-Lift was developed to provide deep-plane control through limited access, combining SMAS suspension, tension-free skin closure and natural aesthetic vectors.

Case Report

Surgical Technique

Under local anesthesia with sedation, the patient is positioned supine with slight head elevation. Preoperative markings outline a U-shaped incision beginning at the lower conchal point, extending along the preauricular crease, curving around the lobule and continuing into the postauricular sulcus. Skin and subcutaneous tissue are elevated in a total plane until reaching the pre-parotideal fascia, exposing the SMAS. Three primary fixation sutures with PDS 3-0 are then placed: (1) at the lower conchal fixation point for vertical and posterior support; (2) preauricular fixation reinforcing the midface and jowl and (3) postauricular fixation securing posterior flap redraping. Complementary deep sutures (PDS 4-0) are applied around the auricle to reinforce closure and avoid tension on the skin. Skin is redraped without traction and closed with a continuous 5-0 mononylon suture. Drain placement is optional depending on flap thickness.

The technique uses dual vectors: vertical elevation of the midface and oblique posterior redraping for the neck. This combination mirrors the principles of deep-plane facelifts while preserving the minimal access concept of short-scar lifts (Fig. 1-5) [2-5].

Figure 1: Preoperative lateral view showing mild skin laxity and jowl descent.

Figure 2: Marking of U-shaped periauricular incision for the U-Lift technique.

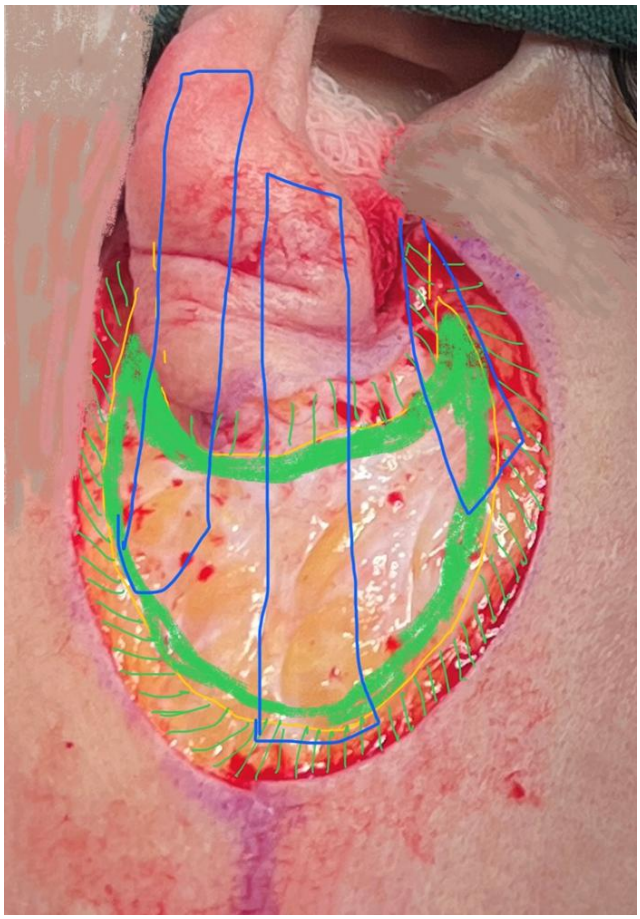

Figure 3: Intraoperative dissection to pre-parotideal fascia showing SMAS exposure and placement of PDS 3-0 fixation sutures.

Figure 4: Early postoperative result (day 7) showing smooth contour, limited scar and harmonious redraping.

Figure 5: Case 2- Pre and post operatory evolution. Short-scar and limited bruising.

Discussion

The U-Lift integrates the principles of both short-scar and deep-plane facelift techniques. It allows direct access to the SMAS while maintaining a limited incision, reducing morbidity and achieving natural results. Hamra, emphasized the importance of repositioning the malar fat pad and retaining ligaments for lasting rejuvenation, while Mendelson and Jacono refined the concept of composite facial movement [2,6,7]. Passot's early periauricular approach introduced the concept of minimal access, which the U-Lift revives with modern anatomical precision [1].

Compared with the MACS lift, which relies on purse-string sutures and vertical suspension, the U-Lift provides more comprehensive repositioning through direct deep-plane dissection [4]. The technique also parallels the MIDE facelift described by Barrera, which uses small incisions and selective deep release [8-10]. However, the U-Lift differs by combining SMAS-skin redraping with defined three-point fixation, giving enhanced vector control and durability.

The limited incision reduces postoperative edema and preserves vascularity, while the total-plane dissection permits tension distribution across the SMAS and deep fascia rather than the skin. These principles align with Ramirez's concept of anatomical suspension and Auersvald's structured cervical approach [11-20]. The result is a hybrid lift that harmonizes lower face and neck contours with reduced recovery time.

Conclusion

The U-Lift provides a reproducible, safe and efficient alternative for facial rejuvenation in selected patients with moderate laxity. It combines the advantages of deep-plane repositioning and short-scar incision, achieving natural and long-lasting outcomes with reduced downtime. The technique bridges the gap between minimal-access and extended deep-plane facelifts, expanding the surgeon's armamentarium for individualized facial rejuvenation.

Conflict of Interest

The authors declare no conflict of interest.

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