Trichophytic Endoscopic Forehead-Lifting in High Hairline Patients

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Since Hunt’s description of the coronal brow-lift in 1926, many techniques for surgical rejuvenation of the upper third of the face have been described in the literature [1]. Although the coronal forehead-lift has been the standard with which all other techniques have been compared, most surgeons and patients prefer the endoscopic approach to forehead-lifting. The disadvantages of the coronal approach include the potential for poor scarring with a noticeable scar in the temporal recession, alopecia, forehead paresthesia, hypoesthesia or numbness of the scalp which may be persistent on occasion, pruritus at the incision site, and elevation of the frontal hairline [2]. Additionally, most patients are reluctant to accept the larger coronal incision and prefer the less invasive endoscopic approach to surgical rejuvenation of the upper third of the face. One noticeable effect of the endoscopic approach is an elevation of the hairline. Although this is an acceptable result for most patients, persons who have high hairlines (greater than 5 to 6 cm) may not wish to move the hairline more posterior. Patients with high hairlines and a curved sloping (“double convexity”) forehead pose a technical challenge to the surgeon because the endoscopic equipment is relatively short and straight, making treatment of the depressor musculature with myotomy or myectomy a difficult endeavor. In 2004, Tower and Dailey [3] described their approach to rejuvenation of the upper third of the face in patients with high hairlines through a long pretrichial incision. Since 2000, the senior author (SWP) has performed a technique combining a short 3- to 4-cm pretrichial incision with endoscopic equipment to lift the forehead in patients who present with brow ptosis and high hairlines. This technique also offers the esthetic advantage of lowering the high hairline. The following is a description of the operative technique.

Surgical technique

Pretrichial endoscopic forehead-lifting is performed with the patient under monitored anesthesia care or general anesthesia. Although intraoperative antibiotics are not typically given to the patient, a 5-day course of cephalaxin is started the day before surgery. In the preoperative holding area, the surgical markings are made, and the patient’s hair is twirled. The pretrichial incision marking is approximately 4 cm in length and is made at the midline following the natural irregular frontal hairline contour in

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