



Article

# Modified Subnasal Upper Lip Lift in Women: A Personal Technique to Consider

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**Abstract:** The ageing process can alter the aesthetic proportions of the upper lip. Such changes may also appear in youth as a result of genetic factors, leading to aesthetic disharmony. Although numerous surgical techniques have been described to address this concern, none has completely achieved the ideal aesthetic standards. To evaluate the aesthetic outcome of a modified indirect subnasal upper lip lift approach. Twenty-five women with elongated upper lips were included in this study. The procedure involved a modified subnasal upper lip lift by suspending the labial superficial musculoaponeurotic system (SMAS) to the pyriform ligament. Both objective and subjective parameters were employed to assess postoperative results. On a visual analogue scale, the mean patient satisfaction score was 7.7. Objectively, postoperative evaluation revealed that 92% of patients achieved the ideal upper lip proportions for skin and vermilion height, while 8% reported under-correction. No major complications were noted, except for transient postoperative dysesthesia in two patients. Suspension of the labial SMAS to the pyriform ligament, as an adjunct to subnasal upper lip lift, is a simple, safe, and essential step in achieving ideal aesthetic outcomes.

**Keywords:** Upper Lip Lift, SMAS Suspension, Subnasal Lip Lift

## 1. Introduction

The ageing process alters the aesthetic standards of the upper lip due to bone remodeling, muscle laxity, and loss of skin elasticity. Consequently, the upper lip loses its youthful contour, gradually droops downwards, leading to increased vertical skin height and reduced vermilion display. The Cupid's bow flattens, and vertical cutaneous wrinkles become more prominent [1].

These changes can also appear in younger individuals due to genetic predisposition, resulting in aesthetic imbalance [1], [2]. The ideal aesthetic proportions of the lips have long been discussed: Leonardo da Vinci suggested that the upper lip should be approximately one-third the height of the lower lip and chin combined, while Albrecht Dürer proposed a ratio closer to one-fourth. Well-balanced proportions between the upper and lower lips are more crucial than their absolute measurements. Ideally, the philtral length measures 12–15 mm from the subnasal to the labiale superius, though this length increases with age [3]. The vermilion height of the upper lip averages  $8-9 \pm 1$  mm, with an ideal upper-to-lower lip vermilion ratio of approximately 3:4.

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Various surgical techniques have been proposed to correct elongated upper lips. Contemporary methods are generally classified as indirect (subnasal resection) or direct (vermilion advancement) approaches [4]. This study evaluates the aesthetic outcome of a modified indirect subnasal upper lip lift technique.

## 2. Materials and Methods

A retrospective study was conducted involving twenty-five women with elongated upper lips. The study took place at Al-Sader teaching Hospital between September 2015 and July 2018. The participants' ages ranged from 47 to 63 years (mean = 52). In adults, the ideal aesthetic dimensions of the upper lip include a skin height of 18–20 mm and a vermilion height of 10–12 mm [5].

Inclusion criteria:

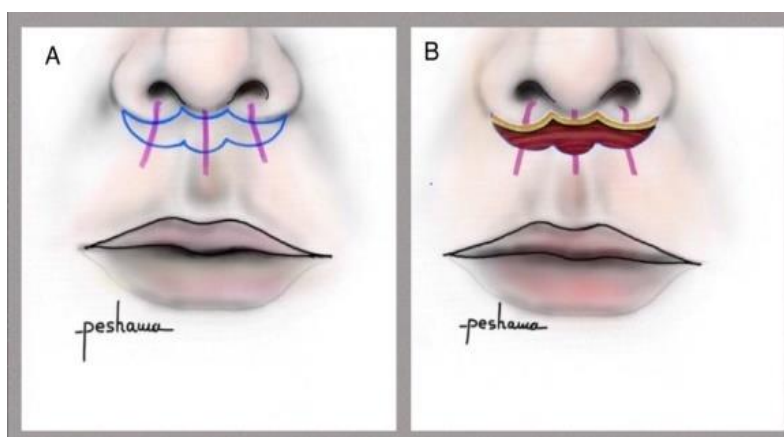
1. Women with upper lip skin height >20 mm.
2. Women with vermilion height <10 mm.
3. Women presenting both criteria.

Exclusion criteria:

1. Normal upper lip (philtral length <18 mm).
2. Congenital facial deformities involving the lip.
3. Concomitant surgical procedures involving the nose or perioral area.
4. History of hypertrophic or keloid scarring.
5. Gummy smile.

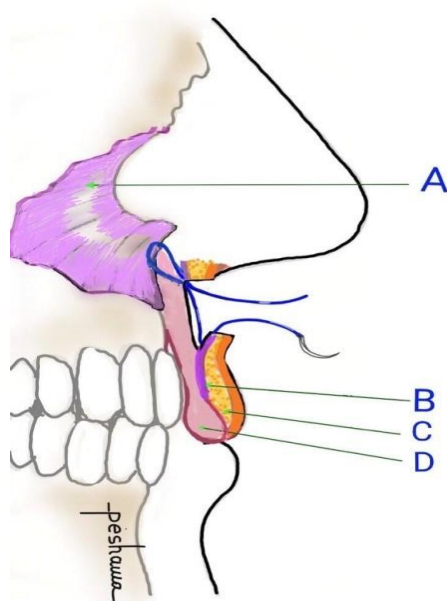
A surgical marker was used to outline a wavy 'bullhorn' ellipse along the nasal base, with three reference markings—one at the center and two at the midpoints of each nostril (Figure 1A). These points indicated the placement of suspension sutures. The width of the ellipse ranged from 5–10 mm, depending on upper lip length. All operations were performed under local anesthesia using 2% lidocaine with 1:100,000 epinephrine to ensure a bloodless field.

The bullhorn ellipse was excised using a No.15 blade, removing skin and subcutaneous tissue above the orbicularis oris muscle, while preserving a thin layer of subdermal fat containing microvasculature (Figure 1B). The distal margin was undermined for 2–3 mm in the sub-SMAS plane, releasing the labial SMAS from the underlying muscle.



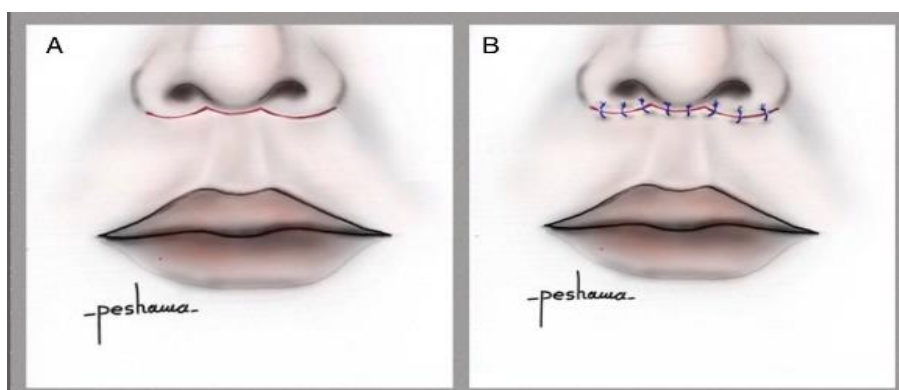
**Figure 1.** A, marking of the bull horn ellipse and the reference markings. B, excision of the ellipse

Hemostasis was secured using bipolar electrocautery. Three 4-0 polydioxanone suspension sutures were placed at the marked reference points, anchoring the SMAS of the labial flap to the pyriform ligament beneath the nasal base through the Orbicularis oris muscle (Figure 2).



**Figure 2.** suspension suture (A, pyriform ligament. B, SMAS layer. C, skin and subcutaneous tissue. D, orbicularis oris muscle.

These sutures approximated the dermal edges of the excised ellipse. Four buried 5-0 polydioxanone dermal sutures were placed between suspension sutures for precise wound coaptation (Figure 3A). The skin was closed with interrupted 6-0 polypropylene sutures (Figure 3B).



**Figure 3.** A, suspension and buried dermal stitches approximate the wound edge automatically. B, the skin closure.

Postoperative care included topical antibiotic ointment twice daily for ten days, followed by topical scar-modulating agents once daily for three to six months. Oral cephalosporin antibiotics were prescribed for 5–7 days. Sutures were removed after seven days. Patients attended monthly follow-up appointments for five to six months, during which healing progress and photographic documentation were evaluated. Final postoperative measurements were compared with preoperative values.

Objective assessments focused on vermilion border symmetry and changes in skin and vermilion height. Subjective evaluation was conducted using a visual analogue scale (VAS) ranging from 0–10, incorporating scores from the surgeon, the patient, and an independent observer.

### 3. Results

Based on the visual analogue scale, mean patient satisfaction was 7.7. Objectively, 23 patients (92%) achieved ideal upper lip proportions for skin and vermilion height (Figure 4).



**Figure 4.** Pre- and post-operative result after 6 months.

Two patients (8%) reported under-correction and underwent successful revision surgery six months later. No cases of overcorrection or excessive dental show were observed. Lip pout improved universally. One patient developed vermilion asymmetry, which was corrected successfully after six months. No major complications occurred, except for transient postoperative dysaesthesia in two patients (lasting two to three months). No instances of persistent oedema, haematoma, necrosis, infection, or wound dehiscence were recorded, and no scar revisions were required (Figure 5).



**Figure 5.** Pre- and post-operative result after 6 months.

### 4. Discussion

Regardless of the chosen technique, the goals of upper lip lifting should include minimizing visible scarring, restoring dental show, increasing vermilion height, enhancing lip projection, and ensuring scar stability [3], [6]. The subnasal ‘bullhorn’ lip lift, first introduced by Cardoso and Sperli in 1971 [7], remains one of the most accepted

approaches, as it provides natural results with minimal scarring. Rozner and Isaacs described closure of the bullhorn excision with a single skin layer, which led to complications such as hypertrophic scarring and wound dehiscence [3]. Greenwald modified this by introducing two-layer closure [8], later supported by Austen, who added a vertical midline excision in patients with wide philtra, flattened Cupid's bows, or bulky lips [9]. While these refinements improved scar quality, aesthetic concerns persisted in some cases.

Marquez and Brenda expanded the excision to include the nasolabial folds, achieving satisfactory rejuvenation in older patients, though this technique is unsuitable for younger patients with hereditary lip elongation [10]. Some surgeons attempted intranasal extensions of the incision to conceal scars [4], [5], [10]; however, Talei [11] criticized this modification, noting that replacing nasal sill skin with labial skin disrupts the natural contour. We concur with this view and maintain that adhering to the classic bullhorn design minimizes scarring and prevents complications such as alar distortion or sill widening. Other authors proposed excision of the orbicularis oris muscle in a T-shaped pattern with suspension to the columellar base [12], [13]. Although this yielded satisfactory lifting, it often resulted in excessive nostril exposure and noticeable scarring, necessitating revision surgeries. In our technique, we preserved the orbicularis oris muscle to avoid fibrosis and dynamic deformities. To prevent long-term downward pull of the subnasal area, we incorporated SMAS suspension to the pyriform ligament, as suggested by Yu Kit Li and Morris Ritz [14]. Talei [11] also described SMAS anchoring but performed a deeper dissection, which we avoided to minimize postoperative oedema and protect the labial elevator complex.

## 5. Conclusion

The modified subnasal upper lip lift is a safe, straightforward technique with minimal complications. Proper patient selection remains crucial. Larger patient cohorts and longer follow-up periods are recommended to further validate these findings.

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