LAS VEGAS – In the early 1980s, combining facelift procedures with chemical skin peeling was considered a no-no because of skin necrosis concerns.

But Dr. David M. Morrow, founder and director of the Rancho Mirage, Calif.–based Morrow Institute, had a hunch that chemical peels that were made from phenols might be causing the necrosis, not those made from trichloroacetic acid (TCA). So in the late 1980s, he started combining TCA peels with lifting procedures of the upper face, midface, and neck – a practice that he has continued to this day.

At the annual meeting of the American Academy of Cosmetic Surgery, Dr. Sheila C. Barbarino presented results from 1,118 men and women aged 35-89 years who have undergone the combined procedures at the Morrow Institute since 1988, "all without a single case of skin necrosis," said Dr. Barbarino, an ophthalmic plastic surgeon at the institute.

Photos courtesy Dr. Sheila Barbarino and Dr. David Morrow
A patient is shown before undergoing combined facelift with chemical peel procedure.

Of the 1,118 procedures, 489 were performed using TCA 35%, 481 with TCA 18%, and 148 with TCA 15%. She noted that 483 of the procedures also involved the use of phenol 89%, which was applied to the lower eyelid and/or periorbital area. She said that the current practice at the institute is to use a moderately deep peel with TCA 18%.

The rationale for chemical skin peeling following lifting procedures is to improve skin color and texture "while creating new epidermis, dermal collagen, and elastic fibers," Dr. Barbarino said. "Combining these two procedures and performing them simultaneously is extremely efficient. It calls for only one operative setting for anesthesia [and] one window of healing time, and it saves the patient time and money."

In the upper face–, midface–, and neck-lifting procedures, undermining consisted of combined blunt and sharp dissection to create long, subcutaneous flaps of the neck and face. Suspension sutures were placed in a favorable vector via superficial musculoaponeurotic system (SMAS) plication and/or SMAS flaps. "The skin flaps were then trimmed and tailored and skin closure was performed, followed immediately by chemical skin peeling," Dr. Barbarino said.

Photos courtesy Dr. Sheila Barbarino and Dr. David Morrow

The same patient is shown 1 month after undergoing the procedure.

Chemicals used were TCA 18%-35% and phenol 89% to nonundermined areas. "You can safely use phenol after transconjunctival lower lid blepharoplasty, but not after transcutaneous lower lid blepharoplasty, because the flap is a little too thin," she said.

Patients who underwent the combined procedures had Fitzpatrick skin types I-IV. Postoperatively, the skin was evaluated based on thickness, color, and condition. "Skin flap thickness and condition [were] also
evaluated immediately after the surgery was performed," Dr. Barbarino said. "If significant swelling, ecchymosis, and/or hematoma were observed, we would defer the peel for another day."

Anesthesia used for the procedures consisted of IV or general sedation, supplemented with local infiltration of 0.5% lidocaine with epinephrine or a dilute local anesthetic solution.

"The benefit of combining these procedures is that you can address two problems with one healing period of approximately 2 weeks," Dr. Barbarino said. "We observed no clinical differences in outcomes from simultaneously performing these procedures versus performing each procedure at separate settings."

A key to preventing complications is to consider if the patient’s skin thickness will tolerate the combined procedures. Assessment for feasibility would involve analysis of the skin texture, turgor, and the presence or absence of ecchymoses under the skin after the face-lifting procedure. "If a patient’s skin was already very thin preoperatively, then the surgeon would be well advised not to proceed with the combined procedure," she said. "Ideally, you’d like to treat with topical vitamin C solution and tretinoin 0.1% cream for 1 month prior to any peel. Sun avoidance is mandatory during the healing process."

Infection with herpes simplex virus is a common complication of all chemical peels. If this occurs, Dr. Barbarino recommends treating with valacyclovir. "You can reassure your patients that these lesions will resolve without any scarring," she said.

No incidence of necrosis was noted in the patients, nor were there any objectionable permanent pigmentary changes. "Transient hyperpigmentation is responsive to bleaching agents or simply re-peeling the patient," she said.

Dr. Barbarino said that she had no relevant financial conflicts to disclose.

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