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Avoiding Platysmal Bands: A Universal Approach

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ABSTRACT

Background: *Rejuvenation of the cervical region remains a significant challenge in facial plastic surgery. Traditional approaches often fail to address structural laxity, leading to the recurrence of platysmal bands and suboptimal definition of the mandibular border. This study presents a novel surgical technique designed to treat deep neck structures and the platysma comprehensively, ensuring improved contour and stability.*

Methods: *The author describes a universal approach to cervical lifting that integrates precise management of deep neck compartments with a distinct platysmal manipulation strategy. The technique focuses on anterior partial square platysmal resection and combined posterior traction. Following the release of retaining ligaments and the reduction of subplatysmal fat and glands, specific suture placement facilitates the redraping of the cervical skin and muscle. A retrospective review was conducted on 60 patients who underwent this procedure between October 2024 and October 2025.*

Results: *Post-operative analysis demonstrated significant improvement in the cervicomental angle and jawline definition across the cohort. The technique effectively addressed deep cervical structures and muscular laxity. Crucially, the recurrence of visible platysmal bands was not observed, with follow-up ranging from 3 to 12 months. Patient satisfaction rates were high, and no major complications were reported.*

Conclusions: *The described technique offers a reliable and reproducible solution for neck rejuvenation. By targeting the deep anatomical causes of cervical aging and employing a specific platysmal strategy, this "universal approach" successfully restores a youthful neck contour while preventing the formation of platysmal bands.*

Keywords
Deep neck lift, Platysmaplasty, Cervicoplasty, Jawline contouring, Platysmal bands.

Introduction
An aesthetically pleasing neck requires a defined mandibular border and the absence of platysmal bands. Despite advancements in rhytidectomy, the neck remains prone to early recurrence of deformities. Traditional superficial approaches often fail to address underlying anatomical causes, such as subplatysmal fat accumulation and glandular hypertrophy, frequently leading to patient dissatisfaction. Recent evidence underscores the necessity of a multi-planar approach; however, a consensus on preventing recurrent banding remains elusive [1-3]. This article introduces a “universal approach” combining anterior square platysmal resection, deep structural release, and strategic posterior traction to restore a youthful profile and specifically prevent recurrent platysmal bands.

A retrospective chart review was conducted on 60 (54 females; 6 males) consecutive patients who underwent the "Universal Approach" neck lift technique between October 2024 and October 2025. The mean age was 57,5 years (range, 41 to 74 years). The study adhered to the principles of the Declaration of Helsinki. Inclusion criteria comprised patients presenting with moderate to severe cervical skin laxity, platysmal banding, and an obtuse cervicomental angle. Patients with a history of neck radiation or significant burn scars were excluded.

All procedures were performed under general anesthesia. A

standard incision layout was utilized, consisting of a submental incision and perilobular incisions with retroauricular extensions. Skin flaps were elevated in the subcutaneous plane, extending caudally to the lowest cervical crease, posteriorly into the postauricular region, and laterally over the mandibular angle and body. Care was taken to preserve the marginal mandibular nerve. The mandibular and cervical retaining ligaments were identified and meticulously released to allow for tension-free redraping.

Deep Neck Compartment Management and Platysmal Approach – Following skin flap elevation, the subplatysmal space was accessed. The interplatysmal fat pad was either excised in the majority of cases or reduced to a minimum. In patients presenting with submandibular gland ptosis or hypertrophy, a partial reduction (approximately 40-50%) was performed via intracapsular resection using electrocautery; the capsule was then closed with 3-0 PDS sutures. Digastric muscle hypertrophy was addressed through tangential excision followed by 2-0 multifilament nylon plication to elevate the hyoid bone [3-5]. To prevent the recurrence of bands and redefine the jawline, a specific "Universal" platysmal protocol (Figures 1 and 2) was applied:

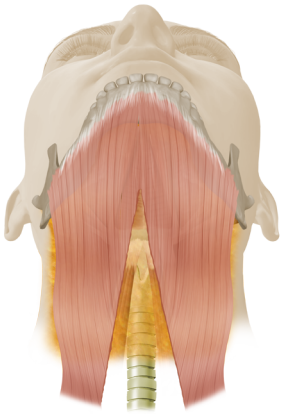


Figure 1: Frontal inferior view: Preoperative state showing laxity of deep musculature and retaining ligaments; hypertrophied and displaced submandibular glands (SMG); and superficial platysmal flaccidity with prominent diastasis bands. (Illustrations: Vagner Coelho).

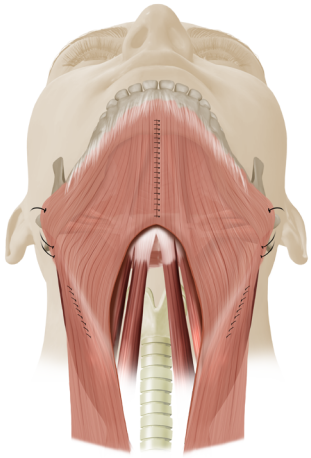


Figure 2: Frontal inferior view: Deep neck structures addressed via muscle repositioning and reduction of excess SMG tissue. The platysma was managed through the "Universal Approach", integrating supra-hyoid plication, Labbé and Crevasse maneuvers for posterior traction, and anterior platysmal resection inferior to the hyoid bone. (Illustrations: Vagner Coelho).

Anterior Square Partial Resection and Plication

A square-shaped partial resection of the anterior platysma was performed, extending from the level of the hyoid bone to the sternal notch. This maneuver aimed to disrupt the anatomical continuity of the medial bands and prevent postoperative myofiber reconnection. Superior to this area, a double-layer platysmal plication was performed, extending from the mentum periosteum to the hyoid bone, using 2-0 multifilament nylon sutures. This combined approach ensures both the elimination of active banding and the structural reinforcement of the submental floor [6-10] (Supplemental Digital Content - Video 1).



Video 1: Intraoperative step: The "Universal" Platysmal Management. Identification of the anterior platysmal bands. Exposure of the subplatysmal space. Partially resected submandibular gland and the tangential excision of the hypertrophic digastric muscles prior to plication. Demonstration of the **Anterior Square Partial Resection** from the hyoid bone to the sternal notch. **Double-layer plication** anchored to the mentum periosteum, creating a stable submental floor. Crevasse maneuver. Mandibular angle and midline contour.

The lateral and superior borders of the platysma were mobilized. First, the superior edge was cephalad-transferred and fixed to Loré's fascia with 2-0 multifilament nylon (Labbé technique) [11]. A distinct posterior traction vector was then applied, anchoring the muscle to the mastoid periosteum using a Crevasse maneuver with 2-0 nylon [12].

To consolidate the lift and define the mandibular angle and midline contour, a continuous suture was performed from Loré's fascia to the anterior border of the sternocleidomastoid muscle using 2-0 multifilament nylon to reinforce the traction [1,4,10,13]. **(Supplemental Digital Content** – Figure 1) Finally, a hemostatic net was performed to obliterate dead space and define the cervicomental angle [14].

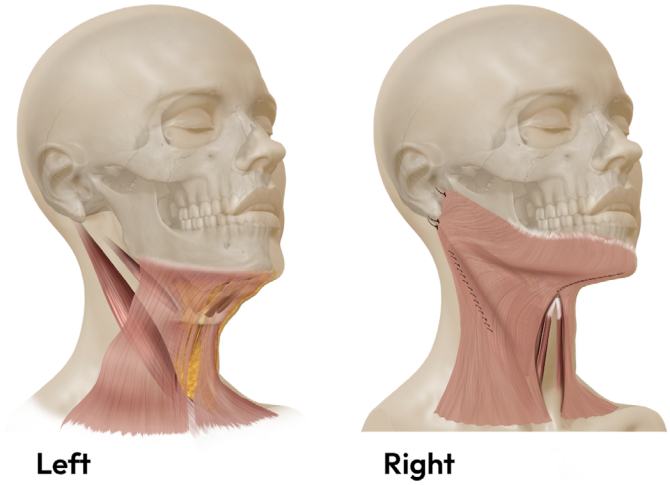


Figure 1: Oblique view: (Left) Preoperative state showing laxity of deep musculature and retaining ligaments; hypertrophied and displaced submandibular glands (SMG); and superficial platysmal flaccidity with prominent diastasis bands. (Right) Postoperative result following deep neck management, including muscle repositioning and partial SMG resection. The platysma was treated according to the "Universal Approach", featuring supra-hyoid plication, Labbé and Crevasse techniques, and infra-hyoid anterior platysmal resection. (Illustrations: Vagner Coelho).

A compressive dressing using kinesiology tape was applied for at least 5 days. Suction drains were utilized in all cases. Patients were advised to avoid strenuous activity for 30 days. Standardized photographs were captured at 3, 6, and 12 months post-operatively.

Discussion

Photographic analysis demonstrated significant improvement in cervicomental angles and mandibular definition[9] in all 60 cases. Notably, no recurrence of anterior platysmal bands was observed (follow-up range: 3–12 months), even in high-dynamic cases (Figures 3 and 4).

Figure 3



Figure 3: Preoperative view: A **65**-year-old female presenting with significant cervical skin laxity, an obtuse cervicomental angle, and visible medial platysmal bands.

Figure 4



Figure 4: Postoperative view: 12 months after the "Universal Approach". Note the sharp definition of the mandibular border and the complete resolution of the platysmal bands. The stability of the cervicomental angle at one year demonstrates the efficacy of the double-layer plication to the mentum periosteum and the anterior square resection.

The complication rate was low, with no permanent nerve injuries or major hematomas. Temporary neuropraxia of the marginal mandibular or cervical branches occurred in 4 cases, resolving within 8 weeks. One case of platysmal plication dehiscence was observed. This complication was not a primary failure of the technique, but rather the result of external blunt trauma and significant physical exertion following a domestic assault in the

early postoperative period; patient required surgical re-exploration and re-suturing. Three patients developed minor seromas managed by aspiration and one case of sialocele was identified following submandibular gland resection. This was successfully managed through a combination of localized botulinum toxin type A injection, the application of a targeted hemostatic net to obliterate dead space, and oral scopolamine to reduce glandular secretion. The hemostatic net effectively prevented major hematomas and limited postoperative edema.

Ellenbogen and Karlin [15] estabilished five visual criteria that are characteristic of youthful, aesthetic neck. (Supplemental Digital Content – Figure 2)The pursuit of a long-lasting cervical contour is often hindered by recurrent platysmal bands. Traditional midline plication or lateral suspension frequently fails to neutralize the dynamic forces of the platysma [1,8,10,16,17]. The "Universal Approach" addresses this by combining deep structural management with a targeted dual-zone treatment.

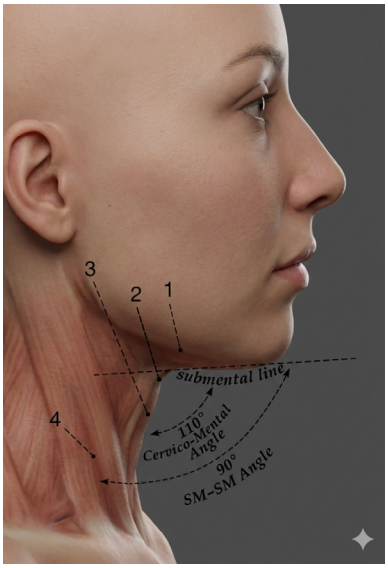


Figure 2: Five visual criteria for success in restoring the youthful neck. A schematic illustration defining the ideal anatomical parameters targeted by the "Universal Approach" neck lift. Key anatomical landmarks are numerically indicated: **1,** Distinct inferior mandibular border; **2,** Subhyoid depression; **3,** Visible thyroid cartilagem bulge; **4,** Visible anterior sternocleidomastoid border; **5,** The Cervico-Mental Angle is depicted at approximately 110°, indicating a deep and defined submental contour and The SM-SM Angle (Submentale to Sternocleidomastoid relationship) is shown at 90°, representing the ideal perpendicularity between the jawline and the vertical neck axis. The dashed horizontal line represents the ideal submental plane.

A key differentiator is the management of the anterior platysma. While the double-layer plication to the mentum periosteum provides powerful skeletal anchorage, the anterior square resection below the hyoid bone disrupts the "bowstring" effect of the medial fibers, preventing myofiber reconnection.

Furthermore, this study reinforces that a youthful neck requires volume management of the deep compartments. Reducing subplatysmal fat, hypertrophic glands, and digastric muscles creates the necessary space for effective muscle redraping. The use of the Labbé technique and the Crevasse maneuver for posterior traction ensures that the vector of pull is anatomically sound and stable.

Although the mean follow-up is 6 months, the absence of recurrent bands at one year suggests that mechanical muscle disruption combined with rigid periosteal fixation offers a more durable solution than traditional suturing. Future studies with larger cohorts are warranted.

The "Universal Approach" offers a comprehensive, reproducible strategy for cervical rejuvenation. By integrating rigid skeletal anchorage, targeted muscular resection, and meticulous deep-compartment management, this technique successfully prevents recurrent platysmal bands while restoring a high-definition jawline.

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