



## PRESTO-One Facelift-Technique: Preserving of the Retaining Ligaments and SMAS-Tethering-(The O Stands For A Surprised Exclamation)

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### Opinion

The PRESTO – One Technique is a safe, fast and identity preserving technique. Value is contributed to the preservation of identity. Why in specific the PRESTO-Technique has this identity preserving features will be discussed in detail. The posterior and cranial borders of the SMAS will be kept intact, as well as the Retaining Ligaments. The highest asset of our facial expression/physiognomy is our own, personal Identity. The identity is the requirement for our development of personality and in addition the basis of our social integrity. The face is the classical representative of human identity. The identity is the basis of our expression diversity and expression possibilities. Via Identity we form our unique, independent non-verbal communication, which is mandatory in our interpersonal relations. A surgical intervention should be independent from ideal of beauty, shapes of beauty and ankles of beauty. The surgical intervention in aesthetic, plastic surgery should be guided by the identity of the patient. The evenly shaped faces, i.e. the artificial beauty faces – I call them no-name-beautys – should be part of the past. The goal of our plastic, aesthetic, surgical interaction should be the attainment of so called named-beautys.

### What was the idea behind the PRESTO One -Technique?

I wanted to develop a facelift technique that is effective in shape and durability. The PRESTO One technique is very effective in the form giving and retains the naturalness of the patient.

It was important to me to develop a facelift technique, which despite maximum effectiveness (which of course always means a large preparation zone) offers high safety for the patient: in the sense of nerve damage, lymph drainage damages and maximum possible vascular supply. In addition this technique offers to preserve safely the patient's identity.

### How can I achieve maximum effectiveness and durability?

I can only achieve this with a maximum mobility and dissection of the soft tissue, but with the preservation of the so-called Retaining Ligaments. The most effective preparation level according to Bryan Mendelson is the Layer 4.

The desire to have the effectiveness on one hand and the safety for the patient (preservation of the nerves, the vessels and the lymph vessels) on the other hand and in addition the preservation of the identity appears to be in sharp contradiction to the maximum effectiveness.

### What are the guardians of the identity?

We have the basic structures of the bony skeleton. What are the static guardians of identity? We have the so-called Retaining Elements, which are made up of the Retaining Ligaments and the interlayer septae, which are also largely spared. The Retaining Ligaments are very individual in shape and in the differentiation in each patient. In the aging process, the vector of force of the retaining ligament migrates from horizontal to caudal, but without showing a significant change. Only the vector is altered after caudal. If we change the bone in the chin-area or also in the maxilla, we change the entire impression and expression of the face. We often see in the case of profile-plasties that we have a completely new (desired by the patient) phenotype. In classical facelift surgery, the patients' desire scale lies firstly in naturalness, and secondly, the patient wants to look rested, and thirdly, the patient wants to have a youthful expression on his face, and fourthly the concept of attractiveness follows. Preparation of the so-called retaining elements, composed of the Retaining Ligaments and the interlayer septae means in the classic SMAS preparation-the interlayer septae are opened. Using the "Superextended" Facelift – technique the Retaining Ligaments are also opened at the mandible (mandibula-cutaneous ligament), the masseterio-cutaneous ligament and the zygomaticocutaneous ligament. In this way, I have a maximum soft tissue mobility, which can lead to a very good result in a practiced hand, when the soft tissue block has been precisely repositioned to the "youthful" place. Very quickly one has exceeded the amount of the cranial vector during the complete opening of the retaining element so that an unnatural expression is preprogrammed in a refixing of the retaining element only in the range of 0.5 to 0.7 cm. When the retention elements are retained, they serve as a natural barrier to overstretching and over-shaping, and thus serve to maintain the identity at maximum desired and possible mobility. The variables of the identity are, firstly, the skin quality, and second, the volume and the storage of the fat compartments and the skeleton, especially the skeletal structures on the orbital margin of the alveolar bone. The patient, who wanted to trace his aging process into the conceptuality of youth, of freshness and naturalness-also in the end with an attractive appearance-would not like to change his essence. Therefore, the measure of the surgical procedure is not necessarily the ideal angle, the ideal volume, but the ideal is the individual face in front of us. There is no higher quality than the identity of the individual face, so that must be our master plan.

We now have more or less than 100 years' facelift tradition. From Holländer to Pitanguy and until the 1960s the cutaneous lift was state of the art. The SMAS preparation followed in the 70s. It showed itself after some critical comments, that the SMAS preparation is until today the supporting facelift structure. The differentiation of the SMAS into the so-called mobile SMAS and the non-mobile SMAS has evoked

different techniques in recent times, e.g. the MACS lift, but also the facelift techniques of Ramirez used this mobility of the entire SMAS - Structure. If you look at all facelift techniques, from the skin to the SMAS, the subperiosteal techniques-the so-called mask-lift-and also the newly developed techniques, they all directly or indirectly use the double function of the SMAS (mobility and fixation). The plications carried out after the major skin preparations also served this double function of the SMAS by mainly fixing the mobile part of the SMAS to the non-mobile part of the SMAS. They have an advantage in the differentiated improvement of individual aesthetic units, which was not always the case in block rotations. In his fantastic and pioneering studies of facelift surgery, Bryan Mendelson had a different definition of the layers within the face, he postulates the so-called "spaces", which have a floor, side walls and a roof, so the mobility of the face is guaranteed. In layer 4, these spaces are used surgically. Bryan Mendelson showed us the possibilities of a pure skin preparation, a SMAS preparation, a preparation in layer 4 and a subperiosteal preparation. It is unquestionable that the maximum mobility is reached through the preparation in layer 4. The increase in the mobility of the soft tissue block is still caused by the opening of the retaining element, i.e. the above-mentioned interlayer septae and the retaining ligaments.

The PRESTO technique differs in that it opens the rooms and uses the spaces, but leaves the retaining elements. That is, on one hand maximum mobility and, on the other hand, maximum fixation of the soft tissue block and prevention of overstretching. Comparing the different facelift techniques, the classic SMAS preparation in layer 4 can be carried out in different dimensions with and without the opening of the retaining ligaments up to the Superextended Facelift (Hamra). Here the non-mobile and the mobile SMAS is maximally used. In the so-called mask lift, which is performed in layer 6, we have a basic solution of the soft tissue block with a re-fixation of the soft tissue block at the desired but not individually fixed placement. In this case, deformation can very quickly lead to distortion in the sense of a trumpet angel face. The modern techniques, i.e. the SMAS-ectomy and the MACS-lift mostly move in their preparation or their mobilization in layer 2. In the SMAS-ectomy also crossing the border in layer 2 and 3. They mainly use the mobile SMAS as a mobile structure and the non-mobile SMAS as its fixation. By the lack of the maximum opening on the one hand and the existing soft tissue system, these techniques mainly work with the concept of compression and not with a real tissue dislocation.

**In the PRESTO One technique, the question arises as to which preparation level is being used and how does the technique use the anatomy?**

1. Preparation in layer 4.

2. Preparation, treatment of mobile and non-mobile SMAS in the sense of a superextended facelift.

In PRESTO One technique, we have no opening of posterior SMAS margins, but still have a maximum mobilization of non-mobile and mobile SMAS. We have no opening of the Retaining Elements; We have no opening of the interlayer septae. This non-opening of the interlayer septum permits a maximum uniform force transmission. On the other hand, we have a maximum mobilization of the tissue between the septae in the sense of a superextended facelift; we have a maximum subplatysmal preparation at the neck up to the front edge of the platysmas up to the jugulum and up to the clavicular line. Decisive to prevent the overstretching and overmolding is the preservation of the septae and thus the possibility to achieve a maximum gradual force distribution in the septal and vector neutrals.

That is maximum mobilization and we have a maximum possible soft tissue lift up to the point that the Retaining elements stop a further overstretch. In the classical SMAS preparation, we have a basic fixation of the SMAS, the force transmission develops a maximum strength and traction component with mobile disfigurement at the basis of the SMAS flap, in the middle of the flap we have the compression component and the neutral zone in the lateral region. This is also prevented by the maximum interseptal force distribution in the PRESTO technique. I have developed PRESTO technology since 1999. To carry out the PRESTO technique, I initially used a nasal speculum, which had served me as a tissue spreader. As a result, these tool have been optimized and developed into a so-called PRESTO instrument, which allows maximum protection and maximum stretching of the tissue. Since 1999 I have carried out 2.176 PRESTO techniques or PRESTO-like techniques at the beginning. The complication rate included temporarily nerve damage the ramus temporalis was affected in 9 cases. That is, 0.38%, the ramus mandibularis was temporarily affected in 4 cases, i.e. 0.17%. Postoperative bleeding - none. Retroauricular seromas 3.2%. Due to the relatively small skin preparation approx. 3 - 4 cm in average I have a maximum reduction of the dead-spaces and thus the technique is also suitable for smokers. The primary development of PRESTO One technology has been divided over time into five different PRESTO techniques, all in a shortscar technique as well as a PRESTO four technique for elderly patients up to 85 years, and the PRESTO five technique, which can be performed on special heavy-weight-lost patients. Convincing with PRESTO technology is the independence of the indication, the effectiveness, the durability and the preservation of the identity and the naturalness of the patient. These parameters are convincing, and I hope that the technology will be tested in every form, and that it will ultimately be felt well.