Correction of Thin Lips: “Lip Lift”

Nabil Fanous, M.D., F.R.C.S.(C)
Montreal, Canada

The aging process of the face is not merely a matter of skin and fat redundancy. With advancing age, the face not only develops a loose, wrinkled skin, but it also acquires droopy, shrunken features—mainly the eyebrows, the eyelids, the nose, and the lips.

When a face lift is performed and the lips are left untouched (as is usually the case), those lips, if thin and atrophic, may strike a dissonant chord in a homogeneous sonata. They will undermine the final result, give the face an unattractive surgical look, and serve as a clue to the person’s true chronologic age.

Different surgical approaches to senile lip correction (or “lip lift” for simplicity) have appeared in the medical literature to lift, avert, advance, and increase the bulk of the lips. Most concentrated on the technique itself rather than on the preoperative meticulous evaluation, which is by far more important. This may be why senile lip correction has failed to achieve the popularity it deserves, since it remained a simple technique plagued by unpredictable results.

In this paper, the lip aesthetics are studied in detail. The preoperative analysis is emphasized, and a systematic approach for the planning is suggested. A recommended surgical technique is presented and its results reviewed.

Lip Aesthetics

To fully understand the changes occurring in senile lips, an analysis of youthful lips is mandatory.

Gross Aesthetics of the Lips (Fig. 1, above)

Attractive upper and lower lips, when seen as one unit, have roughly a lozenge or diamond shape whose contours extend from one commissure to the other. The upper lip vermilion border forms a soft M whose two peaks (B, B’) correspond to the philtral ridges. The upper lip has a central fuller mass, the tubercle, that impinges as a convexity on the lower lip. The interlabial line separating both lips (CEC’) also forms an M, although much less pronounced than that of the upper vermilion. The lower lip completes the general lozenge shape by forming a W. The two bottom peaks (D, D’) correspond to the upper lip peaks (B, B’) but are less prominent.

Fine Aesthetics of the Lips (Fig. 1, center)

The height of the upper lip at its midline (AE) would measure about 7 to 8 mm. From point A, the vermilion runs laterally and superiorly up to points B and B’, ending at a level 3 to 5 mm higher than A. From points B and B’, the vermilion line follows a lazy S or an almost straight line laterally and inferiorly toward the commissure at points C and C’. The central line (CEC’) repeats the undulations of the upper vermilion line, although its curves are much more subtle. The lower lip has a central thickness of about 10 mm (EF) and thus appears fuller than the upper lip. In the lower vermilion border, the line DFD’ can be straight or alternately may form a slight arch at F (in which case, the difference in levels between F and DD’ could be around 1 to 2 mm). The lines DC and D’C’ are straight or a touch convex at the outside.

Changes in Senile Lips (Fig. 1, below)

Aging lips undergo several basic changes, including thinning, inversion, increased lip length, and redundancy. Although both upper and lower lips atrophy, the upper lip is especially prone to shrinkage. The loss of substance is more marked in the central portion of the lips. The peaks of the upper lip cupid’s bow (B, B’) first become

From the Department of Otolaryngology at McGill University. Received for publication April 11, 1983; revised November 1, 1983.
less attractive but also older than his or her true age. The lip correction described here will help to improve both the appearance and the apparent age of the patient.

**Preoperative Planning**

Based on the preceding study of lip aesthetics, it seems obvious that most of the correction should focus on the central labial region. The aim of the surgery is not to restore the lip to what it was 20 or 30 years ago, but rather to improve its apparent age by 10 years or so, much like the objective of a face lift.

Steps for the planning of the aging lip correction could be summarized as follows: First, the existing vermillion border (Fig. 2, above) of both lips should be traced with a fine marking pen and with great accuracy. If the marker tip is broad, it should be sharpened with a blade. It may be helpful to begin with a dotted line, and then join the dots into one continuous line. It is important to identify the cardinal points of the upper lip (A, B, B'), making sure that points B and B' correspond to the philtral ridges. In the lower lip, points D and D' are placed parallel to points B and B'.

**Aging Lips and the Facial Expression**

The "old look" is the result of multiple factors: redundant skin, wrinkles, flabby eyebrows, and so on. An important component of the aging complexion is the aging lips. Being thinner and droopy at the mouth corners, they give the elderly face its characteristic "tired" and "sad" look. Even a successful face lift can be greatly hampered by shrunken, fatigued lips.

**Young but Thin Lips**

In some young individuals, the lips are thin and atrophic secondary to hereditary or racial factors. In this case, the person looks not only
Second, the new vermilion border should be marked (Fig. 2, above center). The new peaks of the upper lip should be placed a few millimeters higher than the present ones (B, B'), depending on the difference in height between these two peaks and point A at the center of the upper vermilion border. An additional 1 mm is added for overcorrection, since the new vermilion border of the upper lip will always droop downward by about 1 to 1 ½ mm in 6 months time. For example, if the difference in height between point A and the two peaks B and B' is 2 mm, then an extra 2 mm will be needed to make a 4-mm difference (the average normal level difference is 3 to 5 mm). We then add 1 mm for overcorrection to these 2 mm. So the new peaks of this upper lip may be placed 3 mm higher than the original peaks. This example is given as a guideline to simplify the evaluation of the lip augmentation needed, but the surgeon's judgment and taste are as important, depending on the general volume of the lips, other facial structures, and so forth.

In the great majority of cases, point A is kept unchanged unless the lip substance has severely diminished at the midline (in this case, point A can be also raised by 1 to 3 mm with a corresponding increase to the height of the new B and B').

The new peaks (D, D') of the lower lip should then be marked. An approximate 2 to 4 mm increase is usually sufficient for the lower lip. If the lower lip changes are minimal, the correction may be restricted solely to the upper lip. No overcorrection is needed.

Then the lateral limits (S, S') of the excision for both upper and lower lips should be marked. In most cases, the incision need not extend beyond 6 to 7 mm short of the commissure. Taking the incision to the commissure does not add any significant benefit to the result. Moreover, it makes a longer scar and increases the operating time.

Finally, all the new points should be joined with a continuous straight line to delineate the new upper and lower vermilion borders. It is important that the new peaks (B, B' and D, D') do not form too sharp angles (pointed peaks), because this will give a surgical look to the corrected lip for a few months before softening.

**Surgical Technique**

**Anesthesia**

Either local or general anesthesia can be used. In both cases, infiltration of the operated field is recommended (for example, using Xylocaine 1% with epinephrine 1:100,000 and a fine needle). Approximately 2 to 3 cc of the solution is ample.

**Incision and Excision (Fig. 2, below center)**

The incision along both the old and new vermilion borders is done with preferably a No. 11 blade (but could be done with a No. 15 blade). This step is a most critical one and should be done with great care and with the utmost precision. Cutting into the lip is no easy job. Unless the lip is held taut, it will keep slipping from under the blade, thus distorting the final incision. To stabilize a lip, it is recommended that it be held between the thumb and the forefinger. Starting at the central part of the upper lip with the cutting edge of the No. 11 blade positioned upward, both the new and old vermilion borders are incised 1 cm at a time until the two incisions meet laterally at S or S'. This is repeated on the other side of the upper lip. The same procedure is then repeated for the lower lip. Having the surrounding skin stretched by an assistant's hand is an extra help. Excision of the excessive skin is simple and quickly done by a pair of plastic or strabismus scissors and a Brown-Adson forceps.

**No Cautery and No Vermilion Undermining**

Cauterization is unnecessary. Hemostasis is instantaneously obtained with wound closure. No undermining is needed either. In fact, it is advisable not to dissect the vermilion skin at all, so that more lip substance is moved forward with closure, resulting in a fuller and bulging new lip. If the vermilion is undermined, the newly formed lip will have a larger vermilion surface, but will remain flat and thin. In addition, postoperative swelling, surgical time, and the potential of hematoma are all increased with undermining.

**Closure (Fig. 2, below)**

The incision can be closed with any fine sutures. The author prefers interrupted 6-0 mild chromic sutures on fine needles. The dressing consists of a half-inch Steri-Strip dressing applied along the vermilion borders. Figures 3 and 4 illustrate the successive surgical steps.

**Postoperative Course**

The dressing is removed in 5 to 7 days. Chromic mild sutures need not be removed. If the sutures are of the nonabsorbable type, they should come out at that time.
FIG. 3. Surgical steps. (Above, left) Preoperative marking in case of upper lip correction. The tracing of the existing and the new vermillion borders has been done. The three dots in the center identify the midline and the philtral ridges. The two lateral dots identify the lateral limits of the upper lip excision. (Above, right) Preoperative marking of both lips. (Center, left) Incisions along old and new vermillion borders of the upper lip. The lip is held taut between the thumb and the forefinger. (Center, right) Incisions for the lower lip along old and new vermillion borders. (Below) Skin excision of upper lips.
FOLLOW-UP AND RESULTS

The lip lift procedure was performed on 32 patients, all females. The follow-up period ranged from 4 months to 3 years, with the majority having about 2 years of follow-up.

Swelling in the first postoperative week or two is moderate and comparable to that of the blepharoplasty. The patient is allowed to use lipstick on the fifth to tenth postoperative day. The scar heals well in most cases and is comparable in thickness with that of a direct brow lift.

Some patients experience an increased tightness of the lips. This gradually subsides within 2 to 4 months. Numbness of the lips along the scar line is temporary and self-resolving. Inflammatory papules and milia along the incision do occur occasionally and usually clear up with time. The upper lip peaks (B, B') were observed to droop about 1 mm (and occasionally 1½ mm) within 2 to 6 months. Therefore, a slight overcorrection of the upper lip (by 1 mm or so) is recommended, as discussed previously. This is an important factor to remember while planning for surgery. The fine wrinkles of the senile lip along the vermilion border were improved in most cases secondary to the skin excision.

COMPICATIONS

Patients should be well informed in advance about the postoperative course and the possible sequelae. Few complications were encountered:

1. Asymmetry was noticed in two cases and was revised and successfully corrected by excising a fine sliver of skin along one vermilion border.

Fig. 4. (Above, left) Skin excision of lower lip. (Above, right) Closure with fine sutures. No undermining is done. Cauterization is unnecessary. (Below, left) Closure terminated. (Below, right) Steri-Strip dressing.
2. *Undercorrection* usually occurs in the upper lip as a result of the postoperative mild drooping. Two cases were revised and readjusted, with lasting results.

3. *Hypertrophic scar* occurred in one patient with heavy, oily-type skin. The lip was locally injected twice with steroid and slowly improved to a fairly acceptable scar by the end of the first year.

**Discussion**

The thin lip correction (or so-called lip lift) is a relatively short (20 minutes) procedure. It has a minimal morbidity and few complications. The scar is usually reasonably hidden in the natural white line along the vermillion border and is further concealed with the use of lipstick. The final scar is comparable with that of brow lift.

This fact is well explained to the patients. Most of them will be ready to trade a thicker, youthful lip for a thin scar that may be further camouflaged by lipstick. Obviously, the procedure is omitted in the case of the occasional patient who will object to any visible scar on the face.

Some patients complain of numbness, tightness, and milia in the early postoperative period, but they are reassured that these symptoms and signs will eventually disappear.

The procedure requires meticulous planning and surgical precision. The incisions should be done slowly and patiently. An extra 3 to 5 minutes here are worthwhile and can prevent having to adjust an asymmetrical incision afterwards. When properly planned and executed, this technique yields rewarding results.

Figures 5 through 7 illustrate the lip lift pro-

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**Fig. 5.** (Above, left) Preoperative view of thin, atrophic lips and aging face. (Above, right) Postoperative view 6 months following a lip lift together with a face lift, blepharoplasty, and brow lift. (Below, left) Preoperative close-up. (Below, right) Postoperative close-up.
Fig. 6. (Above, left) Preoperative view of hereditarily thin, inverted lips in a young French Canadian woman. (Above, right) Postoperative view 11 months following a lip lift and rhinoplasty. (Below, left) Preoperative close-up. (Below, right) Postoperative close-up.
FIG. 7. (Above, left) Preoperative view of mild atrophy of both lips. (Above, right) Postoperative view 7 months following minimal lip lifting and face lifting. (Below, left) Preoperative side view. (Below, right) Postoperative side view.

procedure with preoperative and postoperative photographs.

SUMMARY

Thin, atrophied lips are a stigma of old age. This paper discusses the so-called lip lift, an operation that consists of lifting, everting, and increasing the bulk of the upper and lower lips by means of a simple but meticulous procedure along the vermillion border. An introductory study on lip aesthetics is presented. Preoperative planning is greatly emphasized. This technique has been used by the author in 32 cases as an adjunct to facial lifts or as a separate procedure.
The patients were followed for up to 3 years. The results were quite satisfactory.

Nabil Fanous, M.D., F.R.C.S.(C)
Seaforth Medical Building, Suite 620
3550 Cote des Neiges
Montreal, Canada

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