



Choosing Anchor Points for Lifting

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1. Patient Selection (Most Important)

Ideal candidates:

- Mild to moderate facial ptosis
- Good skin quality and elasticity
- Realistic expectations
- Age typically 35–60 years (although biological age matters more than chronological age)

Poor candidates:

- Severe skin laxity requiring facelift surgery
- Very thin skin (threads may become visible)
- Very heavy faces (threads may not provide sufficient lift)
- Significant facial asymmetry
- Active infection
- Bleeding disorders
- Uncontrolled diabetes
- Autoimmune disease with poor wound healing
- Unrealistic cosmetic expectations

Who is suitable for a thread lift?



Suitable



Suitable



Borderline



Unsuitable

- **Ideal Physical Signs**
- **Early Jowl Formation:** Mild sagging around the jawline or blurring of the lower face profile.
- **Midface Sagging:** Deflation or slight descent of the cheeks, which can deepen the **nasolabial folds**.
- **Marionette Lines:** Mild to moderate sagging at the corners of the mouth.



Anatomical Considerations

Danger structures

Facial nerve

- Avoid injury to:
- Temporal branch
- Zygomatic branch
- Buccal branch
- Marginal mandibular branch
- Know:
- SMAS relationship
- Retaining ligaments
- Course in different facial regions

Facial artery

- Important segments include:
- Inferior border of mandible
- Modiolus region

- Nasolabial fold
- Angular artery
- Blind passage of cannulas may injure vessels.

Facial vein

- More collapsible than arteries but can still bleed considerably.

Parotid gland

- Avoid penetrating:
- Parotid capsule
- Stensen duct
- Facial nerve plexus within the gland

Retaining ligaments

- Understand:
- Zygomatic ligament
- Masseteric ligament

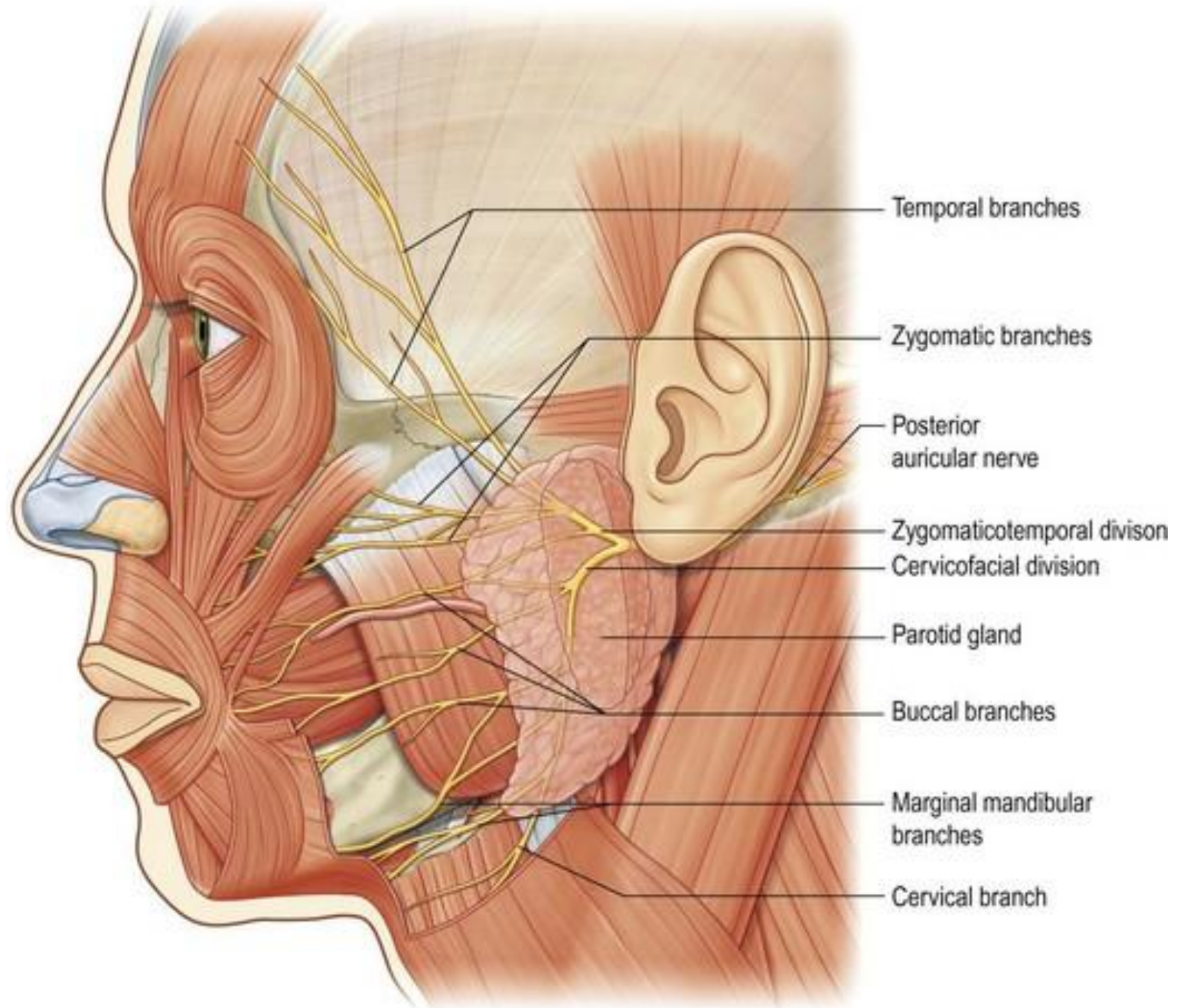
- Mandibular ligament
- Orbital retaining ligament
- These provide anchoring points but also create resistance during thread passage.

Fat compartments

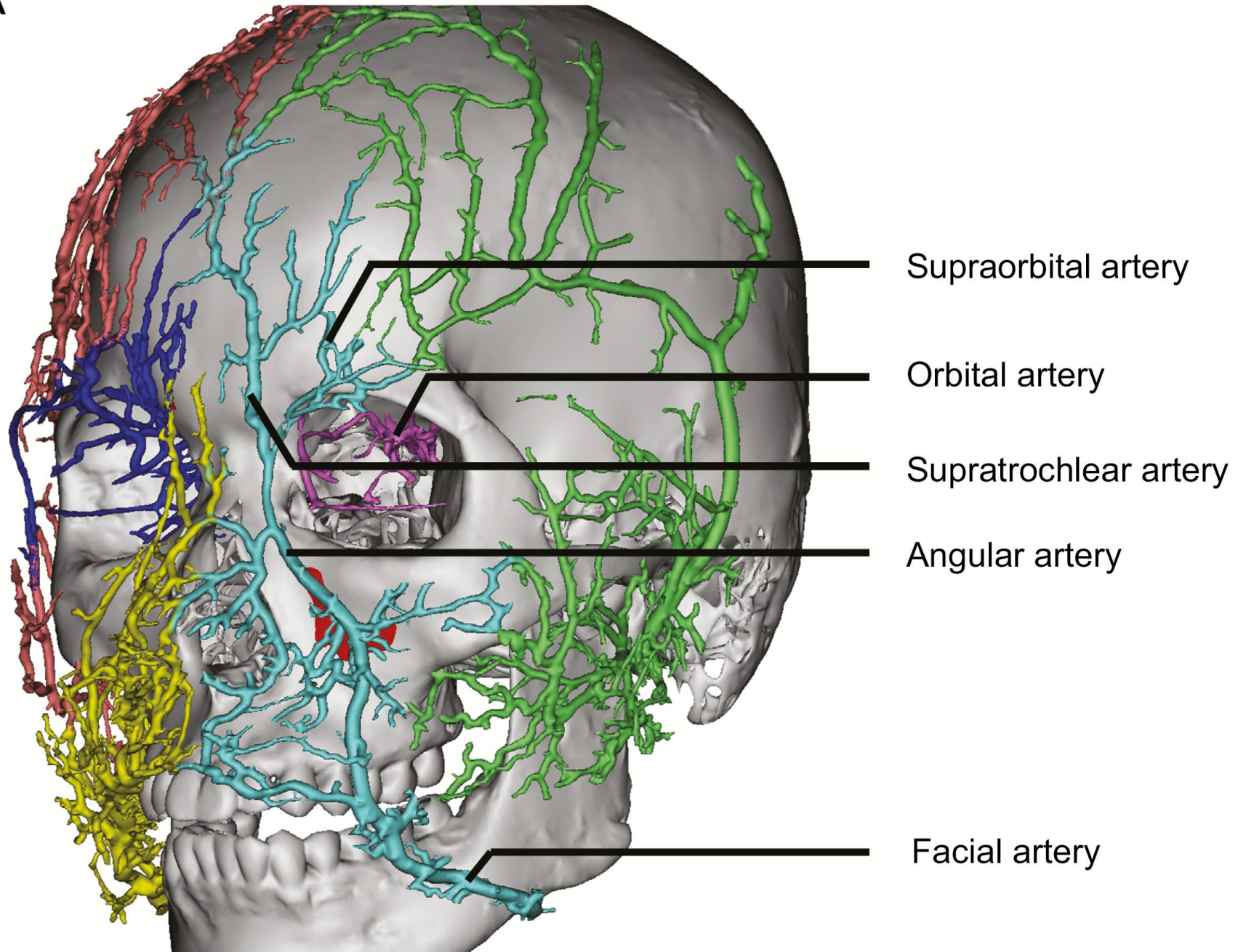
- Different lifting vectors engage different fat compartments.
- Examples:
- Deep medial cheek fat
- SOOF
- Superficial malar fat
- Jowl fat
- Improper placement may worsen contour.

Facial Nerve Anatomy

- Avoiding facial nerve injury is essential.
- Major branches:
- Temporal
- Zygomatic
- Buccal
- Marginal mandibular
- Cervical
- Important danger zones:
- **Temporal branch**
- Crosses the zygomatic arch.
- Risk:
- Brow ptosis
- **Marginal mandibular branch**
- Runs near the inferior border of the mandible.
- Risk:
- Lower lip asymmetry
- **Buccal branches**
- Supply:
- Upper lip
- Buccinator
- Zygomaticus muscles
- Risk:
- Smile asymmetry



A



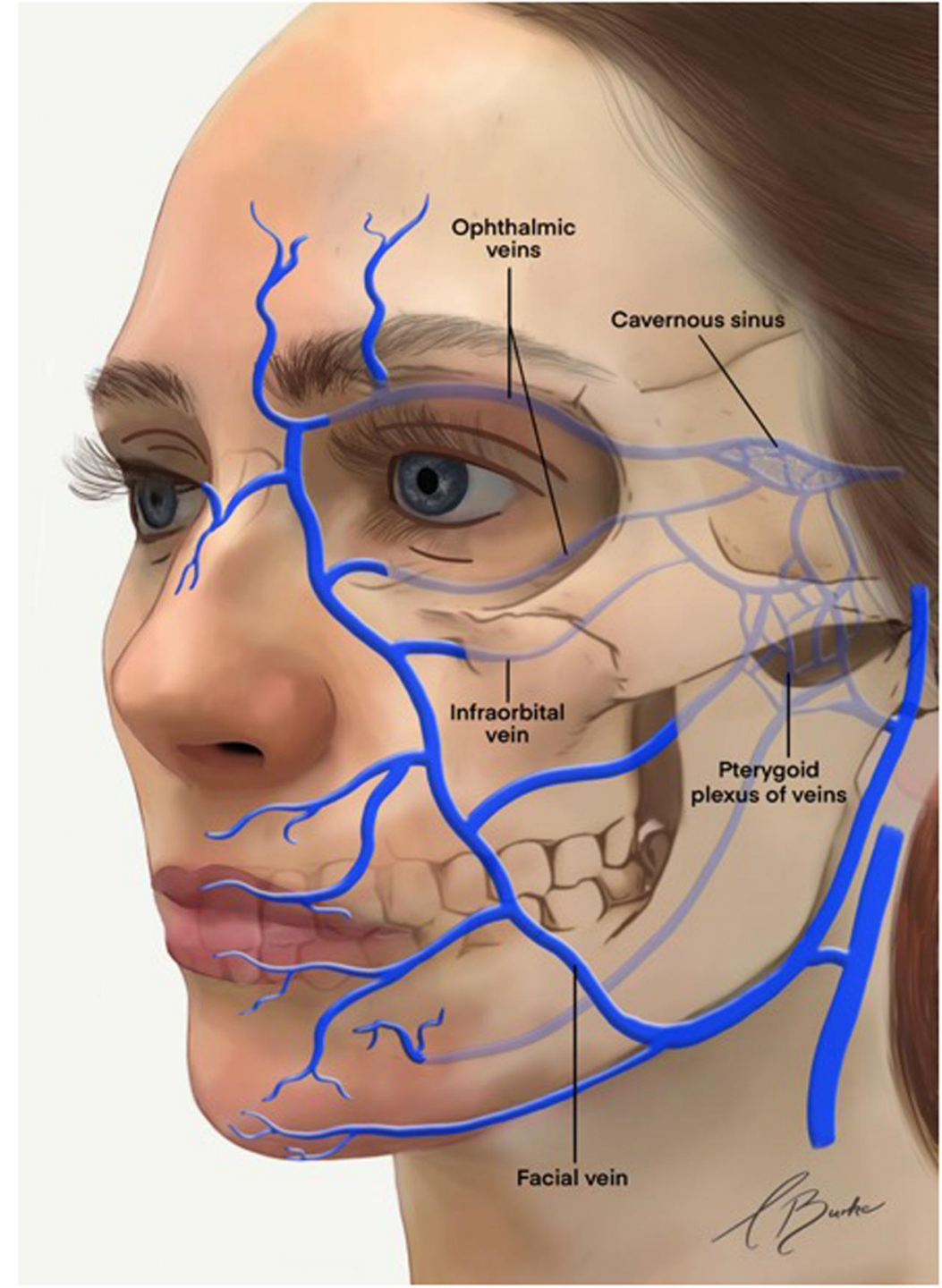
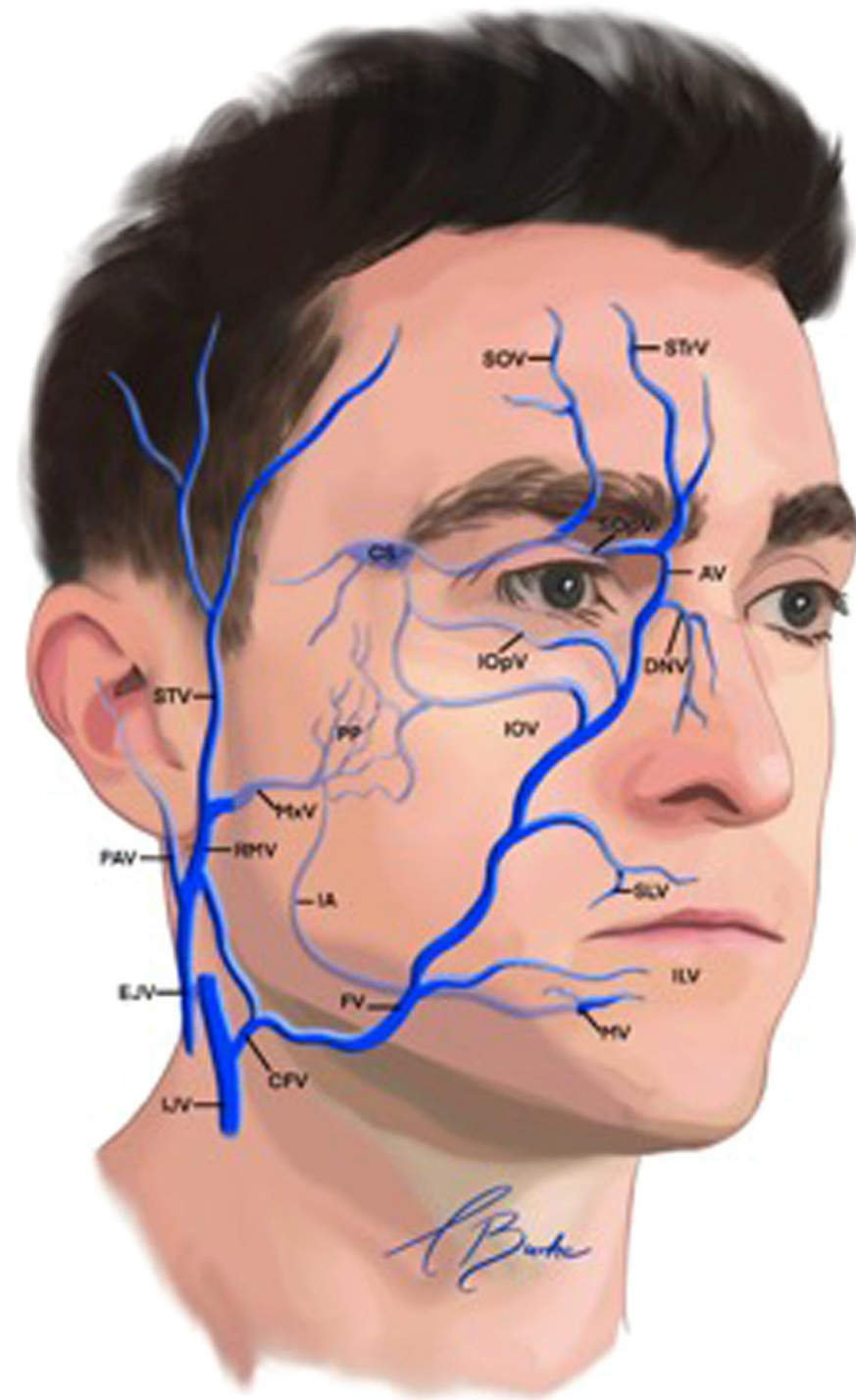
Facial Venous Anatomy

Includes:

- Facial vein
- Angular vein
- Retromandibular vein
- Superficial temporal vein

Venous injury causes:

- Bruising
- Hematoma
- Swelling



3. Correct Tissue Plane

- One of the common causes of complications.
- Possible planes include:
- Subdermal
- Superficial fat
- **Deep fat**
- SMAS
- Sub-SMAS (for certain techniques)
- Supra-periosteal (anchoring)

Too superficial:

- Visible thread
- Skin dimpling
- Palpable barbs
- Extrusion

Too deep:

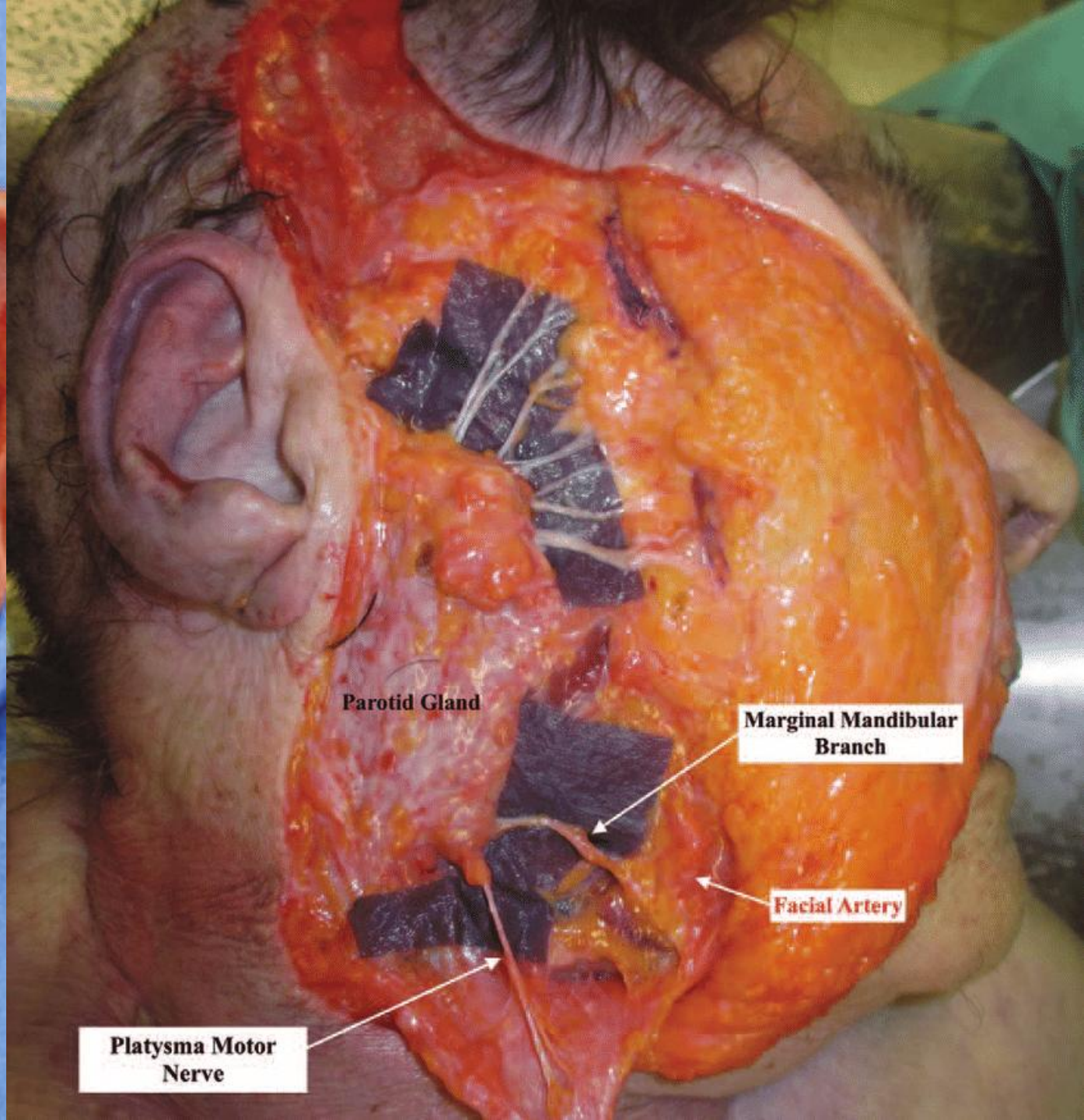
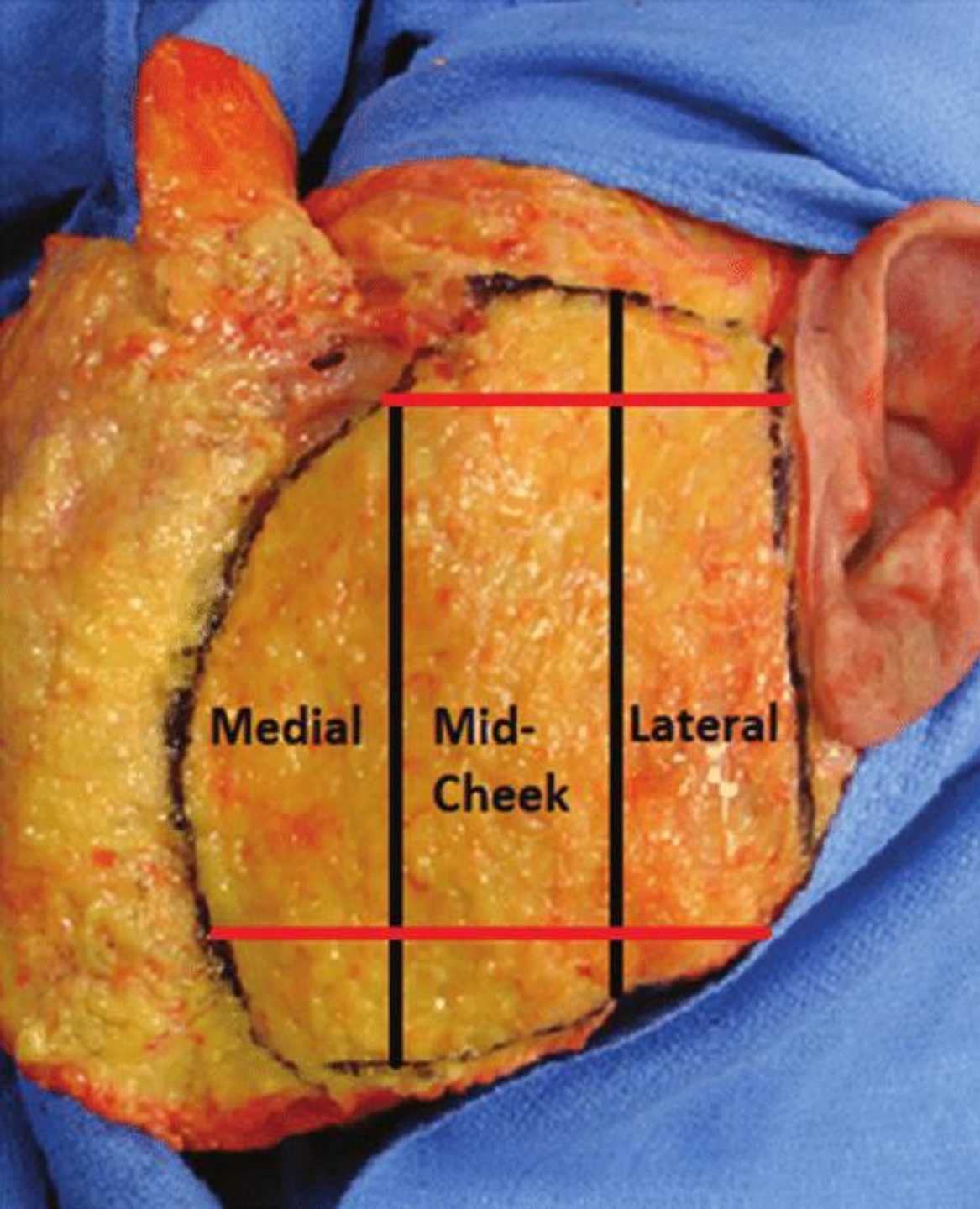
- Facial nerve injury
- Vascular injury
- Parotid injury
- Poor lifting effect

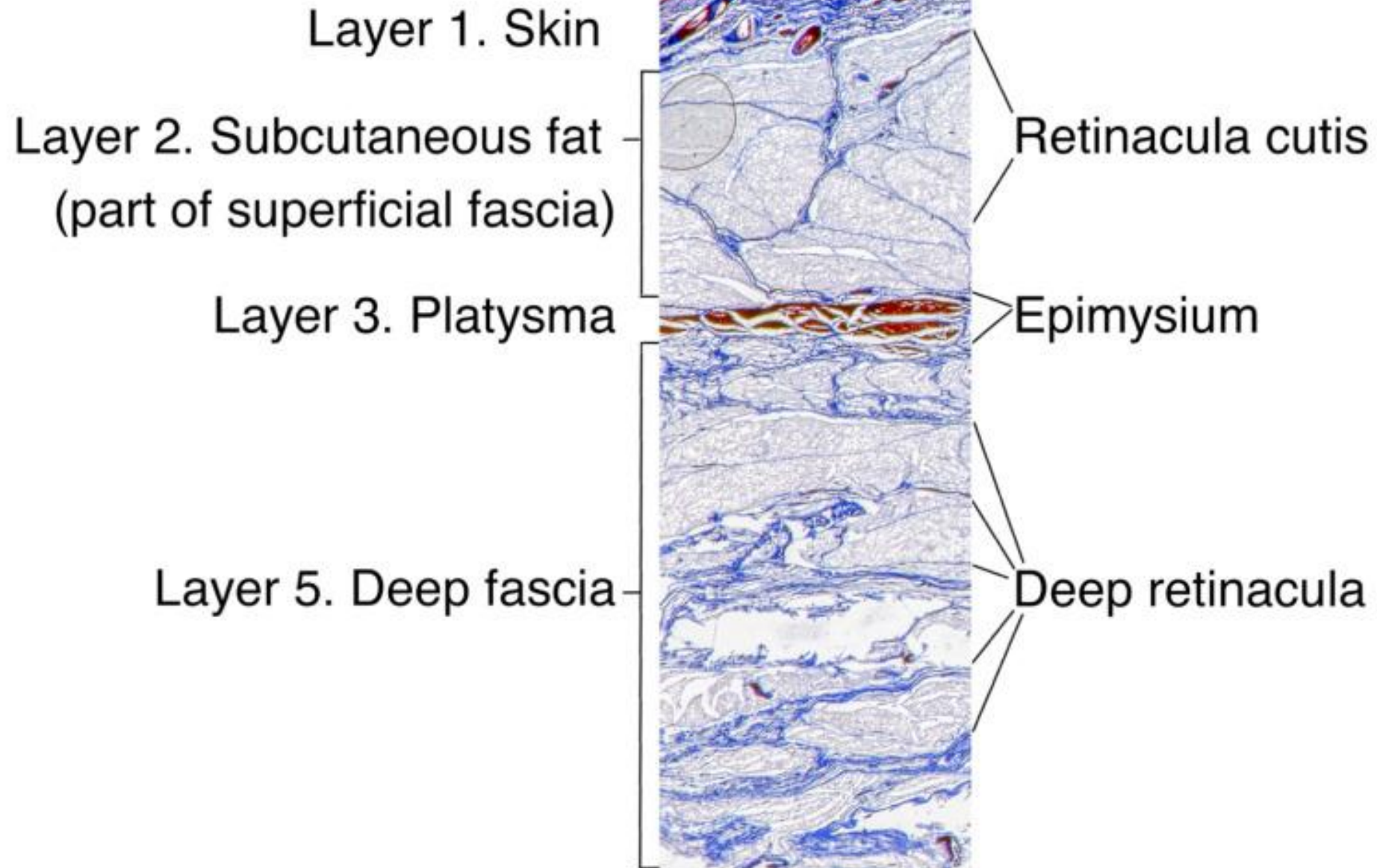
4. Vector Planning

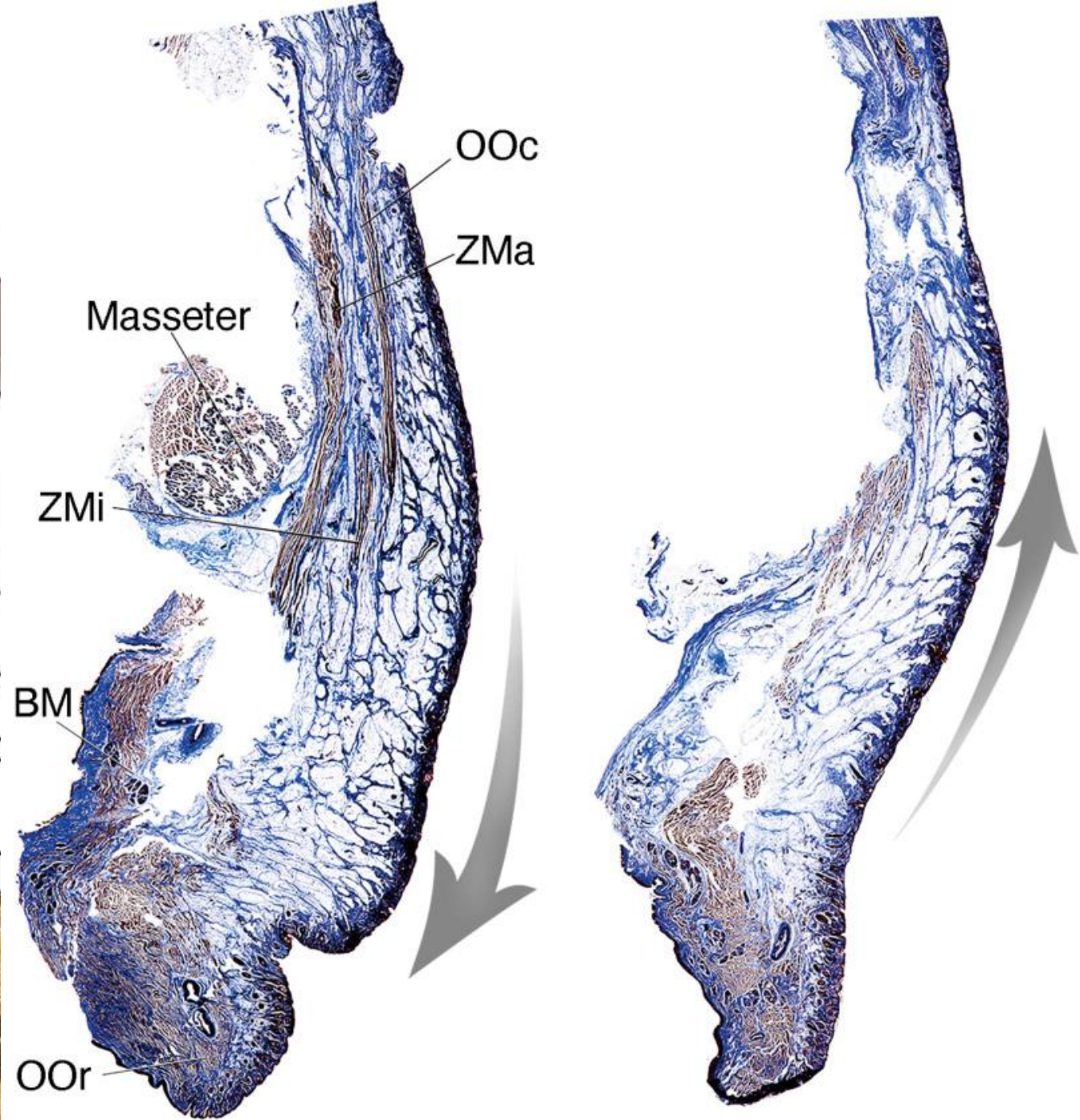
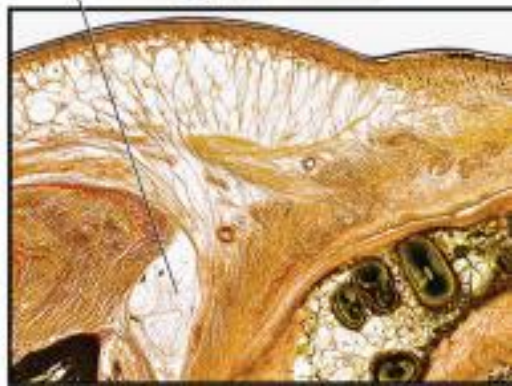
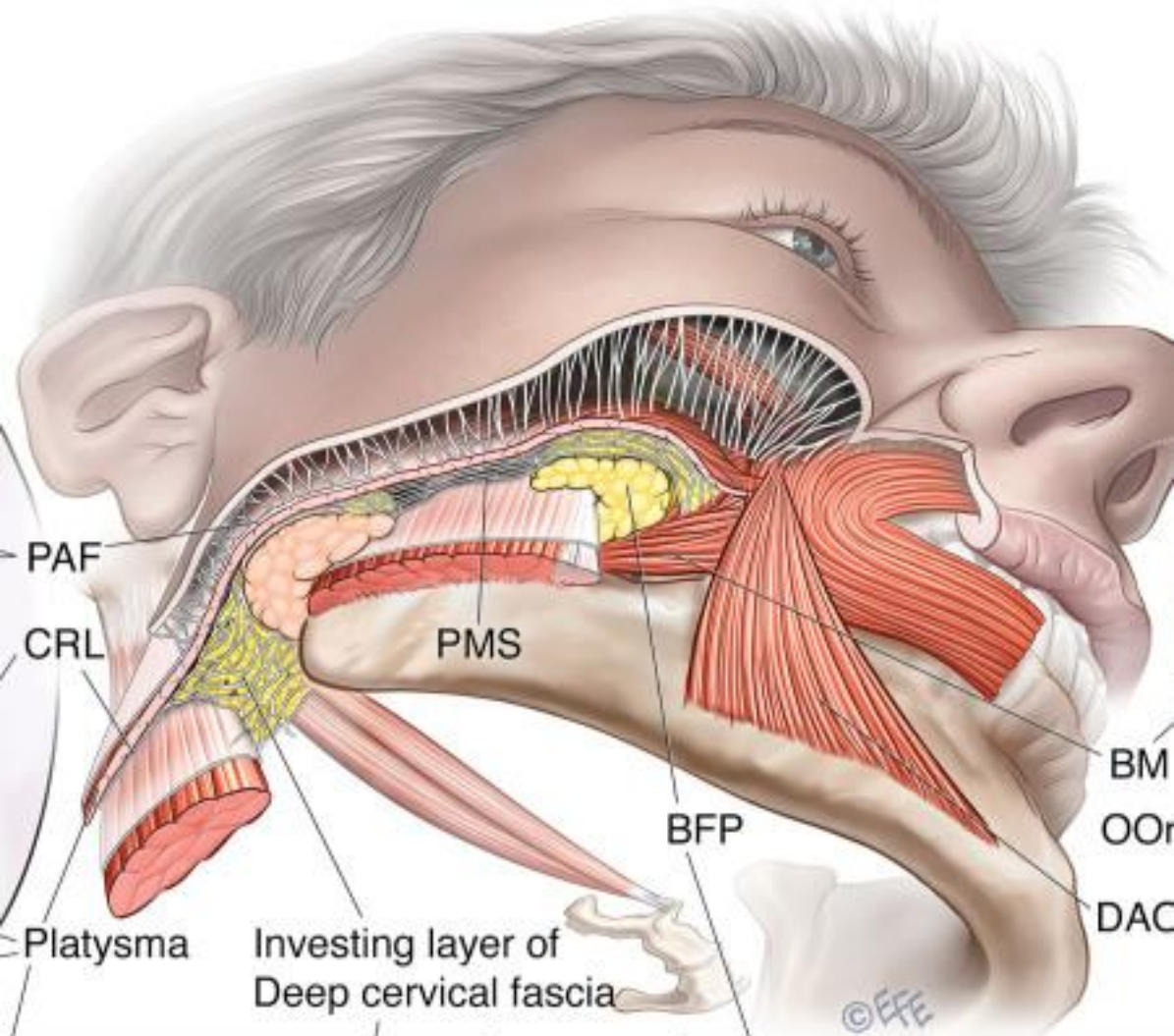
- Lifting success depends on proper vectors rather than simply the number of threads.
- Consider:
- Midface
- Nasolabial fold
- Jawline
- Marionette line
- Neck
- Avoid crossing vectors unnecessarily.

5. Entry and Exit Points

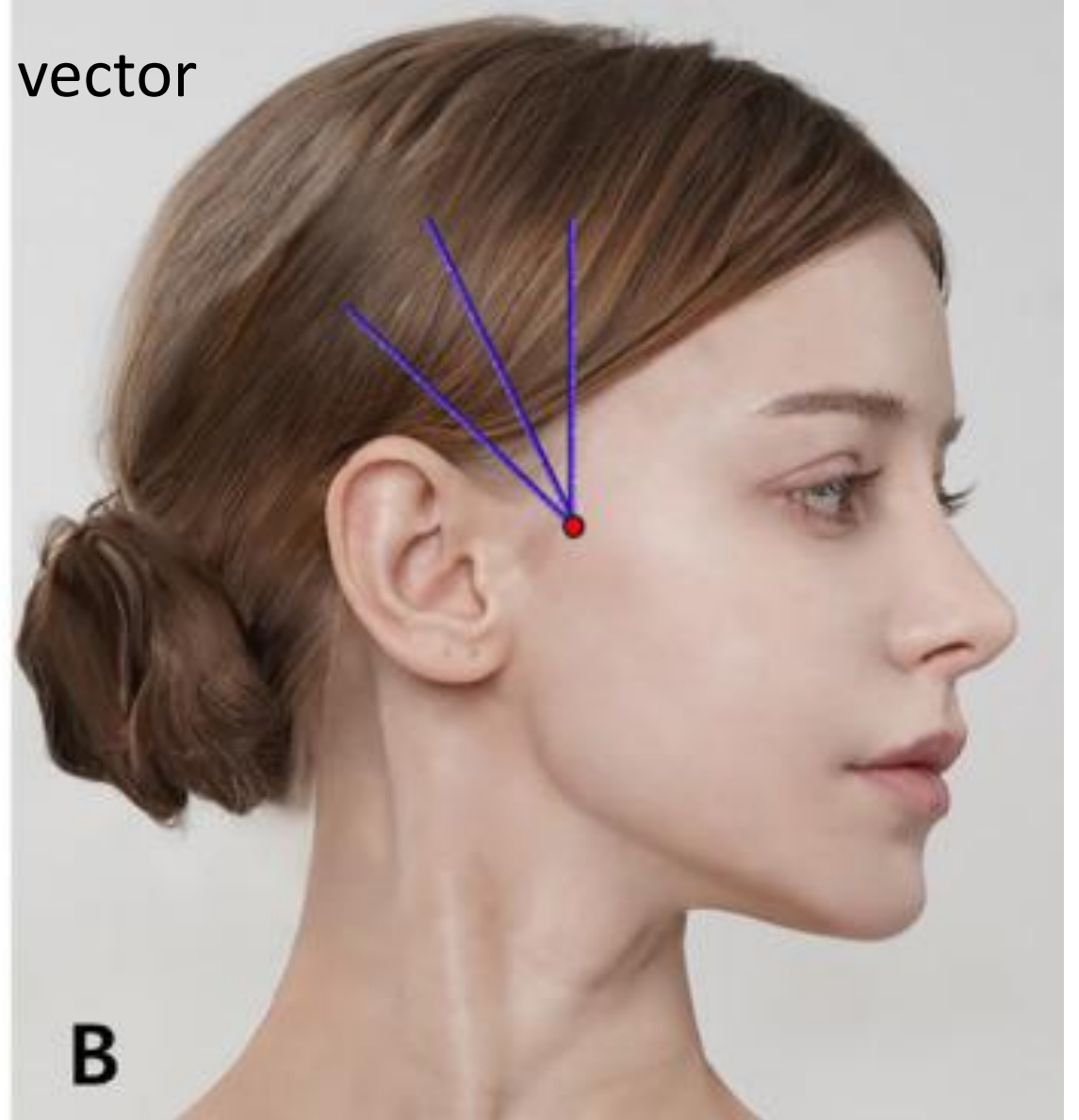
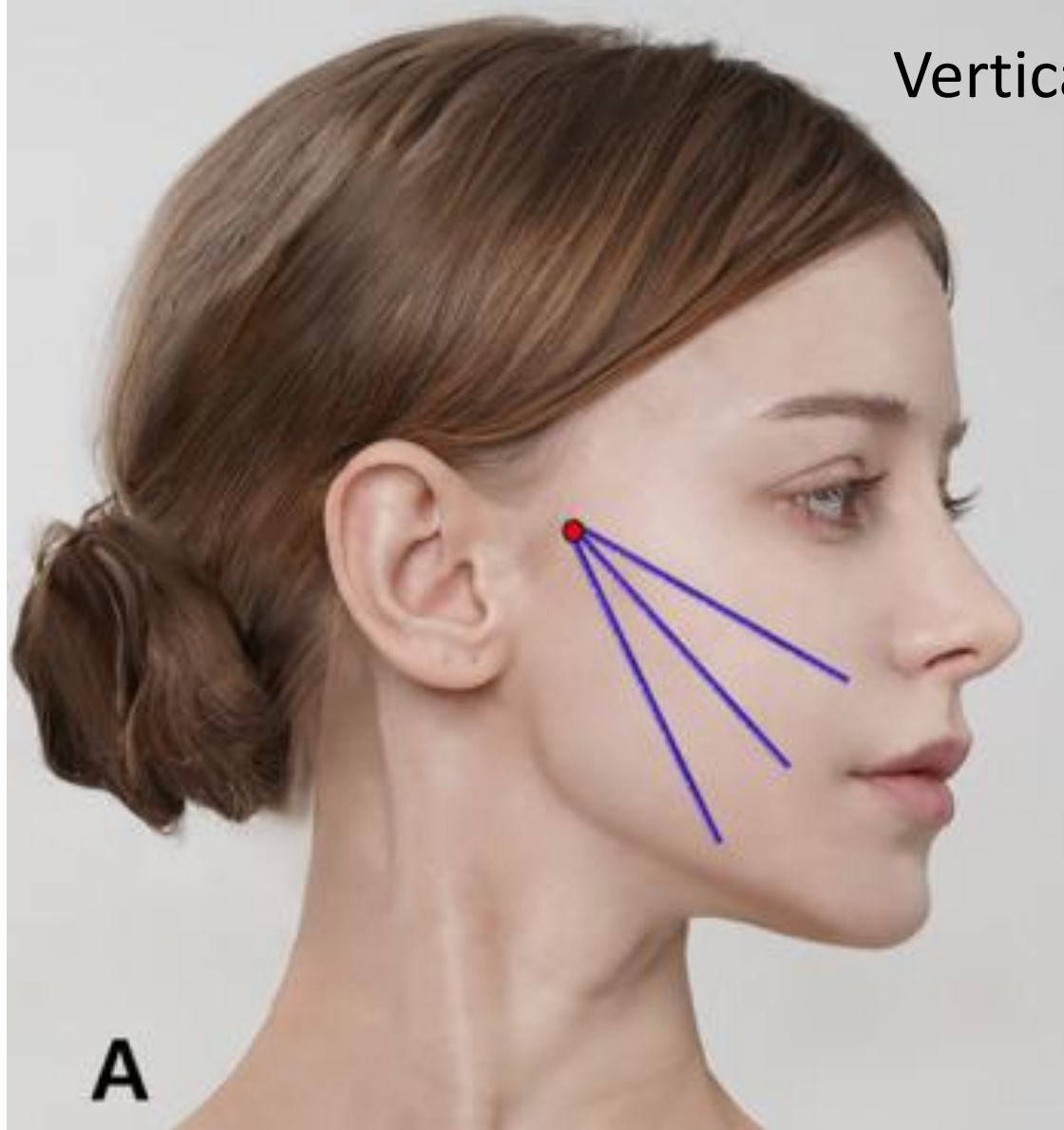
- Need to avoid:
- Hair follicles
- Major vessels
- Temporal vessels
- Supraorbital bundle
- Infraorbital bundle
- Mental neurovascular bundle
- The entry point should allow:
- Adequate thread depth
- Proper vector
- Secure anchorage



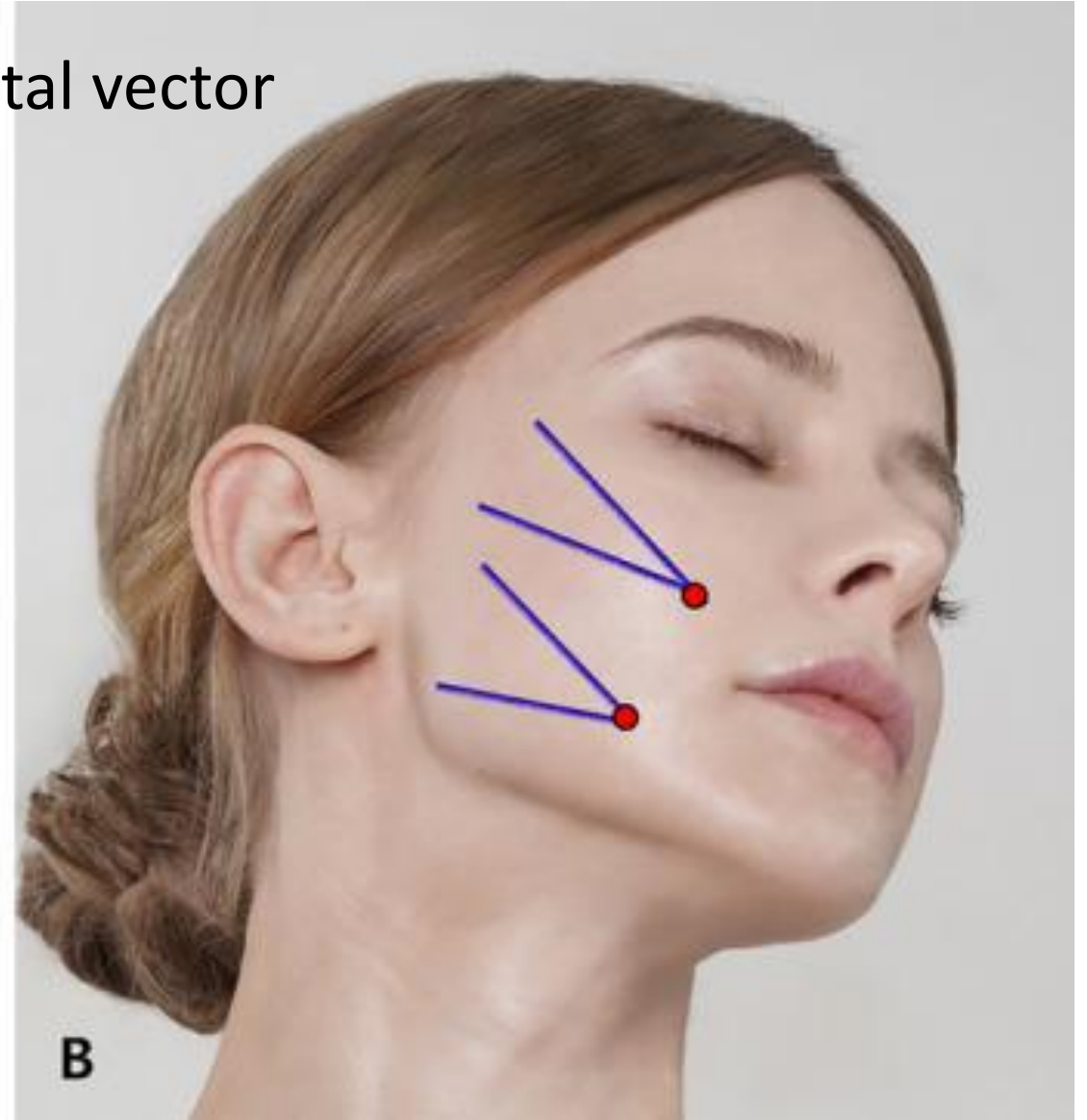
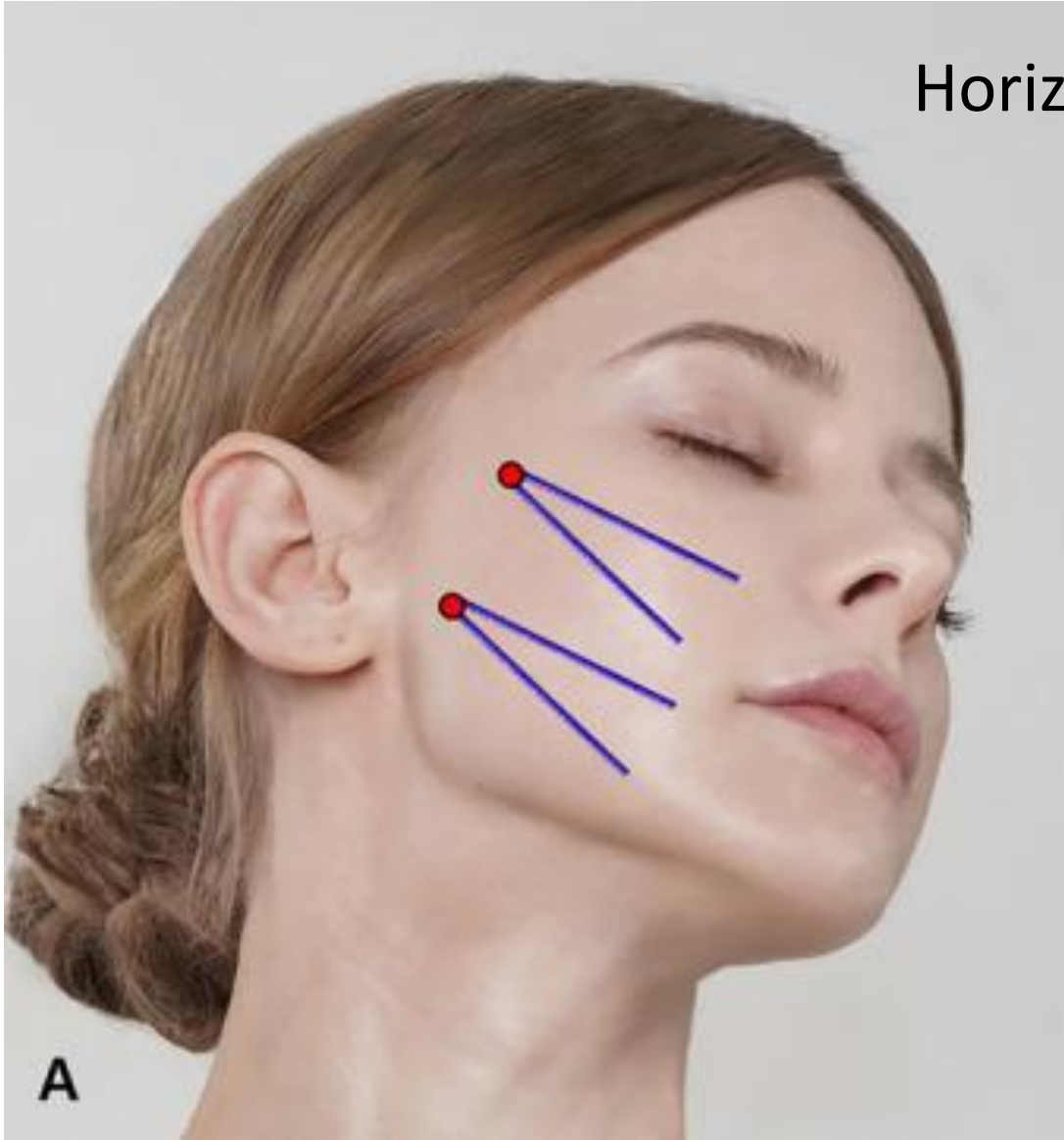




Vertical vector



Horizontal vector



Retaining Ligaments

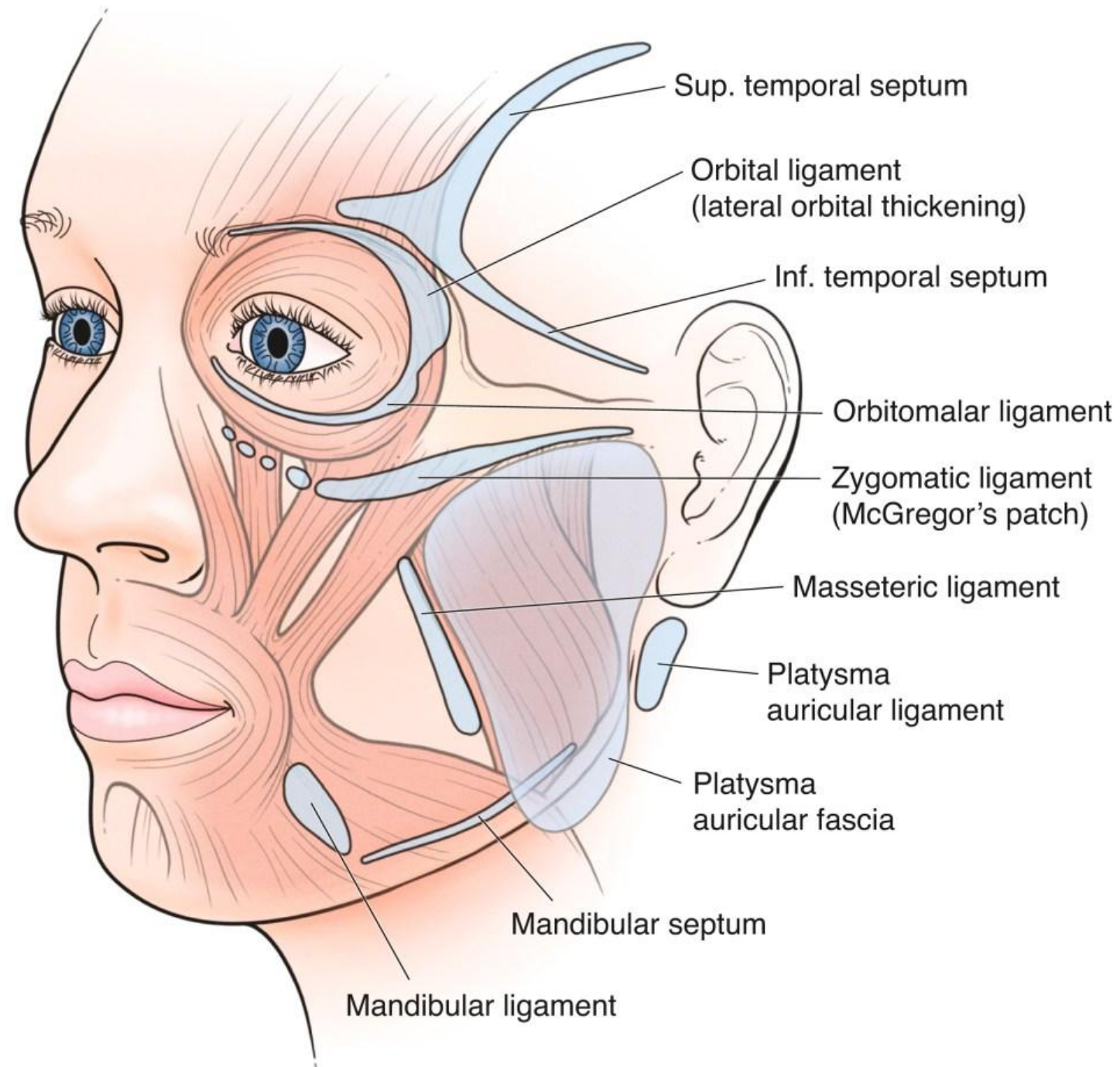
These are the primary anchoring structures.

Important ligaments include:

- Temporal ligament
- Orbital retaining ligament
- Zygomatic ligament
- Masseteric ligament
- Mandibular ligament
- Platysma-auricular ligament

Clinical significance:

- Ligaments create tethering points.
- Aging results in ligament laxity.
- Threads should frequently anchor near strong ligamentous structure



CMAS: cervico-mental angle suspensory ligament

CRL: cervical retaining ligaments

HPL: hyoplatysmal ligament

ITS: inferior temporal septum

LBT: lateral brow thickening

LML: lower key masseteric ligament

LOT: lateral orbital thickening

LSCL: lateral sternomastoid-cutaneous ligament

MOCL: mandibular osteocutaneous ligament

MPCF: medial platysma-cutaneous filaments

MS: mandibular septum

MSCL: medial sternomastoid-cutaneous ligament

ORL: orbicularis retaining ligament

PAF: platysma-auricular fascia

PAL: platysma-auricular ligament

PML: platysma-mandibular ligament

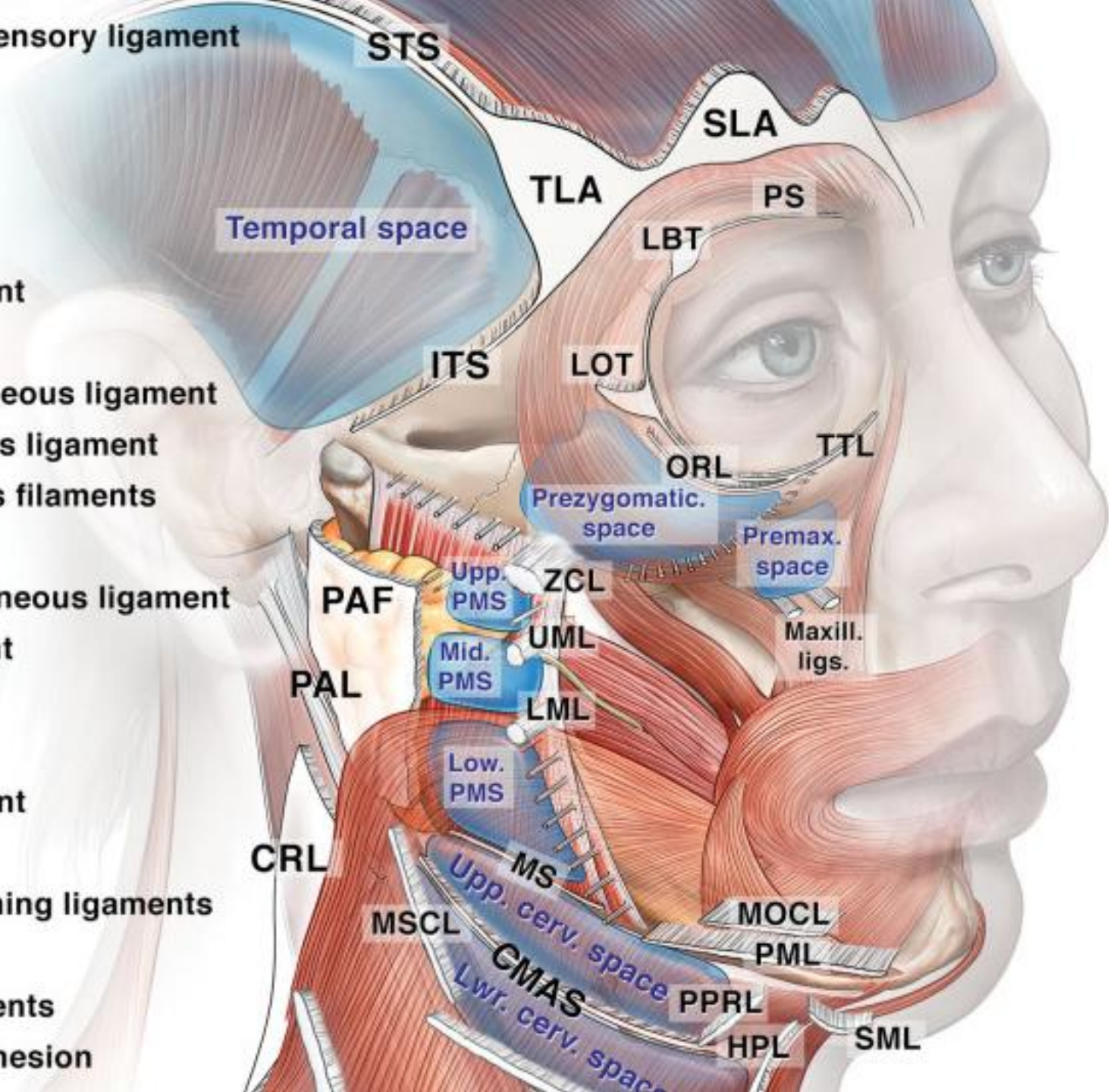
PMS: premasseter space

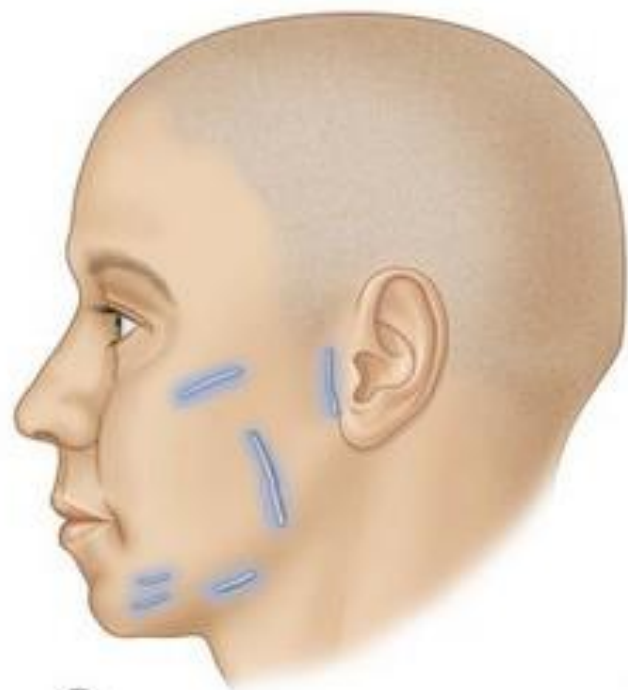
PPRL: paramedian platysma retaining ligaments

PS: periorbital septum

SCPF: skin crease-platysma filaments

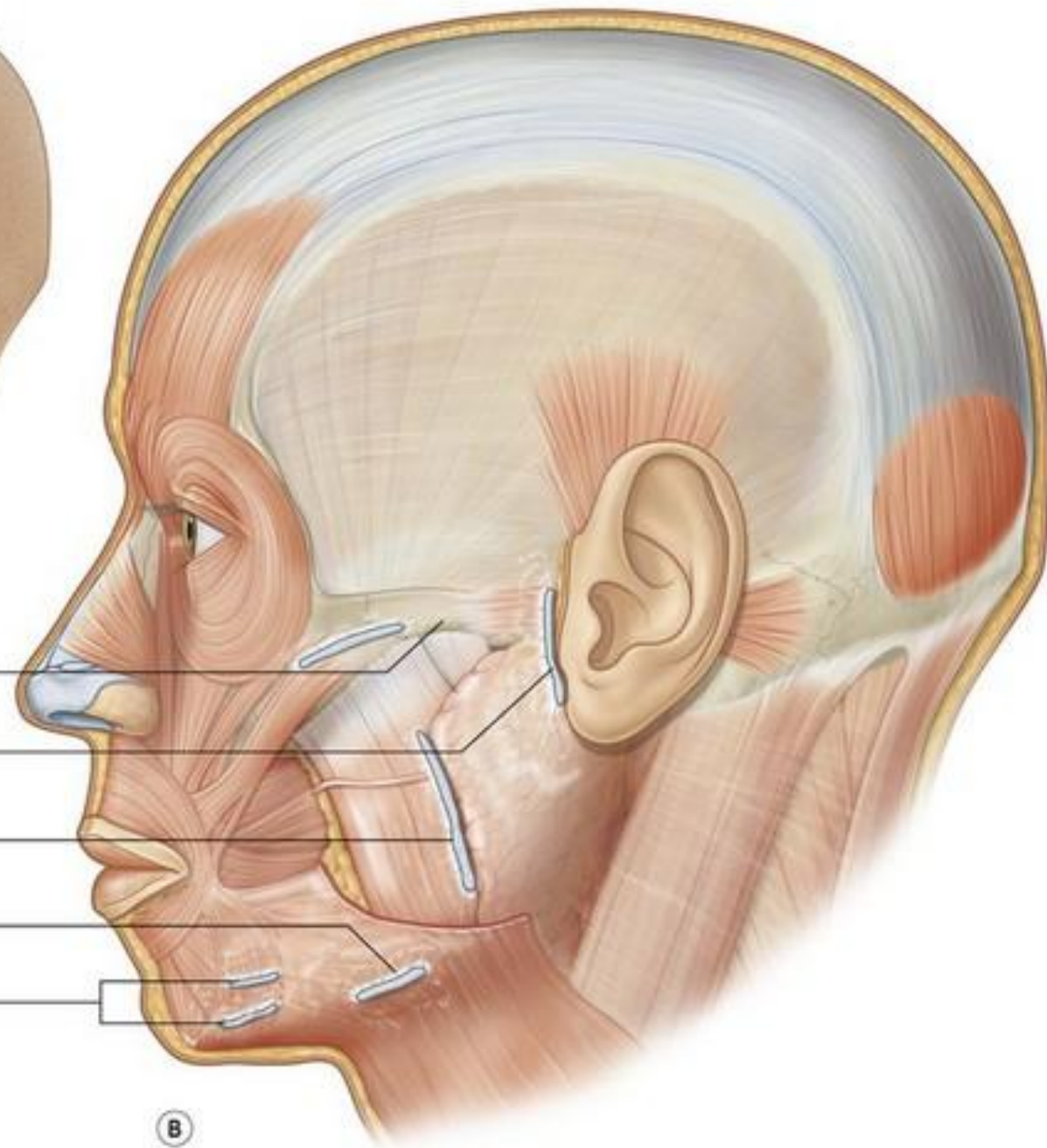
SLA: supraorbital ligamentous adhesion



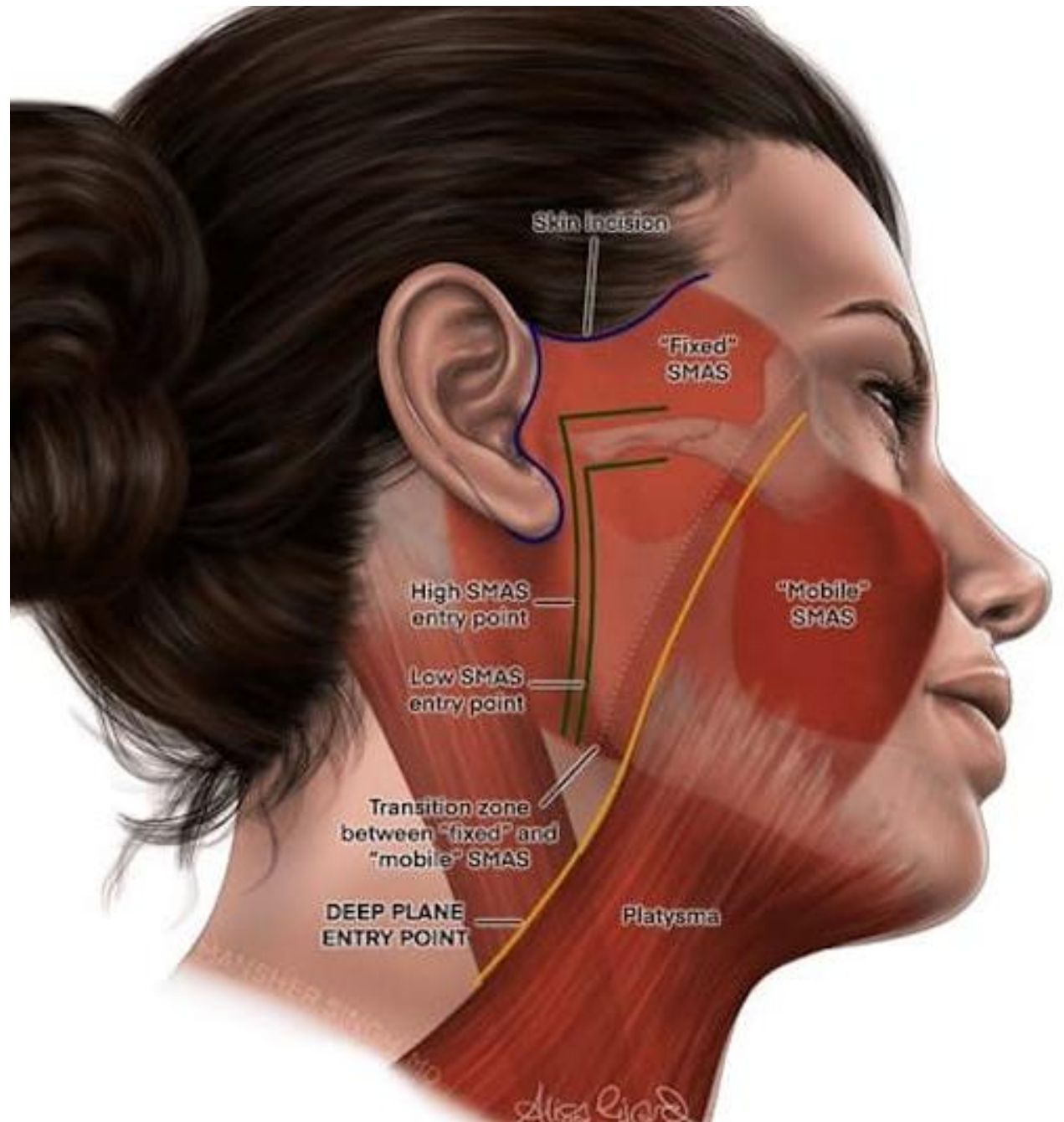
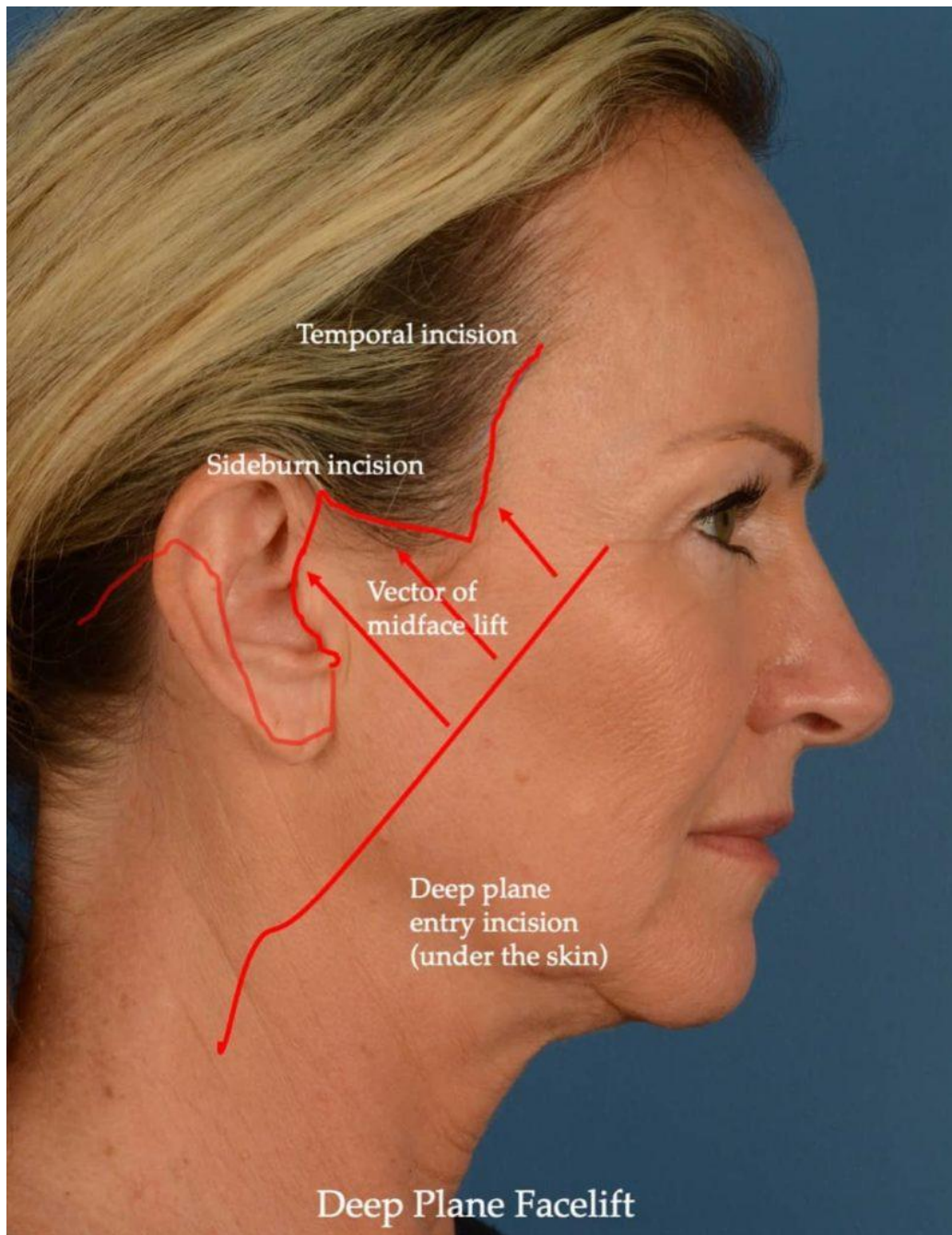


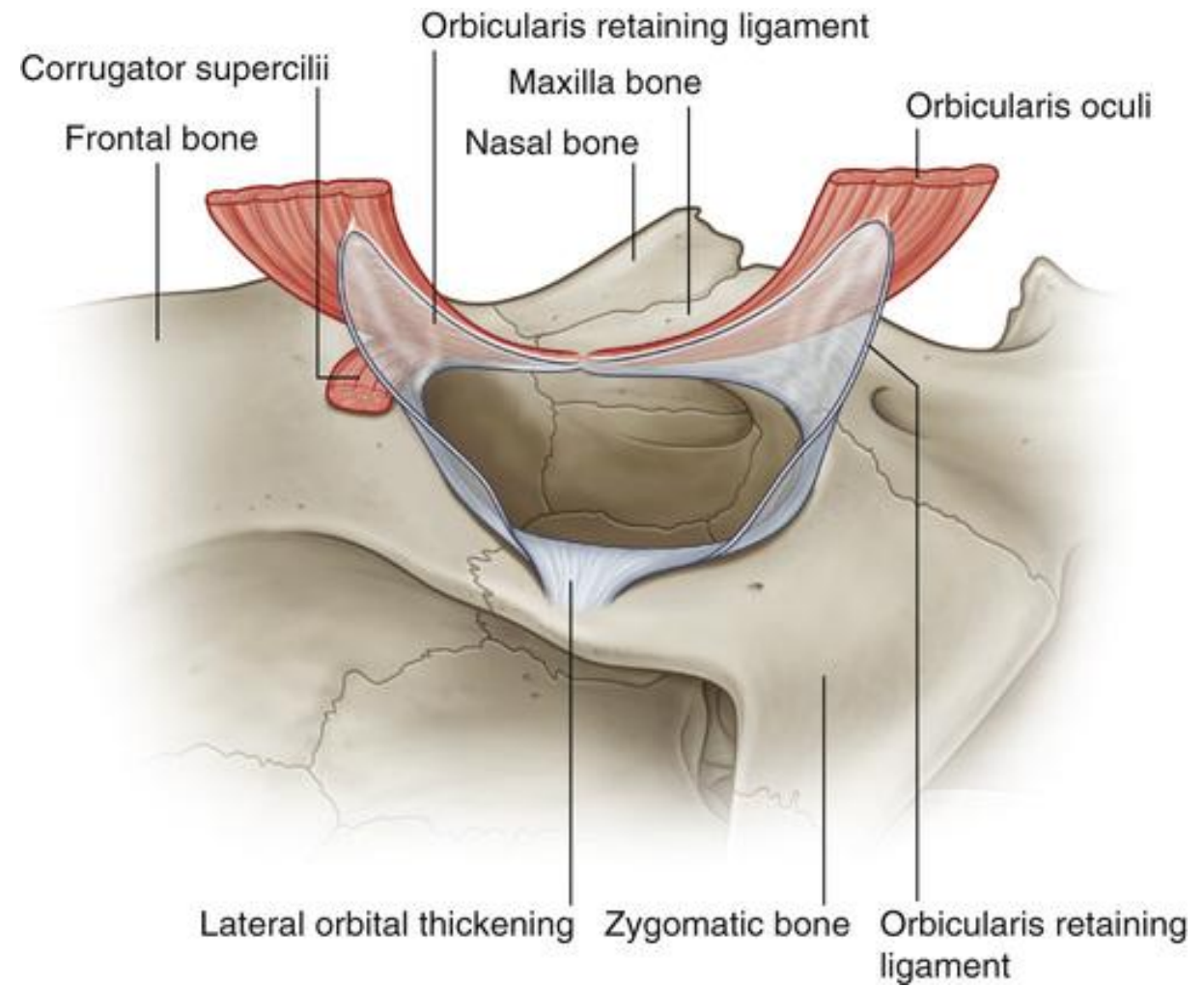
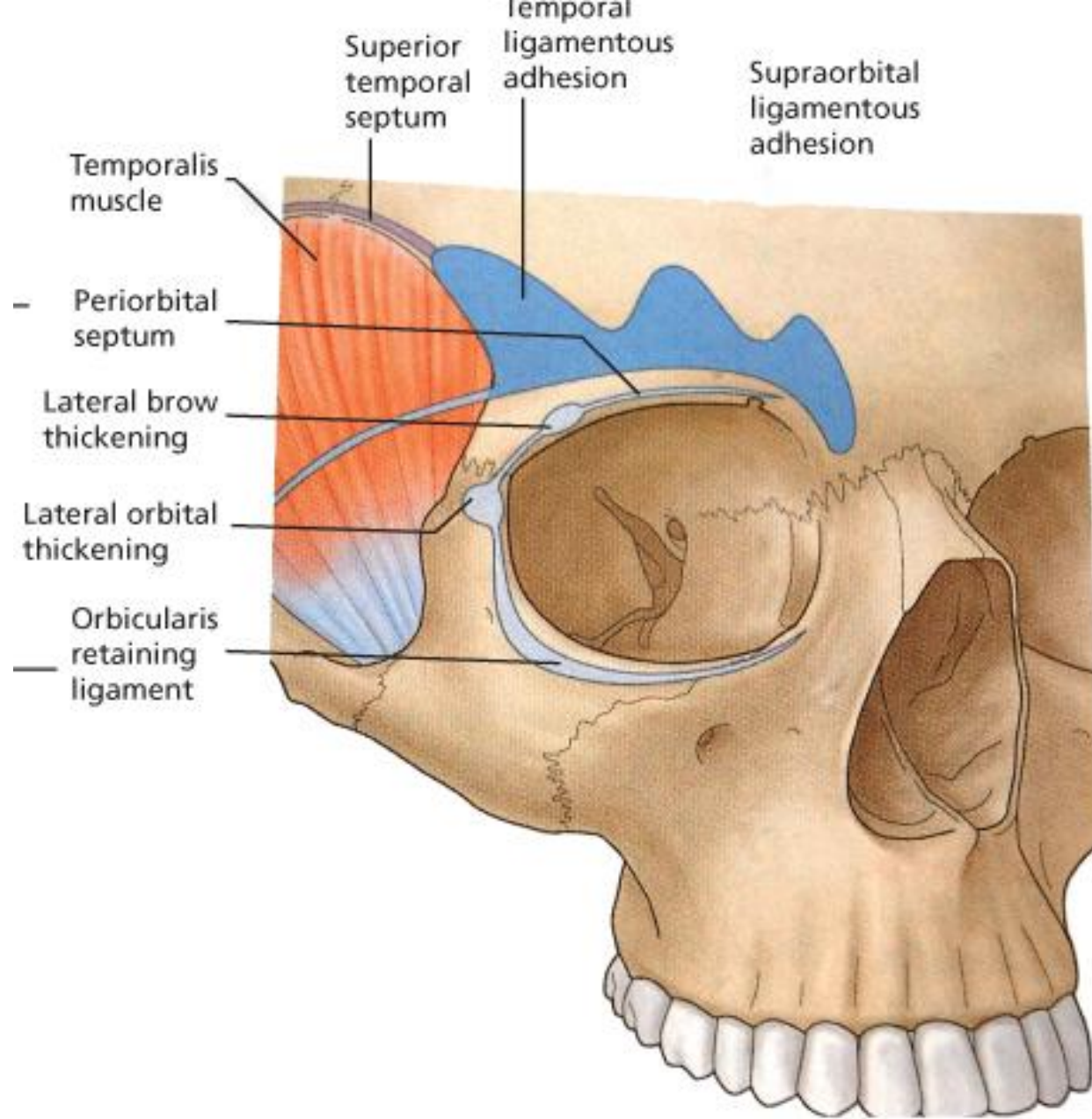
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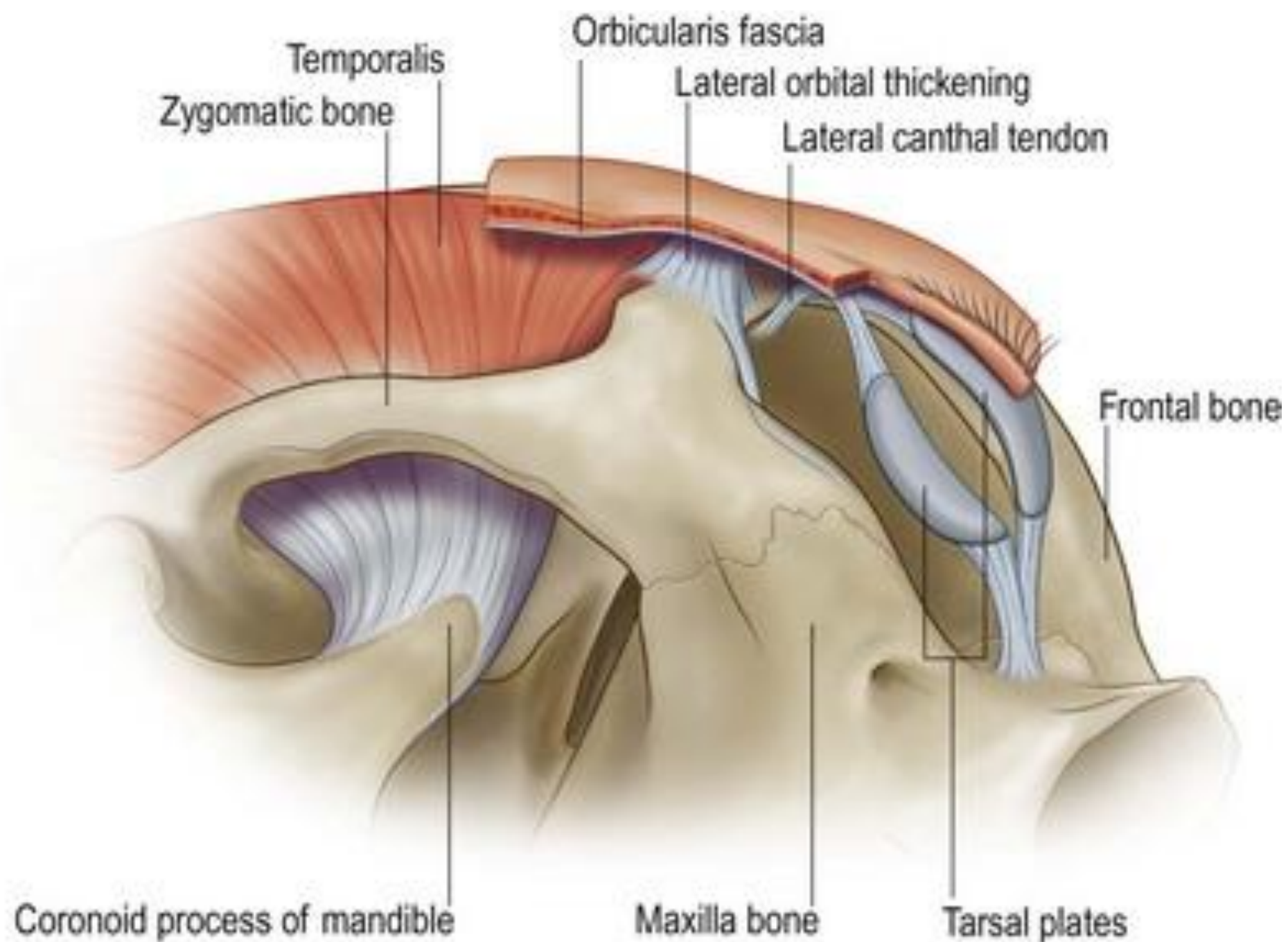
- Zygomatic cutaneous ligament
- Preauricular parotid cutaneous ligament
- Parotidomasseteric cutaneous ligament
- Platysma cutaneous ligament
- Mandibular ligament



B





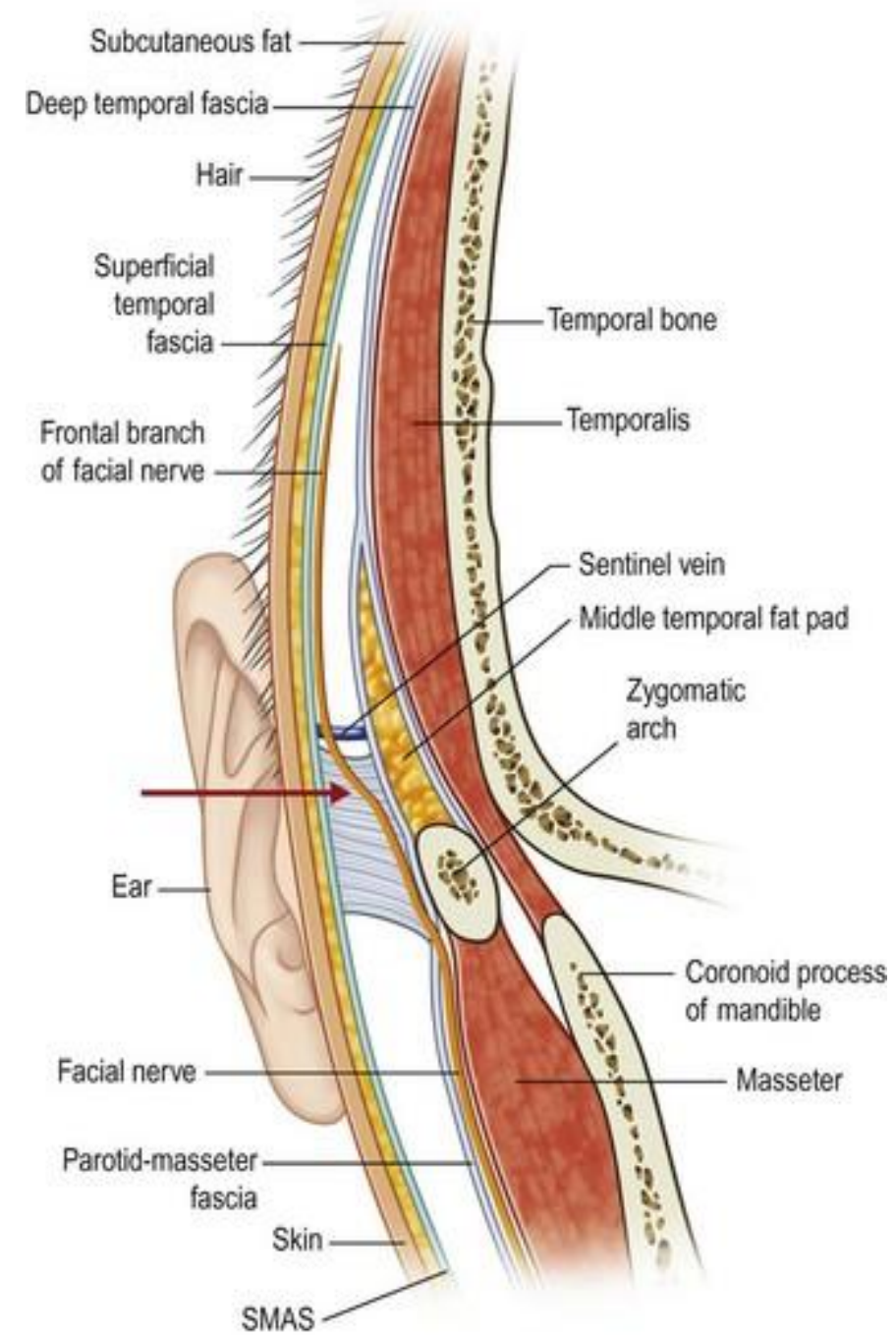
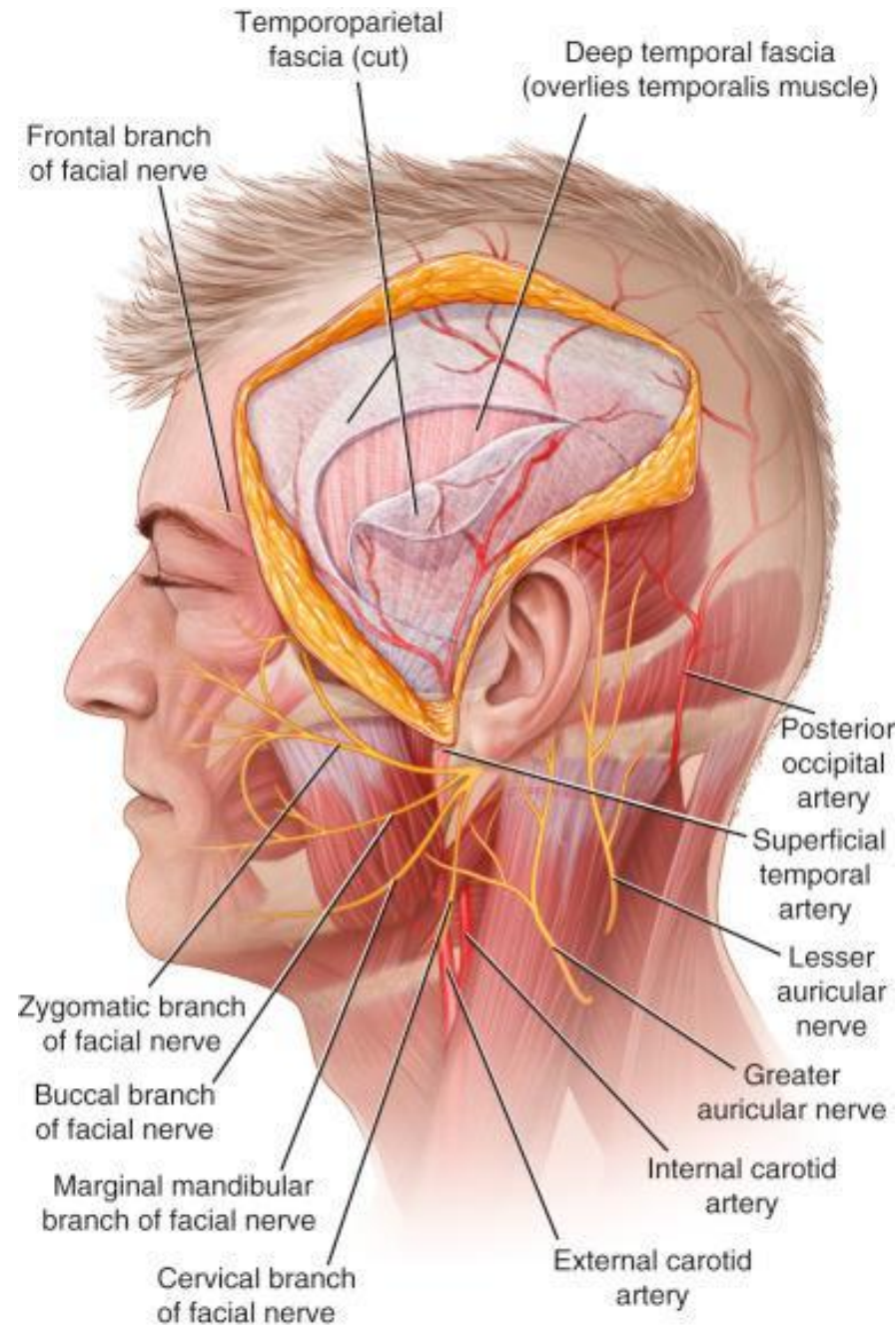


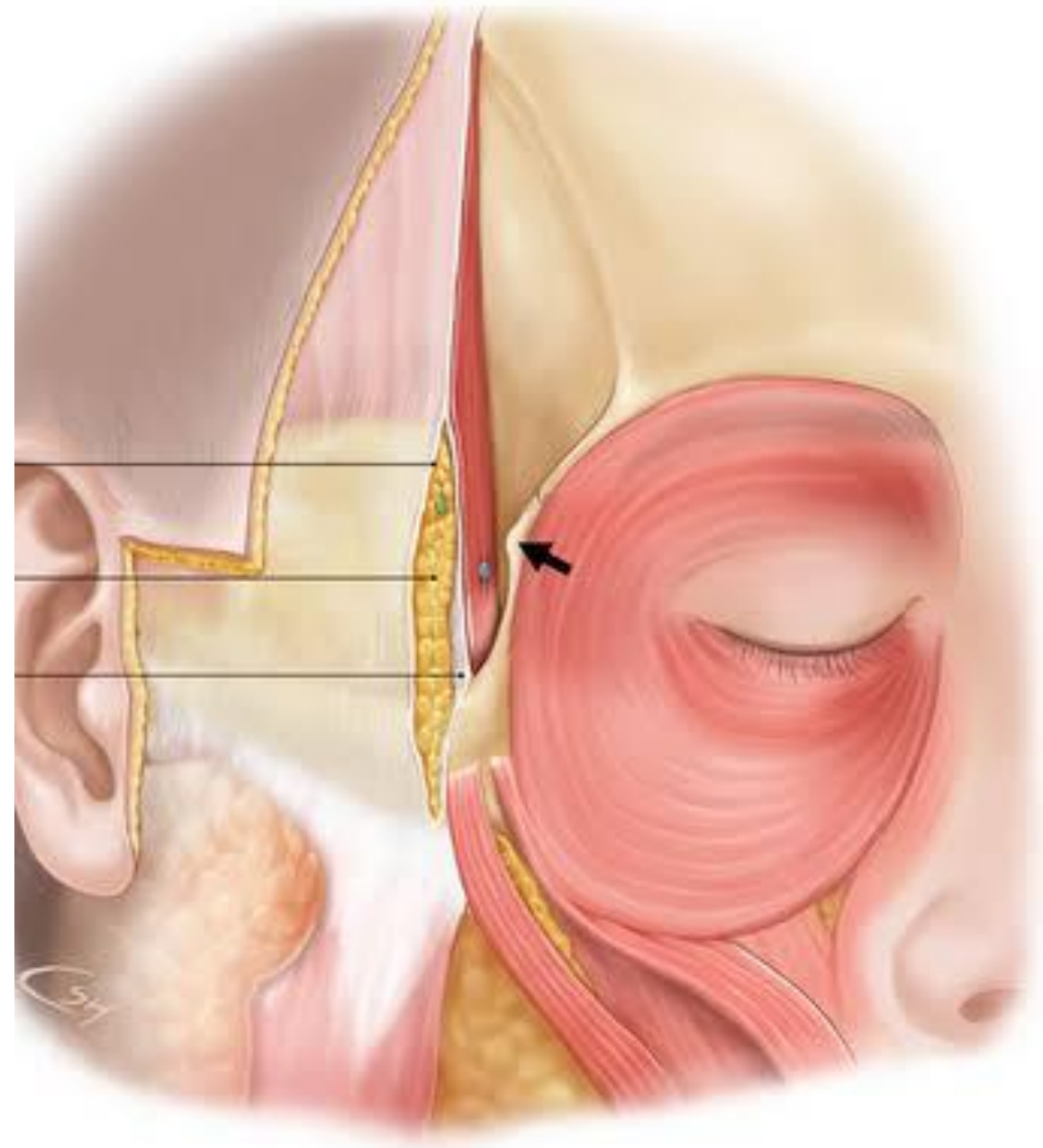
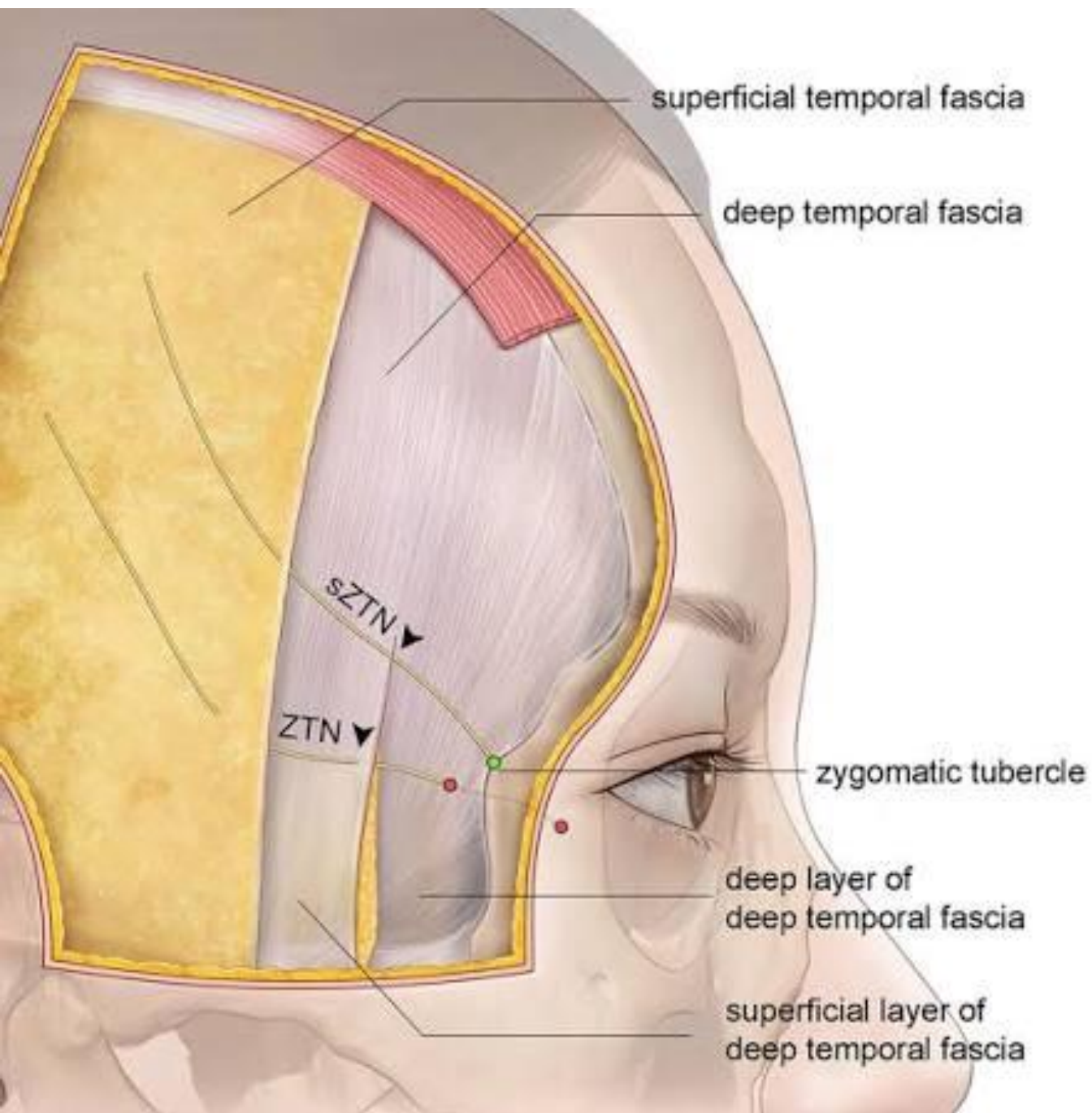
Anatomy Specific to Thread Lift Anchoring

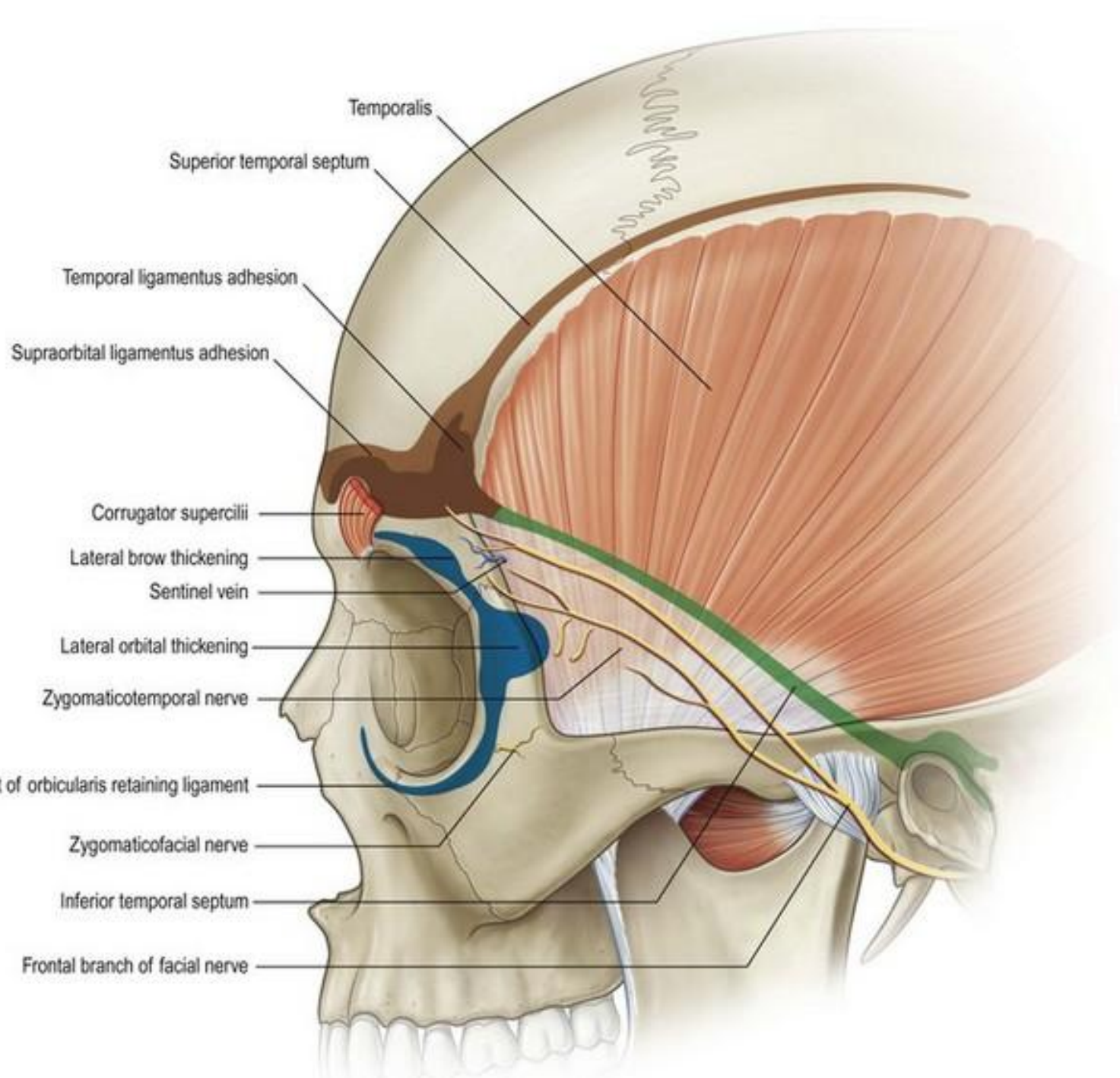
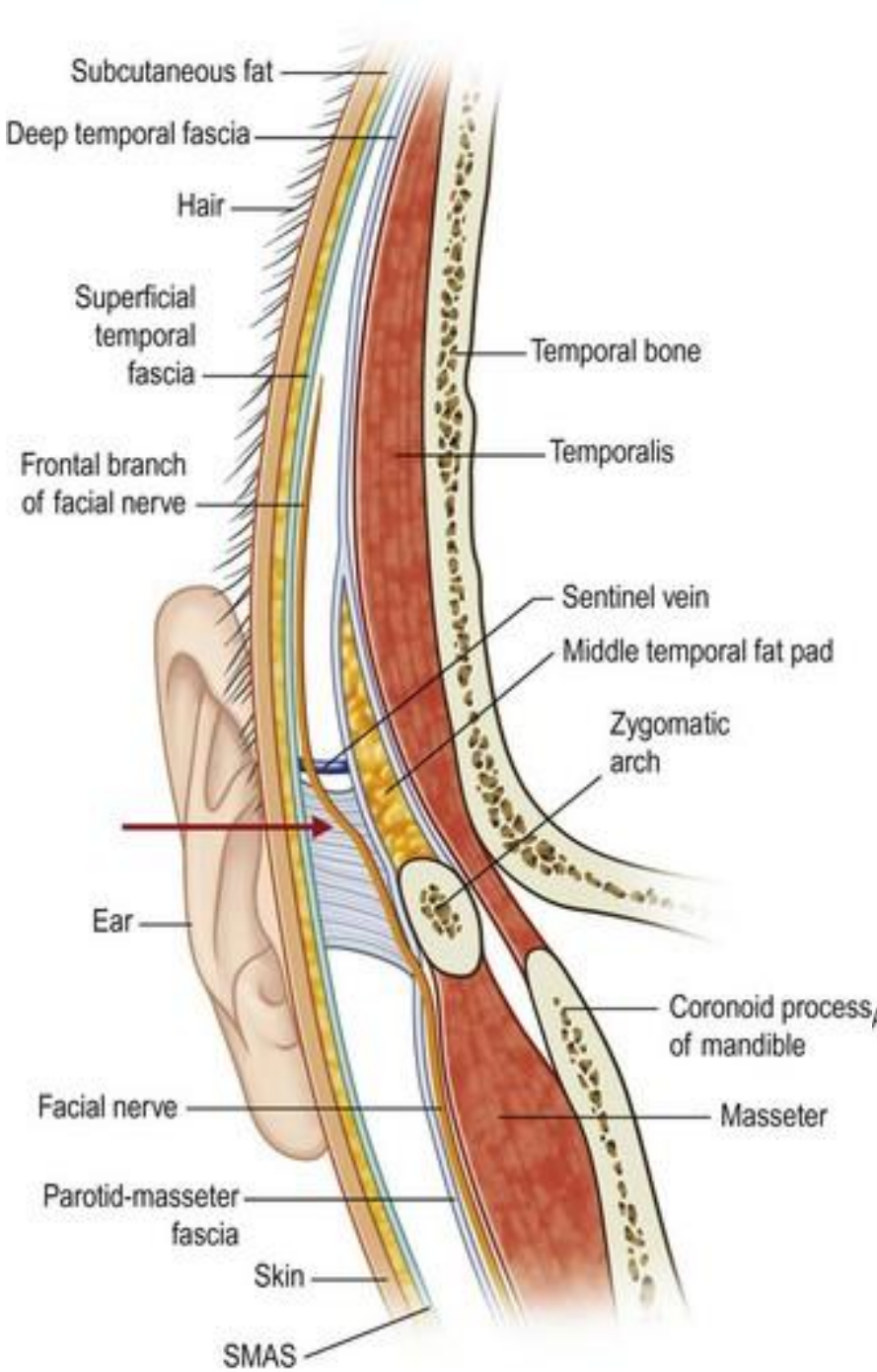
Ideal anchoring structures include:

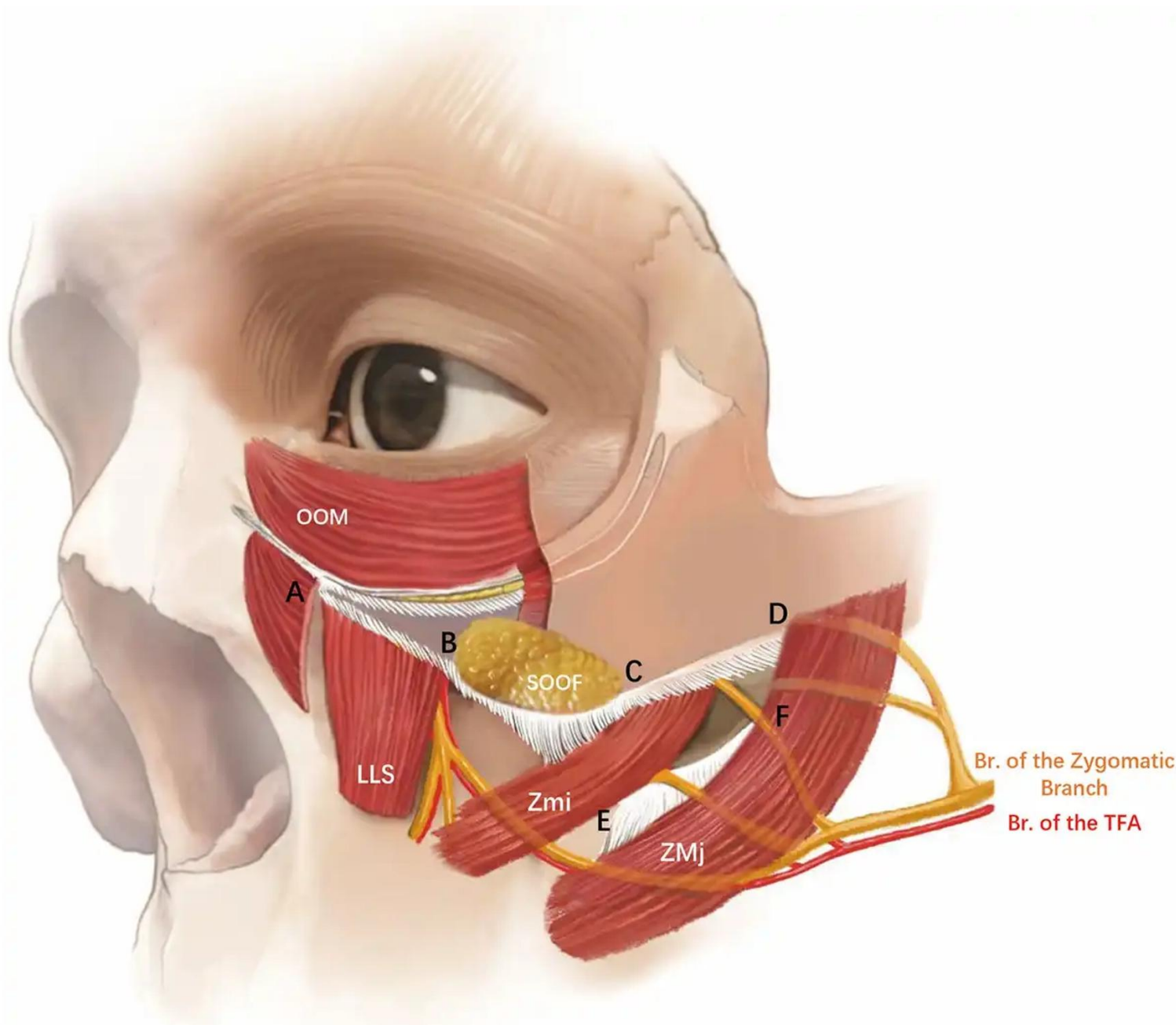
- Temporal fascia
- SMAS
- Zygomatic ligament
- Masseteric fascia
- Platysma
- Mastoid fascia (for neck lifting)

Anchoring to stable fascial structures generally provides more durable lifting than anchoring within mobile subcutaneous tissue alone.



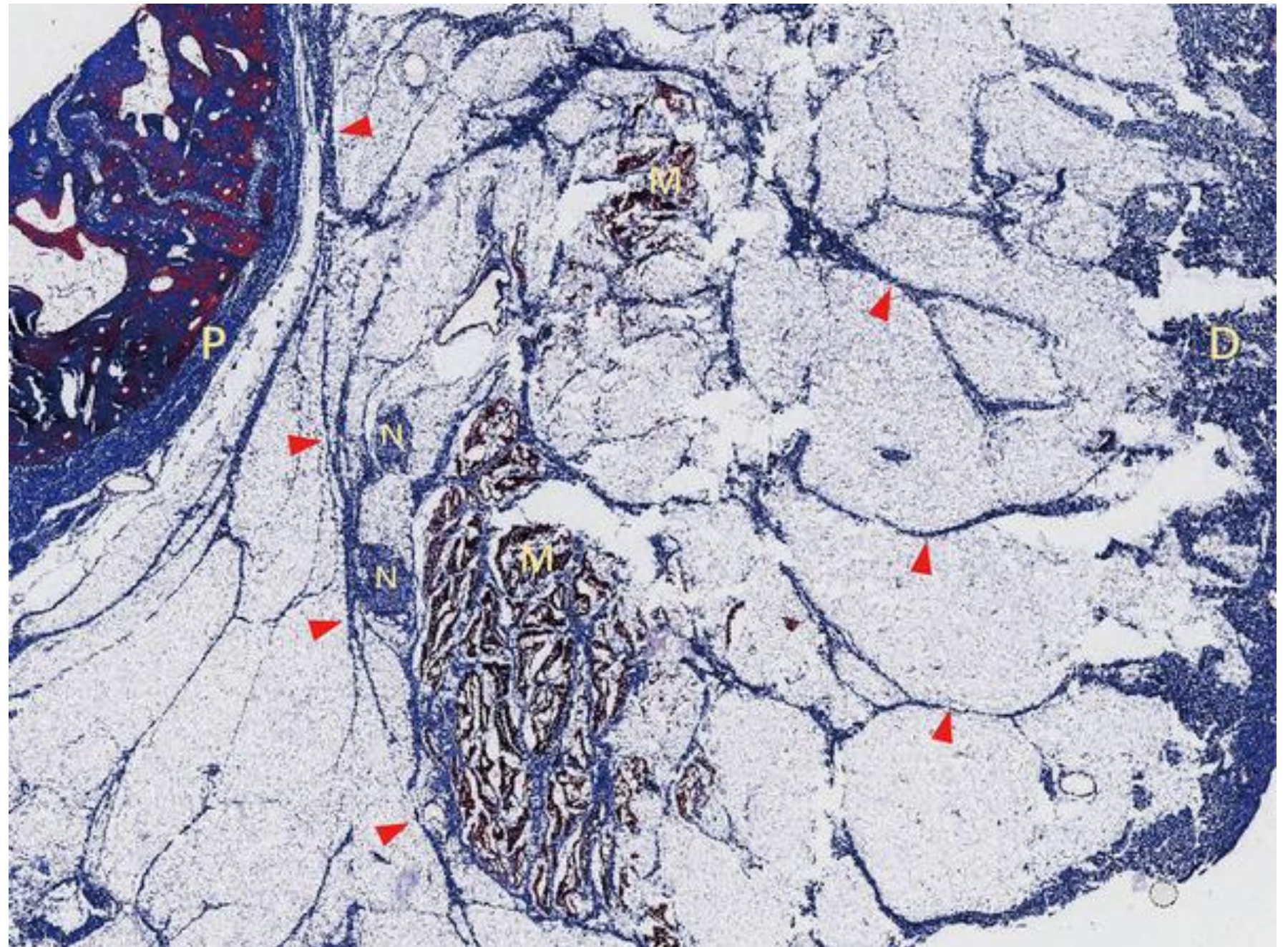




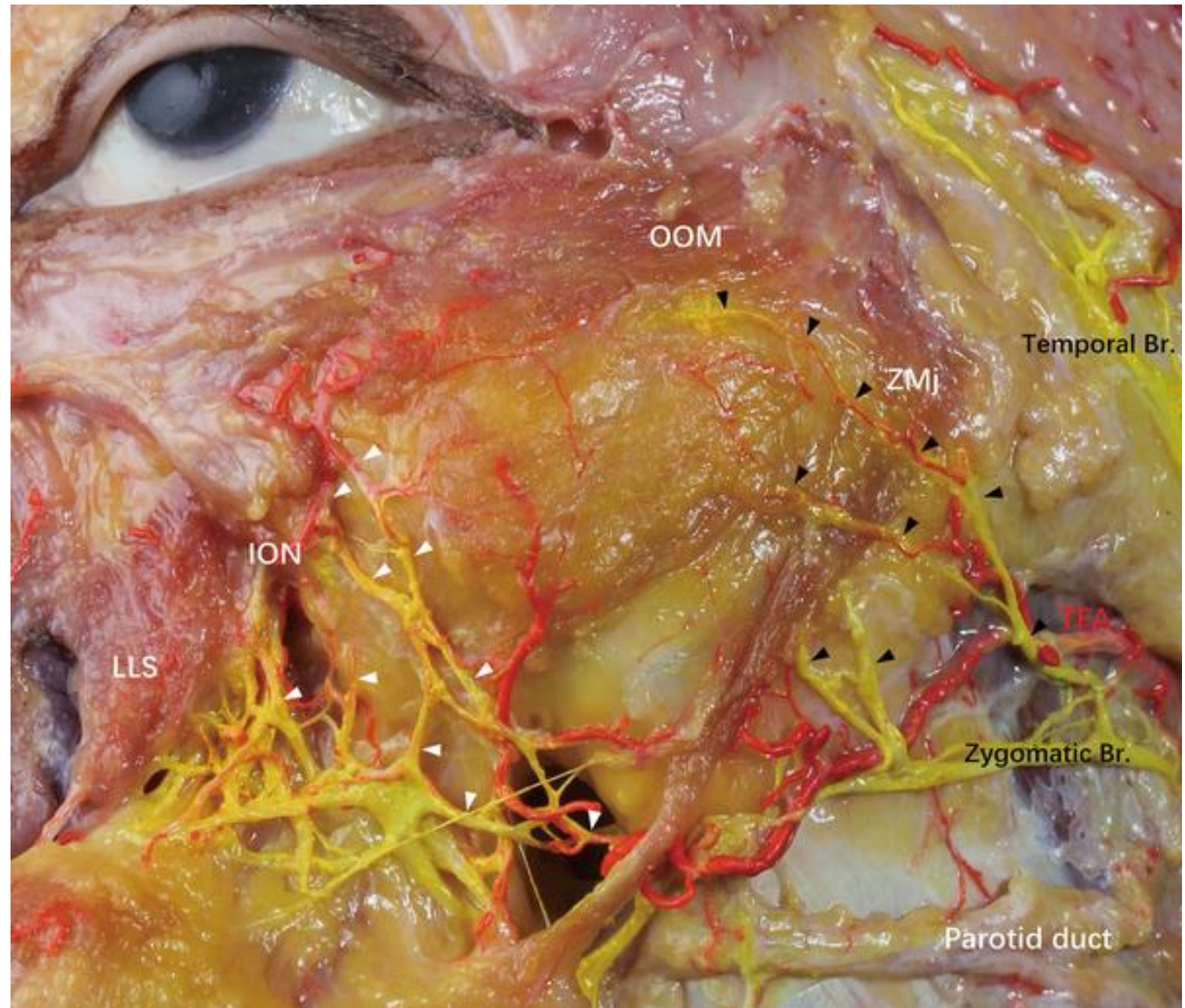


- **The zygomatic cutaneous ligament** is a septum-like osteocutaneous ligament originating from the periosteum of the maxilla and zygoma.
- The overall range of the zygomatic cutaneous ligament starts at the origin of the levator labii superioris and then extends laterally, following the curvature of the inferior bone margin.
- After merging with the ligamentous part at the origin of zygomaticus minor and zygomaticus major muscle¹.
- it continues as the zygomatic retaining ligament on the zygomatic arch.

- the **zygomatic cutaneous ligament** (*arrowheads*) was a fibroelastic tissue with a histologic continuity from its periosteal (*P*) origination, passing outward between and behind the muscles (*M*) to dermal



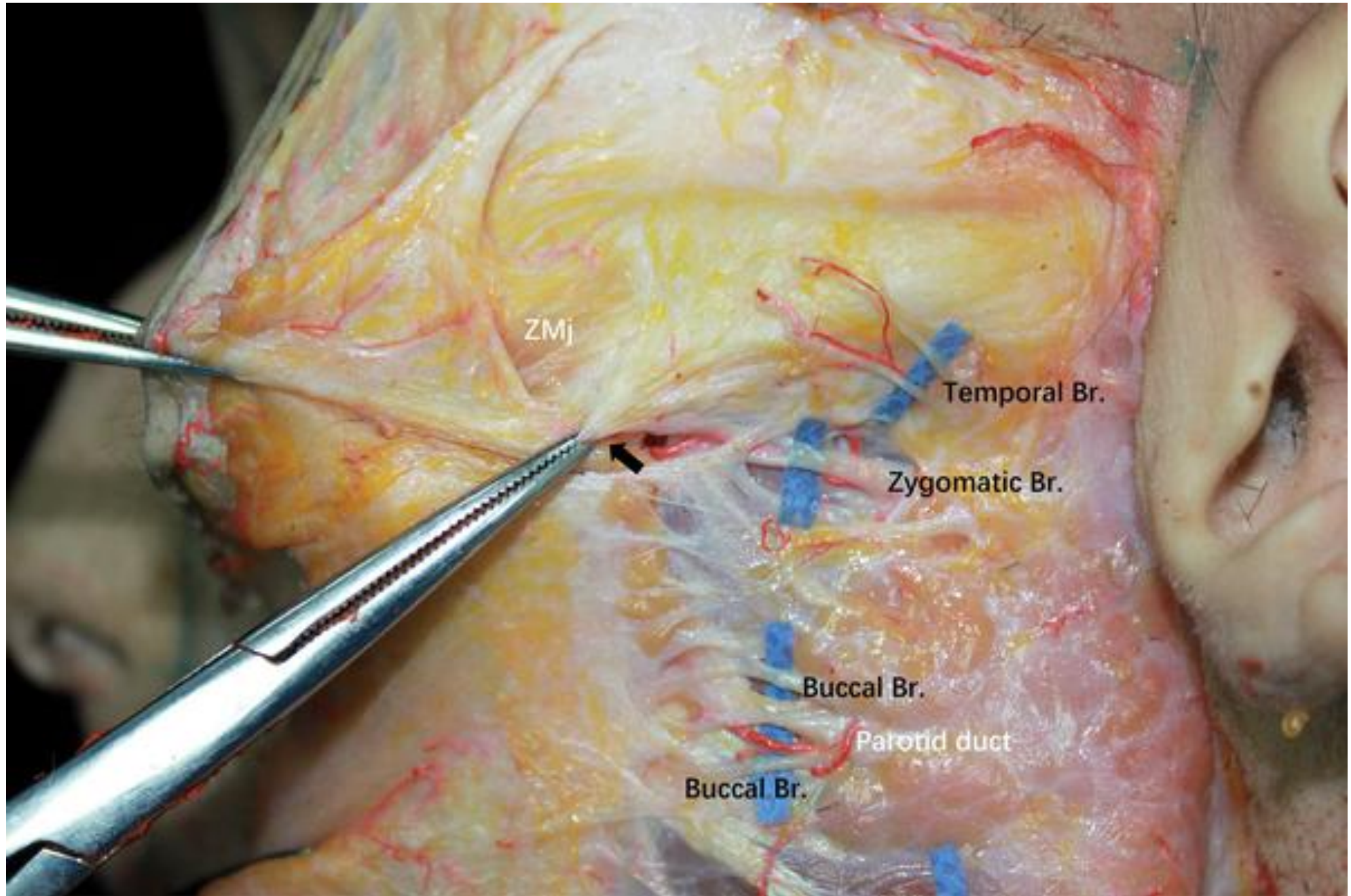
- **Zygomatic branch of the facial nerve and the transverse facial artery (*TFA*)** coursed medially, passing through the zygomaticus major (*ZMj*) to arrive at the anteromedial midface. Small subbranches emanated from the main trunk and rose to the origin of the zygomaticus minor and zygomaticus major muscles (*black arrowheads*). We have removed part of the fibers of the zygomaticus major muscle to expose the entire course of the branch when the branch rose to the origin of zygomaticus major muscle posteriorly. Farther anteriorly, subbranches of the zygomatic branch merged with the branches of the infraorbital nerve (*ION*) to coinnervate the anteromedial region

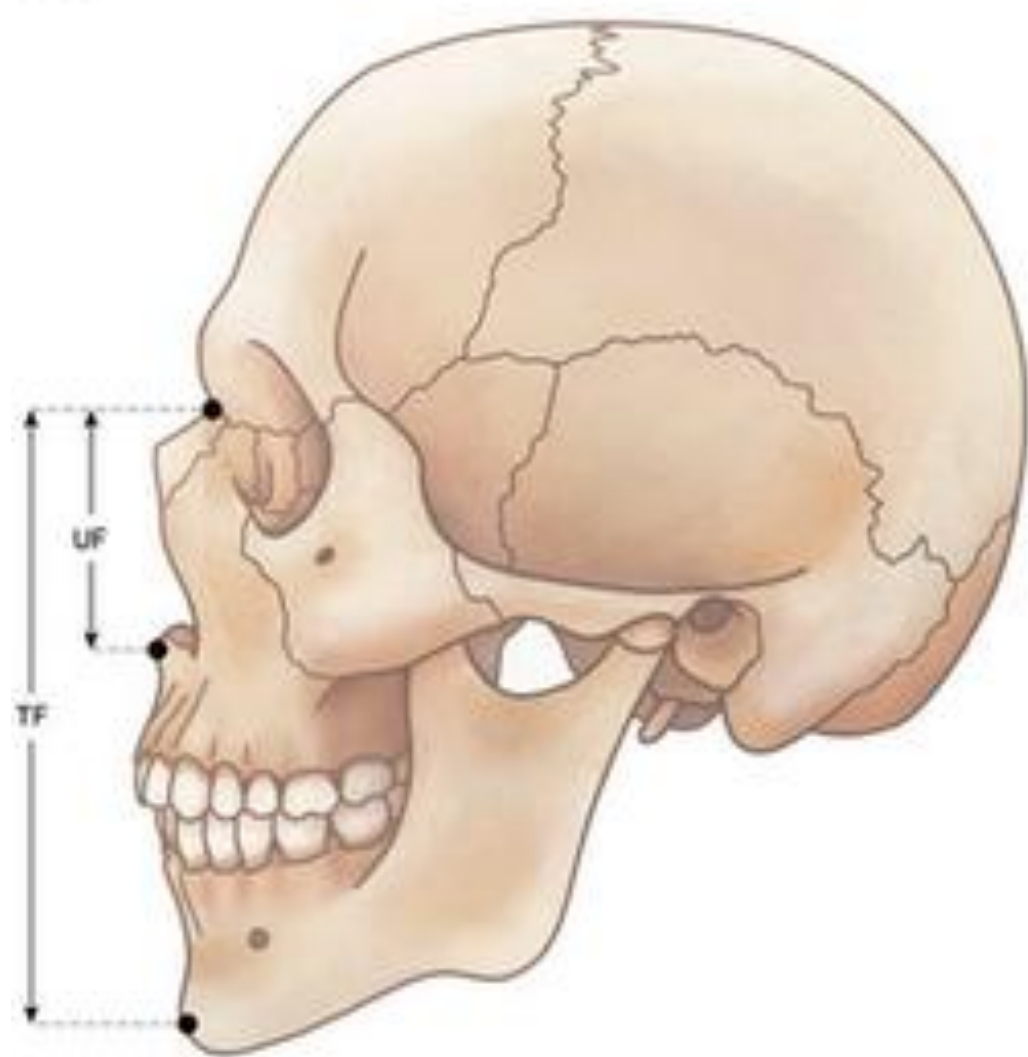
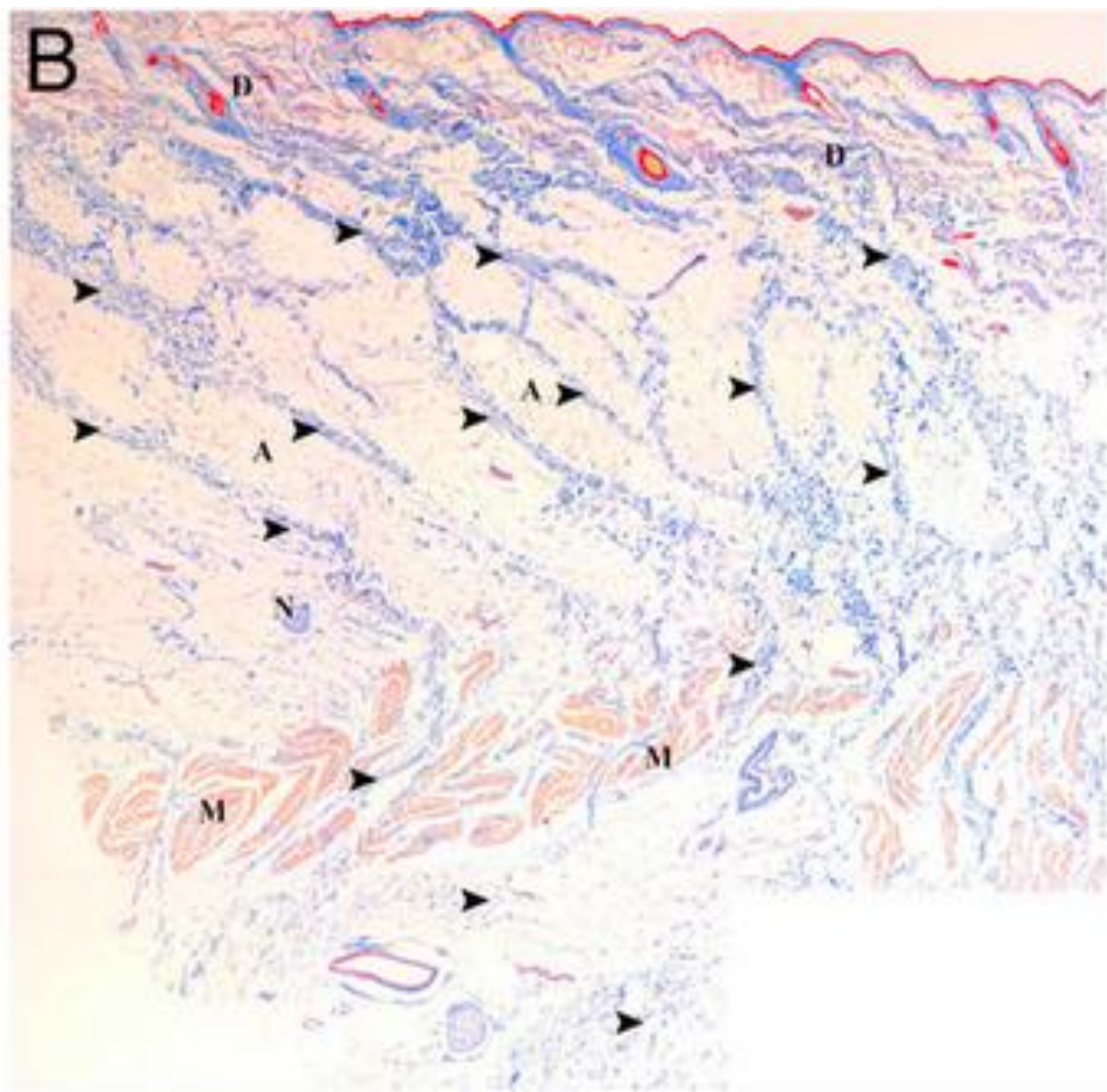


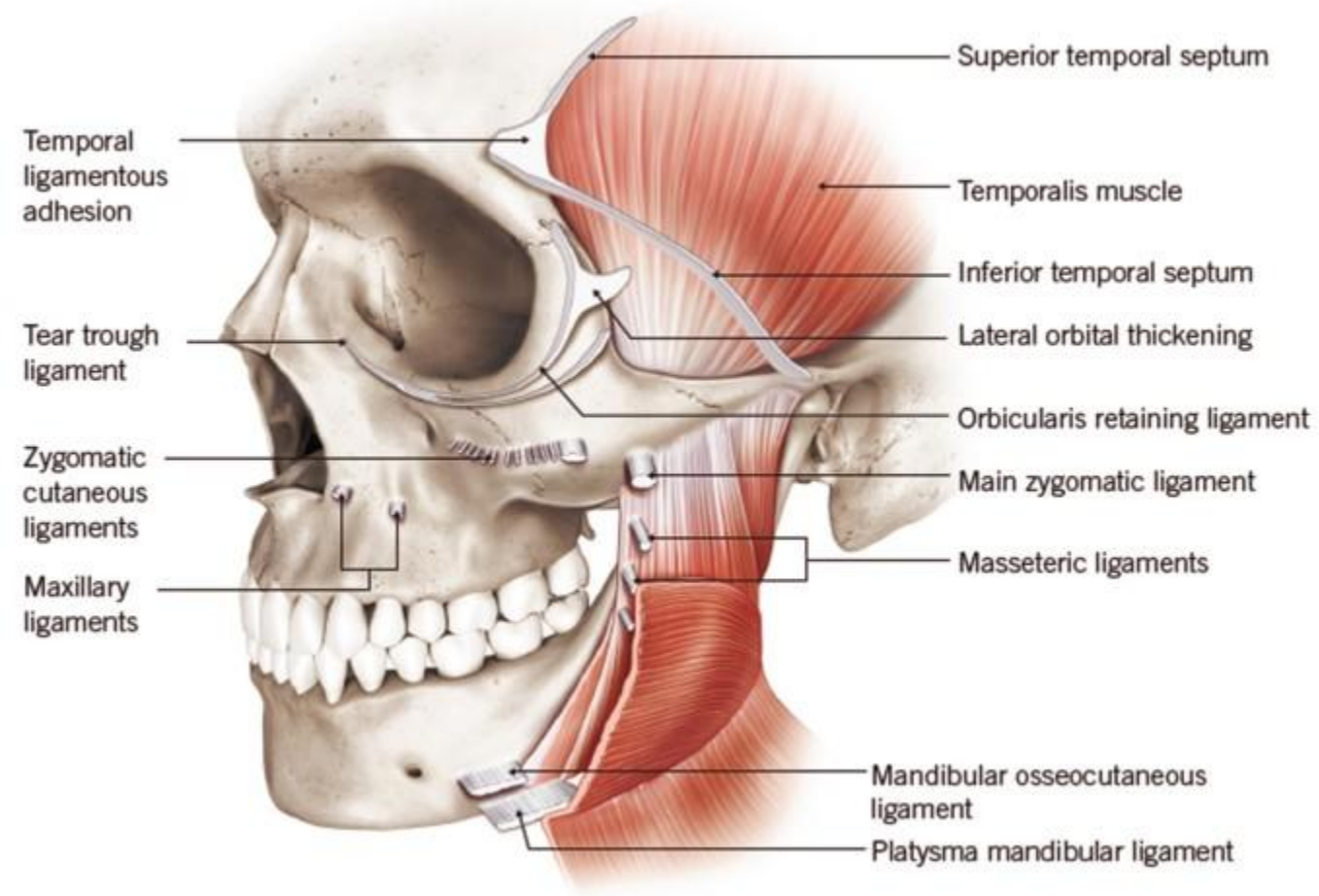
- This part of the ligament was located at the junction of the arch and body of the zygoma, with its medial end being the origin of the zygomaticus minor muscle and the lateral end was medial to the origin of the zygomaticus major muscle.



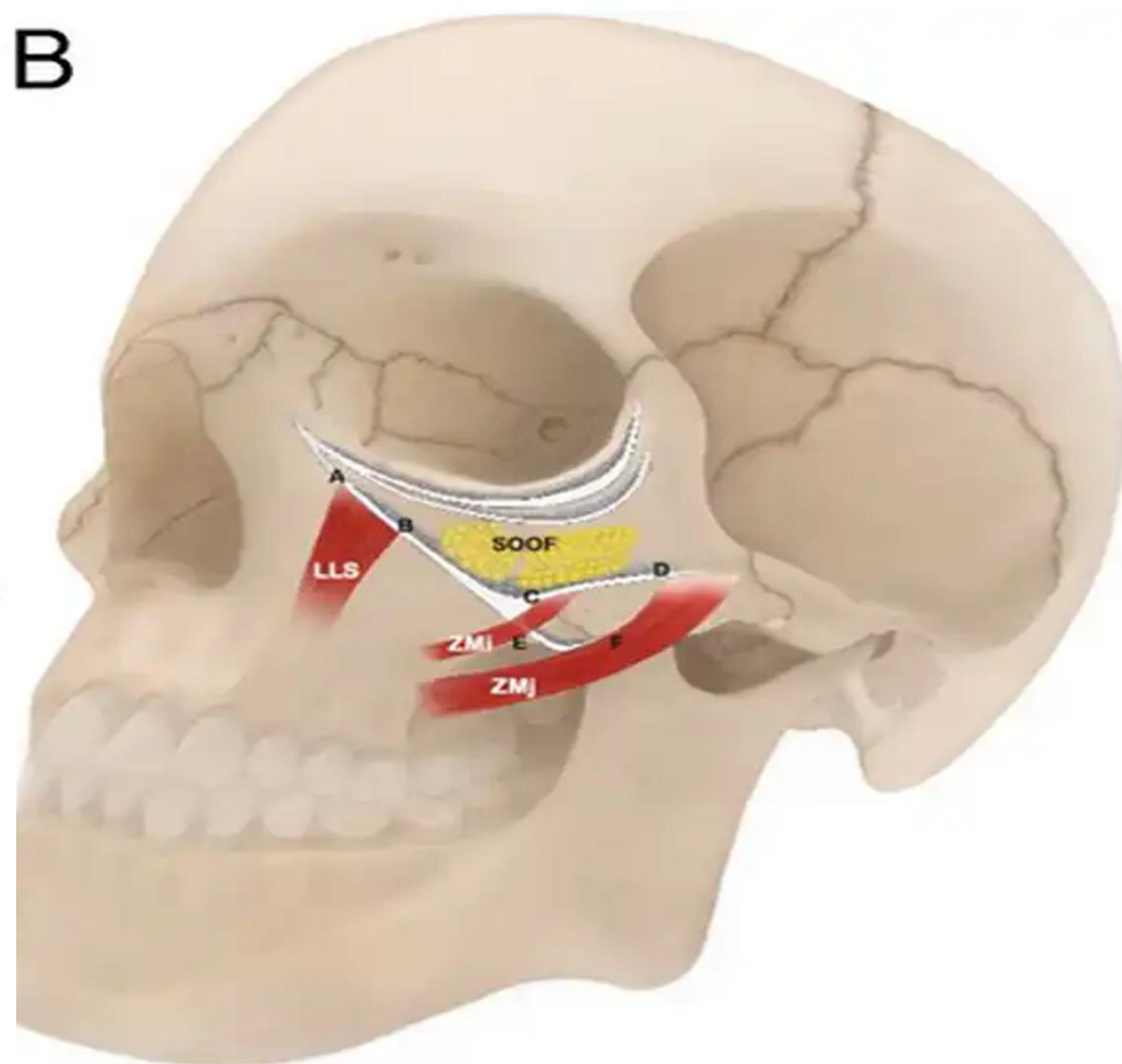
- the strongest part of the **zygomatic retaining ligament** (ZRL) (*black arrow*), which was a strong area of adhesion where the zygomatic retaining ligament merged with the masseteric cutaneous ligaments, which was just below the origin of the zygomaticus major (ZMj).



A**B**

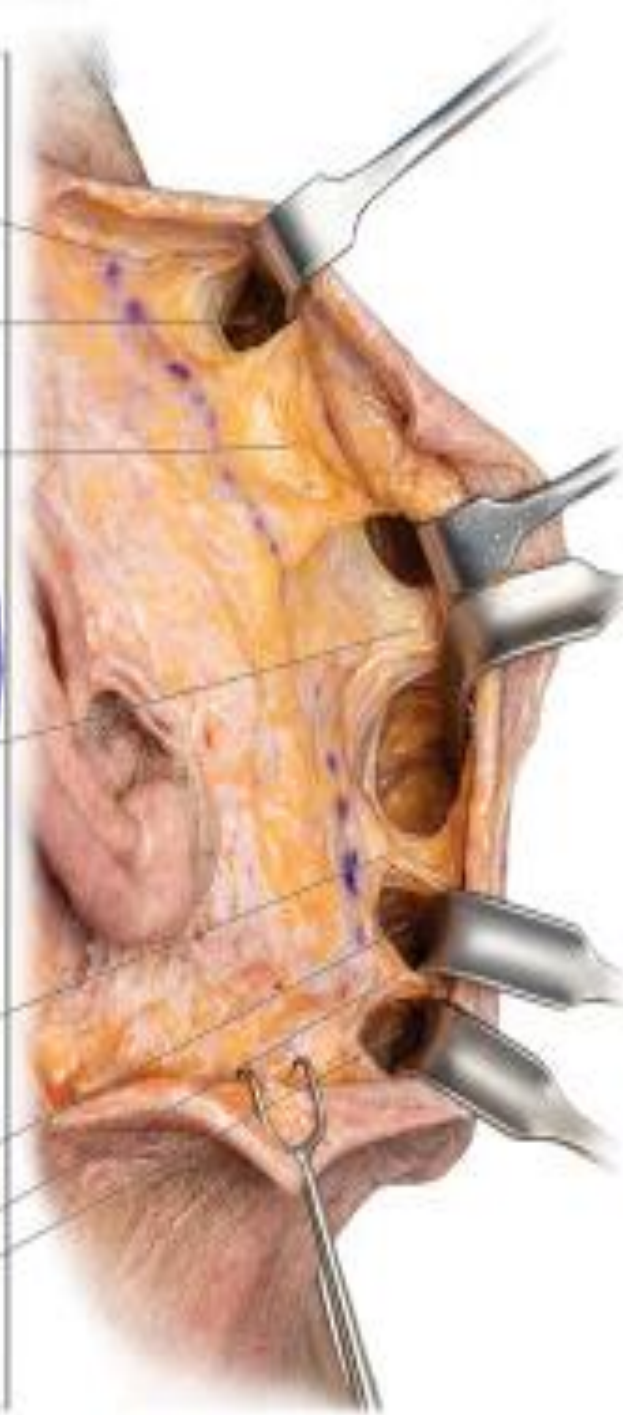
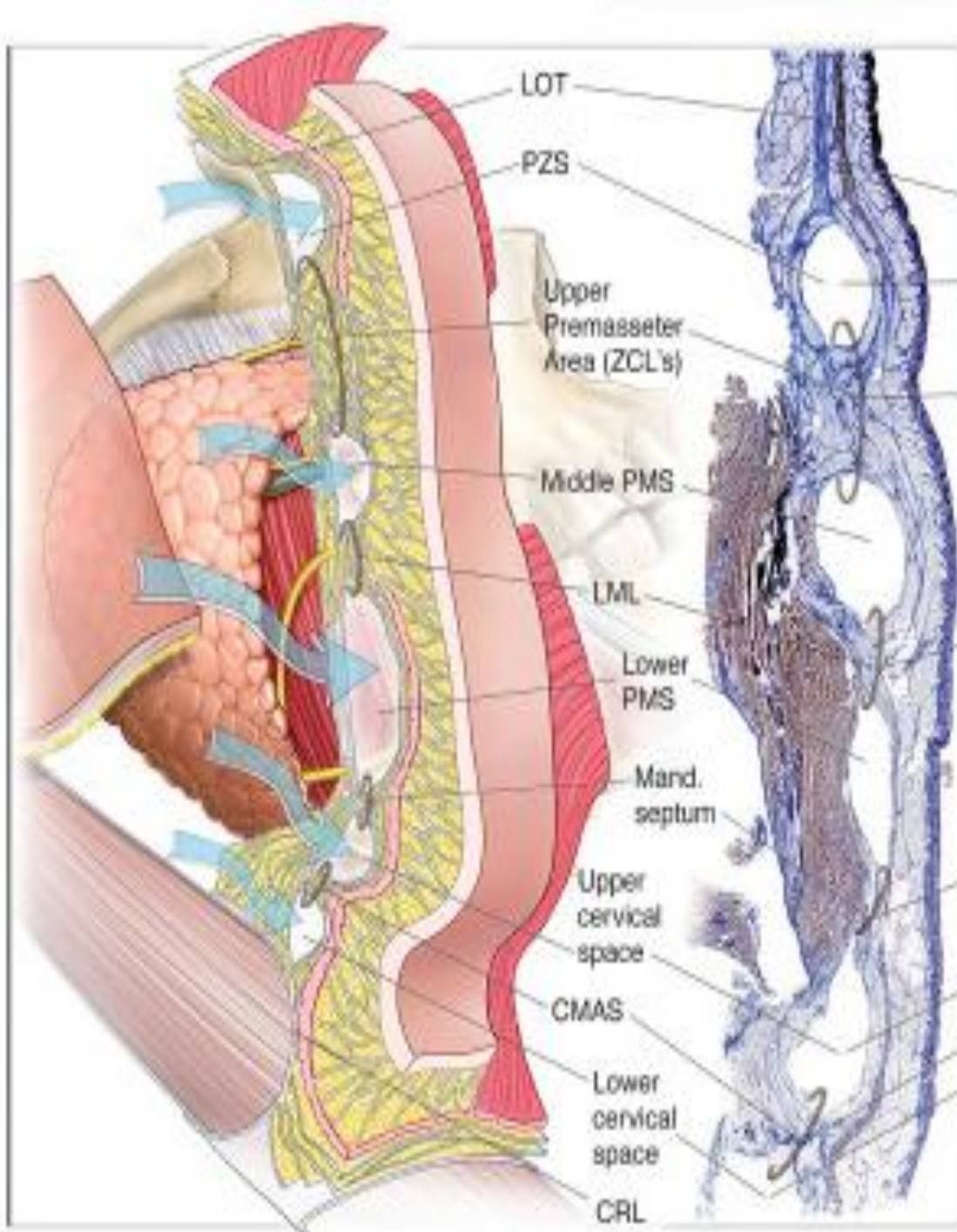


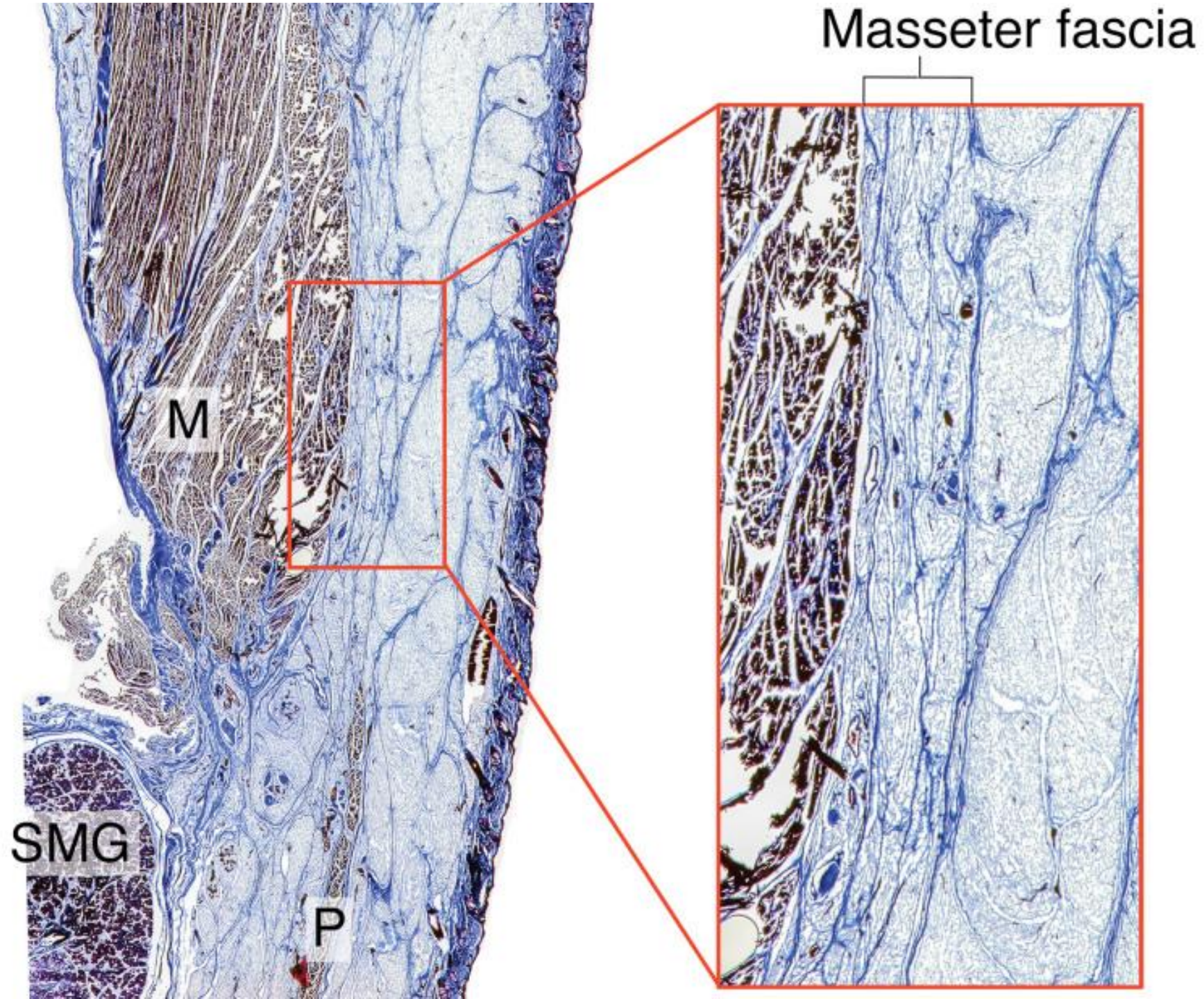
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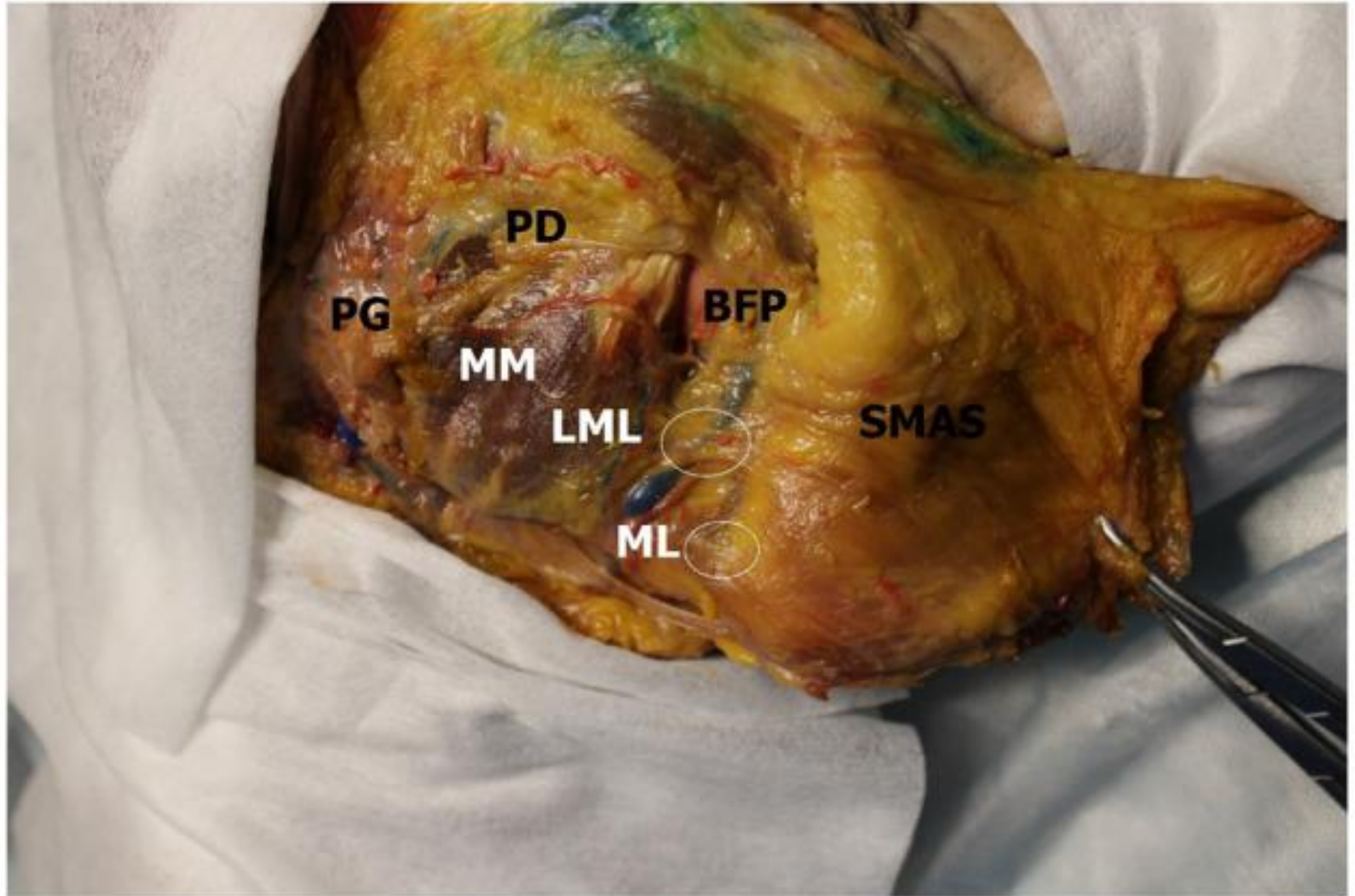
- The **zygomatic cutaneous ligament** was an osseocutaneous septum-like structure originating from the periosteum of the maxilla and zygoma (*arrowheads*), traversing the overlying fat compartment and muscle, and inserting into the skin of the anteromedial midface.



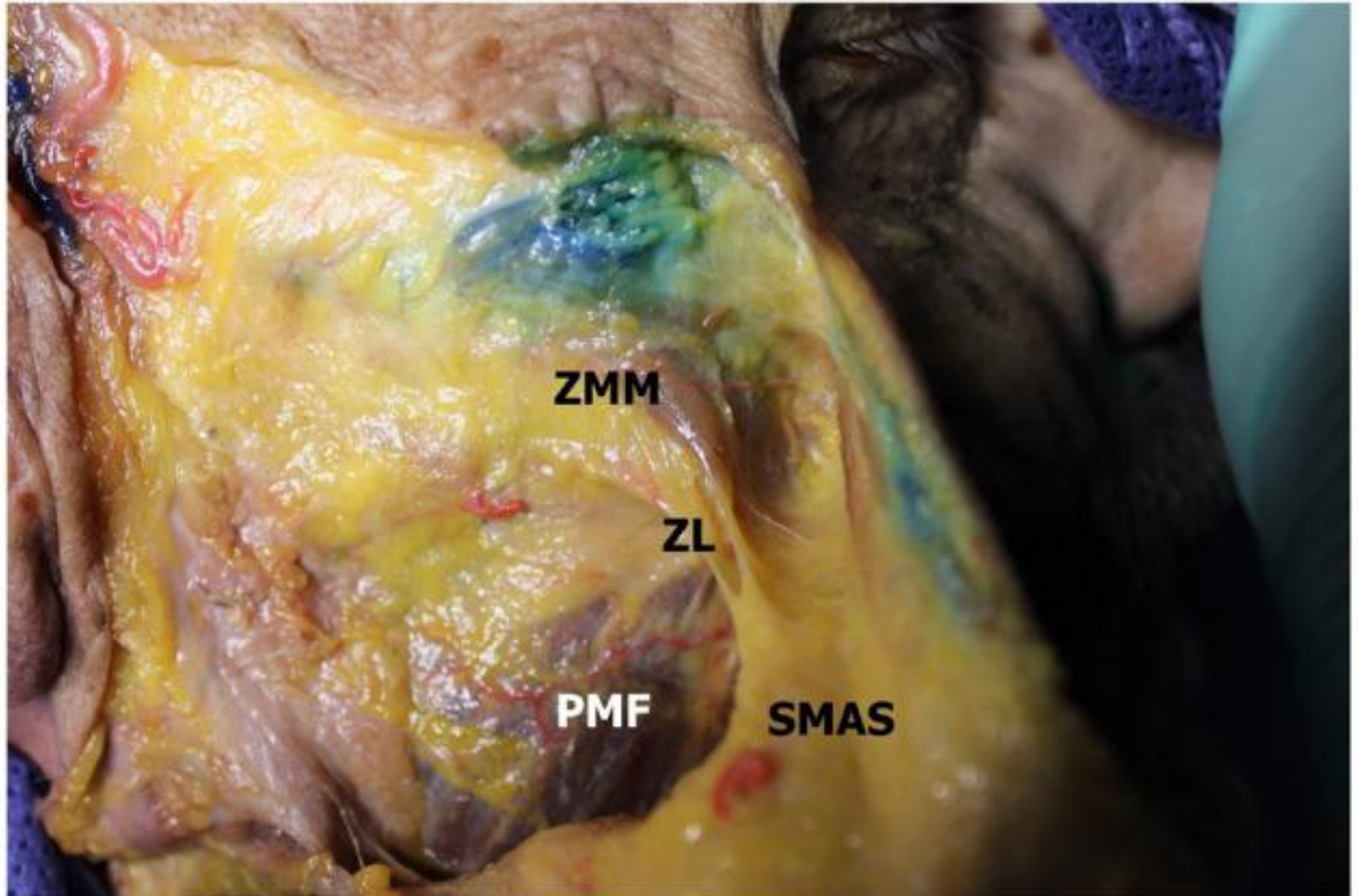




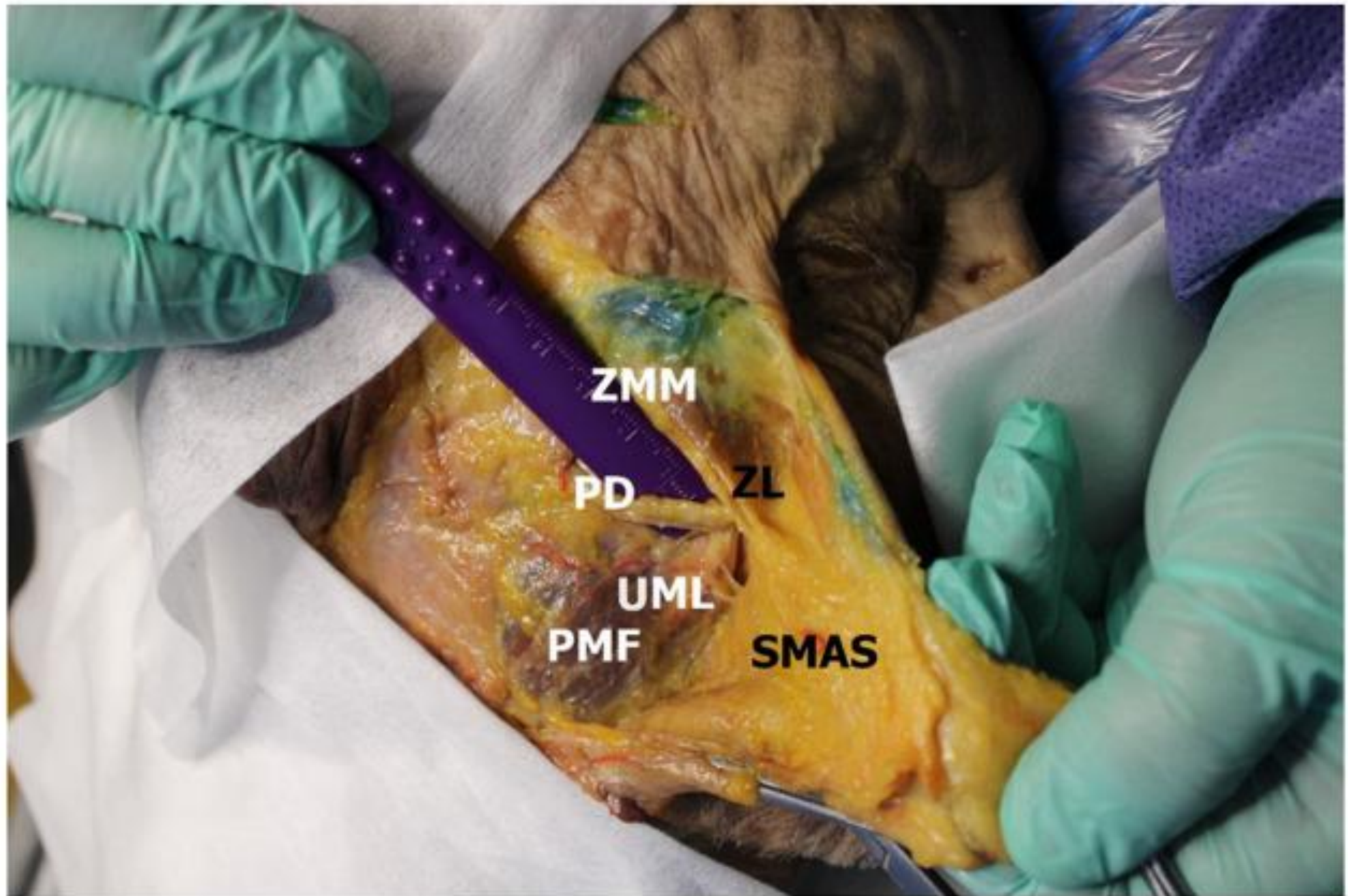
- Retaining ligaments of the face.
- PG—parotid gland;
- PD—parotid duct;
- BFP—buccal fat pad;
- MM —masseteric muscle;
- SMAS—superficial musculoaponeurotic system;
- LML—lower masseteric ligaments;
- ML—mandibular ligament



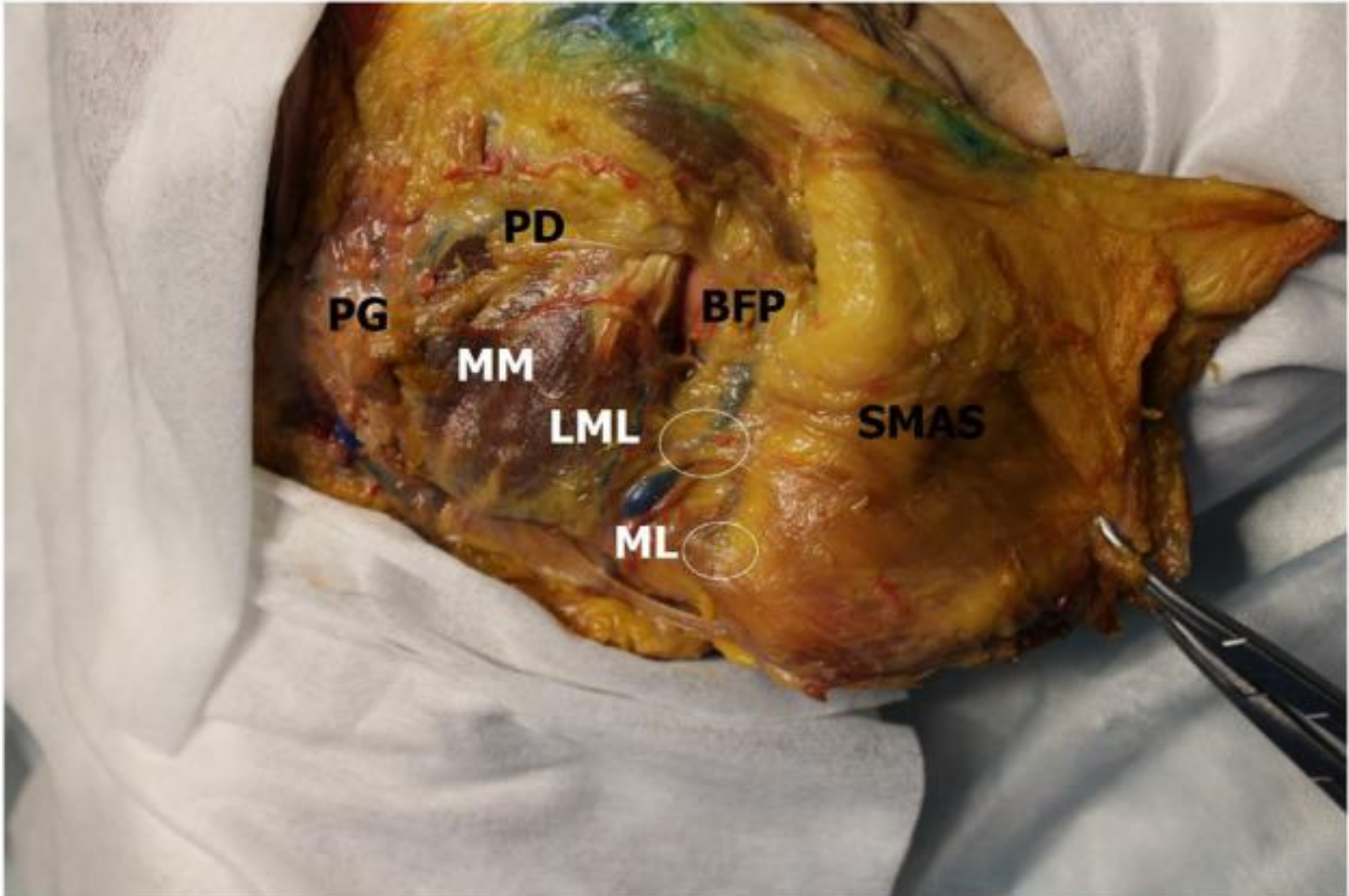
- The **parotid duct** was running near to the zygomatic ligament; its fascial sheath was often attached to the lowest cords of the zygomatic ligament.
- The **transverse facial artery** was related to the zygomatic ligament only in cases when it accompanied the parotid duct or was located above it
- The **zygomatic branch of the facial nerve**, in all observations, was the deepest structure traveling under the zygomatic ligament toward its destination deep in the zygomaticus major muscle. In all cases, the zygomatic ligament cords were running deep into the SMAS and then inserted into the dermis.



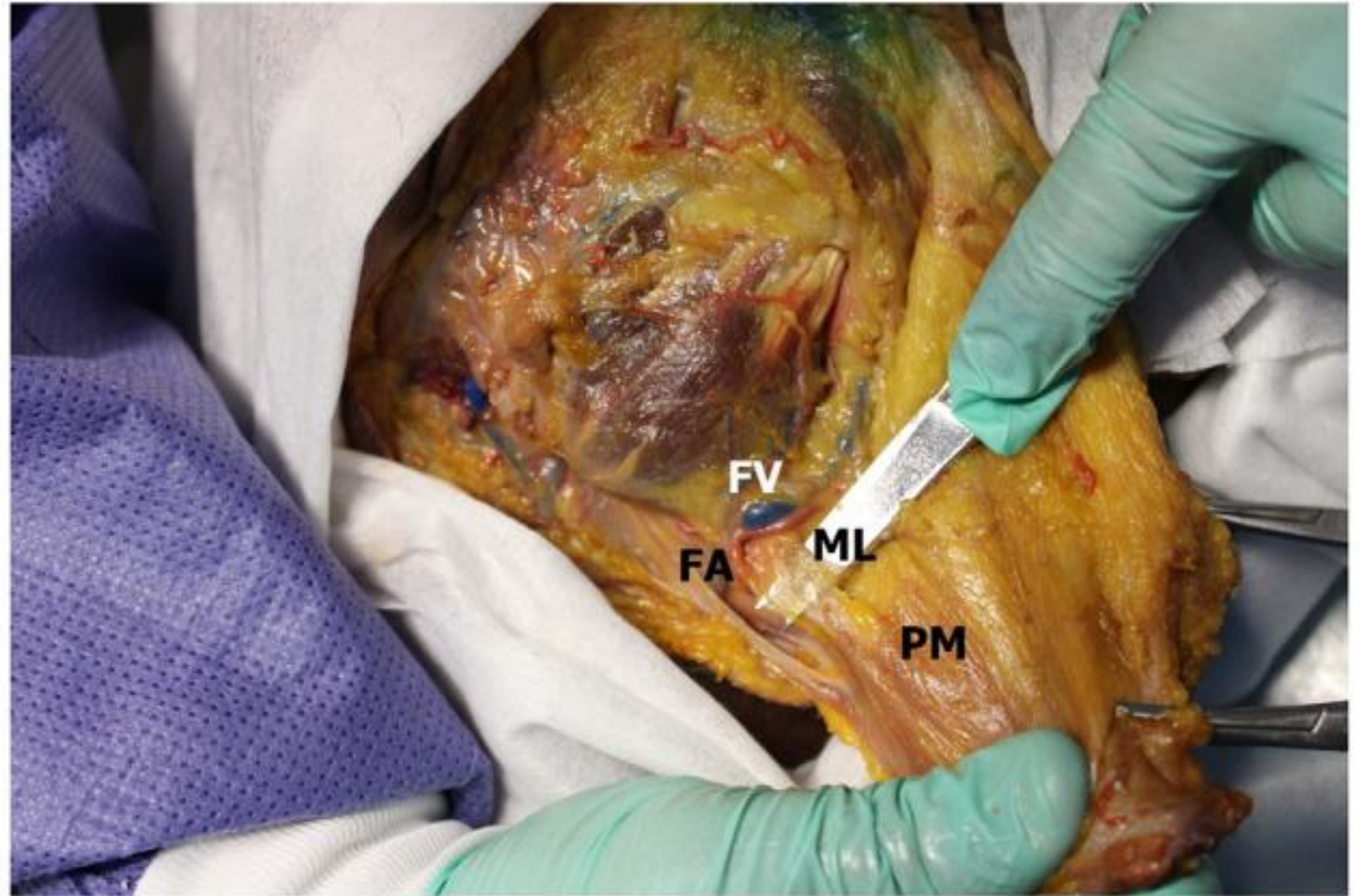
- The upper masseteric ligaments were located more medially, representing two obliquely and horizontally arranged connective tissue laminae extending from the parotidomasseteric fascia.
- The parotid duct in cases of its location under the zygomatic ligament entered the buccal region through the gap between the zygomatic ligament and the upper masseteric ligament.
- Fully presented upper masseteric ligaments were found in 83.33%. In other cases these laminae were thin and could be easily destroyed, including due to blunt dissection.



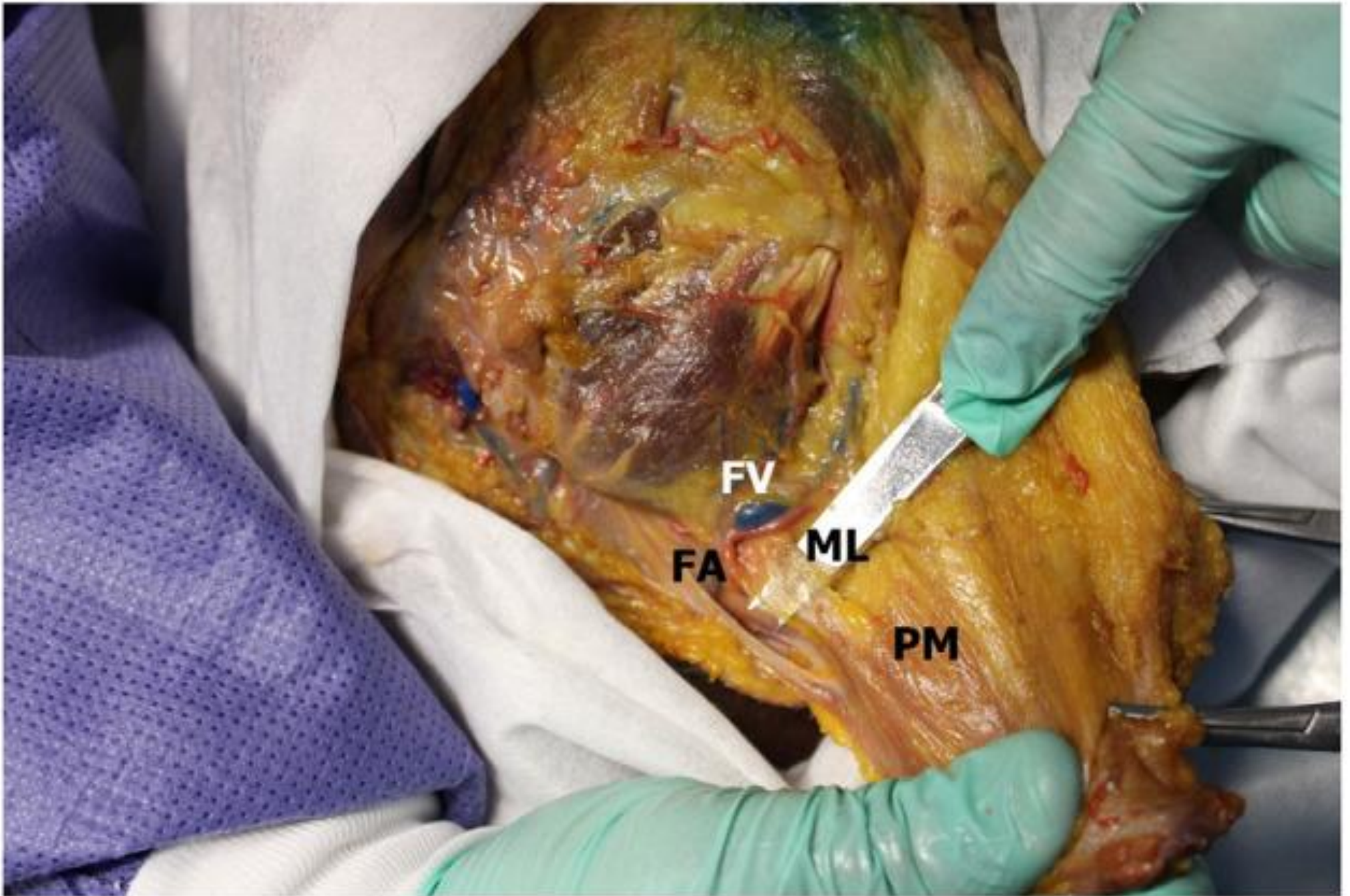
- The lower masseteric ligament was a connective tissue lamina extending from the parotideomasseteric fascia at the level of the **lower third of the anterior edge of the masseter muscle**.
- The part of the connective tissue fibers of this ligament followed from the sheath of the facial vein.
- The lower masseteric ligament was slightly longer in comparison with the upper masseteric ligament.

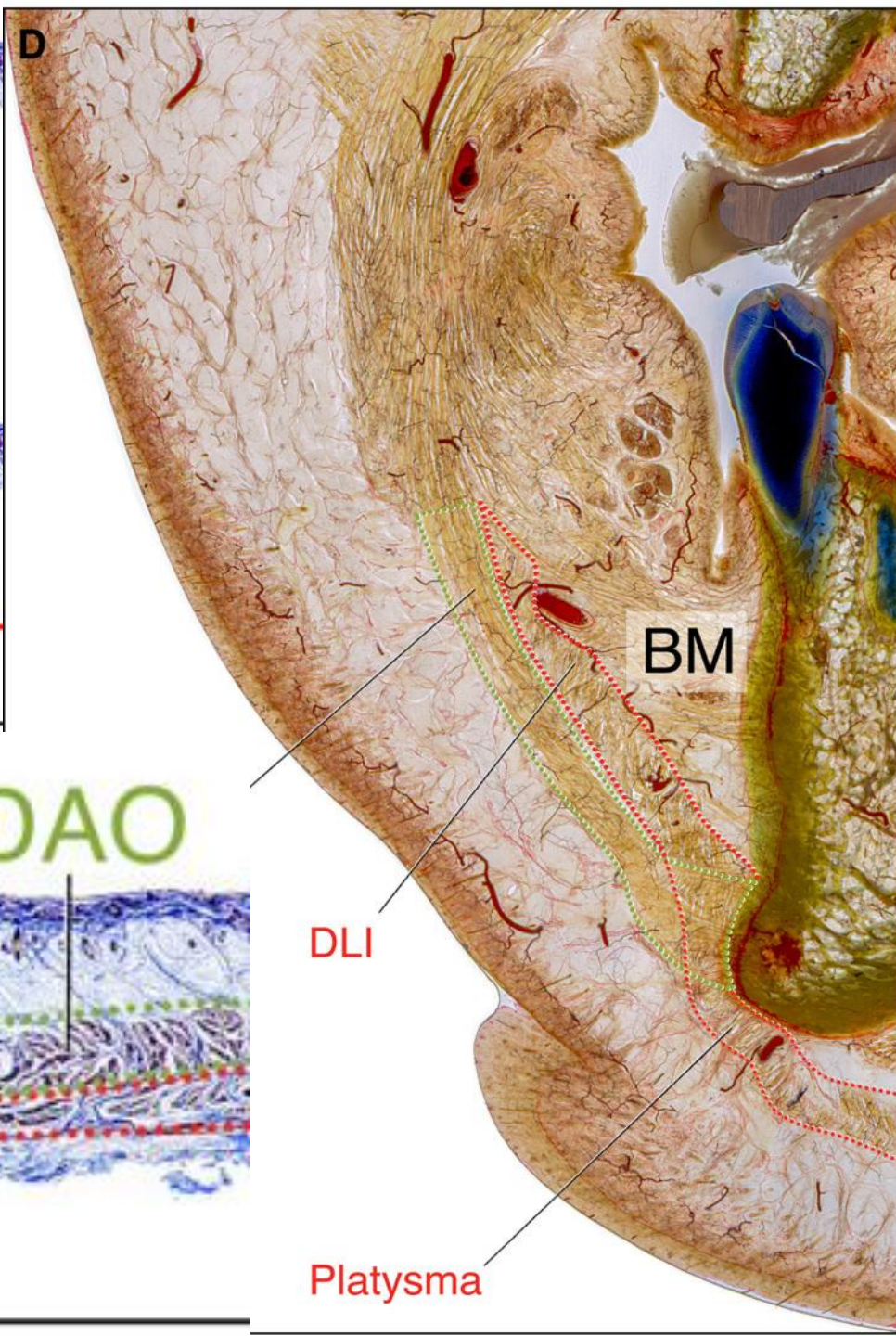
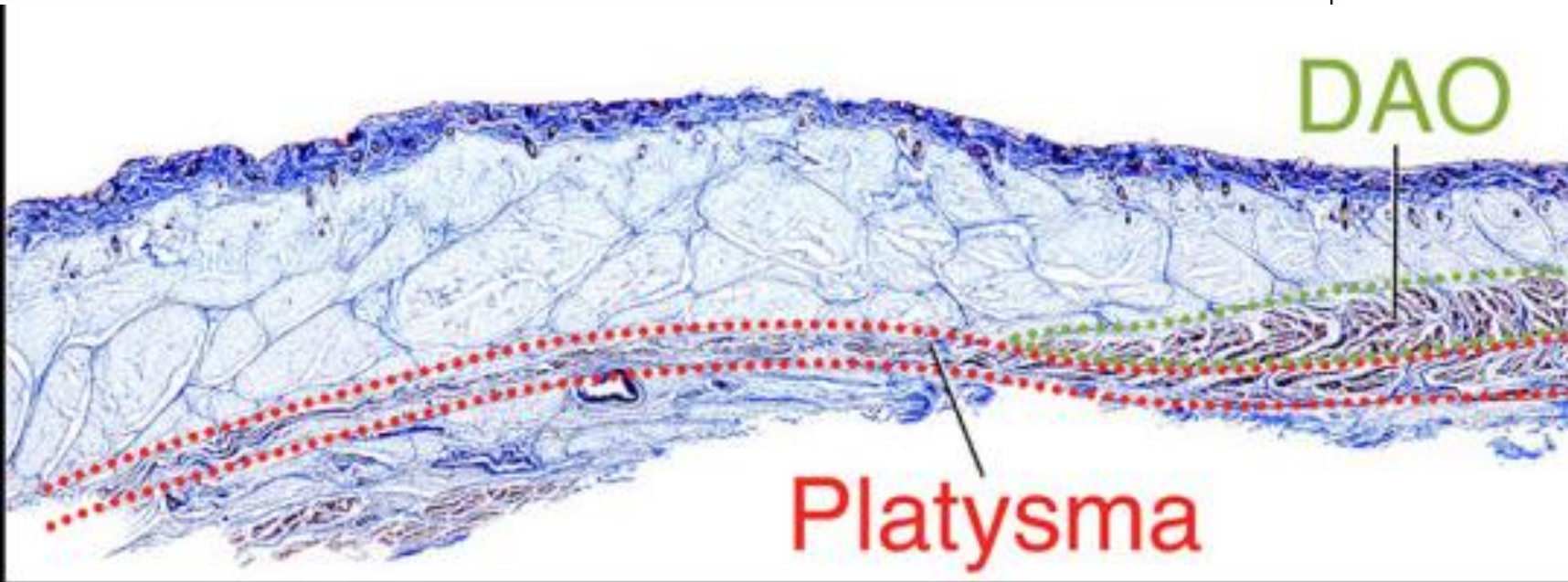
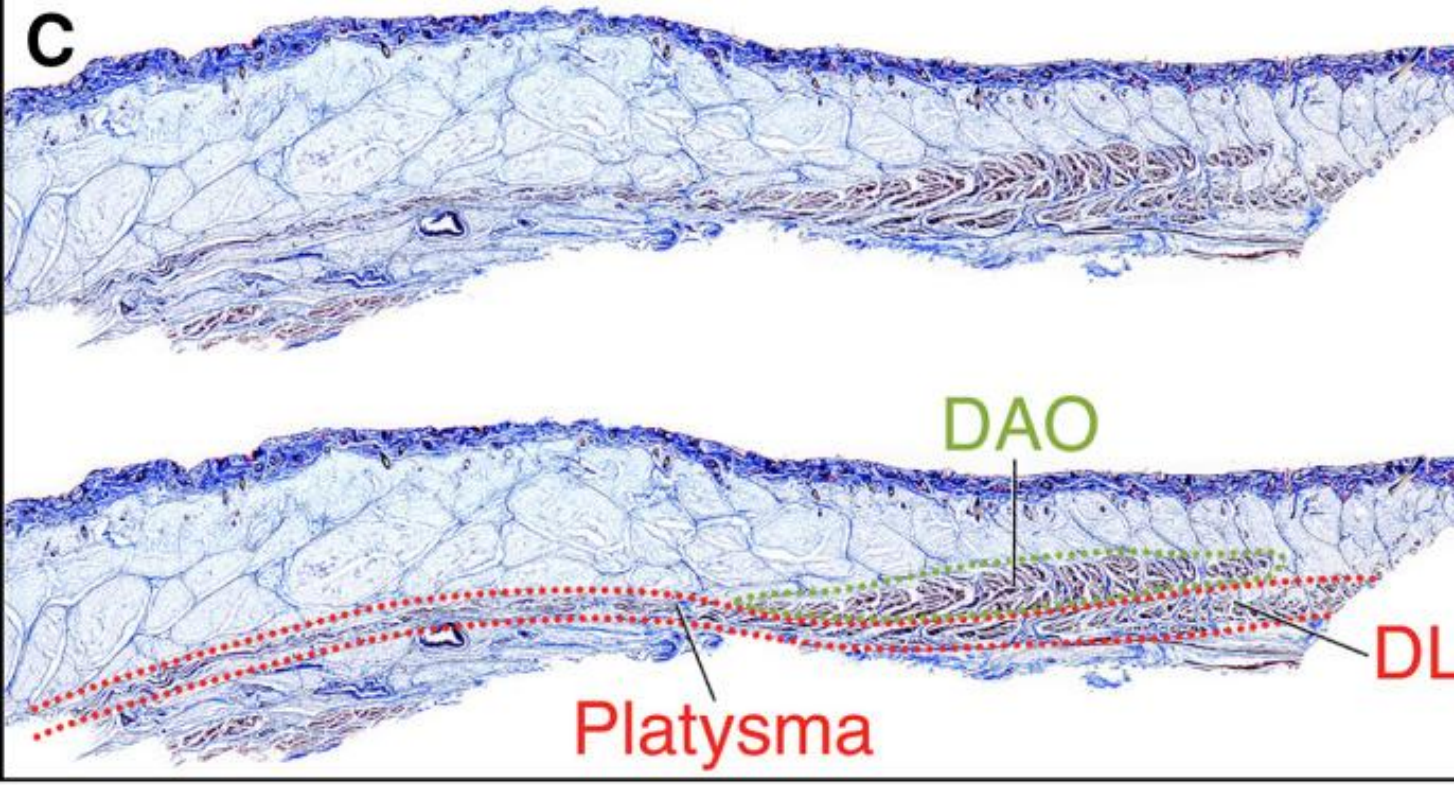


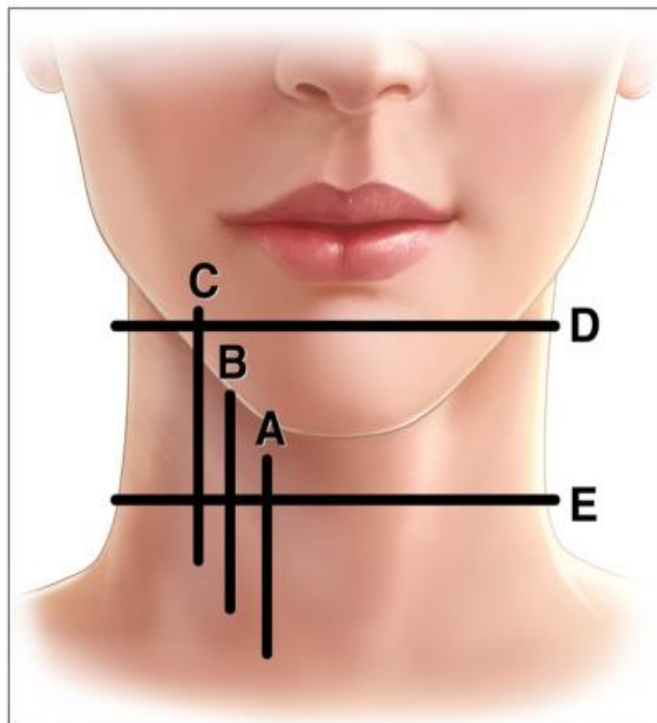
- Retaining ligaments of the face.
- FV—facial vein;
- FA—facial artery;
- ML—mandibular ligament;
- PM—platysma muscle.



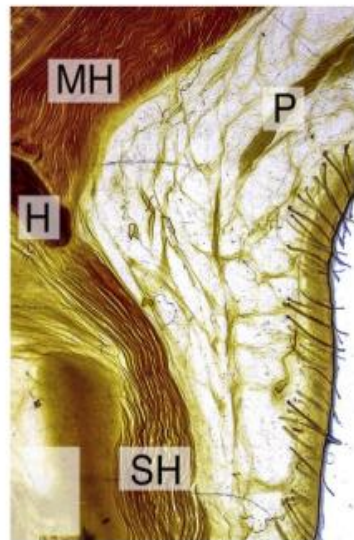
- The mandibular ligament, unlike the upper and lower masseteric ligament was clearly identified.
- The ligament originating from the **parotideomasseteric fascia at the lower edge of the mandible** and from the inner surface of this fascia, along the anterior edge of the masseter muscle. Thus, these two fascial laminae, skirting the sheath of the facial vein and the facial artery obliquely, traveling towards the platysma and the depressor anguli oris muscle, diverging at an angle and merging with these muscles







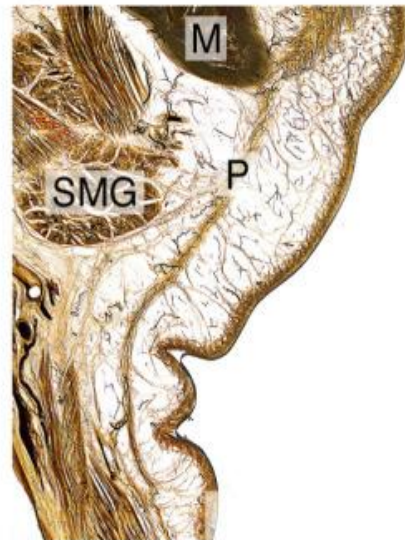
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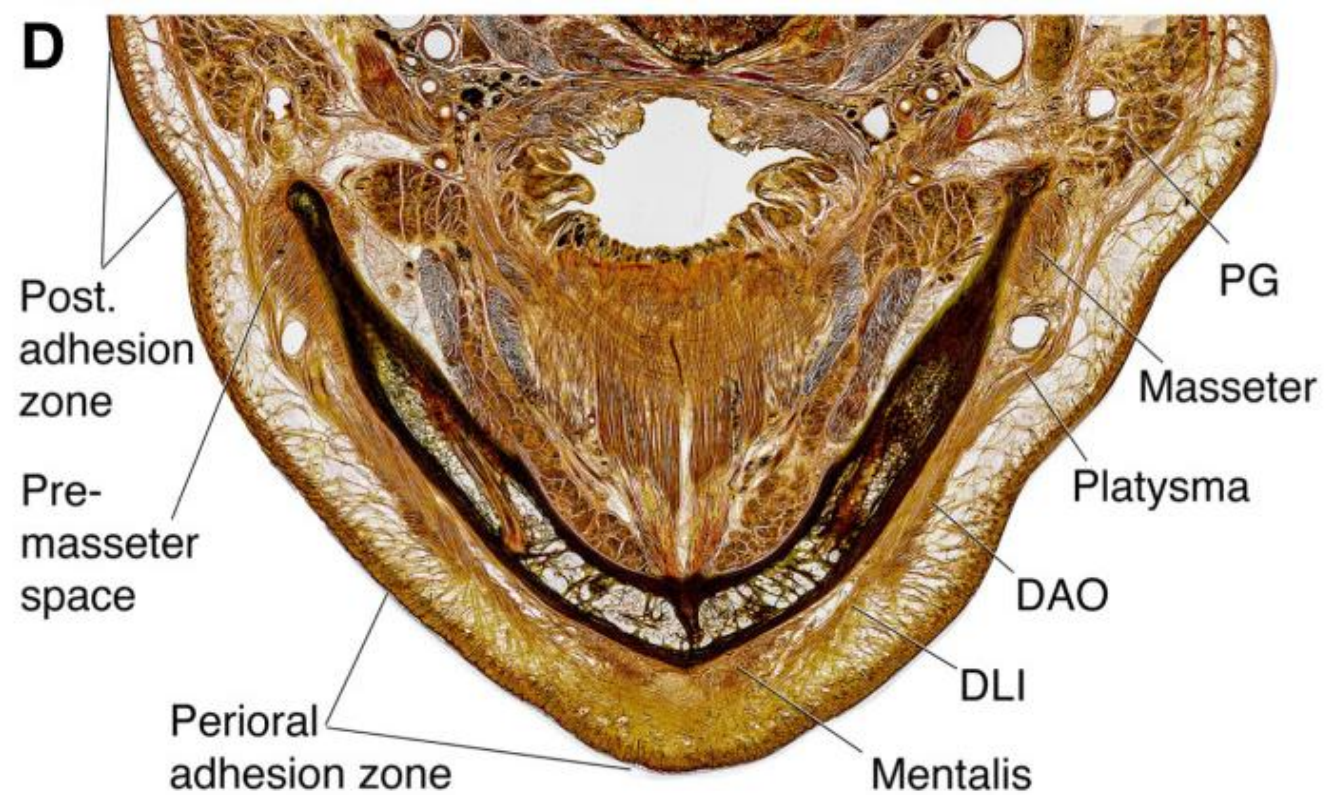
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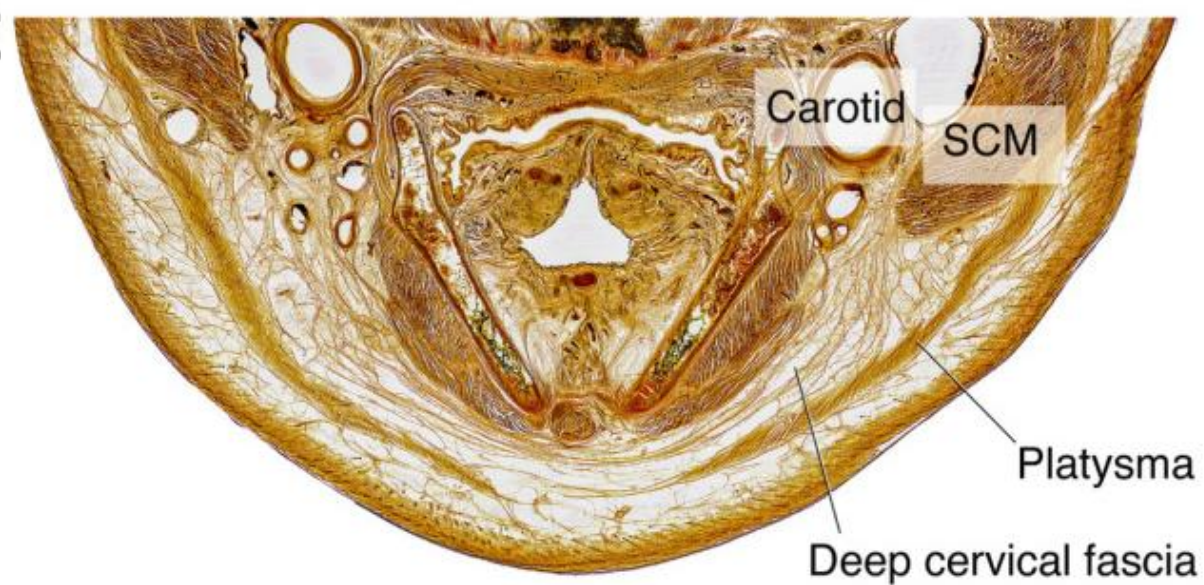
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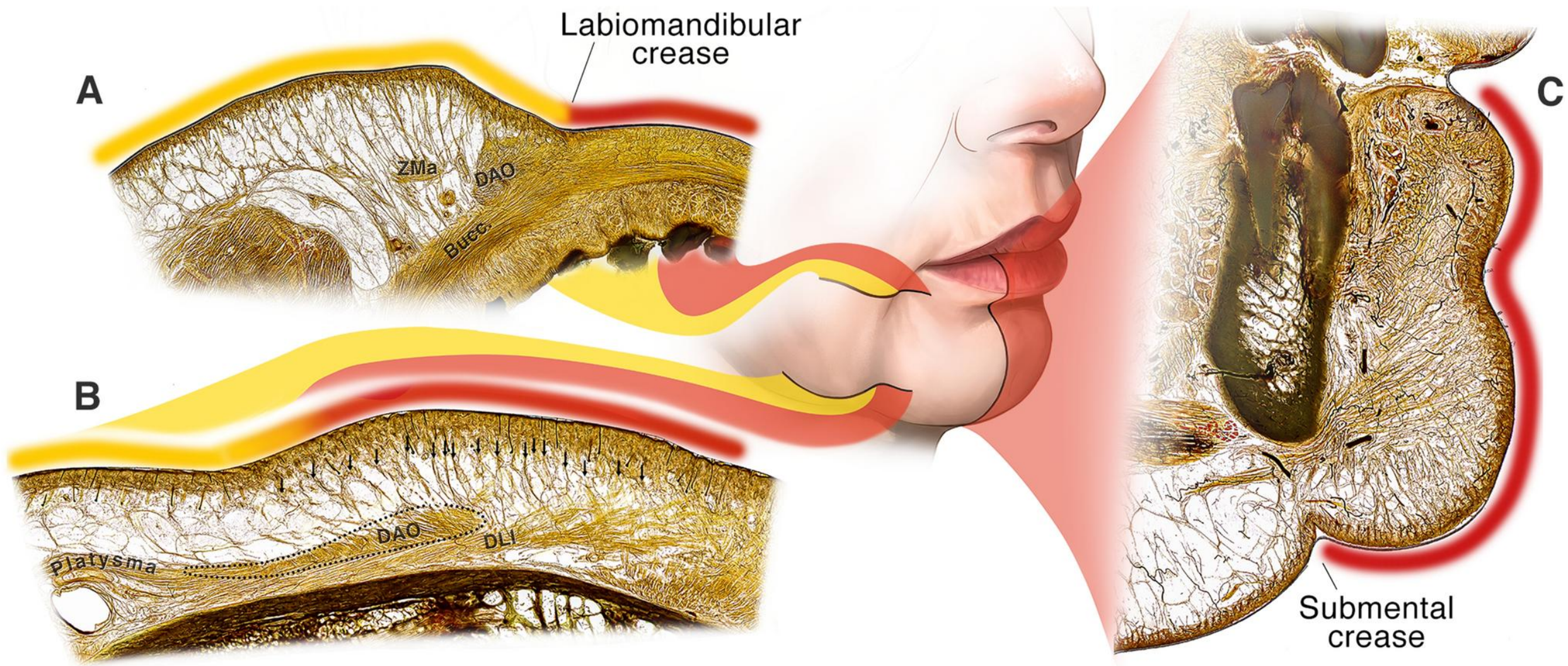


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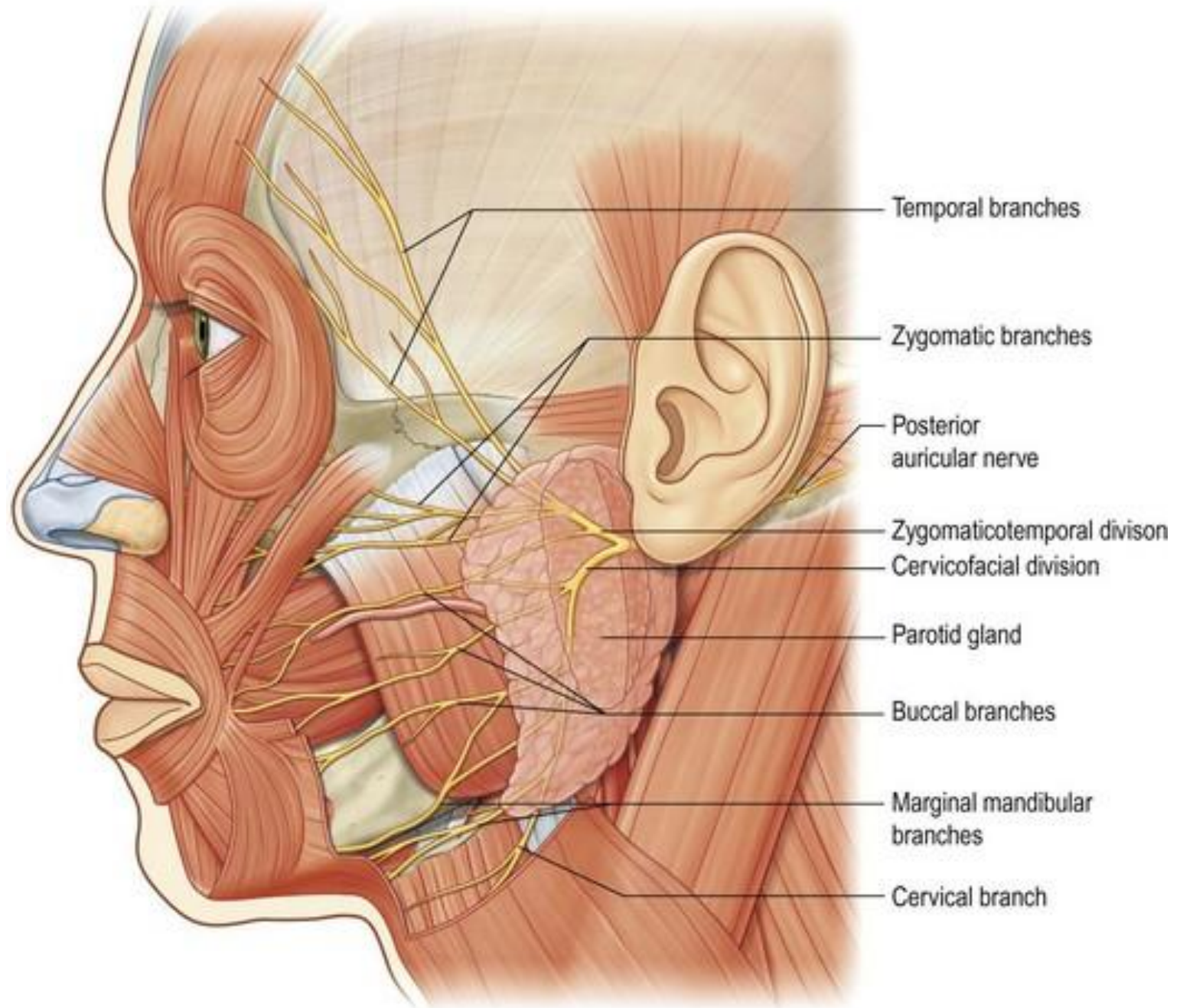
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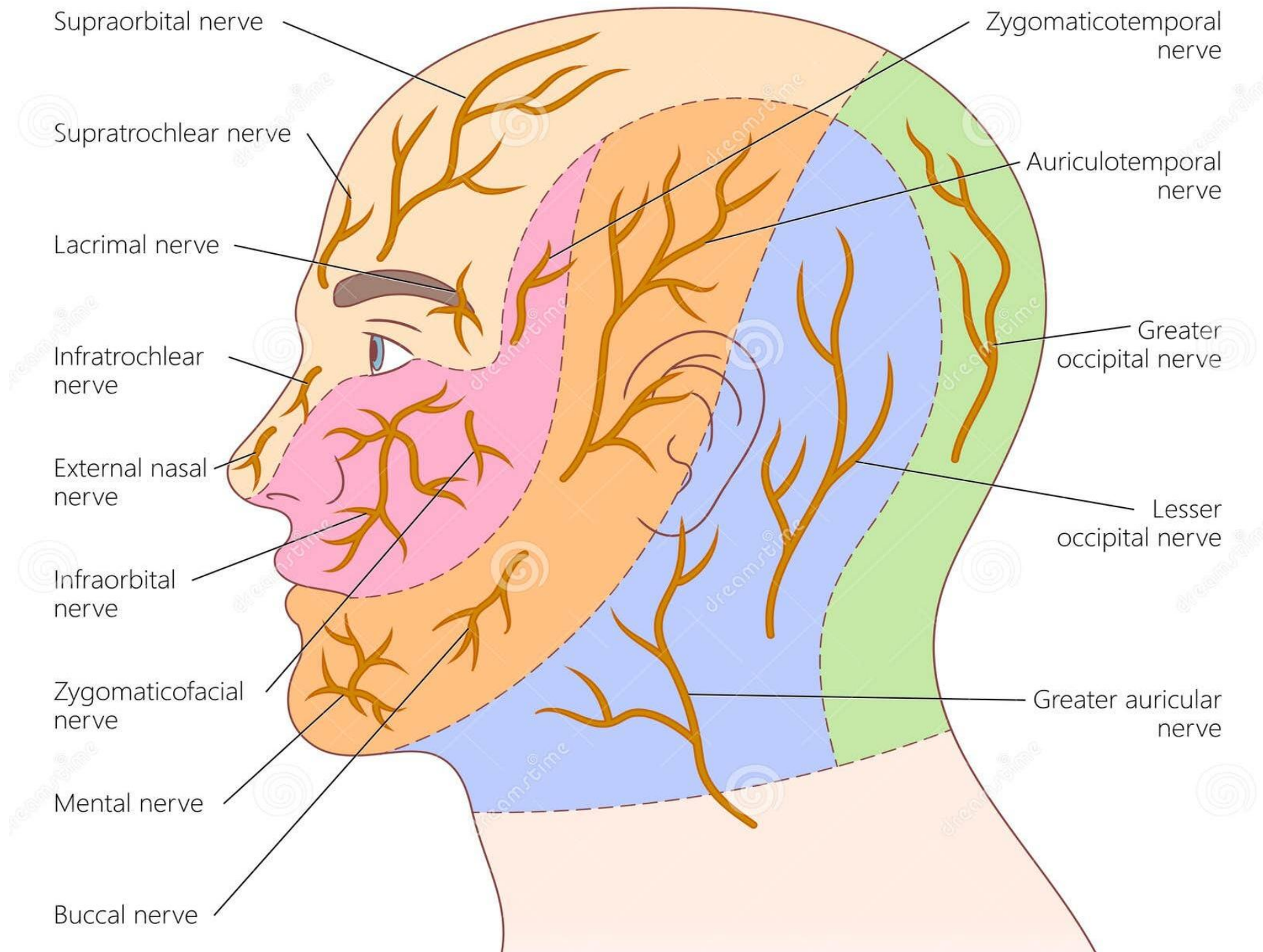


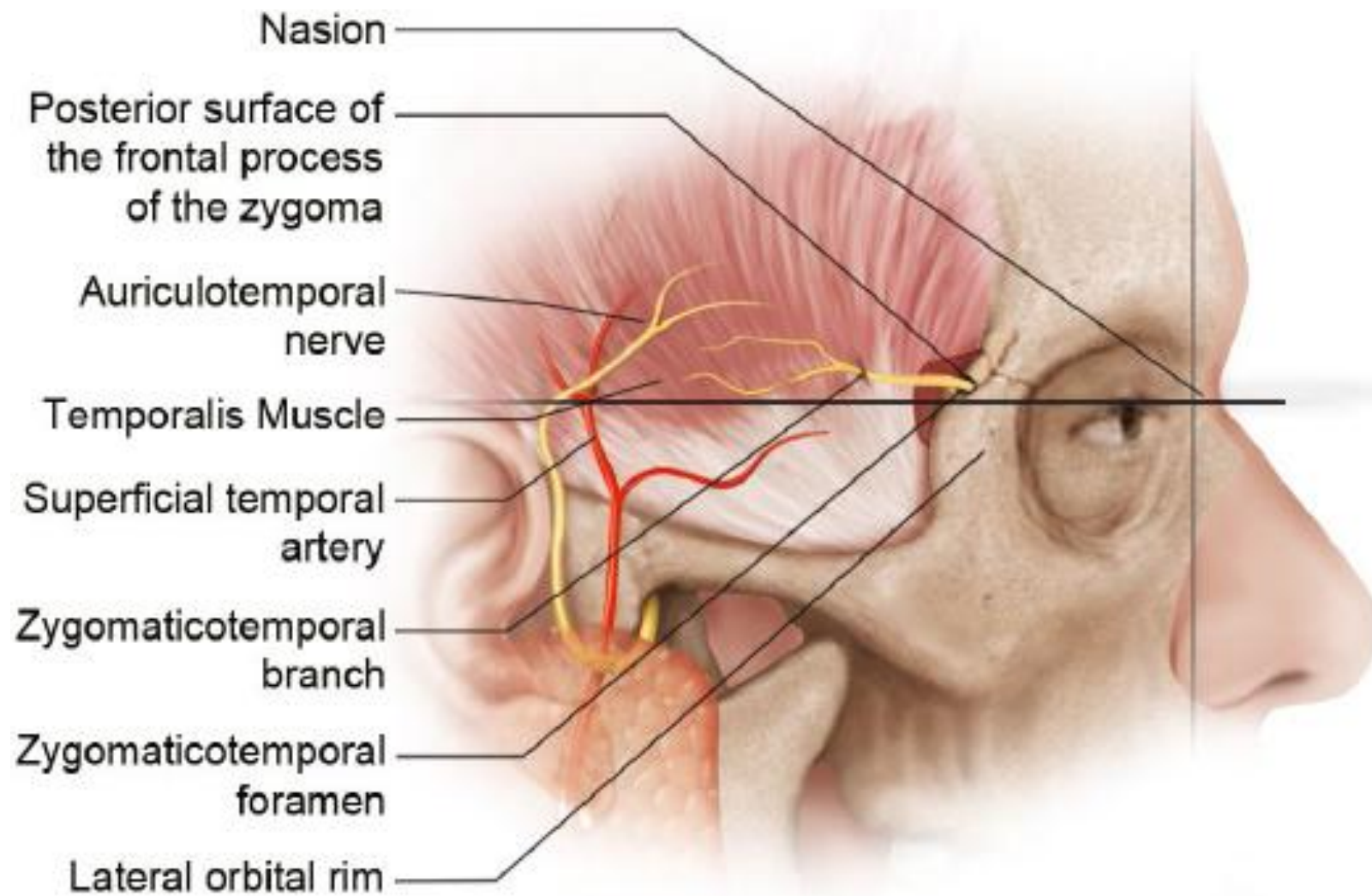


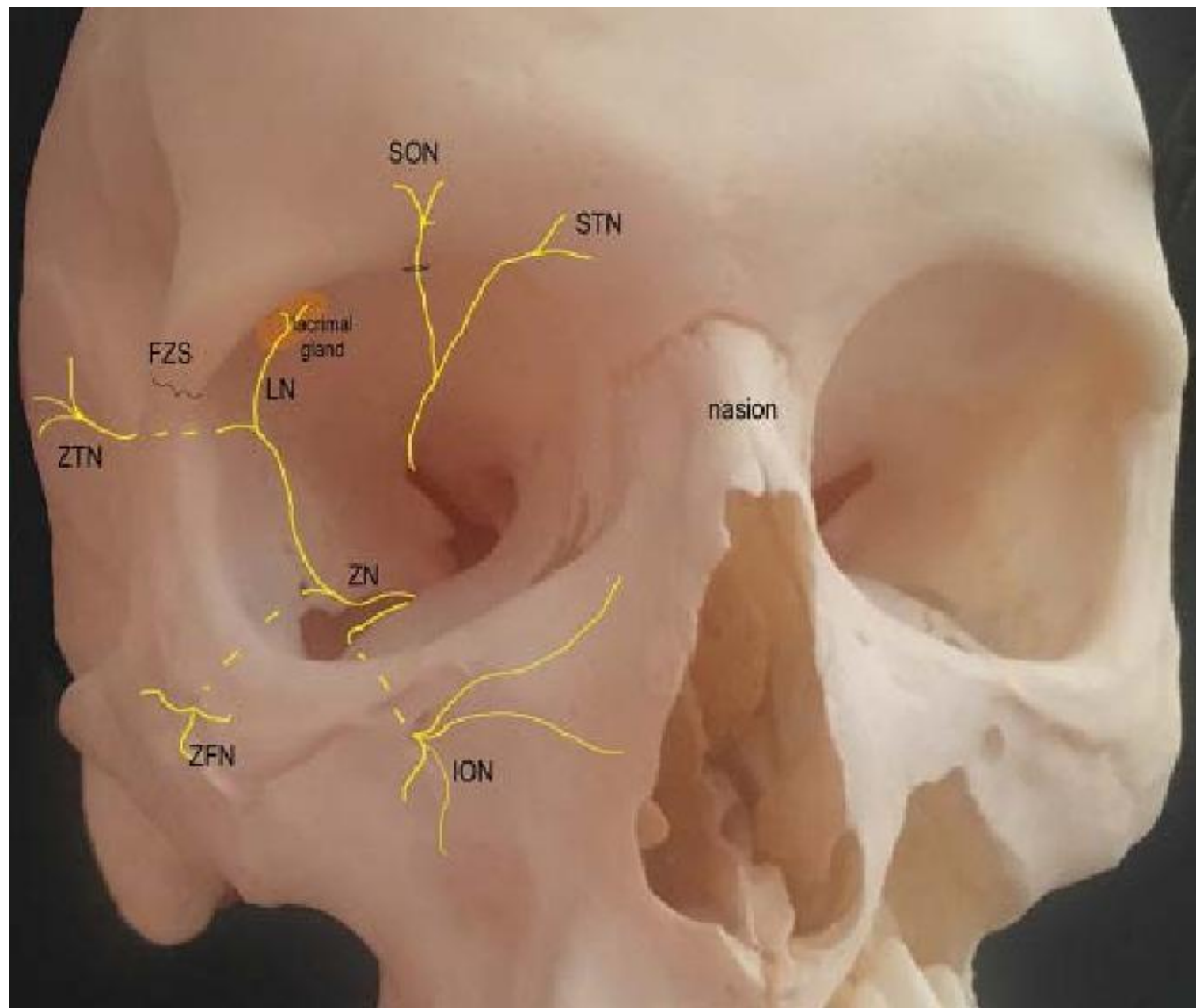
Facial Nerve Anatomy

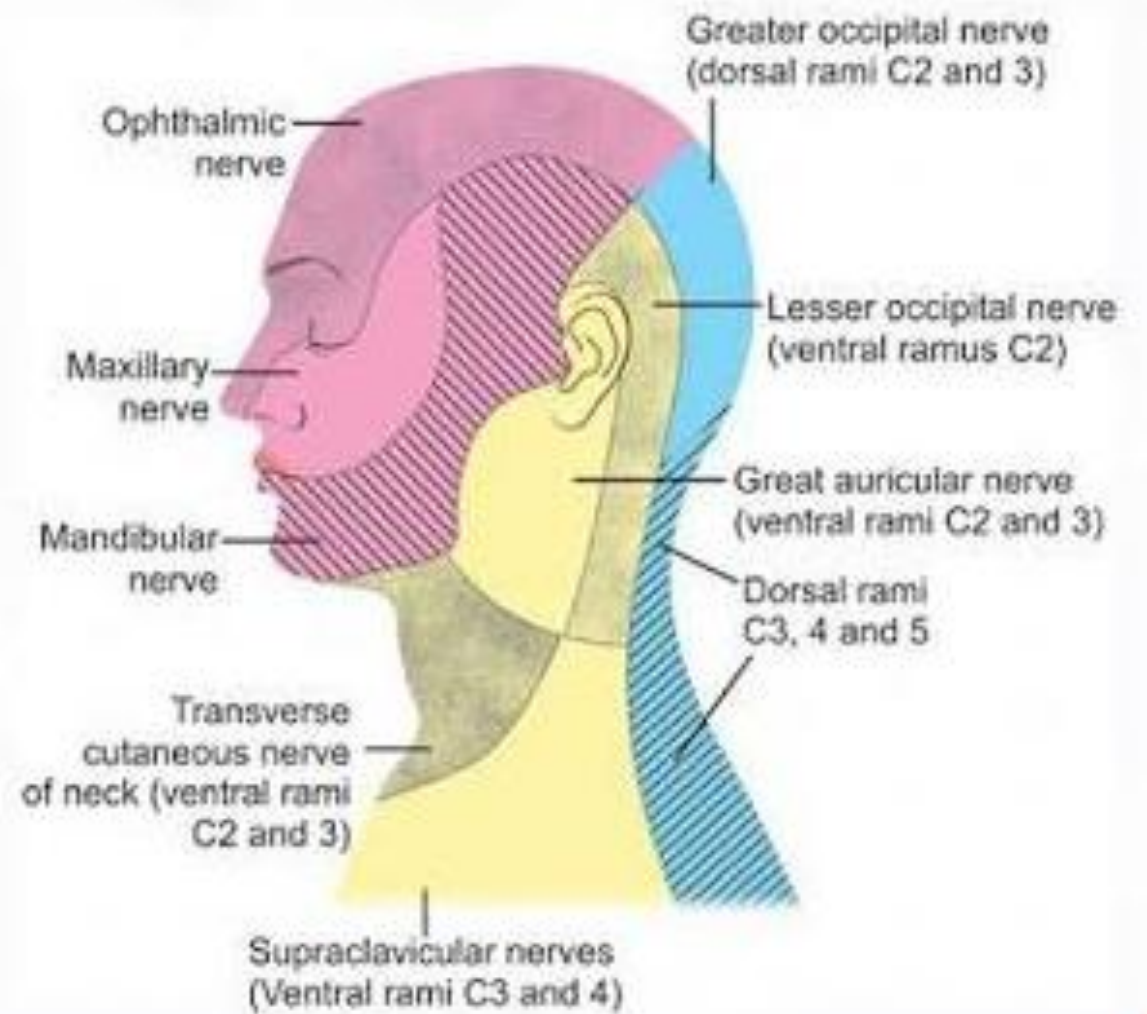
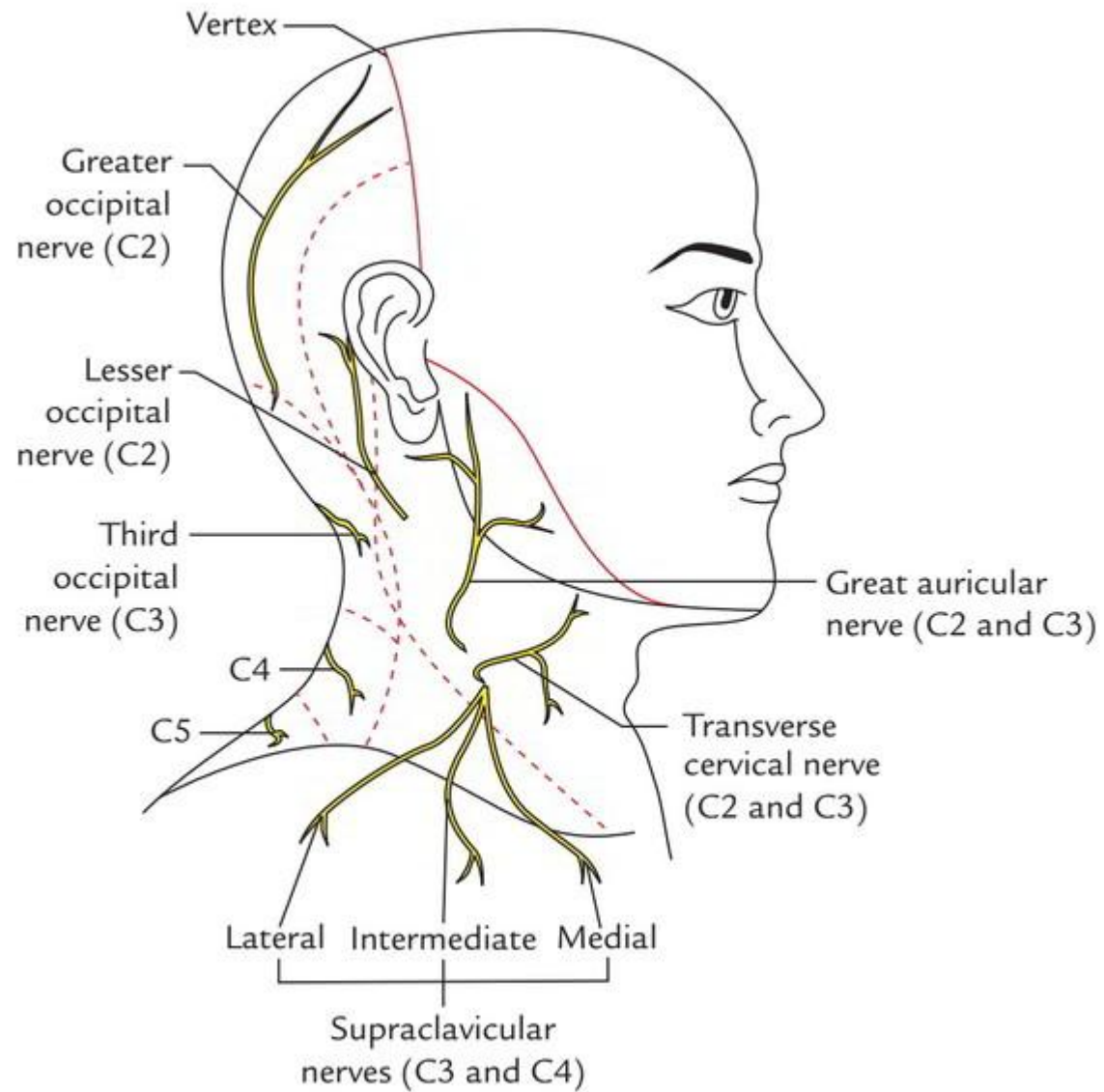
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- Zygomatic
- Buccal
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- Cervical
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- Risk:
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- **Marginal mandibular branch**
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- Risk:
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- **Buccal branches**
- Supply:
- Upper lip
- Buccinator
- Zygomaticus muscles
- Risk:
- Smile asymmetry

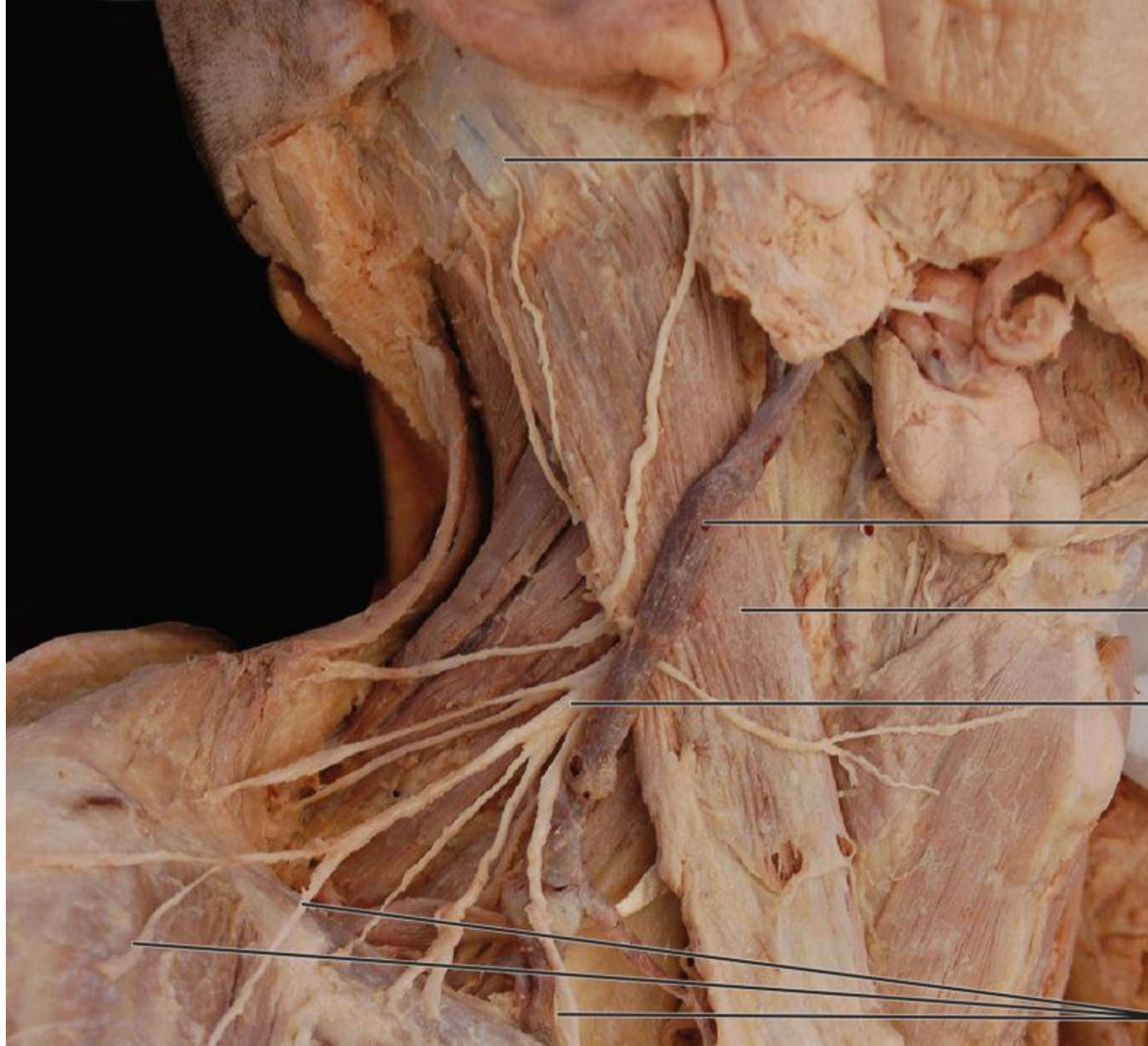












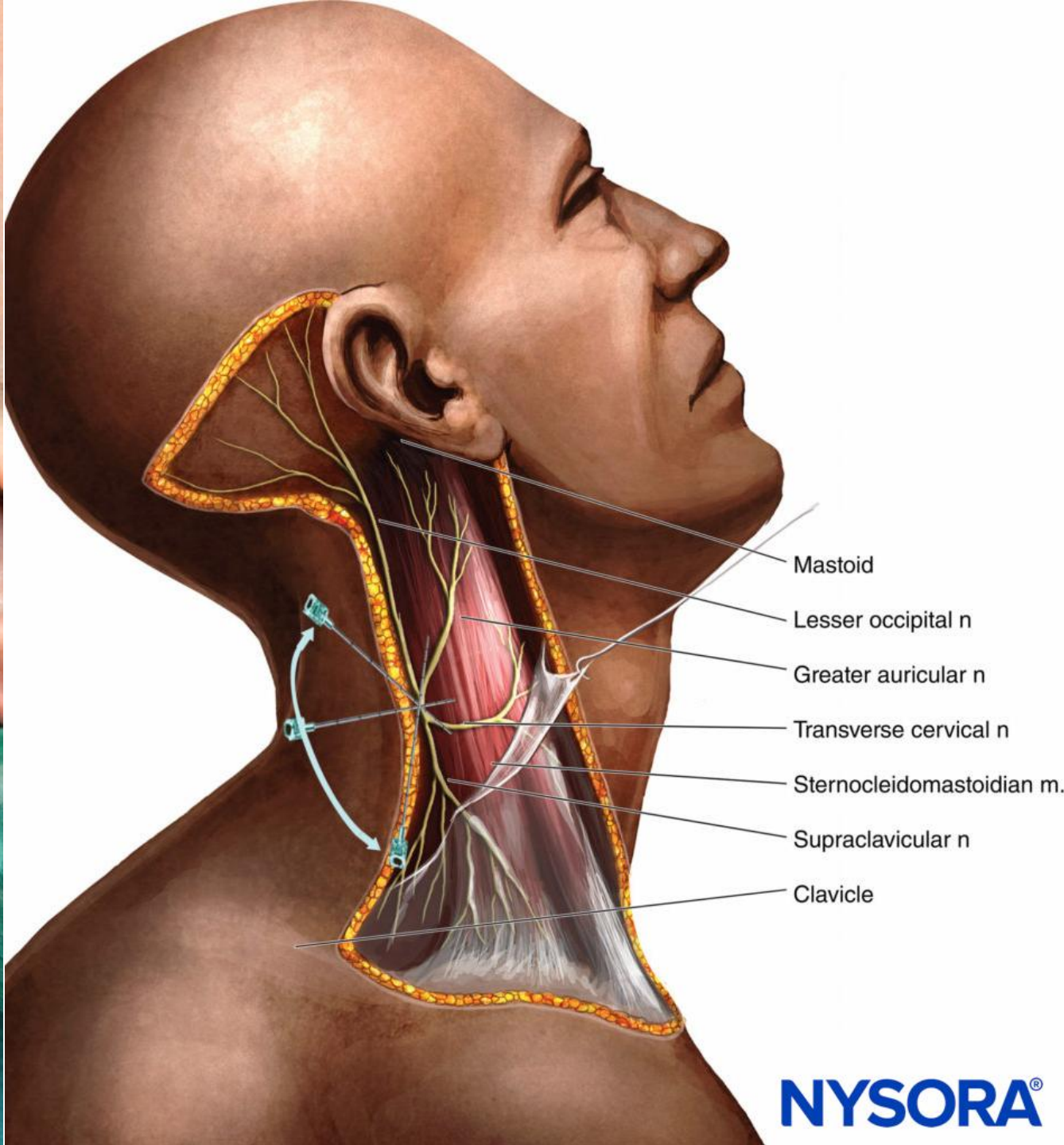
Mastoid process

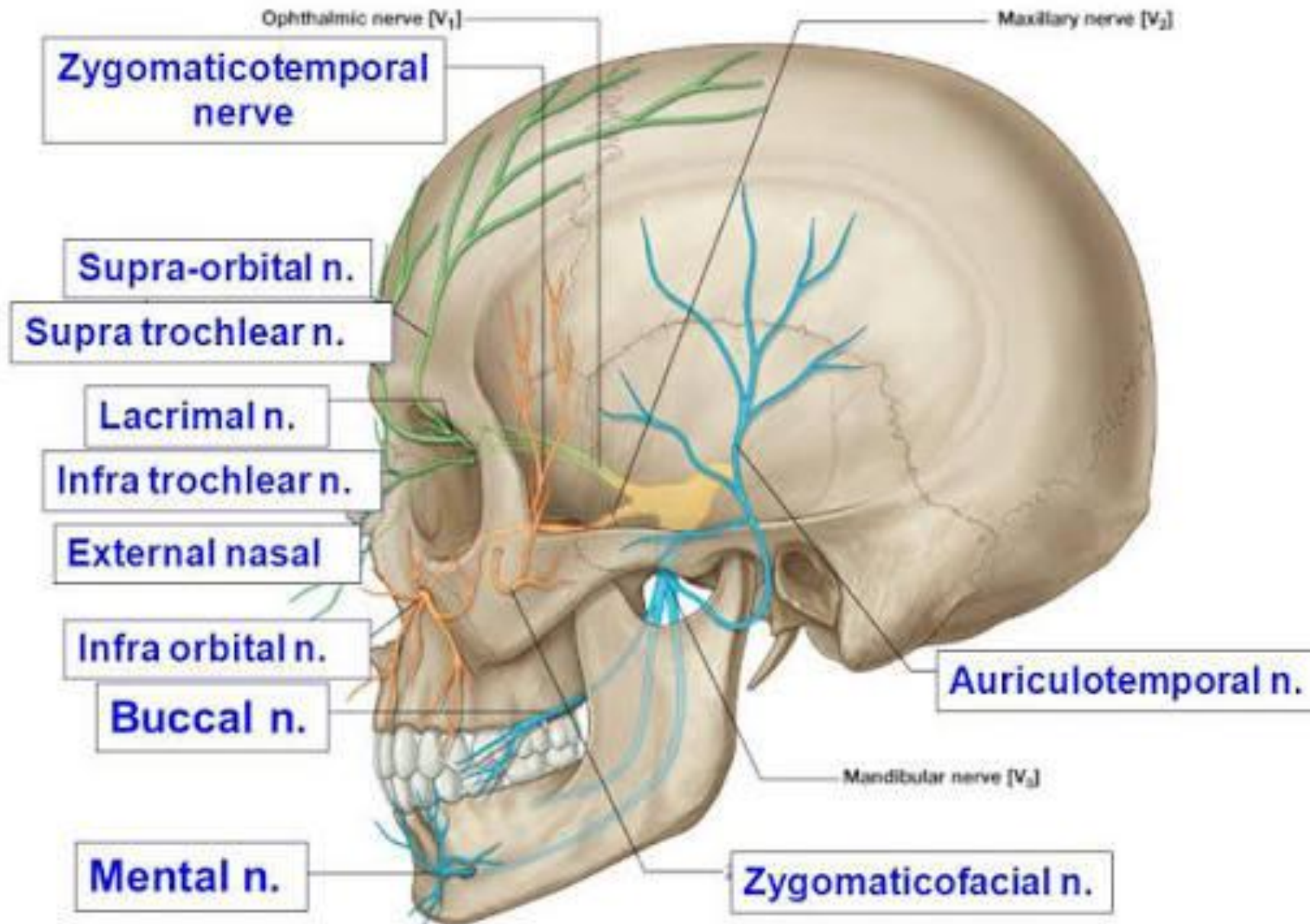
External jugular vein

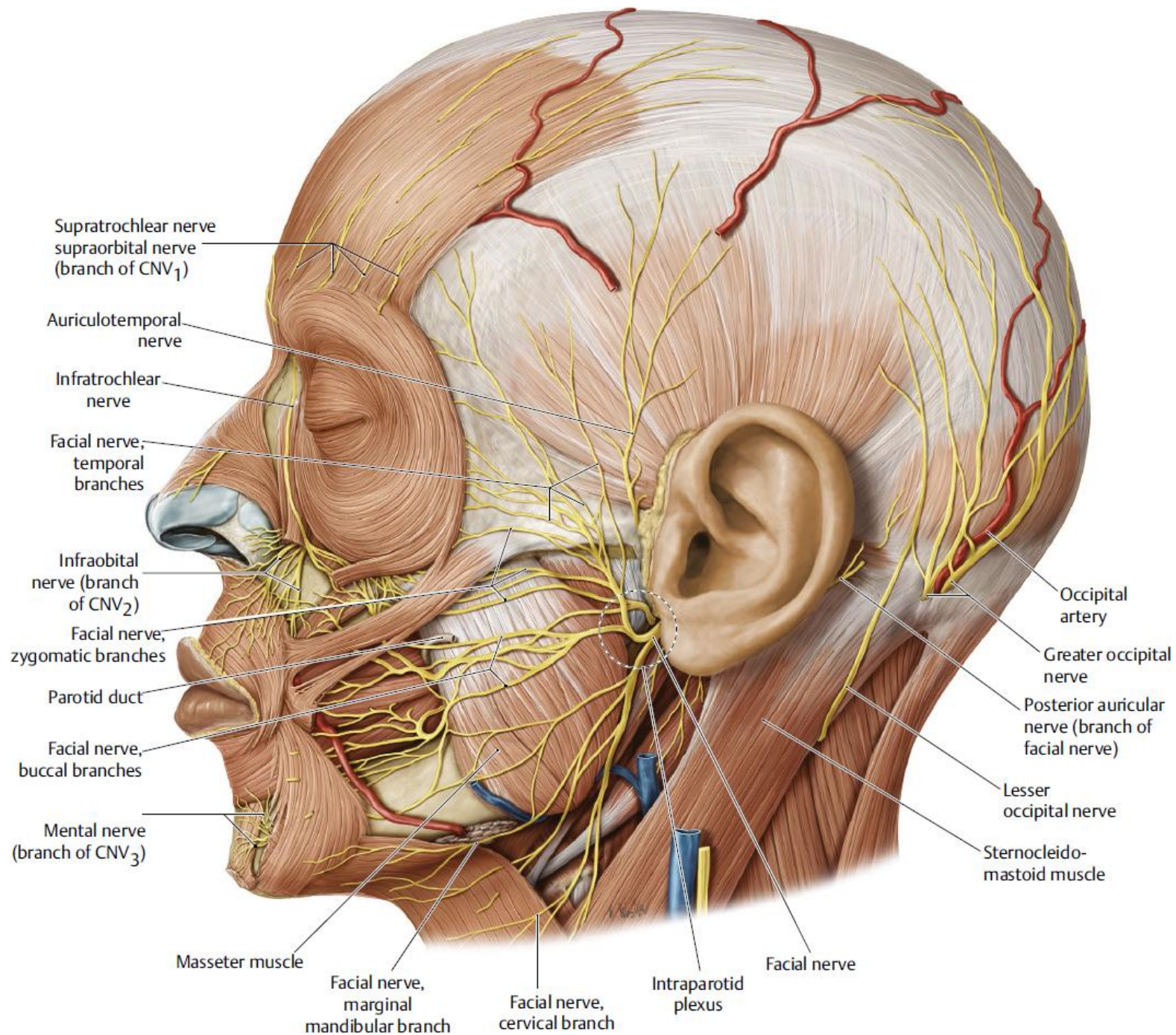
SCM

Cervical plexus
(point of injection)

Supraclavicular nerves







6. Sterility

- Because the thread is an implanted foreign material.
- Prevent:
- Skin contamination
- Hair contamination
- Makeup contamination
- Use:
- Chlorhexidine or povidone-iodine preparation (following product guidance and avoiding ocular exposure)
- Sterile gloves
- Sterile drapes
- Minimal handling of the thread

7. Immediate Complications

Bleeding

- Usually from:
- Facial artery branches
- Temporal vessels
- Management:
- Compression
- Cold packs
- Rarely evacuation

Hematoma

- Risk factors:
- Anticoagulants
- Hypertension
- Multiple passes

Pain

- May indicate:
- Nerve irritation
- Excessive tissue tension

- Incorrect depth

Skin dimpling

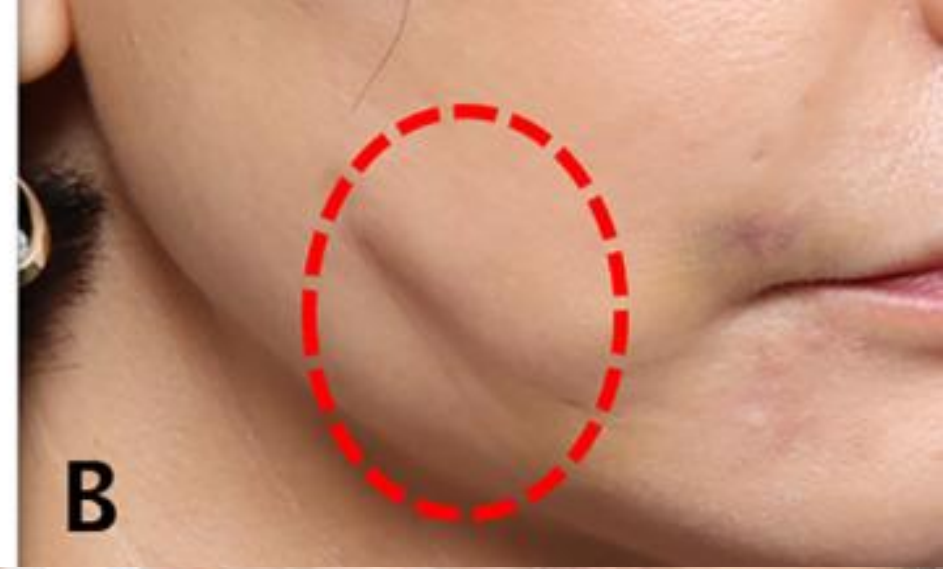
- Often due to:
- Excessive tension
- Superficial barbs
- Uneven tissue capture
- Many cases improve with massage after the initial healing period if appropriate for the thread type and timing.

Asymmetry

- Usually caused by:
- Different vectors
- Unequal tension
- Anatomical variation

Incorrect depth can result in:

- Skin dimpling
- Irregularity
- Tightening band
- Visible threads
- Poor lifting
- Nerve injury
- Vascular injury



8. Delayed Complications

Infection

- Signs:
- Redness
- Swelling
- Tenderness
- Purulent discharge
- Early treatment is essential; persistent infections may require thread removal.

Thread extrusion

- Usually from:
- Superficial placement
- Thin skin
- Poor technique

Thread migration

- Can occur if:

- Poor anchorage
- Weak tissue support
- Excessive facial movement early after treatment

Palpable thread

- Usually improves over weeks but may persist.

Thread breakage

- Often due to:
- Excessive traction
- Poor placement
- Manufacturing defects (rare)

Granuloma

- Although uncommon, foreign-body reactions can occur.

9. Post-procedure Instructions

- Recommend patients:
- Avoid vigorous facial massage

for approximately 2–4 weeks (or according to the thread system used)

- Sleep on their back with head elevated for several nights
- Limit exaggerated facial expressions initially
- Avoid strenuous exercise for about 1–2 weeks
- Avoid dental procedures and prolonged mouth opening for 2–4 weeks when treating the midface or lower face, if feasible
- Report increasing pain, redness, swelling, fever, or drainage promptly

- **Practical Tips to Reduce Complications**

- Mark anatomical landmarks before injecting local anesthetic, as swelling can obscure landmarks.
- Plan lifting vectors before making entry points.
- Advance the cannula gently without forcing through resistance; reassess the plane if resistance is significant.
- Palpate tissue thickness continuously during advancement.
- Avoid repeated blind passes in the same tract.
- Apply only enough tension to achieve the desired lift; over-tightening increases dimpling and discomfort.
- Confirm symmetry before trimming thread ends.
- Provide clear post-procedure instructions and arrange follow-up.