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Commentary

Rhytidoplasty and Blepharoplasty Performed by Dental Surgeons: Imminent Risks

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Rhytidoplasty, also known as facelift, is plastic surgical procedure performed with the objective of diminishing the marks caused by facial aging, such as wrinkles, creases, or deeper expression lines. These procedures can be performed together with others, such as blepharoplasty. Blepharoplasty is plastic surgery carried out with the aim of rejuvenating the eyelids and the eye region. The association of these aesthetic procedures is quite common, aiming at better results for the face as a whole [1].

Under local, or preferably general anesthesia, the excess skin that causes facial sagging is removed. Consequently, existing expression marks, creases, and wrinkles on the face are minimized. Theoretically, the scars resulting from the associated procedures are discrete. However, many of these procedures have been performed by dental surgeons and, due to technical and scientific questions, many serious complications have been observed [1].

The age to start these procedures is from 50 years old [1]. In this perspective, any procedure before this age, seems to become an aggression to the patient, even if intended by hers. The professional is responsible for the information, orientation and education of the patient, even if he declines the procedure and loses the case [2].

Among the main complications resulting from rhytidoplasty and blepharoplasty include post-surgical hematoma, with acute painful symptomatology, edema, ecchymosis, tense skin, trismus and anxiety; seroma (formation of serous content near the surgery scar); facial nerve lesion, with temporary facial weakness; auricular nerve lesion, with paresthesia, numbness and pain in the pre-auricular region; vascular congestion or arterial compromise and subsequent necrosis of the skin flap; formation of hypo- or hyperpigmented and hypertrophic scars; morphologic alterations of the ear, by tragal displacement and deformity of the earlobe or its direct adherence to the cheek ("goblin ear"); parotid duct injury, sialoceles; hair loss; poor aesthetic results [1,3-5]. Secondarily and less frequently, other complications such as infection and deep vein thrombosis can be observed. Deep vein thrombosis and pulmonary embolism are potentially devastating and can lead fatal complications of lifting procedures [1,3].

Attention should be paid to smoking. Smoking increases the risk of skin flap necrosis by 12 to 20 times. Acute symptoms of smoking include vasoconstriction and degenerative changes in the microvasculature, such as obliterative endarteritis, increasing the probability of thrombogenesis, poor wound healing and tissue hypoxia [1]. Anti-smoking campaigns by the dental surgeon, which sometimes is not addressed, should be part of our preventive and educational conduct.

Brilliantly, Nahai (2019) [5] cited that even though complications can and do occur, we agree that there can be some skepticism and disbelief about the professional responsibility of those performing the procedure. The author also cited that when a new procedure or technique is launched by "innovators", there are the so-called "early adopters" (professionals who will follow faster, without much scientific consistency, and higher risk). Then there

are the "early majority", the "late majority" and finally "the laggards". The latter have less reason to regret it. In Brazil, we observe this enthusiastic posture on the part of dental surgeons, especially the younger ones, in Orofacial Harmonization, considering only financial and economic gains on the part of professionals. Many times, patients do not require or do not want such procedures. However, it is important to emphasize that the professional will be held responsible for Civil Liability, under the precepts of negligence, imprudence and incompetence, being liable for material, moral and aesthetic damages in lawsuits [6-12]. Additionally, it is worth noting that there is Brazilian legislation prohibiting the performance of these procedures by dental surgeons [13].

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