

Current Applications of Facial Volumization with Fillers

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Learning Objectives: After reading this article and watching the accompanying videos, the participant should be able to: 1. Assess patients seeking facial volumization and correlate volume deficiencies anatomically. 2. Identify appropriate fillers based on rheologic properties and anatomical needs. 3. Recognize poor candidates for facial volumization. 4. Recognize and treat filler-related side effects and complications.

Summary: Facial volumization is widely applied for minimally invasive facial rejuvenation both as a solitary means and in conjunction with surgical correction. Appropriate facial volumization is dependent on patient characteristics, consistent longitudinal anatomical changes, and qualities of fillers available. In this article, anatomical changes seen with aging are illustrated, appropriate techniques for facial volumization are described in the setting of correct filler selection, and potential complications are addressed. (*Plast. Reconstr. Surg.* 137: 872e, 2016.)

Over the past three decades, anatomical advances by means of cadaver dissection and medical imaging have highlighted volume loss as a principal cause of facial aging. Initial volumization techniques emphasized dermal and superficial subcutaneous injections; however, recently, there has been a paradigm shift in treating the aging face with deep tissue correction. Because of the rapid expansion of minimally invasive cosmetic facial interventions, it is critical that aesthetic surgeons maintain proficiency in these approaches to optimize patient outcomes in a longitudinal and comprehensive manner. It is equally important to educate noncore medical specialists engaging in nonsurgical cosmetic rejuvenation about the limitations and dangers of these approaches and when such treatments may not be constructive for a given patient. This article instructs the reader about tissue dynamics of the aging face, current temporary soft-tissue fillers and injection techniques, detailed injection methods for the correction of specific facial zones of volume loss, and potential injection complications.

TEMPORARY FILLERS AND THEIR CHARACTERISTICS

The two principal categories of temporary fillers approved by the U.S. Food and Drug

Administration for facial rejuvenation are hyaluronic acid and calcium hydroxylapatite. The semipermanent filler polymethylmethacrylate, the biostimulator poly-L-lactic acid, and autologous fat represent distinct alternatives with unique biological properties and injection techniques, and thus are discussed here.¹⁻¹⁷ Hyaluronic acid fillers were introduced for intradermal injection in the United States in 2003 and have since become the predominant fillers for soft-tissue augmentation.¹⁸⁻²⁶ Current U.S. Food and Drug Administration–approved hyaluronic acid fillers are produced by means of nonanimal stabilized hyaluronic acid technology; however,

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Related Video content is available for this article. The videos can be found under the “Related Videos” section of the full-text article, or, for Ovid users, using the URL citations published in the article.

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Table 1. Commonly Used Hyaluronic Acid and Calcium Hydroxylapatite Fillers Currently Approved by the U.S. Food and Drug Administration*

Name	Elasticity (G')	Viscosity (n*)	HA Concentration (mg/ml)	Relative Injection Depth	Lidocaine	FDA Approval Date
Restylane†	514	119,180	20	Superficial-medium	No	2003
Restylane-L†	565	131,310	20	Superficial-medium	Yes	2010
Restylane Silk†	459	107	20	Superficial-medium	Yes	2014
Restylane Lyft†	549	127,090	20	Medium-deep	Yes	2010
Belotero Balance‡	30	9217	22.5	Superficial	No	2011
Radiesse‡	1407	349,830	NA	Medium-deep	No	2006
Radiesse(+)‡	~1180	~310,000	NA	Medium-deep	Yes	2015
Juvederm Ultra XC§	111	27,034	24	Superficial-medium	Yes	2006
Juvederm Ultra Plus XC§	136	32,152	24	Medium-deep	Yes	2010
Juvederm Voluma XC§	274	92,902	20	Medium-deep	Yes	2013
Prevelle Silk	230–260	NA	5.5	Superficial	Yes	2008

HA, hyaluronic acid; FDA, U.S. Food and Drug Administration; NA, not available.

All G' and n measured at 0.7 Hz, physiologically relevant for skin stress [Sundaram H, Voigts B, Beer K, Meland M. Comparison of the rheological properties of viscosity and elasticity in two categories of soft tissue fillers: Calcium hydroxylapatite and hyaluronic acid. *Dermatol Surg.* 2010;36(Suppl 3):1859–1865; and Kablik J, Monheit GD, Yu L, Chang G, Gershkovich J. Comparative physical properties of hyaluronic acid dermal fillers. *Dermatol Surg.* 2009;35(Suppl 1):302–312]. Relative injection depth is divided into superficial (deep dermis to superficial subcutaneous), medium (subcutaneous), and deep (deep subcutaneous to bone) levels, and should be tailored to the patient's soft-tissue quality and anatomy. Duration of product depends on injection depth, anatomical site injected, and product blending, and can range from a few months to several years. As discussed in the text, most filler applications are conducted off label.

†Galderma.

‡Merz Aesthetics, Lausanne, Switzerland.

§Allergan, Inc., Irvine, Calif.

||Mentor Corp., Santa Barbara, Calif.

novel fillers produced by means of alternate technologies such as the Emervel (Galderma, Lausanne, Switzerland) line, manufactured by means of optimal balance technology, will likely enter the market. Calcium hydroxylapatite (Radiesse; Galderma) is another temporary filler with properties similar to those of hyaluronic acids. In this article, we focus on hyaluronic acid- and calcium hydroxylapatite-based soft-tissue facial augmentation.

Temporary soft-tissue fillers are classified by their composition and rheologic properties, specifically, elasticity (G'), viscosity (n*), hydrophilicity, particle size, particle concentration, and crosslinking (Table 1).^{8,27} G' describes a material's ability to resist compression, whereas n* refers to a material's ability to resist shearing forces.⁸ Hydrophilicity is the product's capacity to attract water and expand. Particle size, as determined by the polymerization of the glycosaminoglycan chains and straining techniques, contributes to the filler's overall "lifting and filling power."^{8,28,29} Increased particle concentration and crosslinking strengthens hyaluronic acid durability by means of resistance to enzymatic degradation. These properties differ between fillers, with each product being characterized by a unique set of rheologic features. Consequently, these variables must be judiciously taken into consideration

relative to a patient's specific anatomy and soft-tissue characteristics during facial volumization (Figs. 1 and 2).

TEMPORARY FILLER INJECTION TECHNIQUES

Multiple injection techniques exist for soft-tissue volumization (Fig. 3). The proper technique is dependent on injector preference and training, product selected, and anatomical region addressed.³⁰ For superficial and dermal filling, injectors most often use a threading approach, or less often, fanning or cross-hatching techniques in a retrograde or anterograde manner. Deep volumization techniques in the subcutaneous and periosteal planes more frequently include tower-ing, layering, and depot injections. Irrespective of injection technique and tissue depth, aspiration before product injection is recommended to avoid intravascular injection. Product blending with sterile saline, lidocaine, or lidocaine with epinephrine may be chosen in specific anatomical zones and product combinations to tailor rheologic properties.

Injectors have recently begun using blunt cannulae in place of sharp needles.^{31,32} This technique may lead to increased patient comfort, a reduction in edema and ecchymoses, and a more

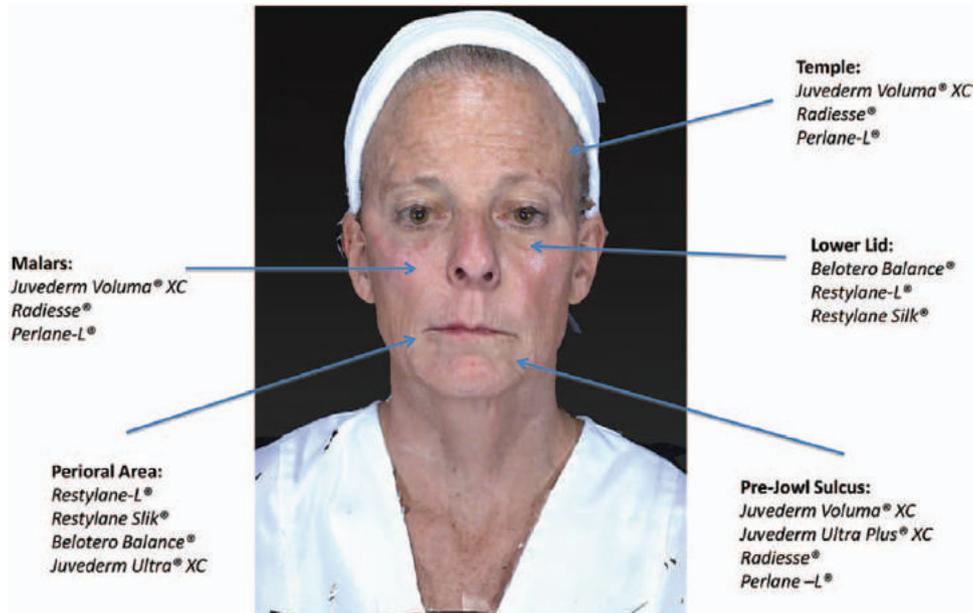


Fig. 1. Image demonstrating suggested filler choices per region. Notably, fillers listed here may not have a U.S. Food and Drug Administration–approved indication for the particular region and are therefore used in an off-label fashion. Fillers with high G' and n^* are best for deep augmentation of the face, whereas fillers with low G' and n^* are best for subcutaneous and dermal volumization.

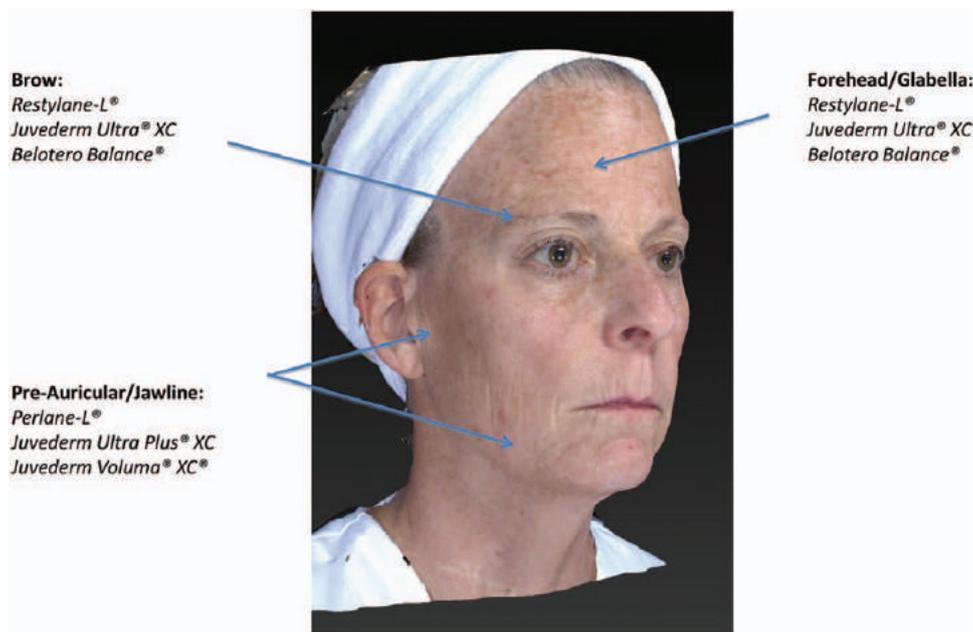


Fig. 2. Image demonstrating suggested filler choices per region. Notably, fillers listed here may not have U.S. Food and Drug Administration–approved indication for the particular region and are therefore used in an off-label fashion. Fillers with high G' and n^* are best for deep augmentation of the face, whereas fillers with low G' and n^* are best for subcutaneous and dermal volumization.

predictable recovery. (See Video, Supplemental Digital Content 1, which displays how the nasojugal groove is treated with a blunt cannula technique, available in the “Related Videos” section of

the full-text article on www.PRSJournal.com or at <http://links.lww.com/PRS/B692>.) Cannulae may be preferable to needles in regions prone to bruising or at higher risk for potential intravascular

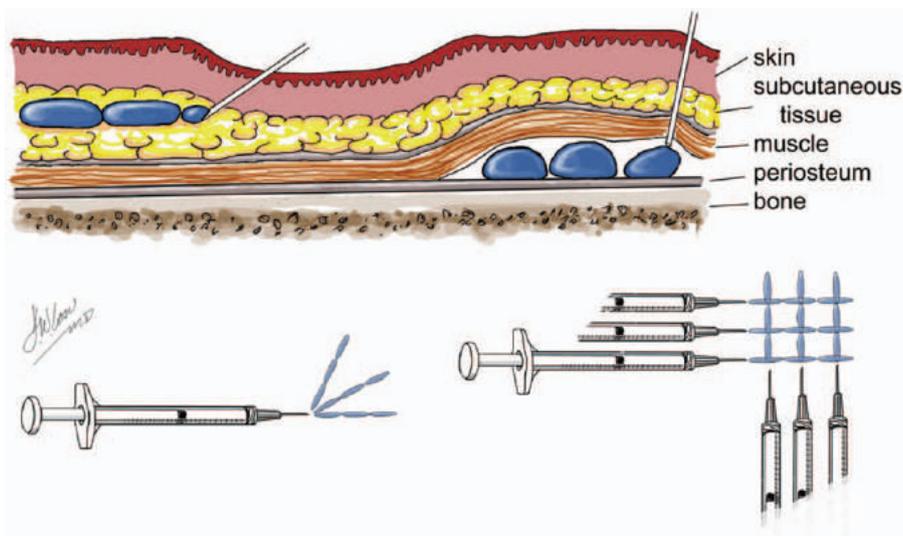


Fig. 3. Injection techniques. (Above, left) Linear threading. Here the needle is inserted and gently retracted while placing consistent pressure, creating a linear deposit of filler. This method, as shown here, is appropriate for subcutaneous and dermal filling of folds and fine lines. (Above, right) Depot injections. For deeper injections the needle is advanced to the level of the bone and retracted slightly. Bolus amounts of filler are then deposited. This technique is often used for malar augmentation with high-G' fillers. (Below, left) Fanning technique. From a single insertion point, the needle is pivoted in multiple angles, placing the product in linear threads along multiple planes. (Below, right) Cross-hatching technique. Used for larger areas for an even distribution of filler. This is appropriate for dermal and subcutaneous filling.



Video 1. Supplemental Digital Content 1, which displays how the nasojugal groove is treated with a blunt cannula technique, is available in the “Related Videos” section of the full-text article on www.PRSJournal.com or at <http://links.lww.com/PRS/B692>.

injection, or when the patient cannot tolerate a standard recovery period. Despite these benefits, many injectors still prefer needle injection techniques, citing additional training for using cannulae, increased cost, difficulty threading the cannulae, and impaired ability to treat all areas effectively. It remains to be determined whether cannula-based techniques will expand and

potentially replace needle-based approaches in the United States.

CHARACTERIZING AND TREATING FACIAL VOLUME LOSS

For consistent and effective facial analysis, it is helpful to consider the topography of the face as being divided into thirds (i.e., the upper face, midface, and lower face). Each region undergoes characteristic volume atrophy or hypertrophy that is combined with increased overall facial strain and an overall decrease in soft-tissue integrity (Fig. 4).^{33–46} Specific changes vary between individuals depending on the patient’s underlying bony structure, weight, and soft-tissue quality.¹⁶ In this article, the anatomical changes associated with aging are described for each third of the face, from the top down and deep to superficial, to simulate clinical scenarios for facial assessment and structural volumization design. For each region, volume correction will address bony and soft-tissue atrophy. Rhytide-specific and superficial (deep-dermal) augmentation is highlighted last as a finishing effect, after structural volumization. Patient assessment

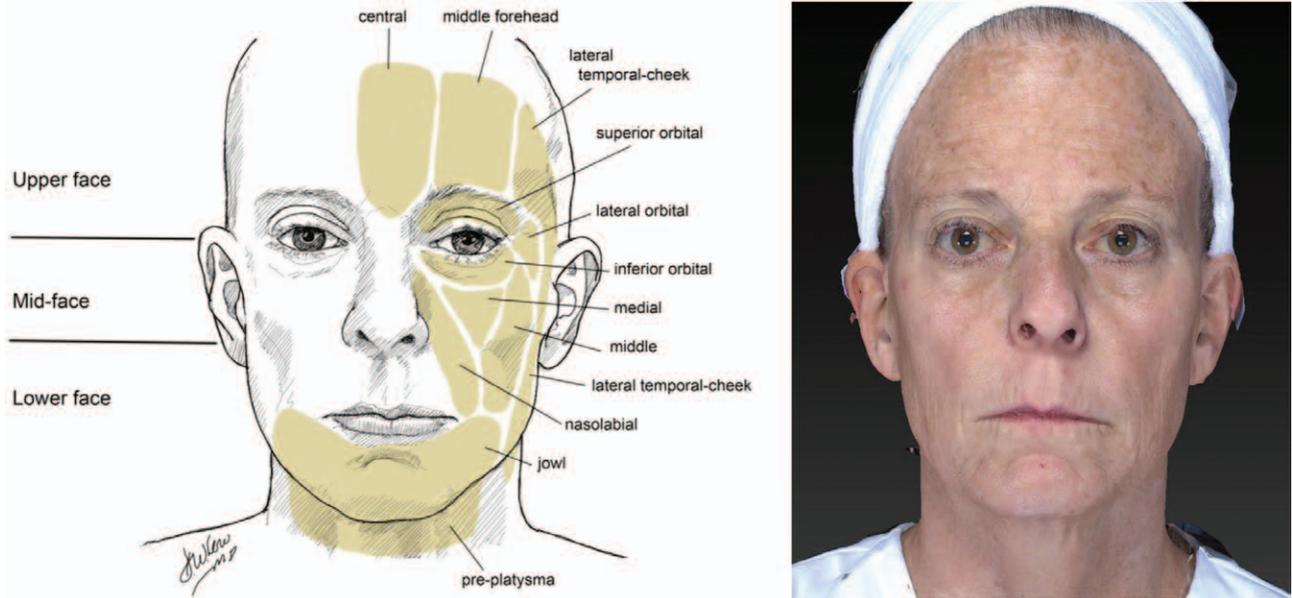


Fig. 4. During facial analysis, the topography of the face is often divided into the upper face, midface, and lower face. For volumization assessment, the upper face is composed of the temples, brows, and periorbital areas, and occasionally the forehead. The mid-face is composed of the malar, submalar, and preauricular regions; the nasolabial folds; and the nose. The lower face is composed of the posterior, middle, and anterior jawline; the perioral area; and the lips. Each region contains anatomically compartmentalized fat pads (labeled), which undergo characteristic and often predictable volume changes.

for each facial region is described, as is the rationale for filler selection and injection techniques. Examples of total facial volumization are provided (Figs. 5 and 6).

METHODOLOGY

Patients that were appropriate medical candidates for filler injections were selected for characteristic age-related facial volume loss. Patients were instructed to avoid aspirin and nonsteroidal antiinflammatory drugs for 1 week before injection. Patients' faces were washed of makeup, and three-dimensional images were taken with the Canfield Vectra System (Canfield Scientific, Fairfield, N.J.) and by means of standard digital photography. LMX 4% topical anesthetic cream (Ferndale Laboratories, Inc., Ferndale, Mich.) was applied to areas to be injected for 15 minutes. The LMX cream was removed and the patients' faces were cleansed first with isopropyl alcohol (70%) and then with chlorhexidine gluconate 4% solution immediately before injection. Injections were conducted as described in the figure legends and videos. After the procedure, injection sites were treated with cold packs for 10 minutes followed by photography. Repeated images of patients were obtained 2 weeks after injection.

Upper Face: Temples, Brows, and Superior Periorbital Area

The youthful upper face is characterized by a subtle convexity of the temple, forehead, and lateral brow and fullness of the upper eyelids.¹⁶ During aging, there is incremental volume loss in these regions. Although the severity of volume loss varies between patients, the ensuing temporal narrowing and periorbital hollowing remain underrecognized and undertreated.^{39,47} Temporal narrowing may result in decreased lateral brow support, with consequent lateral brow ptosis and pseudodermatochalasis of the upper lid. These changes give an overall tired, aged appearance to the upper face, and often represent the first signs of facial aging in the fourth decade of life (Fig. 7).

Upper facial volume loss is secondary to both bony and deep soft-tissue changes. Specifically, there is remodeling of periorbital bone in the superomedial and inferolateral directions, resulting in an altered and vertically lengthened orbital aperture, and an increased susceptibility to lower lid hollowing and contour deformities.^{37,41,42,48,49} Soft-tissue atrophy of the upper face occurs in defined sites of adipose deposition. At the temple, the deep temporal fat pad and the temporal extension of the buccal fat pad atrophy. The forehead and lateral brow undergo thinning of the subcutaneous plane, and the upper lids typically



Fig. 5. This 57-year-old patient has panfacial volume loss in the setting of low body mass index and extrinsic aging secondary to prolonged solar exposure. Both images are of her right side, with the postinjection photograph a mirror image 2 weeks after injection. In the upper face, there is mild volume loss at the temple and upper orbital rim. There is significant volume loss of the lower periorbital region with prominent lower lid bags and tear trough deformity. In the midface, there is significant atrophy of the medial and middle malar fat pads. In the lower face, the upper lip has lengthened and there is significant atrophy of cutaneous and mucosal/vermillion lip with a prominent submental sulcus. She received 2 cc of Juvederm Voluma XC to the bilateral malars, 1 cc of Juvederm Voluma XC to the preauricular region bilaterally, and 1 cc to bilateral jaw lines and prejowl sulcus; 1.5 cc of Radiesse was placed into each temple. Each lower lid and nasojugal groove was filled with 0.5 cc of Belotero Balance. The perioral region was augmented with 1 cc of Restylane-L in the oral commissure and lip columns and an additional 1 cc of Restylane Silk to the upper and lower lip vermilions and vermillion border. Three-dimensional progressive augmentation images are demonstrated in Figure 11.

lose volume in the retro-orbicularis oculi fat pad and the medial and lateral fat pads.

The correction of upper facial volume loss at the temple and the upper brow requires fillers with appropriate rheologic properties for deep volumization, specifically an elevated G' and n^* , whereas fillers for volumization of the upper lid, forehead, and crow's feet should possess lower G' and n^* profiles (Figs. 1 and 2).^{50,51} Currently, there are no U.S. Food and Drug Administration–approved fillers for treatment of these regions and thus fillers are used in off-label fashion for these



Fig. 6. A 58-year-old woman with upper facial volume loss resulting in an aged appearance. Both preinjection and postinjection images are of her right side, with the postinjection image being a mirror image. The patient has not undergone any surgical or minimally invasive treatment. In the upper face, there is atrophy at both the temple and the brow. Before injection, the temple demonstrates significant hollowing, with prominent zygomatic arches, orbital rims, and temporal crests. In addition, there are prominent veins and stigmata of solar elastosis of the skin overlying the temple. In the lower face, there is loss of vermillion volume and emphasized jowls secondary to volume loss in the prejowl sulcus. Given its rheologic properties, Juvederm Voluma XC is used for upper facial augmentation in this patient, although Radiesse and Restylane Lyft are also acceptable options. One cubic centimeter of product was required in each temple for appropriate effacement of temporal hollow, blending of temporal crest, and softening of the prominent orbital rim and zygomatic arch. A total of three injections were performed in each temple: 0.5 cc of Restylane-L was injected into the lateral brow, and a total of 0.5 cc of Belotero Balance was injected into the medial and lateral orbital rims. Thirty units of abobotulinumtoxinA was injected into the lateral orbicularis oculi, and 10 units of onabotulinumtoxinA was injected into the frontalis. The result is a natural softening of the superior and inferior orbital rim and effacement of the pronounced temporal crest and zygomatic arch. In the mid and lower face, she had 1.5 cc of Juvederm Voluma XC to bilateral malars, 0.5 cc of Juvederm Voluma XC to the nasal sill, and 0.5 cc of Restylane Lyft to the prejowl sulcus bilaterally; 1 cc of Restylane-L was injected into the lips and commissures.

indications. Restylane Lyft, Radiesse, and Juvederm VolumaXC and Juvederm Ultra Plus XC are suitable for the deep treatment of the temple and upper brow.⁵⁰ The increased G' of these products



Fig. 7. (Above) A 57-year-old woman without any prior facial surgery or volumization. (Left) Photograph illustrating the youthful face (age 21 years). With age (above, center and above, right), there is volume loss in the highlighted regions, specifically, the temporal fat pad, the malar fat pads, the nasal sill, and the prejowl sulcus. All of these regions are amenable to volumization. (Below) Patient at age 21 (below, left) and at age 59 years (below, right). Notably, in the upper face, there is volume loss at the temples and superior orbital rim. In the midface, there is mild volume loss of the inferior orbit and slight malar deflation. In the lower face, there is perioral volume loss with effacement of the vermillion border and vermillion and volume loss at the prejowl sulcus with resultant jowls.

allows for precise placement on the periosteum, providing structural and lifting support to overlying tissues with a low likelihood of displacement. Restylane-L, Restylane-Silk, Belotero Balance, and Juvederm Ultra XC are suitable fillers for superficial treatment of the temple, upper brow, and eyelid. Selection is based on injector experience, desired product duration, and cost.

We have come to appreciate that the anatomical order of contouring influences the ultimate outcome of facial volumization. Augmentation of the temple alone may provide lateral brow support and therefore should be addressed before moving more caudally. When injecting the temple, careful attention must be paid to the location of temporal

vessels and superficial veins (Fig. 8). Our preferred injection plane is supraperiosteal. Using a 27-gauge needle and the perpendicular depot technique, the needle is advanced to the periosteum. Aspiration is performed and the product is deposited. Serial injections are associated with an increased risk of ecchymosis and injury to critical structures, but may provide more discriminative results. (See Video, Supplemental Digital Content 2, which displays potential techniques for upper facial volumization, with a focus on the temple and the brow, available in the “Related Videos” section of the full-text article on www.PRSJournal.com or at <http://links.lww.com/PRS/B693>.) This approach, in our opinion, provides the longest lasting and

added to the subcutaneous fat of the brow and/or retro-orbicularis oculi fat pad (see **Video, Supplemental Digital Content 2**, <http://links.lww.com/PRS/B693>). Notably, some authors advocate direct suborbicularis injection in the upper lid. Although direct injection in this plane may provide an effective way of correcting upper lid hollowing, given the proximity to the globe and its vasculature, this approach poses additional risks and should be limited to expert injectors.

Midface: Inferior Periorbital Area, Malars, Maxilla, and Nasolabial Fold

Midface deflation manifests as loss of malar projection and nasal support, with accentuation of the lower eyelid contour. Photographic, radiographic, and cadaver studies confirm age-related bony loss of the orbit and maxilla, and a posterior rotation of the maxilla leading to a decrease in the maxillary angle and widening of the pyriform aperture.^{49,52-54} These changes are accompanied by

atrophy of inferior lid fat compartments, the sub-orbicularis oculi fat, and laxity of the orbicularis oculi and associated orbitomalar ligament.^{44,46,55,56} The resulting effect on the lower periorbital region is a decrease in the lateral canthal angle, descent of the lateral canthal tendon, loss of lower eyelid tone and hollowing, and the characteristic tear trough deformity (Fig. 9). The deflated midface is marked by prominent transitions between cheek fat pads, flattening of the malar prominence, increased nasolabial fold depth, lengthening of the cutaneous upper lip, and overall loss of lip volume.^{57,58} Consequently, accurate assessment of midface volume loss is the single most important factor for appropriate correction of facial volume, as precise restoration can rejuvenate both the upper and lower face.

We advocate correction of the malars before tear trough, lower lid, and nasolabial fold injection. This holds true for the majority of patients, in whom malar volume loss contributes to nasolabial

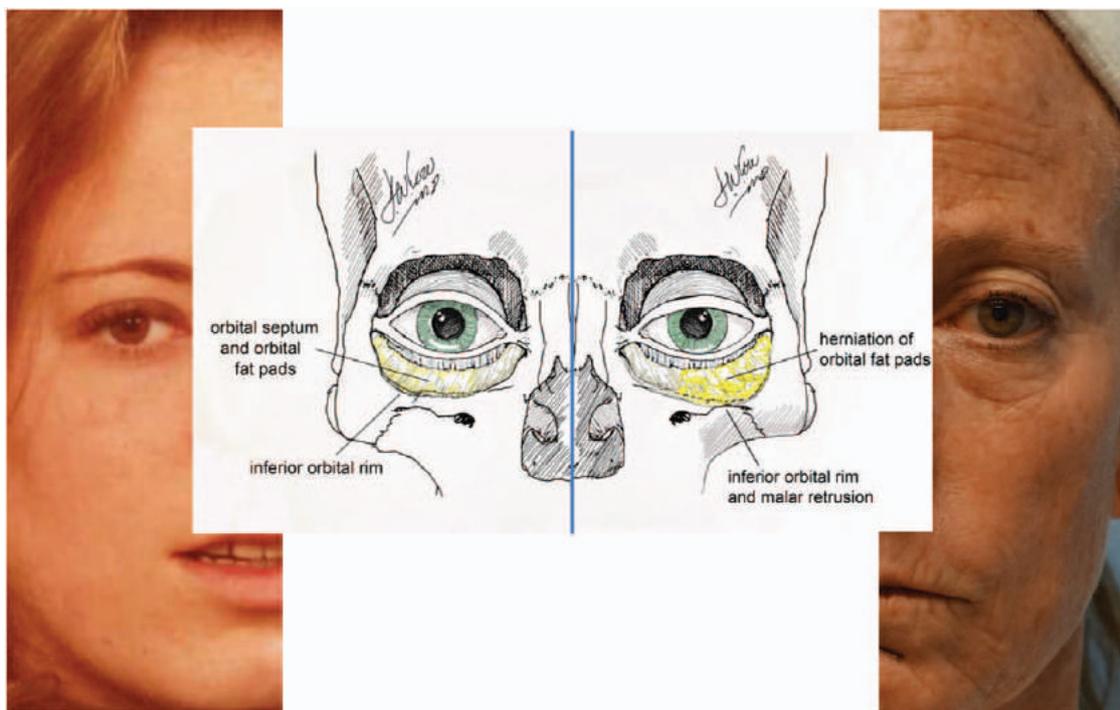


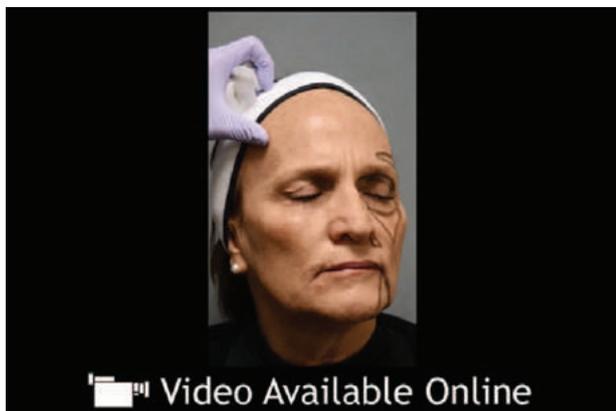
Fig. 9. Lower lid contour is affected by anatomical changes in intrinsic lower lid tissues including atrophy of inferior lid fat compartments, atrophy of the suborbicularis oculi fat, laxity of the orbicularis oculi and associated orbitomalar ligament and, importantly, volume atrophy of the malar region. This constellation of changes is often manifested as a double convexity with prolapsed orbital fat as a superior convexity that is separated from the inferior convexity of the descending malar mound by the skeletonized orbital rim. The medial soft-tissue atrophy of the orbital rim, characterized as the tear trough deformity, or nasojugal groove, extends inferolaterally to accentuate the malar mound and is an easily recognized site of volume atrophy. Less commonly appreciated, however, is the volume atrophy of the lateral orbital rim, which frequently requires augmentation for a cohesive natural result. This image demonstrates the periocular changes that occur with aging. (Left) Patient at age 21 years; (right) patient at age 57 years.

fold severity and the tear trough. The exception, in our opinion, is the rare patient who presents early in the aging process with isolated, fine nasolabial fold rhytides or nasojugal grooves and no discernible malar volume loss. With the exception of Juvederm Voluma XC, no fillers are currently U.S. Food and Drug Administration approved for malar enhancement.^{59,60} Nevertheless, Restylane Lyft, Radiesse, and Juvederm Ultra Plus XC are suitable fillers for deep treatment of the malars, given their elevated G' and n^* (Figs. 1 and 2). Malar injection should be performed in the supra-periosteal or fat pad plane using a depot, stacking, or tower technique, after aspiration. (See **Video, Supplemental Digital Content 3**, which shows a midface volumization with attention to the malar region, available in the “Related Videos” section of the full-text article on www.PRSJournal.com or at <http://links.lww.com/PRS/B694>.) The location of the infraorbital foramen should be appreciated and avoided when treating the anteromedial malar compartment. The quantity of filler used is dependent on the degree of atrophy and product used, typically an average of 1 to 2 cc per side. Careful attention should be paid to restorative effects on the lower lid, nasolabial fold, nasal base, and upper lip during malar augmentation.

If, following malar augmentation, direct correction of the medial or lateral orbital rim is warranted, we advocate conservative linear threading in the supraperiosteal plane with meticulous preinjection aspiration to avoid intravascular injection and catastrophic retinal artery occlusion.⁶⁰ It should be noted that other injectors have reported equally successful results with alternative techniques. The use of cannulae to

avoid vascular injury and minimize bruising in this area is ideal. (See **Video, Supplemental Digital Content 1**, <http://links.lww.com/PRS/B692>. See **Video, Supplemental Digital Content 4**, which displays a needle-based, sharp technique of nasojugal groove treatment, available in the “Related Videos” section of the full-text article on www.PRSJournal.com or at <http://links.lww.com/PRS/B695>.) Treatment of the crow’s feet as an adjunct to periorbital volumization may be conducted in the deep dermal plane using a threading or crosshatching technique. We prefer Restylane-L, Restylane Silk, or Belotero Balance blended with 1% lidocaine and 1:100,000 epinephrine for volumization of the skeletonized orbital rim and crow’s feet and recommend avoidance of hydrophilic products or those with high G' and n^* profiles in this area. This approach encourages minimal contour deformities, edema, and ecchymoses.

Deep volumization at the level of the nasal sill can provide support to the aging nasal tip; a natural correction of the upper nasolabial fold; and, often, a minor lift to the upper lip. Much like the temple and malar regions, we advocate that enhancement at this level requires periosteal placement of high G' , large-particle fillers. In this approach, the needle is placed at the lateralmost point of the alar base; advanced down to the periosteum, superior to the dentition and deep to the oral mucosa; and, after aspiration, a single depot of filler (approximately 0.3 to 0.5 cc per side) is placed. Injection in this plane should provide a natural restoration of age-related maxillary deficits and avoid the major facial vessels that course in a more superficial plane.



Video 3. Supplemental Digital Content 3, which shows a midface volumization with attention to the malar region, is available in the “Related Videos” section of the full-text article on www.PRSJournal.com or at <http://links.lww.com/PRS/B694>.



Video 4. Supplemental Digital Content 4, which displays a needle-based, sharp technique of nasojugal groove treatment, is available in the “Related Videos” section of the full-text article on www.PRSJournal.com or at <http://links.lww.com/PRS/B695>.

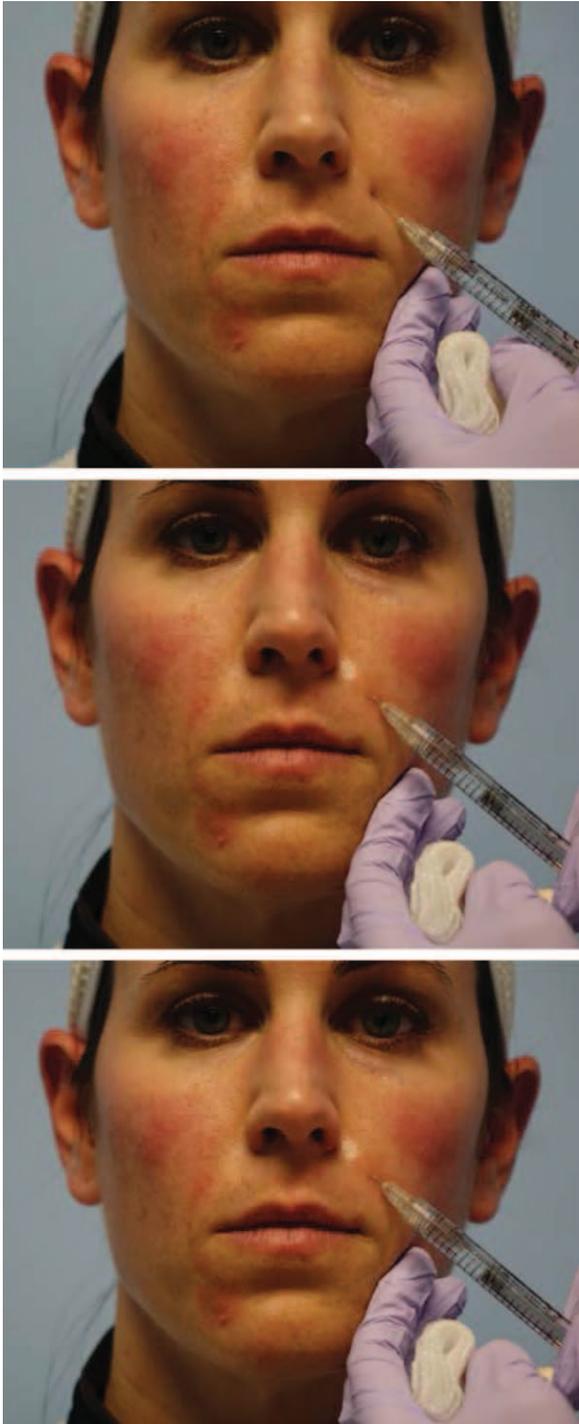


Fig. 10. After malar augmentation and correction, direct nasolabial fold correction should be performed with the fanning or retrograde injection technique within and medial to the fold. Augmentation lateral to the fold should be avoided (as this leads to a more prominent defect), as should complete effacement of the fold to prevent the overfilled boxy appearance of the mouth and anterior face. We support treatment of the nasolabial fold with fillers characterized by moderate elasticity and viscosity such as Restylane-L or Juvederm Ultra XC. Injection planes can range from superficial to deep; however, when combined with

Correction of the nasolabial fold merits specific mention. Although this site was the first to be approved by the U.S. Food and Drug Administration for treatment and continues to be the only approved site of injection for many fillers in the United States, we maintain that the nasolabial fold is overtreated and misunderstood. Unlike the remaining face, the nasolabial fold hypertrophies with age. Fillers in this region, in our opinion, should be used to soften a prominent fold and *not* to volumize. Because the nasolabial fold is most often the patient's chief complaint, it is essential for injectors to educate patients that correction of malar volume will more naturally and effectively treat the aging face. We therefore advocate that deficient malar volume should be corrected before the nasolabial fold. Once the malar region has been augmented, the residual nasolabial fold can be softened conservatively (Fig. 10). (See **Video, Supplemental Digital Content 5**, which displays a technique of nasolabial fold filling, available in the "Related Videos" section of the full-text article on www.PRSJournal.com or at <http://links.lww.com/PRS/B696>.)

Lower Face: Jawline, Perioral Area, and Lips

The general widening and loss of integrity of the lower face can be perceived as a relative increase in volume at the jowls with a concomitant decrease in jawline strength and perioral and lip volume. The jowls, characterized anatomically as three fat pads separated by an intervening septum, become more prominent with age secondary to deflation of the superficial fat exposing deeper fat pads, descent of deep fat pads, and increased septal laxity. These changes are exacerbated by volume loss in the region anterior to the jowls, the prejowl sulcus, and volume loss posterior to the masseter in the posterior jawline and inferior preauricular region.^{45,61–64} The perioral area undergoes both superficial and deep atrophy. This is manifested as a lengthening and flattening of the upper lip complex, and a loss of vermilion and vermilion border volume with formation of vertical perioral rhytides (Fig. 11). There is a concomitant downturning of the oral commissure

Fig. 10. (Continued). nasal base augmentation in the supraperiosteal plane, we prefer the superficial subcutaneous plane, just deep to the dermis, to avoid the facial vessels that travel in the deeper subcutaneous tissues and become more superficial as they course superiorly in the face. As with malar and alar base augmentation, injections of the nasolabial fold can be performed with the classic sharp needle or cannula technique.