**BACKGROUND**

Ptosis of excess chin soft tissue is a problem encountered among a subset of patients seeking treatment for the aging face but can also be seen less commonly among younger patients with a predilection for development of the so-called “witch’s chin.”

The stigma associated with the appearance can be quite disturbing to the individual, and correction of this deformity offers tremendous benefit to patients seeking facial rejuvenation. Several techniques with varying complexity have been proposed over the years in an effort to address the issue.

**METHODS / PATIENT SELECTION**

We report the essential elements of the senior author’s preferred technique developed over years of experience and review the current literature with an emphasis on the importance of an accurate preoperative assessment to evaluate the underlying factors leading to chin ptosis.

The patients selected for review were dissatisfied with chin ptosis and self-conscious regarding the associated stigma. These patients also had concerns regarding more generalized facial aging changes that were also addressed. In our experience, patients seek isolated chin ptosis correction less frequently. This report does not address iatrogenic causes of chin ptosis such as those associated with chin implant placement / removal or repair of mandible fractures.

**TECHNIQUE**

Proper preoperative evaluation is critical because failure to correct the chin deformity can lead to an unsightly prominence following additional aging face surgical procedures (Fig 3). The patient should be examined at rest and while smiling, as this often elicits an exaggerated dynamic component of chin ptosis (Fig 4). The inferior border of the mandible can be marked to highlight redundant ptotic soft tissue below this line that can be excised.

An elliptical excision is performed at the submental crease incorporating some of the tissue anterior to the crease similar to that proposed by Feldman in 1992. Soft tissue excess is often exacerbated by underlying structural abnormalities of the anterior mandible including bone resorption associated with aging and the edentulous mandible. This point should not be overlooked as the final aesthetic result of a direct skin and soft tissue excision may not always be ideal when additional preoperative abnormalities of the mandible or anterior neck are not addressed.

The technique presented for chin ptosis correction is a simple and reliable option with versatility in correcting the stigma associated with ptotic chin soft tissue in a wide variety of patients with static and dynamic chin ptosis. It can be used as a stand-alone procedure or as an adjunct to a neck and lower facelift.

Skin and subcutaneous soft tissue is removed in a direct excision fashion as needed based on the degree of chin ptosis present (Fig 5). No suspension sutures to lift ptotic tissue are needed. A chin implant can be used to restore or augment anterior projection if desired, and this is an appropriate option for many patients.

A simple skin closure is performed without the need for surgical drains. This direct excision technique is often performed in conjunction with a lower face and neck lift.

**DISCUSSION**

Patient satisfaction with this technique has been consistently high. The submental scar heals well and is easily camouflaged.

It should be stressed that preoperative evaluation is the most important factor leading to a successful surgical correction of the ptotic chin. Soft tissue excision is often exacerbated by underlying structural abnormalities of the anterior mandible. Proper preoperative evaluation is critical because failure to correct the chin deformity can lead to an unsightly prominence following additional aging face surgical procedures (Fig 3). The patient should be examined at rest and while smiling, as this often elicits a dynamic component of chin ptosis (Fig 4). The inferior border of the mandible can be marked to highlight redundant ptotic soft tissue below this line that can be excised.

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This report provides a reliable option for surgical correction of chin ptosis and offers a simplified approach that can be more easily incorporated into one’s practice than many of the more complex alternative procedures presented over the past four decades.

**REFERENCES**


**Contact**

David Rodwell, MD
University of Tennessee Health Science Center
Dept. of Otolaryngology - H&N Surgery
Email: drodwell@uthsc.edu
Phone: 901-448-5885
Website: www.uthsc.edu/otolaryngology

**Figure 1:** midline excision of fat and subcutaneous excess with corset suspension and trimming of redundant skin. Image from Sigal 2009.

**Figure 2:** liposuction and removal of a central core of tissue followed by direct reduction mentoplasty and a sliding mentalis-pelvisial lig for closure. Image from Bernardi 1999.

**Figure 3:** face and neck lift without correcting the witch’s chin deformity. It should be noted that this patient has some degree of bony prominence in addition to soft tissue excess with ptosis.

**Figure 4:** static and dynamic chin ptosis. Image from Feldman 1992.

**Figure 5:** elliptical excision with removal of excess tissue. The size of the ellipse and amount of tissue removed can be adjusted as needed.

**Figure 6:** pre-op and early post-op results after correction of witch’s chin along with facelift and blepharoplasty.