

# Combined Rhinoplasty–Lip Lift Technique for Facial Feminization Surgery: An Instructional Video and Technical Report

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**G**ender-affirming facial feminization surgery (FFS) harmonizes facial features with a person's experienced gender through both bony and soft tissue procedures. Single-stage “all-in-one” approaches have become increasingly common, with evidence supporting their safety.<sup>1,2</sup> More recently, rhinoplasty and lip lift have been combined to reconstruct these subunits together during FFS. Using the upper lip lift incision as the base of the columellar flap allows safe elevation for open rhinoplasty without the need for a separate transverse incision.<sup>3</sup> The senior author presents his approach to combined rhinoplasty–lip lift in FFS, accompanied by the first full-length instructional video and a detailed technical description. (See **Video [online]**, which demonstrates the senior author's approach to combined rhinoplasty–lip lift in FFS.) Informed consent for filming and publication was obtained.

## LIP LIFT PLANNING AND MARKINGS

The procedure begins with marking the lip lift incision, which is performed first to establish alar width and set a foundation for the rhinoplasty. Markings are guided by feminine aesthetic ideals, aiming to restore philtral height (typically 12–15 mm) with approximately 2 mm of incisor show at rest and a harmonious vermilion display.<sup>4,5</sup> Excisions generally do not exceed 7 mm and are tailored to each patient's anatomy and desired outcome. The alar point, or the most lateral point on the ala, is marked bilaterally with incisions extended to each nostril sill, meeting at the columellar base. Reference points are marked to define the inferior aspect of the incision, extending from the nasal sill to a desired distance inferiorly. Preexisting lip

asymmetry or baseline incisor show is noted preoperatively and accounted for in the markings. The upper incision is curved and follows the nostril shape, nostril sill, and columellar base, whereas the lower line is designed as a straight line rather than a classic “bull-horn” configuration. This allows slightly more resection in the paramedian areas to mimic a pout, which produces a more pronounced medial tubercle and a more aesthetically appealing contour while maintaining good approximation of the upper and lower incisions upon closure.

## LIP LIFT RESECTION AND CLOSURE

Local anesthesia with a vasoconstricting agent is injected after marking, so as not to alter surface landmarks (8–10 mL of 1% lidocaine with 1:100,000 epinephrine). Next, the skin and subcutaneous tissue overlying the orbicularis oris fascia are excised using a no. 15 blade. Following hemostasis, a single central stitch between the midline of the columella and the midline of the philtrum approximates the lip lift and sets the columellar position. The lateral components of the incision are closed, whereas the central segment is left open to allow for rhinoplasty access. Buried 4-0 polyglactin and interrupted 5-0 polypropylene are routinely used for closure.

## OPEN RHINOPLASTY INITIATION AND CLOSURE

The columellar incision for the rhinoplasty approach utilizes the lip lift incision as its base, with markings extended laterally and endonasally, as in a traditional rhinoplasty technique. The columellar incisions are placed slightly more laterally, helping keep the incision from being visible on the coronal view. Elevating the flap through the lip lift incision permits safe dissection along the entire length of the columella, supported by a robust superior collateral blood supply.<sup>6</sup> This eliminates the need for an additional transverse columellar

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incision, which would leave a small skin bridge. The columellar flap is raised off the perichondrium using a no. 15 blade, where the central stay lip lift stitch is released. Dissection continues with Converse and fine dissecting scissors to elevate the flap and connect to an infracartilaginous incision, progressing toward the soft triangle under countertraction from a double-pronged skin hook. Importantly, the incision is placed within the vibrissae-bearing region to minimize the risk of visible scarring or injury to nontarget tissues. These steps are repeated contralaterally until the columellar flap is fully elevated, after which the rhinoplasty is performed in a standard open fashion.

During closure, the columella and philtrum are realigned at the lip lift incision with a midline stitch. The philtrum is approximated as a single unit, and once healed, the combined incision is effectively hidden in a subnasale scar.

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## DISCLOSURES

*Dr. Alperovich serves as a consultant for Johnson & Johnson. The contents of the article are solely the responsibility of the authors. The other authors have no financial interest to declare in relation to the content of this article.*

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