Installation Protocol

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The Deep J Technique (SMAS)

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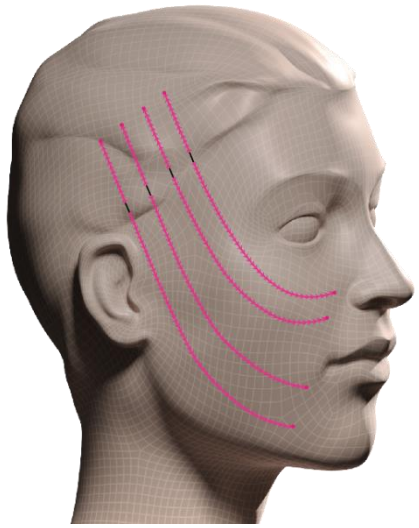
Area treated: Face

The Deep J Technique can be performed on the face alone or in combination with the neck and / or eyebrow treatment. *Please refer to the [Installation Protocol - Eyebrow Lift][1] for details on the eyebrow lift and refer to the [Installation Protocol - Neck Treatment] for details on the neck treatment.*

Thread & Lift offers you the most precise and detailed protocol possible. Its objective is to allow you to find the answer easily and quickly to any technical question. This way, if you have any doubts after our training, you can refer to this comprehensive protocol. This protocol details the Deep J Technique (SMAS).

We also advise you to refer to the video *[Infinite-Thread® - Deep J technique (duration: 34 min) / Area treated: Face]* available here https://www.threadandlift.com/infinite-en.mp4 to see / see again in detail the gestures described throughout this protocol.

Obviously, the Thread & Lift team is at your disposal if you prefer to communicate directly with us, via the telephone number +32 28 08 88 90 and our e-mail address contact@threadandlift.com . We will put you in touch with one of our expert trainers.



Here is the diagram showing the positioning of the 8 Infinite-Thread® for the face - 4 per side of the face - with the Deep J technique.

[1] *Available in the "Documents & Pictures" section of your private area on the website www.threadandlift.com.*

To practice the Deep J technique, here is the list of equipment needed:

- ✓ **8 threads Infinite-Thread® - 30cm (1)**

- ✓ **1 micro-canula Softfil® 22G 50mm (2)** (This cannula is packaged in a pouch that also contains a pre-hole needle. This needle is not useful for the procedure)

- ✓ **1 micro-canula Softfil® 22G 90mm (3)** (This cannula is packaged in a pouch that also contains a pre-hole needle. This needle is not useful for the procedure)

- ✓ **1 needle Nokor® Admix BD - 16G 1'' - 1.65x25mm (4)** (This needle can be replaced by our punch which minimizes the risk of vascular injury)

- ✓ **1 needle Microlance® 3 BD - 21G 1 ½'' - 08x40mm (5)**

In the Infinite-Thread® Kit 4x2

- ✓ **4 curved needles with blunt tips – 19cm (6)**
- ✓ **1 Adson clamp without claws (7)**
- ✓ **1 Mayo-Hegar needle holder (8)**
- ✓ **1 pair of straight scissors (9)**

In the Instrument Kit

NOT PROVIDED:

- ✓ 1 syringe of 10cc **(10)** (3cc or 5cc are also suitable). It is also possible, depending on your preferences, to use two syringes instead of one: 1 syringe for the entry and exit points (concentrated solution) and 1 for the paths (diluted solution). A second set of syringes will be necessary if the anesthesia is not performed under sterile conditions: 1 for the anesthesia step and 1 for the implantation step.
- ✓ 1 needle 30 G 13mm **(11)** (2 needles are necessary if the anesthesia is not performed under sterile conditions: 1 for the anesthesia step and 1 for the implantation step)
- ✓ 1 bottle of 2% adrenalized xylocaine - 20 ml **(12)**
- ✓ 1 bottle of 14‰ isotonic sodium bicarbonate. - 125 or 250 ml **(13)**
- ✓ Sterile pads **(14)** / 3 surgical drapes **(15)** / Two surgical drape clamps **(16)** / 1 felt tip pen to draw the paths **(17)** / 70° Alcohol **(18)** / Hydrogen peroxide to clean the blood that could have stuck to the hair during or after the intervention **(19)**
- ✓ 1 flexible graduated metal ruler – 20cm (or 1 measuring tape) **(20)**
- ✓ 1 tail-comb **(21)**
- ✓ Elastic bands or small clips to keep the hair apart **(22)**

Here are the pictures of the installation of the equipment:

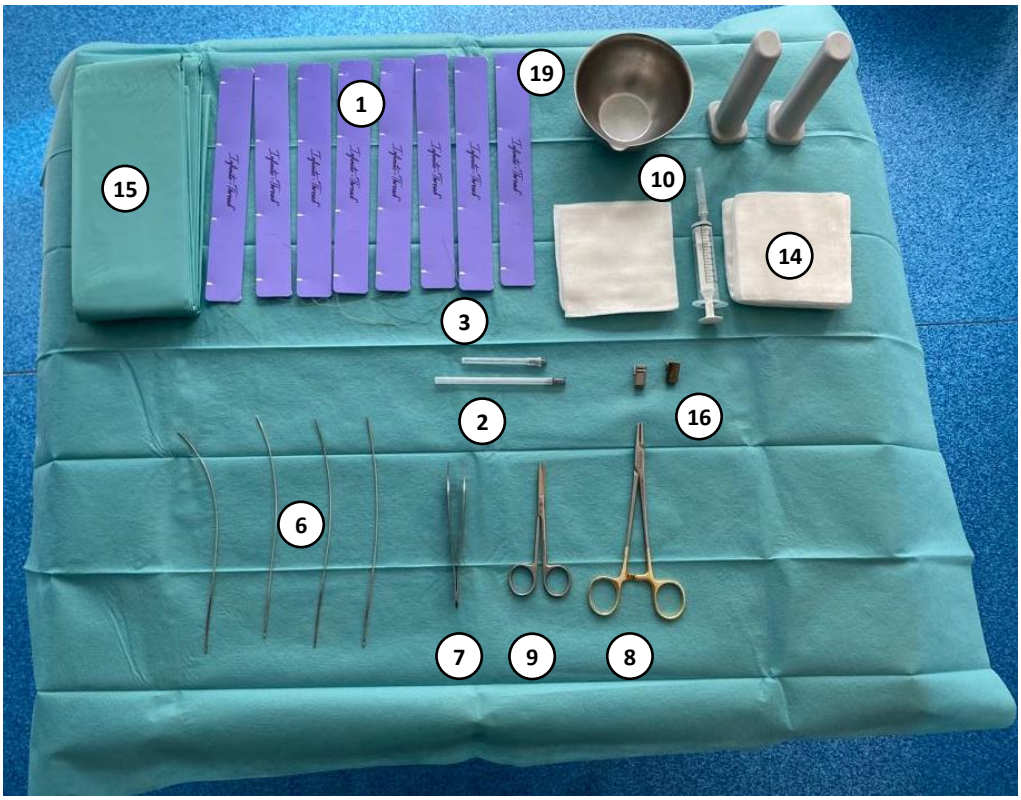


Photo 1: Intervention equipment

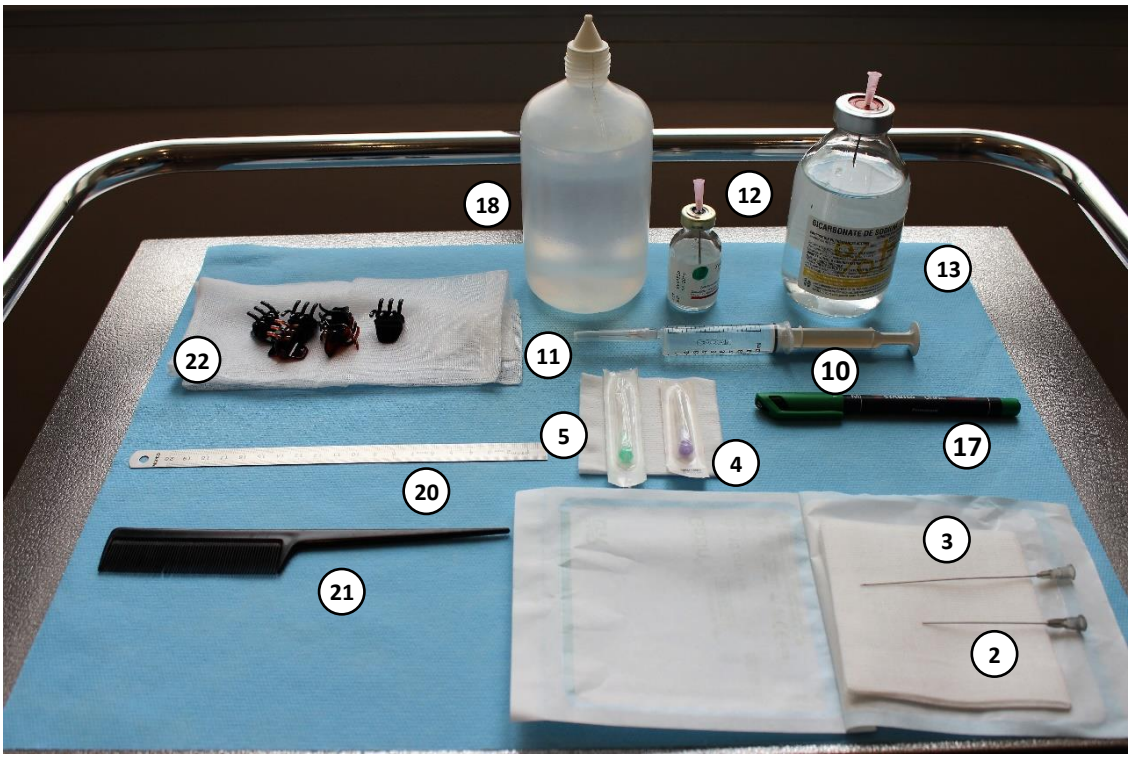


Photo 2: Local anesthesia equipment

The Deep J technique (SMAS) is performed in 5 phases:

Phase 1: The preoperative phase

Before starting the procedure, the patient must have complied with the instructions given to him / her by his / her doctor, an example of which can be found in the document provided by Thread & Lift [Information to patients before – Thread & Lift] available in your private area on the website www.threadandlift.com.

This preoperative phase is based on the recommendations of our expert trainers, according to their patient preparation protocol. An anesthesiologist was consulted to validate this prescription and its dosage. This information is provided as an indication. The choice of products to be given to the patient remains the sole responsibility of the practitioner, according to the mandatory preoperative consultations, the applicable contraindications and the current local legislation.

Right before starting the procedure, our expert trainers recommend:

1) 2 Pristinamycin 500 mg pills (e.g. PYOSTACINE) to be taken 30 minutes before the intervention, to prevent the risk of infection.

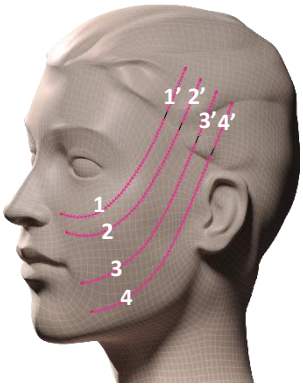
2) 1 pill of non-steroidal anti-inflammatory drug (NSAID) such as Ketoprofen 100 mg (Ex: BI-PROFENID).

3) *Option 1*:
   + 1 tablet of TRAMADOL 50mg as an analgesic treatment.
   + 1 tablet of Metoclopramide hydrochloride 10mg (e.g. PRIMPERAN).
   + 1 tablet of Paracetamol 1000mg (e.g. DOLIPRANE) as a complementary analgesic treatment.

OR

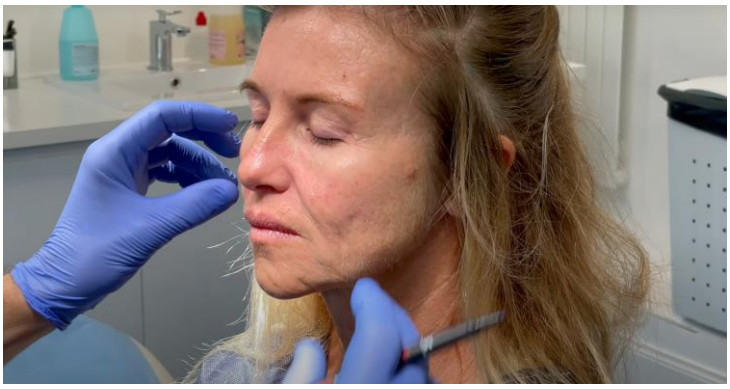
3) *Option 2*:
   + 1 tablet of IZALGI 500mg as an analgesic treatment.
   + 1 tablet of Paracetamol 500mg (e.g. DOLIPRANE) as a complementary analgesic treatment.

Phase 2: The drawing



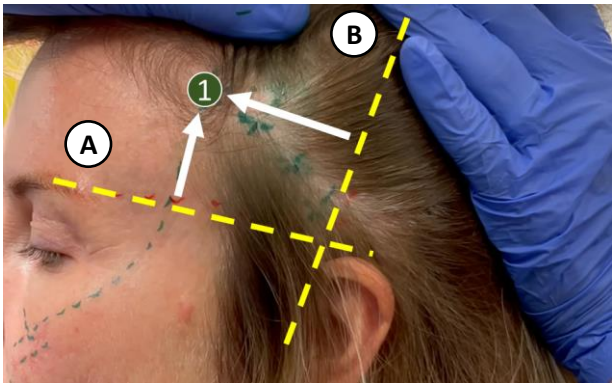
The patient underwent an eyebrow lift at the same time. You can refer to the [Installation Protocol - Eyebrow Lift][2] for this procedure.

The drawing of the paths must be done on a patient sitting facing you.



1) <u>Drawing of the temporal entry points</u>

We locate the entry point area of the most anterior thread (1). This area is characterized by an extremely low mobility.



[2] *Available in the "Documents & Pictures" section of your private area on the website www.threadandlift.com.*

By taking as reference a horizontal line **(A)** connecting the eyebrow to the top of the auricle and a line passing in front of the ear **(B)**, this point 1 is generally located at coordinates 4/4 cm.

To be noted that:

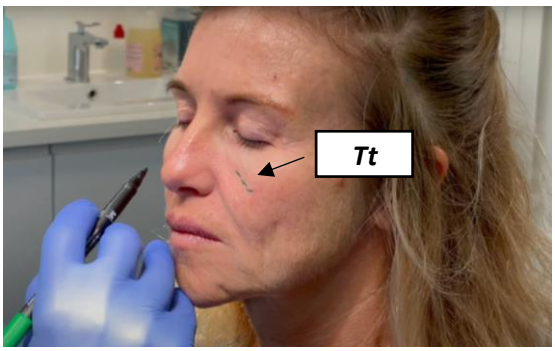
- The higher the point is, the more the thread will be able to lighten and support the upper third and thus support the middle and lower thirds;
- The further away from **(B)** the point is, the more the thread will be able to open the look (to be avoided with men in order not to feminize the look). **It will therefore be in a 5/4 cm or 6/4 cm position**;
- The closer to **(B)** the point is, the more the thread will create folds in front of the ear which will not be harmonious.

Taking the same reference, we trace the other entry points which are uniformly distributed and usually at 3/3, 2/2 and 1/1 cm, while always considering the parameters described above.

Their location is noted in the operative report and this information is supplemented by a photo of the entry points, which will make it easier to find them if necessary.

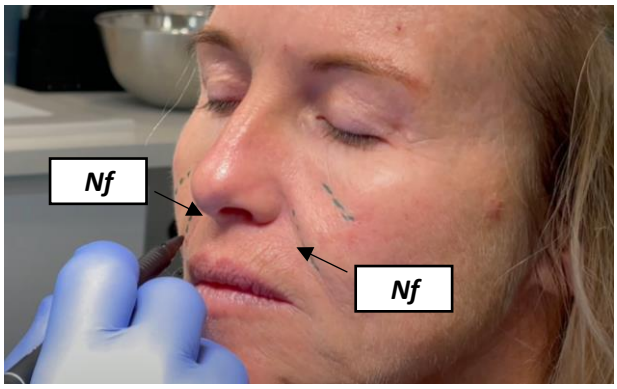
2) <u>Drawings of the cheek paths</u>

For this specific patient, the tear trough ***[Tt]*** is particularly deep. We draw it on each side. The malar fat compartment will be re-imbricated with the zygomatic fat compartment to obtain a shapely and homogeneous cheekbone. *This step does not have to be repeated systematically as it depends entirely on the patient's morphology.*

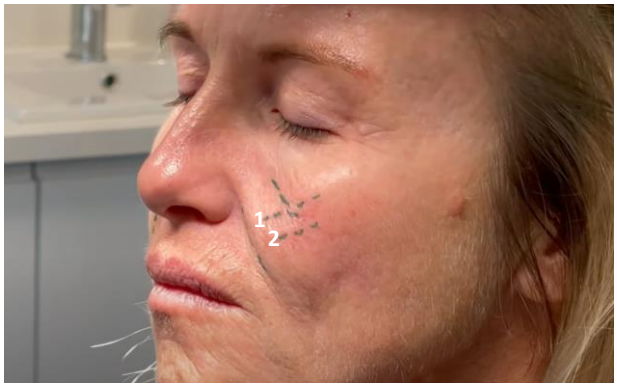


At the level of the nasolabial fold ***[Nf]***, a line is drawn 2 to 3 mm above it. The exit points of the threads **(1)** and **(2)** will be on this line.

We always take care to exit slightly above the nasolabial fold to avoid that the threads get caught in the density of its connective tissue and thus risk to emphasize the nasolabial fold rather than to blur it.

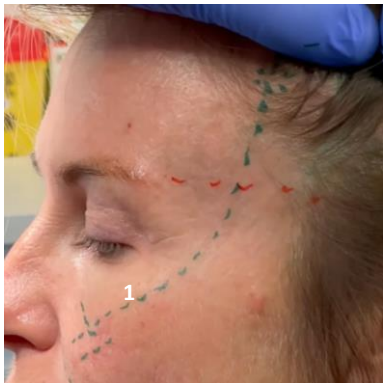


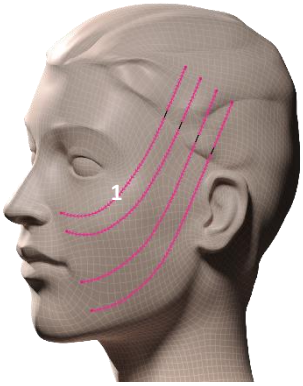
Next, the malar compartment is precisely located by palpation to distribute the path of the two threads **(1)** and **(2)** which are marked with a felt pen.

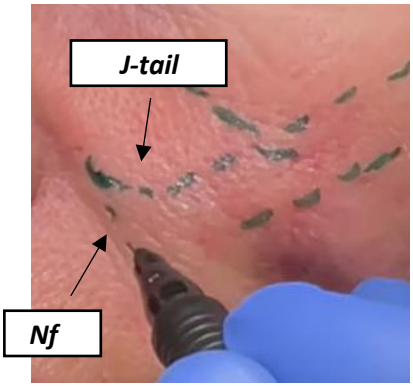


The thread **(1)** will pass through the point marking the middle of the upper part of the malar compartment and the thread **(2)** will pass through the point marking the middle of the lower part of the malar compartment.

The first path, drawn from its exit point, is that of the most anterior thread, the thread **(1)**. It descends from the most anterior temporal entry point identified earlier 1, slightly forward, passing 1 to 2 cm away from the orbital rim and then curves in the direction of the cheekbone. It crosses the anterosuperior part of the malar fat, previously marked with a felt pen, and describes a quarter circle in the shape of a J-tail ***[J-tail]*** over the last two centimetres before reaching the nasolabial fold.

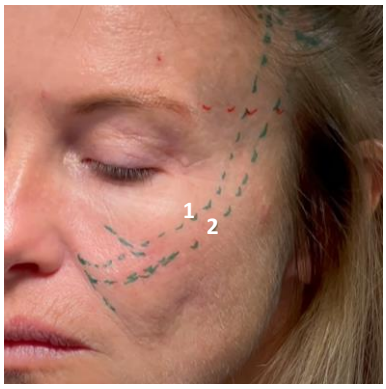


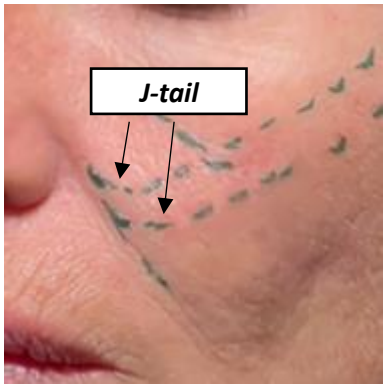




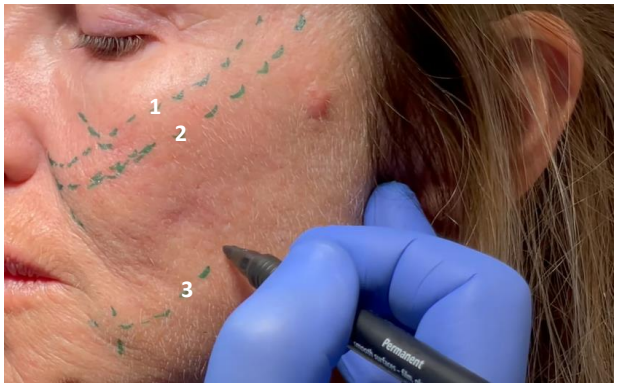
The second path **(2)**, **also drawn from the exit point of the thread**, will follow the drawing of the first path **(1)** in parallel before leaning backwards slightly as it approaches the entry point of the thread at the temporal level.

Here again, the first two centimetres drawn in the area of the nasolabial fold will describe a quarter circle in the shape of a J-tail ***[J-tail]*** going up towards it.



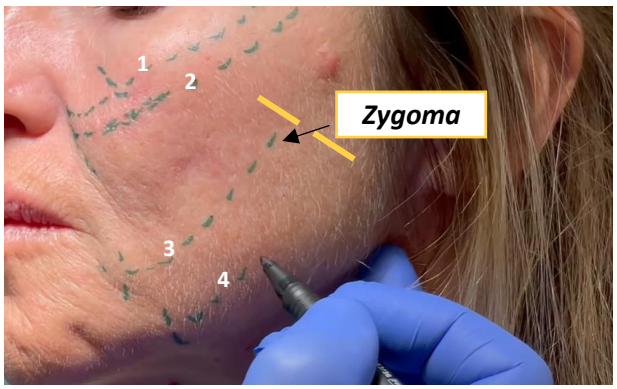


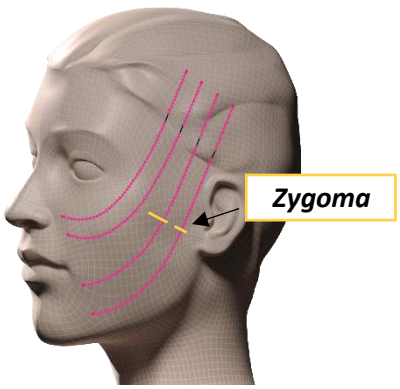
The third path **(3)** targets the correction of the marionette line. The path is drawn upwards from the exit point. The lower part of the path has a slight curve but does NOT follow a J-tail shape.



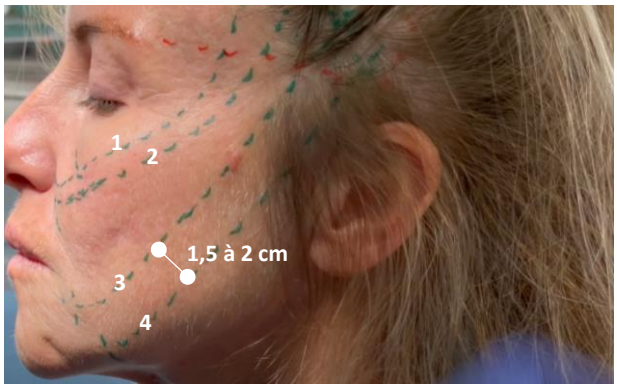
The same applies to the fourth thread **(4)**, the one that aims to tighten the oval; the jowl thread.

It can be particularly useful to draw the lower edge of the zygoma ***[Zygoma]*** which will serve as a visual reference for the implantation of the threads in the mobile SMAS.



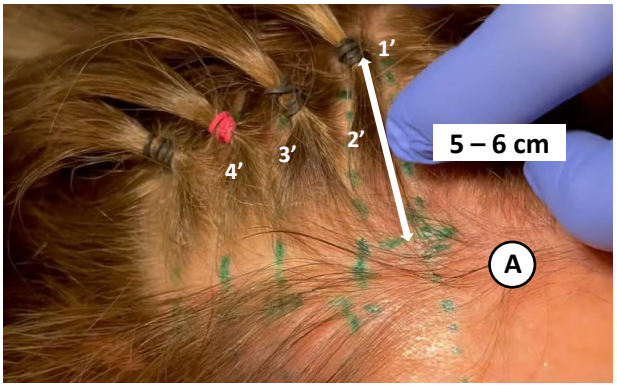


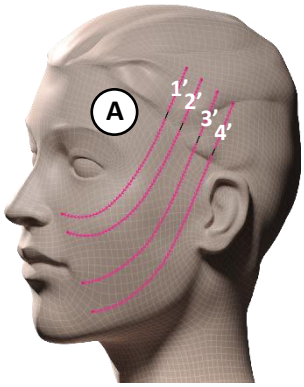
The paths **(3)** and **(4)** are almost parallel, spaced 1.5 to 2 centimetres apart. They are brought up to their respective entry points drawn earlier.



3) Drawings of the extensions under the scalp

The hair is organized with rubber bands to facilitate the drawing of the upper paths. The extensions under the scalp of the 4 threads **(1')**, **(2')**, **(3')** and **(4')** are then drawn over a distance of 5 to 6 cm from the entry points **(A)**.





It is essential to take a picture of the drawings!

These photos will be PARTICULARLY useful if you ever need to remove one or more of these threads.

They will allow you to find the path of the threads with greater ease in order to proceed with the tumescence necessary to unhook the cogs. Indeed, to avoid any risk of marks on the face, the removal must be done from the temporal area, i.e. against the direction of the cogs. Without a large, precise tumescence following the entire path of the thread, the later would be difficult to remove. This is why it is MANDATORY to measure and mark in the operative report the location of the temporal entry zones (in relation to the top of the ear).

You will find a detailed withdrawal protocol on your private area on the website www.threadandlift.com in the "Documents & Pictures" section as well as a template of an operative record.

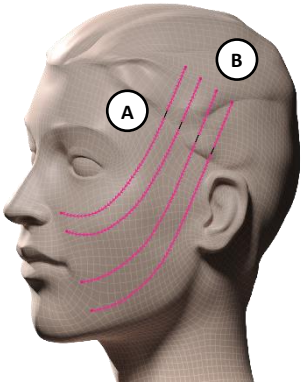
These photos can also be particularly useful in the future if you were to operate the patient again.

Phase 3: Anesthesia

1) **Anesthesia of the entry points**

Required equipment:

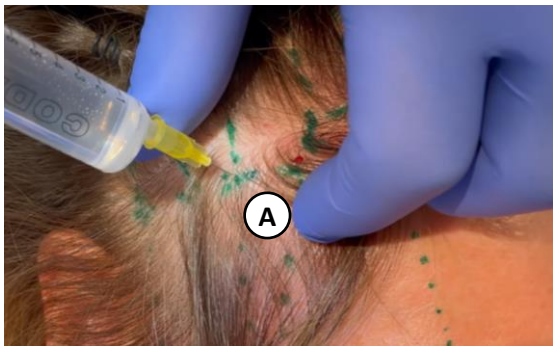
- **1 needle 27 G 40mm** (not supplied)
- **1 syringe of 10cc** (not supplied) (3cc or 5cc are also suitable)
- **20% sodium bicarbonate at 14‰ + 80% adrenalized xylocaine at 2%** (not supplied)

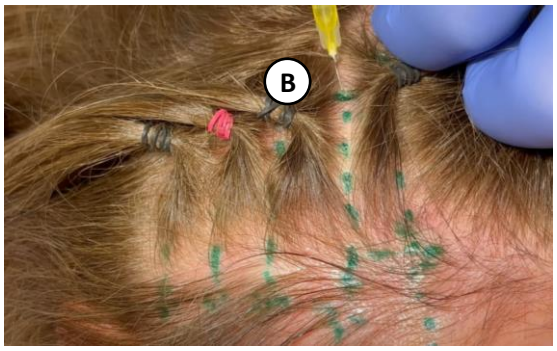


We anesthetize, in order:

- All the entry points of the threads at the temporal level **(A)**
- All the exit points of the threads at the scalp level **(B)**

The anesthesia is done in the form of a large papule of 0.5cc allowing to move the skin away from the subcutaneous tissue and therefore from the vessels.



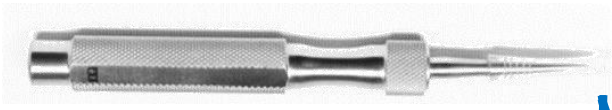


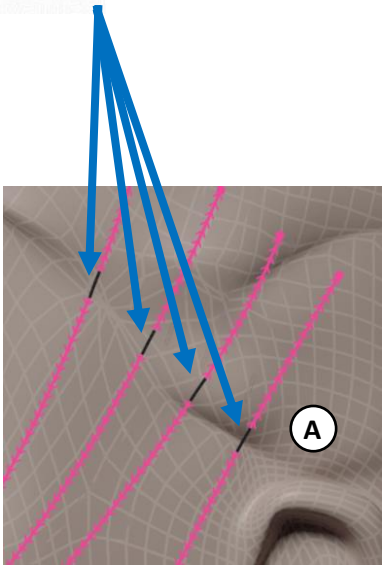
2) Opening of the entry points

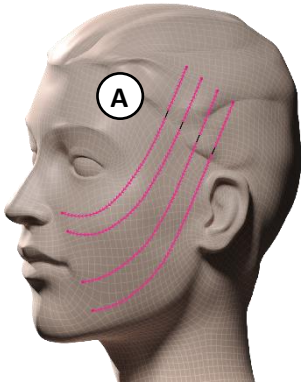
Required equipment:

- **1 punch** (available as a supplement) **or 1 needle Nokor** (provided in the Infinite-Thread® kit 4x2)

One circular opening is made using the punch at each of the temporal entry points **(A)** (4 openings in all at each temple).



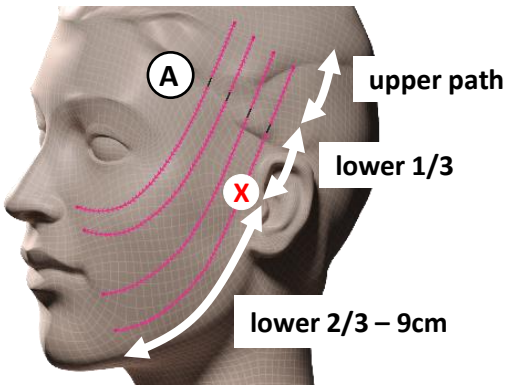




POINT OF CAUTION - If you prefer using a Nokor needle, take particular care not to penetrate too deeply into the subcutaneous tissue in order to avoid any risk of bleeding. This risk is greatly reduced by using our punch.

Since the cannulas are too short to directly anesthetize the entire length of the paths, the anesthesia must be performed in 2 steps:

1) With the 50mm cannula: The anesthesia of the upper paths under the scalp + the lower 1/3 of the cheek paths; starting from the entry points **(A)**;
2) With the 90mm cannula: The anesthesia of the lower 2/3 of the cheek paths starting from the relay openings **(X)**.

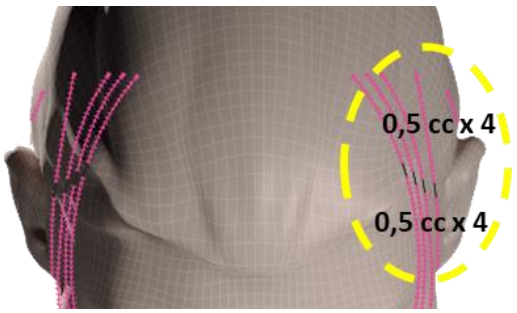


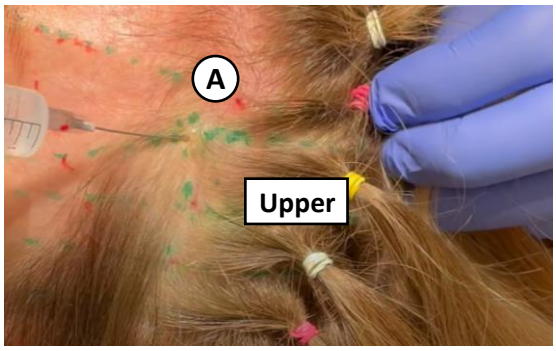
3) Anesthesia of the thread paths – starting from the entry points (A)

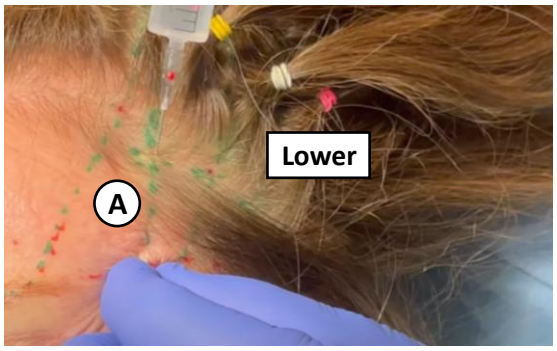
Required equipment :

- **1 cannula 22 G 50mm** (provided in the Infinite-Thread® kit 4x2)
- **1 syringe of 10cc** (not provided)

80% sodium bicarbonate at 14‰ + 20% adrenalized xylocaine at 2%. (not provided) **- The mixture is the reverse of that used to anesthetize the entry and exit points.**







For the upper temporal area ***[Upper]***, we inject between the galea and the scalp :

- 0.5cc per path, from the 4 entry points **(A)** to the 4 exit points, in retrograde.

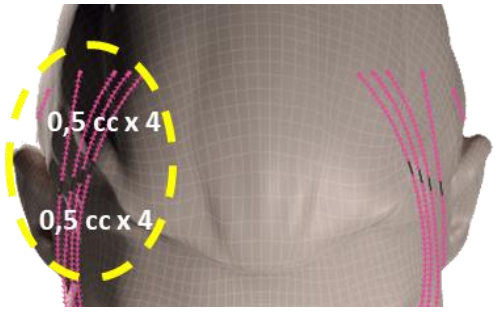
For the lower temporal area ***[Lower]***, on the paths **(1)** and **(2)**, we inject under the fascia superficialis:

- 0.5cc per path (over the 5cm of the cannula), from the 2 corresponding entry points **(A)**, in retrograde.

For the lower temporal area ***[Lower]***, on the paths **(3)** and **(4)**, we inject strictly subcutaneously:

- 0.5cc per path (over the 5cm of the cannula), from the 2 corresponding entry points **(A)**, in retrograde.

Of course, the same is done for the paths of the other temple.

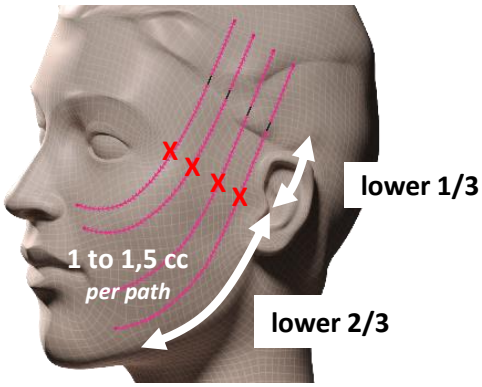


4) Anesthesia of the thread paths - lower 2/3 of the cheek

Required equipment:

- **1 pre-hole needle Microlance 3 - 21 G 40mm** (provided in the Infinite-Thread® kit 4x2)
- **1 cannula 22 G 90mm** (provided in the Infinite-Thread® kit 4x2)
- **1 syringe of 10cc** (not provided)
- **80% sodium bicarbonate at 14‰ + 20% adrenalized xylocaine at 2%.** (not provided) **- The mixture is the reverse of that used to anesthetize the entry and exit points.**

At the extremity of the lower 1/3 of each path already anesthetized, relay openings **(X)** are made using the Microlance needle 3 - 21G. They will allow the insertion of the 90mm cannula, to then anesthetize the remaining 2/3 of the paths.



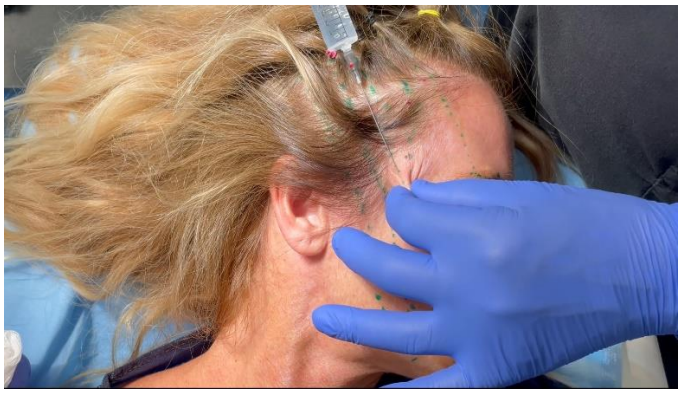
The length of these remaining paths is approximately 9cm. The injection therefore requires the use of a longer cannula, 90mm 22G.

The gesture is similar to that of liposuction, the fat compartment or SMAS is presented between the thumb and middle finger, and the index finger is used to push and press to control the depth of the cannula.

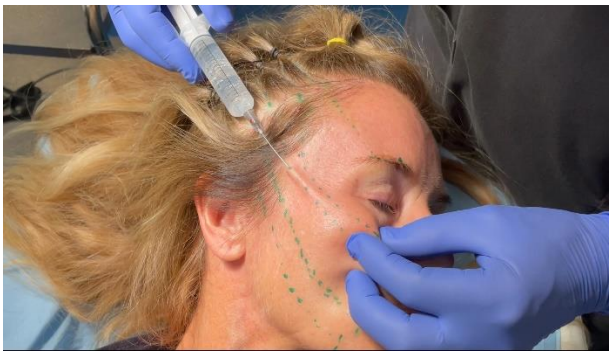
The aim here is to provide anesthesia down to the future exit points by following exactly the drawn paths of the threads on each cheek. It is important that the cannula is positioned in the **EXACT** plane where the threads will be implanted, that is:

➔ For the paths **(1)** and **(2)**, the cannula is first positioned under the orbicularis. If only a subcutaneous passage was to be used, the thread may lift the skin, making it visible. Although it may not be visible in this specific area at the time of the implantation, it is best to safeguard against the possibility that, when the patient has a thinner integument, the thread may become potentially visible.

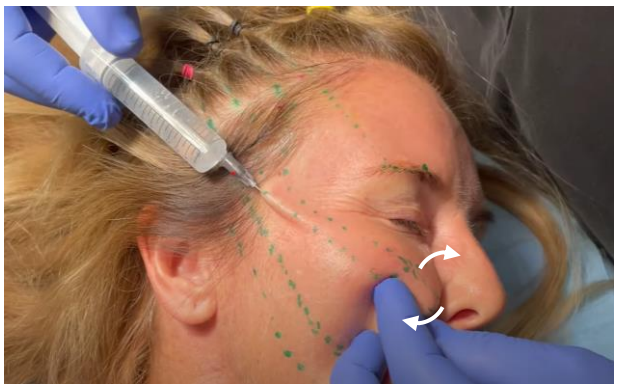
As the path **(1)** can be quite painful for the patient, the anesthesia is started with the path **(2)** in order to benefit from a diffusion of the anesthetic towards the path **(1)** and thus make this step as unpleasant as possible.



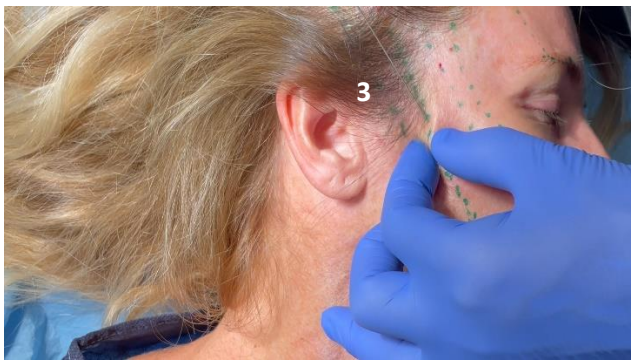
The cannula is then positioned in the fat compartment.



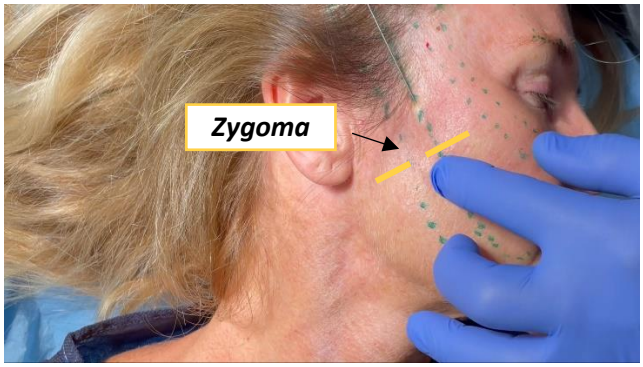
Finally, care should be taken to follow the J-tail shape of the end of the path, by rotating the skin around the needle.



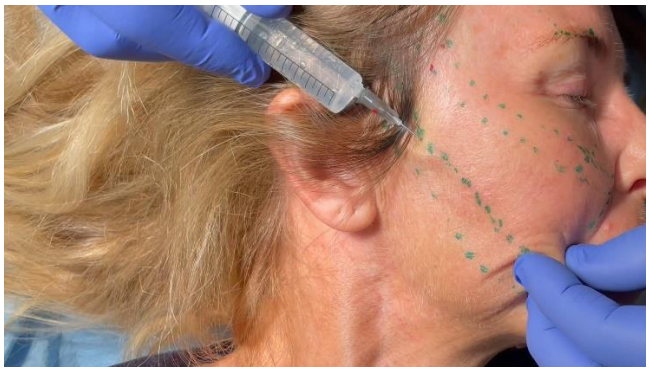
➔ For the path **(3)**, the cannula is first positioned subcutaneously over a few centimeters.



Then, as soon as the cannula reaches the lower edge of the zygoma ***[Zygoma]***, it is positioned in the mobile SMAS.

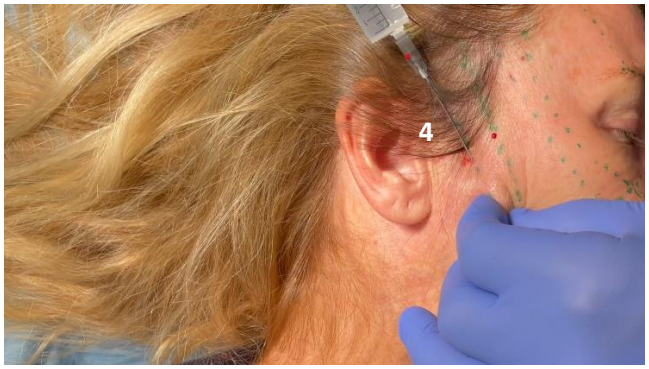


Finally, the cannula is positioned in the fat pad over the end of the path.



It should be noted that it is the anesthesia of the SMAS that will allow to pearl it with the thread and obtain a repositioning of the cheek without gathers or folds at the level of the skin.

➔ For path **(4)**, at the level of the parotid gland, the cannula is also directly lowered deep into the SMAS. There is actually no space between the skin and the SMAS at this location.



We inject 1 to 1,5 cc per path of 9cm, always in retrograde.

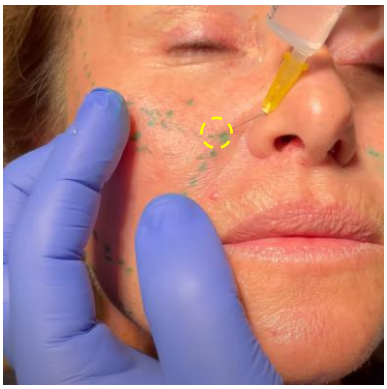
Of course, we do the same for the thread paths of the other side.

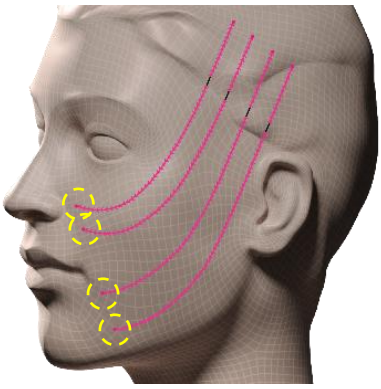
5) Anesthesia of the exit points - lower cheeks

Required equipment :

- **1 needle 27 G 40mm** (not provided)
- **1 syringe of 10cc** (not provided)
- **20% sodium bicarbonate at 14‰ + 80% adrenalized xylocaine at 2%.** (not provided)

A few drops of anesthetic are injected at the exit points at the extremities of each thread path on both sides to prevent any risk of the appearance of ecchymosis.





Phase 4 : Thread implantation

The implantation of the threads is done one whole side of the face after the other and one whole thread after the other.

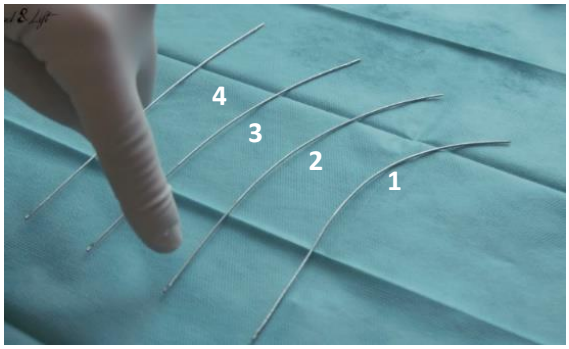
It is now imperative to work in sterile conditions if it was not yet the case.

While it was not mandatory during the previous Phase 3: Anesthesia, it is now imperative to work with sterile gloves, perform antiseptic skin cleansing and set-up 2 sterile fields:

- 1 under the patient's head; and
- 1 starting from the neck and covering the torso.

The practitioner connects the 2 fields according to his or her preference: using adhesive fields or small clamps (not provided).

There are 4 needles[3] **(1), (2), (3) and (4)**. They each have an eye at one end and a semi-blunt tip at the other to avoid injuring any vascular or nervous structure. These needles are 19cm long and 1.3mm in diameter and are curved to follow the anatomical areas you will be crossing.



The needles will be inserted using the **needle holder** (provided in the instrument kit). The later must clamp the needles inside their curvatures, on their flat parts designed for this purpose. It is also possible to insert the needles using a **needle holder-handle** (not supplied in the instrument kit but available on request).

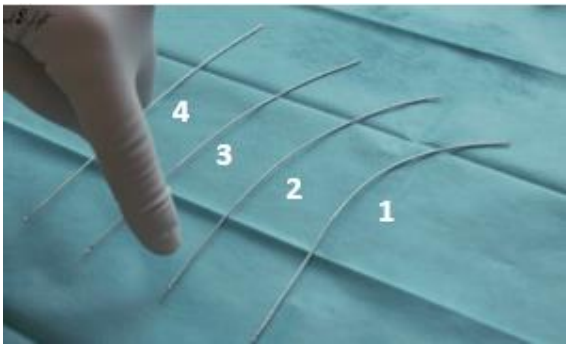
[3] Our reusable instrument kit contains a 5th needle. This needle is straight and is intended to be curved as you wish.

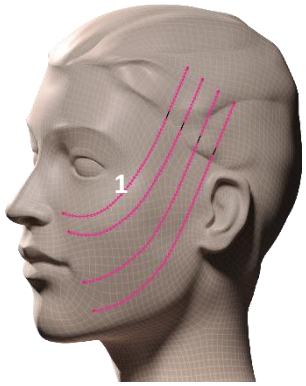
GOOD PRACTICE - If during the implantation of a thread you realize that the curvature of the needle you are using is not the right one, do not hesitate to step back, take it out and change it, to work with the correct curvature. Indeed, a needle that is too curved tends to descend too quickly in the deep planes and a needle that is not curved enough will not allow you to make the desired turns.

In the same way, do not hesitate to bend or unbend the needles slightly as you please, at each step, in order to adapt them to the path. Beyond the differences from one patient to another, it can happen that the curvature of the needle is battered during the insertion process.

1) **Implantation of the 1st thread - the lower half**

The most curved needle **(1)** is used to insert the lower half of the thread **(1)**.





The needle is inserted vertically, never obliquely, so as not to create a dimple by passing the thread through the thickness of the dermis (the thread must be free under the skin). Once the beginning of the subcutaneous space is reached, **the needle is repositioned parallel to the skin** to avoid penetrating the temporal muscle.

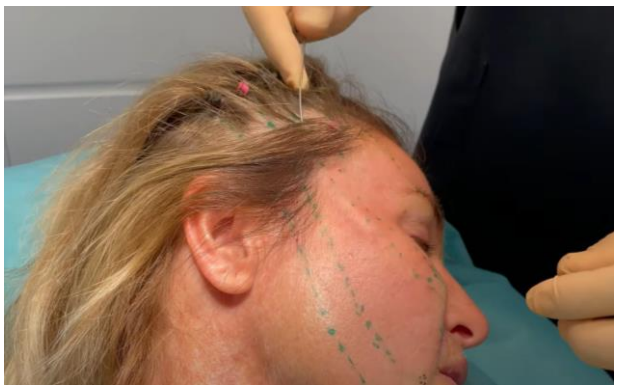
At the beginning of its journey, at the temporal level in the scalp area, the needle will travel **under the scalp**. If the penetration of the needle is difficult because of a dense conjunctive tissue or the presence of a scarred area, generally due to a previous facelift, it may be useful to proceed with additional tumescence with the anesthetic liquid. This additional hydro-dissection will allow the needle to progress more easily, without risking vascular damage responsible for bleeding that is particularly disturbing for the rest of the procedure. However, be careful not to inject too much, so as not to make the final adjustment and symmetry impossible.

As soon as the hairless area is reached, the needle needs to travel deeper**, under the fascia superficialis**, so that the thread is never visible, neither today nor tomorrow.

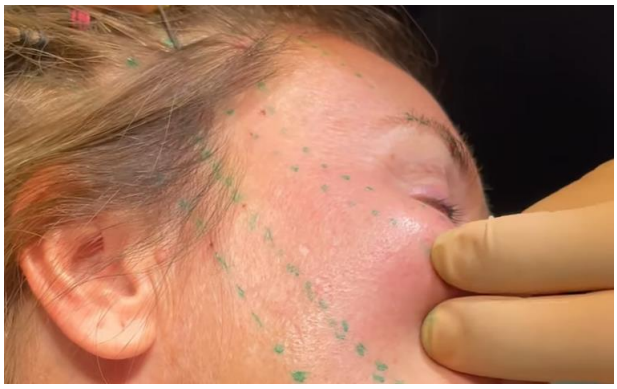
Then, **when in front of the orbicularis muscle, the needle needs to go under it**.

As soon as the needle **meets the zygoma**, **it needs to travel more superficially, that is in the subcutaneous tissue** and then, **once in the malar compartment, the needle is positioned in the middle of the fatty compartment** (or even deeper down if it is thin) so that the thread will have the necessary grip to lift the malar fat pad. It is this elevation which conditions a large part of the success of the intervention, and in particular will allow to obtain a result approaching the one of the malar lift.

GOOD PRACTICE - During the progressive implantation of the needle, it is essential to regularly rotate the needle on itself from right to left and vice versa in order to ensure **that it does not create a depression**. If this were the case, it would mean that the needle is directly hooking the skin and that it is therefore positioned too superficially. This visibility would be definitive once the thread is implanted.

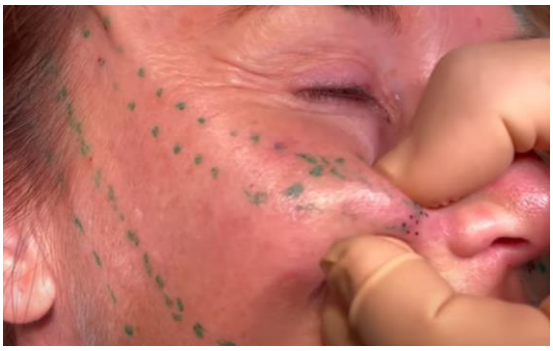


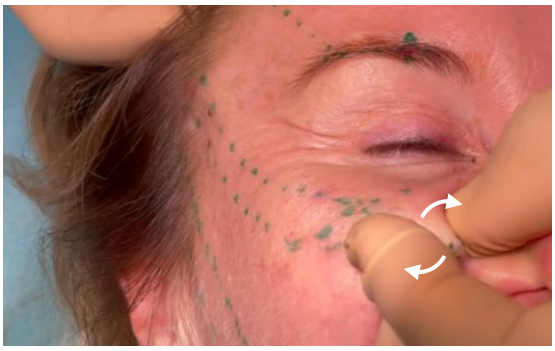
GOOD PRACTICE - During the insertion of the needle, the hand that holds the needle holder is the "worker". The other hand is the "leader". The further the needle is from the entry point, the more difficult it will be to direct it and to position it at the right depth. From then on, it is the "leader" hand that becomes the most important: **it will present the fat to the incoming needle**. It is important to hold the fat **between the thumb and the middle finger** and to position it well in front of the needle. Do not hesitate to **use your index finger to press the needle down** if it does not go deep enough in the centre of the fat that is presented to it.



After every centimetre of path inserted, it is essential to check that the needle is in the perfect implantation plane. In case of doubt, do not hesitate to move it backwards to reposition the needle a second time. A needle in the wrong plane, even on a single point of the path, would tow the thread in this same wrong plane, leading to an implantation defect with no other solution than the outright removal of the thread.

To follow the J-tail shape of the end of the path, **the skin is pinched and turned** to be presented to the needle.

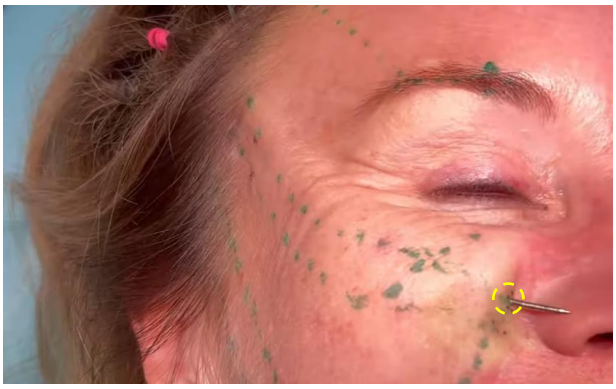




Over these last few centimeters, care must be taken to ensure the implantation of the needle is not superficial.

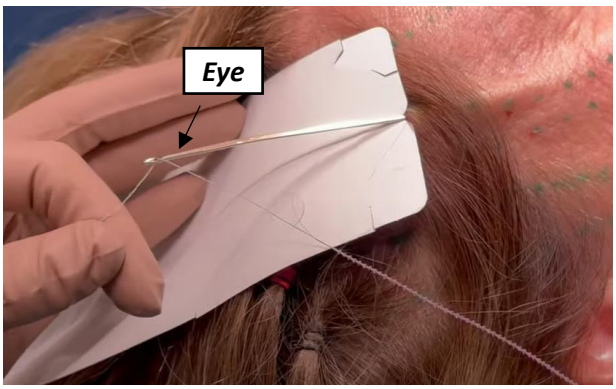
We strongly advise you to refer to the video [Infinite-Thread® - Deep J technique / Treated area: Face] available here https ://www.threadandlift.com/infinite-en.mp4 for a better clarity of this step of the procedure.

The needle exits at the edge of the nasolabial fold. The exit point of the needle is exactly, or as close as possible to the point of anesthesia in order to benefit , as much as possible, from the induced vasoconstriction and thus avoid bleeding at the exit point which would lead to a risk of subsequent ecchymosis.



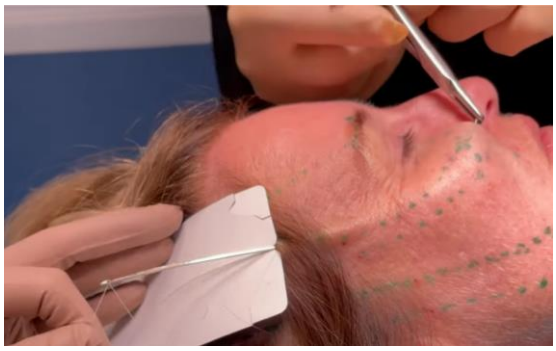
If a permanent filler is present or is suspected to be present in the fold, it is advised to exit the needle sufficiently far upstream of the fold to avoid any risk of reactivation of a post-traumatic inflammation of the filler product.

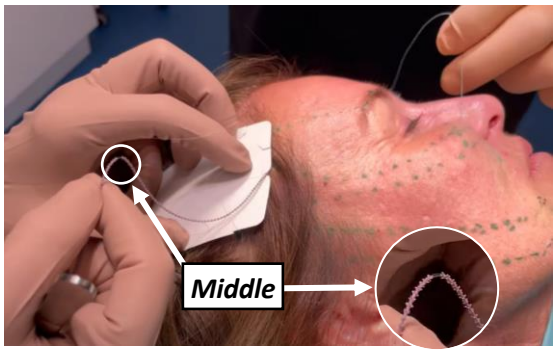
The smooth tip of Infinite-Thread® is then passed through the eye of the needle ***[Eye]***. It is important not to pass any cogs through the eye of the needle to prevent the thread from getting stuck.



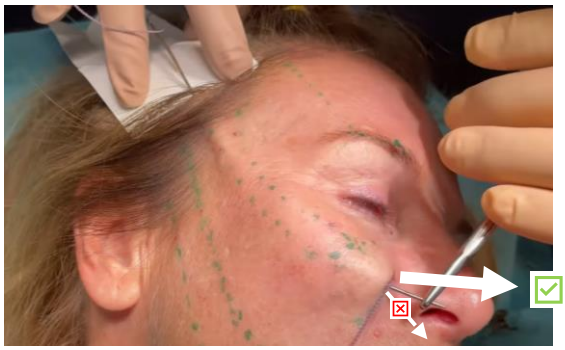
The thread is guided by the cardboard in which it was packed. It is particularly useful to keep the hair pressed underneath and to make sure that it does not slip in with the thread. Nevertheless, if one or more hairs were to be buried with the thread, you would need to gently remove them with the Adson pliers (provided in the instrument kit).

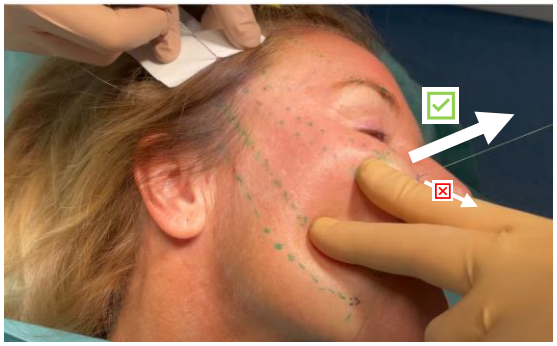
The thread is towed by the needle, an upward tension needs to be maintained on the cheek with the other hand until the thread is completely buried. The thread must be towed through up to its central part materialized by a black marking ***[Middle]***.





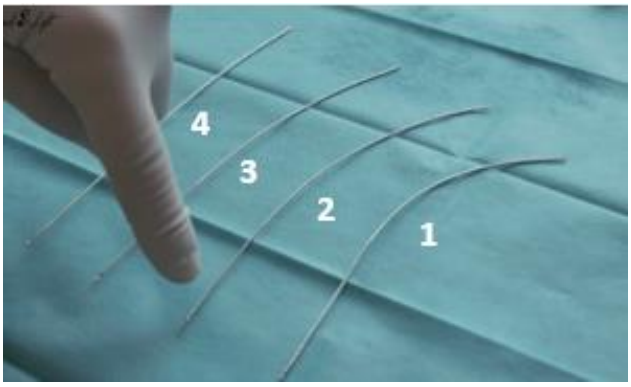
The needle and the thread are to be withdrawn in line with the J-tail shape of the end of the path to avoid splitting the skin at the exit point.

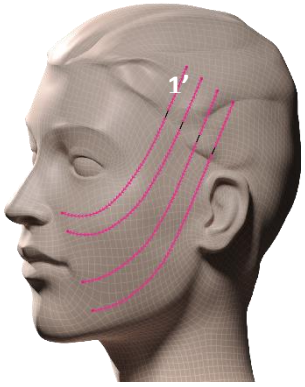




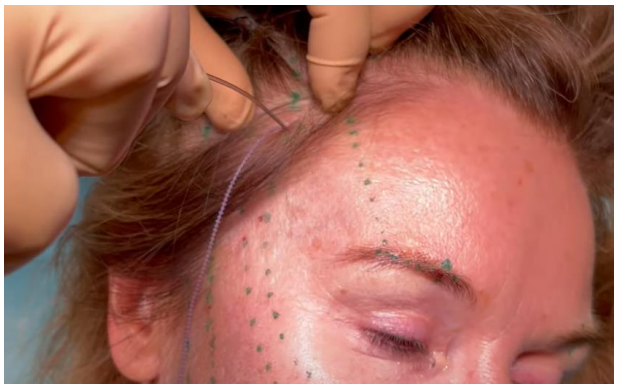
2) <u>Implantation of the 1st thread - the upper half</u>

A medium curved needle **(2)** or **(3)** is used to insert the upper half of the foremost thread **(1')**.



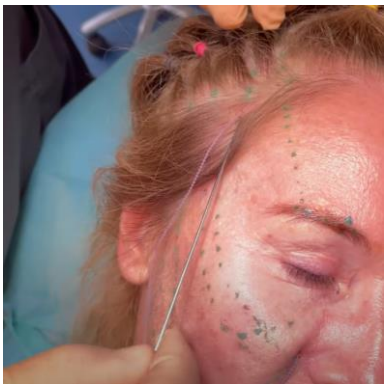


After penetrating the needle vertically until it reaches the right plane, i.e. the beginning of the subcutaneous space, it is repositioned parallel to the scalp to prevent it from penetrating the temporal muscle.



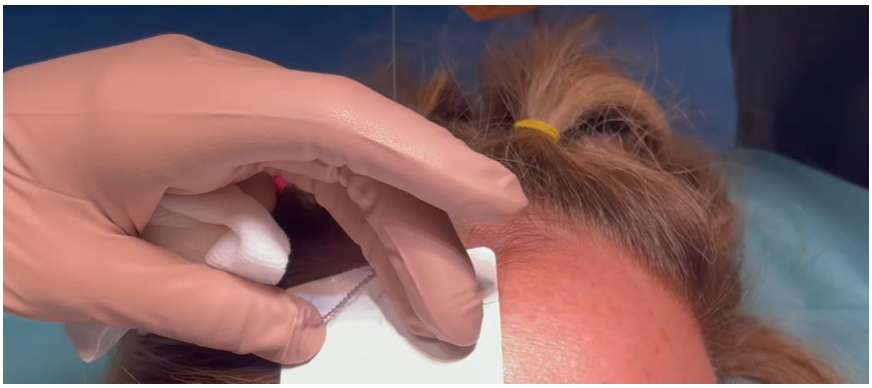
The needle should be inserted between the scalp and the galea, following the path drawn. The needle progresses gently until it reaches its exit point ***[Exit]***. Any resistance to the passing of the needle would mean that it is positioned too superficially.

At the exit point ***[Exit]***, the needle is turned upwards and, using pliers, a counter pressure ***[Counter pressure]*** is applied to facilitate the exit of the needle.

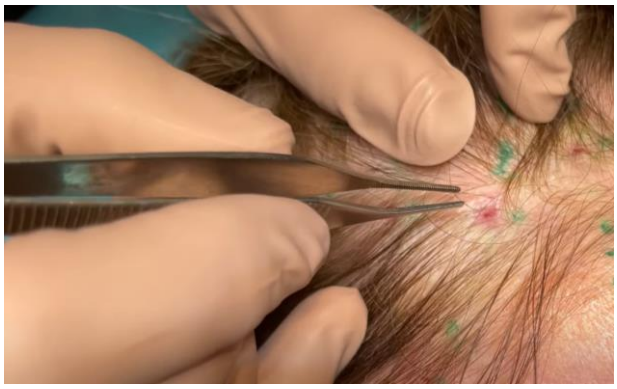


The smooth tip of the Infinite-Thread® is then passed through the eye of the needle.

The needle is then progressively and completely withdrawn, towing the thread until it is completely implanted.

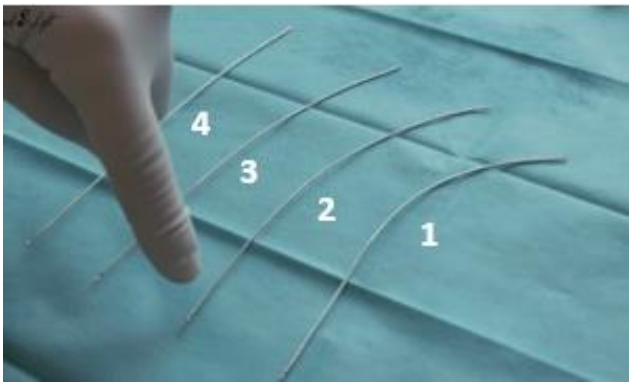


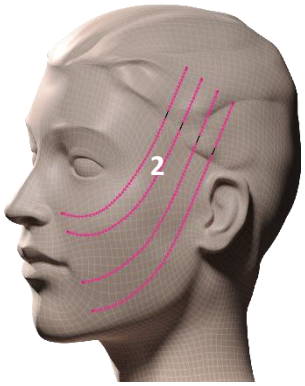
POINT OF CAUTION - **The absence of any buried hair must be checked with extreme caution! It is the presence of a hair half in - half out that is usually responsible for an infection.**



3) Implantation of the 2nd thread – the lower half

For the second thread, usually, the most curved needle **(1)** is used, but sometimes a lesser curvature **(2)** can be considered.

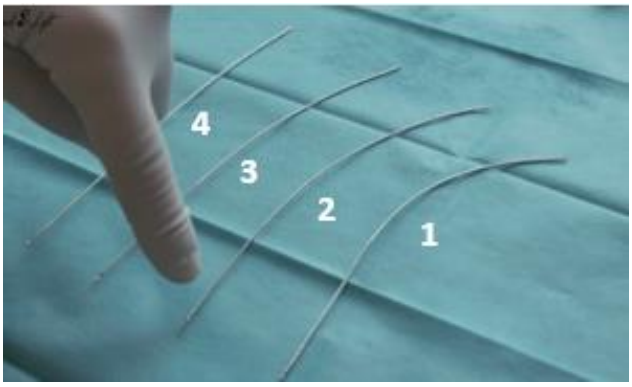


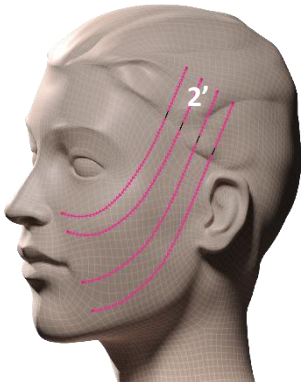


The procedure to be applied is the same as for the lower half of the 1st thread.

4) Implantation of the 2nd thread – the upper half

For the upper half of the 2nd thread **(2')**, the same needle as for the upper half of the 1st thread is used, **(2)** or **(3)**.

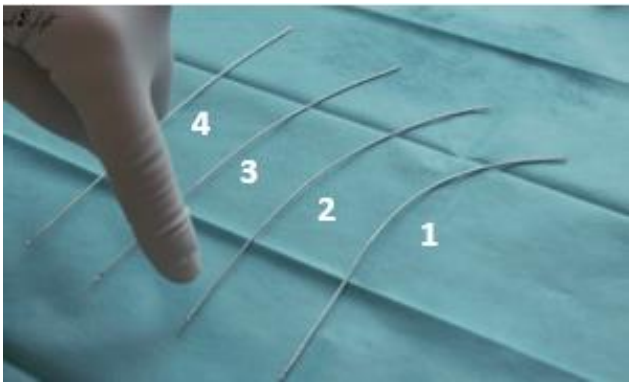


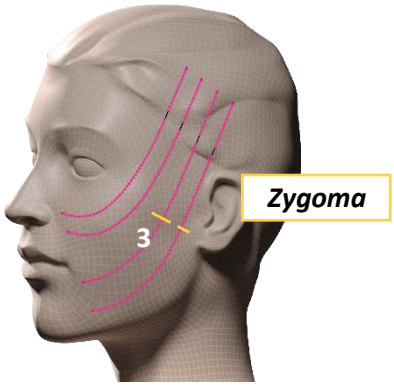


The procedure to be applied is the same as the one used for the upper half of the 1st thread.

5) Implantation of the 3rd thread – the lower half

For the lower half of the 3rd thread, the one dealing with marionette line, the needle **(3)** is used.





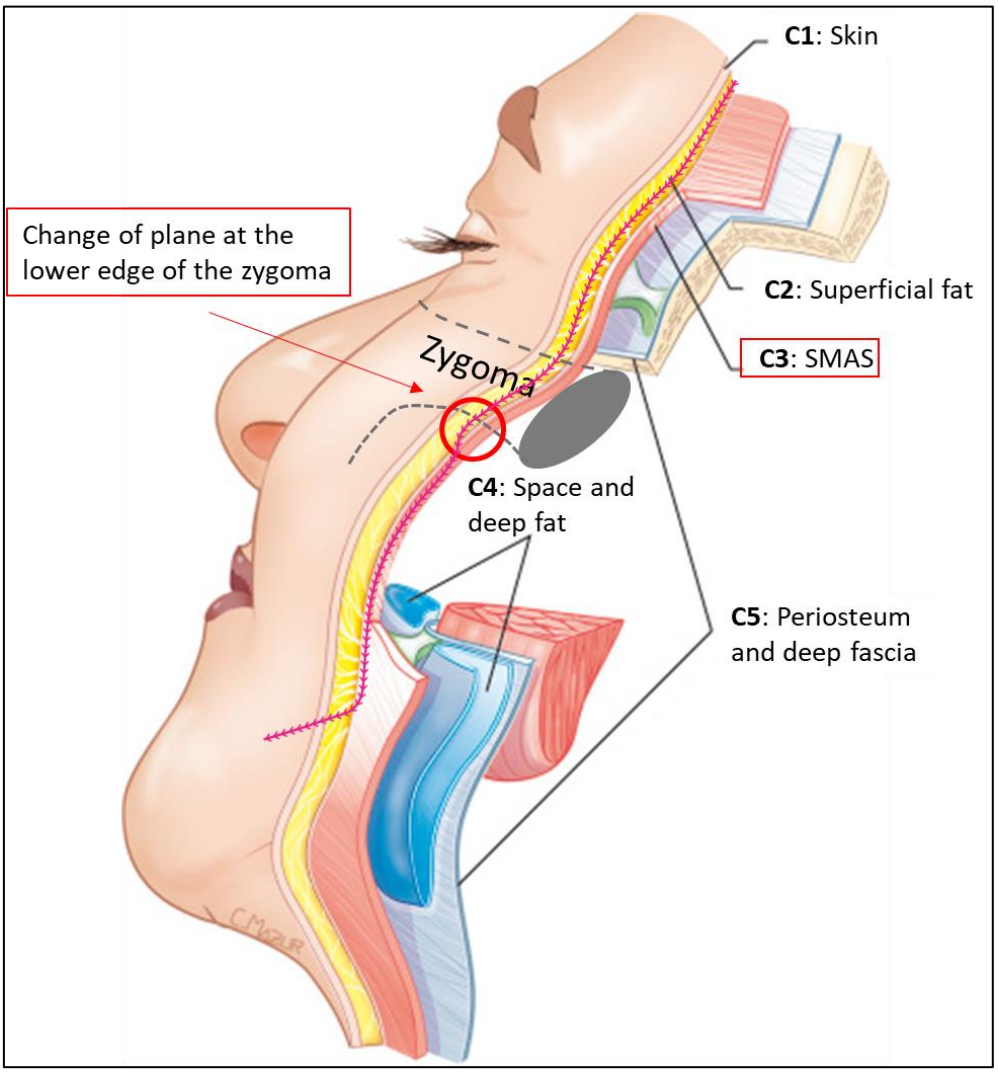
POINT OF CAUTION - The pathway is strictly subcutaneous at the beginning. A deeper positioning in the immobile SMAS would lead to the immobilisation of the thread in a fixed area and therefore the loss of its effectiveness.

When the needle exceeds the lower edge of the zygoma ***[Zygoma]***, the needle needs to go deep, by lifting the skin, to go pearl the mobile SMAS. Small cracks can be perceived. They are associated with a slight resistance which confirms that the needle is in the right plane.

When pearling the SMAS, if you have any doubt about an excessive depth (i.e. having a thread inserted too close to the gum), ask the patient to open their mouth and slide a finger inside to check the positioning of the needle by finger touch.

If the patient were to feel pain when pearling the SMAS, it is likely that the initial anesthesia was given too superficially in the subcutaneous tissue and not enough in the SMAS. It would therefore be necessary to use the few minutes required to complete the anesthesia so that the procedure can continue under good conditions.

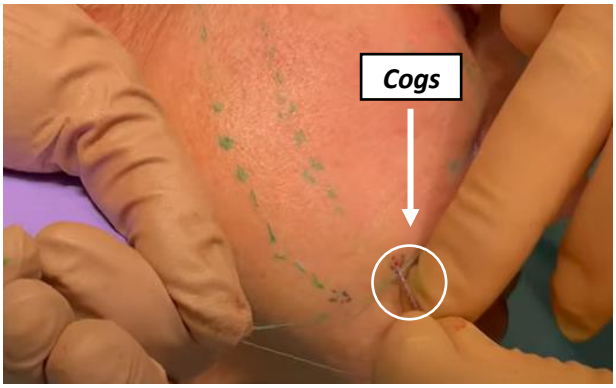
At the level of the exit point, as for the first two threads, the needle needs to stay deep until the last moment in order to avoid any visibility / hollow on the distal part of the path due to a lack of burial.



Schematic view of the thread pathway with SMAS pearling

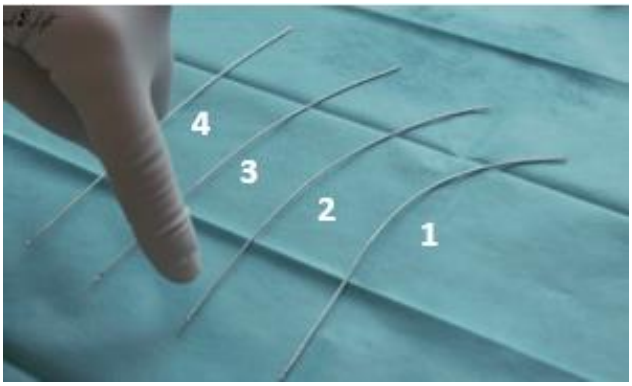
As before, once the thread has been passed through the eye of the needle, the needle is gradually and fully withdrawn, towing the thread until its black mark is implanted.

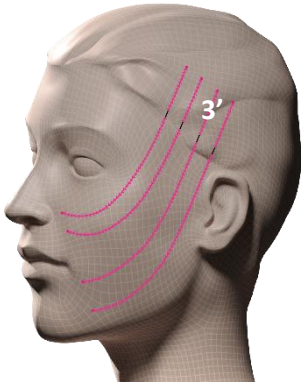
On patients with a long face, the positioning of the black mark is no longer considered. Indeed, even if the black mark is already buried, the thread must still be pulled in until the first cogs ***[Cogs]*** appear at the exit point.



6) Implantation of the 3rd thread – the upper half

For the upper half of the 3rd thread **(3')**, the same needle as for the upper half of the 1st thread is used, **(2)** or **(3)**.

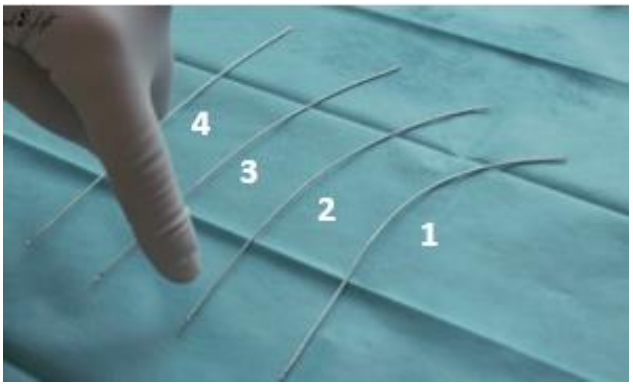


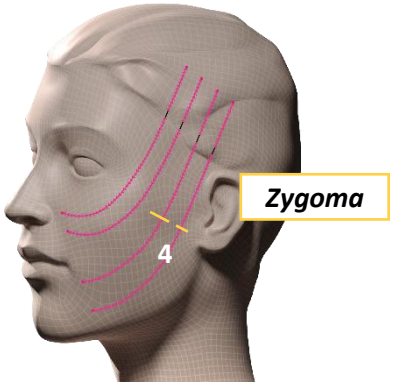


The procedure to be applied is the same as the one used for the upper half of the first two threads.

7) Implantation of the 4th thread – the lower half

For the lower half of the thread in the direction of the jowl **(4)**, we use the needle **(3)**.

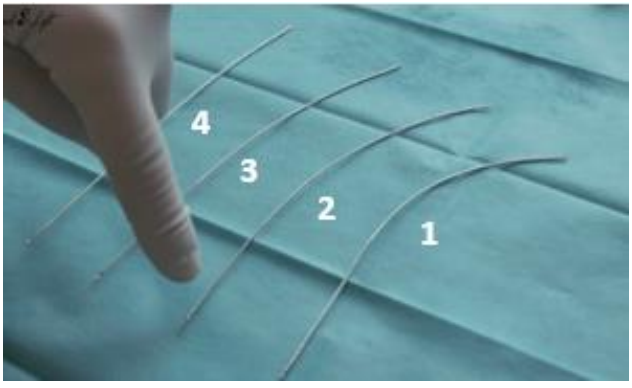


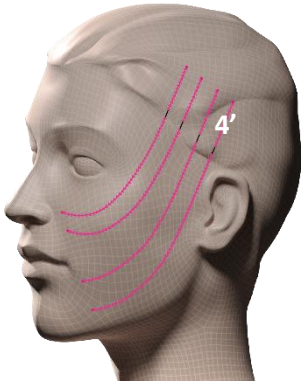


The procedure to be applied is the same as for the lower half of the 3rd thread: first inserted superficially, then deeply into the mobile SMAS once the zygoma *[Zygoma]* is passed.

8) Implantation of the 4th thread – the upper half

For the upper half of the 4th thread **(4')**, the same needle as for the upper half of the other threads is still used, **(2)** or **(3)**.

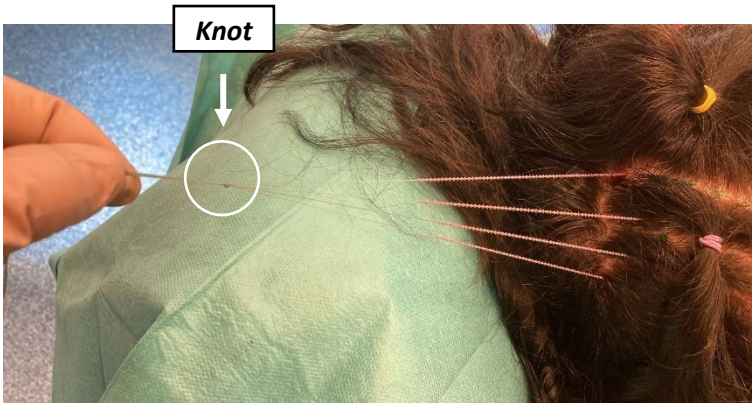




The procedure to be applied is the same as the one used for the upper half of the other threads.

Once this path is implanted, the first side is completed. As for all the paths, always check for the absence of hair at the temporal area!

To facilitate the management of the threads during the following tensioning and adjustment phases, the four uncut thread tips are knotted ***[Knot]*** together.

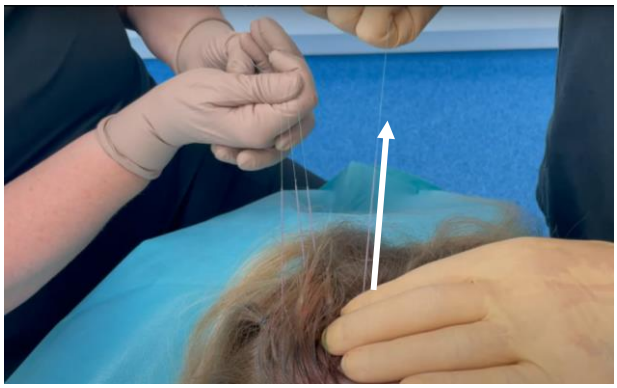


9) Pre-adjustment of the tension of the 1st profile

For the pre-adjustment, the patient must be in a lying position.

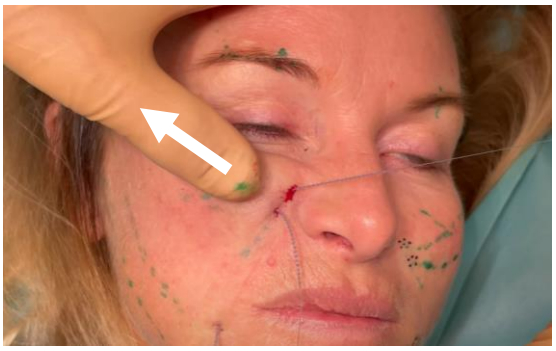
1st step: Apply a strong traction, in turn, on each of the 4 upper strands of the threads, starting with the frontmost strand, to perfectly tension them over the 5 or 6 centimetres of their path and thus ensure the full effectiveness of all the cogs.

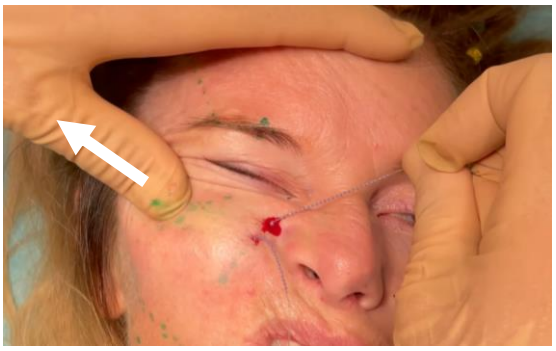
Position two or three fingers on the buried part of the path and briefly pull the thread.



2nd step : Proceed to the individual pre-adjustment of each thread starting from the most anterior.

This tensioning consists in the elevation of the tissues along each thread. **Therefore, for a given thread, do not tension it excessively, but simply hold it firmly taut with one hand** (here the right hand) **then elevate the tissues along the path of the thread with the other hand** (here the left hand)**.**





Every centimetre, the skin is glided up along the thread by applying pressure with the thumb. The skin is draped along the thread up to the entry point.

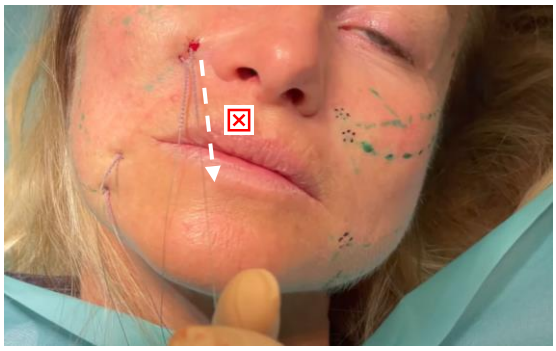
GOOD PRACTICE - Do not make an overall sliding movement of the thumb on the skin, as this can erode the skin. The thumb should slide as little as possible on the skin. It is a movement from one centimetre to the next in order to raise the skin as much as possible along the path of the thread.

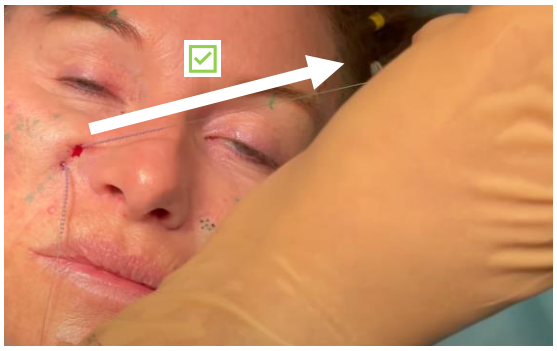
On the cheekbone thread routes, the skin is pulled to the maximum. Nevertheless, the cheekbone lift is adapted to the patient's expectations and desires.

For the other two paths, on the sections implanted in the deep plane of the SMAS, the full power of the threads can be exploited without the risk of forming gathers. This is not possible when the thread is implanted more superficially. **It is therefore necessary to be reasonable on the last 2 centimeters where the thread is no longer in the SMAS** but in the fat compartment.

Care is taken to elevate the skin by precisely following the path of the thread that is being tensioned without drifting onto the paths of the other threads.

The tensioning of the threads of the cheekbone must be done along the axis of exit, i.e. following the J-tail shape of the end of the path, and not downwards to avoid cutting / splitting the skin.





GOOD PRACTICE - In the presence of old skin or a particularly important elastosis, one should avoid asking the thread all that its power can offer in skin repositioning, in order to avoid creating unsightly folds at the level of the crow's feet.

10) Implantation of the second side of the patient's face

We can now perform the thread implantation on the second side of the patient's face following the same procedure as described above for the first side.

Once the implantation phase of the threads is over, the skin is cleaned (drawing of the paths and possible traces of blood).

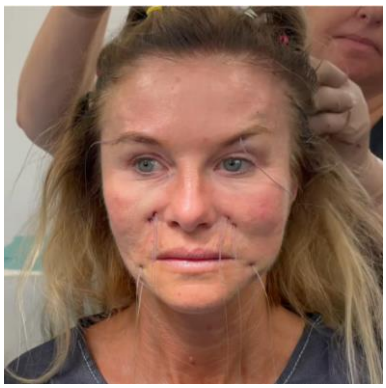
POINT OF CAUTION - The thread tips should not be cut at this point! They will be used for the final adjustment of the tension.

Phase 5 : The final adjustment of the tension

1) Precise tension adjustment

For the final adjustment of the 8 face threads, the patient must be in a seated position.

The objective is to elevate the tissues in a harmonious way, to reposition the cheekbones, to re-draw the oval according to the patient's wishes. The 8 threads of the face will be tightened with energy and adjusted in a symmetrical way.



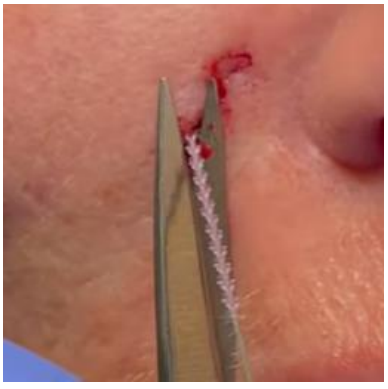
POINT OF CAUTION - Infinite-Thread® is powerful and its cogs are highly effective. Its tensioning must therefore be adapted to the needs of each area of the patient's face. It is not always necessary to use 100% of the power of the thread, particularly on the 3rd and 4th threads:

- ***Cheekbones*** : The cheekbones must be recompacted, fading away, if necessary, the tear trough, without creating excessive volume (unless specifically requested by the patient). In this area, the tissue elevation is no longer homothetic as in the upper third but concentric, except for men, so as not to feminise their face.

- ***Bitterness fold and jowl****:* Beware of an excessive tension on the last two centimetres of the path which could create a dimple. If this were to happen, a downwards massage with the thumb to relax the tension would be necessary, while at the same time and with the other hand, protecting the tension already acquired at the upper level.

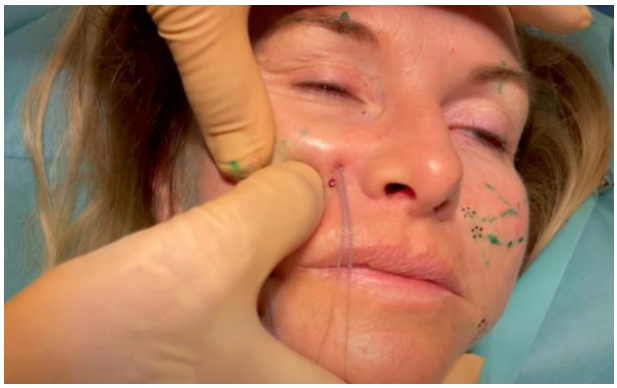
2) Cutting of the extremity of the threads

The tips of the threads are cut flush on each cheek, by pushing the skin back slightly with the scissors.



3) Dimple release

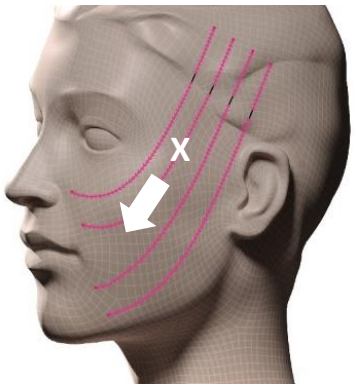
One by one, the tip of each thread is released from its attachment to the skin to eliminate any risk of immediate or secondary (when the oedema disappears) appearance of dimples.



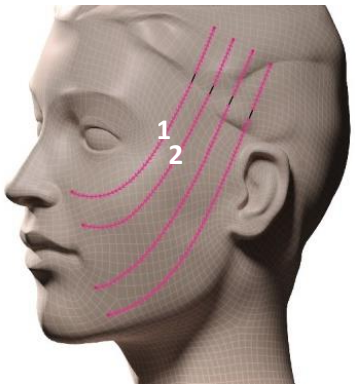
In practice, 2 problems may occur:

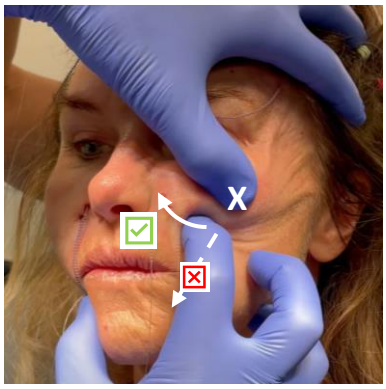
- ***The appearance of dimples***: Dimples at the exit points are due to threads having created a depression of the skin at their exit point. Contrary to what we often hear, **they do not disappear by themselves**. **The patient should never leave with one or more dimples.** Keep in mind that the presence of a fold or a dimple is always the result of an error or a shortcoming in the gesture of the practitioner.

- ***The appearance of furrows***: You may see a furrow of 1 or 2 centimetres along the axis of the thread. If this were to happen, it would reflect an excess of tension at the lower tip of the thread. It would be essential to immediately loosen the tension in this specific area, taking care not to loosen it over the entire thread. One hand must be placed higher up (above the area to be manipulated) on the path of the thread **(X)** - and apply a slight upward tension to protect the thread's attachment – and with the other hand, energetically massage downwards the skin opposite the furrow (in the direction of the arrow →) in order to **TOTALLY** eliminate the defect(s).



When correcting furrows on the extremity of the path of the threads **(1)** and **(2)**, particular care should be taken to massage the skin along the J-tail shape of the end of the path of the threads.





POINT OF CAUTION - A patient should never leave your practice / clinic with folds, dimples or other furrows caused by the implantation of suspension threads! Time does not work for you: any defect will persist and will be more difficult to correct as the days go by due to the resorption of the oedema.

4) Cutting of the high end of the threads

It is best to pull very slightly on the top tip of the threads to bring out 2 or 3 rows of cogs, i.e. about 5mm of thread, before cutting them flush. Once the tips are cut, the threads will retract by the same amount (about 5mm). This step ensures that the tips of the threads are perfectly buried.

GOOD PRACTICE - To be safe, the scalp should then be pushed back over the exit points to ensure that it has properly covered each extremity that has just been cut flush.

Again, check for the absolute absence of any partially buried hair.

POINT OF CAUTION - The upper end of the threads must always be cut at the very end, after the final adjustment!

Indeed, the **NON-CUT** upper extremities of a thread allow a last traction of the thread if ever it had not been tightened enough or if unfortunately, it had been slightly relaxed during the release of a dimple at the level of its lower exit point.

In the post-operative phase, the patient must follow his or her doctor's prescriptions. You can find the prescriptions provided, as an indication, by our expert, Dr. Jean-Paul Foumentèze, in the document [Medical prescription – Thread & Lift] available in your private area on the website www.threadandlift.com.

USEFUL INFORMATION

It is common for local anesthesia to induce a paresis or paralysis observed at the frontal and / or jugal level. This usually disappears within a few hours (exceptionally up to 12 hours in rare cases). No special treatment or action is necessary. However, for better acceptance, the patient should be warned of this eventuality.