

Installation Protocol

-

Double crossing technique

-

Area treated: the Neck

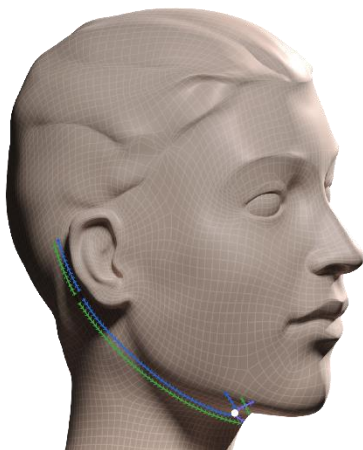
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The Double Crossing Technique can be performed on the neck alone or in combination with the face and / or eyebrow treatment. Please refer to the [Installation Protocol – Face Lift]¹ for details on the face lift and refer to the [Installation Protocol - Eyebrow Lift] for details on the eyebrow lift.

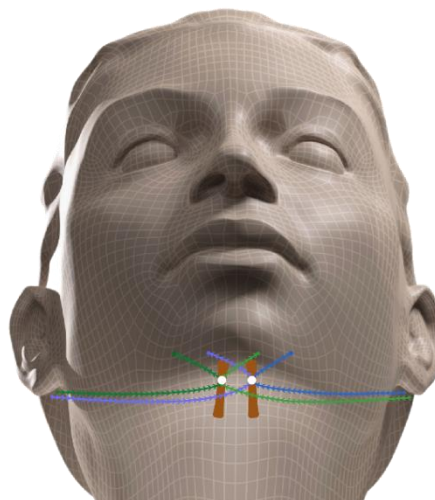
Thread & Lift offers you the most precise and detailed protocol possible. Its objective is to allow you to find the answer easily and quickly to any technical question. This way, if you have any doubts after our training, you can refer to this comprehensive protocol. This protocol details the Double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

We also advise you to refer to the video [Infinite Thread - Neck Lift using the double crossing technique (duration: 39 min) / Area treated: Neck] 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 4 Infinite-Thread® for the neck - 2 per side of the neck - with the Double crossing technique.



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

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To practice the Double crossing technique, the list of equipment needed is as follows:

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



- ✓ **1 micro-cannula 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-cannula 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)**



**2 x Mini-Kit
Infinite-Thread®**

- ✓ **4 curved needles with blunt tips – 19cm (6)**
- ✓ **1 straight needle with a blunt tip – 19 cm²**
- ✓ **1 Adson clamp without claws (7)**
- ✓ **1 Mayo-Hegar needle holder (8)**
- ✓ **1 pair of straight scissors (9)**

**In the
Instrument Kit**

² As this needle is not required for the procedure, it is not shown in the table installation photo - Photo 1: Intervention equipment

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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)

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Here are the pictures of the installation of the equipment:

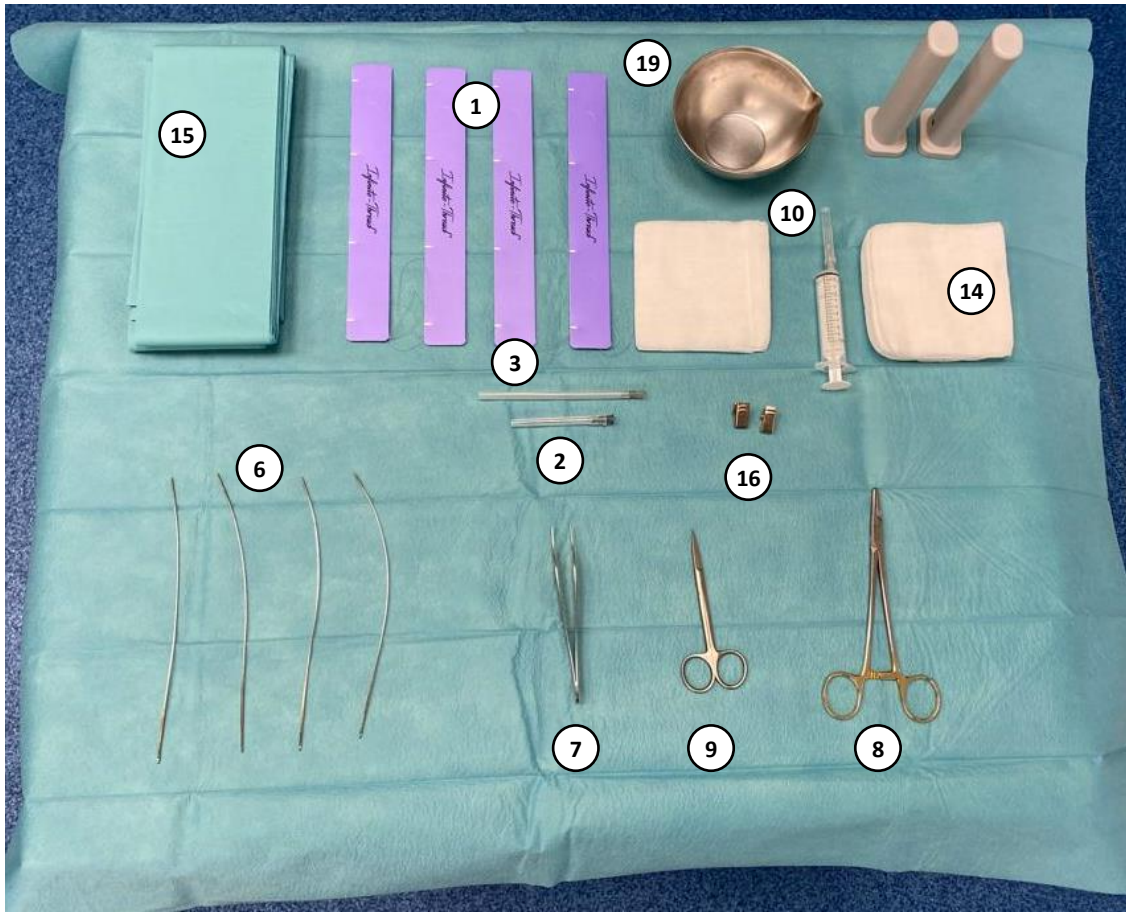


Photo 1: Intervention equipment

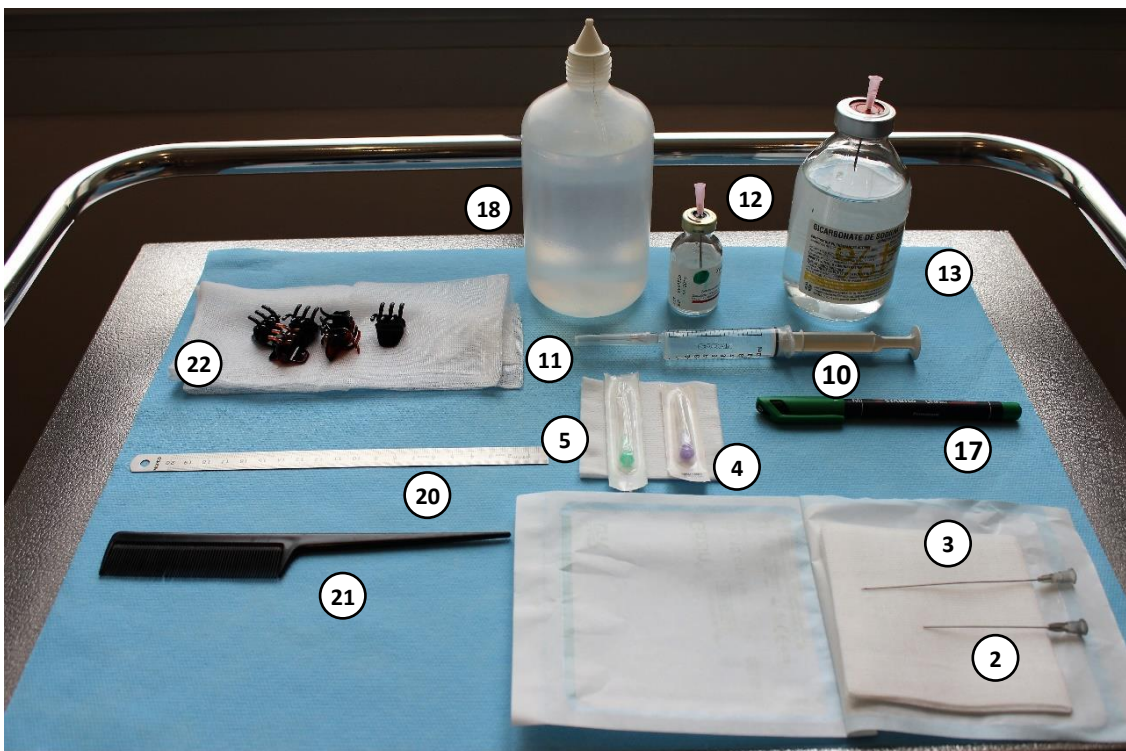


Photo 2: Local anesthesia equipment

The Double Crossing technique is performed in 5 phases:

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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.

1) Preoperative medication

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.

Just before the start of the procedure, our expert trainers recommend the intake of:

- 1) 2 Pristinamycin 500 mg pills (e.g. PYOSTACINE) to be taken 30 minutes before the intervention, to prevent the risk of infection.³
- 2) 1 pill of non-steroidal anti-inflammatory drug (NSAID) such as Ketoprofen 100 mg (Ex: BI-PROFENID), to be taken 30 minutes before the intervention.
- 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)

OR

- 3) Option 2 :
 - + 1 tablet of IZALGI (Paracetamol 500mg, opium powder 25mg)
 - + 1 tablet of Paracetamol 500mg (Ex : DOLIPRANE)

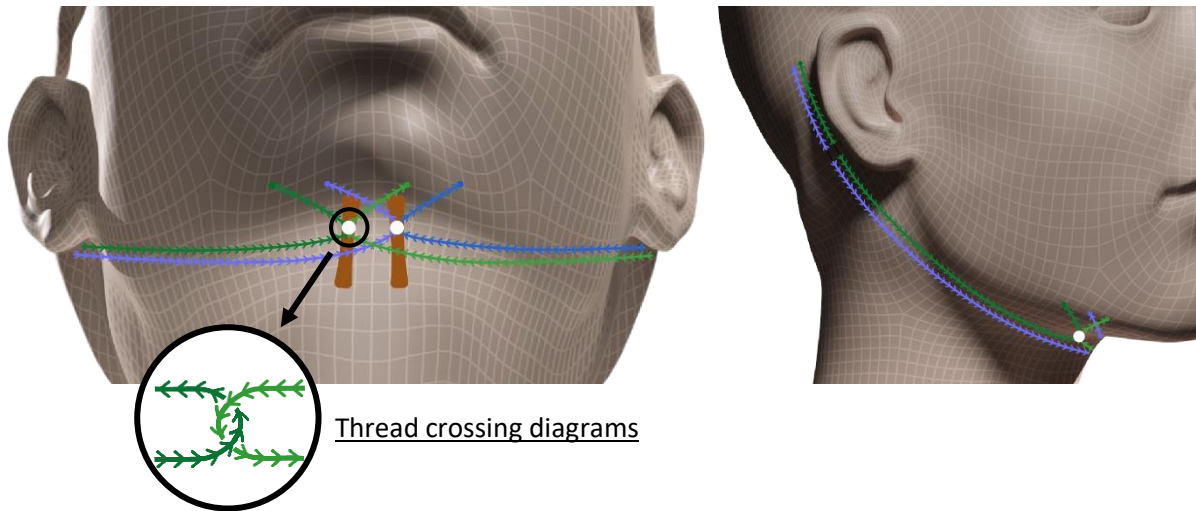
2) Preparation of the patient

As the mastoid area is generally covered with fluff (that is often invisible to the naked eye), it may be useful to shave the area before inserting the threads to avoid introducing fluff through the entry point.

³ Pristinamycin was chosen because of a growing number of allergies to penicillins.

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Phase 2 : The drawing



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



Good Practice - To facilitate the reading of the paths during the intervention, 2 colours will be used to draw them. Thus, all the paths concerning the **left platysmal band** will be drawn in **blue** and those of the **right platysmal band** in **green**.

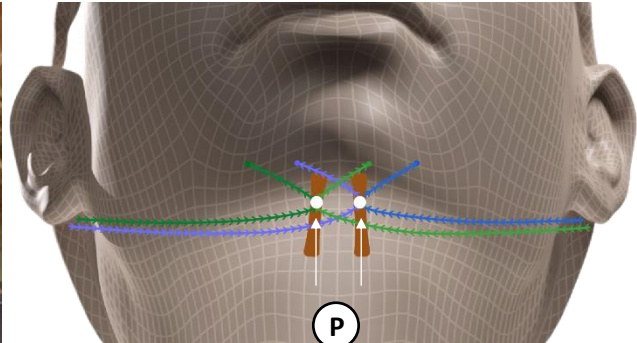
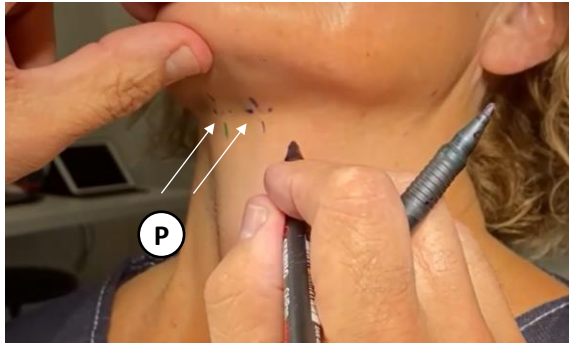
3) Drawing of entry points in the platysmal bands

The point of entry into each of the platysmal bands (**P**) is identified. These are the points where the threads will cross to restore the cervicomental angle. It is important to ensure that the patient's head is not tilted backwards during this identification procedure.



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Once identified, drawing the entry points in each of the platysmal bands (**P**) will however be easier if the patient tilts her head back.



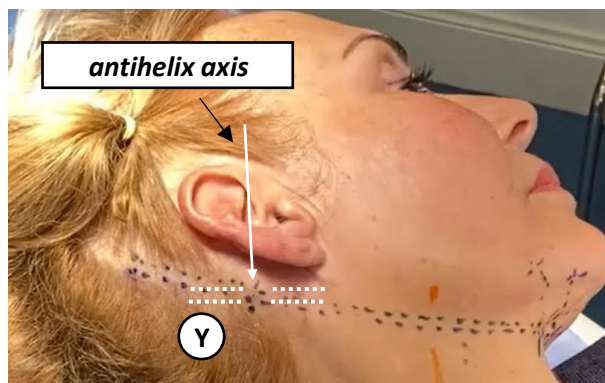
4) Drawing of thread returns after crossing

At the crossings in the platysmal bands, we draw the thread returns [*returns*] over a distance of 3 or 4 cm. These returns will act as locking elements.



5) Drawing of mastoid entry points

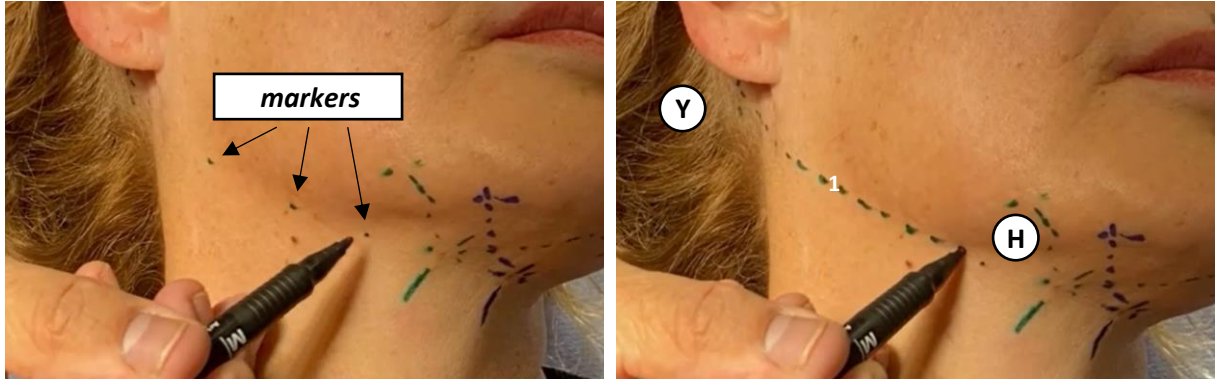
The entry points (**Y**) of the threads are located behind the mastoid, in line with the antihelix [*antihelix axis*]. Their position relative to the back of the ear is measured and recorded in the operative report. Each thread must have its own entry point and superior path.



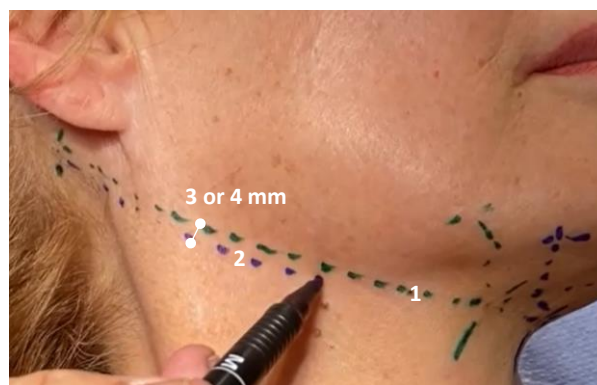
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6) Neck path drawing - right side

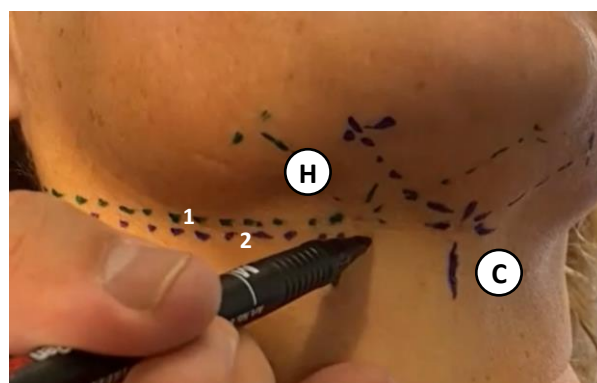
In **green**, the upper path **(1)** is drawn straight from its mastoid entry point **(Y)** to the point of entry into the homo-lateral platysmal band **(H)**. Beforehand, markers **[markers]** are drawn along the path to ensure a straight path (you can use the tail of the comb or a ruler to do this).



In **blue**, the inferior path **(2)** is also drawn from its mastoid entry point **(Y)**. It runs parallel to path **(1)**, 3 or 4 mm below.



Path **(2)** goes beyond the homo-lateral platysmal band **(H)** to join the entry point of the contralateral platysmal band **(C)**.



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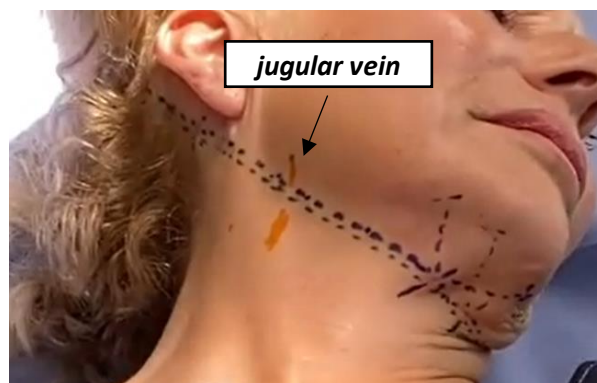
7) Neck path drawing - left side

We can now draw the paths on the left side of the patient's neck following the same procedure as described above for the right side, reversing the colours: **the upper path** is in **blue** and **the lower path** in **green**.



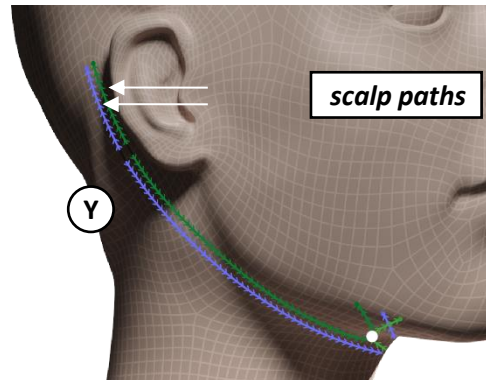
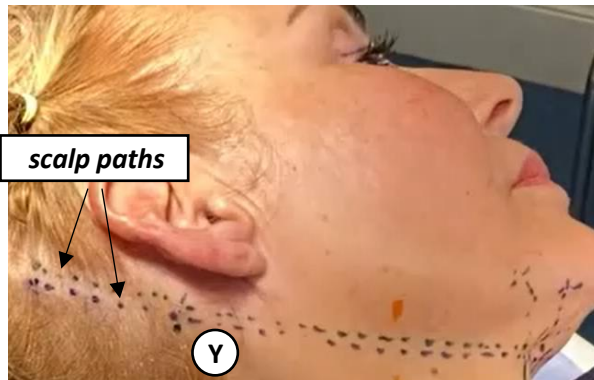
8) Drawing of the jugular vein passage

On each side, we draw the passage of the jugular vein [**jugular vein**] since this is where we will change planes to dip into the platysma.



9) Scalp path drawings

Starting from the mastoid entry points (Y), we draw the scalp paths **[scalp paths]** by extending the neck paths drawn previously over a distance of 5 cm.



It is essential to take photos of the drawings!

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

They will make it easier for you to find the path of the threads in order to carry out the tumescence required to unhook the cogs. In fact, without a precise tumescence following the entire thread path, it would be difficult to remove the thread. This is why it is also IMPERATIVE to measure and mark in the operative report the location of the mastoid entry zones (in relation to the antihelix of the ear).

You will find a detailed removal protocol in your private area of our website www.threadandlift.com, in the "Documents & Photos" section, as well as a sample operative report.

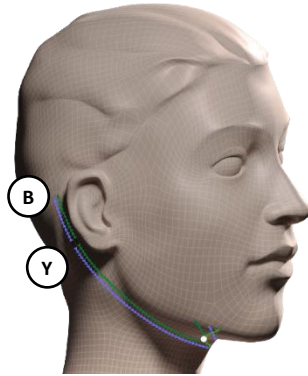
These photos can also be very useful in the future, should you decide to treat the patient again.

Phase 3 : Anesthesia

1) Anaesthesia of mastoid entry points, scalp exit points and platysmal band entry points

Required equipment:

- 1 needle 27 G 40mm or 30 G 13 mm (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)



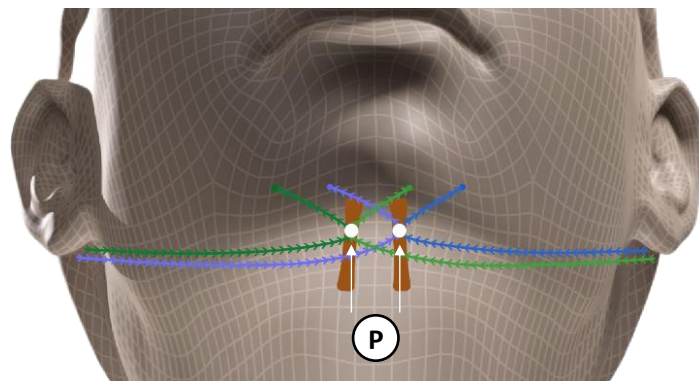
We anesthetize, in order:

- The entry points at the mastoid level (**Y**)
- The exit points at the scalp level (**B**)
- The entry points of the platysmal bands (**P**)

Anesthesia of the mastoid entry points (**Y**) and scalp exit points (**B**) is done in the form of a fairly large 0.5 cc papule, enabling the skin to be distanced from the subcutaneous tissue and therefore from the vessels.



At the entry points of the platysmal bands (**P**), anesthesia is done in depth, from 0.5 to 1 cm.



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We inject just under 1 cc per entry point (**P**) to ensure that the platysmal bands are well numbed.

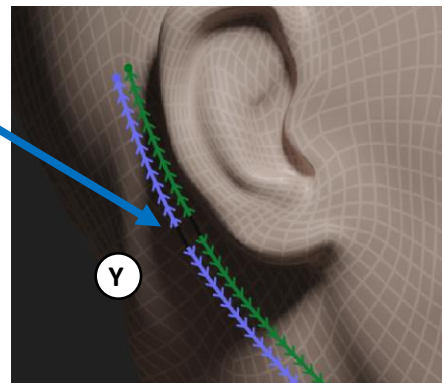
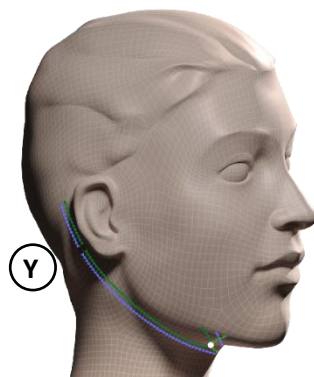
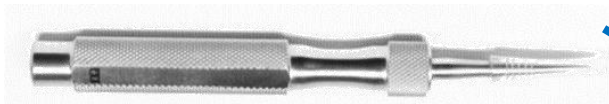


2) Opening of the mastoid entry points

Required equipment:

- 1 punch (preferable) or 1 needle Nokor (provided in the Infinite-Thread® kit 4x2)

1 circular opening is made with the punch at each of the mastoid entry points: (**Y**) (2 openings in all on each side).



IMPORTANT - If you prefer to make an incision, take particular care not to penetrate too deeply into the subcutaneous tissue to avoid the risk of bleeding. This risk is greatly reduced by the use of our punch.

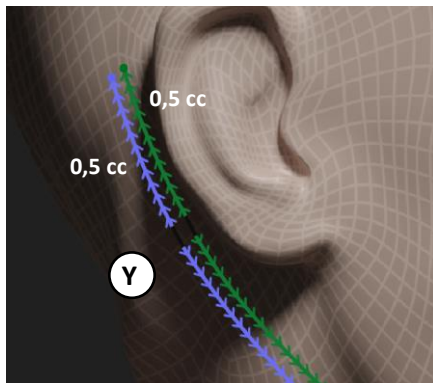
3) Anesthesia of the paths – at the level of the scalp

Required equipment :

- 1 cannula 22 G 50mm (provided in the Infinite-Thread® kit 4x2)
- 1 syringe of 10cc (not provided) (3cc or 5cc are also suitable)
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.**

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Scalp paths [*scalp paths*] are anesthetized in retrograde, using the 22G 50 mm cannula, from the mastoid entry point (Y). It is important that the cannula is positioned in the **EXACT** plane where the threads will be implanted, i.e. **between the scalp and the galea**.



We inject 0.5 cc per path in the scalp [*scalp paths*].

4) Anesthesia of the paths – from the mastoid to the jugular vein

Required equipment :

- 1 cannula 22 G 50mm (provided in the Infinite-Thread® kit 4x2)
 - 1 syringe of 10cc (not provided) (3cc or 5cc are also suitable)
- 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.**

Anesthetize the paths [*paths*] from the mastoid to the jugular vein in retrograde, using the 22G 50 mm cannula, from the point of entry (Y).

To ensure that the cannula is not visible, it is not positioned strictly subcutaneously, but must cross the aponeurosis at the level of the sternocleidomastoid muscle. It is important that the cannula is positioned in the **EXACT** plane in which the threads will be implanted.



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It may be useful to compact the skin upwards to allow the needle to go as low as possible.



We inject 0,5 cc per path [*paths*].

5) Repeating steps 1) to 4) for the 2nd side

Steps 1) to 4) are repeated for the 2nd side. That is:

- 1) Anesthesia of mastoid entry points and scalp exit points
- 2) Opening of the mastoid entry points
- 3) Anesthesia of the paths – at the level of the scalp
- 4) Anesthesia of the paths – from the mastoid to the jugular vein

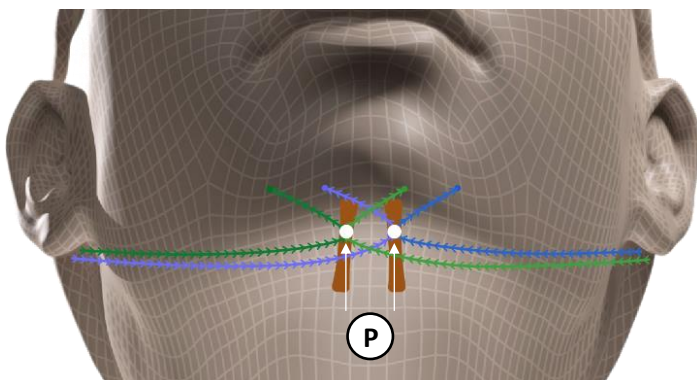
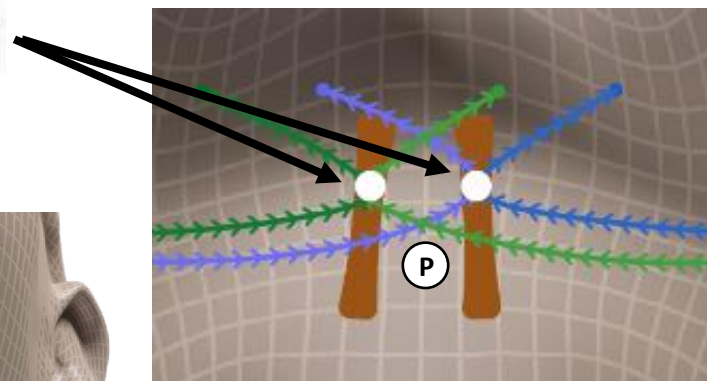
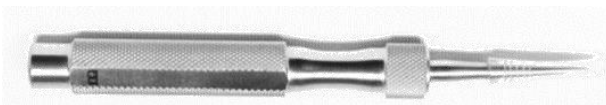
GOOD PRACTICE - The anesthesia of the entry points in the platysmal bands is performed before the anesthesia of the second side. In this way, once the anesthesia of the second side has been completed, anesthesia of the entry points in the platysmal bands will have had time to take effect, enabling the procedure to continue without interruption.

6) Opening of entry points in the platysmal bands

Required equipment:

- 1 punch (preferable) or 1 needle Nokor (provided in the Infinite-Thread® kit 4x2)

The punch is used to make 1 circular opening at each of the entry points into the platysmal bands (**P**).

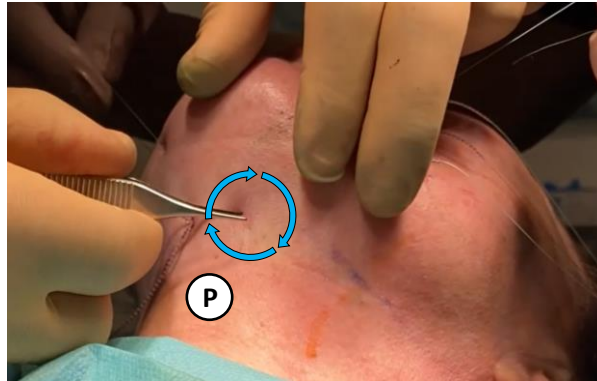


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IMPORTANT - The use of a Nokor needle is discouraged here, as it leads to the formation of a scar at each of the entry points into the platysmal bands, which is not the case with a punch.

GOOD PRACTICE - To limit dimple formation at the points of entry into the platysmal bands (**P**), a 360-degree subcision of the two crossing orifices is performed by rotating the Adson pliers, allowing to detach the skin from the subcutaneous tissue.

Although this procedure can be carried out at the end of the intervention, if necessary, it is preferable to perform it before the threads are implanted (*Phase 4*) to avoid damaging them.



7) Anesthesia of the paths - from the jugular vein to the point of entry into the homo-lateral platysmal band

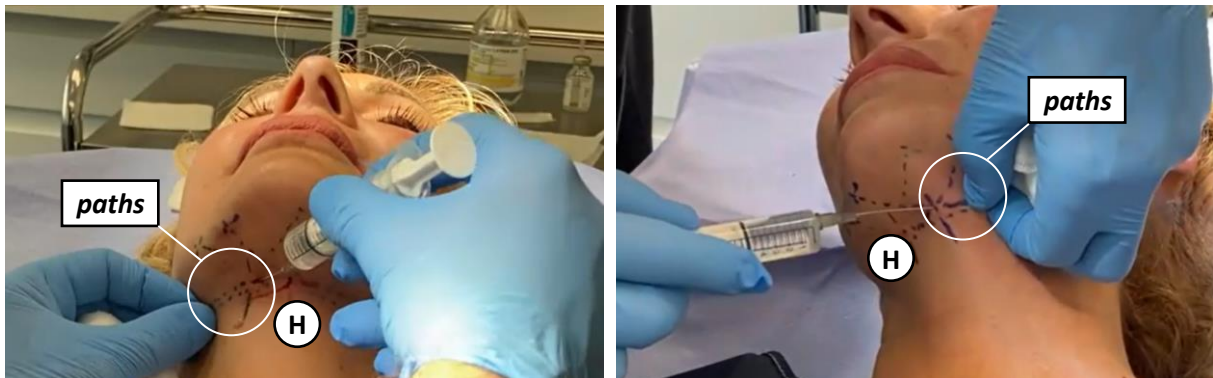
Required equipment:

- 1 cannula 22 G 50mm (provided in the Infinite-Thread® kit 4x2)
- 1 syringe of 10cc (not provided) (3cc or 5cc are also suitable)
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.**

Anesthesia of paths [*paths*] from the jugular vein to the point of entry into the homo-lateral platysmal band (**H**) is performed in retrograde, using the 22G 50 mm cannula, from the point of entry into the homo-lateral platysmal band (**H**).

The cannula is positioned deep inside the platysma.

Note that here, it is not necessary to anaesthetize the 2 paths; only 1 is sufficient.



We inject 0,5 cc per side.

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8) Anaesthesia of thread returns after crossing

Required equipment:

- 1 cannula 22 G 50mm (provided in the Infinite-Thread® kit 4x2)
- 1 syringe of 10cc (not provided) (3cc or 5cc are also suitable)
- 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.**

Retrograde anaesthesia of the thread returns **[returns]** is done with the 22G 50 mm cannula, starting from the point of entry into the platysmal band (**P**).

The cannula is positioned in the strict subcutaneous plane. These returns serve to lock the threads and prevent the crossings from loosening.



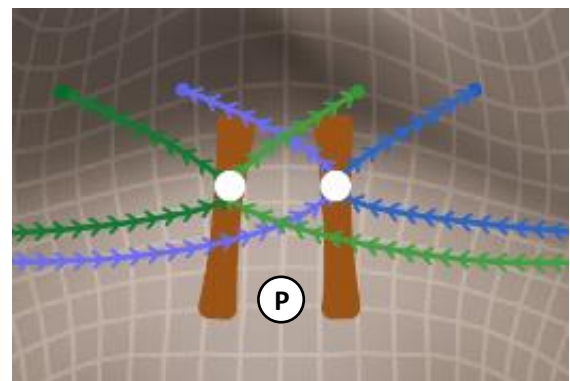
We inject 0,5 cc per path **[returns]**.

9) Anesthesia of the paths - between the 2 entry points into the platysmal bands

Required equipment:

- 1 cannula 22 G 50mm (provided in the Infinite-Thread® kit 4x2)
- 1 syringe of 10cc (not provided) (3cc or 5cc are also suitable)
- 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.**

The paths between the 2 platysmal band entry points (**P**) are anesthetized in retrograde, using the 22G 50 mm cannula, from one platysmal band entry point to the second. **The cannula is positioned in the depth of the platysma and must remain deep.**



We inject 0,5 cc on the path.

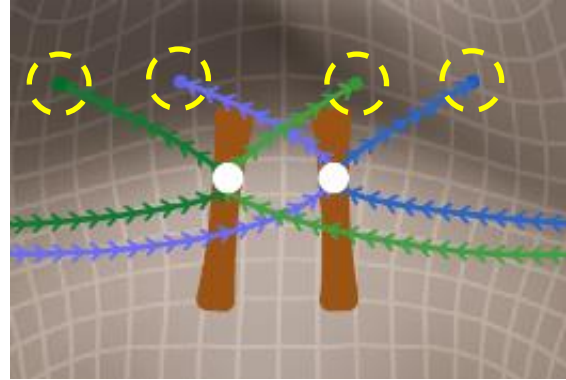
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10) Anesthesia of thread return exit points after crossing

Required equipment:

- 1 needle 27 G 40mm or 30 G 13 mm (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)

For greater comfort and to prevent bruising at the thread exit points, a few drops of anesthetic are injected at the exit points of the thread returns.



Phase 4 : Thread implantation

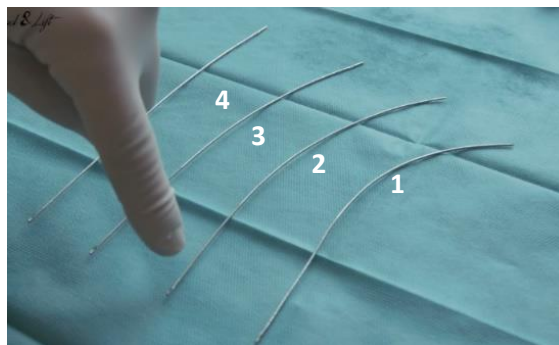
It is now imperative to work in sterile conditions if it was not yet the case.

While it was not mandatory during the previous phase (*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 needles⁴ **(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 latter 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).

⁴ Our reusable instrument kit contains a 5th needle. This needle is straight and is intended to be curved as you wish.

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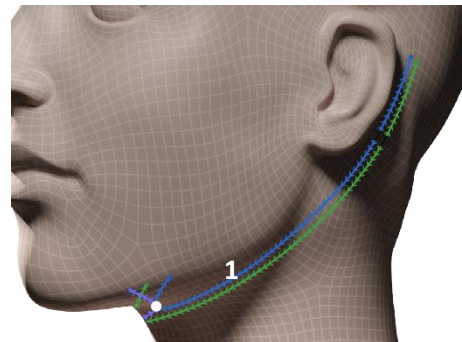
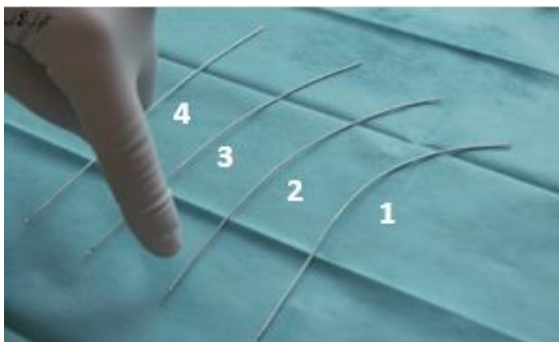


GOOD PRACTICE - If during the implantation of a thread you realize that the curvature of the needle you are using is not the right one, do not hesitate to step back, take it out and change it, to work with the correct curvature. Indeed, a needle that is too curved tends to descend too quickly in the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

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 – in the neck

The needle **(3)** (or needle **(4)** depending on the patient's anatomy) is preferably used to place the thread in the neck **(1)**.

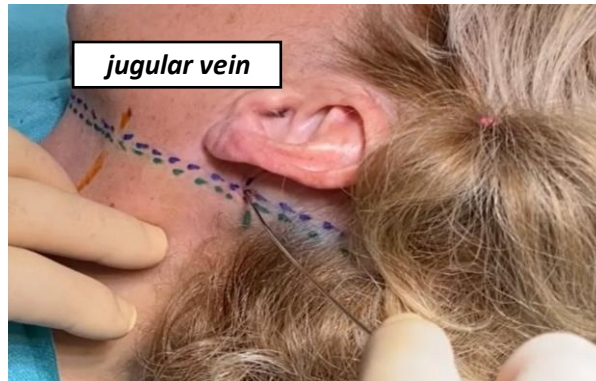


The curvature of the needle should follow the path of the patient's neck.



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The needle is inserted vertically, never at an angle, to avoid creating a dimple as the thread passes through the thickness of the dermis (the thread must be free under the skin). Once the beginning of the subcutaneous space has been reached, **the needle is repositioned parallel to the skin**, to avoid penetrating too deeply.



The start of the path can be quite difficult in this area, which is closely adherent to the sternocleidomastoid muscle.

IMPORTANT - Nevertheless, it is advisable to descend slightly into the aponeurosis of the sternocleidomastoid muscle to avoid any visibility of the needle. Indeed, any visibility of the needle will result in visibility of the thread once inserted. In particular, the needle must not create an arch under the skin, otherwise the thread may appear as a stretched rope.

The needle is guided to the jugular vein **[jugular vein]**, previously marked with a felt-tip pen during the drawing phase (*Phase 2 of the protocol*).



The positioning of the thread, **which is much more superficial than on the face**, results in some slight gathers down to the jugular vein **[jugular vein]**. Of course, these will be smoothed out during final tension adjustment (*Phase 5 of the protocol*).

IMPORTANT - For every centimetre covered when implanting the needle, it is necessary to rotate it regularly, from right to left and vice versa, to ensure that it does not create too great a depression. If this were the case, it would mean that the needle was directly hooking the skin, and that it was positioned too superficially. If in doubt, **do not hesitate to step back and reposition the needle** a second time. A needle inserted in the wrong plane, even at a single point along the path, would pull the entire thread into the wrong plane, resulting in a placement fault and a compulsory thread removal.

Thread & Lift



Once past the jugular vein, the needle is turned downwards to reach the platysma. This movement is more or less difficult to perform, depending on the mobility of the tissues. It is by grasping the skin and the platysma, and bringing them up towards the needle, that the latter is advanced.



The perception of a crackling sound as the needle passes is confirmation that the needle is at the right depth in the platysma.

Continue to advance the needle through the middle of the platysma, or by pearling it, up to the point of entry of the homo-lateral platysmal band.



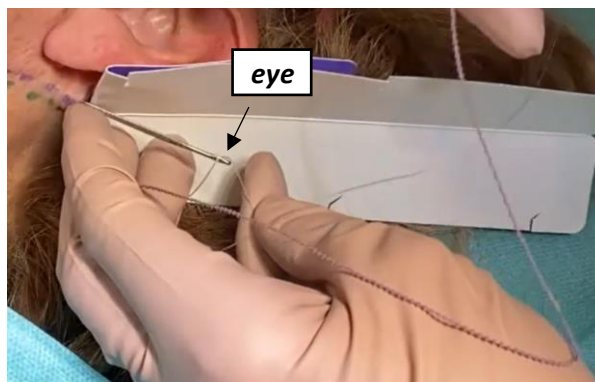
IMPORTANT - It is essential to remain at depth until you reach the needle exit point at the level of the homo-lateral platysmal band (H).

To ensure that the thread is perfectly aligned with the platysmal band, care should be taken to **exit the needle directly from the depth towards the surface**, rather than progressively. Do not hesitate to repeat the exit of the needle in case of doubt, the impression of a hooked needle or the formation of a dimple.

Thread & Lift



The smooth end of the Infinite-Thread® is then passed through the eye of the needle **[eye]**. Care must be taken not to pass any cogs through the eye of the needle to prevent it from becoming blocked.



The thread is guided by the cardboard box in which it is packaged. This is very useful for holding the hair flat underneath and ensuring that it does not slip in with the thread. Nevertheless, should one or more hairs get embedded with the thread, they would be removed using the Adson pliers (supplied in the instrument kit).



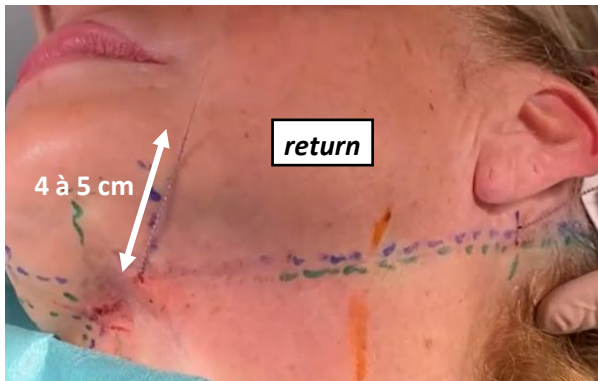
Thread & Lift

Once the thread is passed through the eye of the needle, and while applying upward tension in the middle of the path, it is pulled using the needle until it is completely buried.



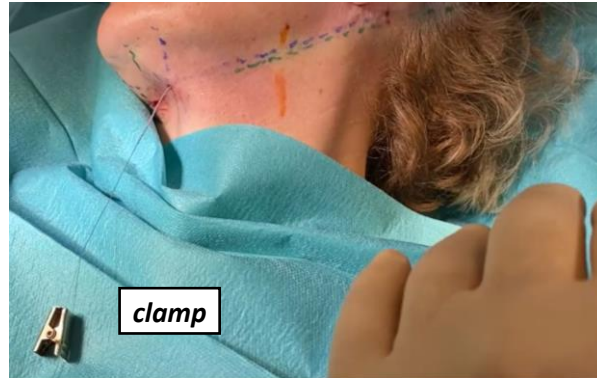
The thread should be pulled until at least 4 to 5 cm of cogs emerge beyond the point of entry of the platysmal band (**P**), a length which corresponds to the thread return after crossing **[return]**. In the case of the patient illustrating this protocol, we will stop once the black marking **[middle]** has been buried.

GOOD PRACTICE - In the case of longer necks, particularly in men, it may be necessary to bury the black marking **[middle]** by 1 to 1.5 cm in order to obtain a sufficient return length (4 to 5 cm) to guarantee an effective locking.



Thread & Lift

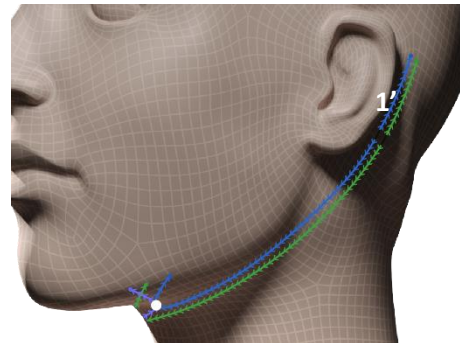
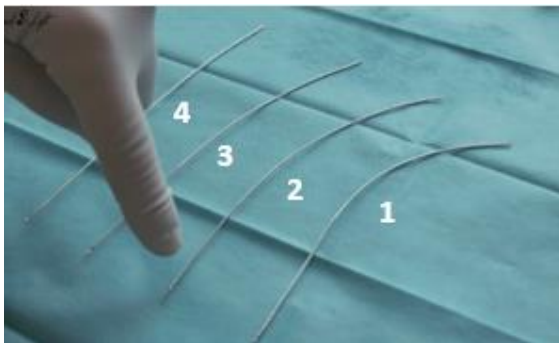
A clamp [**clamp**] is placed on the first thread coming from the left side, to act as a coding device. This will allow you to check when crossing the threads that the left thread is crossed on the left side and that the right thread is crossed on the right side. If you do not have additional clamps, you can tie a small knot at the end of the thread, which you will cut before you insert the thread into the eye of the needle to complete the crossing.



At this point, the return is set aside and will be implanted at a later phase.

2) Implantation of the 1st thread – at the level of the scalp

A moderately curved needle **(2)** or **(3)** is used to position the thread at the level of the scalp **(1')**.



After penetrating the needle vertically until it reaches the correct plane, i.e. the beginning of the subcutaneous space, it is repositioned parallel to the scalp.



The needle should travel between the scalp and the galea, following the drawing. Gently advance the needle until it reaches its exit point [**exit**]. Excessive resistance as the needle passes through would indicate that it is positioned too superficially.

Thread & Lift



The smooth end of the Infinite-Thread® is then passed through the eye **[eye]** of the needle.

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



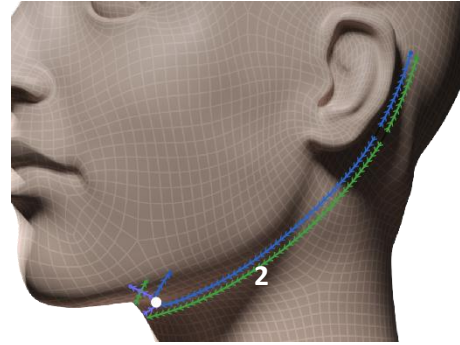
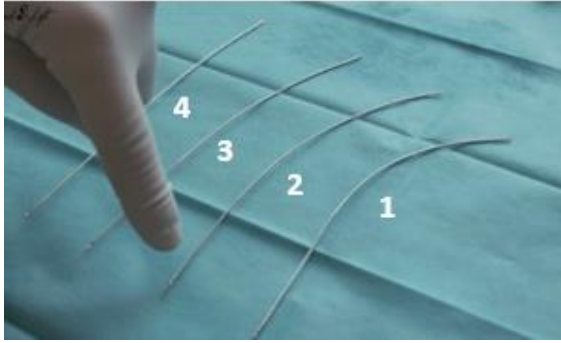
IMPORTANT - The absence of embedded hairs must be checked with extreme caution! It is the presence of a half-in, half-out hair that is generally responsible for an infection.



3) Implantation of the 2nd thread – in the neck

To place the 2nd thread in the neck **(2)**, we use a more curved needle **(2)** than the one used to implant the 1st thread. Indeed, a greater curvature is required to allow the needle to pass beyond the median zone and reach the contralateral platysmal band.

Thread & Lift



From the mastoid entry point to the homo-lateral platysmal band, we use the same procedure as for implanting the 1st thread in the neck.

IMPORTANT - For the first part of the path, the curvature of the needle is too pronounced, making it more difficult to handle than on the 1st path. For this reason, particular care must be taken to ensure that the needle follows the path of the thread on the skin, rather than the shape of its curve. The curvature of the needle is essential for the end of the path, but more complex to manage for its beginning.

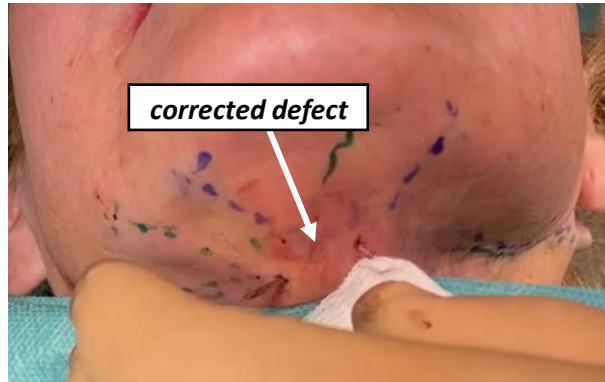
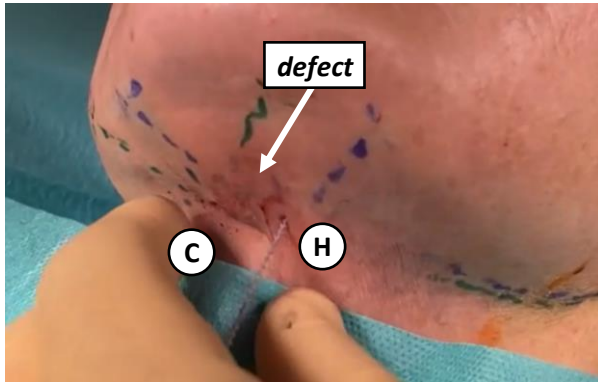


When the needle reaches the homo-lateral platysmal band (**H**), it should remain at the same depth until it reaches the contralateral platysmal band (**C**).

It should be noted that this step may be unpleasant for the patient, hence the importance of providing sufficient anesthesia.

GOOD PRACTICE - Being too superficial when passing from the homo-lateral platysmal band (**H**) to the contralateral platysmal band (**C**) could create a hollow or irregularity [*defect*]. In such a case, it would be sufficient to move the needle back and resume the trajectory in the correct, deeper plane, until arriving at the needle exit orifice of the contralateral platysmal band (**C**).

Thread & Lift

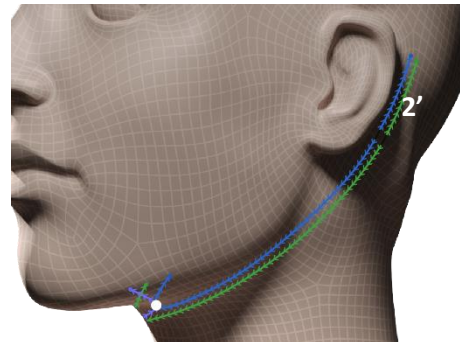


From here, the same procedure as for implanting the 1st thread in the neck is applied; when the needle is pulled out of the platysmal band, and the thread buried. We pull it out until we have extracted 4 - 5 cm from the thread, to allow for the return after crossing: here, we do not bother with the positioning of the black mark.



4) Implantation of the 2nd thread – at the level of the scalp

To implant the 2nd thread at the level of the scalp (2'), the same needle (2) or (3) is used as for implanting the 1st thread at the level of the scalp.



The procedure is the same as for the 1st thread at the level of the scalp.

Thread & Lift

As with all threads, we continue to check for any buried hairs.



5) Repeating steps 1) to 4) for the 2nd side

Steps 1) to 4) are repeated for the 2nd side. That is:

- 1) Implantation of the 1st thread (blue) - in the neck
- 2) Implantation of 1st thread - at the level of the scalp
- 3) Implantation of 2nd thread (green) - in the neck
- 4) Implantation of 2nd thread (green) - at the level of the scalp

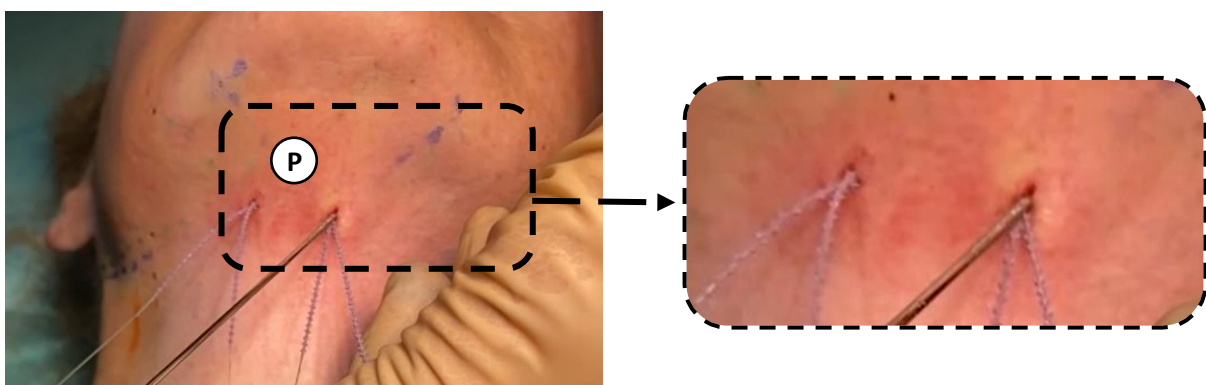
Only the threads from the first side will receive a clamp as a coding device.

6) Implantation of the thread returns

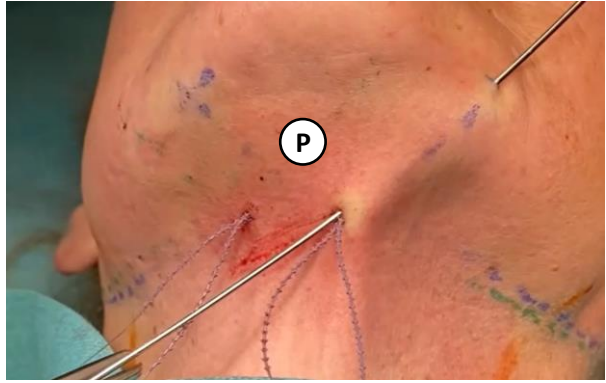
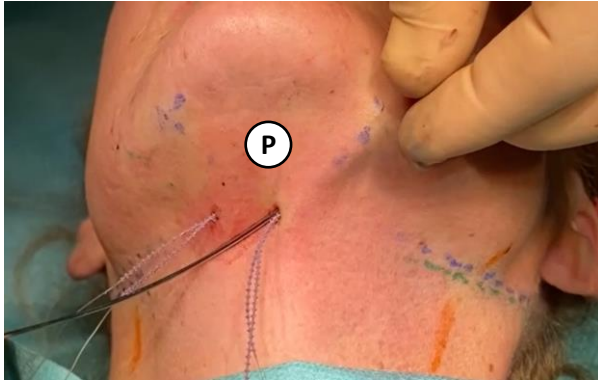
For the thread returns, we use a curved needle, preferably (2), to easily cross the mandibular border.

By grasping the two threads of one of the platysmal bands (P) and pointing them downwards, an access for the needle is created. The needle is inserted into this access, formed above the two threads, so as not to uncross what will later be crossed.

As with all other threads, the needle is inserted vertically. The needle then travels 4 or 5 cm into the subcutaneous tissue, exiting slightly above the mandibular ridge.

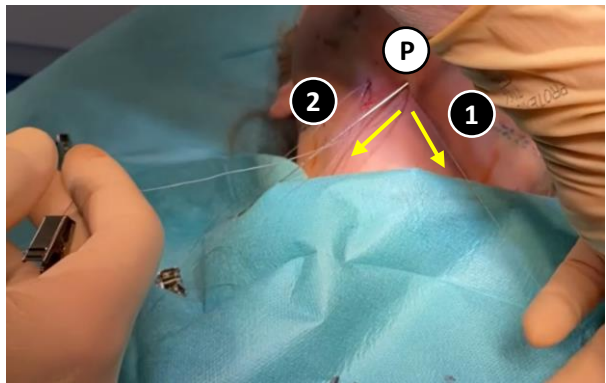
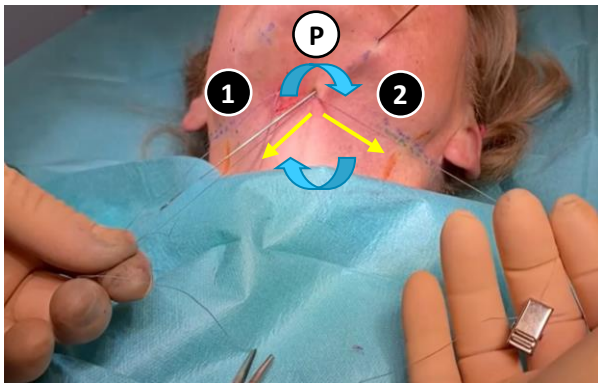


Thread & Lift



We try to exit the needle tip exactly or as close as possible to the point of anesthesia, to benefit from as much vasoconstriction as possible and ease the needle exit.

At the platysmal band entry point (**P**), the threads are crossed.



After crossing, remove the clamp from the left thread and pass it through the eye of the needle.

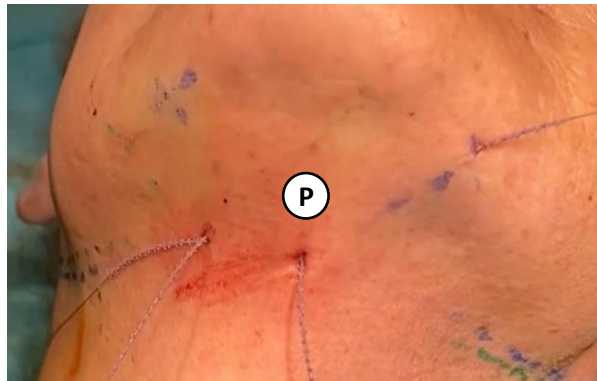


Gently pull the thread through, and notice that as it buries, a loop forms. **Position a finger in this loop to prevent the thread from burying itself too quickly with the needle, and the crossing from becoming slightly off-centred.**

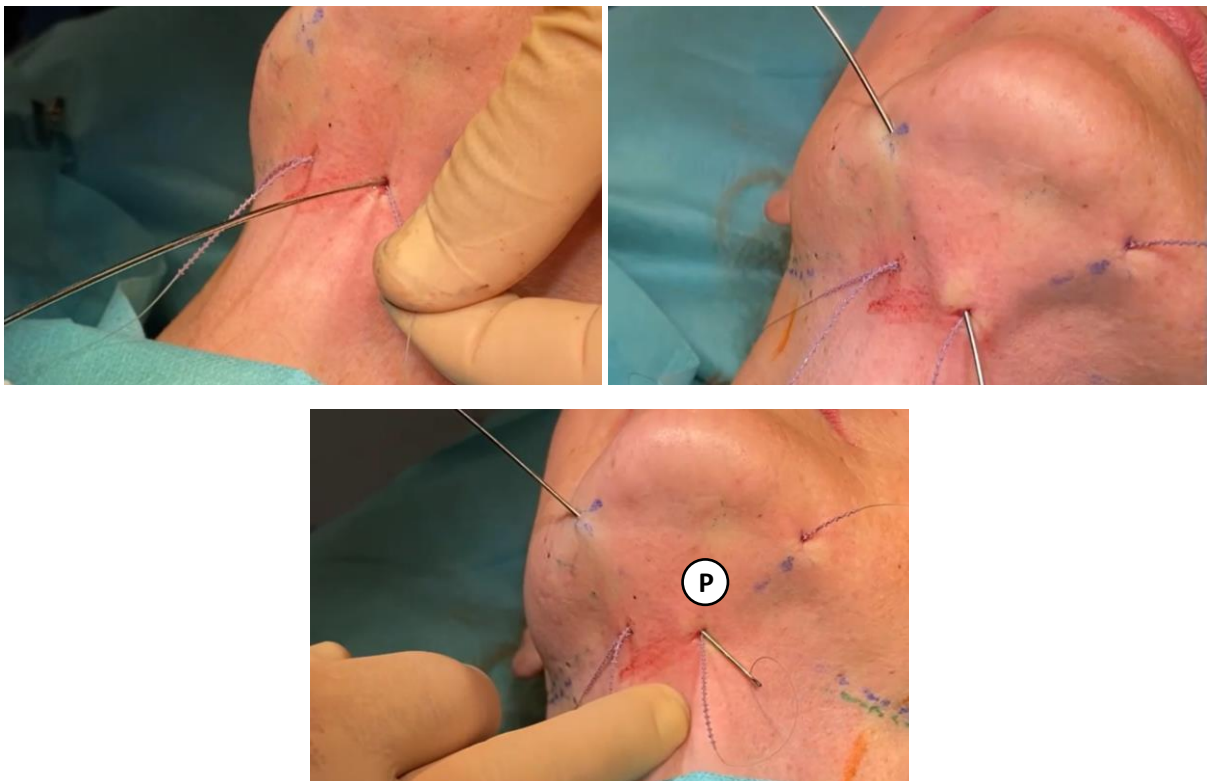
Thread & Lift



Once the finger has been removed from the loop, gently pull the thread until it is completely buried. It is not necessary to bury it deeply, just enough to free up an access for the needle, which will enable the second thread of the crossing to be buried, the one going back to the right in our example illustrating this protocol.



The same procedure is followed for the second return, taking care not to uncross the threads.



Thread & Lift

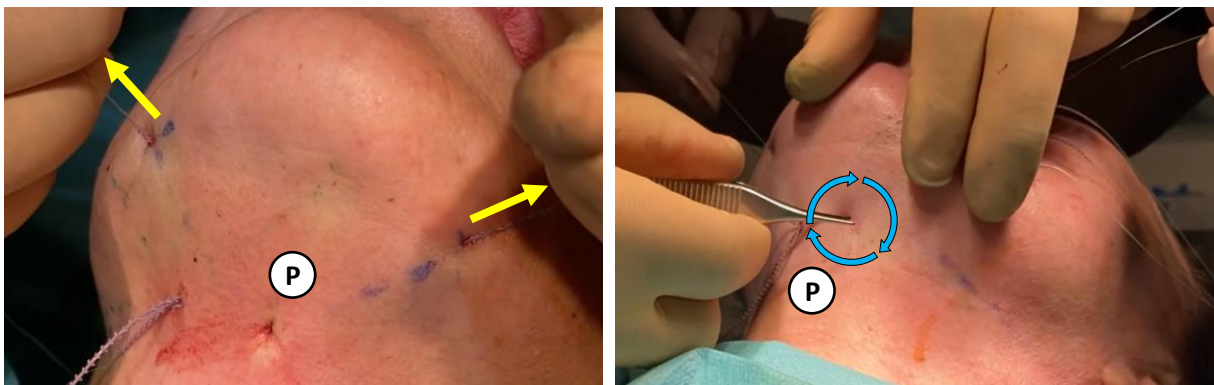
Lightly tension the tips symmetrically.

If a dimple appears at the entry point of the platysmal band (**P**), the thread hooking within the groove formed at that same entry point, should be further released (*see Phase 3: Anesthesia - 6) Opening of the entry points in the platysmal bands*).

While maintaining the tension and using an Adson pliers or one of the implantation needles, release the thread hooking within the groove by a circular movement under its edges.

At the end of this step, the skin should be completely free of thread hooking, which means that the dimple has completely disappeared.

Particular care must be taken not to damage the thread with the Adson pliers (or one of the implantation needles).



The tips are then cut off and buried.



Before cutting the thread tips, take care to push back the skin a few millimetres to reveal 2 or 3 rows of cogs, i.e. about 5 mm of thread, before cutting them flush. Once the tips have been cut, the threads will retract by the same amount (approx. 5 mm). This step ensures that the thread tips are perfectly buried. The exit points are then massaged to ensure that the threads do not hook the skin tissue.

The same procedure is followed for the thread returns of the second platysmal band.

Once the thread implantation phase is complete, the skin is cleaned (path drawings and any traces of blood).

Thread & Lift

7) Closing of the thread crossing openings with 4/0 monofilament polyamide stitches

IMPORTANT - To avoid any risk of infection, the submental crossing points **MUST** be closed with a 4/0 monofilament polyamide stitch. Do not use resorbable stitches.



It is also important to strictly forbid the patient to apply any product whatsoever (healing cream, anti-bruise cream, day cream, etc.) because of the resulting induced risk of infection.

Bathing should also be avoided.

In the case of a liposuction or cannulation, the associated opening is also to be closed with an identical stitch and following the same recommendations.

POINT DE CAUTION - The tips of the threads at the level of the scalp should not be cut at this stage! They will be used for the final tension adjustment.

Phase 5 : Final setting of the tension

1) Precise tension adjustment

IMPORTANT - For the final adjustment of the 4 neck threads, the patient must be in a seated position.

The neck is a delicate area to adjust. The tension to be applied to the tips of the threads at the level of the scalp must be **VERY light**, since the simple placement of the neck threads is sufficient to outline the mandibular contours and restore the cervicomental angle. Excessive tension, even on a young patient, would result in severe puckering or a shear line.



Thread & Lift

Carefully slide your finger from back to front across the thread path to eliminate puckers. Please note that the presence of micro-frowns is normal and acceptable.



The patient is asked to tilt the head slightly forward. The patient should feel supported but not constricted by a sensation of strangulation. If this were the case, the threads would need to be loosened. If, on the other hand, the patient did not feel supported, additional tension could be applied through the tips of the threads at the level of the scalp.

2) Application of an impermeable occlusive bandage

IMPORTANT - The stitches closing the submental crossing points **MUST be covered with a waterproof occlusive bandage** (such as Tegaderm or Opsite with integrated pad), which should be kept on until the stitches are removed on day 7 or 8 following the intervention.

For the application of the impermeable occlusive bandage, the patient should be in a lying position in order to have a good visibility and therefore ensure that all 4/0 monofilament polyamide sutures are well covered (including liposuction or cannulation sutures).

In the case of a liposuction or cannulation, you must use a bandage large enough to cover this stitch as well.

It may be renewed in the event of the bandage coming loose (it is advisable to provide the patient with a spare bandage and advise the patient not to wet the area excessively).



Thread & Lift

3) Cutting the thread tips at the level of the scalp

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



GOOD PRACTICE - To be on the safe side, the scalp should be pushed back to ensure that it has completely covered each flush-cut tip.

Here again, a complete absence of partially buried hair is checked.



IMPORTANT - The upper tip of the threads must always be cut off at the very end, after the final adjustment!

Indeed, the uncut tips of the thread at the level of the scalp allow a final tensioning of a thread that may have been insufficiently tensioned or unintentionally loosened during the release of a dimple along the path of the neck.

In the post-operative phase, patients must follow their doctor's prescriptions. You can find the prescriptions provided by our expert, Dr Jean-Paul Foumentèze, in the document "Medical Prescription - Thread & Lift" available in your private area on www.threadandlift.com.