

Installation protocol

-

The Deep V technique (SMAS)

-

Area treated: face

The Deep V 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 – Central crossing technique - Neck] or to the [Installation protocol – Double crossing technique - Neck] 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 V technique (SMAS).

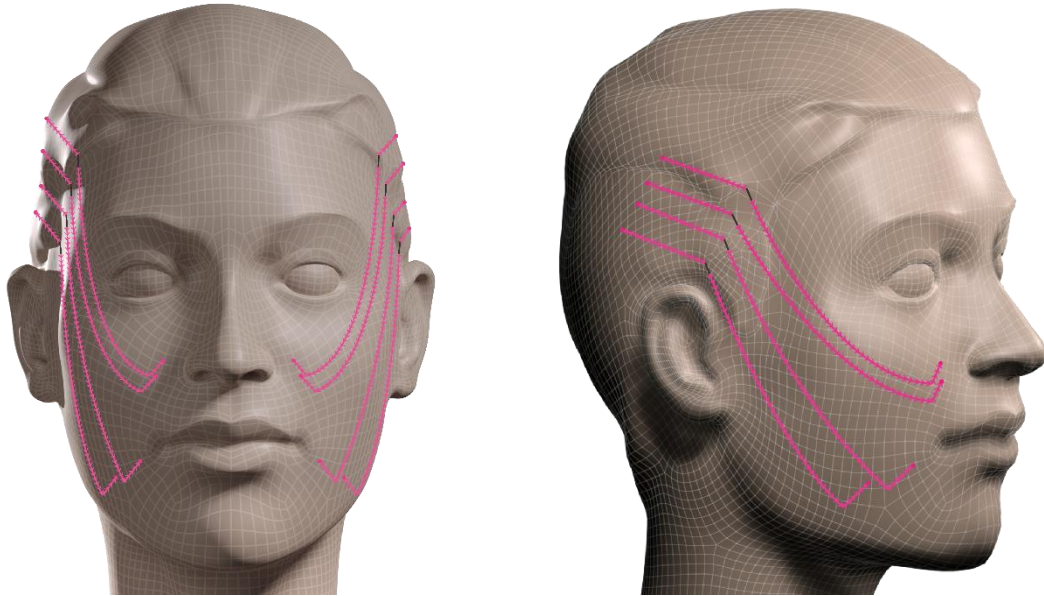
We also advise you to refer to the video [Infinite-Thread® – Area treated: face – Deep V technique (duration: 46 min)] available here <https://www.threadandlift.com/infinite-en.mp4> to see / see again in detail the gestures described throughout this protocol.

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.

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

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



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- LIST OF REQUIRED MATERIAL -

To practice the Deep V technique, here is the list of material needed:

- ✓ **8 threads Infinite-Thread® - 30cm (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 injury².**



or



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



- ✓ **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 Infinite-Thread® kit 4x2

In the Instrument kit

² Since this needle is not required for the procedure, it is not shown in the setup photo of the table – 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 anaesthesia is not performed under sterile conditions: 1 for the anaesthesia step and 1 for the implantation step.
- ✓ 1 needle 30 G 13mm **(11)** (2 needles are necessary if the anaesthesia is not performed under sterile conditions: 1 for the anaesthesia step and 1 for the implantation step)
- ✓ 1 bottle of 2% adrenalized xylocaine - 20 ml **(12)³**
- ✓ 1 bottle of 14‰ isotonic sodium bicarbonate. - 125 or 250 ml **(13)**
- ✓ Sterile pads **(14)** / 3 surgical drapes **(15)** / 2 surgical drape clamps (or an adhesive strip, not shown in the photo) **(16)** / 1 felt tip pen to draw the paths **(17)** / 70° Alcohol to remove the trajectory markings after thread placement **(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)**
- ✓ 1 polyamide 4/0 monofilament suture for closing the submandibular crossing point
- ✓ 1 waterproof dressing (size 5 × 5 cm) (e.g., Leukomed) to protect the submandibular crossing point
- ✓ 1 sterile gown

³ If it is not possible to obtain adrenalized xylocaine, the product can be reconstituted as follows:

- Xylocaine 20 mg/ml: 400 mg, i.e. 20 ml
- Adrenaline 1 mg/ml: 0,1 mg, i.e. 0,1 ml

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The following photos illustrate the material installation:

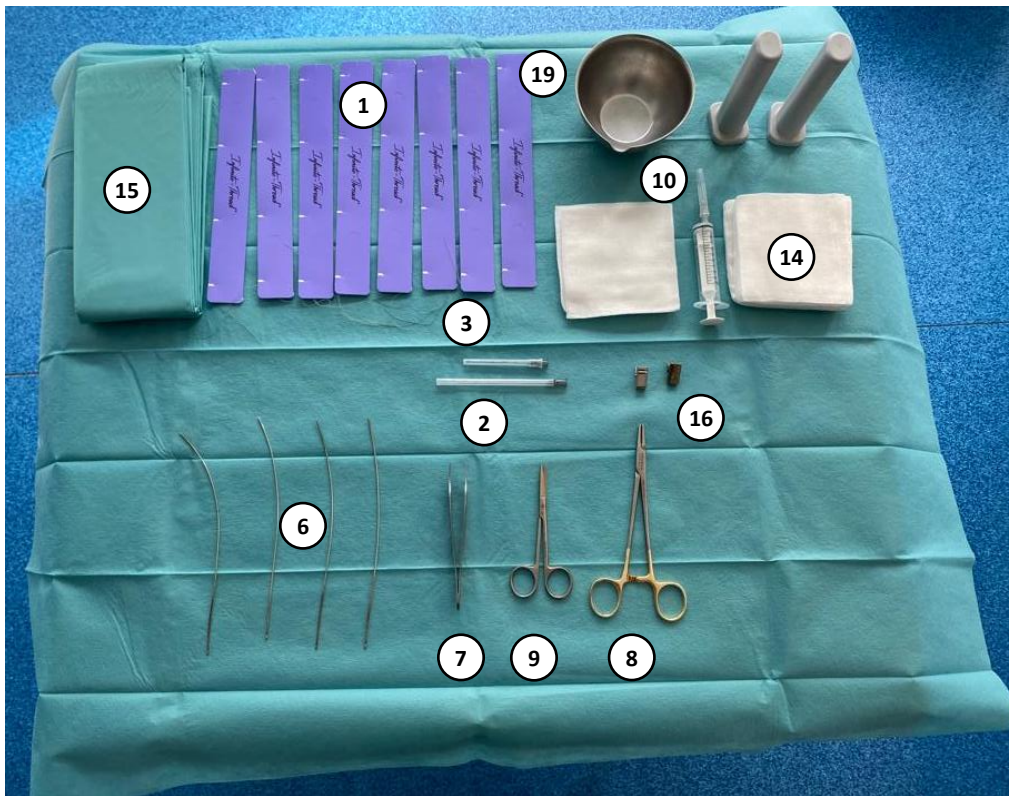


Photo 1: Intervention material

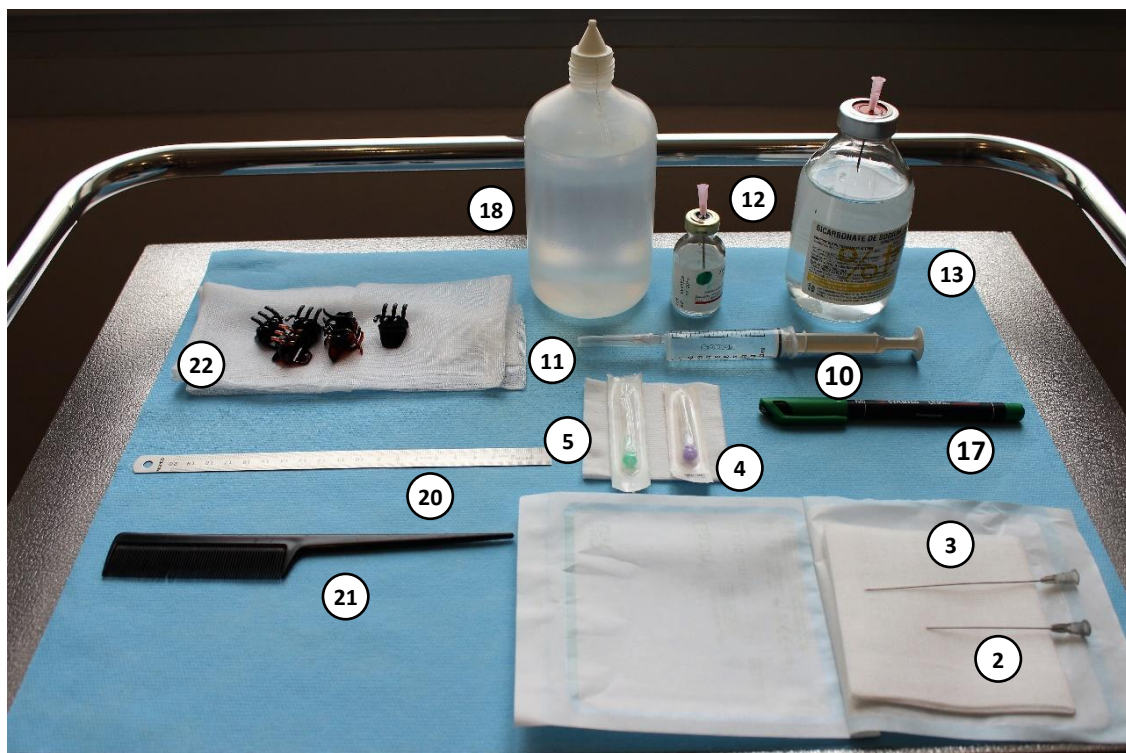


Photo 2: Local anaesthesia material

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The Deep V technique (SMAS) for facial treatment is carried out in 6 phases: the preoperative phase, the drawing of the thread pathways, anaesthesia, thread implantation, the final tension adjustment, and finally the cutting of the thread ends.

The Deep V technique is carried out in 6 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.

This preoperative phase is based on the recommendations of our expert trainers, according to their patient preparation protocol. An anaesthetist–intensive care physician 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.

AND

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

AND

- 3) Preferred option:
 - + 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) Alternative option:
 - + 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

When the face treatment is combined with a neck treatment, the facial marking is always performed first.

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



1) Marking the V tips

We begin by identifying, then marking, the position of the malar and jowl fat compartments by palpation. It is essential to locate them accurately, without however aiming for millimetric precision.



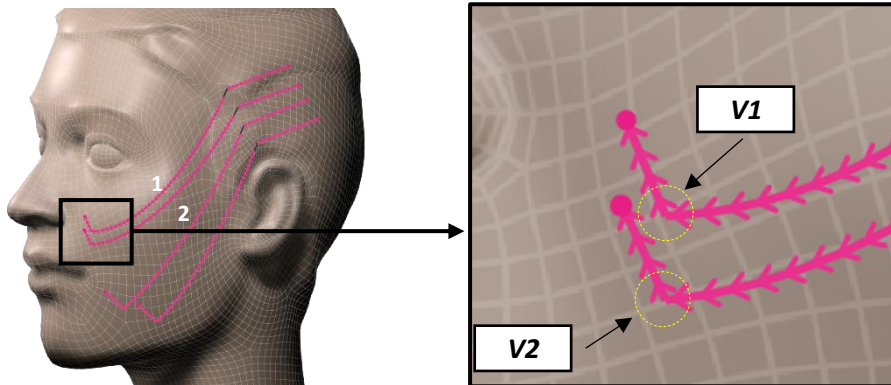
Localization of the malar fat compartment

Localization of the jugal fat compartment

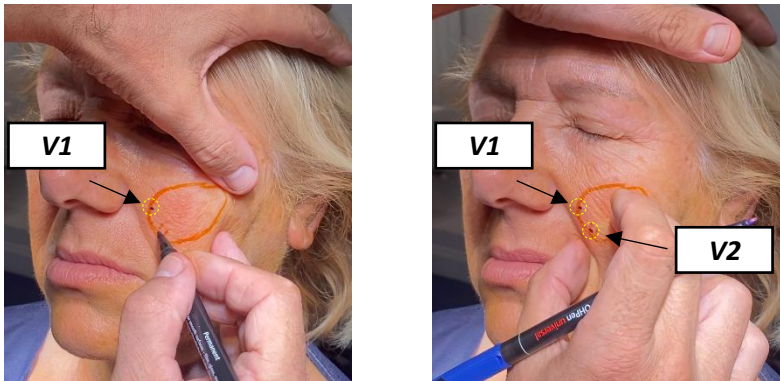


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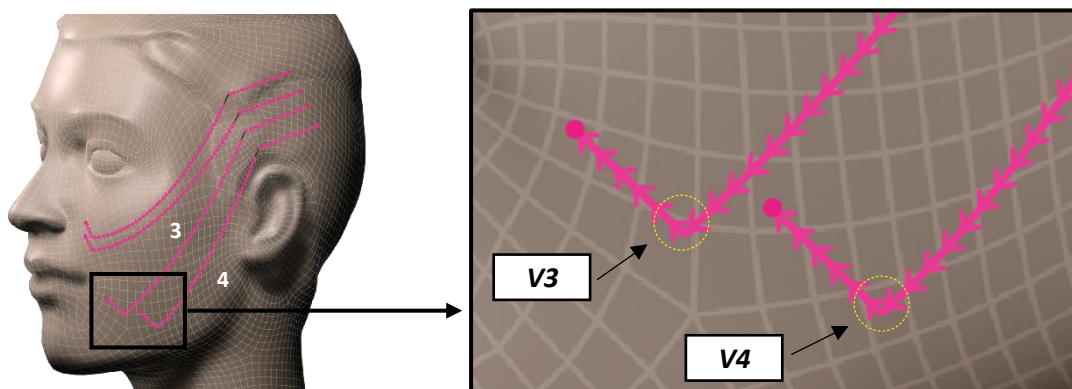
We then locate points **[V1]** and **[V2]**, corresponding respectively to the tips of the V for pathways **(1)** and **(2)**.



These points are located at the centre of the nasolabial bulge, adjacent to the border of the malar fat compartment. They should neither be placed directly in the fold, which could accentuate it, nor too far outside the bulge, to avoid worsening the tear trough.

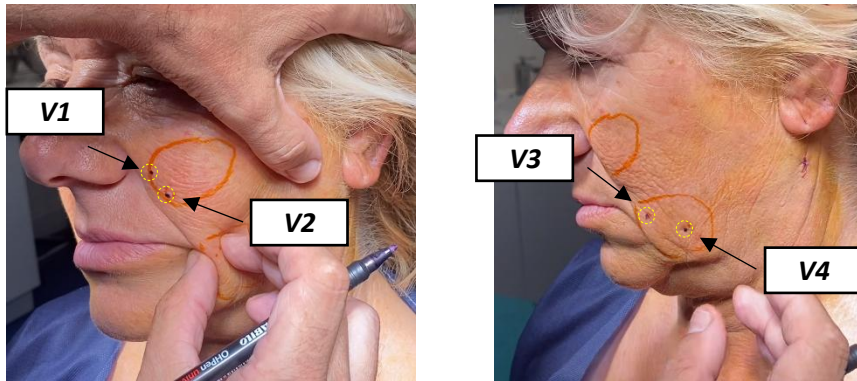


We then identify points **[V3]** and **[V4]**, corresponding to the tips of the V for pathways **(3)** and **(4)**. More specifically, pathway **(3)** aims to soften the marionette line, while pathway **(4)** targets the jawl in order to correct the facial contour.



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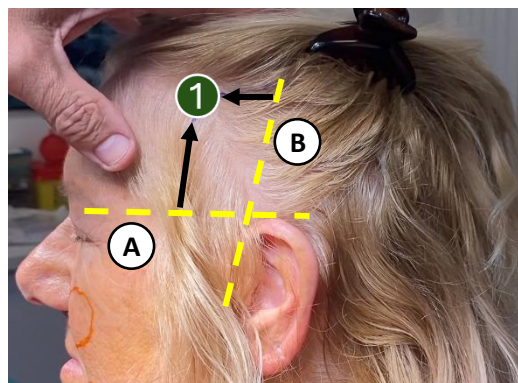
As before, the location of points [V3] and [V4]—at the level of the marionette line and the jowl—is determined by palpation.



2) Drawings of the temporal entry points

We locate the entry point area of the most anterior thread ①.

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 between the coordinates (A;B) 4/2 and 4/4 cm.



The point ① must be positioned according to the desired traction vector:

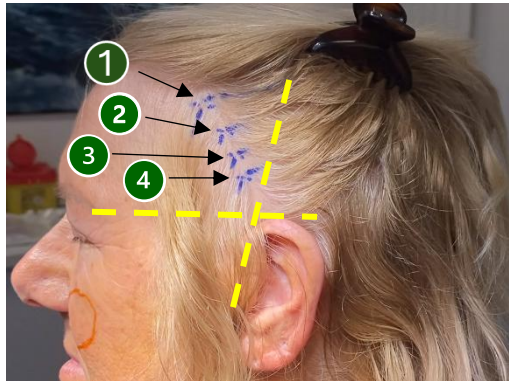
- **At coordinates 4/4 cm for a more vertical traction**, providing better support for the periocular area but with less effectiveness on the nasolabial fold.
- **At coordinates 4/2 cm for a more oblique traction**, offering enhanced action on the cheekbone and a more pronounced correction of the nasolabial fold.

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Using the same reference point, the other three entry points are then drawn. Their position depends on that of the point ① :

- At coordinates $3/3 - 2/2 - 1/1$ cm when the main point ① is placed at $4/4$ cm.
- At coordinates $3/1.5 - 2/1 - 1/0.5$ cm when the main point ① is placed at $4/2$ cm.

The entry points must be spaced at regular intervals.



Their location is recorded in the operative report and supplemented with a photograph of the entry points, which will make it easier to identify them later if needed.

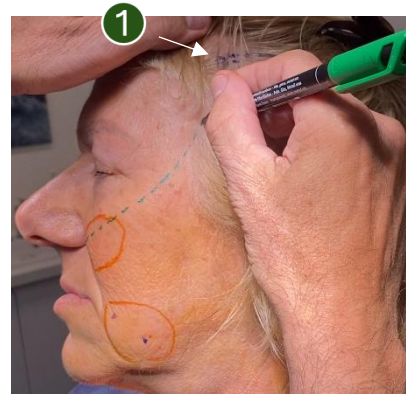
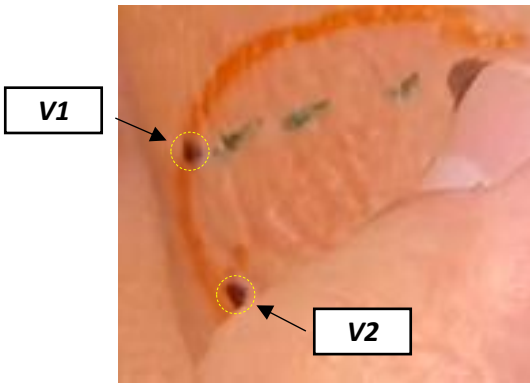
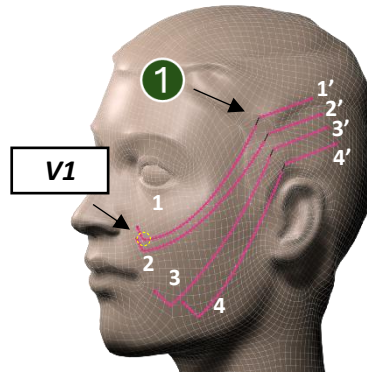
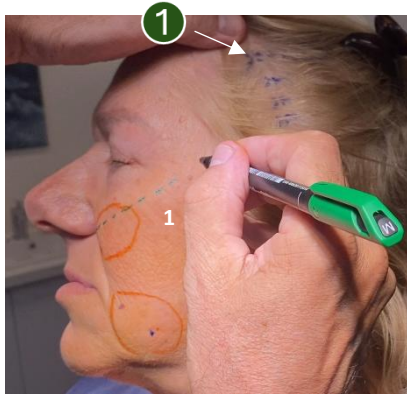
To mark the entry point, it is preferable to draw a target rather than a dot in order to avoid any risk of staining the skin with ink.



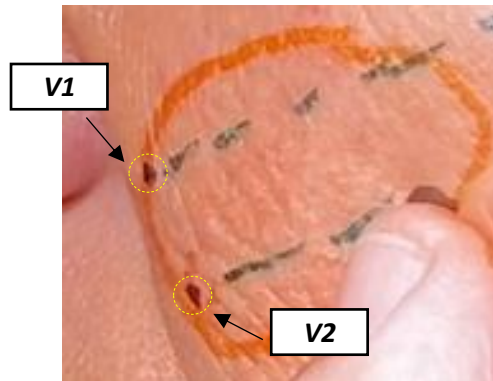
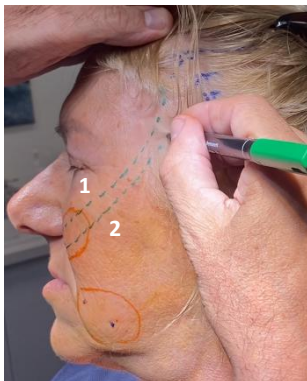
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3) Drawings of the cheek paths

The first pathway, drawn upward from point [V1], corresponds to the most anterior thread (1). It descends from the most anterior temporal entry point previously identified (1), then runs obliquely forward, passing 1 to 2 cm from the orbital rim.

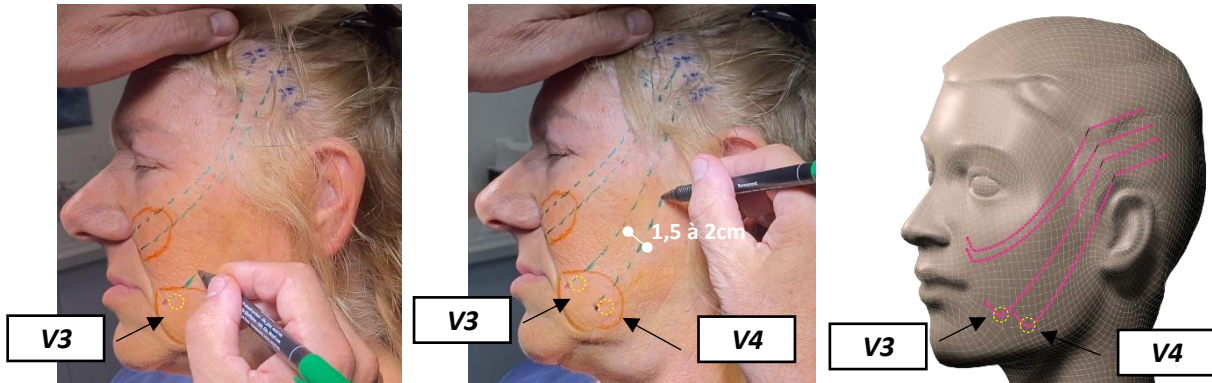


The second pathway (2), also drawn upward from point [V2], follows the course of the first pathway (1) in parallel, then angles slightly backward as it approaches the temporal thread entry point.



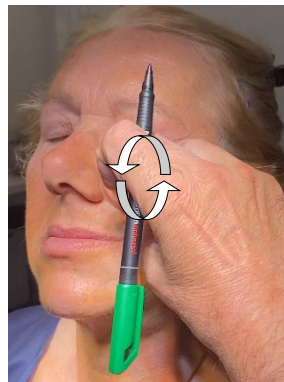
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Pathways (3) and (4) are almost parallel, spaced 1.5 to 2 cm apart. They are drawn upward from points [V3] and [V4] toward their respective entry points previously marked.



4) Drawings the V-returns

Before drawing the second branch of the V, or the “V-return,” which ensures the locking of the thread, it is essential to assess the skin laxity by pinching it and rotating it on itself.



In the presence of significant laxity, the skin can be rotated firmly upstream from the needle's path, allowing for a very tight return angle. On the contrary, when laxity is low—an indication of dense connective tissue, often seen in younger patients—there is no benefit in drawing an excessively tight angle, as it will be difficult to follow the marked pathway and reach the intended exit point.

The V-returns are drawn over approximately 1.5 cm.

It should be noted that near the nose, skin mobility is generally lower than in the perioral region. **Therefore, for threads (3) and (4), a tighter angle can be used compared with threads (1) and (2).**



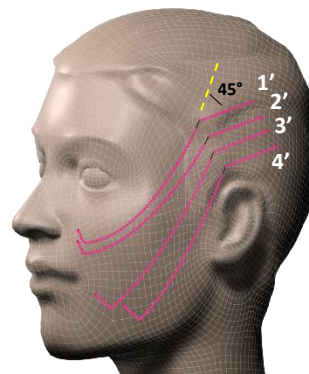
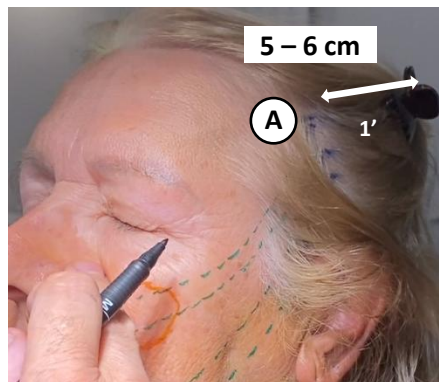
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The exit points are then circled with a marker (shown here in red), in a colour different from the one used for the pathways (shown here in green).



5) Drawings of the extensions under the scalp

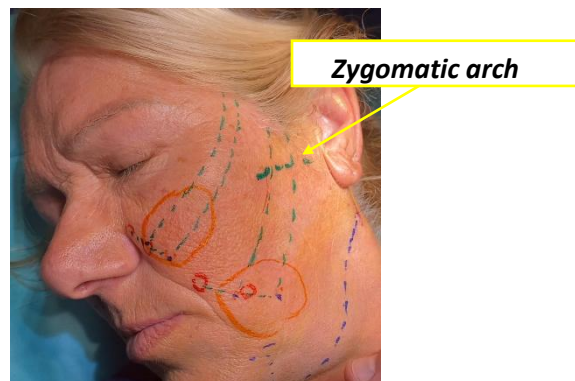
We then draw the extension of the four threads (1'), (2'), (3') and (4') under the scalp, over a distance of 5 to 6 cm from the entry points (A). The upper paths are oriented at an angle of approximately 45° relative to the lower paths, in order to ensure optimal locking of the upper strand of the threads.



6) Drawings of the zygomatic arch

The drawing phase ends with marking the line that represents the lower border of the zygomatic arch [zygomatic arch] on each side of the face. The position of this line is determined by palpation.

POINT OF CAUTION - The zygomatic arch is a key landmark: it marks the transition from the subcutaneous plane to the deeper mobile SMAS, both for anaesthesia and for thread insertion along the planned trajectories.



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It should be noted that in the specific case of a patient with a deep tear trough, it should be drawn on each side. The goal is to re-interlock the malar fat compartment with the zygomatic fat in order to achieve a fuller, harmonious cheekbone. However, this step is not systematic, as it depends entirely on the patient's morphology.

The second side is then drawn, making sure to maintain symmetry of the overall design.

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: anaesthesia

Before starting the anaesthesia, the patient's hair should be tied back with elastic bands to clear the area and improve visibility of the upper trajectories.



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1) Anaesthesia of the entry points

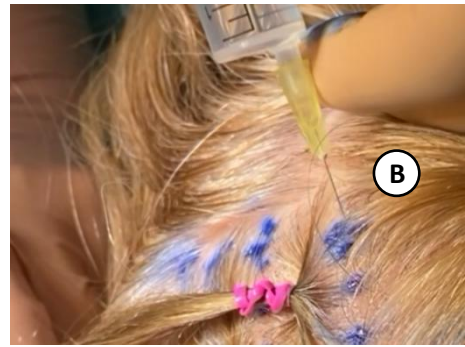
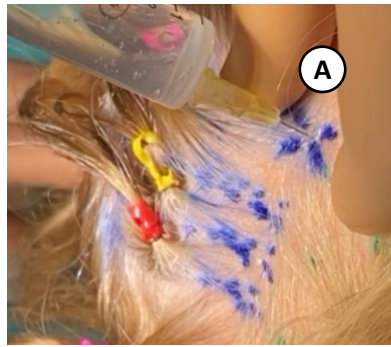
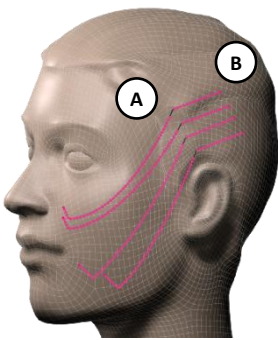
Required equipment:

- 1 needle 30 G 40mm (not supplied)
- 1 syringe of 10cc (not supplied) (3cc or 5cc are also suitable)
- **Concentrated formula - 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 anaesthesia is done in the form of a papule.



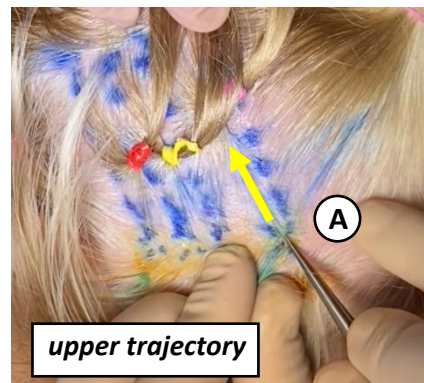
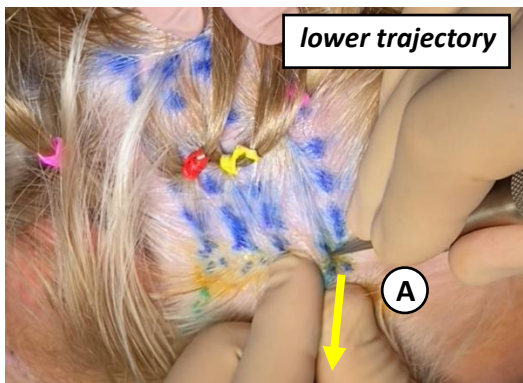
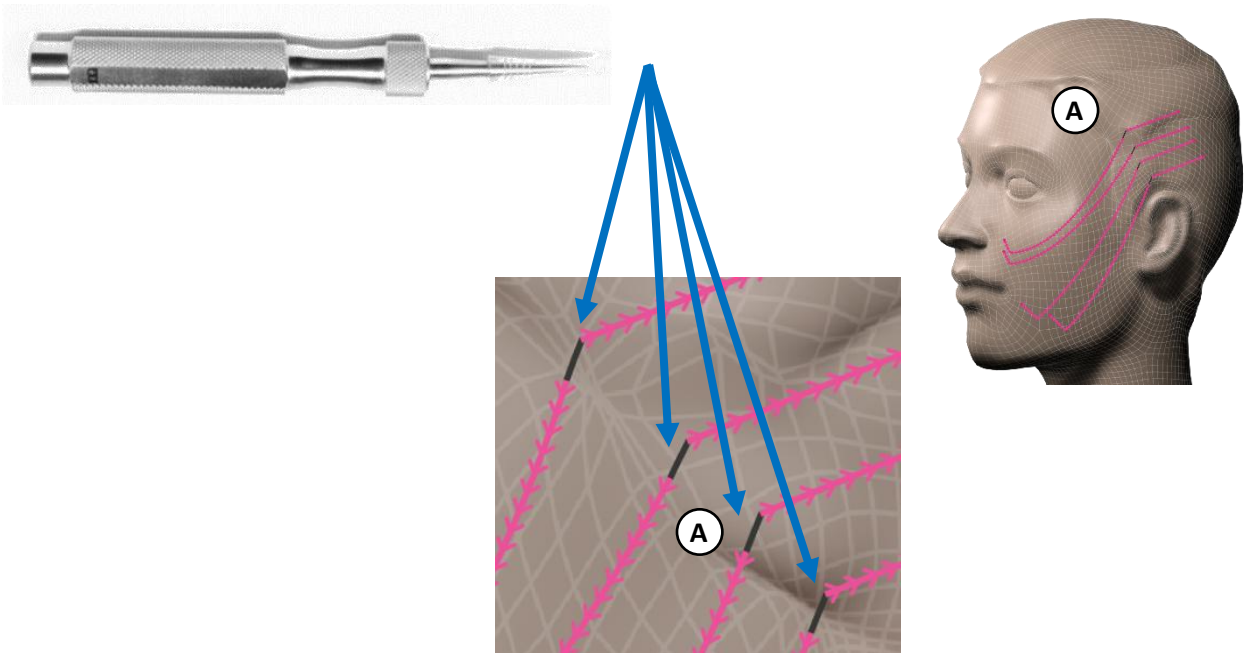
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2) Opening of the entry points

Required equipment:

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

A circular opening is made with the punch at each temporal entry point (A) (i.e., four openings per temple), aligned with the lower and upper trajectories [lower trajectory] [upper trajectory].

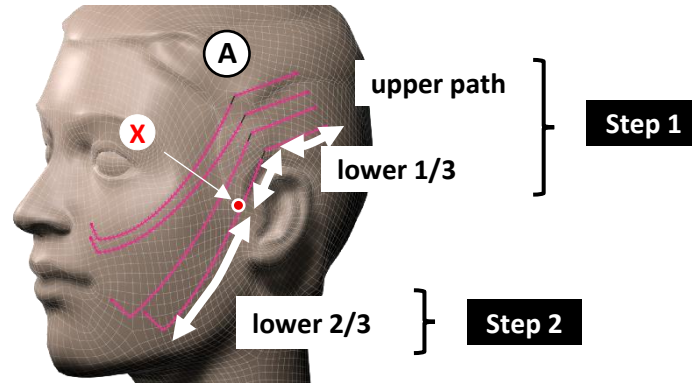


IMPORTANT - If you choose to use a Nokor needle, be careful not to insert it too deeply into the subcutaneous tissue to avoid any risk of bleeding. This risk is significantly reduced when using our punch.

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

- **Step 1:** with the 50mm cannula: the anaesthesia of the upper paths under the scalp + the lower 1/3 of the cheek paths, starting from the entry points (A);
- **Step 2:** with the 90mm cannula: the anaesthesia of the lower 2/3 of the cheek paths, starting from the relay openings (X).



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

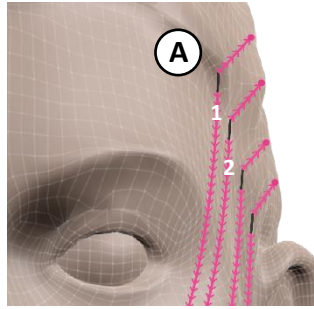
Required equipment:

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

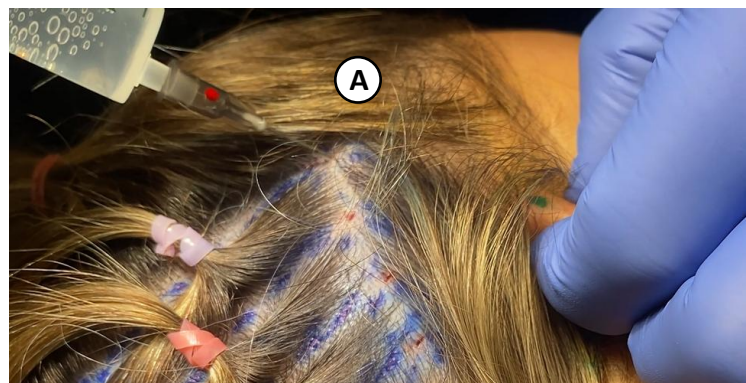
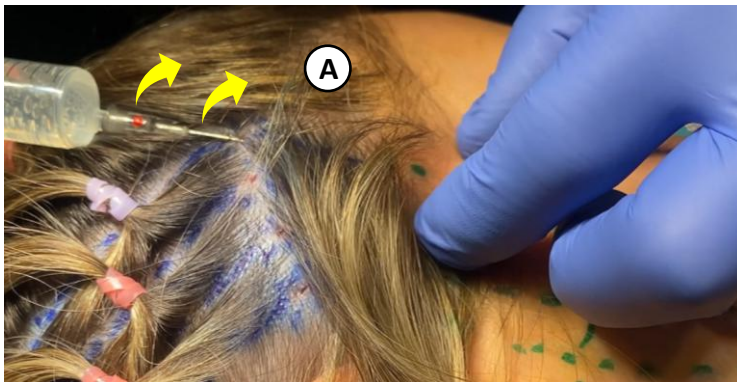
IMPORTANT - Infiltration is always performed in the same plane in which the thread will be inserted.

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For the lower portion of the temporal area of trajectories (1) and (2):

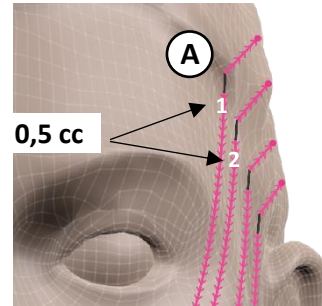
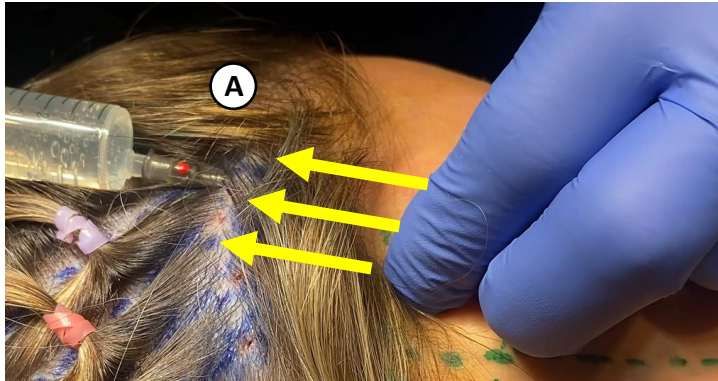


- 1) From the entry point **(A)** to the point where you reach the hairless zone, **the cannula is positioned in the subcutaneous plane.**
- 2) **You then move below the superficial fascia.** To do this, pinch the skin and lift it slightly, then angle the cannula to pass through the fascia. At this moment, a slight “snap” may be felt, indicating that you have passed beneath the fascia. Once this plane is reached, the cannula becomes less visible on the surface.

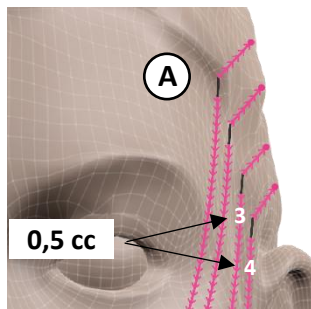


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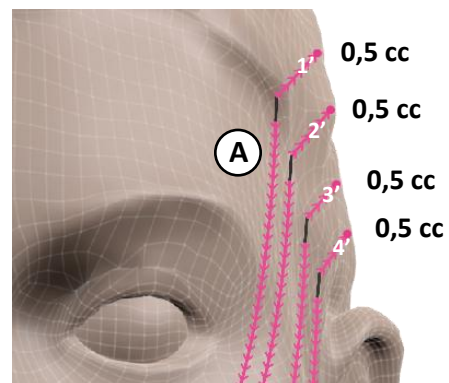
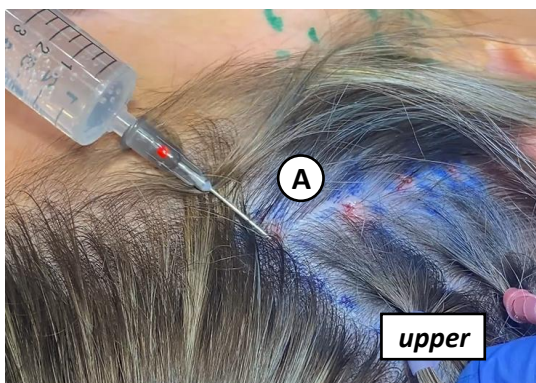
- 3) Once the cannula reaches its end point, **the skin is mobilised by pushing it onto the cannula** to gain an additional centimetre, then **0.5 cc** is injected in a retrograde manner.



For the lower portion of the temporal area of trajectories (3) and (4), infiltration is performed strictly in the subcutaneous plane. A total of 0.5 cc is injected per trajectory (over the 5 cm length of the cannula) from each corresponding entry point (A), in a retrograde manner. **Here as well, the skin is mobilised by pushing it onto the cannula** to gain an additional centimetre.

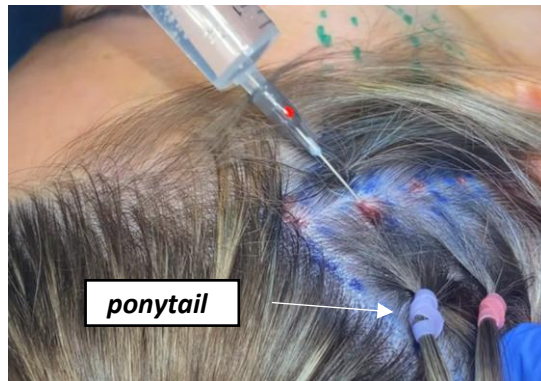


For the upper portion of the temporal area [upper], infiltration is performed between the galea and the scalp. Inject 0.5 cc per trajectory from the four entry points (A) to the four exit points (B), in a retrograde manner.

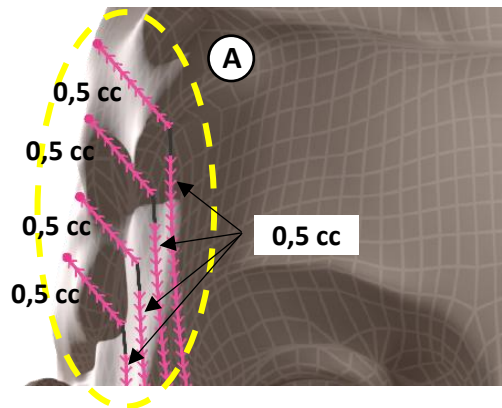


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It should be noted that separating the hair into small ponytails [*ponytail*] makes it easier to identify the trajectories precisely, thereby improving visibility and the ergonomics of the procedure.



Of course, the same is done for the trajectories on the other temple.



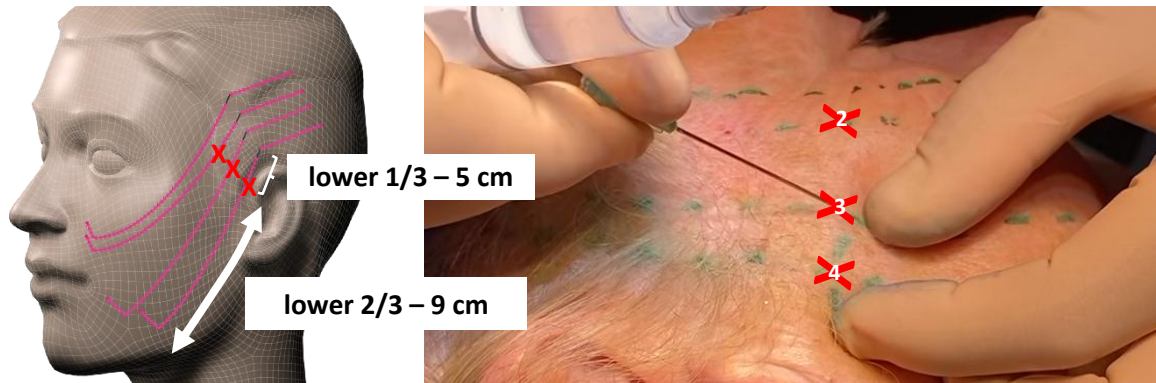
4) Anaesthesia of the thread paths - lower 2/3 of the cheek

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) (3cc or 5cc are also suitable)
- **Diluted formula - 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.**

Thread & Lift

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



Only three relay openings (X) are made, because the anaesthesia for trajectory (1) will be performed through the relay opening of trajectory (2), making a relay opening on trajectory (1) unnecessary.

The remaining trajectories are approximately 9 cm in length. Injection therefore requires the use of a longer cannula, 90 mm, 22G.

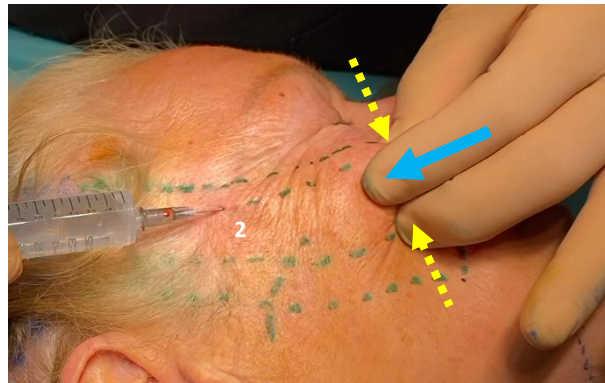
The goal here is to ensure anaesthesia up to the future exit points by following exactly the drawn trajectories on each cheek. It is important that the cannula be positioned in the exact plane in which the threads will be implanted, namely:

- **For trajectory (2), pursuing in the same plane used for the first 5 centimetres, namely the superficial fascia plane. Then, as soon as the malar fat compartment is reached, the cannula is advanced deeper into that compartment.**



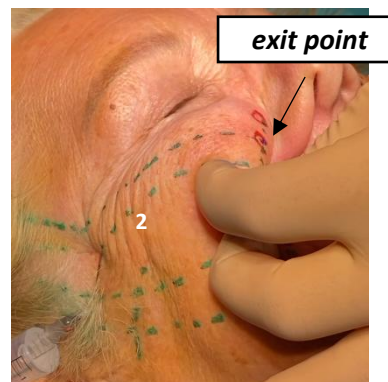
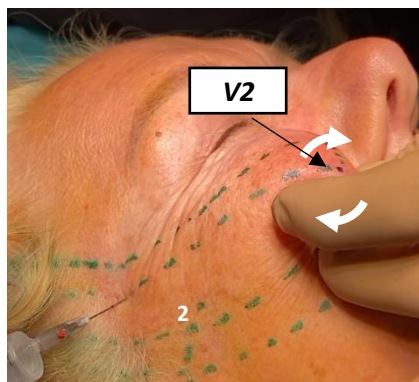
Thread & Lift

IMPORTANT - The manoeuvre is similar to that used in liposuction: the fat compartment is positioned between the thumb and middle finger, while the index finger controls the depth of the cannula. **It is not the cannula that is directed downward, but rather the tissues that are presented to the cannula, allowing controlled advancement within the targeted tissue plane.**



Once point **[V2]** is reached — previously identified — the skin is gently grasped between the thumb and middle finger, then twisted through a rotational movement. This manoeuvre helps align the return path of the V as closely as possible with the axis of the cannula.

Using the index finger, the cannula is guided toward the exit point **[exit point]**. When it is positioned directly in line with this landmark, 1 cc is injected in a retrograde manner.

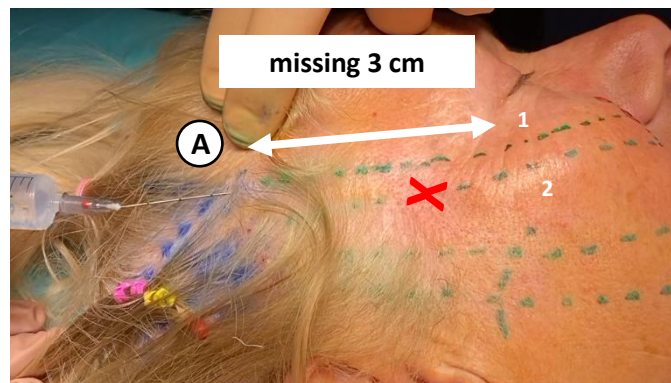


Thread & Lift

- For trajectory **(1)**, the procedure is identical to that of trajectory **(2)**, using as a starting point the previously established relay point **(X)** for trajectory **(2)**.

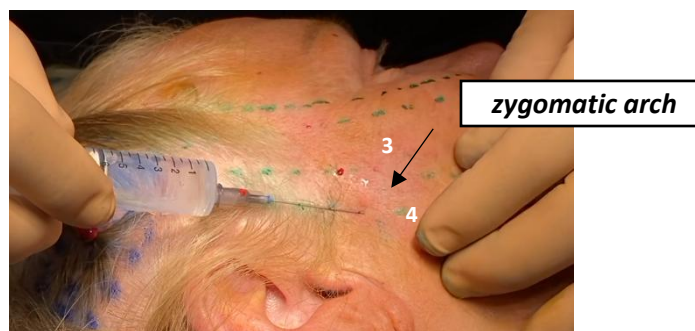


Since the anaesthesia for trajectory **(1)** was performed from the relay point **(X)** of trajectory **(2)**, a residual area of approximately 3 cm at the level of the orbicularis remains non-anaesthetised. Using a 90 mm 22G cannula introduced from the entry point **(A)** of trajectory **(1)**, anaesthesia of this area is completed.



IMPORTANT - The anaesthesia is performed beneath the orbicularis so that the thread is never visible — neither now nor in the future. Indeed, as the tissues thin with aging, the thread could otherwise become visible.

- For trajectories **(3)** and **(4)**, the initial path is subcutaneous. As the zygomatic arch [*zygomatic arch*], previously marked during Phase 1 of the drawing, is approached, a **change of plane is performed to move deeper into the SMAS**. To do this, the cannula should be angled downward until the characteristic resistance of the SMAS is felt. It is completely normal to perceive slight crackling sensations beneath the cannula as it progresses through this layer.

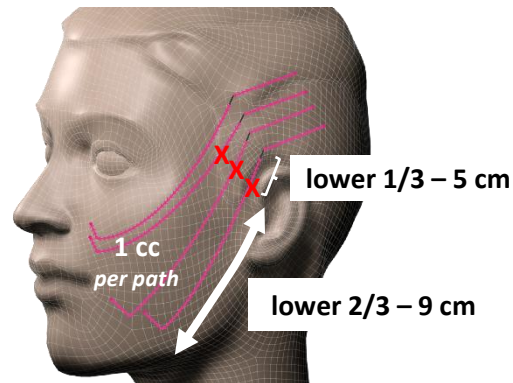


Thread & Lift

At the end of the trajectory, you continue in the same deep plane, within the fat, until reaching the blue mark indicating the tip of the V. As with trajectories (1) and (2), twisting the skin helps guide the cannula toward the exit point.



Injection of 1 cc is then performed in a retrograde manner.



5) Anaesthesia of the trajectories on the second side

Repeat steps 3) and 4) for the second side, that is:

- 3) Anaesthesia of the thread paths – starting from the entry points (A)
- 4) Anaesthesia of the thread paths - lower 2/3 of the cheek

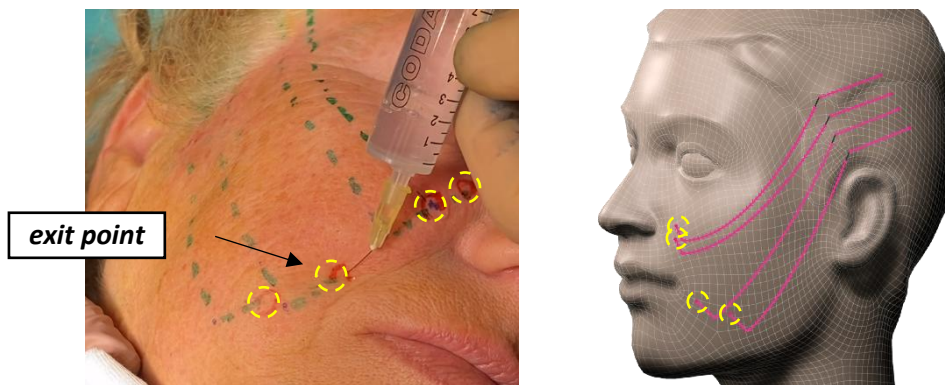
Thread & Lift

6) Anaesthesia of the exit points of the cheekbones and cheeks

Required equipment:

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

A few drops of anaesthetic are injected at the exit points at the extremities of each thread path [**exit point**] on both sides.



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.

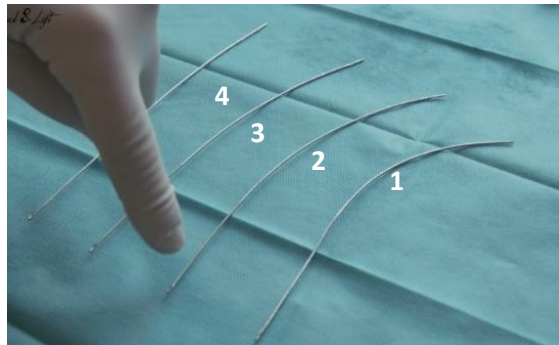
It is now imperative to work in sterile conditions if it was not yet the case.

While it was not mandatory during the previous phase of the anaesthesia, it is now imperative to work with sterile gloves, a sterile gown and a cap, perform antiseptic skin cleansing and set-up 3 sterile fields:

- 1 under the patient's head; and
- 2 adhesive drapes on the torso (one on each side)

Thread & Lift

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). It must grasp the needle on the inside of its curve, on the flat area designed for this purpose. It is also possible to insert the needles using a **needle-holder handle** (not included in the instrument kit but available upon request).



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

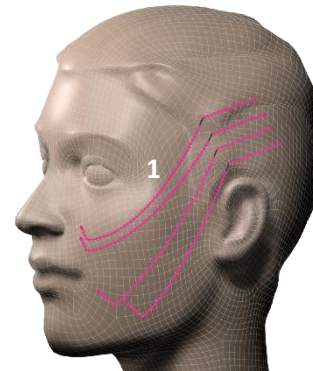
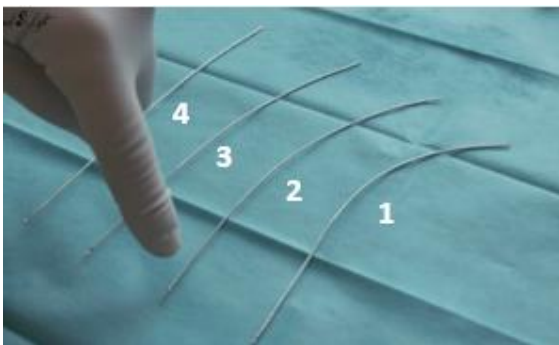
Thread & Lift

GOOD PRACTICE - If, during the insertion of a thread, the curvature of the needle proves unsuitable, it should not be hesitated to remove and replace it. A needle that is too curved tends to dive prematurely into deeper planes, whereas insufficient curvature makes it difficult to navigate the bends of the trajectories.

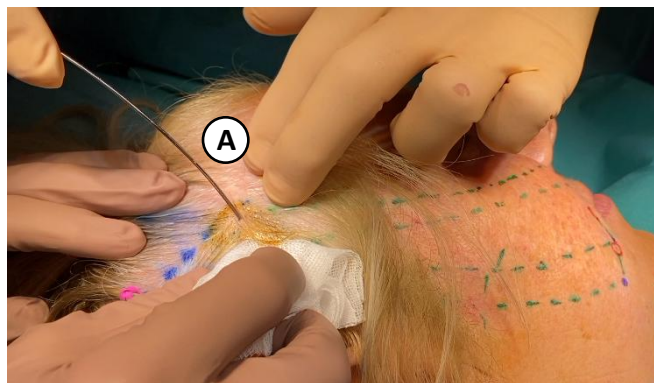
Likewise, do not hesitate to slightly curve or un-curve the needles as needed at each step, in order to adapt them as precisely as possible to the path. Beyond inter-patient anatomical differences, the curvature of the needle may also become altered as the procedure progresses.

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 through the entry point **(A)**, never at an angle, to avoid creating a dimple caused by the thread passing through the thickness of the dermis (the thread must remain free beneath the skin). Once the beginning of the subcutaneous plane is reached, **the needle is repositioned parallel to the skin** to avoid penetrating the temporalis muscle.



Thread & Lift

At the beginning of its path, in the temporal area within the hair-bearing zone, **the needle will advance beneath the scalp.**

To optimize the anchoring of the thread in the subcutaneous plane, **the needle is advanced in a zigzag pattern** up to the edge of the hairline. Throughout this manoeuvre, it is important to hold the skin in place to prevent it from moving along with the needle.



Upon reaching the hairless area, the needle is guided deeper, **beneath the fascia superficialis**, to ensure that the thread is not visible either immediately or in the long term.

Then, as soon as **the level of the orbicularis muscle** is reached, the needle is advanced even deeper in order to cross an additional anatomical plane and proceed beneath the muscle itself.



The needle is then advanced within the same plane until it reaches the **malar compartment**. At this stage, **it is rotated and oriented so as to position it at the centre of the fat compartment**, ensuring optimal thread anchorage—essential for lifting the malar fat. This elevation is a key element in the success of the procedure, as it is what allows for a result comparable to that of a malar lift.



Thread & Lift

IMPORTANT - During the advancement of the needle, the hand holding the needle holder plays the role of the worker, while the other hand acts as the conductor. The farther the needle moves from the entry point, the more difficult it becomes to guide it precisely and maintain the correct depth. At that stage, the hand not holding the needle holder becomes the most important: **it guides the manoeuvre by presenting the fat to the needle**. It is essential to hold the fat between the thumb and middle finger and position it directly in the axis of the implanting needle. If the needle does not descend sufficiently into the centre of the fat, one should not hesitate to **use the index finger to apply slight pressure and correct its trajectory**. As explained previously, the index finger must be used as a depth sensor.



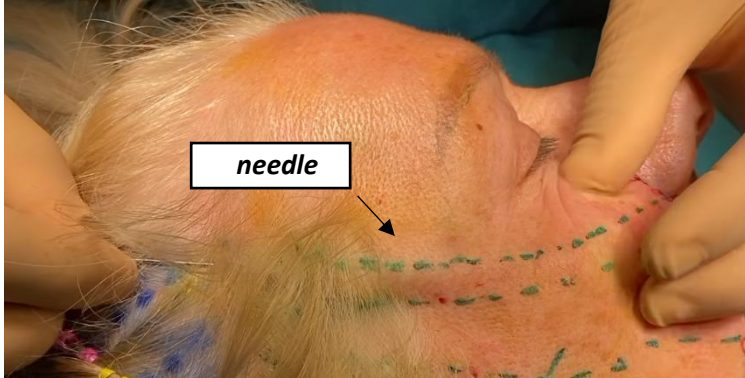
*Note that in the presence of a **pronounced tear trough**, it is recommended to create a deeper pathway at the level of the tear trough, then immediately return to the intermediate fat plane. This manoeuvre makes it possible to effectively re-engage both the upper and lower zones.*

The effectiveness of the manoeuvre is assessed by palpating the skin above the needle:

- *if the fat layer feels homogeneous, this confirms adequate fat recruitment;*
- *otherwise, one will sense that the needle remains too superficial at the level of the tear trough. In such cases, the needle should be withdrawn and the manoeuvre repeated while recruiting more fat.*

Thread & Lift

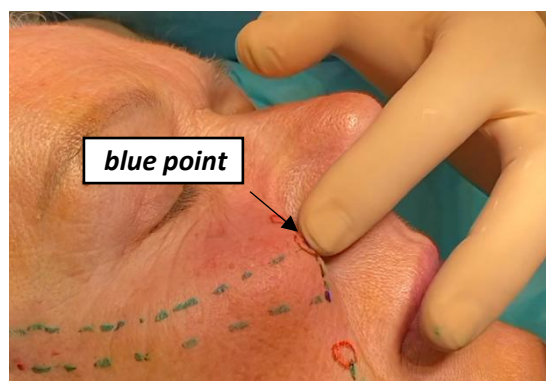
IMPORTANT - During the advancement of the needle, it is essential to rotate it regularly on its axis, from right to left, every centimetre. This rotation allows 1) verifying that the needle is correctly following the intended pathway without deviating, and 2) detecting any formation of undesired depressions.



Example of a skin depression (or crease) created intentionally for demonstration purposes, resulting from an insertion of the needle that is too superficial.

If a depression appears, this indicates that the needle is catching the skin and is positioned too superficially. In case of doubt, it is **preferable to withdraw the needle** and reposition it correctly. Indeed, a needle inserted into the wrong plane—even at a single point along its pathway—would drag the thread into that incorrect plane, creating a defect that would require removing the thread.

Upon reaching the blue point [**blue point**], which indicates the tip of the V, it is important to check with the finger that the needle is correctly aligned with this marker.



Thread & Lift

The skin is then grasped between the thumb and middle finger, gently lifted, and rotated.



Along the return path of the V and up to the exit point, the needle must remain deep. To achieve this, it should be rotated about 45° on its axis. The index finger applies slight pressure to the needle, while the thumb guides the skin toward it.



Once the **red circle [red circle]** is reached — a landmark previously anesthetized from the outside — the needle is pushed until it exits. However, the flexibility imposed by the curvature of the pathway can make this extraction difficult, as it reduces the available leverage. In such cases, it is helpful to use the cap of a cannula (previously used for anaesthesia) as a counter-support. Additionally, in the presence of thick or resistant skin, pressure should be applied to the curve of the needle to prevent it from bending.

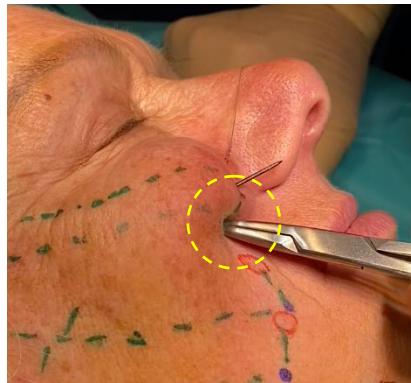


Before continuing, it is essential to verify that the needle is positioned at the correct depth:

- at the tip of the V: no visible dimple should be present (note that a slight depression is normal at this stage, as the needle exerts traction on the tissues).
- at the return of the V: palpation should reveal a thin layer of fatty tissue between the skin and the needle.

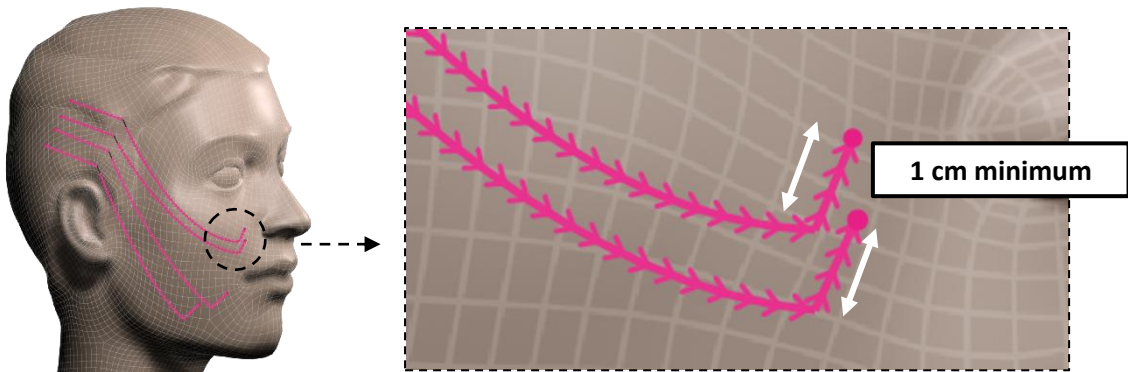
Thread & Lift

If this is not the case, the needle should be withdrawn up to just before the blue point, then the manoeuvre should be repeated while inserting deeper, in order to engage a sufficient amount of fatty tissue.



Example of an artificially created dimple for demonstration purposes, produced by applying pressure beneath the needle using forceps.

IMPORTANT - To ensure the effectiveness of the V, the return must measure at least 1 cm. Indeed, when the end of the thread is trimmed (*refer to the dedicated section of the protocol*), a few millimetres will be removed to allow complete burial of the thread. **If the V return is too short, the needle should be withdrawn in order to redo the end of the trajectory and ensure a sufficient return length.**



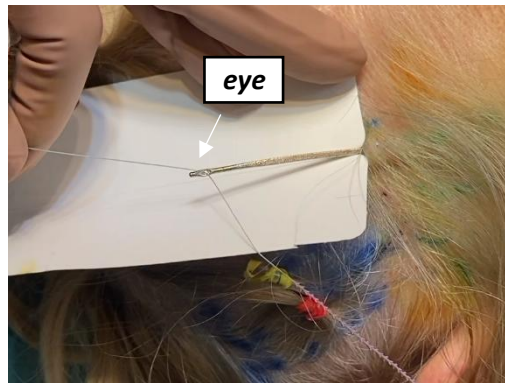
We strongly recommend referring to the video Infinite-Thread® – Area treated: face – Deep V technique available here: <https://www.threadandlift.com/infinite-en.mp4> for greater clarity of the manoeuvre.

Thread & Lift

The card holding the thread is placed beneath the needle in order to isolate the hair as much as possible. It keeps the hair pressed down underneath, preventing it from sliding along with the thread during insertion.



The smooth, green polyester end of the Infinite-Thread® is then passed through the needle's eye **[eye]**. **Care must be taken not to pass any of the thread's cogs through the eye of the needle, to prevent them from becoming trapped.**

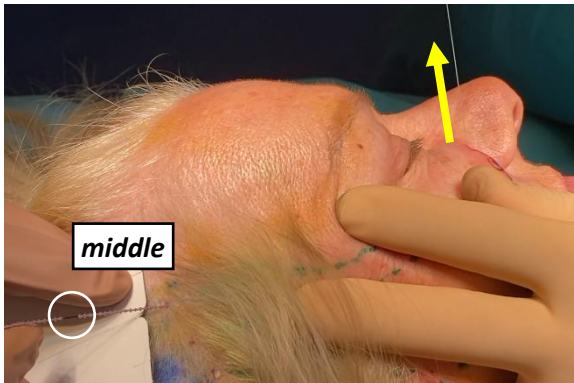


The thread is pulled through using the needle, which has been previously grasped with the needle holder. During its extraction, the free hand applies pressure on the cheekbone to keep it in place and ensure a controlled exit of the needle.

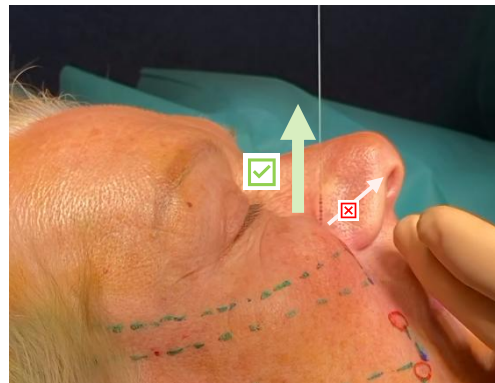
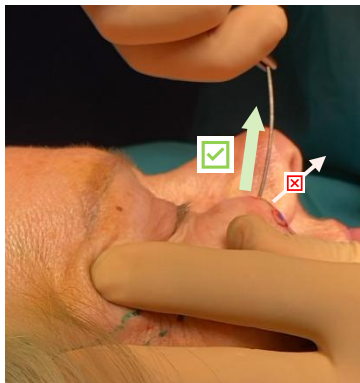


Thread & Lift

The thread must be pulled until its central section, marked by a black indicator [middle].

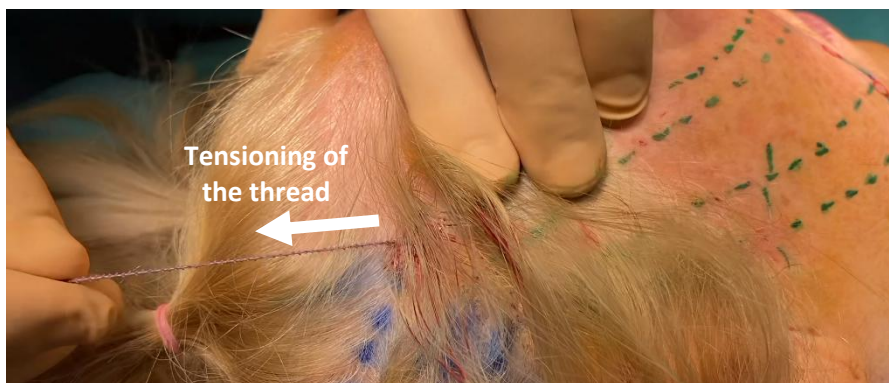


To prevent any risk of skin tearing at the exit point, the needle and thread must be extracted along the axis of the V return, and not along the main trajectory.



Before proceeding with the implantation of the upper half of the first thread, it is essential to **verify proper tissue mobilisation by applying traction to the non-inserted half of the thread**. Harmonious mobilisation of the upper and mid-face thirds should be observed. If the insertion is too deep—particularly beneath the temporal muscle aponeurosis—only the mid-face area will be mobilised, resulting in an absence of traction in the upper zone and the appearance of folds at the crow's-feet area when tension is applied to the thread.

If this were the case, the thread should be removed by gently massaging it out progressively and reinserted into the correct plane once it has been checked that no hair is caught on it.



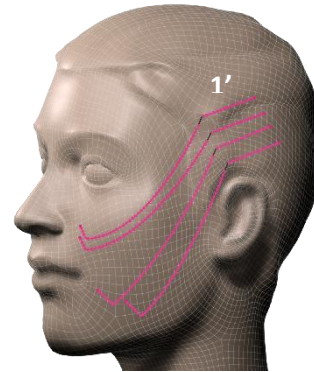
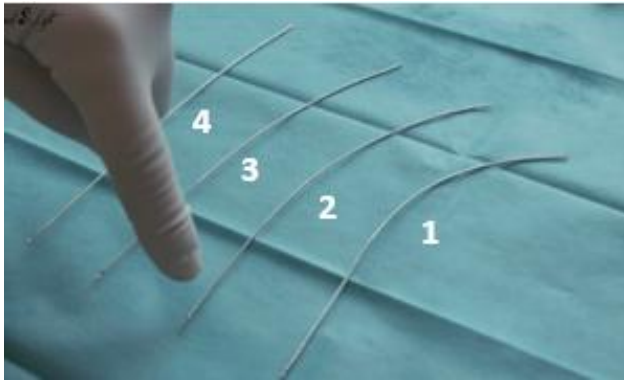
Thread & Lift

IMPORTANT - If, despite the protection of the card, one or more hairs become caught with the thread, they can simply be gently removed using the Adson forceps provided in the instrument kit.

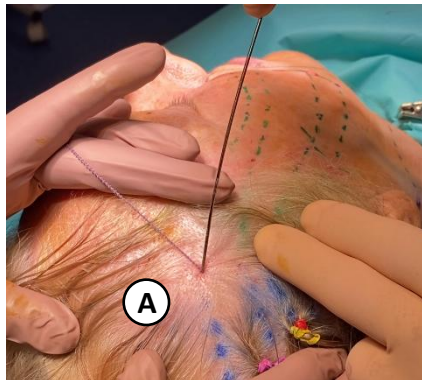


2) Implantation of the 1st thread - the upper half

A moderately curved needle **(3)** is used to position the upper half of the most anterior thread **(1')**. Its curvature must follow that of the temporal and parietal bones.



After inserting the needle vertically through the entry point **(A)** until it reaches the correct plane—namely, **the beginning of the subcutaneous space**—it is then repositioned parallel to the scalp to prevent it from penetrating the temporal muscle.



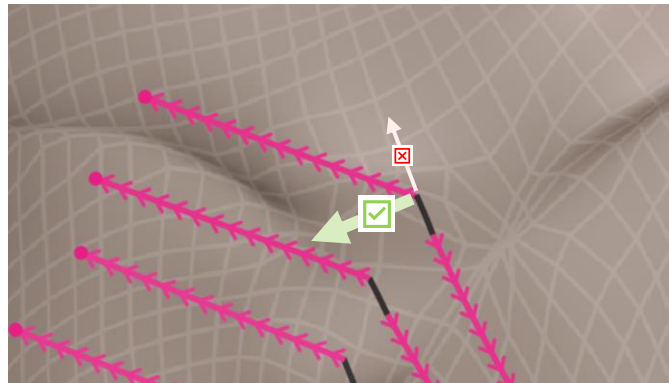
The needle must travel between the scalp and the galea, following the marked trajectory. The needle is advanced gently until it reaches its exit point. **Any resistance encountered during needle passage indicates that it is positioned too superficially.**

Thread & Lift

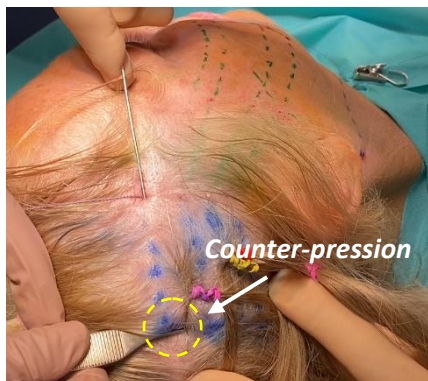
IMPORTANT - To optimise thread anchorage within the subcutaneous plane, the needle is advanced along a zigzag path until the exit point.



For an effective zigzag, it is important to close the angle directly rather than follow the vector of the lower trajectory.



Once aligned with the exit point, the needle is rotated 180° so that its tip is directed outward, thereby facilitating its emergence.



Thread & Lift

After placing the card beneath the needle to minimise hair entrapment, the smooth polyester end of the Infinite-Thread®, coloured green, is inserted into the needle's eye. The needle is then gradually and fully withdrawn, pulling the thread along until it is completely implanted.

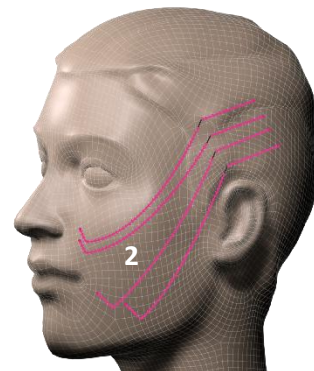


POINT OF CAUTION - The absence of buried hairs must be checked with extreme care. Indeed, it is most often the presence of a partially buried hair—half inside and half outside—that is responsible for infections.



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

For the second thread, the most curved needle **(1)** is generally used, although a less pronounced curvature **(2)** may sometimes be selected.

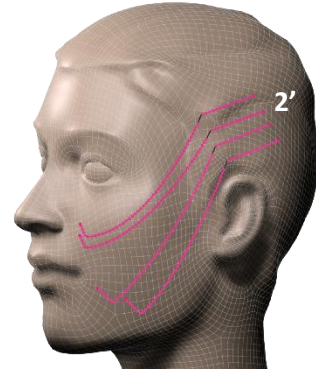


The procedure to follow is the same as for the lower half **(1)** of the first thread.

Thread & Lift

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

For the upper part of the second thread (2'), the same needle (3) is used as the one selected for implanting the upper half (1') of the first thread.

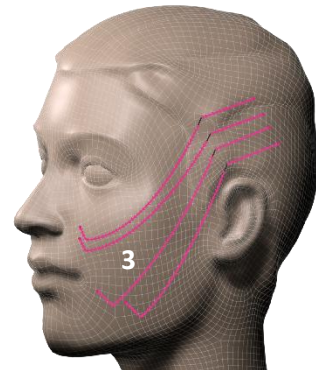
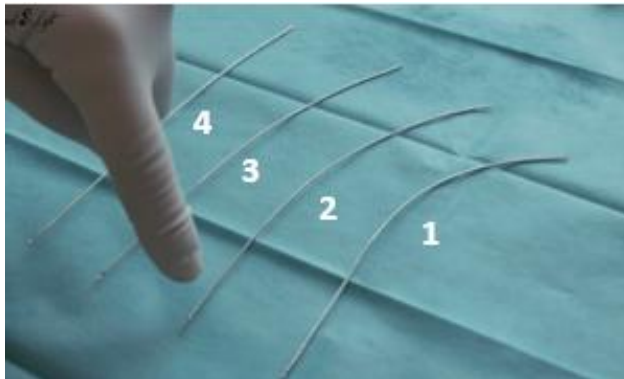


The procedure to follow is identical to that used for the upper half (1') of the first thread.

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

For the lower half of the third thread, **the bitterness thread**, needle (3) is used.

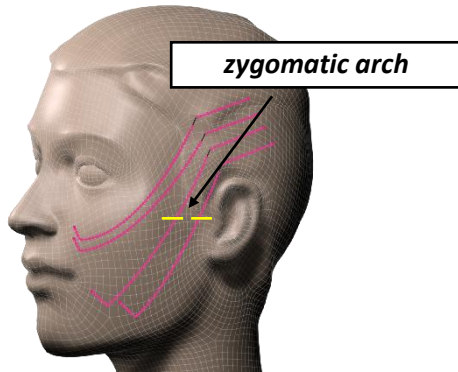
The procedure to follow is broadly the same as for the lower half of the first thread (1).



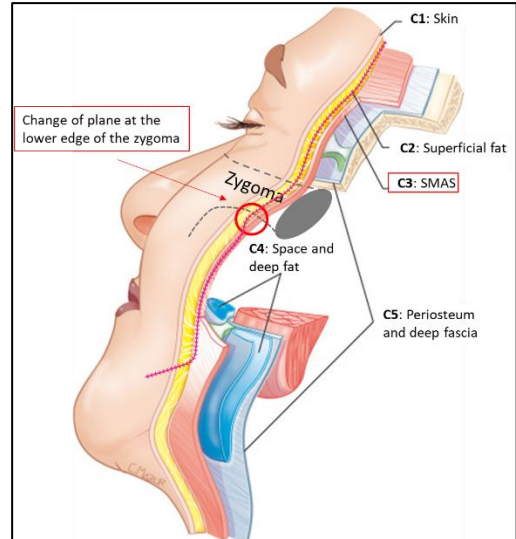
POINT OF CAUTION - The beginning of the trajectory must be strictly in the subcutaneous plane. A deeper placement within the immobile SMAS would immobilise the thread in a fixed area and consequently result in a loss of effectiveness.

Thread & Lift

It is only once the needle passes below the lower border of the zygomatic arch [zygomatic arch], previously marked during the drawing phase, that the depth is increased by lifting the skin to navigate through the mobile SMAS. At this stage, small cracking sounds, accompanied by slight resistance, confirm that the correct plane has been reached.



Schematic view of the thread path with SMAS tunnelling



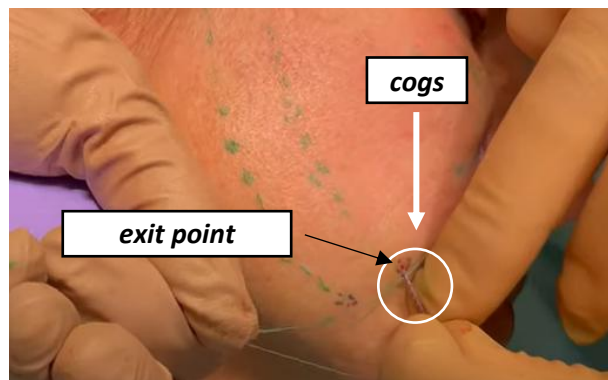
If there is any doubt about the needle being positioned too deep along a pathway that should remain within the SMAS (for example, if the thread appears too close to the gum), the patient should be asked to open their mouth so that a finger can be inserted to verify, by touch, the position of the needle.

If, while tunnelling through the SMAS, the patient experiences pain, this may indicate that the initial anaesthesia was administered too superficially in the subcutaneous tissue and insufficiently within the SMAS. In that case, a few minutes should be taken to complete the anaesthesia so that the procedure can continue under optimal conditions.

Once the blue point, marking the tip of the V, is reached, the procedure for completing the pathway is identical to that used for the lower portion of the first trajectory **(1)**.

As before, once the thread is inserted into the needle eyelet, the needle is gradually and fully extracted, pulling the thread along until reaching the implantation of the black mark.

Note that in patients with elongated faces, the position of the black mark is no longer taken into consideration. Indeed, even if this marker becomes buried, it is essential to pull the thread until the first cogs [cogs] appear at the exit point [exit point].

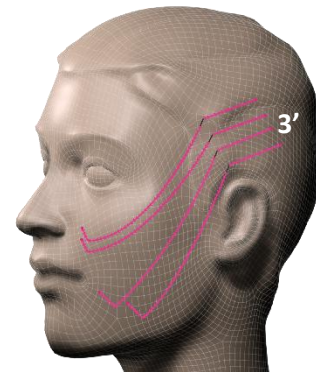
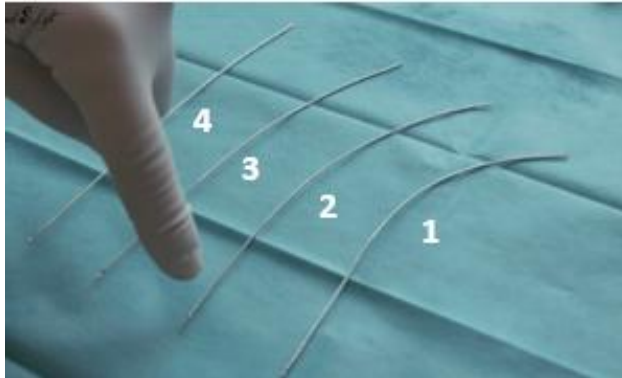


Thread & Lift

As with the first two pathways, before implanting the upper half of the third thread, **it is essential to verify proper tissue mobilization by applying traction to the thread from its entry point**. Harmonious mobilization of the upper, middle, and lower thirds of the face should be observed. If the insertion is too deep, particularly within the non-mobile SMAS, only the area beneath the zygoma will move.

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

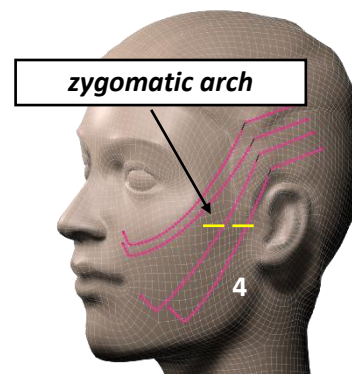
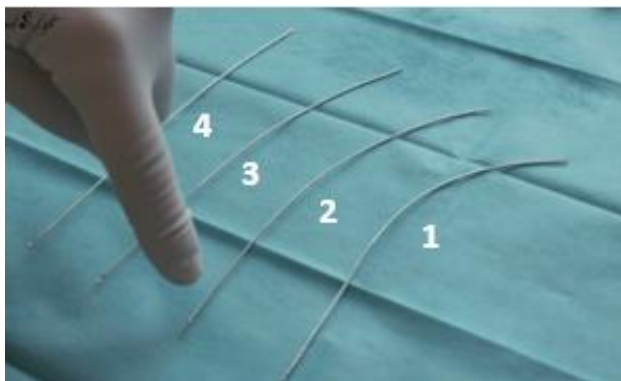
For the upper portion of the third thread (**3'**), the same needle (**3**) is used as the one selected for implanting the upper half of the first thread.



The procedure to follow is the same as for the upper half of the first two threads.

7) Implantation of the 3rd thread - the lower half

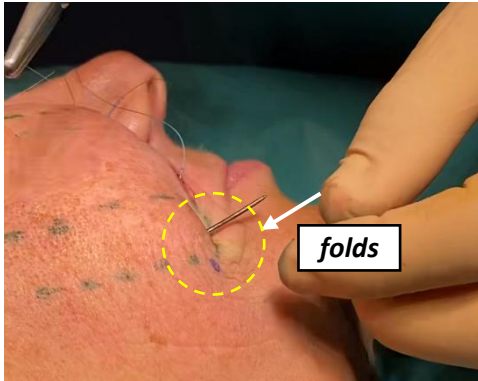
For the lower half of the thread directed toward the jowl (**4**), needle (**3**) is used.



The procedure to follow is identical to that of the lower half of the third thread: it is first inserted superficially and then, once the zygomatic arch [*zygomatic arch*] has been passed, more deeply into the mobile SMAS.

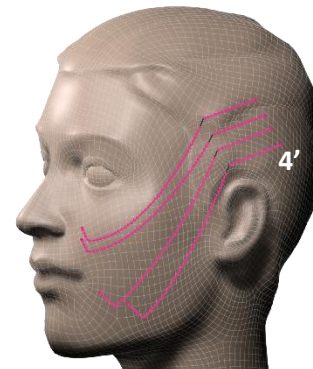
Thread & Lift

Once the needle is extracted, any folds [*fold*s] that may appear at the exit point should be disregarded. These are simply due to the compression exerted by the needle. **They tend to be more visible in the cheek area than over the cheekbone because of the greater skin laxity there.** It can also be observed that if the needle is gently lifted with a finger—thus releasing the pressure on the skin—these folds disappear immediately.



8) Implantation of the 3rd thread - the upper half

For the upper portion of thread (4'), the same needle (3) is used as the one selected for implanting the upper half of the other threads.



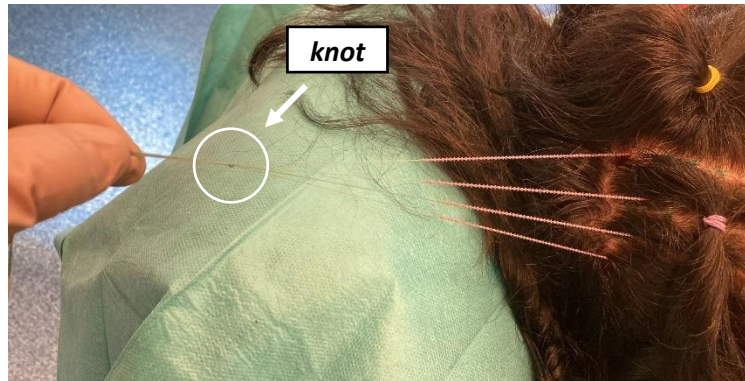
The procedure to follow is identical to that used for the upper half of the other threads.

As with all pathways, it is essential to continue checking for the absence of buried hairs in the temporal area!

Once this pathway has been implanted, the work on the first cheek is complete.

Thread & Lift

To facilitate handling of the threads during the subsequent tensioning and adjustment phases, the four upper ends of the threads are tied together.



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

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

First step: firm traction is applied, successively, to each of the four upper strands, starting with the most anterior one. This ensures that they are perfectly tensioned along the first 5 to 6 centimetres of their pathway, thereby guaranteeing optimal engagement of all the cogs.

To do this, two or three fingers are placed over the buried portion, then a brief pull is applied to the thread.

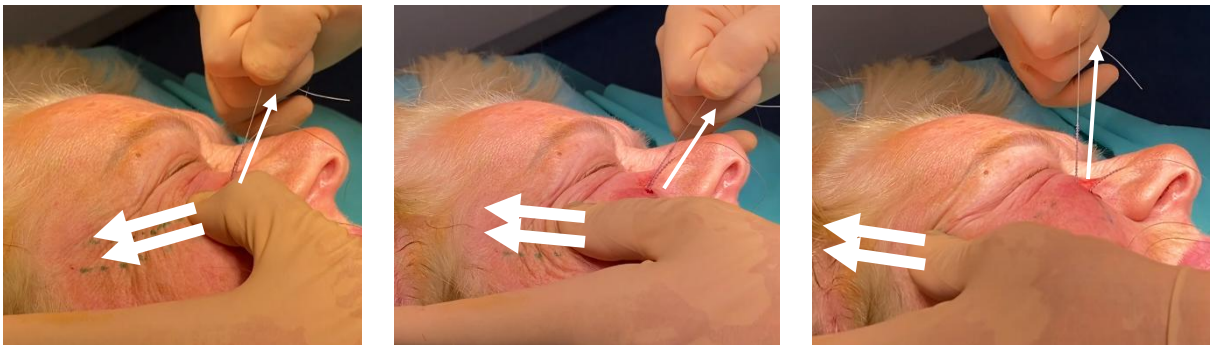


Thread & Lift

Second step: the individual pre-adjustment of each thread on the cheek is performed, starting with the most anterior one.

Tensioning consists of lifting the tissues along each thread. **The goal is not to pull excessively, but rather to hold the thread firmly under tension with one hand** (here, the right hand) — enough to cause a slight movement of the patient's head — **while the other hand** (here, the left hand) **progressively elevates the tissues upward, following the thread's pathway.**

Centimetre by centimetre, starting from the tip of the V, the skin is slid and lifted along the thread using the thumb, applying gentle but firm pressure. The skin is gradually draped upward all the way to the entry point. **Care must be taken to traction the skin precisely along the pathway of the thread under tension, without drifting onto the pathways of the other threads.**

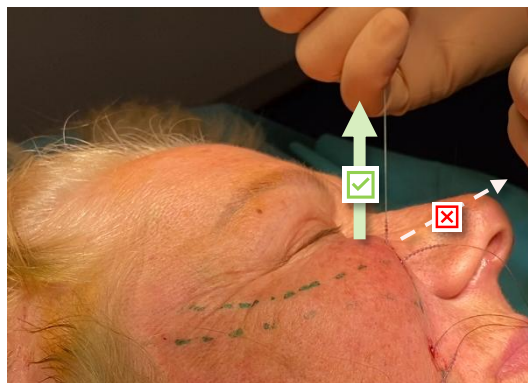


IMPORTANT - **The thumb must not perform a large, continuous sliding motion over the skin, as this could cause skin erosion.** The thumb should glide as little as possible over the surface. The movement must be incremental, advancing every centimetre, in order to elevate the skin as much as possible along the thread's pathway.

Along the pathways of the cheekbone threads, the skin is lifted to the maximum. However, the degree of cheekbone elevation should be adjusted according to the patient's expectations and preferences. **For threads (3) and (4), in the sections implanted within the deep SMAS plane, the full strength of the thread can be used** without risk of creating creases.

*Note that in cases of aged skin or **marked elastosis**, it is preferable **not to use the thread's full lifting potential**, to avoid forming unsightly folds in the crow's feet area.*

Tensioning of the threads at the cheekbone level must be performed along the axis of the V's exit, and not along the main axis of the pathway, in order to avoid any risk of tearing the skin.



Thread & Lift

10) Thread implantation on the second side of the patient's face

The thread implantation on the second side of the patient's face can now be performed, following the same procedure as previously described for the first side.

Once the thread implantation phase is complete, the skin should be cleaned (removal of pathway markings and any traces of blood).

POINT OF CAUTION - The tips of the threads must not be cut at this stage! They will be needed for the final tension adjustment.

Phase 5: the final adjustment of the tension

1) Precise tension adjustment

For the final adjustment of the 8 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.



We begin by re-tightening all the threads one by one, to ensure that the applied tension is maximal and that each thread has indeed been used to its full potential. This step is performed as a precaution, as the threads should normally already have been tightened to 100% while the patient was in the lying position.



Thread & Lift

POINT OF CAUTION - Infinite-Thread® is particularly powerful, with highly effective cogs. Its tensioning must therefore be adjusted with precision according to the specific needs of each area of the face.

- ***Cheekbones***: the cheekbones should be re-compacted, smoothing the tear trough if necessary, without creating excessive volume (unless specifically requested by the patient). In this area, tissue elevation is not homothetic as in the upper third of the face, but concentric—except in men, to avoid feminizing their facial features.
- ***Marionette lines and jowl***: be careful to avoid excessive tension over the last two centimetres of the pathway, as this may create a dimple. If this occurs, the area should be massaged downward with the thumb to release the tension, while protecting the area with the other hand.

2) Release of dimples

One by one, the ends of the threads are released from their cutaneous anchorage by massaging the skin. This step eliminates any risk of dimpling, whether immediate or delayed, as the oedema resolves.

The massage must be vigorous, given the strong anchoring of the thread.

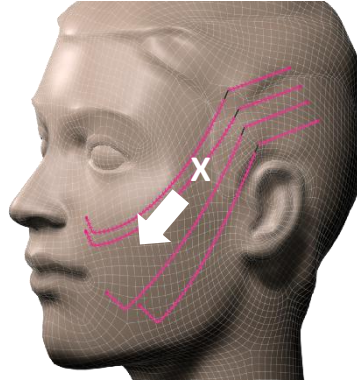


Indeed, two problems may occur:

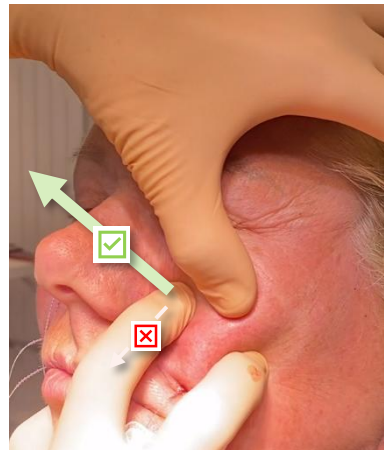
- ***Appearance of dimples***: dimples at the exit points are caused by threads creating a depression of the skin at their exit point. **They do not disappear on their own**, contrary to what is often claimed. **The patient should never leave with one or more dimples. The principle is the same for folds.** A fold or a dimple is always the result of an error or a technical flaw in the practitioner's gesture.

Thread & Lift

- **Appearance of grooves:** a 1- to 2-centimeter groove may appear along the axis of a thread. This indicates excessive tension on the lower end of the thread. It is therefore essential to immediately release tension in this specific area, **while being careful not to loosen the entire thread.** To do this, one hand is placed higher up (above the area to be corrected) along the thread's pathway (X). This hand applies slight upward tension to protect the thread's anchorage. With the other hand, the skin over the groove is vigorously massaged downward (in the direction of the arrow →) to **COMPLETELY** eliminate the defect(s).



When correcting grooves near the end of a thread pathway, particular care must be taken to massage the skin along the axis of the V-return, and not along the main axis of the pathway.



Note that as long as the upper ends have not been cut, it is still possible to apply additional tension if needed, after releasing dimples or correcting any defects. In such cases, it is important to check again for the absence of irregularities related to the added tension and, if present, to release them through massage.



Thread & Lift

Phase 6: cutting of the extremity of the threads

1) Cutting the lower ends of the threads

Once the final tension adjustment is confirmed, the lower end of each thread is cut flush on each cheek.



Before cutting the ends, care is taken to push the skin back by a few millimetres to expose two rows of cogs—about 5 mm of thread—before cutting them flush. **For thread (1), only one row of cogs should be cut, as the return pathway of the V is generally shorter due to the limited skin laxity near the nose.**

All dimples caused by cutting the threads are then released, following the previously described recommendations—namely, securing the upstream portion of the pathway and massaging in the direction of the corresponding segment.



POINT OF CAUTION - A patient should never leave your practice (clinic) with folds, dimples, or grooves related to the placement of suspension threads. Time is not on your side: as the oedema resolves, any defect will persist and become increasingly difficult to correct.

Thread & Lift

2) Cutting the upper ends of the threads

As with the cutting of the lower ends of the threads, it is advisable to pull very gently on the upper ends to expose 2 or 3 rows of cogs — approximately 5 mm of thread — before cutting them flush. **This step ensures the complete and proper burial of the thread ends.**



IMPORTANT - As a safety measure, it is essential to push back the scalp to ensure that it properly covers each thread end that has been cut flush.



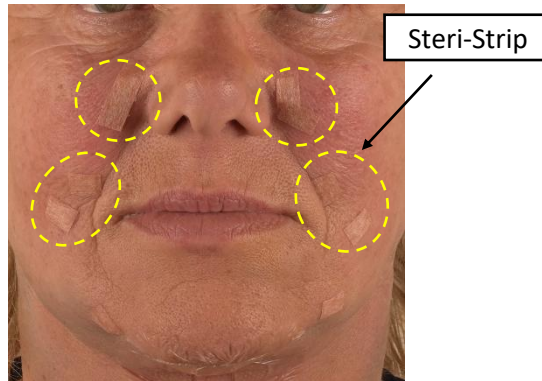
Again, verify the complete absence of partially buried hairs.



POINT OF CAUTION - The upper ends of the threads must be cut only at the very end, that is, after the final adjustment, and never before! Indeed, the upper ends that have **NOT YET BEEN CUT** allow for a final tension adjustment if a thread becomes insufficiently tightened or loosened during the release of a dimple at the lower exit point.

3) Protection of the exit points of the lower pathways

At the end of the procedure, in order to protect the exit points of the lower pathways, a Steri-Strip [*Steri-Strip*] is applied to each exit point (i.e., four Steri-Strips per side).



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 anaesthesia 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.

Special Case: large J for the cheekbone

The Large J pathway helps optimize the correction of a pronounced nasolabial fold in a patient with heavy skin, low-density fat, and relatively lax connective tissue.

In this type of skin, it is essential to position the thread as close as possible to the nasolabial fold in order to achieve a satisfactory corrective effect. However, in the standard protocol, the V shape is generally implanted 1 to 1.5 cm from the fold, which proves ineffective in this situation.

Furthermore, the V-shaped pathway concentrates tension at its tip, without benefiting here from sufficient tissue resistance, which limits its effectiveness.

In this specific case, it is preferable to opt for a **large J-shaped pathway** that extends as close as possible to the nasolabial fold. **This design allows for a gradual overhang of the cheekbone while distributing the tension more evenly.**

Thus, the **Large J** is a more effective alternative for achieving a marked correction of the nasolabial fold in heavy, low-resistance tissues.

The Large J is also useful when the nasolabial mound lacks sufficient fat.