COMPLICATIONS CORNER

A Pixie Earlobe Following Facelift

by Eyal Levit, MD, Deborah Daly, DO,
Dwight A. Scarborough, MD, and Emil Bisaccia, MD

Complication

A 56-year-old female presented with a difference in the appearance of her earlobes following a facelift procedure. The right earlobe was free while the left was attached and pulled downward; ie, "pixie earlobe" deformity (Figure 1). Why does it happen and how do I prevent and treat it?

Discussion

A pixie earlobe is an attached tapering low-set earlobe. It can be inherited or acquired. The acquired form can be seen following face and neck lift procedures, or full ear otoplasties.

Facelift procedures begin and end with the periauricular incisions. Common problems decreasing the aesthetic outcome of the facelift include: visible scars that are hypertrophic and/or hypo- or hyperpigmented, low and visible mastoid skin scars, a "hidden/buried" or "retracted" tragus, excessively elevated temporal hairline known as "sideburn elevation" as well as a "step" deformity of the postauricular hairline, and a deformed ear lobule or "pixie ear" deformity.[1,2]

The object of performing a facelift is to tailor the procedure allowing for a balanced and natural-looking lift. This gives the patient a rested appearance while minimizing unnecessary scars and a "wind blasted" appearance.[3] Location of the sideburn, the occipital hairline, the desired facial areas to be addressed in the lift, and the gender of the patient are all factored when deciding upon the design of the incisions for the facelift.[3]

While a free or attached earlobe is the most easily notable change in the ears, 2 other important factors are the size of the earlobe and the direction of the long axis of the ear. The earlobe should be proportional in size to the face and the angle of the long axis of the ear should

Drs. Levit and **Daly** are Fellows in dermatologic, cosmetic, and Mohs' micrographic surgery; **Dr. Bisaccia** is a practicing dermatologist and Clinical Professor of Dermatology at the Columbia University College of Physicians and Surgeons in New York City. **Dr. Scarborough** is a practicing dermatologist and Assistant Clinical Professor of Medicine, Dermatology Division, at the Ohio State University Hospital in Columbus.

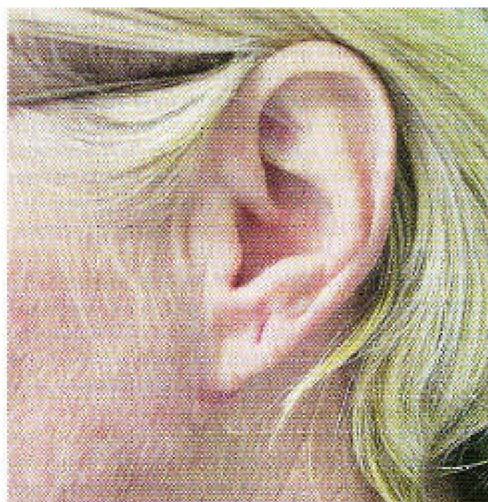

Figure 1. Note the earlobe is attached and slightly tapered postoperatively.

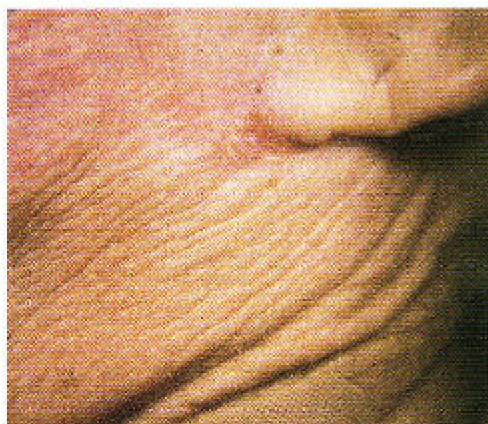

Figure 2. The earlobe following the correction has been freed and the tapered edge reshaped becoming symmetrical to the contralateral side.

be approximately 15° more vertical than that of the nasal dorsum.[2] Even if the earlobe is initially placed in a correct angle, the forces of tension on the ear usually result in a net pull ventrally and caudally rotating the ear into an axis parallel to that of the nasal dorsum.[2]

As mentioned earlier, the positioning of the ear is one of the important aesthetic factors for the patient. There are 3 common problems that can lead to a malformed earlobe or "pixie ear" deformity: lack of attention to preoperative photographs of the patient's ear lobule shape, absent or poor intraoperative markings of the natural earlobe position,[3] and the design of and tension on the periauricular incisions. As time progresses, the ear is pulled and stretched in a down and ventral direction, and this expected pull may vary with the degree of surrounding skin tension and should be factored into the positioning of the earlobe at the completion of surgery. The pull is such a common factor that some surgeons suggest as a rule to place the earlobe a distance above its "ideal" intraoperative position (5 mm for females and 8 mm for males).[2] Meticulous attention to all these factors is paramount for optimal symmetry and natural appearance of the earlobe.[2,3]

While the methods for repair of the pixie ear vary,[4-7] the procedures are quite simple and depend on the desired final shape of the earlobe. Marking of the area prior to infiltration with local anesthetic is important, as distortion may hamper the attempt to recreate a natural and contralaterally symmetrical earlobe.

If the size of the earlobe is correct and the only problem is the attachment of the earlobe then a bovie in a cut and coag mode can be utilized to separate the earlobe, producing a free earlobe to match the other side. The healing of the incision can be by secondary intention or by primary closure (Figure 2).

If the earlobe shape is too tapered, then the correction must address both the shape and the separation of the earlobe.[1,5] An interesting and simple method described by Hoefflin and Rubin[4] is to use a permanent 4.0 Nylon placed like a pulley with its base at the subdermal base of the earlobe and its apex symmetrically anchored at about the level of the antitragus anteriorly and posteriorly.[4] The pulley allows the creation of a curved and separated earlobe while avoiding the excision of auricular tissue, which would decrease the size of the earlobe.

If, on the other hand, the earlobe size also has to be addressed, then another technique can be used.[6] The earlobe is separated completely to the level of the newly desired earlobe attachment sight. The periauricular skin is undermined and sutured together. The free earlobe is then trimmed and shaped as desired and its lateral edges are sewn back together.[6]

On occasion, the patient may prefer the pixie ear look and ask for the other earlobe to be attached as well. In this case, a thin sliver of the earlobe to be attached and of the recipient site is removed and the earlobe is attached with basting and running sutures to the recipient site.

References

1. Knize DM. Periauricular face lift incisions and the auricular anchor. *Plast Reconstr Surg*. 1999,104:1508–1520.
2. McKinney P, Giese S, Placik O. Management of the ear in rhytidectomy. *Plast Reconstr Surg*. 1993;92:858–866.
3. Scarborough D, Bisaccia E. The Webster-type face and neck lift: an extensive cervico-facial rhytidectomy employing a minimally invasive technique. *Derm Surg*. 2001;27:747–755.
4. Hoefflin S, Rubin A, Cleveland C. Simple repair of a pixie earlobe. *Plast Reconstr Surg*. 2001;107:1623–1624.
5. Boo-Chai K. A method of correction. *Plast Reconstr Surg*. 1985;76:636–638.
6. Rich J, Colonel M, Gottlieb V, et al. A simple method for correction of the pixie earlobe. *Plast Reconstr Surg*. 1982;69:136–138.
7. Chait L, Nicholson R. One size fits all: a surgical technique for the correction of all types of prominent ears. *Plast Reconstr Surg*. 1999;104:190–195.