

Minimally Invasive Techniques of Oculofacial Rejuvenation

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Teeth and the Perioral Area in Facial Aesthetics

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Similar to the expanding diversity of aesthetic disciplines in the medical specialties, general dentistry has begun to emerge into its own subspecialty. On its own merit, aesthetic dentistry has become a mainstream for treatment alternatives, from both the functional and the purely aesthetic aspects. Biological and mechanical improvement of the oral cavity is many times a necessity. Decay, fractured teeth, and periodontal disease are all manifestations that cannot be overlooked. There is a medical and dental responsibility by the clinician to address these problems as they develop in an individual. With proper maintenance, a person can avoid many of the dental afflictions that debilitated earlier generations. Newer understandings of disease processes have made early diagnosis and treatment easier. Recent technology and material advances have made it possible to restore teeth and their supporting structures to almost their original state. This can now be termed rejuvenation dentistry. It is also these advances that have made it possible to restore a person when there is a need for only aesthetic improvement.

◆ Muscle Distribution and Innervations

From a surgeon's perspective, to have a good understanding of the perioral aesthetics, form, and function, it is important to review muscle distribution and innervations. There are 20 muscles of facial expression, each with a unique location and function. Because this chapter focuses on the perioral region, only a few of the major muscles are discussed.

Orbicularis oris originates in the maxilla above the incisor teeth and inserts in the skin of the lip. Its action is to close the lips.

Levator anguli oris originates in the canine fossa of the maxilla and inserts at the angle of the mouth. Its action is to elevate the angle of the mouth medially. Levator labii superioris originates in the maxilla above the infraorbital foramen and inserts on the skin of the upper lip. Its action is to elevate the upper lip.

Zygomaticus major originates on the zygomatic arch and inserts on the angle of the mouth. Its action is to draw the angle of the mouth upward and backward. This action is what we most commonly refer to as a smile.

Depressor anguli oris originates on the oblique line of the mandible and inserts at the angle of the mouth. Its action is to depress the angle of the mouth. This muscle plays a major role in frowning.

Risorius originates over the masseter and inserts at the angle of the mouth. Its action is to retract the angle of the mouth laterally.

Buccinator has multiple points of origin—the mandible, pterygomandibular raphe, alveolar process. The insertion is located at the angle of the mouth. Its action is to press against the cheeks and keep them taut.

Mentalis originates in the incisive fossa of the mandible and inserts on the skin of the chin. Its action is to elevate and protrude the lower lip.¹

Motor innervation to the muscles of facial expression is provided by the facial nerve. The facial nerve comes from cranial nerve seven. The terminal branches include the temporal, zygomatic, buccal, marginal mandibular, and cervical.

Of all these muscles, the zygomaticus major and risorius are key players in positioning the lips into a smile position. With this in mind, the surgeon can begin