Objective: To test the validity of the subzygomatic fossa as a possible landmark in identifying the origin of the zygomaticus major muscle (ZMM).

Methods: Twenty-three fresh cadaver facial halves were dissected. Four reference points were identified in each cadaver head: the zygomatic arch, the malar eminence, the modiolus, and the ZMM insertion notch. The ZMM insertion notch is a palpable landmark that is typically identified midway between the zygomatic arch and the malar eminence. A straight line was drawn from the ZMM insertion notch to the modiolus. An additional line was drawn from the malar eminence to the modiolus. An incision was made along the each line to the depth of the facial muscles. The presence or absence of the ZMM was recorded, and the location of the ZMM insertion notch was characterized in each cadaver.

Results: The ZMM insertion notch was palpated and identified in 23 of 23 facial halves. It was accurate in identifying the course of the ZMM in all 23 facial halves. The line created by the malar eminence to the modiolus was inaccurate in all 23 facial halves.

Conclusion: The ZMM insertion notch is a reliable landmark for identification of the ZMM.

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The identification of the course of the zygomaticus major muscle (ZMM) plays an important role in facial plastic surgery. First of all, the ZMM serves as an important landmark in deep plane rhytidectomy.1 The facial nerve courses deep to the plane of the ZMM, providing the face-lift surgeon with a reliable guide to dissection into the medial portion of the face.1,2 Also, some surgeons report plication of the ZMM to provide rejuvenation of the aged face.3,4 For patients receiving botulinum toxin type A (Botox) injections for "crow's feet" within the orbicularis oculi, avoidance of the ZMM is critical to prevent the unwanted sequelae of a lip drop.5

The ZMM is responsible for lifting the corners of the mouth, which serves several expressive purposes, including smiling. It is typically a fan-shaped muscle, which may be single headed or bifid in nature.6 The muscle increases in size and thickness in males and in patients with an increasing body mass index.7 Located anterior to the ZMM is the zygomatic cutaneous ligament, or MacGregor's patch.8 Release of this ligament is crucial in providing mobilization of the malar fat pad and rejuvenation of the midface structures. The superficial musculoaponeurotic system layer can be mobilized further and with less tension with release of the zygomatic ligament.2 A backcut of the ZMM itself will also provide improved mobilization of the superficial musculoaponeurotic system layer.4

Deep to the ZMM lies the plexus of the zygomatic branch of the facial nerve. The orbicularis oculi may be partially innervated in certain patients by some nerve branches that lie superficial to the ZMM.9 However, the plexiform innervation of the zygomatic branch of the facial nerve and the vast majority of nerves that lie deep to the ZMM make permanent sequelae unlikely. The ZMM, along with the other upper lip mimetic muscles, inserts at the modiolus.10 The ZMM originates anterior to the zygomatic temporal suture within the subzygomatic fossa11 (Figure 1).

Despite this anatomical description, surgeons have sought complex means of ascertaining the clinical origin of the ZMM (Figures 1, 2, 3, and 4). Mendelson12 described the origin as “a vertical line dropped from the lateral orbital rim to the lower border of the zygoma.” Tremolada et al13 described the origin from the ma-
lar bone on a line drawn from the lateral canthus to the mandible. Furnas reported that the ZMM was located along the zygomatic body, coursing to the modiolus. In a more recent article, Mowlavi and Wilhelmi found that the lateral border of the ZMM was 4.4 mm lateral and parallel to an oblique line drawn from the mental protuberance to the notch defined as the most anterior-inferior aspect of the temporal fossa at the junction of the frontal process and temporal process of the zygoma. Finally, Spiegel and DeRosa published an anatomical article in which they describe the origin of the ZMM to be 1.4 cm inferior to the Frankfort horizontal line at 1.0 cm lateral to the lateral canthus.

While the previous descriptions were fairly accurate in illustrating the course of the ZMM, their overall complexity has prevented them from being universally adopted by facial plastic surgeons. The origin of the ZMM is the subzygomatic fossa, which is located posterior and inferior to the malar eminence and anterior to the zygomatic temporal suture. Despite some contrary reports, the subzygomatic fossa is an easily palpable landmark. The senior author (P.J.M.) has developed a technique for locating the course of the ZMM (Figure 5). By using

**METHODS**

Twenty-three fresh cadaver facial halves were dissected. Four reference points were identified in each cadaver head: the zygomatic arch, the malar eminence, the modiolus, and the subzygomatic fossa, which is a palpable landmark that can be identified midway between the zygomatic temporal suture and the malar eminence. A straight line was drawn from the ZMM insertion notch to the modiolus. An additional line was drawn from the malar eminence to the modiolus. An incision was made along the each line to the depth of the facial muscles. The presence or absence of the ZMM was recorded when each of the above landmarks was used (Figure 6). The palpation of the landmarks was performed by a junior resident (S.S.) to ensure that novice surgeons could easily learn to use this technique. The clinical application of the efficacy of the zygomatic notch was applied in 28 consecutive deep-plane rhytidectomies. The zygomatic notch, as well as the modiolus and the proposed location of the ZMM, was identified and marked before the face-
lift. A deep-plane rhytidectomy was performed with location of the ZMM using the external landmark as a guide.

RESULTS

The subzygomatic fossa was palpated and identified in 23 of 23 facial halves. The ZMM insertion notch was also accurate in identifying the course of the ZMM in all 23 facial halves. The line created by the malar eminence to the modiolus was inaccurate in all 23 facial halves. Clinically, the location of the subzygomatic fossa correlated well with the location of the ZMM in 58 consecutive rhytidectomy procedures.

COMMENT

We found the subzygomatic fossa to be an easily palpable landmark. Because the subzygomatic fossa is the recognized origin of the ZMM in several textbooks and anatomy books, we chose to use it as the landmark rather than a tangential correlation. We found both the palpability of the subzygomatic fossa and its underlying relationship with the origin of the ZMM to be highly accurate. Mowlavi and Wilhelmi14 found the subzygomatic fossa difficult to palpate. However, we found that, by clearly palpating and identifying the zygomatic arch and the malar eminence, the subzygomatic fossa could be easily palpated. As a testament to its ease, a junior resident (S.S.) was able to palpate the fossa in each cadaver case. Landmarks are useful in surgery to provide the surgeon with an appropriate reference to the surrounding structures. A landmark must be accurate and identifiable to be useful. The use of the ZMM as a landmark in deep-plane rhytidectomy has been limited by lengthy descriptions on the origin of this muscle. The subzygomatic fossa simplifies its location and allows ease of identification.

Minimizing complications in such procedures as botulinum toxin injections are crucial to providing optimal patient results. Paralysis of the ZMM has been reported as an inadvertent adverse effect of treating periorbital rhytids.13 Limiting the dilution content of botulinum toxin, experience with injection, and knowledge of the facial anatomy will limit the possibility of this potential sequela occurring. Knowledge of the course of the ZMM will reduce the likelihood of an inadvertent injection.

Extensive knowledge of anatomy is required for safe performance of the deep-plane face-lift, and the ZMM is an important landmark for a safe and effective procedure. We hope that the identification of this landmark muscle will provide improved safety in deep-plane rhytidectomy.

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REFERENCES


Announcement

Identifiable Patient Photographs

Please do not send masked photographs of patients.

Until the late 1980s, placing black bars over the eyes of patients in photographs was accepted as a way to protect the identities of patients. However, journals began to discontinue this practice when it became apparent that bars across eyes do not protect identities. Photographs with bars placed over the eyes of patients should not be used in publication.1 Authors may obtain the Patient Consent Form from www.archfacial.com. The patient should be offered the opportunity to see the manuscript before submission. When the manuscript is submitted electronically, send the patient consent by fax to the editorial office: (206) 386-3553.