

MAPP AESTHETICS

CLINICAL GUIDE

Peri-Oral Ageing

*The clinical picture,
and how we treat it*

A PATIENT EDUCATION AND CLINICAL REFERENCE GUIDE

What this guide covers

The peri-oral region is among the earliest areas of the face to show visible ageing, and among the most functionally demanding. This guide sets out why that happens, how the area is assessed, and what the evidence-based, non-surgical treatment options are, together with their mechanisms, timelines, limitations and risks.

01	Overview	4
02	Anatomy of the Peri-Oral Region	5
03	The Pathophysiology of Peri-Oral Ageing	9
04	Contributing and Accelerating Factors	12
05	The Clinical Signs of Peri-Oral Ageing	13
06	Assessment and Classification	15
07	Treatment Option 1: Muscle-Relaxing Treatment	18
08	Treatment Option 2: Skin Boosters and Bio-Remodelling	21
09	Treatment Option 3: Structural and Volume Support	25
10	Treatment Option 4: Resurfacing and Energy-Based Devices	27
11	Treatment Option 5: Medical Skincare and Modifiable Risk Factors	29
12	Building a Combination Treatment Plan	31
13	Patient Selection, Contraindications and Cautions	33
14	Pre-Treatment Preparation	35
15	Aftercare	36
16	Complications and Safety	37
17	Realistic Expectations	39

18	Prevention and Long-Term Maintenance	40
19	Special Patient Populations	41
20	Frequently Asked Questions	42
21	Glossary	43
22	Important Information	44

SECTION 01

Overview

The peri-oral region, meaning the skin, muscle, fat and bone surrounding the mouth, is among the earliest and most conspicuous areas of the face to display visible ageing. It is also one of the most functionally demanding regions of the body. The mouth is in near-constant motion during speech, eating, drinking and emotional expression, and the tissue surrounding it is structurally among the thinnest and least supported on the face.

The combination of high mechanical load and low structural reserve explains why change here appears early, progresses steadily, and is disproportionately noticeable to the patient. Vertical lip lines, thinning of the vermilion, downturning of the oral commissures and loss of definition at the lip border can shift the perceived age, mood and even health of the lower face, often well before a patient feels they have aged elsewhere.

Patients frequently describe these changes as “smoker’s lines”, a term that has persisted despite the majority of affected patients being lifelong non-smokers. It is a misleading label. The underlying process is multifactorial and largely universal. Smoking is an accelerant, not a prerequisite.

The purpose of this guide is to explain, in clinical detail, why peri-oral ageing occurs, how it is assessed, and what the evidence-based, non-surgical treatment options are, including their mechanisms, timelines, limitations and risks.

SECTION 02

Anatomy of the Peri-Oral Region

Effective treatment of this region depends entirely on an accurate understanding of its anatomy. The peri-oral area is anatomically dense, highly vascular and functionally critical.

2.1 AESTHETIC BOUNDARIES AND SUBUNITS

The peri-oral region is conventionally bounded:

- **Superiorly** by the base of the nose (subnasale) and the nasolabial folds
- **Laterally** by the nasolabial folds extending inferiorly toward the labiomandibular folds
- **Inferiorly** by the labiomental crease and the chin

Within this region, the recognised aesthetic subunits are the two lateral upper lip subunits, the central philtral subunit, the lower lip and the chin. Treatments and any resurfacing are ideally planned by subunit to avoid visible demarcation lines.

Key surface landmarks include:

- **Vermilion:** the reddish, keratinised but non-hair-bearing mucocutaneous portion of the lip
- **Vermilion border, or “white roll”:** the slightly raised ridge of pale skin at the junction between vermilion and cutaneous lip. This is a critical light-reflecting structure that blurs with age.
- **Cupid’s bow:** the double-arched contour of the upper vermilion border
- **Philtral columns:** the paired vertical ridges running from the nasal base to Cupid’s bow, formed by decussating fibres of the orbicularis oris
- **Oral commissures:** the corners of the mouth
- **Labiomental crease:** the horizontal fold between the lower lip and chin

2.2 THE SKIN

Peri-oral skin has several distinguishing features that predispose it to early ageing:

- **A thin dermis** with a relatively low collagen density compared with cheek skin
- **Minimal subcutaneous fat**, particularly over the cutaneous upper lip, meaning the dermis sits almost directly on muscle
- **A high density of pilosebaceous units** in the upper lip, which contributes to a fine but irregular surface texture
- **Direct dermal attachment to the underlying orbicularis oris muscle** via short, dense fibrous septae. This is a defining anatomical feature in peri-oral rhytid formation, because it means every muscle contraction is transmitted directly and efficiently into the overlying skin.
- **Little to no protective bony convexity**, unlike the forehead or malar region

2.3 THE MUSCULATURE

The peri-oral musculature is a complex, interdigitating sphincteric and radial system.

The sphincter

Orbicularis oris is a sphincteric muscle organised into two functional components: the *pars marginalis* (deep, adjacent to the vermilion, responsible for lip pursing and eversion) and the *pars peripheralis* (superficial and peripheral, contributing to lip closure and compression). Its fibres run predominantly **circumferentially**, meaning horizontally around the mouth. Because dermal rhytides form perpendicular to the direction of underlying muscle fibre contraction, this circumferential orientation is precisely why peri-oral lines are **vertical**.

The elevators of the upper lip

- Levator labii superioris
- Levator labii superioris alaeque nasi
- Levator anguli oris
- Zygomaticus major and minor
- Risorius

The depressors of the lower lip and commissure

- Depressor anguli oris (DAO), the principal driver of downturned mouth corners
- Depressor labii inferioris
- Mentalis, responsible for chin dimpling and lower lip protrusion
- Platysma, whose superior fibres contribute to lower face and commissure depression

The modiolus

A dense, mobile fibromuscular node located approximately 1 cm lateral to each oral commissure, where the orbicularis oris, DAO, levator anguli oris, zygomaticus major, risorius, buccinator and platysma converge. The modiolus is the pivot point of lower facial expression. Its position descends with age, and it is an anatomically hazardous zone. Treatment placed carelessly here can cause profound functional impairment of the mouth.

2.4 VASCULAR ANATOMY

The peri-oral region is one of the most richly vascularised areas of the face, and this is the primary source of procedural risk.

- The **facial artery** ascends from the inferior mandibular border, anterior to the masseter, and gives rise to the **inferior labial artery** and the **superior labial artery**, typically near the oral commissure.
- The labial arteries most commonly run **submucosally or intramuscularly**, deep to the orbicularis oris and posterior to the vermilion. Their course is highly variable between individuals and even between sides in the same individual. Studies report submucosal positioning in the majority of cases, with intramuscular and subcutaneous variants also documented.
- The superior labial artery gives off the **septal and alar branches** supplying the columella and nasal base.
- Critically, the facial artery system **anastomoses with the ophthalmic artery** via the angular and dorsal nasal arteries. This creates a potential retrograde embolic pathway from the peri-oral region to the retinal circulation, and it is the anatomical basis for the rare but catastrophic complication of blindness following facial treatment.
- Venous drainage occurs via the facial vein into the internal jugular system, with anastomotic connections to the pterygoid plexus and cavernous sinus.

2.5 INNERVATION

Sensory, via the trigeminal nerve (CN V)

- **Infraorbital nerve (V2)** exits the infraorbital foramen approximately 5 to 8 mm below the infraorbital rim, supplying the upper lip, lateral nose and lower eyelid
- **Mental nerve (V3)** exits the mental foramen, typically between the first and second premolar roots, supplying the lower lip and chin

Both are relevant to dental block anaesthesia and to the localised sensory disturbance occasionally reported after treatment.

Motor, via the facial nerve (CN VII)

- **Buccal branches** supply the orbicularis oris, buccinator and upper lip elevators
- **Marginal mandibular branch** supplies the DAO, depressor labii inferioris and mentalis. It runs along or below the mandibular border and is vulnerable in the lateral lower face.

2.6 THE SKELETAL AND DENTAL FOUNDATION

The soft tissues of the peri-oral region are entirely dependent on their bony and dental scaffold.

- **Maxilla and pyriform aperture:** the pyriform aperture widens and its angle becomes more obtuse with age, withdrawing support from the nasal base and central upper lip
- **Maxillary alveolar ridge:** resorbs, particularly with tooth loss, reducing anterior projection of the upper lip
- **Mandible:** undergoes reduction in both height and angle, with the mandibular angle becoming more obtuse
- **Mental foramen:** with alveolar resorption the foramen effectively migrates superiorly toward the alveolar crest, an important consideration in chin and pre-jowl treatment
- **Dentition:** attrition, loss or ill-fitting prostheses collapse vertical dimension and directly worsen peri-oral folding and commissure downturn

A patient with significant dental compromise will have a structurally different, and treatment-limited, peri-oral region compared with an age-matched patient with intact dentition.

2.7 FAT COMPARTMENTS

The peri-oral region contains discrete, septated fat compartments rather than a continuous fat layer:

- Superior and inferior labial (orbicularis oris) fat compartments
- Superficial and deep nasolabial fat
- The deep medial cheek fat, whose deflation contributes to nasolabial deepening
- Buccal fat, whose descent contributes to jowling and secondary commissure heaviness
- Deep chin fat and the mentalis fat pad

These compartments do not deflate uniformly. Selective deflation and inferior displacement, rather than global atrophy, is the pattern most commonly observed.

SECTION 03

The Pathophysiology of Peri-Oral Ageing

Peri-oral ageing is better understood as **simultaneous change occurring across all five anatomical layers**, being skin, superficial fat, muscle, deep fat and bone, rather than as a skin problem.

3.1 SKIN AND DERMIS

Intrinsic, or chronological, ageing

- Dermal collagen content declines by an estimated 1% per year from approximately the third decade onward, with accelerated loss in the perimenopausal and early postmenopausal period.
- The ratio of type III to type I collagen shifts, and the remaining collagen becomes increasingly cross-linked, disorganised and mechanically stiff.
- **Elastin fibres fragment and degrade**, and functional elastogenesis in adult skin is minimal, meaning elastin loss is largely irreversible.
- **Glycosaminoglycans, the water-binding molecules of the dermis, decline substantially**, reducing the dermis's water-binding capacity and producing the characteristic dehydrated, crepey appearance.
- The **dermal to epidermal junction flattens** as rete ridges efface, reducing the surface area for nutrient exchange and weakening the mechanical bond between epidermis and dermis. This flattening is a major contributor to the fine, crinkled surface texture of the ageing upper lip.
- **Fibroblast number and secretory activity decline**, and remaining fibroblasts become senescent, adopting a pro-inflammatory secretory phenotype that further degrades the matrix.
- Epidermal turnover slows and the stratum corneum barrier becomes less efficient, increasing transepidermal water loss.

Extrinsic, or photo-, ageing

- **UVA radiation** penetrates to the reticular dermis and generates reactive oxygen species, upregulating **matrix metalloproteinases (MMP-1, MMP-3, MMP-9)** which enzymatically degrade collagen and elastin.
- UV simultaneously **downregulates procollagen synthesis** via suppression of TGF-beta signalling, a dual insult of accelerated breakdown and reduced production.
- Chronic exposure produces **solar elastosis**, the accumulation of amorphous, dysfunctional elastotic material in the dermis, histologically characteristic of photoaged skin.

- The cutaneous upper lip is horizontally oriented and highly sun-exposed, receiving a UV dose comparable to the nose and forehead, while being far less frequently protected. Sunscreen application typically stops at the lip margin.

3.2 MUSCLE

- The orbicularis oris is in near-continuous use. Over decades, cumulative contraction produces **repetitive dermal folding** along fixed lines.
- Once dermal collagen and elastin can no longer restore the skin to its resting configuration, a **dynamic line becomes a static, etched rhytid**.
- Peri-oral muscles also demonstrate **age-related hypertonicity and shortening**. DAO hyperactivity in particular becomes more pronounced, actively pulling the commissures inferiorly.
- Partial **inversion of the vermilion** occurs as the orbicularis contracts and shortens, reducing visible red lip show independently of true volume loss.

3.3 FAT

- Deflation of the superficial and deep labial fat compartments reduces lip projection and eversion.
- Deflation of the deep medial cheek fat and descent of the superficial nasolabial fat deepen the nasolabial fold and add weight above the commissure.
- Inferior migration of the buccal fat and jowl formation places downward load on the modiolus and labiomandibular region, producing or worsening **marionette lines**.
- The retaining ligaments, particularly the **mandibular ligament**, remain fixed while surrounding tissue descends, creating the tethering point that defines the pre-jowl sulcus and the medial extent of the jowl.

3.4 BONE

- Bone loss is not passive shrinkage. It is **regionally selective resorption**.
- Resorption at the **pyriform aperture, maxilla and anterior alveolus** withdraws the foundation beneath the upper lip, allowing it to lengthen, flatten and roll inward.
- Mandibular changes reduce chin projection and alter the labiomental relationship.
- Because skin surface area does not reduce in proportion to skeletal volume loss, the result is **relative soft tissue excess over a contracted frame**, one of the principal drivers of folding, redundancy and rhytid formation.

3.5 THE FINAL COMMON PATHWAY

Increased mechanical loading from muscle activity, applied to a **structurally weakened dermis** through collagen, elastin and glycosaminoglycan loss, over a **contracting foundation** of bone and fat volume loss, with **impaired repair capacity** from fibroblast senescence and MMP upregulation, produces the characteristic clinical picture of peri-oral ageing.

This is why single-modality treatment so often disappoints. Relaxing a muscle does not restore a dermis, and hydrating a dermis does not restore a skeleton.

SECTION 04

Contributing and Accelerating Factors

FACTOR	MECHANISM
Chronological age	Progressive collagen, elastin, glycosaminoglycan, fat and bone loss
UV exposure	MMP upregulation, collagen degradation, solar elastosis, reduced procollagen synthesis
Smoking	Nicotine-induced dermal vasoconstriction and hypoxia, direct MMP-1 upregulation, oxidative stress, reduced tissue vitamin C and impaired collagen cross-linking, plus the mechanical contribution of repetitive lip pursing
Vaping	Repetitive pursing action and dehydration. Longer-term dermal effects are not yet fully characterised.
Oestrogen decline	Skin collagen content falls by approximately 30% in the first five years post-menopause, with continued loss thereafter. Dermal thickness, dermal water-binding molecule content and sebum production all decrease.
Repetitive mechanical habits	Straw use, whistling, wind instruments, singing, habitual lip pursing or compression, sleeping face-down
Dental status	Tooth loss, attrition and collapsed vertical dimension remove upper and lower lip support
Weight fluctuation	Repeated deflation and re-expansion of fat compartments within a fixed skin envelope
Genetics and skin type	Fitzpatrick I and II skin photoages earlier and more severely. Ethnic variation exists in dermal thickness and bone remodelling patterns.
Nutritional status	Protein, vitamin C, zinc and essential fatty acid deficiency impair collagen synthesis
Systemic factors	Chronic sleep restriction, high glycaemic diet producing advanced glycation end-products, chronic inflammatory disease, chronic corticosteroid use
Prior surgery or trauma	Cleft repair, previous excisions or scarring alter muscle vectors and tissue compliance

SECTION 05

The Clinical Signs of Peri-Oral Ageing

Clinically, patients present with some combination of the following.

Skin and surface changes

- Vertical rhytides of the cutaneous upper lip, and less commonly the lower lip, which may be dynamic, static, or both
- Crepey, finely wrinkled skin texture at rest
- Loss of the light-reflecting definition of the vermilion border, causing **lipstick migration or bleeding** into fine lines
- Dyspigmentation, actinic damage and telangiectasia
- Actinic cheilitis of the lower lip in significantly sun-damaged patients, which requires assessment to exclude dysplasia

Structural and volumetric changes

- Reduced vermilion show, particularly of the upper lip
- Loss of Cupid's bow definition and flattening of the philtral columns
- **Lengthening of the cutaneous upper lip** with reduced or absent maxillary incisor show at rest and on smiling
- Inversion or inward rolling of the vermilion
- Flattening of the lip's anterior projection in profile

Positional and expressive changes

- Downturned oral commissures, giving a resting expression that reads as sad, tired or disapproving
- Deepening of the labiomandibular, or marionette, folds
- Pre-jowl sulcus formation and loss of a clean jawline
- Deepening of the nasolabial folds
- Peau d'orange chin dimpling from mentalis hyperactivity
- Deepening or, alternatively, effacement of the labiomental crease

Functional changes in advanced cases

- Oral commissure moisture pooling, leading to angular cheilitis
- Difficulty with lipstick retention or with denture fit

SECTION 06

Assessment and Classification

A structured assessment is the principal determinant of treatment outcome. The purpose is to establish **which layer or layers are driving the presenting concern**.

6.1 HISTORY

- Presenting concern in the patient's own words, and what specifically bothers them
- Duration and rate of progression
- Smoking, vaping, sun exposure and photoprotection habits
- Dental history, including recent extractions, dentures, orthodontics or planned dental work
- Menopausal status and hormone therapy
- Occupation and hobbies with peri-oral relevance, such as wind instruments, professional singing, voice work, scuba diving and swimming
- Full medical history, medications (particularly anticoagulants, antiplatelets, immunosuppressants and aminoglycosides), and allergies
- History of cold sores (herpes labialis)
- Previous aesthetic treatment in the area, including type, timing and outcome
- Psychological screening, including a low threshold for identifying body dysmorphic disorder

6.2 EXAMINATION

Assessment is performed at rest, in animation and in profile, under consistent lighting.

At rest

- Number, depth and distribution of static rhytides
- Skin quality: hydration, texture, elasticity on snap test, thickness, pigmentation, actinic damage
- Vermilion height and upper to lower lip ratio. A commonly cited aesthetic reference is approximately 1 to 1.6.
- Cutaneous upper lip length, measured subnasale to upper vermillion border. Commonly quoted normative ranges are approximately 15 to 18 mm in women and 18 to 22 mm in men, with increases indicating lip lengthening.
- Maxillary incisor show at rest, typically 2 to 4 mm in younger patients and reducing with age
- Oral commissure position relative to the intercommissural line
- Symmetry, including pre-existing asymmetry, documented before treatment
- Philtral column definition and Cupid's bow projection

In animation

- Rhytid depth on maximal pursing, differentiating dynamic from static components
- DAO activity on forced commissure depression
- Mentalis activity and chin dimpling
- Smile pattern and gingival show
- Lip competence and speech clarity

In profile

- Lip projection relative to standard reference lines
- Chin projection and labiomental angle
- Nasolabial angle

6.3 CLASSIFICATION TOOLS

Standardised scales support consistent documentation and outcome measurement:

- **Perioral Lines at Rest and at Maximum Contraction scales**, which are validated photonumeric gradings of peri-oral rhytid severity
- **Lemperle Wrinkle Assessment Scale**, from 0 (none) to 5 (very deep), applicable to the upper lip
- **Fitzpatrick Wrinkle and Elastosis Scale**, which grades both wrinkling and the degree of elastosis
- **Glogau Photoageing Classification**, types I to IV, guiding the choice of resurfacing intensity
- **Fitzpatrick Skin Phototype I to VI**, critical for predicting post-inflammatory hyperpigmentation risk with any resurfacing or energy-based modality
- **Validated lip fullness and oral commissure scales**

6.4 STANDARDISED PHOTOGRAPHY

Baseline photography is mandatory. Standard views comprise frontal at rest, frontal in maximal pursing, frontal smiling, and bilateral obliques and profiles, with fixed lighting, distance, background and head position. Without standardised imaging, both patient and clinician consistently misjudge the degree of change achieved.

6.5 THE DIAGNOSTIC QUESTION

At the end of assessment, one question should be answerable:

*Are these lines predominantly **dynamic** and movement-driven, **static** and skin-quality driven, **structural** and support-driven, or, most commonly, a **combination**, and in what proportion?*

The answer dictates the treatment plan. Treating a static, elastotic rhytid with muscle relaxation alone will fail. Treating a purely dynamic line with a skin booster alone will underdeliver.

SECTION 07

Treatment Option 1: Muscle-Relaxing Treatment

7.1 RATIONALE

Where vertical lip lines are driven predominantly by repetitive orbicularis oris contraction, reducing the strength of that contraction reduces the mechanical folding of the overlying skin. Over time, this also permits a degree of passive dermal recovery, as the skin is no longer being repeatedly creased along the same lines.

7.2 MECHANISM OF ACTION

The treatment works at the **neuromuscular junction**. Following administration, the product is taken up by presynaptic cholinergic nerve terminals, where it interferes with the protein complex responsible for fusing acetylcholine-containing vesicles with the nerve terminal membrane. Without this fusion, acetylcholine cannot be released into the synaptic cleft, and the muscle fibre does not receive its contraction signal.

The effect is **temporary and reversible**. The blockade is not permanent because the nerve terminal responds by sprouting new axonal branches and, over subsequent weeks to months, the original terminal recovers function. Clinically, this manifests as a gradual return of movement.

Importantly, the effect is **local and dose-dependent**. The intent in the peri-oral region is *partial* weakening, never full paralysis, because full paralysis of the oral sphincter would be functionally unacceptable.

7.3 TREATMENT APPROACH

- Product is placed **superficially and in small quantities** along the cutaneous upper lip, close to the vermillion border, at a small number of symmetrically distributed points.
- Doses used in this region are **substantially lower than those used in the upper face**, typically by an order of magnitude, because the therapeutic window is narrow.
- Placement is deliberately kept **away from the oral commissures and the modiolus** to avoid affecting the muscles of the commissure complex.
- Placement depth is kept **intradermal or immediately subdermal** rather than deep intramuscular, to limit diffusion into the pars marginalis.
- Symmetry of dosing is essential. The mouth is the most scrutinised region of the face, and asymmetry here is immediately apparent.
- Where DAO hyperactivity is contributing to commissure downturn, separate treatment of the DAO may be considered. This is a distinct treatment with distinct anatomical considerations and is planned independently.

Treatment takes a few minutes. Discomfort is mild and brief. No anaesthetic is routinely required, although topical anaesthetic can be used for needle-sensitive patients.

7.4 SUITED TO

- **Dynamic** vertical lip lines, meaning lines that appear or deepen markedly on pursing, whistling or drinking through a straw
- Patients seeking subtle, reversible, low-commitment improvement
- Patients in their thirties and forties using treatment **preventatively**, before lines become etched
- Patients not yet ready for volume-based or resurfacing treatment
- Use as a **component of a combination plan**, reducing ongoing mechanical stress while other modalities improve skin quality

7.5 RESULTS TIMELINE

TIME POINT	EXPECTED FINDING
Day 0	No visible change
Day 3 to 5	Onset of softening becomes noticeable
Day 10 to 14	Peak effect, and the formal review point
Week 4	Stable clinical result
Approximately 4 to 8 weeks	Movement begins to return in most patients
Approximately 8 to 12 weeks	Full return of movement in some patients

Duration in the peri-oral region is **consistently shorter than in the upper face**, where three to four months is typical. This is expected and is not a treatment failure. The reasons are the low doses used, the very high baseline activity of the muscle, and its large motor unit turnover.

Review at two weeks after a first treatment is recommended so that dose and placement can be refined for subsequent sessions.

7.6 DOWNTIME AND RECOVERY

Minimal. Small marks at each treatment point and occasional pinpoint bruising may be present for a short period and are readily concealed with makeup after 24 hours.

7.7 POSSIBLE SIDE EFFECTS

Common and self-limiting

- Small transient papules at each treatment point
- Pinpoint bruising
- Mild swelling
- Brief tenderness

- Headache

Functional, dose-related and temporary

- **Difficulty whistling**, the most commonly reported functional effect
- **Difficulty drinking through a straw** or from a narrow-rimmed vessel
- **Altered articulation of plosive consonants** (p, b, m) and labiodental sounds (f, v), usually subtle, but significant for professional voice users
- **Difficulty with wind instruments**, often a contraindication for professional players
- Sensation of lip flatness, stiffness or reduced dexterity
- Mild lip inversion or reduced vermilion show
- Minor drooling or difficulty retaining liquid, in over-treatment

Uncommon

- Asymmetry of the smile
- Oral incompetence, typically resulting from excessive dose or inappropriately deep or lateral placement
- Localised infection at a treatment point

Rare

- Hypersensitivity reaction
- Distant spread of effect with systemic symptoms. This is extremely rare at aesthetic doses, but patients should be advised to report any difficulty swallowing, difficulty breathing, or generalised weakness immediately.

7.8 THE CRITICAL LIMITATION

This treatment reduces movement. It does not improve skin quality.

If the dermis is thin, dehydrated, elastotic and etched, softening muscle contraction will improve lines *in animation* while leaving them substantially unchanged *at rest*. Patients presenting primarily with static, resting lines who are treated with muscle relaxation alone are a frequent source of disappointment in this region.

This is not a shortcoming of the treatment. It is a mismatch between the treatment and the underlying pathology. It is also the clearest argument for combination therapy.

SECTION 08

Treatment Option 2: Skin Boosters and Bio-Remodelling

Skin boosters remain one of the most under-utilised and under-appreciated treatments for peri-oral ageing. Where muscle-relaxing treatment addresses *movement*, skin boosters address *the substrate*, meaning the quality, hydration, thickness and elasticity of the dermis itself.

8.1 RATIONALE

The core deficits in peri-oral skin ageing are reduced dermal water content, reduced collagen and elastin, and a thinned, disorganised extracellular matrix. Skin boosters are designed to intervene directly at this level, rather than to soften a single line or restore a volumetric contour.

8.2 MECHANISM OF ACTION

Product is placed **into the dermis**, not deep into the subcutaneous plane and not into muscle, where it acts through two complementary pathways.

1. Immediate hydration, a physical mechanism

The product is strongly **hygroscopic**, binding many times its own weight in water. This restores dermal water content, improving turgor, light reflection and surface smoothness. This effect is apparent early, often within one to two weeks, and accounts for the initial glow patients report.

2. Fibroblast stimulation, a biological mechanism

This is the more clinically significant and more durable effect. Restoring dermal hydration and volume mechanically **stretches the resident fibroblasts**. Fibroblasts are mechanosensitive cells, and physical stretch triggers **mechanotransduction** signalling that reactivates their synthetic programme.

Documented downstream effects include:

- Increased synthesis of **type I and type III collagen**
- Increased **elastin** production
- Increased production of the skin's own water-binding molecules
- **Downregulation of matrix metalloproteinases**, reducing ongoing matrix degradation
- Improved dermal thickness and echogenicity on ultrasound assessment
- Reduced markers of fibroblast senescence

In effect, the treatment does not simply add hydration. It **restarts the skin's own repair machinery**. This is why the clinical improvement continues to build for weeks after the product itself has been metabolised, and why results substantially outlast the residence time of the product.

8.3 TREATMENT APPROACH

- The area is cleansed and topical anaesthetic applied for approximately 20 to 30 minutes.
- Product is delivered into the dermis via a series of small, precisely placed deposits, commonly using a papular or micro-bolus technique, sometimes with linear threading or fanning depending on the area and product characteristics.
- Placement is planned across the cutaneous upper lip, the peri-oral field, and where indicated is extended to the chin, jawline and lower cheeks. Peri-oral skin does not exist in isolation, and treating an isolated square of skin creates a visible demarcation.
- A fine needle or a cannula may be used depending on the technique and region.
- Treatment typically takes 20 to 30 minutes including anaesthetic time.

8.4 PROTOCOL

- **1 to 2 sessions**, spaced approximately **4 weeks apart**
- Some protocols use a third session in significantly photodamaged or very thin skin
- **Results last approximately 9 to 12 months**
- Maintenance sessions are usually recommended at 6 to 12 month intervals depending on individual response, skin quality and lifestyle factors

8.5 SUITED TO

- **Static** vertical lip lines, visible at rest and not only on animation
- Thin, crepey, dehydrated peri-oral skin
- Patients with fine surface etching rather than deep folds
- Smokers and former smokers with established dermal damage
- Peri- and post-menopausal patients with generalised dermal thinning
- Patients seeking skin rejuvenation without volumetric change to the lips
- Patients who explicitly do not want larger or altered-looking lips
- Combination with muscle-relaxing treatment for mixed dynamic and static lines

8.6 RESULTS TIMELINE

TIME POINT	EXPECTED FINDING
24 to 48 hours	Small papules at each placement point settle
Week 1 to 2	Visible improvement in hydration, light reflection and surface smoothness
Week 4	Second session, with early collagen-mediated change becoming apparent
Week 6 to 8	Improvement in dermal thickness, texture and fine etching
Week 8 to 12	Peak result
9 to 12 months	Gradual decline, and maintenance considered

8.7 COMFORT

Discomfort is **mild to moderate**, with a characteristic brief stinging sensation on placement. Topical anaesthetic cream is used routinely and makes the treatment well tolerated by the great majority of patients. The peri-oral region is more sensitive than the cheeks or neck, and patients should expect this area to be the least comfortable part of a wider treatment.

8.8 WHAT TO EXPECT AFTERWARDS

- **Small raised bumps** at each deposit point. These are expected, are the product itself, and typically resolve within 24 to 48 hours. Patients should be warned about these explicitly at consultation, as unwarned patients frequently interpret them as a complication.
- Mild swelling, particularly of the upper lip, for 24 to 72 hours
- Redness for several hours
- Bruising in a proportion of patients, lasting up to 7 to 10 days
- Tenderness on palpation for 1 to 2 days

8.9 POSSIBLE SIDE EFFECTS

Common and expected

- Swelling
- Bruising
- Tenderness
- Small papules at each placement point
- Transient erythema

Uncommon

- Prolonged swelling
- Palpable or visible product if placed too superficially
- Reactivation of herpes labialis in susceptible patients
- Localised infection

Rare

- **Vascular compromise**, meaning inadvertent intravascular placement or extravascular compression causing tissue ischaemia. This is the most serious risk in this region, and is why practitioner training, anatomical knowledge and immediate access to a reversal agent are non-negotiable. Warning signs include disproportionate immediate pain, immediate blanching, dusky or mottled discolouration, and delayed capillary refill.
- **Delayed inflammatory reactions**, meaning nodules or induration presenting weeks to months after treatment, sometimes triggered by intercurrent infection, dental procedures or vaccination
- Biofilm formation
- Granuloma formation
- Hypersensitivity reaction

8.10 THE LIMITATION

Skin boosters improve skin **quality**. They do not lift, they do not restore skeletal or fat volume, and they will not eliminate a deep, long-standing, fully etched rhytid on their own. In severely photodamaged skin with grade 4 to 5 rhytides, resurfacing or a combination approach will be required for meaningful change.

SECTION 09

Treatment Option 3: Structural and Volume Support

This section addresses the layer most often overlooked in peri-oral treatment planning.

Where assessment identifies **volume and support loss** as a primary driver, rather than movement or skin quality, restoring structure produces changes that neither of the previous two options can achieve.

9.1 WHAT STRUCTURAL TREATMENT ADDRESSES

- **Loss of vermilion show and lip eversion**, by restoring red lip height and outward roll rather than adding projection
- **Loss of vermilion border definition**, by restoring the light-reflecting white roll. This directly addresses lipstick migration.
- **Flattened philtral columns and Cupid's bow**, by restoring the central architecture of the upper lip
- **Downturned oral commissures**, by supporting the commissure and modiolus complex
- **Labiomandibular, or marionette, folds**, by supporting the tethered tissue rather than treating the crease itself
- **Pre-jowl sulcus and chin projection**, by restoring the mandibular framework
- **Pyramidal and maxillary support**, addressing the foundation of the upper lip rather than the lip itself
- **Deep medial cheek deflation**, treating the *cause* of nasolabial deepening rather than the fold

9.2 PRINCIPLE

A common error in peri-oral treatment is treating the **visible line** rather than the **anatomical deficit that created it**. A marionette line is a shadow cast by descended tissue over a tethered ligament. A deep nasolabial fold is frequently a mid-face volume problem. Restoring support in the correct anatomical plane, often at a distance from the visible line, is both safer and less conspicuous than treating the line directly.

9.3 COLLAGEN-STIMULATING OPTIONS

Beyond immediate structural support, **biostimulatory products** may be used to induce neocollagenesis over a period of months, gradually improving dermal and subdermal thickness and support. These act more slowly than hydrating skin boosters, with results developing over 8 to 12 weeks and typically lasting longer. They are generally placed subdermally rather than intradermally, and are not usually used within the vermilion itself.

9.4 CAUTIONS

The peri-oral region, and the lips in particular, is the **highest-risk region on the face for vascular complications** after the glabella and nose. Structural treatment here demands detailed anatomical knowledge, appropriate product selection, conservative volumes, aspiration or cannula technique where appropriate, and immediate access to a reversal agent.

Over-treatment in this region is also unusually conspicuous. Conservative, staged treatment across multiple sessions is strongly preferred over single-session volume.

SECTION 10

Treatment Option 4: Resurfacing and Energy-Based Devices

Indicated where rhytides are deeply etched and dermal remodelling beyond what product-based treatment can achieve is required.

For **grade 4 to 5 static rhytides** and advanced photoageing, resurfacing achieves a degree of dermal remodelling that other non-surgical options do not. Product-based treatments soften. Resurfacing remodels.

10.1 ABLATIVE FRACTIONAL LASER (CO₂, ER:YAG)

Creates columns of controlled thermal injury through the epidermis and into the dermis, triggering wound healing, collagen remodelling and dermal contraction, while sparing intervening tissue to permit rapid re-epithelialisation.

- The device modality with the largest published evidence base for etched peri-oral rhytides
- Downtime typically 5 to 10 days, with erythema persisting for weeks
- Requires strict photoprotection and careful patient selection
- Higher post-inflammatory hyperpigmentation risk in Fitzpatrick III to VI
- Peri-oral skin heals well due to high adnexal density, but antiviral prophylaxis is required

10.2 FULLY ABLATIVE RESURFACING AND DEEP CHEMICAL PEEL

Full-field ablative laser resurfacing and **phenol with croton oil peel** remain the deepest-acting available treatments for severe peri-oral rhytides, capable of results approaching surgical outcomes for this specific indication. They carry correspondingly greater downtime, prolonged erythema, permanent hypopigmentation risk, and, for phenol, systemic cardiac monitoring requirements. These are specialist procedures with strict patient selection criteria.

10.3 NON-ABLATIVE FRACTIONAL LASER

Lower downtime, more sessions required, and more modest results. Suitable for mild to moderate rhytides and for patients who cannot accommodate ablative downtime.

10.4 RADIOFREQUENCY MICRONEEDLING

Delivers thermal energy into the dermis via insulated or non-insulated needles, stimulating collagen with relative epidermal sparing. Lower pigmentary risk in darker skin types than ablative laser. Effective for texture, fine rhytides and mild laxity. Typically a course of three sessions.

10.5 MEDICAL MICRONEEDLING

Mechanical induction of collagen without thermal injury. Modest but genuine improvement in fine peri-oral lines and texture, with minimal downtime, and well tolerated in all skin types. Often used in combination with skin boosters.

10.6 MEDIUM-DEPTH CHEMICAL PEELS

TCA-based peels at appropriate concentrations can improve fine peri-oral rhytides, texture and dyspigmentation, and can be applied as a focal peri-oral treatment or as part of a full-face peel.

10.7 SEQUENCING CAUTION

Resurfacing and product-based treatments should be appropriately spaced. Energy-based and ablative treatments are generally scheduled with an adequate interval before or after product-based treatment in the same area. Antiviral prophylaxis is required for any peri-oral resurfacing in patients with a herpes labialis history, as reactivation in a resurfaced field is a significant complication.

SECTION 11

Treatment Option 5: Medical Skincare and Modifiable Risk Factors

No in-clinic treatment will outperform, or compensate for, an unmanaged skincare and lifestyle foundation. This component is inexpensive, evidence-supported, and consistently under-implemented by patients.

11.1 TOPICAL AGENTS WITH EVIDENCE

Retinoids (tretinoin, retinaldehyde, retinol) The topical agent with the largest published evidence base in photoageing. Retinoids increase epidermal turnover, stimulate procollagen synthesis, inhibit MMP activity, thicken the viable epidermis and improve dyspigmentation. Peri-oral skin is retinoid-sensitive, so introduce gradually with buffering and expect an adjustment period. Continuous use over 6 to 12 months is required for dermal-level change.

Sunscreen, SPF 50+, broad spectrum The foundational intervention in any peri-oral plan. It must be applied to and over the lip area, which is routinely missed. A separate SPF lip product should be used and reapplied. Photoprotection prevents further MMP-driven collagen degradation and protects the investment made in every other treatment.

Vitamin C (L-ascorbic acid) Antioxidant activity against UV-generated reactive oxygen species, and an essential cofactor for prolyl and lysyl hydroxylase in collagen cross-linking.

Niacinamide Improves barrier function, reduces transepidermal water loss, improves dyspigmentation, and has anti-inflammatory effects.

Peptides and growth factors Adjunctive signalling support for matrix synthesis. Evidence is less robust than for retinoids, but the tolerability profile is favourable.

Alpha hydroxy acids Improve surface texture and epidermal turnover, and with sustained use, dermal glycosaminoglycan content.

Emollients and barrier repair Peri-oral skin loses water rapidly. Consistent barrier support improves the appearance of fine lines independently of any structural change.

11.2 MODIFIABLE LIFESTYLE FACTORS

- **Smoking cessation**, which removes an ongoing driver of dermal damage. Dermal perfusion improves relatively quickly, though established elastotic damage does not reverse.
- **Reducing vaping** and the associated repetitive pursing
- **Eliminating straw use** where habitual
- **Photoprotection behaviour**, meaning hats, shade and reapplication, not sunscreen alone

- **Nutrition**, with adequate protein, vitamin C and zinc, and reduction of high-glycaemic intake to limit advanced glycation end-product formation
- **Hydration and sleep**
- **Dental review**. Restoration of vertical dimension and adequate dental support can produce more peri-oral improvement than any in-clinic treatment in the appropriate patient.
- **Menopause management**, which is a conversation to have with the patient's GP or specialist. Systemic hormonal status materially affects dermal collagen.

SECTION 12

Building a Combination Treatment Plan

Peri-oral ageing occurs across five anatomical layers. A treatment plan addressing one layer will produce a one-layer result.

12.1 A FRAMEWORK

PREDOMINANT FINDING	PRIMARY APPROACH	ADJUNCTS
Dynamic lines only, minimal static change	Muscle-relaxing treatment	Retinoid, SPF
Static fine lines, crepey texture, good volume	Skin boosters	Microneedling, retinoid, SPF
Mixed dynamic and static lines	Muscle-relaxing treatment and skin boosters	Retinoid, SPF
Loss of vermillion show and border definition	Structural support	Skin boosters, muscle-relaxing treatment
Downturned commissures, marionette folds	Structural support, with or without DAO treatment	Mid-face support
Deep etched rhytides, advanced photoageing	Resurfacing	Skin boosters, structural support
Global lower face descent	Structural support with mid-face and jawline planning	Skin quality treatments

12.2 TYPICAL SEQUENCING

A staged approach is generally preferred.

1. **Foundation first.** Establish skincare, photoprotection, and address modifiable factors.
2. **Structure next.** Restore support at the skeletal and volumetric level where indicated, working from deep to superficial and from lateral to medial.
3. **Skin quality.** Skin boosters, with a second session at four weeks.
4. **Movement.** Muscle-relaxing treatment, which can generally be delivered within the same treatment course.
5. **Resurfacing.** Where etched lines persist after the above, appropriately spaced from product-based treatment.
6. **Maintenance.** Reassess at intervals, with photographic comparison.

The order is flexible and is determined by the individual assessment, but the principle is consistent.

Treat the deepest causative layer first, then refine superficially.

12.3 WHY COMBINATION WORKS

Muscle-relaxing treatment removes the ongoing mechanical insult. Skin boosters rebuild the substrate that was damaged by that insult. Structural treatment restores the foundation that both sit upon. Resurfacing remodels damage too established for biology to reverse unaided. Skincare protects all of it.

Each modality makes the others work better and last longer.

SECTION 13

Patient Selection, Contraindications and Cautions

13.1 YOU MAY BE A GOOD CANDIDATE IF

- You have visible vertical lip lines, at rest or on movement
- Lipstick migrates or bleeds into fine lines
- You notice crepey or dehydrated skin around the mouth
- Your mouth corners turn downward at rest and you are told you look tired or unhappy
- You have lost definition at the lip border
- You are a current or former smoker with established peri-oral change
- You are approaching or past menopause and have noticed accelerated change
- You are in your thirties or forties and wish to intervene preventatively
- You are in good general health, not pregnant, not breastfeeding, and have realistic expectations

13.2 ABSOLUTE CONTRAINDICATIONS

- Pregnancy and breastfeeding
- Active infection, inflammation or skin breach at or near the treatment site
- Known hypersensitivity to the product or its components
- Active herpes labialis outbreak, in which case treatment is deferred until fully resolved

Additionally, for muscle-relaxing treatment:

- Neuromuscular junction disorders, including **myasthenia gravis, Lambert-Eaton syndrome and motor neurone disease**
- Known hypersensitivity to the preparation

13.3 RELATIVE CONTRAINDICATIONS AND CAUTIONS

- Autoimmune or systemic inflammatory disease, or current immunosuppression
- Anticoagulant or antiplatelet therapy, given bruising risk. Do not cease without approval from the prescribing doctor.
- Aminoglycoside antibiotics and other agents affecting neuromuscular transmission
- Bleeding disorders
- Poorly controlled diabetes or impaired wound healing
- History of hypertrophic or keloid scarring
- Recent or planned dental work. Defer treatment around dental procedures to reduce infection and inflammatory nodule risk.
- Recent vaccination

- History of delayed inflammatory reaction to previous products
- Professional wind instrument players, singers and voice professionals, for whom muscle-relaxing treatment in this region may be inadvisable
- Unrealistic expectations, or fixation on a minimal or non-existent deformity
- **Suspected body dysmorphic disorder**, in which case treatment is contraindicated and referral is appropriate
- Patients under significant acute psychosocial stress, or making treatment decisions during crisis
- Patients under 18

13.4 ANATOMICAL AND STRUCTURAL LIMITATIONS

Some findings are not fully correctable by non-surgical means, and this must be stated at consultation.

- Severe cutaneous upper lip lengthening may require surgical lip lift
- Advanced skin laxity with true tissue excess may require surgical management
- Severe dental collapse requires dental restoration first
- Deep, fully etched grade 5 rhytides will require resurfacing for meaningful change
- Significant established solar elastosis is not reversible by product-based treatment

SECTION 14

Pre-Treatment Preparation

- Avoid alcohol for 24 hours before treatment
- Where medically safe and with prescriber approval, avoid non-essential blood-thinning supplements such as fish oil, high-dose vitamin E, ginkgo and garlic supplements for 5 to 7 days. **Never cease prescribed anticoagulants or antiplatelets without medical advice.**
- Avoid non-essential NSAIDs for 3 to 5 days where clinically appropriate
- Reschedule if you have an active cold sore, an active infection, or are unwell
- Advise the clinic of any history of cold sores, as antiviral prophylaxis may be prescribed
- Avoid treatment within two weeks either side of dental work, including cleaning
- Attend without makeup where possible
- Do not schedule treatment within two weeks of a significant event
- Arrive well hydrated and having eaten

SECTION 15

Aftercare

FIRST 24 HOURS

- Do not massage, rub or apply pressure to the treated area unless specifically instructed
- Avoid makeup over treatment points
- Avoid strenuous exercise
- Avoid alcohol
- Avoid saunas, steam rooms, hot yoga and very hot showers
- Remain upright for four hours after muscle-relaxing treatment, and avoid lying face down
- Avoid facials and other dermal therapies

FIRST 48 TO 72 HOURS

- Expect small papules after skin booster treatment. These resolve without intervention.
- Expect swelling of the upper lip. A cool compress applied gently may help.
- Avoid straws and excessive lip pursing after muscle-relaxing treatment
- Sleep on your back where possible

FIRST TWO WEEKS

- Apply SPF 50+ daily to the peri-oral area and lips
- Resume retinoids after 48 hours, or as directed
- Avoid dental procedures where possible
- Attend the two-week review

CONTACT THE CLINIC PROMPTLY IF YOU EXPERIENCE

- Severe or increasing pain that is disproportionate to the treatment
- Skin blanching, white patches, or mottled purple discolouration
- Progressive dusky discolouration
- Increasing redness, heat, swelling or discharge after 48 hours
- Fever
- Blistering or skin breakdown
- Vision change of any kind
- Difficulty swallowing, difficulty breathing, or generalised muscle weakness

Vision change, severe pain with blanching, or difficulty swallowing or breathing are emergencies. Seek immediate medical attention.

SECTION 16

Complications and Safety

16.1 VASCULAR OCCLUSION

The most serious complication of product-based treatment in this region. It occurs when product is placed within a vessel or compresses one externally, interrupting perfusion to the tissue that vessel supplies.

Recognition

- Immediate, disproportionate pain, although occlusion can be painless
- Immediate blanching along a vascular distribution
- Delayed capillary refill
- Progressive dusky, mottled or reticulated discolouration
- Later, blistering, pustulation and, if untreated, tissue necrosis

Why it matters here. The labial arteries are large, superficial in variable degrees, and anastomose extensively with the ophthalmic circulation. Retrograde embolisation to the retinal artery, though extremely rare, is the mechanism of treatment-related blindness.

Management is a time-critical emergency requiring immediate cessation, high-dose flooding of the affected territory with the appropriate reversal agent where the product used is reversible, repeated dosing until perfusion returns, warm compresses, massage, and escalation as required. Any clinic offering these treatments must hold a reversal agent on site and have a documented emergency protocol.

16.2 DELAYED INFLAMMATORY REACTIONS

Nodules or diffuse induration presenting weeks to months after treatment, often triggered by intercurrent illness, dental work or vaccination. Managed with anti-inflammatory therapy, antibiotics where infection or biofilm is suspected, and a reversal agent where indicated.

16.3 INFECTION AND BIOFILM

Uncommon with appropriate aseptic technique. Biofilm-related presentations may be indolent and resistant to standard treatment.

16.4 FUNCTIONAL IMPAIRMENT

Predominantly associated with muscle-relaxing treatment, dose-related and self-limiting. Prevention is through conservative dosing, symmetric placement, superficial depth, and avoidance of the commissure and modiolus.

16.5 THE ROLE OF THE PRACTITIONER

The overwhelming majority of serious complications in this region are **technique- and knowledge-dependent, not product-dependent**. Appropriate qualification, detailed anatomical training, adequate treatment volume experience, on-site emergency equipment and reversal agents, and a formal complication protocol are the determinants of safety.

Patients should ask: who is treating me, what is their qualification, how often do they treat this area, and what happens if something goes wrong?

SECTION 17

Realistic Expectations

Honest expectation-setting is a clinical intervention in its own right, and is closely linked to patient satisfaction.

What non-surgical treatment can reliably achieve

- Meaningful softening of dynamic lines
- Improved skin hydration, texture, elasticity and light reflection
- Restoration of lip border definition and reduction of lipstick migration
- Improved vermilion show and lip shape
- Elevation of downturned commissures
- A rested, softer lower face without an obviously treated appearance

What it cannot achieve

- Complete elimination of deep, long-standing etched rhytides
- Reversal of established solar elastosis
- Restoration of a significantly lengthened cutaneous upper lip to youthful dimensions
- Correction of true skin excess or advanced laxity
- Compensation for absent dental support
- Permanent results. All non-surgical treatment in this region requires maintenance.

A realistic target for most patients is a 40 to 70% improvement in the appearance of peri-oral change, achieved across a combination of modalities over several months, and maintained with ongoing treatment. Patients seeking complete elimination of all lines in a single session should be redirected, and in some cases declined.

SECTION 18

Prevention and Long-Term Maintenance

Peri-oral ageing is progressive. Early, consistent, low-intensity intervention achieves more over time than late, high-intensity correction.

Core principles

1. **Daily broad-spectrum SPF 50+**, including the lips and peri-oral skin, reapplied
2. **A retinoid**, used consistently and long-term
3. **Smoking and vaping cessation**
4. **Early, low-dose muscle-relaxing treatment** where dynamic lines are emerging, before they etch
5. **Regular skin quality treatment**, meaning skin boosters at 6 to 12 month intervals rather than waiting for visible deterioration
6. **Preservation of structure**, addressing volume and support gradually and early rather than attempting large-volume correction late
7. **Dental maintenance**
8. **Photographic monitoring** at annual intervals

Prevention is substantially more effective, and less expensive, than correction. A dynamic line treated at 35 may never become a static line at 50. A static line at 50 requires resurfacing.

SECTION 19

Special Patient Populations

Smokers and former smokers Established dermal damage with elastosis, impaired healing, higher infection risk and less predictable response. Results are achievable, but require realistic framing and typically more intensive combination treatment. Cessation support should be offered.

Peri- and post-menopausal patients Accelerated collagen loss, dermal thinning and reduced sebum. This group often responds very well to skin boosters. Systemic hormonal management is a relevant conversation with their treating doctor.

Fitzpatrick IV to VI Higher risk of post-inflammatory hyperpigmentation with any resurfacing or energy-based treatment. Requires conservative device settings, pre-treatment with pigment-modulating topicals, strict photoprotection, and often a preference for product-based and non-ablative approaches.

Patients with dentures or significant dental change Peri-oral treatment should follow dental optimisation, not precede it. Treating soft tissue over an unstable dental foundation produces unstable results.

Wind instrument players, professional singers and voice professionals Muscle-relaxing treatment in this region may impair professional function. Discuss thoroughly. These patients are often better served by skin boosters and resurfacing alone.

Patients with prior peri-oral surgery, cleft repair or trauma Altered muscle vectors, scarring and unpredictable tissue compliance. Requires experienced assessment and conservative, staged treatment.

Patients with a history of cold sores Antiviral prophylaxis before any peri-oral product-based or resurfacing treatment.

SECTION 20

Frequently Asked Questions

Do I have to be a smoker to get “smoker’s lines”? No. The term is a misnomer. The great majority of patients with vertical lip lines have never smoked. Smoking accelerates the process, but is not required to cause it.

Will muscle-relaxing treatment change my smile? When correctly dosed and placed, no. Doses in this region are very low, and placement deliberately avoids the muscles that control the corners of the mouth. Excessive dose or inappropriate placement can affect the smile, which is why conservative treatment by an experienced practitioner matters.

Will skin boosters make my lips bigger? No. Skin boosters are placed into the skin, not into the body of the lip, and are not intended to add volume. They improve the quality of the skin, not its size.

Which do I need, muscle treatment or skin boosters? It depends on whether your lines are present at rest, only on movement, or both. Most patients over 45 have a combination and benefit from both. This is precisely what assessment determines.

How long until I see results? Muscle-relaxing treatment: 3 to 5 days for onset, and 10 to 14 days for full effect. Skin boosters: 1 to 2 weeks for hydration, and 4 to 8 weeks for collagen-mediated improvement.

Is it painful? Muscle-relaxing treatment is mildly uncomfortable and brief. Skin boosters are mild to moderately uncomfortable with a stinging sensation, and topical anaesthetic makes this well tolerated.

Can I have treatment before an event? Allow a minimum of two weeks before any significant event for either treatment, and longer for skin boosters if you bruise easily.

Do the results look obvious? Correctly performed, no. The aim is improved skin quality and softened lines, not an altered mouth.

What happens if I stop? Your skin returns gradually to its untreated trajectory. Nothing worsens as a result of having had treatment.

Can I combine treatments in one appointment? Frequently yes, though sequencing depends on the modalities involved. Your clinician will advise.

How much does maintenance involve? Typically muscle-relaxing treatment every 2 to 3 months where used, and skin boosters every 6 to 12 months, alongside daily skincare.

SECTION 21

Glossary

TERM	MEANING
Dynamic rhytid	A line visible only, or predominantly, on muscle movement
Static rhytid	A line visible at rest, indicating established dermal change
Vermilion	The red portion of the lip
Vermilion border, or white roll	The pale ridge at the junction of red lip and skin
Philtral columns	The paired vertical ridges above the upper lip
Oral commissure	The corner of the mouth
Modiolus	The fibromuscular convergence point lateral to each mouth corner
Orbicularis oris	The circular sphincter muscle of the mouth
DAO	Depressor anguli oris, the muscle pulling the mouth corners down
Rhytid	Medical term for a wrinkle
Elastosis	Accumulation of degraded, dysfunctional elastic tissue from sun damage
MMP	Matrix metalloproteinase, an enzyme that degrades collagen and elastin
Glycosaminoglycan	The water-binding molecules of the dermis, which hold moisture in the skin
Fibroblast	The dermal cell responsible for producing collagen and elastin
Mechanotransduction	The process by which cells convert physical stretch into biological signalling
Neocollagenesis	New collagen formation
Vascular occlusion	Blockage of a blood vessel, interrupting tissue perfusion

SECTION 22

Important Information

Assessment is the treatment. The critical part of managing peri-oral ageing is not the procedure itself. It is determining whether the presenting concern is driven by movement, skin quality, volume loss, structural collapse, dental change, or a combination, and in what proportion. A treatment plan built on an incomplete assessment will underdeliver regardless of technical execution.

For this reason, we recommend a **full-face assessment** rather than a request for a specific treatment. The peri-oral region does not age in isolation, and it cannot be treated in isolation.

MAPP AESTHETICS

This article is general information only and does not constitute medical advice, a diagnosis, or a recommendation for any individual. All treatments carry risks. Individual results vary, and no outcome can be guaranteed. Suitability for any treatment can only be determined through an in-person consultation and assessment with a qualified practitioner. If you are considering treatment, book a consultation with our nursing team at Mapp Aesthetics.