

Stand in front of a mirror, clench your jaw lightly, and say “eee.” See those vertical cords along your neck rise as strands under the skin? That is your platysma telegraphing tension from the lower face into the neck. Treating those bands with botulinum toxin is deceptively simple on paper, yet the choice of pattern changes outcomes. When to lay a grid across the anterior neck and when to run vectors along the bands is a practical question with real consequences for neck contour, jawline support, and even speech comfort.

What the platysma does to your neck and jaw

The platysma is a thin, superficial sheet that runs from the mandible down over the anterior neck and upper chest. It acts as a depressor of the lower face and a flexor of the superficial neck skin. In youth, its tone sharpens the mandibular border and supports cervical skin tension. With age and repetitive expression, the muscle separates into visible bands, tugs down the corners of the mouth, and contributes to jowling by antagonizing elevating muscles like the zygomaticus and the elevators of the lip and brow.

Two clinical patterns dominate. Some patients show clear medial and lateral bands that pop with animation, especially when saying “eee,” grimacing, or clenching. Others show diffuse neck crepiness and vertical lines without prominent cords, often tied to chronic micro-movements and thin skin. This split sets the stage for two different injection philosophies.

The grid pattern, the vector pattern, and why they behave differently

The grid approach treats the platysma as a sheet. The clinician marks a uniform lattice across the anterior neck, often from just under the mandibular border down 4 to 6 centimeters, and laterally toward the sternocleidomastoid’s medial edge. Small aliquots are placed at each intersection at a consistent plane. This is most effective for diffuse dynamic lines and mild skin rippling, where the tension is distributed rather than confined to a single cord. It aims to smooth and relax without creating focal weakness that could telegraph as asymmetry.

The vector approach follows the cords themselves. The clinician palpates and identifies the band trajectories during animation, then places a linear series of injections along each band, often with higher micro-aliquots per point than the grid. The vector method targets hyperdominant slips that over-recruit during grimace or speech, which is key when discrete strands, often two medial and two lateral, create the visual problem.

In practice, I rarely use a pure version of either. Most necks benefit from a vector-led plan to address the most visible bands, with a minimal grid overlay to soften adjacent rippling. For patients with minimal banding but pervasive micro-wrinkling, a light grid alone can work, ideally paired with skin-directed therapies like biostimulators or microneedling. Choosing the wrong pattern often shows up as undercorrection of cords with a grid, or over-focal weakening with vectors that leaves the spaces between bands still mobile and creased.

Dosing strategy matters more than brand loyalty

The platysma tolerates a broad range of total dose, but the neck is unforgiving if you misjudge distribution. For most adult patients, a total range of 30 to 70 units of onabotulinumtoxinA is common, concentrated where function is excessive. Smaller frames or thin skin often sit closer to 20 to 40 units. Larger frames, hypertrophic platysma, or hyperactive expressers may require 60 to 90 units across the sheet and bands. The deciding factor is muscle strength testing: ask the patient to pull the corners of the mouth down, clench slightly, then say “eee.” Note band prominence, migration, and how fast the cord catches the skin. Strong catch, thick cord, and fast activation signal higher dose along vectors.

Patients ask about brands. Conversion between onabotulinumtoxinA and abobotulinumtoxinA is not 1:1. A common clinical ratio is roughly 1:2.5 to 1:3 in the lower face and neck, though individual response varies. When I switch to abobotulinumtoxinA for platysma in a patient who metabolizes fast, I plan for a higher unit count but maintain the same biologic effect target by careful micro-aliquoting and spacing.

Dilution needs a thought. A higher dilution spreads more but reduces per-site potency. The grid benefits from a moderate dilution to even out coverage without forcing too many needle entries. Vectors benefit from a slightly lower dilution to keep the toxin where you place it, especially near the [botox NC](#) mandibular border where diffusion into depressor anguli oris or depressor labii inferioris can over-relax, causing functional heaviness. Over-dilution is the quickest route to unwanted spread in the neck.

Plane, depth, and diffusion control change the result

The platysma sits superficially, so the injection plane should be intramuscular but shallow. If you see a visible wheal at the surface, you are too superficial. If the needle sinks deep or bleeds more than a pinpoint, you are flirting with deeper structures and increased spread. A 30 or 32 gauge half-inch needle offers good control. Insert at a shallow angle, bevel up, advance just into the muscle belly, then inject slowly. The goal is a peppering effect rather than a pool.

Spacing between points in the grid is typically 1.5 to 2 cm. Vector points can sit closer, often 1 to 1.5 cm, to ensure contiguous relaxation along a cord. Slowing injection speed reduces hydrostatic pressure and caps diffusion. Avoid massaging afterwards; it pushes toxin off target. If band dominance is asymmetric, adjust spacing and dose asymmetrically. Symmetric maps for asymmetric muscles create asymmetric outcomes.

When treating near the submandibular triangle or the anterior border of the sternocleidomastoid, respect the safety margins. Too lateral can affect neck flexion and turn. Too superior near the mandibular border risks diffusion into marginal mandibular nerve territory and mouth corner control. When in doubt, slide slightly inferior and reduce per-point dose, assess at two weeks, and plan a touch-up if needed.

Who needs grid, who needs vectors, and who should wait

Consider the patient in front of you, not a protocol. The person with clear medial bands that activate on every smile benefits from a vector map along those bands, with a light softening grid between them. The person with fine, accordion-like vertical lines across the anterior neck but no cord dominance is a grid candidate. The patient with very thin skin and marginal platysma strength does not need aggressive dosing; a gentle grid combined with skin-directed treatments yields a better texture change without function loss.

Sex, frame, and expression patterns influence the plan. Men often have thicker platysma with stronger pull. Their dosing per point can be higher, but the spacing must remain disciplined to avoid patchy weakness. Highly expressive personalities who talk with their whole face will recruit platysma more often; they tend to burn through toxin faster and need tighter follow-up. First-time patients do better with conservative dosing and planned reassessment at two to three weeks. Repeat patients with known response patterns can be optimized by nudging doses up or down by 10 to 20 percent in focal areas.

There are also patients who should defer or avoid platysma treatment. Someone with baseline neck weakness, a neuromuscular disorder, or swallowing difficulty sits in a higher risk category. Patients with severe platysmal laxity and significant skin redundancy often need structural lifting or skin tightening first; neurotoxin alone cannot fix a hammock that has lost its fabric.

The jawline and lower face are part of the same system

Treating platysma in isolation sometimes backfires. If the depressor anguli oris, mentalis, and platysma are all driving the corners of the mouth downward, relaxing only the neck can unmask lower face disharmony. A measured dose to the depressor anguli oris, sometimes 2 to 3 units per side of onabotulinumtoxinA, can balance the vector effect and prevent a scenario where the neck looks calmer but the mouth corners still pitch south.

Conversely, over-relaxation around the lower face while ignoring the platysma can produce a shelf at the mandibular border, particularly in patients with early jowling. A coordinated plan for jaw slimming in masseters, mentalis smoothing, and platysma band treatment creates a cleaner silhouette. For masseters, a starting range might be 20 to 30 units per side for onabotulinumtoxinA in smaller frames and up to 40 to 60 units in stronger jaws, with strict posterior placement to avoid smile spread. The more you relax masseter bulk, the more the platysma's contribution to jawline contour shows, so dosage balance across these zones matters.

Practical mapping in the chair

Before marking, watch the patient talk. Ask for a big smile, a forced frown, a chin jut, and the “eee” sound. Put two fingers along the anterior neck and feel the bands catch, then track their paths with a washable pencil. Have the patient relax, then mark your grid in light ink, leaving space to prioritize the drawn bands.

For a band-dominant neck with two medial and two lateral cords, I might run a vector of five to seven points per band from submentum to mid-neck, 1 to 1.5 cm apart, with 1 to 2 units per point depending on thickness and metabolic profile. I then lay a light grid between the bands with 0.5 to 1 unit per point, spaced at 1.5 to 2 cm, stopping roughly 1 to 1.5 cm

below the mandibular border to protect lower lip depressors. For a diffuse crepe neck, I drop the vector and distribute 15 to 30 points per side in a grid, lowest dose per point, slightly more inferior than superior to avoid upper spill.

I adjust for thin skin by lowering per-site dosing and widening spacing. I adjust for athletes and fast metabolizers by keeping per-site dosing intact but adding one or two extra vector points per strong band and planning a four to six week touch-up window.

The role of dilution and storage in predictable outcomes

Potency depends not just on reconstitution volume but also on storage and handling. Keep toxin refrigerated per the manufacturer's guidelines. Reconstitute gently, no shaking. Use within the designated potency window. Over-dilution to stretch a vial creates noisier outcomes in the neck because micro-movements and gravity amplify spread. I prefer a moderate dilution that allows fine metering without sacrificing positional accuracy. When switching between brands, recalibrate both the dilution and expected spread; abobotulinumtoxinA often diffuses a bit more at equal biologic effect, which can help a grid but demands tighter borders during vector work.

Touch-ups, longevity, and the moving target of metabolism

Neck treatments [botox deals Greensboro](#) typically declare their effect by day 7 to 10, sometimes a bit later than crow's feet and a bit earlier than masseters. I schedule review at two to three weeks. Touch-ups are an optimization tool, not a patch for poor planning. If a single band is still active, add micro-aliquots along the same vector with the same spacing. If diffuse rippling persists, fill the grid gaps, not the areas already quiet.

Longevity varies. The neck often holds 3 to 4 months in average metabolizers, sometimes only 2 months in exercise-heavy patients or those with high baseline tone, and up to 5 months in lighter frames. Fast metabolizers benefit from slightly higher per-point dose rather than broader spread. High-intensity exercise can shave weeks off effect in some individuals. Counsel accordingly and align maintenance intervals with their lifestyle, typically 3 to 4 times per year for consistent smoothing without over-relaxation.

Preventative use and retraining over repeat sessions

You can reduce the prominence of bands over time by lowering the muscle's baseline recruitment. Microdosing at earlier stages, especially in expressive patients in their thirties and forties with emerging cords, can delay band separation and vertical line etching. Preventative use does not mean blanket paralysis. It means finding the early vectors and quieting them before they dominate expression mechanics.

Over repeat sessions, many patients need fewer units to achieve the same effect, a combination of partial muscle atrophy and learned movement change. Be cautious with chasing uniform stillness. The neck contributes to speech and emotion. The goal is a rested contour and softer vertical lines, not a rigid neck panel that dulls lower facial expression.

Safety, complications, and how to pivot

Most issues with platysma treatment fall into two categories: undercorrection of dominant bands and unwanted diffusion. Undercorrection is solved with targeted vector reinforcement at review. Unwanted diffusion shows as lower lip heaviness, asymmetry in corner smile, or subtle swallowing effort. If a patient reports trouble with liquids dribbling or a fatigue in speaking, pause further dosing, document the areas treated, and support them while the effect fades. Reversal is time based; there is no antidote. For future sessions, reduce superior dosing, increase spacing, and consider a lower dilution to tighten spread.



Avoid injecting too inferiorly over the thyroid cartilage region where skin is thin and deeper structures sit closer. Stay superficial and intramuscular. Respect vascular structures along the anterior border of the sternocleidomastoid. If bruising occurs, it is usually minor and resolves. Cold compress immediately after can help. Significant dysphagia or breathiness is rare with proper plane control and spacing, but counsel patients on the small risk.

Integrating skin and structure for better texture

Neurotoxin softens dynamic lines; it does less for etched-in static vertical creases and structurally lax skin. Combine with collagen-stimulating treatments. Light biostimulators or dilute calcium hydroxylapatite micro-droplets can improve radial firmness and texture when used judiciously, staying superficial and away from vessels. Microneedling or energy-based tightening improves skin quality that a grid cannot address. Time these sessions a few weeks apart to track each modality's contribution.

You will also see a side benefit: reducing platysma pull can refine the cervicomental angle modestly, but if fat compartments or submandibular gland prominence dominate the contour, toxin cannot fix that. Setting expectations based on anatomy preserves trust.

Lessons from the forehead that apply to the neck

Clinicians are comfortable with unit mapping for forehead and glabellar lines because the planes and risks are well codified. The neck deserves the same respect for diffusion control. Think of the glabella's safety margins near the orbital rim; in the neck, your analog is the mandibular border and the depressor complex. As with the forehead, dosing should follow muscle strength, not a template. Thin skin needs lighter aliquots. Heavy brows call for eyebrow lift mechanics that avoid frontalis fatigue; the neck equivalent is avoiding excessive weakening that would compromise natural neck tension and subtly affect posture.

Special cases: asymmetry, male anatomy, and expressive outliers

Asymmetrical bands are common. Treat the stronger side with either more points along the vector or slightly higher per-point dose. Do not mirror-map out of habit. Recheck animation at two weeks and match tone across sides.

Male necks often tolerate higher totals without compromise, but the visual goal may be different. Many men want less shine and smoothness and more quieting of the most aggressive cords. Keep the grid minimal, favor vectors, and protect the lower face depressors.

Highly expressive personalities who use platysma to punctuate speech will need consistent maintenance and often benefit from microdosing approaches that preserve movement while limiting peak recruitment. These are the patients where grid-only treatments can look more natural than heavy vector work that silences a single cord but leaves gaps with exaggerated motion.

The broader Botox context that sharpens neck decisions

Understanding how toxin behaves in other regions informs neck work. Microdosing to maintain natural movement applies from crow's feet to the neck. Injection plane selection dictates both safety and effect in the periorbital area, just as in the platysma. Diffusion control near the orbital rim mirrors the caution near the mandibular margin. Fast metabolizers who burn through masseter or glabellar treatments will likely do the same in the neck, so plan shorter intervals or slightly denser vectors. Patients with a history of resistance or poor response, whether due to antibody development or unrealistic expectations tied to prior dilution strategies, need honest counseling and possibly a brand switch to test responsiveness.

For combination treatments, the sequence matters. If you are treating upper face, lower face, and neck in one session, map and inject from superior to inferior, then reassess before committing to additional lower face dosing. That sequencing helps you avoid stacking depressor relaxation. When managing multiple areas, give each a role. The glabella controls frown, the forehead scales the brow lift, and the platysma refines the jaw and neck contour. Balance them like a mobile. Move one piece, reassess the others.

A compact comparison you can carry into clinic

- Grid pattern: best for diffuse vertical lines and crepiness, moderate dilution, low per-point dosing, 1.5 to 2 cm spacing, avoid superior spread near the mandibular border.
- Vector pattern: best for discrete bands, slightly lower dilution to limit spread, 1 to 2 units per point depending on strength, 1 to 1.5 cm spacing along each band, prioritize stronger cords.
- Mixed plan: address dominant bands with vectors, overlay a light grid between them for texture harmonization, reassess at 2 to 3 weeks for fine-tuning.
- Safety focus: shallow intramuscular plane, slow injection, no massage, stay inferior to the mandibular border by roughly 1 to 1.5 cm, respect lateral limits near the sternocleidomastoid.
- Follow-up: expect onset by day 7 to 10, plan touch-up at 2 to 3 weeks, maintain every 3 to 4 months adjusted for metabolism and expression patterns.

Final thoughts from the chair

The best platysma work feels almost invisible. The jawline looks cleaner. The cords don't jump when the patient tells a story. Nothing feels heavy when swallowing. Getting there is less about memorizing a map and more about reading a living muscle in motion, then choosing the pattern that fits. Grid when the problem is general tension and texture. Vector when the problem is a cord that bosses the lower face around. Blend when the neck asks for both.

Accept that two necks with the same age can need entirely different strategies. The variables that matter are muscle strength, skin thickness, expression habits, and risk tolerance. Dial in dilution, depth, spacing, and dose with those variables in mind. Protect function, respect margins, and resist the urge to over-smooth. When you treat the platysma as part of a bigger expressive system, your results will last longer, look better, and keep patients speaking, smiling, and moving the way they want, only with less pull where it counts.

