

# Blepharoplasty

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# 84

## Core Messages

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## Introduction

Blepharoplasty remains one of the most common surgical procedures performed in facial plastic surgery for both men and women. Indeed, according to a survey of members of the American Academy of Facial Plastic and Reconstructive Surgery, blepharoplasty was the third most common cosmetic surgical procedure performed on the male patient in 2004, following hair restoration and rhinoplasty [1]. Whereas the initial motivation for the patient seeking surgery of the upper lids may be a functional defect, an interest in aesthetic improvement, or a combination of the two factors, it is an interest in aesthetic improvement that is the primary motivating factor for the patient considering lower lid surgery. In fact, it is not uncommon for a patient to present earlier in life wishing to address the “tired” look associated with age-related changes to the upper and/or lower lids. Upper and lower lid blepharoplasty will be reviewed in this chapter.

## Contents

Introduction .....	849
Relevant Surgical Anatomy of the Upper and Lower Lids ...	849
The Aging Eyelid Complex .....	850
Preoperative Assessment .....	850
Upper Lid Blepharoplasty .....	850
Lower Lid Blepharoplasty .....	852
Postoperative Course .....	855
Complications of Blepharoplasty .....	856
Adjunctive Procedures .....	857
Conclusions .....	859
Acknowledgements .....	859
References .....	859

## Relevant Surgical Anatomy of the Upper and Lower Lids

A thorough understanding of the eyelid anatomy is essential to both proper diagnosis and surgical planning. The upper and lower lids consist of three lamellae [1]. The anterior lamella consists of skin and pretarsal orbicularis oculi muscle. The middle lamella contains the orbital septum, which is an extension of the periosteum of the orbital rim. The posterior lamella consists of the tarsus and conjunctiva; the inferior retractor muscles are also found within the posterior lamella of the lower lid. Orbital fat is located posterior to the orbital septum and is compartmentalized: the upper lid consists of a medial (nasal) fat pocket and a middle fat pocket while the lower lid consists of lateral, central, and medial pockets with the inferior oblique muscle dividing the middle fat pocket from the medial fat pocket. In the upper lid, the lacrimal gland is a grayish structure and is found laterally.

## The Aging Eyelid Complex

Progressive loss of organization of elastic fibers and collagen lead to dermatochalasis (loss of skin elasticity and subsequent excess laxity of lower eyelid skin) [1]. Additionally, the orbital septum weakens with age leading to steatoblepharon (pseudoherniation of orbital fat) [1]. Orbicularis oculi muscle hypertrophy is also associated with age-related changes of both the upper and lower eyelid complex [1]. In the lower lid, festoons may form as a manifestation of aging. Festoons are folds of orbicularis oculi muscle in the lower lid that hang in a hammock-like fashion from the medial to lateral canthi; festoons may contain protruding orbital fat. Malar mounds refer to skin and fat that bulge from the malar prominence. Age-related changes of the midface, such as ptosis and volume loss of the midfacial soft tissue, may contribute to the formation of malar mounds [1]. When ptosis and volume loss of the midfacial soft tissue occur in conjunction with pseudoherniation of orbital fat, a double convexity contour is noticeable and the nasojugal groove, or tear trough deformity, deepens [1].

## Preoperative Assessment

### History

During the consultation, one must assess the motivating factors that lead the patient to consider blepharoplasty. Typically, the patient is bothered by hooding of the upper lid and fullness of the lower lid, which make the patient appear tired and older; the patient seeking upper and/or lower lid blepharoplasty desires to achieve a younger and refreshed look about the eyes.

The preoperative assessment of the patient seeking rejuvenation of the upper and/or lower eyelid complex includes a history to evaluate for systemic disease processes, such as collagen vascular diseases and Grave's disease, dry eye symptoms, and visual acuity changes. It is important to delineate whether the changes to the upper and/or lower lids are related to the age-related changes to the lids (dermatochalasis and steatoblepharon) or a manifestation of a systemic process, such as allergy or an endocrine disorder. For example, while a patient with Grave's disease may have upper lid retraction and exophthalmos, the myxedematous state of hypothyroidism may mimic dermatochalasis. Therefore, a screening thyroid stimulating hormone (TSH) level should be obtained if one suspects a thyroid disorder. As well, if any unusual history is gleaned from the preoperative assessment, it may be prudent to obtain an ophthalmologic evaluation prior to endeavoring upon blepharoplasty. Finally, it is important to discuss the limitations of blepharoplasty with the patient and the role of adjuvant procedures. For example, the patient seeking periorbital rejuvenation with significant crow's feet may benefit from botulinum toxin treatment while the patient demonstrating fine wrinkling, "crepe" paper skin may find significant improvement with skin resurfacing.

## Physical Examination

The physical examination should include evaluation of the patient's skin, paying particular attention to the Fitzpatrick skin type and areas of previous scars to assess the patient's tendency for wound healing, pigment issues, hypertrophic scar, and keloid formation. Consider adjunctive treatments in patients demonstrating crow's feet and/or fine wrinkling of the skin.

Assess visual acuity and extraocular movements on all patients. A visual field test may be necessary for the individual with significant upper lid dermatochalasis resulting in a visual field defect; this individual would benefit from functional upper lid blepharoplasty. During the evaluation of the patient considering upper lid blepharoplasty, the forehead should be assessed for ptosis as this may confound the dermatochalasis seen in the upper lid. The surgeon should evaluate the upper lid to rule out blepharoptosis. The ideal position of the upper lid is at the level of the superior limbus. If unilateral blepharoptosis is identified, it behooves the surgeon to rule out blepharoptosis in the contralateral eye as Herring's Law may apply in this situation.

Pseudoherniation of orbital fat can be demonstrated on the direction of the patient's gaze. Gaze in the superior direction will accentuate the lower central and medial fat pockets, whereas superior gaze in the contralateral direction will accentuate the lateral pocket.

Evaluation of both lower eyelid position and laxity is an essential component to the preoperative examination. The ideal position of the lower eyelid margin is at the inferior limbus [1]. A snap test and lid distraction test are key components to the evaluation of lower eyelid laxity. A snap test is performed by grasping the lower eyelid and pulling it away from the globe. When the eyelid is released, the eyelid returns to its normal position quickly. However, in a patient with decreased lower eyelid tone, the eyelid returns back to its position more slowly. The lid distraction test is performed by grasping the lower eyelid with the thumb and index finger; movement of the lid margin greater than 10 mm demonstrates poor lid tone and a lid tightening procedure would be indicated. Finally, a Schirmer's test is indicated if there is concern for dry eye syndrome.

## Upper Lid Blepharoplasty

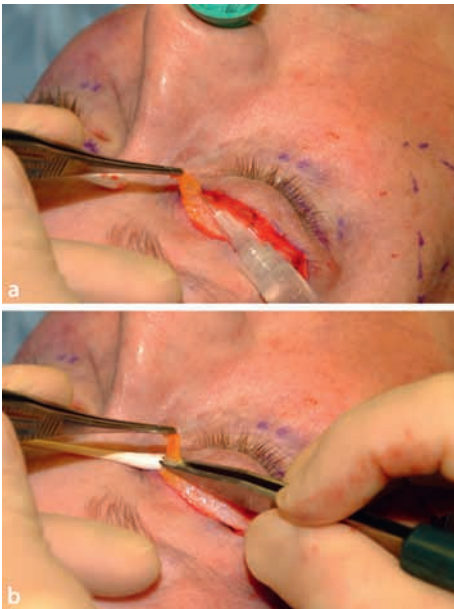
It behooves the surgeon to be meticulous in the surgical markings for upper lid blepharoplasty prior to surgery as a difference of 1 to 3 millimeters (mm) from one lid to the next may create noticeable asymmetries. Therefore, the surgical markings for both upper lids are made using a fine tip marker and small calipers. With the patient looking up, the supratarsal crease is identified and measured from the lid margin using small calipers; this denotes the location of the inferior limb of the surgical marking. This measurement ranges from 8–12 mm (10–11 mm in females; 8–9 mm in males) (Fig. 84.1). The inferior limb of the marking is curved gently and parallels the lid margin; the inferior limb of the marking is carried medially to within 1–2 mm of the punctum and laterally to the lateral canthus. If the marking is carried along the curve of the lid crease lateral to the lateral canthus, the final closure scar line will bring the



**Fig. 84.1** The supratarsal crease is identified with the patient looking upward; the supratarsal crease is then measured from the lid margin using small calipers. This denotes the location of the inferior limb of the surgical marking and ranges between 8–12 mm.



**Fig. 84.2** The marking sweeps diagonally upward from the lateral canthus to the lateral eyebrow margin.



**Fig. 84.4a–c** A small opening is made in the orbital septum to access the middle and medial fat compartments. Gentle pressure on the globe demonstrates redundant fat from each compartment; forceps are used to grasp the herniated fat (a). Local anesthesia is infiltrated at the base of the herniated fat (b) and then the base is cauterized (c). Excision of the fat is then performed at the cauterized base.



**Fig. 84.3a,b** The superior limb of the surgical marking is made. Smooth forceps are used to pinch the excess amount of upper eyelid skin so as to roll the lashes upward (a). The superior limb is connected with the inferior limb medially and laterally (b).

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upper lid tissue downward, thus resulting in a hooded appearance. In an effort to avoid this unsightly result, the marking sweeps diagonally upward from the lateral canthus to the lateral eyebrow margin (Fig. 84.2). This modification of the lateral incision makes it easy for women to camouflage with makeup. Medially, the nasal-orbital depression should not be violated as an incision in this area may result in a webbed scar; ending the

incision medially within 1–2 mm of the punctum avoids this result. Next, the superior limb of the surgical marking is made. This is facilitated by a smooth forceps which is used to pinch the excess amount of upper eyelid skin so as to roll the lashes upward (Fig. 84.3). The surgeon's contralateral hand is used to reposition the eyebrow superiorly so as to isolate the perceived contribution of brow ptosis from upper lid dermatochalasis.

Alternatively, if the patient is planned for a forehead lift at the same time as the upper lid blepharoplasty, the surgeon may elect to perform the forehead lift first and then measure the appropriate amount of upper lid skin excision necessary to provide rejuvenation of the upper lid complex while minimizing the risk of lagophthalmos.

Typically, isolated upper lid blepharoplasty can be performed under local anesthesia with intravenous sedation. Two percent lidocaine with epinephrine (1:50,000) is infiltrated deep to skin but superficial to the orbicularis oculi muscle, thus minimizing the risk of ecchymosis caused by the injection of local anesthesia. Stabilization of the skin in the eyelid is paramount to making the "skin-only" incision of the upper eyelid; therefore, the help of an assistant is required to place tension on the skin. A round handled scalpel with a #15 Bard Parker blade is ideal for following the curves of the upper lid surgical markings. Once the skin incision is made, the skin is then sharply dissected from the underlying orbicularis oculi muscle with the blade or dissecting beveled scissors. The preseptal orbicularis oculi muscle is then evaluated. If it is atrophic or very thin, then the muscle need not be excised. However, most often, a thin strip of preseptal orbicularis oculi muscle is excised medially, thus exposing the fat compartments. If the muscle is robust, then the excision is performed along the entire length of the lid.

Attention is then directed to the pseudoherniation of orbital fat. A small opening is made in the orbital septum overlying the middle and medial fat compartments. Gentle pressure on the globe demonstrates redundant fat from each compartment. Using a Griffiths-Brown forceps, the herniated fat is grasped from its respective compartment and, unless the patient is under general anesthesia, the fat is infiltrated with local anesthesia to minimize discomfort associated with subsequent cautery and excision of the redundant fat (Fig. 84.4). Meticulous hemostasis is of utmost importance to not only maintain a clear operative field, but also minimize the risk of postoperative bleeding. Indeed, once fat removal is completed from both compartments, bipolar cautery is used to ensure hemostasis prior to closure.

The preferred technique for skin closure is as follows (Fig. 84.5): 7-0 blue polypropylene suture is used in an interrupted fashion to reapproximate the skin edges. While a 6-0 mild chromic or fast absorbing gut suture may create an inflammatory response and subsequent milia, a 7-0 size suture rarely produces milia. The upper lid blepharoplasty incision closure is then completed with a running 6-0 blue polypropylene in a subcuticular fashion with knots tied at the medial and lateral aspects of the incision (Fig. 84.6).



**Fig. 84.5** Skin closure is performed with blue polypropylene sutures used in an interrupted fashion to reapproximate the skin edges; the remainder of the skin closure is performed with 6-0 blue polypropylene suture in a subcuticular fashion with knots tied at the medial and lateral ends.

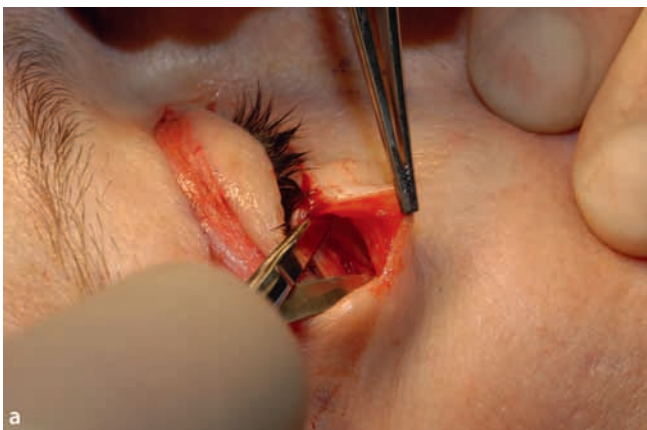


**Fig. 84.6a,b** An example of a patient before (a) and after (b) upper lid blepharoplasty.

### Lower Lid Blepharoplasty

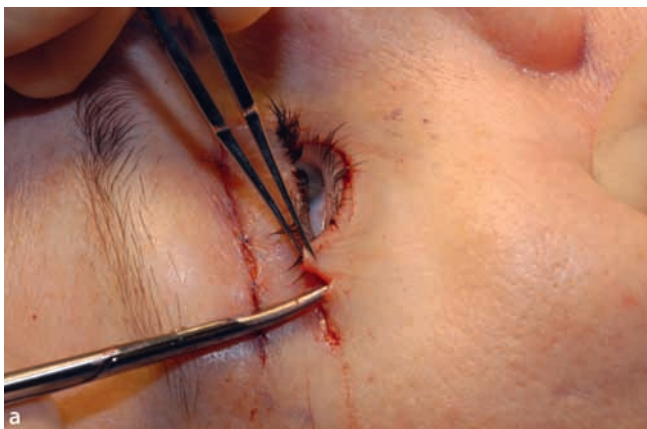
Lower lid blepharoplasty may be performed via a transconjunctival or transcutaneous approach. Among the transcutaneous approaches, the skin-muscle flap is the most commonly used technique by the senior author (SWP). The indications for this technique include true vertical excess of lower eyelid skin, orbicularis oculi muscle hypertrophy, and presence of pseudohermiation of orbital fat. The incision is 2 mm inferior to the lower lid margin and extends from the lower punctum medially to a position 6 mm lateral to the lateral canthus; lateral extension of the incision to this position minimizes rounding of the canthal angle. Following the skin incision, fine curved scissors are used to dissect through the orbicularis muscle at the lateral aspect of the incision (Fig. 84.7a). Then, blunt scissors are positioned posterior to the muscle at the lateral aspect of the incision and,

with spreading motions of the blunt scissors, the skin-muscle flap is elevated off the orbital septum along an avascular plane (Fig. 84.7b). The subciliary incision is then completed using the scissors in a beveled manner to ensure the preservation of the pretarsal portion of the orbicularis oculi muscle, thus minimizing the risk of postoperative lower lid malposition. Small openings are made in the orbital septum to obtain access to the orbital fat compartments. Gentle palpation of the globe results in herniation of orbital fat through the aforementioned openings of the orbital septum. Bipolar cautery is used to cauterize the fat pad prior to excision; prior to cauterization, local anesthesia is infiltrated in the fat pocket to minimize pain. This procedure is performed for the lateral, middle, and medial fat pockets. Gentle palpation of the globe following resection of orbital fat allows for reassessment of orbital fat. A conservative approach to fat resection is maintained to avoid the creation of a sunken



**Fig. 84.7 a** The incision is 2 mm inferior to the lower lid margin and extends from the lower punctum medially to a position 6 mm lateral to the lateral canthus. Following the skin incision, fine curved scissors are used to dissect through the orbicularis muscle at the lateral aspect of the incision, thus exposing the orbital septum. **b** Outwardly-beveled

blunt scissors are introduced posterior to the muscle at the lateral aspect of the incision and, with spreading motions of the blunt scissors, the skin-muscle flap is effectively elevated off the orbital septum along an avascular plane to the level of the inferior orbital rim inferiorly and the incision superiorly.



**Fig. 84.8 a** Maximal stretch effect is achieved by single-finger pressure at the inferomedial portion of the melolabial mound. Then, an inferiorly-directed segmental cut is made at the lateral canthus to determine the amount of excess skin and muscle to excise. A tacking suture is placed

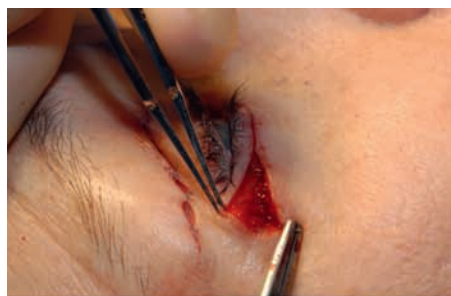
to maintain the position of the skin-muscle flap. **b** The overlapping skin and muscle are excised. Conservative resection will decrease the incidence of postoperative lower eyelid malposition. **c** see next page



**Fig. 84.8** (continued) c If orbicularis oculi muscle hypertrophy is evident, an additional 1- to 2-mm strip of muscle is resected to prevent overlapping of muscle and ridge formation with closure of the subciliary incision.



**Fig. 84.10** The subciliary incision is closed with 7-0 blue polypropylene suture at the lateral canthus in a simple, interrupted fashion; the remainder of the incision is closed with 6-0 mild chromic suture in a running fashion.



**Fig. 84.9** Suspension of the orbicularis oculi muscle to the periosteum of the lateral orbital rim at the tubercle with 5-0 polypropylene (Maxon) maintains proper lid position.

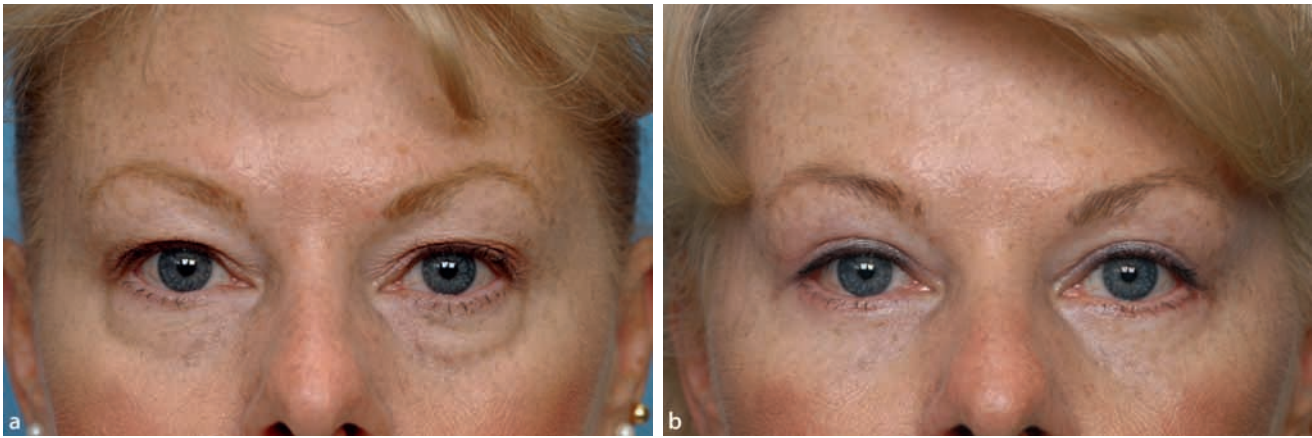


Fig. 84.11a,b Preoperative (a) and postoperative (b) photographs following transcutaneous lower blepharoplasty.

appearance. Then, the skin-muscle flap is repositioned. If mildly sedated, the patient is asked to open their mouth and look up; this maneuver allows for maximal separation of wound edges and subsequent conservative resection of skin and muscle. On the other hand, if the patient is completely sedated, single-finger pressure at the inferomedial portion of the melolabial mound will create the same maximal stretch effect. Following this, an inferiorly directed segmental cut is made at the lateral canthus to determine the amount of excess skin to excise (Fig. 84.8a). A tacking suture is placed to maintain the position of the skin-muscle flap; eyelid scissors are then used to excise the overlapping skin (Fig. 84.8b). If orbicularis oculi muscle hypertrophy is evident, a 1- to 2-mm strip of muscle is resected to prevent overlapping of muscle and ridge formation with closure of the subciliary incision (Fig. 84.8c). Conservative resection of both

skin and muscle will decrease the incidence of postoperative lower eyelid malposition. Additionally, suspension of the orbicularis oculi muscle to the periosteum of the lateral orbital rim will assist in maintaining proper lid position (Fig. 84.9). If there is evidence of festoons or malar mounds, an extended lower lid blepharoplasty is performed inferior to the infraorbital rim; the redundant orbicularis oculi muscle and/or malar mounds are addressed by advancing the entire skin-muscle flap and suborbicularis oculi fat (SOOF) unit superior-laterally [1]. Following muscle suspension, the subciliary incision is closed (Fig. 84.10) with 7-0 blue polypropylene suture at the lateral canthus in a simple, interrupted fashion; the remainder of the incision is closed with 6-0 mild chromic suture in a running fashion (Fig. 84.11).

Compared to the transconjunctival approach, the transcutaneous approach affords the ability to correct true vertical excess of lower lid skin and orbicularis oculi hypertrophy. However, there are specific indications for the transconjunctival approach [1]. For example, young patients with excellent elasticity, presence of hereditary pseudoherniation of orbital fat, and no evidence of skin excess are ideally suited for the transconjunctival approach. Additionally, patients with Fitzpatrick skin types V-VI may benefit from the transconjunctival approach as the transcutaneous lower lid blepharoplasty scar may depigment in these patients. Finally, the transconjunctival approach results in transection and release of the inferior retractor muscles, thus allowing for a temporary rise in the lower lid position. This fact makes the transconjunctival approach an ideal procedure for secondary lower lid blepharoplasty [1]. During transconjunctival blepharoplasty, a preseptal approach via an incision located

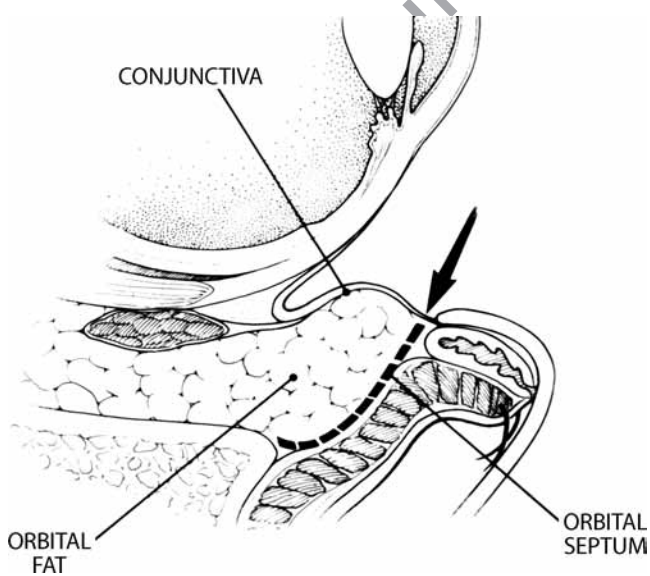


Fig. 84.12 The preseptal approach to the transconjunctival blepharoplasty utilizes an incision located inferior to the tarsus and not deep to the inferior fornix, thus allowing for a more anterior to posterior approach to the fat pockets [1].

inferior to the tarsus and not deep in the inferior fornix; this allows for a more anterior to posterior approach to the fat pockets (Fig. 84.12) [2].

### Postoperative Course

Immediately following surgery, ointment (antibiotic/steroid ophthalmic) is applied to the eye and the suture lines. Cold compresses are applied in the recovery room and the patient is instructed to apply the cold compresses until the second postoperative day as swelling occurs during this time. To that end, head of bed elevation is important as this also minimizes postoperative swelling.

Postoperative swelling may interfere with normal tear production and flow. Indeed, epiphora may result. In order to minimize the risk of dry eye, it is imperative to instruct the patient of the importance of the routine use of artificial tears throughout the day and an ointment in the evenings. The ointment is applied to the suture lines on a regular basis throughout the day as well.

The patient is instructed to restrain from physical activity for the first 48 h and is encouraged to avoid any form of heavy lifting, bending, or straining for 2 weeks postoperatively to minimize the risk of hematoma formation.

The medial knot of the upper lid subcuticular suture is removed on the first postoperative day. However, the subcuticular suture remains in place until 1 week postoperatively, when all sutures are removed. At that time, the patient is provided with a makeup consultation by the esthetician to allow for cosmetic camouflage and makeup application.

### Complications of Blepharoplasty

#### Dry Eyes

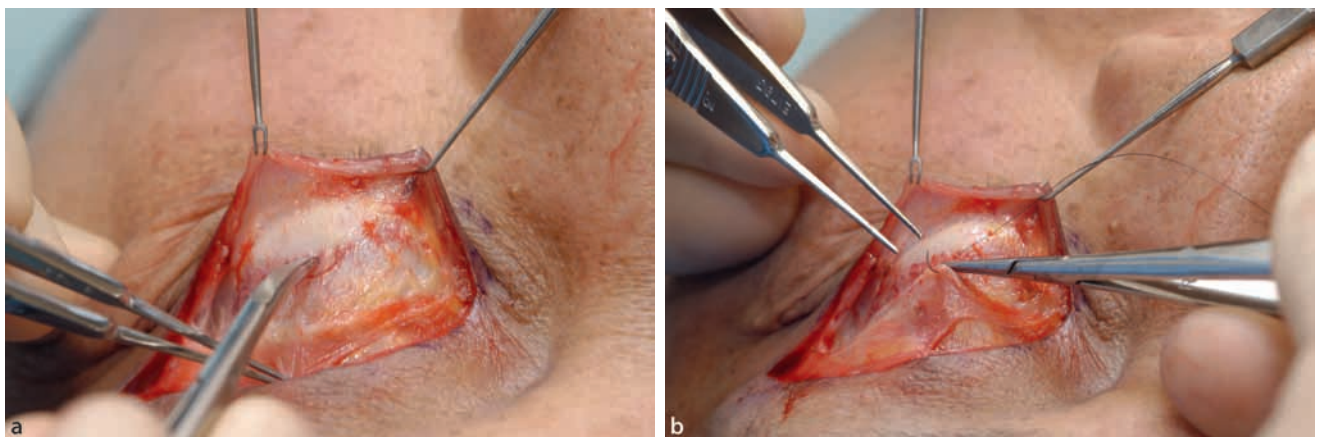
As previously mentioned, postoperative edema interferes with normal tear flow. The astute surgeon should identify the signs

and symptoms of dry eye; these include a dry or scratchy sensation to the eye, epiphora, and presence of conjunctival bleb. If identified early and managed aggressively, one will avoid the problem of exposure keratitis. First, the patient is educated with respect to the issue at hand as some patients may find it difficult to comprehend that the eye is dry when they are experiencing copious amounts of epiphora. Second, the generous and frequent use of artificial tears throughout the day and ointment in the evenings is re-emphasized. One may consider transitioning to a more viscous artificial tear product in those individuals demonstrating a conjunctival bleb. If the conjunctival bleb is persistent and/or quite prominent, other maneuvers such as placement of a Frost suture or taping of the lower eyelid may be of benefit.

#### Hematoma

Hematomas after blepharoplasty may range from a small collection under the suture line that is self-limiting to an expanding hematoma that may extend into the retrobulbar space. The incidence of hematomas is lowered by a thorough history prior to surgery. A review of medications is essential; one must not only inquire about such medications as aspirin and ibuprofen, but also herbal medications which may increase the risk of postoperative hematoma. Meticulous hemostasis intraoperatively with bipolar cautery also minimizes the risk of hematoma. Additional maneuvers that will minimize the risk of hematoma include control of the blood pressure both intraoperatively and perioperatively, head of bed elevation, application of cold compresses, and aggressive treatment of postoperative nausea with antiemetic medication.

Most hematomas are self-limiting. However, organization of the hematoma beneath the skin may present as an indurated mass beneath the skin and subsequently form into a thickened scar. Therefore, treatment with steroid injection may be required. Although rare, a retrobulbar hemorrhage is an emergency as there is an undeniable risk of blindness associated



**Fig. 84.13a-c** Blepharoptosis repair. Intraoperative evaluation demonstrates intraoperative dehiscence of the levator muscle (a). Subsequently, 7-0 silk sutures are used in a mattress fashion to reapproximate the levator aponeurosis to the upper tarsal border (b, c). *c see next page*

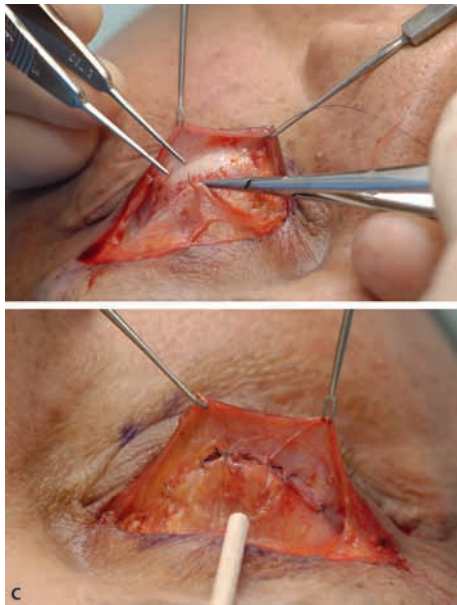
with the increased pressures that result in either retinal artery occlusion or ischemic optic neuropathy. A lateral canthotomy with inferior cantholysis performed immediately will alleviate the pressure. As well, an ophthalmologic consultation should be requested.

## Adjunctive Procedures

### Repair of Upper Lid Blepharoptosis

Repair of upper lid blepharoptosis is possible during upper lid blepharoplasty; the upper lid blepharoplasty is performed first in the standard manner with excision of redundant skin and prolapsed fat.

Following this, the orbital septum is opened in a horizontal fashion and then retracted inferiorly with single hook retractors. This exposes the preaponeurotic fat, which is then resected or retracted to expose the entire levator aponeurosis up to Whitnall's ligament and down to the anterior face of the tarsus. Intraoperative evaluation confirms the etiology of blepharoptosis, which is typically levator dehiscence or separation (Fig. 84.13a). Preoperative photographs are reviewed to confirm the location and extent of the blepharoptosis. Subsequently, 7-0 silk is used to suture the levator aponeurosis to the upper tarsal border in a mattress fashion (Fig. 84.13b, c). Care is taken to make sure the suture is not exposed through the conjunctiva. The suture is tightened to achieve the appropriate position of the upper lid. If needed, multiple mattress sutures are placed.

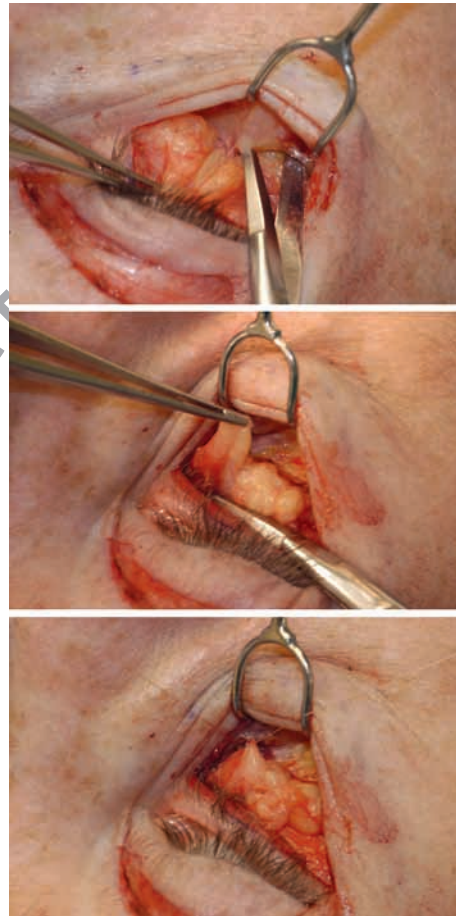


**Fig. 84.13a–c** (continued) Blepharoptosis repair. Subsequently, 7-0 silk sutures are used in a mattress fashion to reapproximate the levator aponeurosis to the upper tarsal border (b, c).

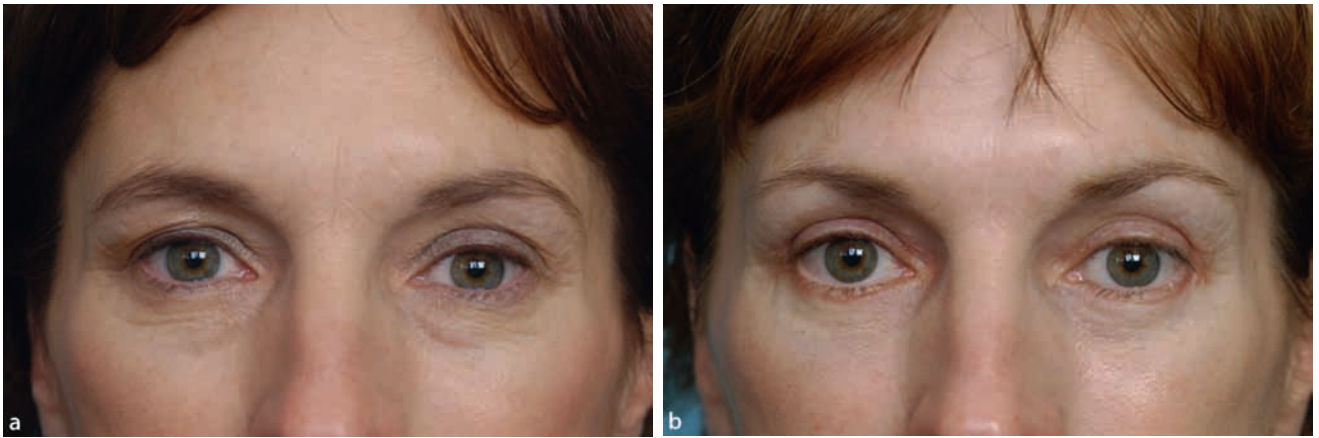
The incision is then closed as in a standard upper lid blepharoplasty.

### Fat Transposition

Many methods have been utilized to efface the tear trough deformity including fat grafts, injections with fat or injectable fillers [1], alloplastic implants [1], and transposition of pedicled orbital fat over the orbital rim [1]. Fat transposition via a transcutaneous approach in conjunction with lower lid blepharoplasty is the preferred method of addressing a tear trough deformity. Preoperatively, the tear trough deformity is marked out with a pen. Lower lid blepharoplasty with extension below the infraorbital rim is performed. Once the orbital fat from the medial pocket is isolated from the orbital septum, it is transposed



**Fig. 84.14** Fat transposition. A pocket is created posterior to the orbicularis oculi muscle but anterior to the periosteum. The medial fat pocket is released from the surrounding orbital septum and subsequently sutured over the infraorbital rim into the previously made pocket with 6-0 polyglycolic acid (Dexon).



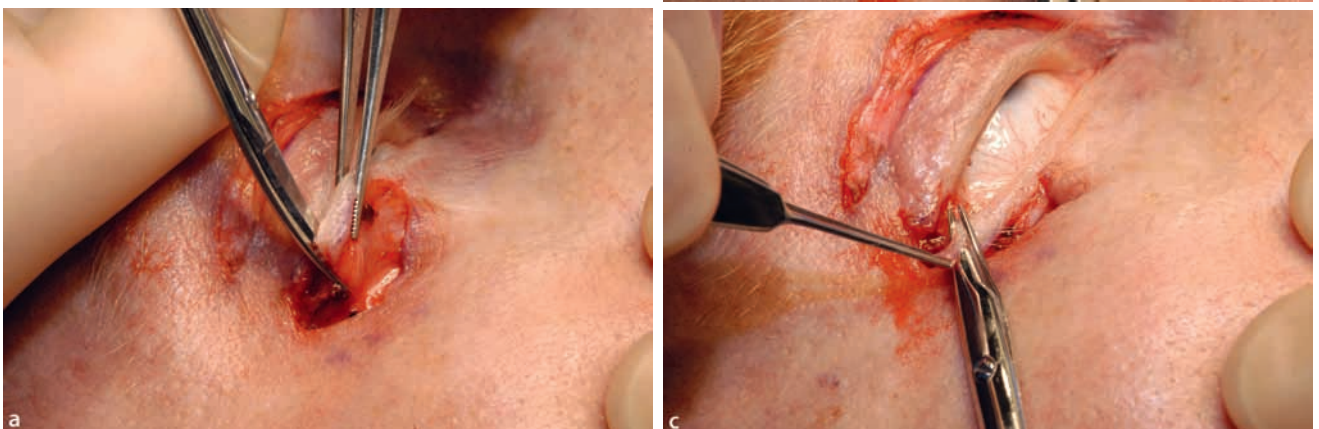
**Fig. 84.15a,b** Preoperative (a) and postoperative (b) photographs demonstrating effacement of the tear trough deformity following transcutaneous lower lid blepharoplasty with fat transposition.

over the orbital rim and positioned into a pocket posterior to the orbicularis oculi muscle and anterior to the periosteum to efface the tear trough deformity. The transposed orbital fat is then secured to the periosteum using interrupted 6-0 polyglycolic acid (Dexon) sutures (Fig. 84.14). The contour of the orbital fat is then softened with the use of bipolar cautery. Subsequently, the lower lid blepharoplasty is completed as previously described (Fig. 84.15).

### Lateral Canthoplasty

Several intraoperative maneuvers will minimize postoperative lower lid malposition during lower lid blepharoplasty, such as preservation of the pretarsal orbicularis oculi muscle, conservative resection of skin and muscle, and suspension of the orbicularis oculi muscle to the periosteum of the lateral orbital rim. If the lower lid demonstrates malposition or poor tone preoperatively, then a lateral canthoplasty is performed in conjunc-

tion with lower lid blepharoplasty. Following lateral canthotomy and inferior cantholysis, the tarsus is dissected from the skin, muscle, and conjunctiva. The tarsal strip is then attached using permanent suture to the medial aspect of the lateral orbital rim



**Fig. 84.16 a-c** Lateral canthoplasty. Following lateral canthotomy and lateral cantholysis, the tarsus is separated anteriorly from the skin and orbicularis oculi muscle and posteriorly from the conjunctiva. 5-0 poly-

propylene (Prolene, usually clear) is passed through the periosteum of the medial aspect of the lateral orbital rim in a postero-superior position (a) and the tarsus (b) to improve lid position and support (c).

periosteum in a postero-superior position. Then, the appropriate amount of lower lid is excised (Fig. 84.16a–c).

### Skin Resurfacing

Lower lid blepharoplasty cannot effectively efface periorbital fine wrinkling of skin. Therefore, skin resurfacing can be performed in conjunction with lower lid blepharoplasty. However, vertical contracture of the lower eyelid may occur following blepharoplasty and result in lower lid malposition. Additionally, skin resurfacing may result in skin tightening of the lower eyelid and subsequent ectropion. Therefore, it is essential to evaluate both lid position and lid support prior to performing skin resurfacing in conjunction with lower lid blepharoplasty and consider canthoplasty if the lower eyelid demonstrates malposition and/or poor support.

Ideal candidates for skin resurfacing of the lower eyelid include patients with Fitzpatrick skin types I–III. An 88% phenol peel or CO<sub>2</sub> laser resurfacing for the lower lid skin is the preferred method of skin resurfacing and are safely performed in conjunction with the transcutaneous blepharoplasty. However, as previously discussed, one should consider performing a lateral canthoplasty if the lower eyelid demonstrates malposition and/or poor support.

### Conclusions

Rejuvenation of the lower eyelid complex in the male patient requires proper preoperative evaluation. In doing so, the facial plastic surgeon can select the proper treatment modality. Blepharoplasty performed in conjunction with fat transposition, canthoplasty, and/or skin resurfacing can result in a less tired, more youthful appearance of the lower eyelid complex.

### Acknowledgements

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