Marking Strategies for Upper Blepharoplasty

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Pinching skin to leave lids closed without redundancy of the upper lid skin is the safest way to approach upper blepharoplasty. There may be a need for revision (especially temporally) on probably 20 % of patients—especially in the cosmetic population, whose expectations are high. This revision rate is lower in functional patients whose expectations are not as high. Leaving lash eversion and even up to 2 mm of incomplete closure is typically safe if orbicularis strength is good (check by forced eyelid closure and attempt to pry lids open), and other corneal protective mechanisms are intact (Bell's phenomenon, tear production, and corneal sensation).

Laterally one must balance skin excision with brow position and final outcome and discuss reasonable expectations with patients preoperatively. More aggressive excision laterally is appropriate. It is very unlikely to develop corneal problems from excess temporal skin excision unless to the extreme. The brow tends to give and compensate for this. Unfortunately, the brow can become ptotic, which can in itself cause a problem.

This is why, in patients who express a desire for more pretarsal show laterally, I often recommend brow lift (if not to elevate, then at least stabilize brow height). Elevating the temporal brow also reduces the lateral skin excision by reducing the pseudo-dermatochalasis components of the full temporal lid (by eliminating brow ptosis). In addition, postoperative sub-brow botulinum toxin injections (6U per side) are helpful during recovery.

Another helpful tip to prevent nasal webbing is to angle the incision up and medial slightly (mirror image of lateral incision). This tends to offset the vertical/horizontal disequilibrium that can occur and leads to the development of webs.

Other hints:

- Wash off all skin prep before marking (especially Betadine) as it is harder to mark on skin with prep solution on it (especially when dry).
- Use a fine-tip marker. Thicker markers spread more, especially if lid gets wet from injection or if eyelid opens. This can lead to marks being millimeters off, which in the cosmetic population makes a difference.
- Mark, inject, and score (MIS). In my opinion this is critical. Many physicians mark before the prep and inject. After prepping I find the markings to be off (spread). I find MIS to be DOGMA. After prep (MIS), when both sides are scored, no matter what happens to the lid, the incisions will not change. The downside is less time for hemostasis from injection. This can be compensated for by waiting or doing lower lids (if scheduled).

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I avoid muscle excision in most cases. There is enough lid thinning (anterior-posterior) by skin excision. I especially avoid this if orbicularis strength is not excellent in my preop evaluation. In addition, post-op lagophthalmos can be divided into two types: (1) tethered, due to skin shortage or septal (or deep tissue) scar (adhesion), and (2) paretic (I find most common), due to weak orbicularis muscle. One can differentiate by what I call the tether test. Pull lashes down to close the eye—if restriction present type 1 above is the case. This is rare compared to type 2. This is why I manipulate muscle as little as possible (the older the patient, the more prone to this). Lagophthalmos (especially nocturnal) can occur with adequate skin and is more likely to occur from orbicularis weakness. Avoid manipulating orbicularis as much as possible.

The best way to avoid hematoma is not to get one. When injecting, start temporal and hydrodissect skin from muscle. Bend needle to angle superiorly, keep tip up, and just under skin.

There are a percentage of patients that complain of misalignment of the relaxed skin tension lines of the lids after blepharoplasty. It is an arched incision—slight misalignment in patients with obvious vertical lines can lead to this. It helps to place two cardinal sutures (centrally and temporally) in the blepharoplasty incision. This turns a long arched incision into three small ellipsed ones and reduces the chance of webbing and skin misalignment.

I find that locking lateral sutures (a few) during the running suture is key. That is a dynamic area, and this prevents dehiscence. Another option is to run the suture and then place several interspaced interrupted sutures laterally for tension. This has the added benefit of everting the wound edges.

I have become less of a fan of brow fat sculpting in recent years. In some cases, I believe more in fat injections to elevate the ptotic brow fat pad.