Upper Blepharoplasty: Pearls for the Procedure

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1. Meticulous marking is critical. We recommend marking prior to injection of local anesthesia. A fine-tip marker is preferred, as the larger markers smear and do not allow the precision necessary for eyelid surgery (see Fig. 26.1).
2. The supratarsal lid crease should be marked from punctum to lateral canthus. If the patient's natural creases are appropriate and symmetrical, they can be used. Otherwise adjustments should be made, keeping in consideration that the lid crease incision's height should be as symmetrical as possible.
3. The pinch technique will determine how *little* skin can be excised to achieve optimum results. Be careful to make the endpoint the eversion of lashes. This part is critical to prevent lagophthalmos. It is also important to keep in mind that patients with severe brow ptosis may not develop lash eversion while using the pinch technique, which can lead to removal of too much skin. It is also acceptable to leave approximately 20 mm of vertical skin distance (VSD) measured from the lash line to the inferior border of the brow. Avoid aggressive medial skin excision or going too close to the lid margin medially, as this can cause webbing. Care is taken not to remove sub-brow skin to prevent postoperative brow ptosis. Less is more with skin removal.

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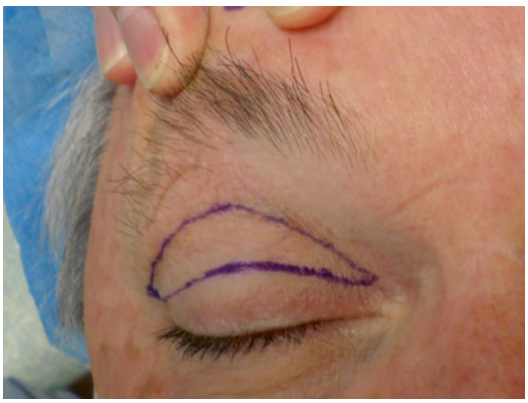

Fig. 26.1 Blepharoplasty marking showing the medial and lateral upswing, "lazy S" configuration

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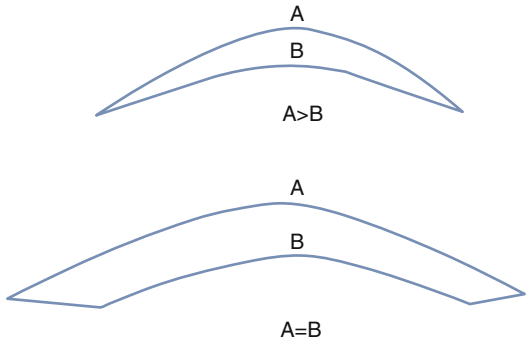

Fig. 26.2 Marking for blepharoplasty showing how the increased radius of curvature of line A in the top drawing causes excessive skin horizontally, potentially necessitating excision of dog-ears, denoted by the dashed lines. The lower "lazy S" drawing creates two incisions of the same length that are easily approximated

4. The lid crease marking should slope gently upward medial to the punctum and lateral to the lateral canthus. The upward slopes medially and laterally have two important functions. Medially, it helps prevent webbing. In addition, the medial and lateral upswings increase the length of the lower incision to equal that of the upper, preventing excessive skin superiorly and the need to excise dog-ears (Fig. 26.2).
5. To achieve adequate hemostasis, 2 % lidocaine with 1:100,000 epinephrine mixed with 0.5 % Marcaine with 1:200,000 epinephrine is used. Hyaluronidase can be used in the mixture to help disperse the anesthetic.
6. When incising the skin–muscle complex, be careful not to damage the levator complex. This can result in ptosis. Orbital fat is a good landmark as it lies anterior to the levator.
7. Prominent lacrimal gland tissue may need to be tucked to create an aesthetically pleasing appearance to the lateral eyelid.
8. With fat removal, a conservative approach is often better. A subjective preoperative grading system should be implemented to prevent undercorrection or overcorrection of the orbital fat. Prominent medial fat pads should be reduced by dissecting through the orbital septum and excising.
9. Excessive cautery medially can damage the trochlear region, resulting in diplopia. One should be meticulous with hemostasis, however, to avoid the rare complication of orbital hemorrhage. Use of handheld or bipolar cautery is useful.
10. Lid crease fixation suture can be used to enhance the appearance of the crease, especially in females or when less skin is taken. A prominent or elevated crease can aid in improving the margin fold distance. A lid crease fixation can be done in several ways. If the lid is being closed with a running or interrupted suture, bites can be taken of the orbicularis or levator aponeurosis at the desired height.
11. Absorbable sutures such as 6-0 plain gut can be used with the benefit of not needing Steri-Strips; however the chance of granuloma or epithelial suture cysts can be reduced by using subcuticular closure with a nonreactive permanent suture such as 6-0 polypropylene and Steri-Strips. Patients commonly complain of irritation from the Steri-Strips and can also have an allergic reaction. If an absorbable suture is used, the remaining sutures should be removed at about 7 days. There is no "perfect suture" for bleph closure or everyone would use the same one!