Tissue Removal Considerations in Blepharoplasty Surgery

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When deciding how much tissue to remove in cosmetic upper blepharoplasty, it is important to remember a few critical mantras:

1. It is not the tissue that you remove, but what you leave behind that counts. As we are all asymmetric, measure not what you remove, but the residual eyelid tissue for symmetry.
2. Function trumps form every time. Blepharoplasty is not a procedure designed to achieve maximum tautness of the lids. An overly taut lid is surgical rather than youthful in configuration. It is critical to ensure that the patient can close their eyes completely on the OR table. It is not recommended that the patient have residual lagophthalmos. If the patient has lagophthalmos in the OR, he or she certainly will have lagophthalmos in the office the next day. This situation does not improve spontaneously. Additionally, it is important to leave the orbicularis. The orbicularis does not become redundant with age. The orbicularis is important to ensure adequate eyelid closure and blink strength, especially in a population at risk for dry eye. In addition, the imbricated orbicularis, after skin excision, provides for a youthful upper eyelid configuration.
3. Well-performed blepharoplasty provides the opposite of maximum skeletonization or excavation of the eyelids. Fat is the lubrication of the eyelid. A cushion of fat is a sign of "youthfulness," ensures adequate levator function, and decreases the possibility of postoperative scarring and adhesion formation. Overexcision of fat can overly hollow the eyelids, leading to a "lost in time," obviously surgical appearance.
4. My technique for upper blepharoplasty is as follows:

Under intravenous sedation, 1–2 cc of a 50:50 mixture of 2 % Xylocaine with 1:100,000 epinephrine, 0.25 % Marcaine with 1:200,000 epinephrine, sodium bicarbonate, and hyaluronidase are injected into the lateral aspect of each upper eyelid. The local anesthetic is then wiped across the eyelid using a "digital diffusion" technique. The patient is then prepped and draped in the usual sterile fashion. Attention is first directed to the upper eyelid crease where a marking pen and caliper are used to mark the intended skin incision. This incision is placed in the natural crease of the eyelid. 0.5 Castroviejo and Brown-Adson forceps are used to gently pinch the upper lid tissue to determine the amount of skin to be excised. It is important to ensure that adequate tissue is removed in the area of the temporal brow to improve preoperative temporal hooding if needed.

Care is taken to ensure that there is no lagophthalmos but that sufficient skin is removed to ensure an aesthetic result. A frill of thin eyelid

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tissue should remain at the superior incision to avoid the excision of too much tissue and the "sewing of the eyelid to the eyebrow," dragging the brow down in the process. The marking is made bilaterally, simultaneously, and symmetrically. Care is taken to ensure that the lateral extension of the marking, in length, angle, and distance from the horizontal, is symmetric to maximize the symmetry of the postoperative incision. Calipers are used after the markings to verify symmetry.

In the event of significant preoperative asymmetry, perhaps secondary to brow position, neural innervation, or underlying boney asymmetry, the patient may be marked in the upright position in the holding area prior to being taken into the operating room. These markings are taken into consideration when the routine supine markings are created.

As a rule of thumb, a minimum of 21 mm of skin should remain between the eyelid margin and the brow cilia. This is equivalent to 6–8 mm from the lash margin to the incision and 13–15 mm from the incision to the brow cilia.

A 5-0 silk traction suture is then placed through the eyelid margin and the lid placed on downward tension. A #15 Bard-Parker blade is used to incise the skin. The cutting mode of a monopolar cautery with a Colorado needle tip is used to excise the redundant skin. The orbicularis oculi is left intact. If the preoperative plan calls for fat removal, a small incision through orbicularis and orbital septum is made in the medial aspect of the upper eyelid. Through this small incision, the medial and central fat pads may be trimmed according to the plan outlined prior to surgery. Hemostasis is maintained with monopolar cautery. The incisions are then closed in a running fashion with a 6-0 plain or nylon suture. A small skin hook is placed at the lateral edge of the incision. Once the suture has been started at the medial end of the incision, a small hemostat is applied to the suture end. The hemostat is draped across the nose and placed on a sterile gauze pad. The combination of the medial hemostat and the lateral small skin hook aligns the wound edges allowing for rapid, precise incision closure.

A combination of corticosteroid and antibiotic ointment is applied after incision closure is complete. Iced saline wet gauze is applied in the operating room to reduce swelling after the completion of each incision closure. These techniques help promote a dry field maximizing surgical precision. Postoperatively, the patients are asked to use cool compresses for the first 2 days, except when they are sleeping. They switch to warm compresses for a week after the cool compresses are discontinued. Ointment is applied at night. Patients return in 1 week for a postoperative evaluation and suture removal or trim.