62 Making Lower Eyelid Transconjunctival Blepharoplasty Easier, Safer, and More Comfortable

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Younger patients seeking lower eyelid blepharoplasty and not requiring skin removal can be a challenge owing to the tight eyelid and canthal anatomy. I have found it much easier in such patients to sever the lateral canthal inferior crus by an internal approach either through an upper blepharoplasty incision or by performing a lateral inferior cantholysis with Stevens or Westcott scissors via a transconjunctival approach. Either of these maneuvers spares a lateral canthal skin incision for better postoperative cosmesis but relaxes the lateral canthal angle allowing for more effective lower eyelid retractor placement. This affords a larger working area with which to make the transconjunctival incision and for safer fat sculpting and repositioning. Personal observation from trauma and reconstructive cancer cases has shown that in normally taut youthful eyelids a subsequent tightening canthoplasty is generally not necessary as they spontaneously heal in proper position following inferior cantholysis. If the patient has some preexistent laxity and is undergoing a simultaneous upper blepharoplasty, I perform the upper blepharoplasty first, then release the inferior crus, perform the now more easily accessible lower eyelid transconjunctival blepharoplasty, and finally tighten with a 5-0 Vicryl plus on a P-3 needle as has also been similarly described by others (Taban et al. 2010a, b; Georgescu et al. 2011). If no upper blepharoplasty is performed and lower eyelid skin is to be removed or aggressive chemical peel or laser resurfacing, then a small incision lateral canthopexy can be performed to support the lower eyelid and avoid postoperative lower eyelid retraction.

Additional Pearls

- One to two drops of phenylephrine causes conjunctival vessel constriction minimizing bleeding during anesthetic injection and incision placement. Topical ophthalmic anesthetic is then placed, and proparacaine is considered preferable over tetracaine owing to less ocular irritation. Next a small amount of diluted (0.5 cc of 1 % lidocaine to 2.5 cc of preserved saline) lidocaine anesthetic infiltration of the lower eyelid conjunctiva is placed followed by an additional bolus of bupivacaine 0.5 % with epinephrine for more effective analgesia. By following this stepwise approach, patient comfort is maximized while anxiety is kept to a minimum.
- Hyaluronidase helps further spread the anesthetic and facilitates deeper fat anesthesia and patient comfort.
- A sharp 4-prong skin retractor provides easy access for making the transconjunctival incision.

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- After the conjunctiva incision has been made, a nonconducting coated desmarre retractor avoids Bovie cautery transmission of electrical current through the metallic retractor, which patients can find uncomfortable.
- Patients also find it more comfortable to excise fat with scissors than with Bovie cautery.
- Necessary cauterization of active bleeders is also better tolerated with bipolar forceps rather than Bovie.
- The often-challenging lateral fat pad access is made easier by the lateral inferior cantholysis approach described above, and lateral lower eyelid fat is often more easily approached through an upper blepharoplasty incision. Dissecting preperiosteally from the lateral upper blepharoplasty incision downward towards the lateral lower eyelid fat provides an easy approach.
- A final intraoperative check of the success of fat sculpting and repositioning can be done by pulling gently cephalad on the lower eyelid with forceps and checking the lower eyelid contour. Gentle ballottement of the upper eyelid is also helpful to accentuate subtle areas of asymmetry that may still need to be addressed.

References

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