Chapter 100
Eyelid: Blepharoplasty, Upper Lid

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Abstract Dermatochalasis, or the excess of skin of the upper eyelid, may cause obstruction of the visual axis or patient dissatisfaction with cosmesis. Prominence of the nasal orbital fat compartment and/or the pre-aponeurotic fat pad often accompanies these age-related cutaneous changes. Upper eyelid blepharoplasty may be performed to either improve the superior visual field or for cosmesis. Patients should be educated about the risks of the procedure, including alternatives. It is important to recognize when blepharoplasty alone is sufficient to address the patient's complaints and when it is necessary to perform adjunctive procedures such as eyelid and brow ptosis repair to optimize surgical outcomes.

Keywords Blepharoplasty • Dermatochalasis • Upper eyelid • Superior visual field • Fat prolapse

Indications

Dermatochalasis and upper eyelid fat prolapse resulting in visual symptoms or cosmetic complaints.

Essential Steps

1. Careful measurement and marking of the upper eyelid creases and region of excision
2. Removal of skin only or skin-orbicularis flap
3. Opening of the orbital septum for excision or sculpting of pre-aponeurotic and nasal orbital fat
4. Lid crease reformation (if appropriate)

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Complications

- Retrobulbar hematoma
- Scarring or keloid formation (rare)
- Milia or inclusion cysts along lid crease incisions
- Asymmetry
- Infection
- Ptosis
- Unmasking of brow ptosis due to postoperative relaxation of frontalis muscle
- Lagophthalmos
- Dry eye exacerbation

Template Operative Dictation

Preoperative diagnosis: (*Right*/*Left*/*Bilateral*) *upper eyelid dermatochalasis*

Procedure: (*Right*/*Left*/*Bilateral*) upper eyelid blepharoplasty

Postoperative diagnosis: *Same*

Indication: This __-year-old *male*/*female* patient has redundant eyelid soft tissues obstructing the visual axis and causing difficulties with activities of daily living. Suprathreshold Humphrey visual fields demonstrated greater than 30 % improvement with taping of the excess skin. The risks, benefits, and alternatives to the procedure were discussed with the patient including the risk for infection, bleeding, pain, exacerbation of dry eye symptoms, poor cosmesis, asymmetry, and need for further procedures. Afterwards, the patient requested that we perform surgery and signed the required consent forms.

Description of the procedure: The patient's clinical history was reviewed in detail and the appropriate eye was marked in the preoperative area. The patient was brought into the operating room where the (*right*/*left*) eye, adnexal structures, and face were sterilized with 5 % Betadine ophthalmic solution. *General* anesthesia was administered without complications. The patient was draped in the standard sterile fashion for oculoplastic surgery. A time-out was then performed confirming the correct patient, sites, surgery, and any known drug allergies.

The patient's natural lid creases were identified and found to be ___ mm above the lid margin in the midpupillary axis. A sterile violet marking pen was used to delineate these creases. Medial to the punctum and lateral to the outer canthus, these markings were gently inflected upwards to prevent webbing and eliminate temporal hooding. Castroviejo calipers were then used to measure a (*11–13*) mm margin of sub-brow skin to preserve. Using 0.5 mm non-toothed forceps, the redundant tissue within these confines was then grasped and marked. The pen was then used to complete elliptical outlines for excision. Contour and symmetry were carefully evaluated and adjustments were made as needed.

Attention was then directed toward the (*right*/*left*) upper eyelid. Approximately 2 cc of the _____ anesthetic was infiltrated subcutaneously. Gentle traction was applied, and the previously marked ellipse was incised with a #15 Bard Parker blade. A skin muscle flap (*or skin only flap*) was subsequently elevated with blunt Westcott scissors and 0.3 mm forceps (*or Bovie cautery*). Hemostasis of the tissue bed was achieved with judicious application of monopolar electrocautery. The underlying orbital septum (*or orbicularis and underlying septum if skin only*) was buttonholed and then opened along the horizontal axis. The nasal fat pad was then identified and pediclized using gentle blunt dissection. Supplemental anesthetic was infiltrated at the base. The pedicle was then subsequently cross-clamped with a Kelly hemostat and transected. Meticulous electrocautery was applied to the base of pedicle and complete hemostasis was confirmed before permitting it to retract. The pre-aponeurotic fat pad was then sculpted with cautery. The eyelid crease was reformed with _#_ interrupted *7-0 nylon* sutures, incorporating small bites of the underlying levator into the closure (*this step not needed if skin only blepharoplasty*). The skin was then closed with running *7-0 nylon* suture. The drapes were removed and ophthalmic ointment was applied to both incisions.

The patient tolerated the procedure well without any intraoperative or immediate postoperative complications. All needle and sponge counts were correct at the end of the procedure. The patient was then taken to the recovery room in stable condition and will be seen in the eye plastics clinic in/on _____. The patient was informed to apply frequent ice packs the eyelids for 48 h, and abstain from heavy lifting, straining, or use of blood thinners. The patient was instructed to return to the emergency room immediately if any loss of vision or deep orbital pain is noted.