Upper and Lower Blepharoplasty

Johnson C. Lee, MD,* Mark A. Codner, MD†

INDICATIONS

Indications are as follows: dermatochalasis, skin laxity, eyebrow descent, prominent fat compartments, lacrimal gland descent, suborbicularis brow fat, prominent orbital rim, laxity of the tarsoligamentous sling, and hypertrophic or atrophic orbicularis oculi.1 Evaluating medical history, brow stability, and levator function will help determine if ptosis is a contributing factor or if a browlift is needed. Unsatisfactory results occur when untreated brows compensate asymmetrically because of Herring’s law of equal innervation (See Video 1, Supplemental Digital Content 1, which displays a standard examination of a patient’s upper and lower eyelids when planning for blepharoplasty, available in the “Related Videos” section of the full-text article on PRSGlobalOpen.com or available at http://links.lww.com/PRSGO/A217).

INSTRUMENT LIST

Instrument list is as follows: Westcott scissors, 0.5-mm Castroviejo forceps, fine-toothed Adson forceps, Castroviejo needle holder, corneal protectors, straight iris scissors, curved iris scissors, sterile cotton-tipped applicators, bipolar cautery, Blair retractors, Guthrie retractors, and insulated Desmarres retractor, sterile marking pen, and caliper.

PREP

The face is prepped with dilute betadine solution, and the eyes are irrigated with balanced saline solution.

STEPS

Upper Blepharoplasty

1. Lidocaine 2% with epinephrine injected into the eyelids and the lateral orbital rim periosteum.
2. The crease is marked 8 to 10 mm above the central lid, tapering medially and laterally, and leaving 10 to 15 mm of skin between the upper incision and the brow. Markings vary according to sex and ethnicity.
3. Open-sky incisions are made with a scalpel.2

Lower Blepharoplasty

1. Skin is incised below the lateral canthus.
2. Straight scissors dissect the skin from the pretarsal muscle 3 mm below the lashes.
3. The muscle is divided in a stair-step fashion.
4. Preseptal to preperiosteal undermining of the skin–muscle flap and release of the orbitomalar ligament are performed.
5. The septum is excised to expose protruding fat compartments for resection.
6. Excised fat can be grafted to blend the lid–cheek compartments for resection.
7. Canthopexy is performed with a 4-0 Mersilene or 5-0 polydioxanone suture passed through the lateral edge of the lower lid without passing through the conjunctiva.
8. The corneal shield is removed, and the suture is anchored and tightened to periosteum inside the lateral orbital rim at the level of the pupil and at the depth of Whitnall’s tubercle, palpated by the forcep tips. This may be placed higher or lower for prominent or deep-set eyes, respectively.
9. Lid tension is tested with gentle retraction.3
10. The skin–muscle flap is pulled in a vertical vector.
11. Excess skin is excised under minimal tension.
12. A supporting 4-0 Vicryl suture suspends the orbicularis to periosteum.
13. Interrupted 6-0 nylon sutures close the skin laterally.
14. A 6-0 continuous fast absorbing gut closes the subciliary portion.

Disclosure: The authors have no financial interest to declare in relation to the content of this article. The Article Processing Charge was paid for by the authors.

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See Video 2, Supplemental Digital Content 2, available in the “Related Videos” section of the full-text article on PRSGlobalOpen.com or available at http://links.lww.com/PRSGO/A218.

POSTOPERATIVE CARE

Postoperative care includes the following: polysporin ophthalmic ointment, cooling packs × 24 hours, oral antibiotics, and pain medication.

Patients are discharged after the procedure and may shower the following day but should avoid activity, medication, and foods, which increase blood pressure and edema. Sutures are removed at 1 week (See Video 3, Supplemental Digital Content 3, which demonstrates postoperative instructions, medications, and results, available in the “Related Videos” section of the full-text article on PRSGlobalOpen.com or available at http://links.lww.com/PRSGO/A219).

Johnson C. Lee, MD
Johnson C. Lee MD Plastic Surgery
120 S. Spalding Drive,
Beverly Hills, CA 90212
E-mail: Johnsonlee1@gmail.com

PATIENT CONSENT

Patients provided written consent for the use of their images.

REFERENCES