



plastic surgery

corner



by
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BLEPHAROPLASTY: A CLOSER LOOK AT THE EYES

Signs of aging often appear first in the periocular area, and people pay attention to the appearance of these “windows to the soul.” Cosmetic eyelid surgery is the most common esthetic procedure performed by plastic surgeons.

Factors that can adversely affect the appearance of one’s eyelids include sun exposure, habits (squinting, smoking), age, heredity, recurrent bouts of swelling (related to the menstrual cycle, systemic disease, etc.), unusual or asymmetrical eyeball size, and forehead/eyebrow sagging.

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and enthusiastic.*

BENEFITS

Blepharoplasty improves dermatochalasis, more commonly known as “baggy eyelids.” As we age, fat that used to be inside the bony cavity surrounding the eyeball moves forward out of the eye socket. This produces bulging “bags” above and below the eyelids. Excess skin in the upper eyelids can be removed, which makes this area appear more youthful. A lesser amount of skin can be removed in the lower eyelids, which results in some smoothing of the skin adjacent to the lower lid margin. Blepharoplasty can make a person look more alert, attentive, and enthusiastic.

POTENTIAL DRAWBACKS

Blepharoplasty alone does not necessarily improve wrinkled or baggy skin much below the level of the bony rim of the orbit. Eyelid surgery does not have a major effect on “crowsfeet,” nor does it alter skin characteristics. Eyelid surgery cannot compensate for asymmetry in eyeball size or position, nor does it alter the bony contour of the orbit. When eyelid-related “bags” fluctuate in size, this is not improved—and may be worsened—by blepharoplasty. Interestingly, when a person’s eyebrow position is low, their forehead (frontalis) muscle tone often increases, to prevent further lowering of skin and tissue onto the upper eyelid area. Then, when excess upper eyelid skin is surgically removed (with blepharoplasty), the person’s frontalis muscle tone decreases. The brow often then descends, resulting in an upper eyelid appearance that is not very different from the person’s preoperative condition.

CONTRAINDICATIONS

Relative and absolute contraindications to blepharoplasty include significant ptosis (drooping) of the eyebrows (see above), eyes that are prominent in relation to the lower and/or lateral bony orbital rim, lower lid laxity, systemic conditions such as excessive bleeding, and symptoms of “dry eyes.”

“DRY EYES”

There is a moist “tear film” over the eyeball, which has three layers. An inner layer of mucous (layer one) adheres to the eyeball itself; this mucous attracts and holds an overlying thin layer of the water-like tear liquid (layer two). (This water-like liquid is the component of tears that can run

down the face during crying.) The outer layer is composed of oil (layer three), which slows evaporation of the tear film. A deficiency of any one of these layers results in “dry eye” symptoms. When the eye is irritated or dry, the large lacrimal glands reflexively secrete large amounts of the water-like liquid (layer two), which paradoxically can result in excessive tears, even when the person’s eyeballs do not have a uniform protective three-layer tear film.

PREOPERATIVE WORK-UP

If the patient and doctor agree that the potential benefits outweigh the risks, a surgical plan is formulated. The goal is to provide maximal improvement while minimizing the risks. Sometimes, raising the eyebrows via a forehead lift (without blepharoplasty) is most appropriate. A forehead lift can be performed at the same time as blepharoplasty, or at a later date.

Patients usually are surprised at how much skin can be removed.

Important points to cover in the preoperative work-up include findings related to the above issues, family history of eyelid abnormalities, thyroid disease, tobacco use, and prior eyelid surgery. Visual acuity and eye movement is assessed. The surgeon looks for upper eyelid ptosis, symmetry of eyebrows and lids, and the position of the lacrimal glands and tear drainage puncta. Frequent blinking can be a sign of inadequate tears. Lower eyelid tone/elasticity is carefully assessed by pulling each lower lid forward and watching the speed of lid recoil; this is repeated after pulling each lower lid downward. Bulges of hypertrophic orbicularis muscle are noted, as these will be excised during the surgery.

“Festoons” of muscle that droop toward the malar/maxillary areas are also noted, as they can be improved via plication and contouring.

PROCEDURES

UPPER BLEPHAROPLASTY

The most common procedure that I perform is upper blepharoplasty with removal of excess skin and some excess orbicularis muscle. This can be accomplished in an appropriate treatment area under local anesthesia only. If the doctor is patient, knowledgeable, and methodical, the anesthetic causes very little discomfort. The amount and shape of the skin to be removed is very carefully drawn on the eyelid skin. The corner of the eye that is toward the temple is called the lateral canthus. The lateral end of the skin removal pattern usually extends 1 to 2.5 cm beyond the lateral canthus (but not as far if a forehead lift also is performed or planned).

Patients usually are surprised at how much skin can be removed. If there is not a large amount of excess fat (bulging) in the upper eyelid, this may be left alone, because there will be some fat loss with additional aging, and risks and recovery are affected by the removal of such fat.

LOWER BLEPHAROPLASTY

The lower eyelid presents a unique challenge, because if the lid were to be pulled downward by the surgery, a “staring” appearance can result. This usually means that less skin can be safely removed than the patient may desire, and even fat bag removal can cause subsequent scarring, which can also pull the eyelid inferiorly. Thus, lower eyelid fat bag removal or repositioning often is performed via an incision in the conjunctiva. This fat can

be removed, repositioned back into the orbit, or brought down over the orbital rim to fill the depression beneath the “bag.” It also is not uncommon to tighten the lower eyelid (canthoplasty) at the same time that blepharoplasty is performed. Several methods of canthoplasty are used. I most often use a technique of suturing the lateral canthal tendon upward and laterally to the periosteum of the lateral orbital rim at about the level of the upper edge of the pupil.

The recovery after blepharoplasty varies quite a bit between patients, even when similar procedures were used.

Despite appropriate care, some patients develop a sagging of the lower eyelid after lower blepharoplasty. This usually resolves spontaneously, but if necessary, there are a number of surgical options to improve this condition. After the above issues are addressed, wrinkled lower eyelid skin usually is still visible; this can be improved using a resurfacing technique, but not without all of the recovery and side-effect issues that resurfacing entails. Because of the above issues, lower blepharoplasty very often is performed under general anesthesia, which requires the use of an accredited operating room.

The addition of these prerequisites influences recovery and dramatically increases the cost.

RECOVERY

The recovery after blepharoplasty varies quite a bit between patients, even when similar procedures were used. Sutures are removed within a week (makeup can be applied after the sutures are removed). The portions of scars that extend lateral to the lateral canthus are barely visible at first, becoming more red over the first 6 to 8 weeks, and then usually fade to nearly invisible. Few patients have enough pain to warrant more than about two doses of pain medication. Some patients are not quite able to completely close their eyes for the first few days, and special care is necessary to prevent corneal drying. I prepare patients for the “worst case scenario,” which means that swelling can interfere with visual fields and bruising can last up to 3 weeks.

POSSIBLE COMPLICATIONS

In rare cases, a bruised appearance can last for a few months. In the very rare cases where blindness has occurred, it apparently has been due to bleeding that tracked posteriorly,

interfering with optic nerve function. Infection also is rare, as is corneal injury. Ptosis can occur due to separation of the levator palpebrae aponeurosis (a sheet of fascia that connects the muscle that raises the eyelid to the rim of the eyelid). This is rare, but can occur, for example, in an elderly patient with pre-existing weakness of this structure. If ptosis is present preoperatively, it is difficult to obtain perfect symmetry; thus several techniques for postoperative adjustment are described in the literature. Very often, blepharoplasty improves upon a patient’s pre-existing asymmetry, however, if some asymmetry persists for several months, a second “touch-up” procedure is easily done. Certain skin conditions, such as vascular telangiectasias, can be worsened by blepharoplasty.

This article highlights that the procedure of blepharoplasty itself is not extremely complex, but that patient evaluation and the judicious use of adjunctive procedures require some sophistication. You are now well on the way to a good understanding of the benefits and challenges of esthetic eyelid surgery. *AGD*



It is with sadness that we announce the recent death of our colleague

Dr. Thomas G. Gleghorn

of Colleyville, Texas. Dr. Gleghorn will be remembered for his contributions to the AACD and the field of cosmetic dentistry, for the uncountable smiles he restored, and for all the lives that he helped to change. Dr. Gleghorn will be missed by us all. The AACD extends its deepest sympathy to his family and friends.

