

# Upper Eyelid Blepharoplasty



Michael J. Will, MD, DDS

## KEYWORDS

• Upper eyelid blepharoplasty • Brow lifting procedure • Periorbital region

## KEY POINTS

- Upper eyelid blepharoplasty has become more conservative, where there is less excision and more emphasis on repositioning and restoring orbital anatomy and volume.
- Thorough periorbital preoperative evaluation is necessary to determine the appropriate blepharoplasty procedure with or without the need for a brow lifting procedure.
- Conservative approaches that reduce the risk of complications such as lagophthalmos should always be considered.
- Periorbital skin quality improvement and reduction of rhytids may require skin tightening or resurfacing procedures in addition to blepharoplasty as adjunctive therapy.
- Ancillary procedures such as neurotoxin or dermal filler injections may be combined with blepharoplasty techniques to provide more complete rejuvenation and a higher degree of patient satisfaction.

## Introduction

The periorbital region is one of the earliest and primary locations on the face where patients seek rejuvenation. When we interact and speak to one another, we tend to look at each other's eyes for signs of approval, understanding, and any emotional responses elicited. Therefore, the patients who are considering facial rejuvenation typically begin their quest for a more youthful appearance by pursuing periorbital cosmetic procedures. Frequently, patients state during the consultation with their cosmetic surgeon that they do not like their aging face as a whole; however, they emphasize that they would like to start by rejuvenating their eyes. If the periorbital cosmetic procedures go well and result in a high degree of patient satisfaction, the patient gains confidence in cosmetic surgery and frequently goes on to rejuvenate other cosmetic regions of the face and body.

## Anatomy of the periorbital region

The eyebrow position, shape, and form must be considered along with the eyelids and periorbital skin when evaluating this region for age-related changes and surgical rejuvenation. Cosmetic surgery of the brow and forehead will be discussed in other articles (see [Tirbod Fattahi's article, "Open Brow Lift Surgery for Facial Rejuvenation"](#) and [Jon D. Perenack's article, "The Endoscopic Brow Lift,"](#) in this issue); however, the aging brow must be given equal attention when considering cosmetic surgery of the eyelids and surrounding skin.

The upper eyelid anatomy must be clearly understood, with each layer identified when traversing through the lid to address cosmetic concerns ([Fig. 1](#)). The Caucasian eyelids should

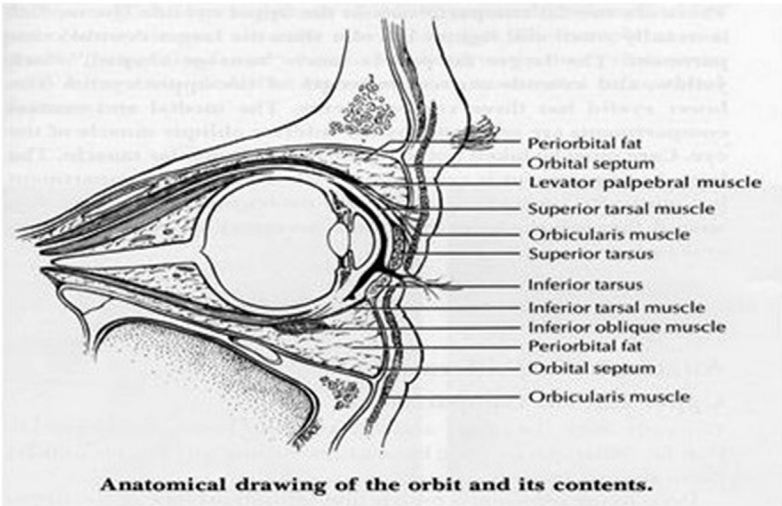
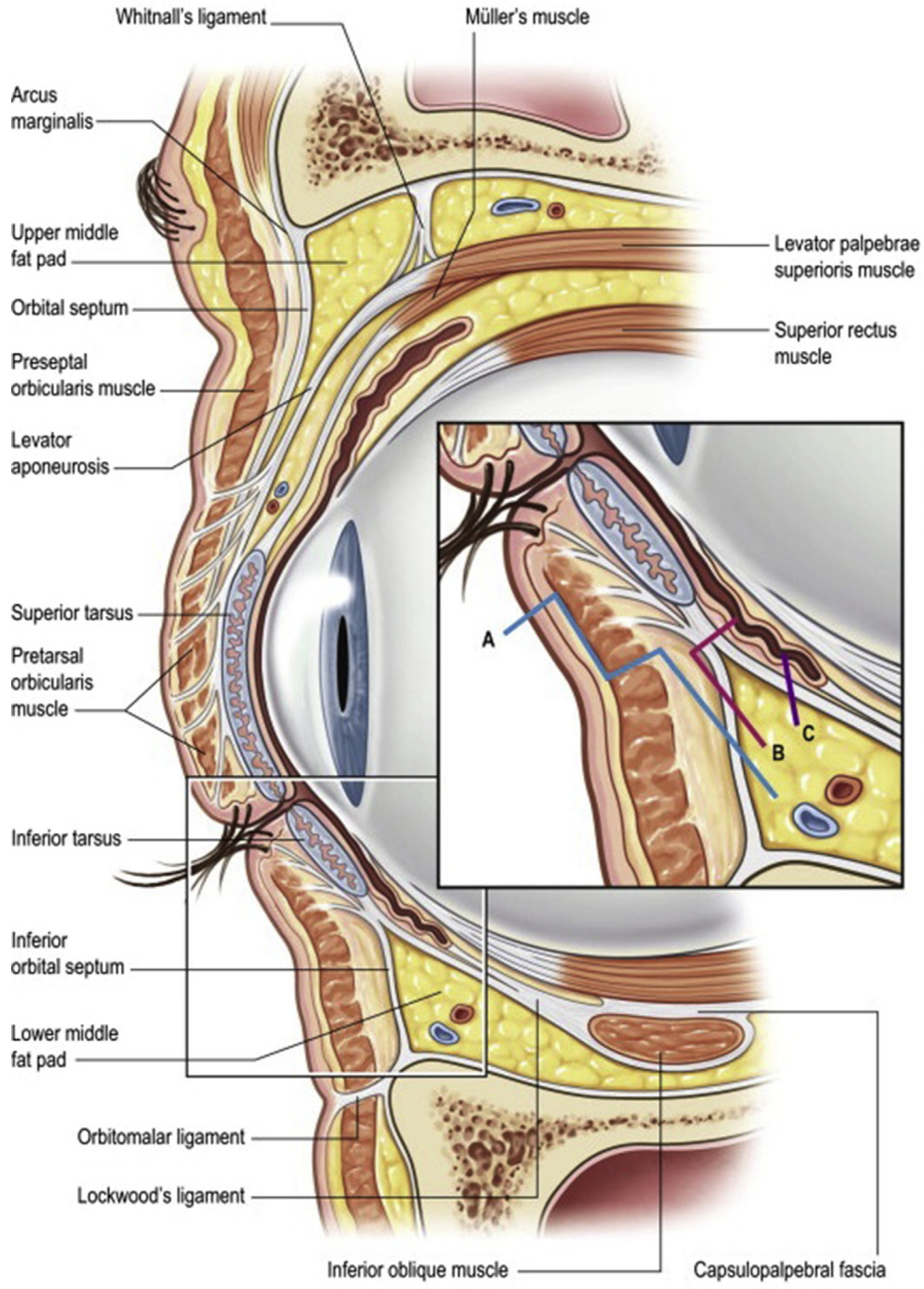
demonstrate a dominant lid crease 8 to 11 mm from the palpebral margin, and if absent with a deep upper lid sulcus, may indicate levator disinsertion and eyelid ptosis ([Figs. 2 and 3](#)). This eyelid crease in the Caucasian patient is at 8 to 11 mm from the palpebral margin and represents a line of fusion of levator aponeurosis with the tarsal plate with its concomitant dermal attachments providing the crease ([Fig. 4](#)). In the Asian eyelid, this line of fusion is below the cephalic margin of the tarsal plate, which allows some preaponeurotic fat to extend over the tarsal plate and diminish the appearance of a tarsal crease. The skin overlying the tarsal plate, which is about 8 to 10 mm in length, is considered the pretarsal skin that overlays the pretarsal orbicularis oculi muscle. The skin superior to the tarsal plate is the preseptal skin overlying the preseptal orbicularis oculi muscle ([Fig. 5](#)).<sup>1,2</sup>

Superior to the tarsal plate and just below the orbicularis oculi muscle lays the orbital septum, which originates from the periorbita and inserts into the undersurface of the tarsal plate and fuses with the levator aponeurosis. Just deep to the orbital septum lays the preaponeurotic fat that is contained in 2 compartments, the central and medial fat pads ([Fig. 6](#)). The lateral space that would contain the lateral pad, if it existed, is occupied by the lacrimal gland. The medial fat pad is typically lighter in color than the central fat pad, and the lacrimal gland is more orange in color and more vascular on its surface. Fullness of the upper eyelid is frequently due to attenuation of the orbital septum, allowing the preaponeurotic fat to bulge forward (pseudofat herniation) (see [Fig. 1](#)).<sup>2</sup>

Fullness of the eyelids can be related to endocrine disease and other systemic disorders that must be ruled out before performing blepharoplasty. Deep to the preaponeurotic fat lays the levator aponeurosis and the levator palpebrae superioris muscle. These structures must be preserved and respected during cosmetic eyelid surgery to prevent levator disinsertion and subsequent ptosis. This layer is addressed for ptosis repair surgery through levator suspension. The only

Will Surgical Arts, 3280 Urbana Pike, Suite 201, Ijamsville, MD 21754, USA

E-mail address: [drwill@willsurgicalarts.com](mailto:drwill@willsurgicalarts.com)



**Fig. 1** Cross-sectional anatomy of the eyelids with subciliary (A) and transconjunctival incision outline (B and C). (From Saadeh P. Conventional upper and lower blepharoplasty. In: Aston S, Steinbrech DS, Walden JL, editors. Aesthetic plastic surgery. St Louis (MO): Elsevier; 2012. p. 325; with permission).

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