

The Management of Festoons



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KEYWORDS

- Festoons • Oculoplasty • Facial aging • Tired eyes • Aesthetic surgery • Midface aging
- Surgical procedures

KEY POINTS

- The orbicularis retaining ligament (ORL) is the structure responsible for defining the palpebromalar groove and is a key structure in the appearance of aging of the midface.
- A major anatomic basis for the appearance of festoons seems to be the downward descent of tissues superior to a lax ORL and orbicularis muscle against the resistance of the stronger lower border, effectively creating a surface trough.
- The focus of treating festoons involves addressing the laxity of the ORL along with redistribution of muscle, skin, and fat within the lid-cheek junction to re-establish a smooth and youthful contour.
- Historically, surgical technique addressed maximizing excision of the skin-muscle responsible for the visible appearance of the festoons; currently, surgical approaches involve direct excision of the affected tissue or indirect redraping of the affected soft tissue.

INTRODUCTION

Aging of the midface and lower lid complex can be evident even in the late 30s, making this one of the earliest detectable areas of facial aging and frequently requested sites for surgical rejuvenation.¹ When present, malar festoons can complicate successful rejuvenation because they present a difficult problem to treat. Festoons occur when portions of the orbicularis oculi muscle attenuate, thereby undergoing a progressive course of sagging muscle that becomes visible to even the most casual observer.^{2,3} Beyond aesthetic concerns, severe festoons can cause visual field obscuration on downgaze, leading to difficulty with near-vision tasks.⁴ Although typically seen and referred to in the lower eyelid, because the orbicularis oculi encircles the eye, festoons can

occur in the upper or lower eyelid. Because upper eyelid festooning is uncommon and the emphasis in the literature is on lower eyelid festoons, the latter are the focus of this article.

Although a genetic basis for the etiology of festoon formation is suspected, the precise reason why some individuals are susceptible to this condition whereas others are not is largely unknown. When present, festoons can impart the appearance of being excessively tired and when more severe can be deforming, resulting in issues of self-confidence. Every effort should, therefore, be made to improve the appearance of patients with this condition to enhance self-image and social well-being. Limitations in surgical correction are, however, a genuine challenge confounded by their unclear cause.

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ANATOMY

The midface is a complex anatomic area that separates the orbital cavity from the oral cavity.⁵⁻⁸ It is often defined as the area of the cheek medial to a line extending from the frontal zygoma to the oral commissure and the medial border defined by a line extending from the medial canthus to the nasolabial fold. The midcheek is composed of 2 functionally distinct parts⁷:

1. The prezygomatic part that overlies the mid-cheek skeleton
2. The infrazygomatic part that covers the vestibule of the oral cavity

The prezygomatic area can be considered a transition zone where the skeletal attachments of the lower lid, including the ORL, are attached to the upper border of maxillary bone. The ORL (or malar septum) is the structure responsible for defining the palpebromalar groove; the junction between the preseptal portion of the lower lid and the cheek and is a key structure in the appearance of aging of the midface (Fig. 1).^{9,10} The ligament acts as a functional and structural barrier defining the lower extent of several clinical entities, including malar mounds, malar edema, periorbital ecchymosis, and malar festoons.¹⁰

Patients presenting for periorbital rejuvenation commonly complain of eyelid bags with a resulting tired look. The anatomic basis of eyelid bags is multifactorial, where orbital fat prolapse, eyelid fluid, tear trough depression, loss of skin elasticity, orbicularis prominence, and malar mounds and festoons can each contribute to their development.¹¹ Correct diagnosis of the cause of eyelid bags is, therefore, critical when addressing this

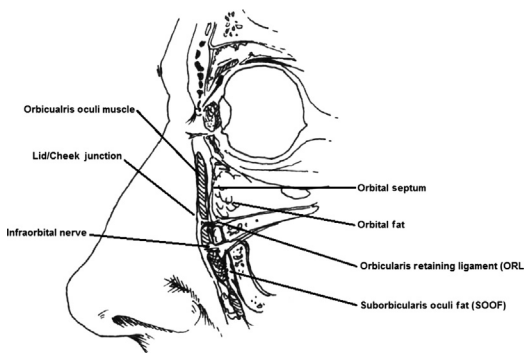


Fig. 1. Cross-sectional anatomy of the lower eyelid with graphical representation of the orbital septum, suborbicularis oculi fat (SOOF), and ORL (or malar septum). The ORL extends from the periosteum deep to the skin superficially, is responsible for defining the palpebromalar groove, and is critical in the characteristic appearance of the aged lower eyelid.

problem, with festoons one possible unique clinical entity among the possible causes.

A major anatomic basis for the appearance of festoons seems to be the downward descent of the tissues superior to a lax ORL and orbicularis muscle against the resistance of the stronger lower border, effectively creating a surface trough (Fig. 2).^{2,3,8,10} The festoon phenomenon can affect any part of the upper or lower eyelid, with 5 distinct type of festoons described. They are divided by the level of the orbicularis that they affect (Figs. 3-5):

1. Upper eyelid
2. Pretarsal
3. Preseptal
4. Orbital
5. Malar

The outward appearance of this process can differ among individuals and can range from the sagging of individual levels in a cascade of festoons with overlapping folds to the coalescence of layers together, sagging into a single festoon.³ When present in the malar region, a festoon is defined superiorly by the ORL over the previously described prezygomatic area and inferiorly by the stout zygomatico-cutaneous ligament, which is considerably stronger than the ORL.⁸ The ORL is also important because it is the inferior boundary of the inferior orbital fat compartment and provides an area of fixation against which the prolapse of fat can lead to the appearance of eyelid bags and be confused with malar festoons.^{5,9-11}

The focus of treating festoons involves addressing the laxity of the ORL along with redistribution of muscle, skin, and fat within the lid-cheek junction to re-establish a smooth and youthful contour.

EVALUATION

Prior to surgical intervention, a full examination of the periorbital and malar contents and anatomy should be performed. Patients should be evaluated with the head in neutral position, while they are either standing or sitting upright in good lighting. Examination should occur initially with the eyes at neutral gaze followed by upward and downward gaze to evaluate for any vision obstruction.⁴

During evaluation, as well as preoperative marking, the surgeon should manipulate the periorbital skin with fingers or forceps. This allows for proper diagnosis as to the level of orbicularis affected and the amount of tension in the skin. Pinching the festoon (the pinch test) allows a surgeon to judge the composition of the festoon (skin muscle or skin only) (see Fig. 2). A lower lid snap test should be performed as well to assure

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