

Blepharoplasty Complications Prevention and Management

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KEYWORDS

• Blepharoplasty • Complications • Eyelid • Cosmetic surgery

KEY POINTS

- Preoperative assessment and counseling of expectations is essential to avoid complications and to maximize patient satisfaction after blepharoplasty surgery.
- Photograph the patient before surgery at multiple angles to help address patient concerns if questions arise after surgery.
- Upper eyelid blepharoplasty markings should take into account the patient's natural eyelid crease, desired crease placement, and ethnic background.
- Eyelid fullness is a sign of youth; avoid excessive resection of soft tissue.
- Become familiar with the management of all complications of surgery.
- Be cautious of the possibility of dry eye syndrome in the patient who has had previous laser in situ keratomileusis and is undergoing blepharoplasty.
- Avoid the temptation to intervene too early after surgery when unexpected results occur. Many imperfections resolve spontaneously.
- Blepharoplasty revisions are expected. It is important not to intervene until stability has been attained.

INTRODUCTION

Blepharoplasty is one of the most common cosmetic operations performed in the United States.¹ In addition to cosmetic improvement, patients may also benefit from functional improvement with increased field of vision and quality of life.^{2,3} As the population continues to age, the demand for both cosmetic and functional blepharoplasty will increase.

With the growth of the information age, patient expectations and desires for precise results and minimal downtime after surgery are growing. Even patients undergoing functional blepharoplasty expect a rejuvenated appearance. In essence, every patient is a cosmetic patient. However, even in the most skilled hands, delayed healing, other

complications, or unexpected results may occur. Unless properly counseled, patients may perceive normal healing (postoperative bruising and swelling) as an untoward effect; however, with the proper patient education, surgeon skill, and training, most adverse outcomes of blepharoplasty can be minimized and prevented.

It is important to recognize not only how but why complications from blepharoplasty occur. Most postoperative complications are in 1 of 4 categories:

1. Inaccurate preoperative assessment
2. Improper surgical technique
3. Miscalculations in judgment
4. Idiosyncratic outcome (unexplained complication)

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Categorizing unexpected results into 1 of these 4 groups and recalling each of them before surgery is important and helps to continually improve surgeon skills and results.

PREOPERATIVE CONSIDERATIONS

The cornerstone of any successful operation is an adequate preoperative evaluation, consisting of a patient history, examination, and medical evaluation. Patient counseling should stress expected results, normal time frame and range of wound healing response, possible unexpected results, and potential need for revision. Preoperative evaluation for blepharoplasty and brow ptosis is discussed elsewhere in this issue by Czyz and colleagues. A detailed photodocumentation of the preoperative state is an essential step in the surgery. Preoperative photographs of the eyelids and periorbita at multiple angles serve as a basis for comparison after surgery, and may help dispel patient concerns about supposed changes that were present before surgery.

INTRAOPERATIVE CONSIDERATIONS

Anesthesia

Most blepharoplasty procedures are performed under local anesthesia with or without monitored anesthesia care. General anesthesia can be used if additional facial surgery is added. Even when performed under general anesthesia, local anesthetic with vasoconstrictors is administered to aid in hemostasis. The type of anesthetic used should be individualized to each patient and according to surgeon preference.

We use a 1:1 mixture of 2% Xylocaine with epinephrine 1:100,000 and 0.75% bupivacaine. For upper eyelid blepharoplasty, we typically inject 2–4 mL per lid. Potential risks of anesthetic

injection are intravascular injection and damage to vital orbital structures (Fig. 1).⁴ Our injection technique always directs the needle away from the globe. In addition, gentle traction is applied to the upper eyelid to separate it from the globe, minimizing the risk of globe penetration (Fig. 2). To completely anesthetize the deeper nasal fat pad, we inject additional anesthetic retroseptally in this quadrant (Fig. 3).

If lower eyelid surgery is added, we typically perform surgery with monitored anesthesia care. Additional sedation is often needed during local anesthetic injection for patient comfort. It may be helpful to have an assistant steady the head during injection for added support. To decrease the risk of sneezing during administration of local anesthetic, the addition of fentanyl or alfentanil to propofol infusion has been advocated.⁵ Fifteen minutes should be allowed after injection to achieve the hemostatic effect of the epinephrine before incision.

Marking and Measuring

Marking eyelid crease

The skin marking for blepharoplasty is one of the most crucial portions of the operation. Although the technical aspect of blepharoplasty is straightforward, marking is an art. We typically mark within the patient's natural eyelid crease unless an altered lid crease is desired. If no crease or an ill-defined crease is present, our general guidelines are to mark the eyelid crease 7 to 8 mm above the lash line centrally in white men and 8 to 10 mm in white women (Fig. 4). The degree of lateral hooding, medial skin redundancy, and ethnicity also influence marking placement.^{6,7} For example, in Asian patients, the eyelid crease should be marked lower, no higher than 5 to 6 mm above the lash line in men and 6 to 7 mm in women. The crease is completed across the length of the lid, tapering medially at the

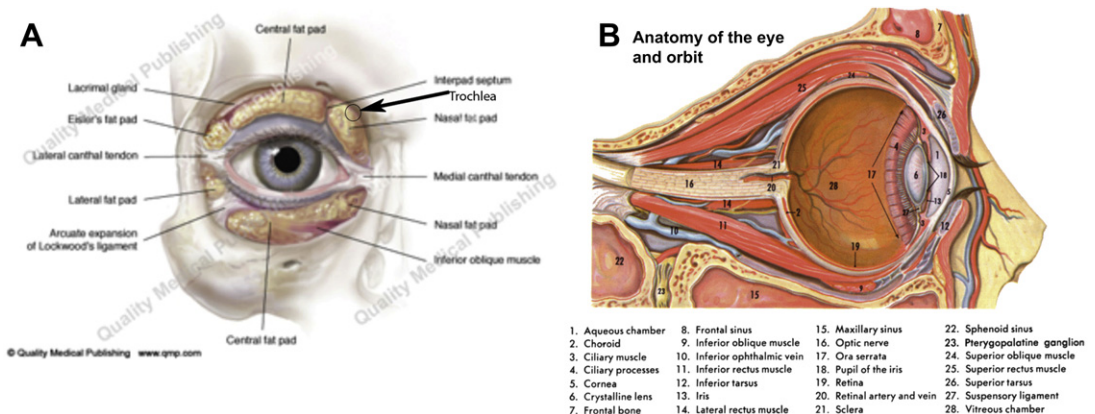


Fig. 1. Normal orbital anatomy showing location of globe and trochlea.

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