# Controversies in Facial Cosmetic Surgery

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**KEYWORDS**

• Blepharoplasty • Genioplasty • Alloplastic chin augmentation • Facial cosmetic surgery
• Controversy

**KEY POINTS**

- Facial cosmetic surgery is performed by a variety of surgeons with different surgical backgrounds.
- New facial cosmetic surgery techniques are described constantly to meet with the expectations of patients who demand less invasive procedures and less recovery time.
- Current trends in lower eyelid surgery call for periorbital fat repositioning rather than excision of fat.
- Controversies still exist in chin augmentations because some surgeons prefer to perform an osseous genioplasty and other surgeons prefer to use an alloplastic chin implant.

## INTRODUCTION

Facial cosmetic surgery techniques have been described since the early twentieth century. Every year, more contemporary techniques are described in the literature in an effort to address the limitations or to minimize the risks of more traditional facial cosmetic techniques. In addition, there are multiple surgical specialties that perform facial cosmetic surgery. Both of those factors, combined with the increased demands of facial cosmetic patients seeking the least invasive procedure with minimal recovery time that can address their chief complaint in a predictable fashion, contribute to some of the controversies. There are controversies in almost all the cosmetic surgeries that are performed in the head and neck region, but their scientific discussion is difficult because many of these surgeries are performed mainly based on the level of experience and not necessarily based on the level of scientific evidence. As an example, many facelift modifications have been described in the literature and it is fair to assume that not every facial cosmetic surgeon performs the same facelift procedure. Therefore, this article does not discuss every modification or controversy in facial cosmetic surgery but, instead, 2 topics in facial cosmetic surgery of which every oral and maxillofacial surgeon should be aware.

## LOWER BLEPHAROPLASTY: TO TAKE OUT PERIORBITAL FAT OR TO REPOSITION IT?

For many years, facial cosmetic surgeons have searched for the best, most reliable, and predictable technique that provides aesthetic rejuvenation of the lower eyelid and its transition to the cheek (Fig. 1). The traditional treatment of bulging lower eyelid fat has been resection of fat.[1] However, new trends are pointing toward decreasing the removal of tissue and favoring tissue repositioning,[2–10] but it is still controversial because each surgical technique comes with several advantages and disadvantages.

When evaluating a patient for lower eyelid surgery, the preoperative evaluation should include a careful examination of the patient's medical history and ophthalmic history, along with a visual examination. It should also take into account the position of the eyebrow, the presence of upper eyelid ptosis, lower eyelid margin position, and the projection of the cheek. Upper eyelid surgery in which skin is removed and medial orbital fat is excised is a procedure that is reliable and has

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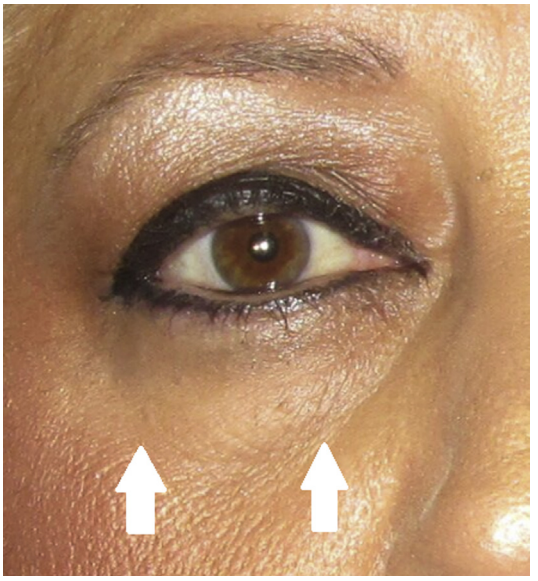

**Fig. 1.** The tear trough deformity, also known as the nasojugal groove, is the natural depression that extends inferolaterally from the medial canthus of the eye (*white arrows*). Laterally, it demarcates the lid-cheek junction.

consistent results. Lower eyelid blepharoplasty is a bit more controversial.

One of the reasons why the topic is thought to be controversial is because healing after lower eyelid surgery can be unpredictable in nature. This has allowed some surgeons to adopt a more conservative approach to lower blepharoplasty.

In 1995, Hamra[10] described the release of the arcus marginalis to reposition the herniated fat pads over the entire orbital rim by securing it to the periosteum. In 2000, Goldberg[7] described repositioning the fat in a subperiosteal plane to decrease the change of a visible demarcation. In 2003, Kawamoto and Bradley[11] suggested there was better filling of the nasojugal groove when the fat was repositioned in a supraperiosteal plane.

Other less invasive approaches to ablate the tear trough deformity have been described. Coleman[12,13] described fat grafting the periorbital area to camouflage the defect and Trepsat[14] described a combination of periorbital fat grafting and transconjunctival blepharoplasty (Fig. 2A).

Several surgeons consider resection of the excess skin if a skin pinch test with forceps warrants it. This is performed via a subciliary incision. A more aggressive technique involves a skin-muscle flap in which the skin and the underlying orbicularis oculi muscle fibers are excised. At that point, the periorbital fat can be excised via small incisions in the septum. This, however, may lead to lower eyelid malposition and muscle denervation due to violation of the middle lamella, a complication known as ectropion (Fig. 3).

The main aesthetic concerns that are addressed with a lower blepharoplasty include pseudoherniation of periorbital fat, excess skin, and a certain degree of skin laxity. A good technique that can be used in younger individuals with minimal skin laxity is a transconjunctival approach that allows fat excision via a retroseptal dissection, which has the advantage of keeping the middle lamella intact (Fig. 4). The skin can then be treated with either laser skin resurfacing or a chemical peel and fat grafting of the cheek to allow for a smooth transition at the tear trough region. As previously mentioned, lower eyelid excess skin can also be addressed with a conservative pinch excision rather than laser resurfacing or a chemical peel (1–2 coats of 30% trichloroacetic acid). The

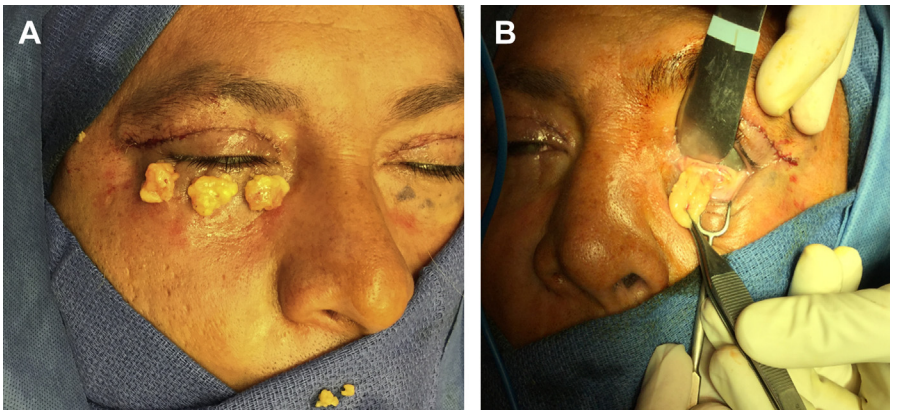


**Fig. 2.** Transconjunctival blepharoplasty with periorbital fat excision (*A*) versus a transconjunctival blepharoplasty showing medial fat pat repositioning over the arcus marginalis (*B*). (*Courtesy of* Angelo Cuzalina, MD, DDS, Tulsa Surgical Arts, Tulsa, Oklahoma, USA.)