

Contemporary blepharoplasty: less can be more

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Response to: Hantash BM, Gladstone HB. An algorithm and review of blepharoplasty and canthopexy. *Expert Rev. Dermatol.* 5(4), 479–487 (2010).

The paper by Hantash and Gladstone ‘An algorithm and review of blepharoplasty and canthopexy’, does an excellent job reviewing the key aspects of common blepharoplasty procedures and canthopexy.

I certainly agree with the authors that less has become more in blepharoplasty and contemporary surgeons have become less aggressive, especially with regards to fat removal. Although many techniques and trends have come and gone with blepharoplasty, most surgeons obtain good results with traditional skin, muscle and fat removal in the upper lids and transconjunctival lower blepharoplasty with ancillary lower-lid skin tightening. Blepharoplasty is in reality a simple procedure, but one with many nuisances that can make or break the result. There is no doubt that blepharoplasty is more about what the surgeon leaves than what he or she removes.

I also agree that lower subciliary skin/muscle approaches can be fraught with lower-lid malposition problems, and feel that this is related to middle lamellar contraction from scarring of the incised lower orbital septum and, as the authors point out, orbicularis involvement. It appears that even previous staunch supporters of subciliary approaches are now moving away from this technique. I have also been told that some recent lawsuits have had plaintiff experts that say the pre-septal orbicularis (especially in the lateral canthal region) should never be incised and removed, and to do so is malpractice.

The transconjunctival approach to lower blepharoplasty is retroseptal and for this reason does not produce septal scarring.

The authors are correct that the lateral lower fat pad is the one most frequently undertreated by surgeons. With experience and persistence, this should be a minimal problem. Extending the incision all the way to the lateral canthus, and persistence using a small forcep in the lateral orbit while tenting the skin with a skin hook, will locate the pad.

Using the transconjunctival approach does require the use of adjunct techniques to address the lower eyelid skin. In my practice, I address this with CO₂ laser, 30% trichloroacetic acid chemical peel and lower skin pinch, in that order. I feel the CO₂ laser produces the best result, but has the most formidable recovery. I generally perform two, high-fluence, high-density laser passes without debriding between passes. Unlike the authors of the Hantash and Gladstone paper, I do not use closed dressings and use only open wound care with Aquaphor or Vaseline®. This makes the postoperative care much easier and palatable for the patient and family.

On the subject of canthopexy, this is a hugely important part of blepharoplasty, and all seasoned blepharoplasty surgeons should have some form of canthopexy in their armamentarium. Lower-lid malposition with scleral show, canthal rounding and ectropion can be a crippling deformity, functionally and aesthetically. The best

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way to avoid this complication is to carefully screen patients with the snap and pull tests, as described by Hantash and Gladstone. Another means of evaluating lower lid laxity is to pull the lid laterally. In the normal lid the punctum should not pull past the medial limbus. In the lax lid, the punctum can easily be pulled much further laterally. In any event, an ounce of prevention is worth a pound of cure. Novice surgeons should completely avoid operating on patients with loose lids. This is a great opportunity to forge a reciprocal relationship with an oculoplastic surgeon. By referring patients, they are more likely to assist when needed.

I disagree with the thought that all lower lid procedures should be accompanied by canthopexy, but can appreciate that some do require it and there is no easier time to perform this procedure than at the time of surgery.

I have personally experienced lower-lid malposition from overzealous skin excision with the subciliary approach or skin pinch, as well as chemical peel and laser. Therefore, it can happen with various modalities. Many patients will return to normal spontaneously, especially with skin resurfacing procedures, but stretching exercises can be extremely dramatic in the first 6 weeks after the surgery. Patients can stretch upper or lower lids for 10 s, ten times a day. I have had patients with lower-lid malposition that I was sure would require surgery, and got them back to normal with stretching.

As to which type of procedure to perform to tighten the lid, Hantash and Gladstone cover that well. Obviously, the suture suspension techniques are frequently and more easily performed. Canthal strip procedures or other similar techniques that involve inferior cantholysis are more technique-intensive and require a higher level of expertise. Regardless, if you can't perform the technique, someone else can. Personally, I perform only simple canthopexy where I capture the junction of the lateral tarsus and medial tendon with a 5-0 Vicryl suture with a P-2 needle and attach it 5–10 mm in the lateral orbit to the periosteum. This must be carried out at a level superior to the canthus to pull it posteriorly and superiorly. As mentioned by the authors, over-tightening of this sling can produce a 'Santa's belt' effect, where the lid is pulled under the globe.

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