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ABOUT COVER

Peer Reviewer of *World Journal of Clinical Cases*, Suman Baral, MD, Assistant Professor, Department of Surgery, Mediplus Hospital and Trauma Center, Pokhara 33700, Nepal. brylsuman.sur@gmail.com

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EDITORIAL

Practical surgical tips on performing upper blepharoplasty

Sunny Chi Lik Au

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Abstract

Upper lid blepharoplasty is a surgical procedure that requires meticulous planning and execution. It is not a standalone procedure but can be combined with ptosis correction surgery. Prior to surgery, thorough lid examinations are essential to determine the appropriate approaches. Skin markings for incision sites should be drawn before anesthesia injection to avoid distortion of lid wrinkles and creases. The design of the lid crease is crucial, with a nasal tapered crease serving as a guide for subsequent parallel crease drawings. Incisions should be made with care to avoid excessive bleeding, particularly from the orbicularis muscles. It is important to control bleeding promptly to prevent secondary ptosis during the early post-operative period. When releasing the orbital septum, care should be taken to avoid injury to surrounding structures, particularly the trochlea nasally and the lacrimal gland laterally. Moist cotton tip applicators can be used to safely separate fat from the underlying aponeurosis.

Key Words: Blepharoplasty; Plastic surgery; Ophthalmology; Eye; Eyelids

Core Tip: Upper lid blepharoplasty is a surgical procedure that requires meticulous planning and execution. Prior to surgery, thorough lid examinations are essential to determine the appropriate approaches. Incisions should be made with care to avoid excessive bleeding, particularly from the orbicularis muscles. It is important to control bleeding promptly to prevent secondary ptosis during the early post-operative period.

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INTRODUCTION

Dermatochalasis is one of the most prevalent lid conditions among the elderly populations. Upper lid blepharoplasty can serve the purposes for cosmetic improvement, as well as visual field widening in severe cases. We read with interest the systematic reviews titled "Fat management in upper blepharoplasty: Addition or subtraction blepharoplasties, how and when"[1]. Miotti *et al*[1] discussed many important points on performing upper blepharoplasty from the systematic review of literature from the decade of 2013 to 2023. Here in this editorial, more additional practical tips on performing upper blepharoplasty would be shared by the authors.

PATIENT SELECTION

Upper lid blepharoplasty alone could not correct ptosis, but could be combined with ptosis correction surgery. Therefore, thorough lid examinations before surgical planning on which procedures to perform are essential before rushing into the operation room. Good candidates for blepharoplasty are individuals with stabilized drooping eyelids that affect their appearance, visual field, or vision for driving or computer work. Caution is advised for patients with thyroid orbitopathy or idiopathic orbital inflammatory disease. Generally, orbital decompression surgery is usually performed first, followed by strabismus surgery, and then lid surgery. Dry eye patients should be evaluated before deciding on blepharoplasty, and ideal patients should have realistic expectations about the results of the surgery. Selecting patients for blepharoplasty involves a thorough evaluation to ensure they are suitable candidates for the procedure.

SURGICAL PLANNING

Before the start of upper blepharoplasty, skin markings with marking pen for the intentional incision sites should be drawn first before the injection of anesthesia. Any anesthesia solution, no matter how concentrated it is, would swell up the lid wrinkles and creases, and mislead the surgeon's contour judgement. For upper blepharoplasty, there is always an unconscious tendency to converge the parallel lid crease markings towards the medial canthal angle. Therefore, better to start the skin drawings from nasally to create a nasal tapered crease. This would then be a visual guide on drawing the subsequent parallel crease towards the temporal side. Remember, the lower line of incision would be the new crease line post-operatively[2]. From our experience, medial lid crease post-blepharoplasty does not flare upward excessively away from the medial canthus, whereas the lateral one usually does. Therefore, laterally the crease design should not transverse past the lateral canthal angle[3]. Minimal volume of anesthesia solution as required for pain control is suggested. Too large the volume of fluid injected would cause tissue and anatomy distortion, and surgical plane dissection would be difficult subsequently.

INCISIONS

Oozing from skin and fat are usually limited, yet bleeding from orbicularis muscles are profound. Stabilize the tarsal plate with the overlying soft tissues and skin to make a continuous incision. Right-handed surgeons are more familiar with incising the skin from left to right continuously. Thus, for one sitting at the head of the surgical table, surgeons would be more comfortable to start incising the right upper lid medially, and left upper lid *via* the lateral tip. As Miotti *et al*[1] mentioned in his systematic review, latest trend of upper blepharoplasty is on removing adipose tissue only. Never incise too deep beyond the fat to touch the orbicularis muscles. Bleeding will immediately obscure the operative field. For any bleeding seen, best control them with bipolar diathermy to minimize tissue swelling or hematoma formation, which would distort incision line and tissue planes for distinguishing orbital septum from levator aponeurosis along the superior tarsal border. Also, be meticulous with bleeding control, one should control each new bleeder as soon as it arises, rather than cutting off the whole strip and going back to control the bleeder. Occult bleeding may accumulate under the skin level and causes secondary ptosis during early post-operative period, though usually transient.

When going to either side of the horizontal release of the orbital septum, be careful of injury to the surrounding structures, particularly the trochlea nasally and the lacrimal gland laterally. Always tilt the tips of the scissors upward to avoid the vessels within the fat pads or the levator aponeurosis. If monopolar diathermy is used instead of scissors, do not cauterize excessively towards the ends which could result in post-operative forth nerve palsy or torsional diplopia if the superior oblique trochlea complex are injured[4]; or dry eyes if the lacrimal glands are destroyed[5]. Moist cotton tip applicators are often the good and safe tools to separate fat from the underlying aponeurosis, without much bleeding.

FAT IN UPPER BLEPHAROPLASTY

For the fat management part in upper blepharoplasty, the systematic review by Miotti *et al*[1] has already covered the pearls on the cosmetic, grafting and volume manipulation. Few included articles in the systematic review are discussing on Asian upper blepharoplasty, which is slightly different from Caucasian ones, particularly over lid crease creation and

epicanthal fold adjustment. Miotti *et al*[1] well written systematic review also covered the upper blepharoplasty post-operative considerations and rejuvenation issue.

POST-OPERATIVE CARE

The journey of blepharoplasty does not end when patients step out of the operating room, post-operative care is crucial for a smooth recovery after lid surgery. Applying cold compresses for first few days reduces swelling and bruising around the surgical site. Keeping the head elevated, and sleeping with high pillows at night also helps. Daily wound dressing gently with sterile solutions and gauze should be practiced, along with the application of combined antibiotic and steroid ointment after cleaning the wound. Attending follow-up appointments with the surgeons to monitor healing and scar formation is essential. Surgeons will decide on the sutures removal date to achieve optimal results after blepharoplasty.

Last but not least, in Miotti *et al*[1] article, there was a typo in Figure 1's top box of left column: "Records identified from databases", which *n* should be 146 instead of 16. Also, there should be 3 more reports that were excluded but without mentioning of reasons in the preferred reporting items for systematic reviews and meta-analyses flow chart.

CONCLUSION

Upper lid blepharoplasty is a surgical procedure that requires meticulous planning and execution. Prior to surgery, thorough lid examinations are essential to determine the appropriate approaches. Incisions should be made with care to avoid excessive bleeding, particularly from the orbicularis muscles. It is important to control bleeding promptly to prevent secondary ptosis during the early post-operative period.

FOOTNOTES

Author contributions: Au SCL designed the research, acquired the data, performed the analysis and interpretation of data, drafted and revised the article; the author read and approved the final version of the manuscript to be published.

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