

**PROCEDURAL OPTIONS IN COSMETIC
BLEPHAROPLASTY**
**A Logical Approach to Intraoperative Decision
Making**

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ABSTRACT

A logical system of surgical alternatives during cosmetic blepharoplasty is presented. In addition, several innovative techniques which are deemed particularly efficacious are described. These include reconstruction of the supratarsal crease and a new, minimally invasive technique for removing herniated periorbital fat- Transseptal Lipolytic Diathermy. This procedure is found to be exceptionally efficient and predictable while at the same time obviating many of the complications associated with fat excision during aesthetic blepharoplasty.

Key Words: Blepharoplasty; Supratarsal crease; Transseptal Lipolytic Diathermy.

INTRODUCTION

The complete aesthetic blepharoplasty is an operation devised to remove redundant eyelid skin, excess “herniated” orbital fat, hypertrophic orbicularis oculi muscle and surplus soft tissues. A surgeon should consider the blepharoplasty as a series of discrete steps, each one designed to eliminate a component of the overall pathology. These steps are envisioned as a continuous flow of options that are selected at precise points during surgery. A logical series of maneuvers results in minimal complications and superior results.

This article outlines currently accepted methods of performing the cosmetic blepharoplasty and reports several innovative techniques which are particularly efficacious. It is not the intention of the authors to review the multiple techniques reported in the literature. The substance of the article reveals the authors’ approach to the intraoperative decision making process necessary to complete a safe and effective blepharoplasty.

REALISTIC PROCEDURAL GOALS

The primary goal of aesthetic blepharoplasty is the attainment of a youthful, natural eye. The physiologic effect of enhanced superior peripheral vision is secondarily obtained in some patients. The cosmetic blepharoplasty operation is a series of interrelated steps, each with its own intrinsically defined limitations. The surgeon cannot expect to ameliorate defects that are not within the realistic scope of the operation. Misinterpretation of this tenet will result in failure. To insure a result that is mutually satisfactory to the patient and the surgeon, the limitations of the procedure must be comprehended.

Figure 1 depicts a 20-year-old patient with both youthful and natural characteristics. The eyebrows frame the prominent superior orbital rim. There is a slight fullness of soft tissue just inferior to the rim. The skin overlying the superior sulcus flows gently into a well-defined supratarsal fold, extending the full intercanthal distance. The supratarsal fold roughly parallels the upper ciliary margin with a gently curving contour and with minimal yet noticeable skin slightly overlying the crease. This conformation remains distinct because there is no redundancy of skin, muscle or septum, and no "herniation" of periorbital fat. The medial extend of the supratarsal crease is deep and well-defined, but diminishes gradually as the skin approaches the nasal bridge and the medial canthal angle.

Inferiorly, there is fine wrinkling of the pretarsal skin, which is intrinsic to the dermis and is considered natural. Laterally, the skin is smooth with no discernible "crow's feet." The pretarsal orbicularis muscle is flat, with no orbicularis oculi muscular hypertrophy. The eyelids are not ptotic or retracted. The superior sulcus is not sunken. Animated expressions normally cause the eyes to wrinkle laterally and inferiorly; maintenance of these characteristics is desired.

To surgically obtain the youthful, natural eye, the three basic potentially pathologic components-skin, muscle, orbital fat and septum-must be evaluated in each patient. When planning the surgery, it is best to regionalize the pathology to the upper and lower eyelids, nasal or temporal, and then subcharacterize each of the above entities that

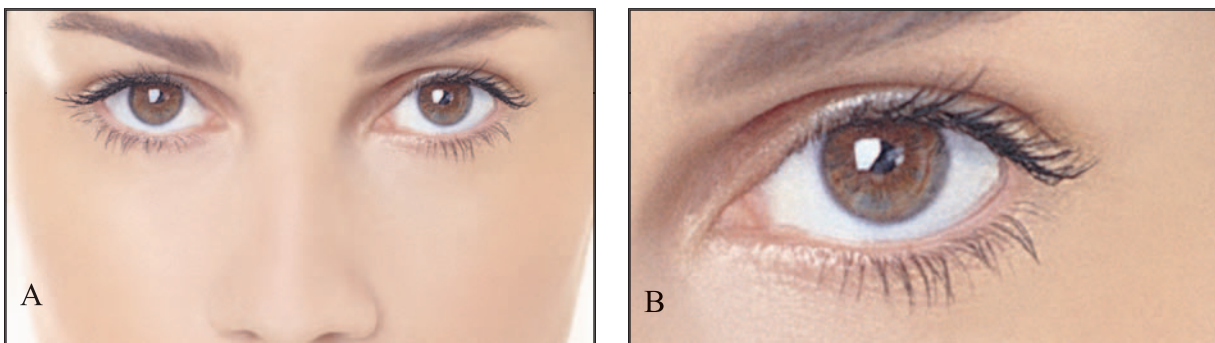


FIGURE 1. (A) Unoperated 20-year-old patient exhibiting youthful yet natural characteristics; (B) Close-up view.

are present. Blepharochalasis and dermatochalasis are generally descriptive terms but are not localizing. Any combinations of these three factors can exist in each individual patient. Thus, one must examine each eyelid for excess skin, hypertrophied muscle, herniated fat or attenuated orbital septum. These entities may cause a blunting of the supratarsal fold or obscure the crease entirely, which connotes a tired, sad expression. The brow is prudently observed, as well as the overall nature of the superior orbital rim. Brow ptosis may cause temporal hooding of the upper lids.

In the lower lid intrinsic wrinkling of the skin must be identified and pointed out to the patient. These fine lines may be handled postoperatively by chemabrasion; if correction is attempted by stretching the lower lid skin excessively, an ectropion may result. Orbicularis oculi hypertrophy will be visualized as a horizontally oriented linear or sausage-shaped protuberance just below the cilia.

Herniated periorbital fat can usually be separated inferiorly into three compartments. Lateral "crow's feet" can partially be eliminated by routine blepharoplasty procedures; however, chemabrasion or ancillary techniques performed with an associated face lift may be necessary. Hyper- or hypopigmentation intrinsic to the skin will never be helped by cosmetic blepharoplasty; this should be definitively explained to the patient. Fat deposits on the malar eminences (secondary bags or festoons) can be removed at the same time as the initial procedure with a technique that will be described below. Finally, ptosis of the lacrimal gland, which can simulate an upper lateral fat pad, should be noted preoperatively. The essence of natural expression must be maintained. The operated eye that exhibits youthful characteristics but is overly conspicuous, is by definition an unsuccessful result.

TECHNIQUE

While meticulousness, not speed, is the essence of blepharoplasty, efficiency will shorten operating time and decrease patient discomfort. Injecting the lids with a solution containing 1:200,000 of epinephrine 15 minutes before incision and operating on two lids simultaneously, moving from one to the other and back, will enhance hemostasis.

We have found the following operational flow helpful. Each step is followed by packing the wound with damp sterile gauze or weck cell sponges soaked in 0.1% adrenaline, and then directing the surgeon's attention to the next operative site.

Mark upperlids;	Suture lower lids.Incise right lower lid;
Inject upperlids;	Incise left lower lid;
Resect skin/muscle right upper lid;	Resect fat right lower lid;
Resect skin/muscle left upper lid;	Resect fat left lower lid;
Resect fat right upper lid;	Trim skin/muscle right lower lid;
Resect fat left upper lid;	Trim skin/muscle left lower lid;
Inject lower lids;	Suture lower lids.
Suture upper lids;	

Upper Lid Skin

Methylene blue is utilized to outline incisions before local anesthesia is injected. Preferred anesthetic infiltration is Xylocaine 2% with 1:200,000 epinephrine, on a 30-gauge needle. Direct placement of the anesthetic solution in the subdermal plane simplifies dissection. The ballooning effect of the anesthesia in the upper lid causes tension on the skin, facilitating the creation of an exact incision line.

To appropriately handle the incision and closure of the upper lid skin, the characteristics of its intrinsic thickness must be appreciated. The superior aspect of the upper eyelid skin is considerably thicker than that near the tarsal plate. Figure 2 illustrates the basic incisions with modifications for excising upper lid skin. The inferior extent of the incision is placed in the supratarsal crease just above the tarsal plate, which is readily identified as the patient looks upward. The superior extent is determined by the amount of redundant tissue that can be grasped, causing the lashes to evert slightly.

Pinch techniques that use a clamp to grasp upper lid skin should probably not be used. The technique is traumatic and leaves "dog ears" at either end of the incision which must be secondarily trimmed. It is far better to design a careful incision which obviates this secondary reconstruction. It is also unnecessary and imprudent to traumatize lid skin unnecessarily.

Figure 2 (A, B, C) shows the medial canthal alterations necessary when significant hooding exists in this area. Note that the incision should never extend onto the nasal skin, since this invites webbing. This postoperative complication is readily visible and quite resistant to secondary reconstructive techniques. Instead, the modifications as illustrated should be employed to obviate the necessity of cutting into nasal skin. The incision can, with great care, be extended medial to the puncta up to the nasal skin if needed.

Figure 2 (D, E, F) shows incision modifications which can be outlined to enhance the lateral aspect of the eyelid and correct lateral redundancy to the skin. It is important to appreciate at this juncture the contribution of the eyebrow region to lateral hooding, and note that a certain percentage of patients may indeed need an eyebrow lift as a separate adjunctive procedure to completely improve this aspect of the pathology. It would be an error to excise additional skin in this region when the primary pathologic entity is eyebrow ptosis and not excess upper eyelid skin. This misinterpretation would result in a further inferior pull of the eyebrow, compounding the original deformity.

Upper Lid Muscle

The concept that upper lid orbicularis muscle should be surgically resected is relatively new. The rationale behind this logic is primarily to obtain a significantly

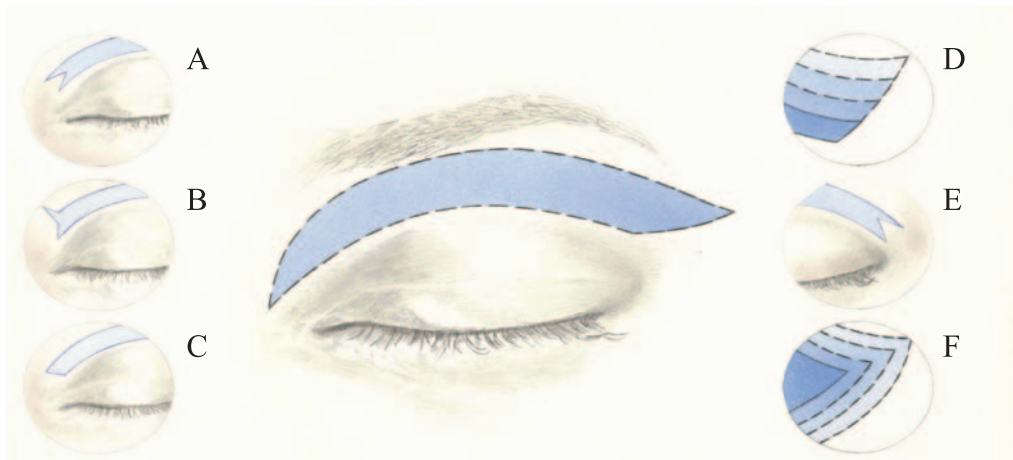


FIGURE 2. Upper lid skin incisions: Medial Modification. (A) Z-Plasty for excess medial skin; (B) Burrow's triangle; (C) Basic oblique incision to decrease of webbing. Lateral Modifications. (D) Extended wing incisions for superior hooding; (E) W-plasty; (F) Extended incisions for ameliorating lateral excess skin.

more defined supratarsal crease, and secondarily to allow effective suturing of the skin with a minimum of tension. The basic technique is to first resect skin and then excise a 2-3 mm strip of muscle in the region of the supratarsal fold.

Upper Lid Fat

Upper lid fat is identified in two separate areas: a large sausage shaped middle fat pad, and a more rounded medially placed fat pad which is usually quite deep. Excision of the medial fat pad is necessary to recreate the medial extension of the supratarsal crease. As opposed to the lower lid, it is difficult to remove too much upper lid fat.

Routinely, fat excision is accomplished by placing gentle pressure on the globe, incising the septum and gently teasing the delicate septae off the fat, allowing it to prolapse. The base of the fat pad is then clamped, cut and cauterized. It is imperative to obtain excellent hemostasis before the fat is allowed to retract deeply back into the orbit. A new alternative technique is described separately under transseptal lipolytic diathermy, which, in our opinion, is the preferred procedure in most instances.

Supratarsal Crease Reconstruction

The clean, youthful effect of the well-defined and properly situated supratarsal crease is widely accepted. The recreation of this structure in the caucasian eyelid is necessary for obtaining consistently excellent results. The actual creation of the crease in the non-caucasian eyelid is a separate consideration and deals instead with the westernization of the Oriental eyelid.

It should be noted that the crease in cosmetic blepharoplasty is really not constructed; it is simply exposed and accentuated by removing the tissues obscuring the natural crease—the excess skin, muscle and herniated orbital fat. The supratarsal crease, at the level of the superior border of the tarsal plate, is created by the anterior expansions of the levator aponeurosis, which attach to the pretarsal and preseptal orbicularis muscles as well as the overlying skin.

There has been a multitude of techniques described to recreate a youthful crease. Flowers and Sheen [1,2] have employed techniques of approximating the eyelid skin to various portions of the levator aponeurosis and the superior tarsal plate. This “anchor” blepharoplasty, however, was deemed unnecessary by Baker [3] and Rees [4], who accomplished the same results by an excision of the orbicularis oculi muscle and primary skin to skin suturing. We have substantiated Rees’ results, and, in addition, feel that suture fixation may cause unnatural distortion.

The technique found to be consistently efficacious combines the excision of an appropriate amount of upper eyelid skin with orbicularis oculi muscle in one layer, thereby quickly exposing the septum and the herniated fat (Figure 3). The fat is then appropriately handled, preferably by the transseptal lipolytic diathermy technique (described separately), which causes an infolding of the soft tissues and the septum, and helps form the supratarsal crease. The orbicularis oculi muscle is then welded together with the portable cautery (Figure 4), further emphasizing the crease. The welding technique sets up controlled scarring at the incision line of the orbicularis, which causes adherence of the overlying skin at the exact point of the crease, immediately above the tarsal plate. The result is a clean, distinct appropriately situated supratarsal crease. The skin is then closed in a routine manner.

Upper Lid Closure

Three important factors are operative in closure of the upper lid skin defect. The first is that the skin at the inferior portion of the wound is much thinner than at the superior edge and must be superficially advanced while suturing to gain a precise approximation. The second element relates to the intrinsic nature of the upper lid skin to heal quickly, which allows rapid epithelialization along suture tracks, causing cyst formation. The cysts often form medial to the lateral canthus if the sutures are left longer than three days. The third factor is that more tension exists at the suture line lateral to the lateral canthus, thus requiring certain additional considerations outlined below.

The preferred suture technique (Figure 5) is designed to effectively handle the above factors. It is simply an intradermal running 6-0 prolene stitch which runs the length of the incision, reinforced with 6-0 nylon interrupted stitches lateral to the

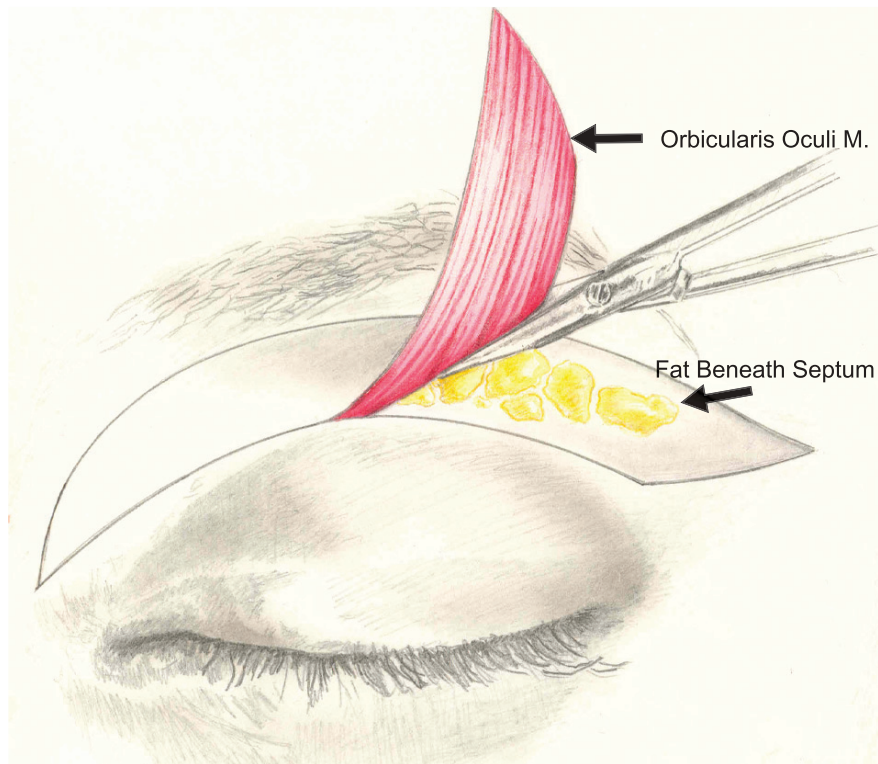


FIGURE 3. Technique of skin-muscle excision in one layer.

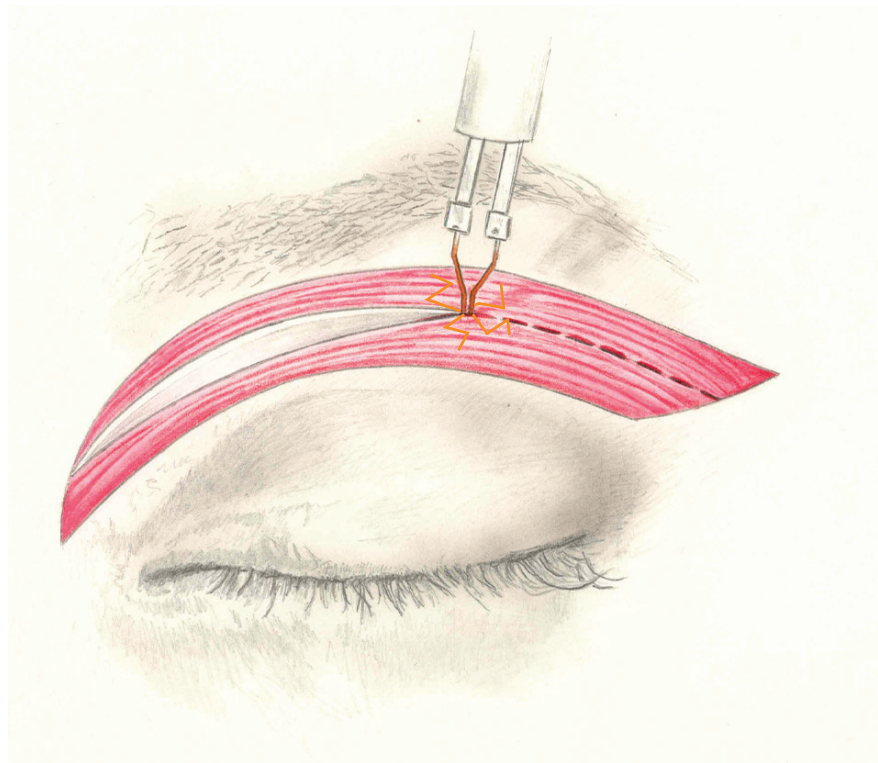


FIGURE 4. Portable cautery "welding" orbicularis oculi muscle this maintaining its functional integrity, and setting up a controlled scar in the exact location of the recreated STF.

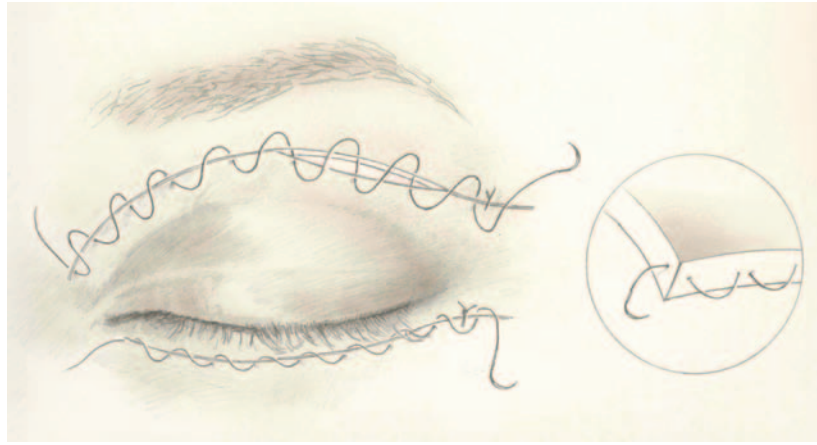


FIGURE 5. Skin closure technique (upper and lower lids).

lateral canthus. The intradermal stitch allows for a precise level of approximation and minimal potential for cyst formation. On the second postoperative day, the prolene is cut flush with the skin at its medial entrance so that cysts do not have a chance to form. On the fifth day, the lateral end of the prolene suture is pulled out and the interrupted stiches are removed. Steri-strips are occasionally needed laterally if excess tension still exists at this time.

Upper Lid-Preferred Technique

The preferred technique is outlined below and is deemed most efficient and predictable. The incisions are appropriately marked with methylene blue and infiltrated in a plane below the orbicular occult muscle. The scalpel is beveled outward, by slightly rotating the blade approximately 200 from the vertical, incising skin and muscle in one layer. A scissor then excises this sandwich of tissue in one maneuver (Figure 3). Note that the width of the orbicularis muscle and skin excised is identical. Hemostasis is assured with portable cautery, which has been found to be more efficient than microtip bipolar forceps. The fat is now readily visible and is cauterized as described under transseptal lipolytic diathermy. Orbicularis muscle is then “welded” (Figure 4), and the skin is closed (Figure 5). The series of steps just described only relates to the general flow of surgical technique and in no way compromises the exacting judgement, which must always be incorporated at every level of the operation.

Lower Lid Incisions

Lower lid incisions should be placed in the immediate subciliary area and extend laterally as far as necessary for adequate flap advancement. It is important that the lateral limb of the incision be exactly horizontal and preferably be situated in a natural skin crease line. This produces less tension and distortion than incision lines with a slight vertical inclination. A scalpel is utilized laterally and a curved iris scissors completes the incision medially. We have found that almost imperceptible

scars are routinely evident when the incision is located just anterior to the cilia.

Figure 6 illustrates the various modifications of the incision which can be used for exact trimming. Figure 6A depicts a medial advancement modification. Figure 6B demonstrates in the use of a Burrow's triangle temporally to correct lateral redundancy. Figure 6C shows a multiple Z-plasty technique incorporating the upper and lower lid incisions for lateral laxity and temporal loading; and Figure 6D shows the importance of lateral undermining so that the skin or skin muscle flap can be adequately repositioned, resulting in minimal tension and excellent healing.

Lower Lid Flaps

The choice of flaps for lower lid blepharoplasty depends upon the existing deformity. When a combination of redundant skin and muscle is evident, or there is prolapsed fat without excess skin, then a skin muscle flap is advisable. This flap affords excellent exposure of the septum and prolapsed fat, a thick cushion of tissue to tamponade the operative bed and reduce postoperative edema, and an vascular plane for dissection. The direct visualization of the fat allows complete control of fat contouring and excision.

If there is minimal muscle excess and the skin is particularly wrinkled, then a skin flap is performed. If a significant disparity exists between the amount of muscle and skin, then separate skin and muscle flaps are raised and each component is trimmed and tailored separately, permitting a precise closure [5] (Figure 7).

Lower Lid Fat

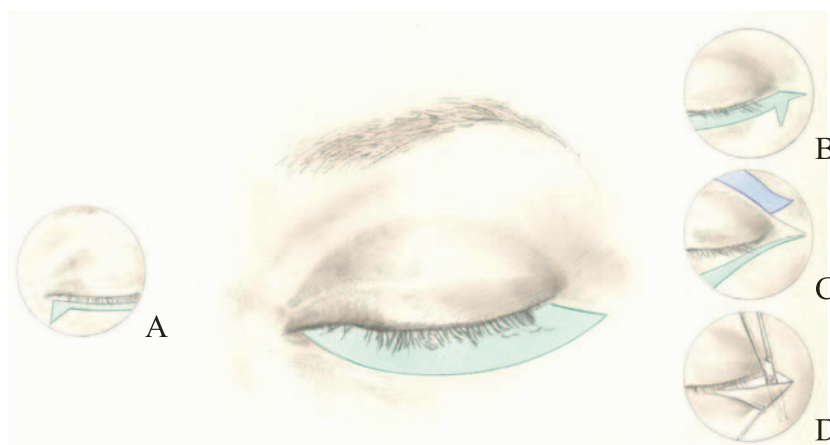


FIGURE 6. Lower lid incisions with medial and lateral modifications. (A) A Burrow's triangle used to trim medial excess; (B) A Burrow's triangle used to resect temporal redundancy; (C) Incorporating upper and lower lid incision into a Z-plasty to raise the lateral canthus and correct lateral lower lid redundancy; (D) Undermining the temporal aspect of the lower lid to facilitate wound closure.

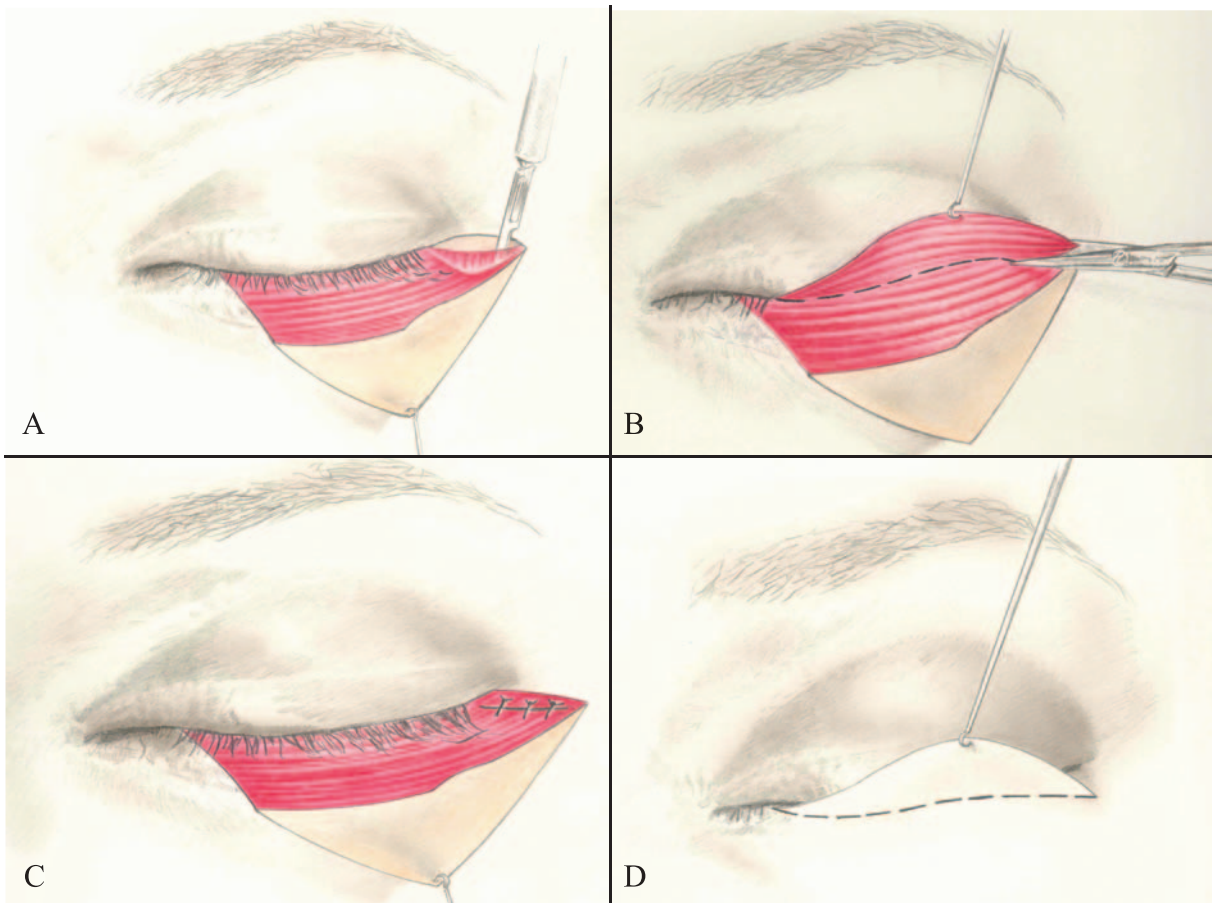


FIGURE 7. Separate skin and muscle flap used when significant quantitative disparity exists between skin and muscle pathology. (A) Skin flap raised primarily, followed by muscle flap; (B) Muscle trimmed; (C) Muscle flap sutured (periosteal suture may be used if deemed necessary); (D) Skin trimmed.

Lower lid fat herniates in 3 separate regions corresponding to the anatomical fat pads situated medially, laterally and in the midline. The principal concept operative in lower lid fat removal is that the natural eye is not sunken or cadaver-like in appearance, but blends gently with the mid-facial structures. Excessive fat removal is to be avoided as it is extremely difficult to secondarily correct. It is for this reason that the skin muscle flap is preferentially used, so that direct visualization of fat and controlled removal is easily accomplished. Removing fat transmuscularly under a skin flap is less predictable. The fat is removed by the same technique as described for upper lid fat removal.

Lower Lid Skin-Muscle Excision

Figure 8 illustrates a technique to trim excess skin and muscle, which, when performed precisely, prevents ectropion or inferior scleral show. Gentle digital pressure is placed on the globe and the patient is asked to open his mouth and look upward. The skin is then pulled in a directly superior direction, and straight iris scissors are used to resect the skin where it overlaps the incision. A stitch of 6-0

nylon is used at the base of the two triangles at the lateral canthal angle to secure the skin or skin muscle flap superiorly; the excess tissue is trimmed. The lateral flap is then resected appropriately and secured.

In general, slightly more muscle than skin should be excised to allow for accurate closure at the subciliary incision line. A slight beveling of the scissors will accomplish this task quite adequately. When truly hypertrophic muscle exists, simple excision is preferable to plication techniques that tend to accentuate the deformity. If the lid margin appears redundant or lax, there should be no hesitation to perform a wedge or pentagonal resection (Figure 9), or a lateral tarsal strip procedure [6], at the same time.

Lower Lid Closure

Secure lower lid closure is dependent upon the realization that the lateral aspects of the incision must bear more tension. A subcuticular intradermal stitch similar to that applied superiorly is also used for the lower lid, and interrupted stitches of 6-0 nylon are fixed laterally. There is no need for medial stitches, and the temporal sequence of removal is identical to the upper lid (Figure 5). Adjunctive taping is appropriate in the area of the inferior flap; this decreases edema and tends to stabilize the wound, allowing better adherence of the flap to deep structures and a decreased incidence of postoperative ectropion. The suture lines themselves should be protected with either a Bacitracin Ophthalmic Ointment or "Aeroplast" liquid dressing, which seals the incision line. Iced gauze is placed immediately on the eyes and is continued for approximately 24 hours to increase comfort and decrease postoperative edema.

Lacrimal Gland Ptosis

Bulging of the upper lateral aspect of the eyelid can be caused by a prolapsed lacrimal gland. Palpation may differentiate it from orbital fat. Occasionally a ptotic gland is encountered intraoperatively, and must be appropriately handled at that time. The gland can be identified by differentiating its gray, firm lobulated structure from the more diffuse, soft, yellow, temporal fat pad. Once diagnosed, a simple procedure for resuspension of the ptotic gland into the lacrimal gland fossa of the frontal bone is accomplished by two or three 6-0 nylon or Mersilene sutures placed anteriorly at the edge of the gland substance and into the periosteum behind the superior orbital rim. Suturing in a mattress fashion will secure the gland quite adequately, and when tightened, will aid in contouring the upper eyelid. Partial excision of the lacrimal gland should be avoided due to decreased tear production and a danger of postoperative dry eye syndrome.

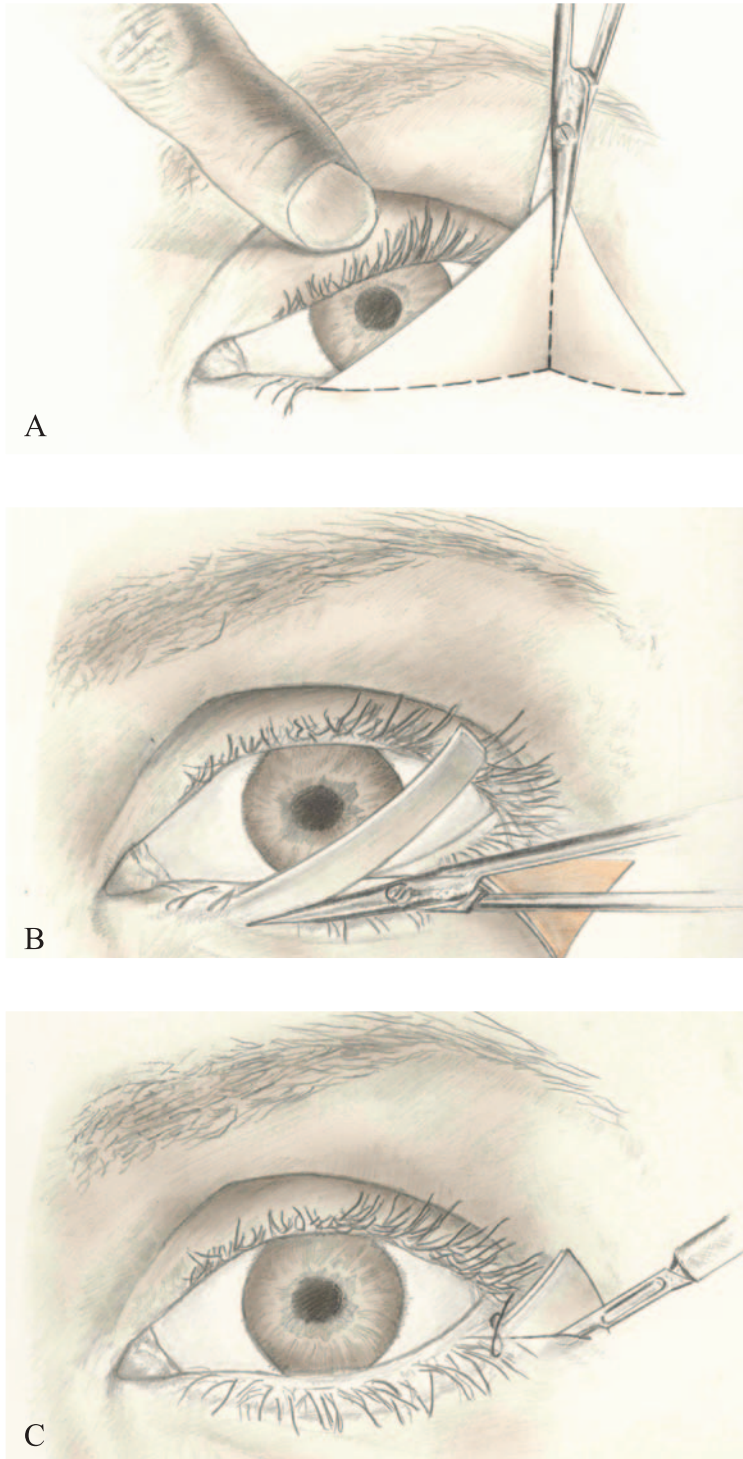


FIGURE 8. (A), (B), (C) Technique of skin or skin-muscle trimming

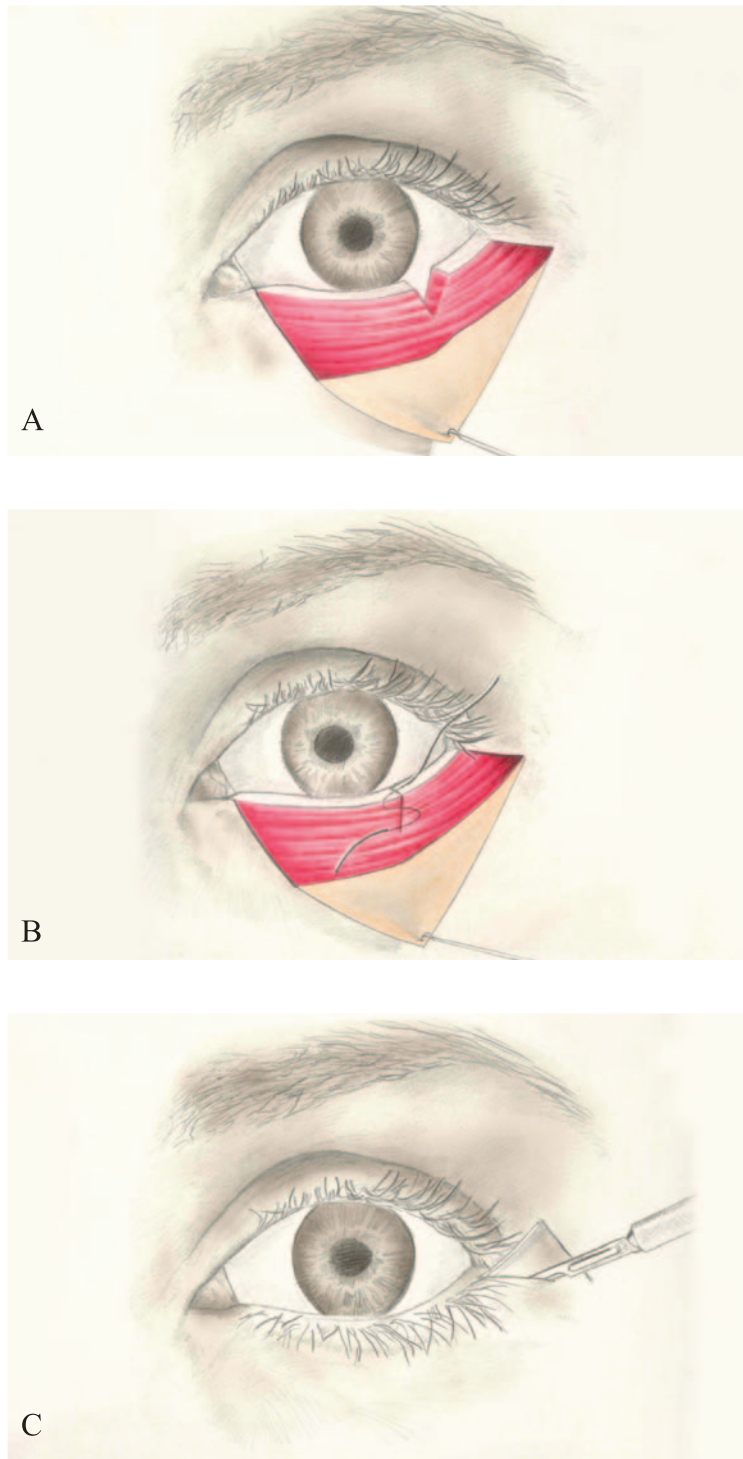


FIGURE 9. Wedge resection performed concomitantly with lower lid blepharoplasty. (A) Wedge resection of tarsus; (B) Reapproximation of tarsus with pull through suture of 5-0 prolene and lid margin with interrupted sutures; (C) Closure of skin flap over resected area to obviate local scar (note that skin-muscle flap is also closed in the same manner).

Transseptal Lipolytic Diathermy (TLD)

The removal of "herniated" periorbital fat is a fundamental component of most blepharoplasty procedures. Various techniques for accomplishing this goal have been reviewed, and are, in general, highly effective, safe and predictable. There are, however, certain limitations and associated complications which can occur using the techniques described; these complications are essentially obviated by the transseptal lipolytic diathermy technique described here for the first time.

This technique has been used successfully in over 30 patients during the past three years. The main impetus for its development was the desire to overcome the necessity for dissecting and excising fat. This part of the technique is associated with many of the untoward results of cosmetic blepharoplasty, which, if eliminated, would significantly increase the safety of the procedure.

When excising fat in the upper lid, the levator aponeurosis, as well as the superior oblique muscle, located just lateral to the medial fat pad, are at risk. Minimizing dissection of these two fat pads would prevent postoperative ptosis from inadvertent levator injury, and diplopia on downward gaze from injury to the superior oblique muscle. Similarly, lower lid fat excision risks injury to the inferior oblique causing possible upward gaze diplopia. In a general sense, however, fat excision necessitates dissection in a subseptal plane with the inherent danger of uncontrolled hemorrhage causing retrobulbar hematoma and possible blindness. There are valid data which suggest that the relatively rare but disastrous complication of blindness associated with aesthetic blepharoplasty always includes septal manipulation, by either deep orbital injection or fat excision by routine techniques [6].

TECHNIQUE

The technical aspects of the transseptal lipolytic diathermy procedure are direct, safe and predictable. Figure 10 illustrates the technique, which includes isolating the fat in the lower lid under a skin-muscle flap. The fat pockets are visualized by gentle pressure on the globe, and a 30-gauge stainless steel needle is inserted into the fat pocket and cauterized. The cautery is adjusted to obtain liquefaction necrosis of the fat and simultaneous scarring of the overlying septum. The technique is applied to all subsequent fat pads, taking care to manipulate the needle so that the direction of insertion assures maximal contact with the major substance of the fat pad. This allows for more efficient and controlled cauterization. Inferiorly, a skin muscle flap is utilized for excellent exposure of the fat pockets, and direct viewing of the fat necrosis; this insures excellent control of the inferior lid contouring. We recognize the fact

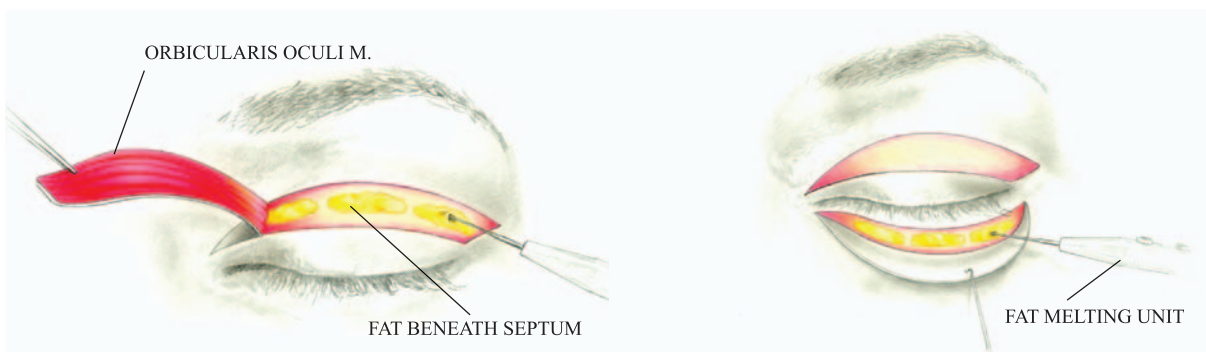


FIGURE 10. Technique of Transseptal Lipolytic Diathermy.

that the septum is still being entered. However, we feel that a 30-gauge needle is minimally invasive and unlikely to puncture a subseptal vessel. If, however, a vessel is punctured, certainly it will be controlled by the almost immediate cauterization which follows the puncture.

The advantages of the technique are obvious and will undoubtedly minimize the postoperative complications described above. In addition, we feel that reherniation will be prevented by the concomitant reinforcement of the septum, caused by a controlled burn and subsequent scar formation. The concept of true herniation versus pseudo-herniation is still in dispute with two opposing etiologic theories. Most surgeons feel that orbital fat, analogous to an inguinal hernia, exerts pressure on an attenuated septum, which eventually allows the fat to balloon out. Putterman et al. [7] feel that a true hernia exists between the rim of the septum and levator aponeurosis in the upper lid, between the rim of the septum and the capsulopalpebral fascia in the lower lid. In reality, a combination of these two theories may exist in any individual case.

At this point in time, direct visualization of the fat is advised, thus necessitating a skin muscle flap inferiorly and a partial excision of muscle superiorly. Future developments of this technique include the use of an intrinsically insulated bipolar needle which could be used transcutaneously or transmuscularly to reach the fat and then effect the cauterization. This would be particularly valuable in cases of congenital fat herniation in the very young age group where prominent fat pockets are the only deformity and there is no need for revision of muscle or skin. This future technique would also allow for a bipolar cauterization to take place, thus decreasing theoretical potential danger for injury to the orbital structures via direct current passing through the orbit. Figure 11 reveals photographic documentation of the technique's efficacy. Photos enlarged from a 16mm movie to illustrate sequential elimination of the inferior, middle and medial at pads. Figure 12 reveals a 2-year post-op result following the use of the technique on the lower lids of a 45-year-old female.

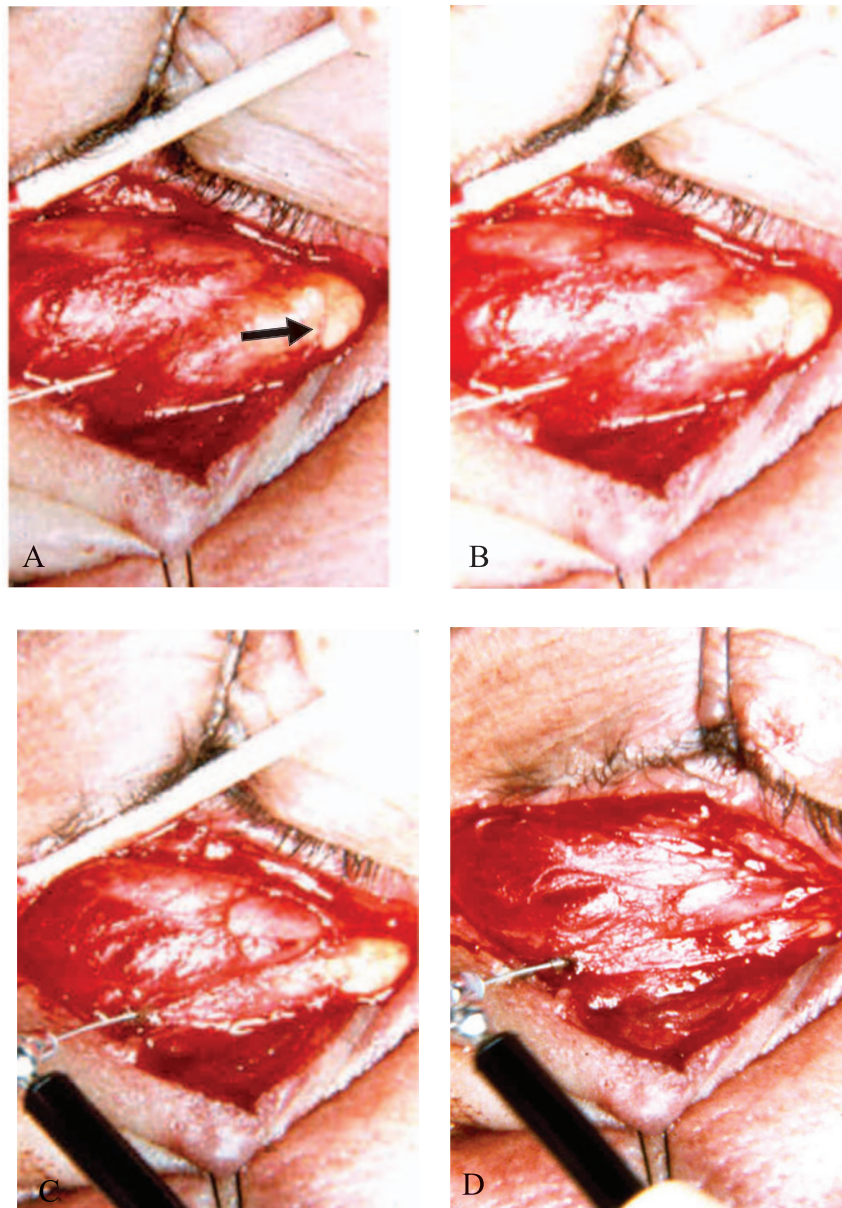


FIGURE 11. Enlargements of Transseptal Lipolytic Diathermy technique made from 16mm movie film. (A) Arrow points to lower lid fat herniation; (B) Fat melting middle fat pad. (C) Continuation (D) Operative bed with no fat visible.

Additionally, TLD has been used successfully to remove the fat pads overlying the malar eminence exists, a separate incision overlying the bulge is recommended so that exact skin tailoring can be executed.

CONCLUSIONS

A logical operative philosophy for aesthetic blepharoplasty has been presented. The successful technique requires a balanced series of alternative maneuvers that match the presenting pathology. Preconceived operative steps performed as a routine should not be encouraged. Realistic expectations based on age, sex, skin character and facial contour must be operative. A surgeon who exceeds the limitations of the procedure¹⁵

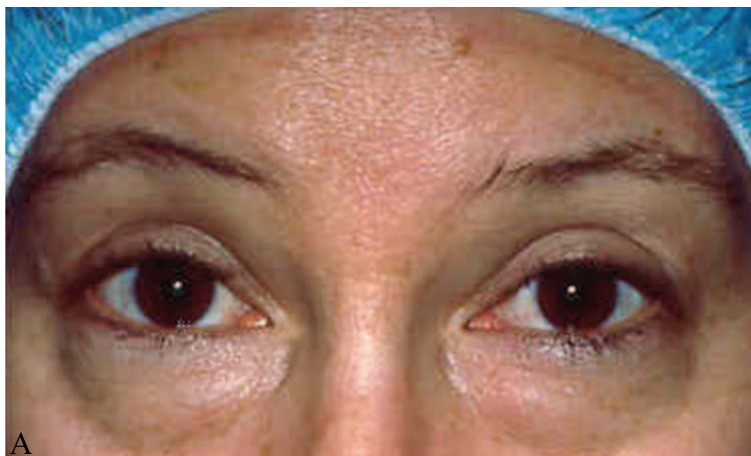


FIGURE 12. 45-year-old white female treated for lower lid fat herniation with transseptal lipolytic diathermy. (A) Preoperative; (B) 3 months postoperative.

risks complications and poor results. A conspicuously appearing operative eye must be avoided. Adherence to the above outlined principles and willingness to rethink the operative procedure each time it is performed will result in a natural, youthful eye and a satisfied patient (Figure 13).



FIGURE 13. 46-year-old white female treated with completed blepharoplasty utilizing preferred techniques described in text. (A) Pre-operative; (B) 6 months postoperative; note natural expression.

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