



Eyelid Surgery: Blepharoplasty



Eyelid Plasty (Blepharoplasty)

“The eyes are the windows of the soul”.

You may see tiredness or fatigue in your eyes, or people may ask you too often whether you are tired.

You may have excess skin of your upper eyelids or weakness of the upper lid muscle (ptosis).

Our eyes are vital to our sense of who we are and small alterations can make large differences. Any procedure must leave you still looking like your **self** or there will be problems. There is much discussion among plastic surgeons as to the best approaches to rejuvenating the eyes.

Anatomy: What the Plastic Surgeon sees:

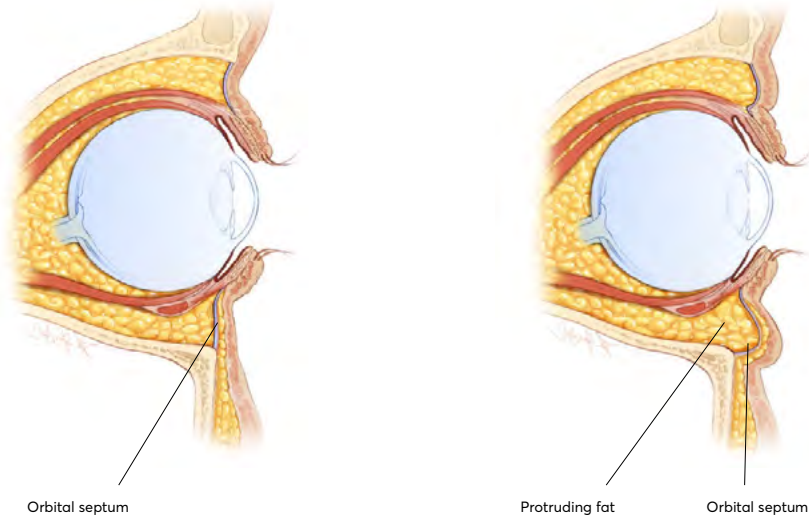
Skin Excess of the upper lid skin may hang over the eyelids and even rest on the eyelashes. In some people, it may partially obstruct peripheral vision. When that happens insurance may cover part of the cost.

When the forehead and brow droop, the upper lid is crowded by the brow, and there appears to be more excess skin than there actually is. See Brow lift page [\(link\)](#).

There is usually much less excess skin in the lower lids. Removal of too much skin from the lower lids used to be one of the main reasons people looked strange after cosmetic surgery.

Protruding fat, and **prominent fat** The eye floats in the eye "socket" in a cushion of fat cells. This fat is held in place by a thin membrane which acts as a retaining wall. The "orbital septum", as it is known, runs from the lower lid to the rim of the cheek bone and from the upper lid to the brow.

Muscles that move the eye pass from the back of the eye socket (the orbit) through the fat and attach to eye. The Levator muscle also passes through this layer and attaches to the eyelid. It acts to raise the eyelid. The optic nerve and other nerves are also found in this space. All these structures are surrounded by orbital fat.



Cross section diagramme of the eye and eye socket (orbit). On the left the Orbital septum is firm. On the right the septum and the fat behind it are sagging forming a bulge under the lower lid.



The diagrammes above show a common appearance of bulging fat and skin excess, in a late 60's age man. The typical locations of fat "pockets" is seen in the middle and the result after surgery of both upper and lower lids on the right.

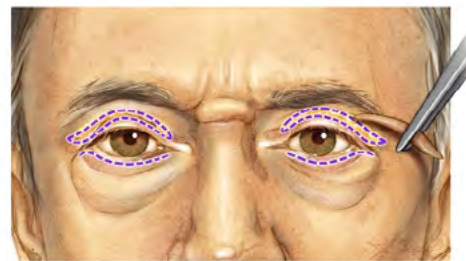
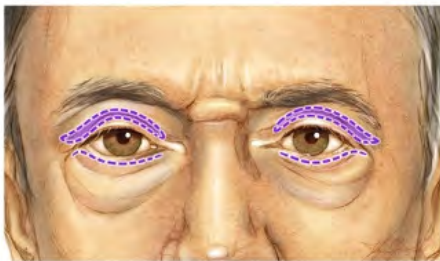
Sometimes people as young as in their teens or early 20's have fat beginning to bulge into the skin of the lower eyelids. This is usually familial. We also see this above the upper eyelid.

As people age, sometimes it is the shrinkage of everything around the eye and loss of both fat and bone that makes the eyelid seem to bulge with fat. We now believe reducing fat must be done conservatively. Selective fat grafting is also often needed to treat the aging face.

Technical Details

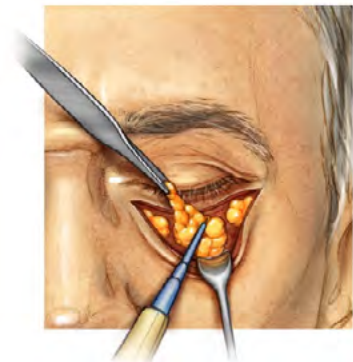
Upper eyelids

- Incisions are marked out and skin excess estimated (attention is paid to how much of this is actually forehead sag)
- Local anaesthesia, local with sedation (twilight) or general anaesthesia
- Removal of excess skin
- Shifting, adding or removing fat
- (Occasionally) tightening or shortening the levator muscle which opens the eye for "ptosis" or droop repair
- Often combined with facelift, brow/forehead lift or other procedures



Lower lids

- Incisions may run just under the lashes (trans-cutaneous, sub-ciliary) and out past the outer corner of the eye OR may be internal, inside the lid (*transconjunctival*)
- Excess skin is trimmed along the incision under the lashes
- Bulging fat is dealt with in many different ways
 - Traditionally by removal
 - Shifting it (transposition) onto the rim of the cheekbone
 - Returning it into the original position and repairing the septum
- Possible fat grafting
- Support of the lower lid corner (*canthopexy* stitch)





It is uncommon to have a lot of excess skin to the lower eyelids and attempts to **lift** the lower eyelid by means of trimming skin can pull the eyelid down. To help prevent this, whenever we use through-the-skin techniques, an internal supportive stitch is done (canthopexy). This may have a temporary effect of making the eyes look "oriental", but this only lasts a few weeks and the benefits of preventing problems are worthwhile.

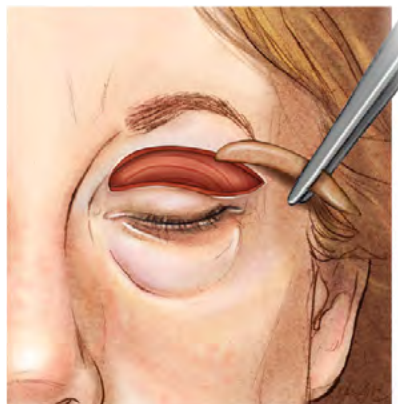
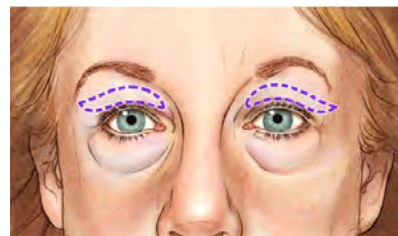
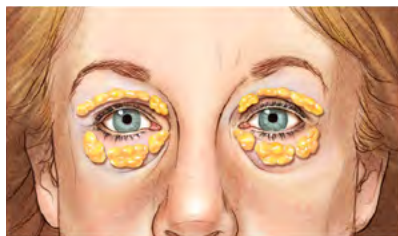
Fat conservation techniques

Many surgeons now believe that excess removal of fat may lead to a rather hollow and operated look in later years. New techniques involving the traditional external incision but with repair and repositioning of the fat pockets, have been developed. One way is to repair the septum's weak wall, and to put protruding fat back in place and sometimes remove some. This is a lot like a hernia repair. There are other methods used to perform lower eyelidplasty and conserve fat. Most commonly this involves moving the bulging fat out and onto the upper edge of the cheekbone, to fill this area.

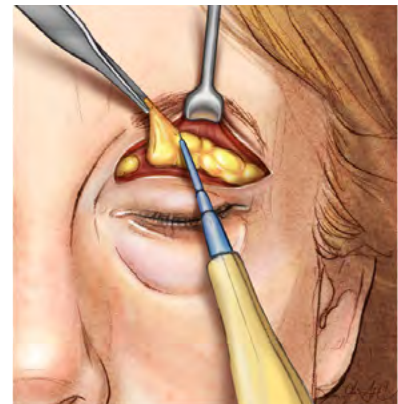
Decision making

There are many decisions in planning what is best. These include whether to remove, reposition or add fat, whether to remove skin and if so how much. These are among many factors to be assessed in any individual case. You will want to discuss your particular anatomy as well as other factors particular with your case.

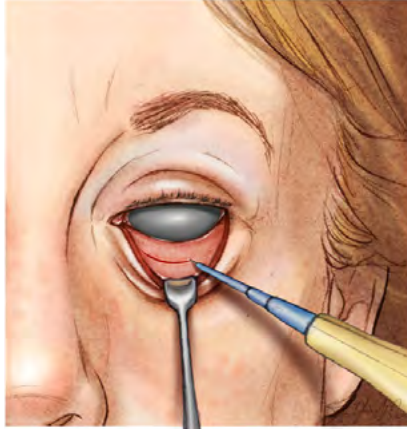
The following diagrammes show a case which was treated with skin and fat removal from the upper eyelids, followed by fat removal through the inside (trans-conjunctival) of the lower lids.



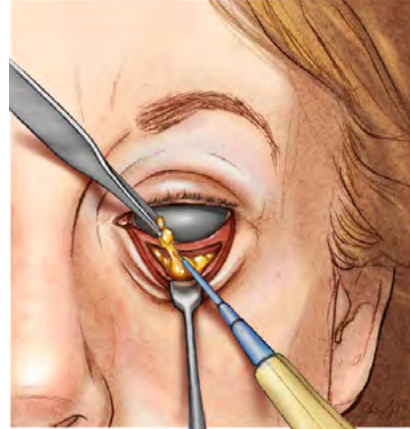
Removal of skin from upper eyelids



Excess underlying fat can now be removed



Trans-conjunctival approach to lower eyelid fat: the incision is made with an electro-surgery unit (ESU) Note gray cornea shield protects the eye



Fat is removed through the internal incision

Risks

Residual skin excess

Sometimes you will feel there is still too much skin after surgery. It is safer to remove less skin than to risk problems from excess removal. If needed, it is far safer to take out a little more skin out under local anaesthesia, several months later. This is more common for the upper eyelids, especially when a browlift is recommended but a patient has chosen not to have it done.

Infection and bleeding

As with any surgical procedure, blepharoplasty can result in infection, bleeding, and delayed healing. The risk of these occurring is very small. Generally, the risk of infection in clean, elective surgical procedures is about 1%, and that of significant post-operative bleeding is about the same. Infection and post op bleeding in eyelidplasty procedures is much lower than 1%. We avoid operating on patients with untreated high blood pressure, those with an unexplained history of bleeding, or those taking blood thinning medications including anti-inflammatories like aspirin.

Bleeding inside the eye socket is an extremely rare but very serious problem which can lead to compromise to vision and is a true emergency.

“Lower lid malposition” and “ectropion”

All lower eyelidplasty runs the risk of the lower lid getting pulled down, either because too much skin is removed or because of the forces of healing and scar formation. This can be mild with just excess white showing under the eyes or it may cause the lower lid to fall away from the eye, a condition known as ectropion. Ectropion causes problems with the way tears moisten the eye and can cause



irritation and inflammation. The affected eye looks inflamed and the appearance of the eye causes huge concern. Fortunately, with current techniques and routine canthopexy (see above) for all external approaches to lower lid blepharoplasty, ectropion has become a rare complication.

Dry eyes

The surface of our eyes is kept moist by tears. Tear coverage of the cornea diminishes as we age. When we get excess tearing outside on a windy day it actually indicates dry eyes. The eye reacts with a gush of tears and this may spill over the lower lid and run down the cheek (epiphora).

Allergies and other illnesses can also cause dryness.

Skin removal from the upper lids and changes to the function of the lower lid can cause or aggravate dryness.

Extreme dryness can lead to damage to the cornea. If you have symptoms of dry eyes, tell your doctor, in advance of surgery. Tear gel and artificial tears are helpful.

Aesthetic dissatisfaction

Perfection is rare in cosmetic surgery. It is important that you and your surgeon have similar aims for surgery, before setting out. This requires a careful evaluation of your concerns, a proper diagnosis, and a treatment plan which considers all the options with the risks and benefits taken into consideration. There is no one right way to treat the anatomical changes that contribute to your concerns.

Some degree of asymmetry prior to surgery is almost always present. It is better to know if differences exist in advance. Often one eye is smaller than the other, or higher, or on a different angle. Patients will look at their healing eyes more closely after than they ever did before surgery. There may be small areas where bulging fat is still noticeable and these may or may not improve over time. If you are striving to eliminate wrinkles and skin damage from smoking or sun, you almost certainly will be disappointed. Improvement, not elimination of these factors, should be the goal.

Some patients may benefit from skin resurfacing with laser or other techniques but these have their own risks and benefits and are best discussed with an expert in that field.

Loss of vision

There are recorded cases of vision loss with blepharoplasty. This has become virtually unknown. Pre-operative control of blood pressure, stopping all foods and medications that can have blood thinner effects, and properly planned post op care with a responsible adult have all contributed to making this dreaded complication nearly a thing of the past.



Summary

Blepharoplasty procedures are done for many reasons and in many ways.

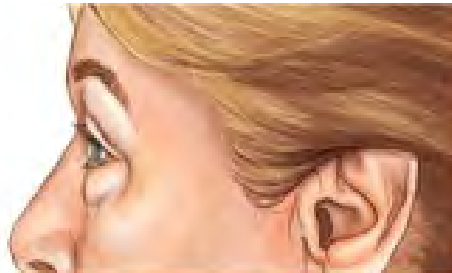
After a discussion of the many different options available, with careful planning and execution of surgery, patients and surgeons can be rewarded with truly gratifying outcomes.



Before procedure



After procedure



Before procedure



After procedure



Meet the Doctor

Benjamin Gelfant, MD FRCSC

Dr Gelfant is a member of the Canadian Society for Aesthetic (Cosmetic) Plastic Surgery (CSAPS), as well as the American Society of Plastic Surgeons (ASPS) and the American Society for Aesthetic Plastic Surgery (ASAPS).

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