Blepharoplasty Complications

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Abstract

Keywords

- blepharoplasty
- lid retraction
- orbital hemorrhage
- dry eye syndrome
- ptosis

There are three major areas of concern for a patient who has complications following a cosmetic blepharoplasty: cosmetic issues, functional issues, and uncomfortable/symptomatic issues or a combination of the above. An emphasis will be placed on avoiding cosmetic eyelid complications as well as the medical and surgical management of complications.

Eyelid Anatomy

The facial cosmetic surgeon should have a thorough understanding of the normal eyelid anatomy. Shaped like an almond, the normal upper eyelid has the highest point just nasal to the pupil with the normal brow position higher temporally (► Fig. 1). The upper eyelid has a more arched contour than the lower eyelid and the palpebral fissure, defined as the distance between the upper and lower eyelids, is ~10 mm. The typical Caucasian upper eyelid crease is at ~8 to 9 mm, where the uppermost fibers of the levator aponeurosis insert into the lamellae and subcutaneous tissue. The lateral commissure is 1 to 2 mm higher than the medial commissure with the horizontal length of the eyelids to be 30 mm. The lower eyelid margin rests in apposition along the entire length of the eye. The eyelid is divided into three lamellae: anterior, middle, and posterior lamella. Skin and orbicularis muscle make up the anterior layer, the middle lamella is comprised of the orbital septum, and the posterior lamella includes tarsus and conjunctiva.

History

A detailed preoperative medical history should be obtained as it is important to identify prospective surgical candidates who may be at an increased risk for possible complications from cosmetic eyelid surgery. A history of systemic disease, such as Graves’ disease, Sjögren’s syndrome, rheumatoid arthritis, rosacea, Bell’s palsy, and myasthenia gravis or other neuromuscular diseases should be documented and

Issue Theme Avoiding and Managing Complications in Facial Plastic Surgery; Guest Editor, Steven J. Pearlman, M.D., F.A.C.S.

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discussed at length with the patient. Any past history of ocular allergies, facial trauma, previous facial surgery including skin cancer excision, or any previous periocular procedures should also be identified and discussed.

A past history of LASIK (laser-assisted in situ keratomileusis) surgery is extremely important to obtain because these patients are at an increased risk for postoperative dry eye symptoms following cosmetic eyelid surgery. Following LASIK surgery, patients develop a transient neurotrophic keratopathy secondary to the severing of corneal nerves, which leads to a 15 to 25% chance of developing dry eyes. It is important to note that the normal corneal reflex arc is triggered by foreign body sensation or ocular irritation, which causes ocular surface desiccation leading to the subsequent blink reflex resulting in sweeping the cornea with tears. Following blepharoplasty, patients have a transient lagophthalmos, but the corneal reflex arc blinking pattern is increased to prevent or decrease dry eye symptoms. During LASIK surgery, transection of the corneal sensory nerves occurs and the normal blink reflex is blunted which results in decreased corneal sensitivity and a decreased blink rate, thus resulting in decreased tear production. Therefore, the combination of LASIK and blepharoplasty can potentially lead to a greater risk for the development of severe dry eye condition. An algorithm for the workup and possible treatment of patients with a history of prior LASIK who are planning to undergo blepharoplasty was developed by Korn et al.

**Brow/Upper Eyelid Examination**

In addition to the complete review of the patient’s history, the prospective surgical candidate should have a complete periocular examination, including the brow, lid, and cheek regions as well as the ocular surface to avoid many of the complications that can occur following cosmetic blepharoplasty. Any preoperative asymmetry should be documented and discussed with the patient. The patient should undergo a complete ocular examination including documentation of vision, pupil exam, extraocular motility, and slit-lamp examination to evaluate corneal status. Any signs of ocular surface problems, dry eye syndrome, and blepharitis or eyelid inflammation should be documented and treated preoperatively.

The diagnosis of underlying brow ptosis is important for surgical planning as patients may exhibit contraction of the frontalis muscle in an attempt to raise the brows to correct underlying upper eyelid ptosis or significant dermatochalasis. An aged, tired appearance may result as the distance between the brow and lid margin is increased from this secondary brow compensation. Assessment of the eyelid-brow complex should be made with the patient in a sitting position. Unmasking of underlying brow ptosis is accomplished by applying manual pressure to immobilize the brow region while having the patient look in primary gaze (Fig. 1). It is important to have an in-depth discussion with patients who have evidence of both brow ptosis and dermatochalasis, making certain that if the patient declines brow ptosis correction at the time of the planned blepharoplasty, then the final surgical aesthetic results may be compromised.

The examination should include documentation of the eyelid crease and position, evidence of preexisting lagophthalmos, floppy eyelid syndrome, deep superior sulcus, prolapsed lacrimal gland, and/or underlying eyelid ptosis. Evidence of eyelid ptosis is documented by the margin reflex distance (MRD1), which is defined as the distance from the corneal light reflex to the center of the upper eyelid as the patient gazes in primary position. The normal MRD1 in an adult is 1 to 2 mm below the superior corneal limbus in primary gaze (Fig. 1). Many of the above-described issues can be addressed at the time of surgery and should be included in the surgical plan.

**Lower Eyelid/Cheek Examination**

Thorough evaluation of the lower eyelid/cheek region of the face is crucial as the vast majority of cosmetic eyelid surgery

**Table 1** Cosmetic Complications

| 1. Lower lid hollowing | 7. Eyelid malposition |
| 2. Deep superior sulcus | 8. Lid retraction |
| 3. Lid crease/fold asymmetry | 9. Ptosis |
| 4. Lateral canthal dystopia | 10. Blepharitis |
| 5. Eyelid malposition | 11. Dermatochalasis |
| 6. Ptosis | 12. Malignancy |

**Table 2** Functional Complications

| 1. Dry eyes/keratopathy | 7. Lid retraction |
| 2. Tearing/ocular irritation | 8. Ptosis |
| 3. Orbital hemorrhage/hematoma | 9. Lagophthalmos |
| 5. Lagophthalmos | 11. Vascularization |
| 6. Chemosis | 12. Lid retraction |

**Figure 1** Normal almond-shaped eyelid, including normal margin reflex distance. lateral commissure 1 to 2 mm higher than medial commissure (arrow), the upper eyelid highest point just nasal to the pupil (*), and the brow position higher temporally (diamond).
complications occur following lower eyelid blepharoplasty. Secondary to aging changes associated with deflation and descent of tissues, as well as loss of elasticity of the skin, the lower eyelid/cheek junction develops an uneven contour with increased prominence of lower eyelid fat resulting in a nasojugal fold and tear trough deformity. During the preoperative examination, patients should be evaluated for lower eyelid malposition, poor maxillary bony support with a negative facial vector, and lower eyelid laxity. Hester et al reported that patients were at an increased risk for postoperative lower lid malposition if there was preoperative evidence of enophthalmic orbits and significant lower lid laxity (Table 3). Patients should also be evaluated for lagophthalmos, lower lid hollowing, stretching of the lateral canthal tendons, eyelid retraction, Bell’s phenomenon, alteration in the tear film/blink reflex, ineffectiveness of the tearing lacrimal pump, evidence of corneal exposure, eyelid or punctal ectropion, inferior scleral show, and dry eye syndrome.

It is recommended that the preoperative lower eyelid evaluation include both the distraction test and the snap-back test. During the distraction test, the eyelid is pulled anteriorly; if the distracted distance is greater than 6 to 8 mm, then there is evidence of lower lid laxity, which should be addressed intraoperatively (Fig. 3A). The snap-back test, which assesses orbicularis muscle function and the amount of lid tone, is performed by pulling the lower lid inferiorly toward the orbital rim and released. A normal test results when a fast “snap” of the lower eyelid to the proper position occurs, thus indicating normal lid tension, whereas poor snap-back test is evidence of poor lid tone (Fig. 3B). It is also important to check for any evidence of preoperative lagophthalmos by having patients passively close their eyelids as if they were sleeping (Fig. 3C).

Lower eyelid retraction, which can be a very severe complication that occurs after cosmetic lower lid blepharoplasty, is defined as inferior malposition of the lower eyelid margin without eyelid eversion. The assessment for evidence of lower eyelid retraction is made by placing upward traction on the lower eyelid, which results in the lower eyelid being raised to at least the mid pupil level under normal conditions. Evidence of lower lid retraction exists if this level is not achieved with raising the lower eyelid (Fig. 4). Lower lid retraction occurs secondary to inflammation, scarring, shortening, and cicatricial tethering of the middle and posterior lamellae.

**Management of Dry Eye Syndrome/Ocular Irritation**

Facial cosmetic surgeons must be aware of the long-term implications of eyelid surgery from both an aesthetic and functional standpoint to assure correct lid position and closure for adequate corneal protection and ocular lubrication. Ocular irritation following cosmetic eyelid surgery can occur from multiple etiologies including: dry eye syndrome, lid retraction, lower eyelid malposition, lagophthalmos, blepharitis, and alterations in the tear film and/or blink reflex. Typically, postoperative ocular irritation can be managed medically and with the tincture of time, thus avoiding any further surgical intervention. The preoperative diagnosis and treatment of dry eye syndrome is important as this diagnosis is very common, affecting up to 17% of women and up to 12% of men in the general population, with the incidence of dry eye syndrome following blepharoplasty between 8% and 21%. When obtaining the patient’s history, it is important to ascertain risk factors for dry eye syndrome, including underlying systemic disease, menopause, previous lid surgery, and history of LASIK. In addition to obtaining a complete history, patients should be assessed preoperatively for possible dry eye syndrome with a Schirmer’s test. The Schirmer strip is inserted in the lower eyelid at the lateral limbus after a topical

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**Table 3 Preoperative Identification of High-Risk Patients**

<table>
<thead>
<tr>
<th>1. Dry eye syndrome</th>
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<tr>
<td>2. Thyroid disease</td>
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<tr>
<td>3. Lower lid laxity</td>
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<tr>
<td>4. Negative vector</td>
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<tr>
<td>5. Scleral show</td>
</tr>
<tr>
<td>6. Previous facial trauma</td>
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<tr>
<td>7. Previous facial surgery</td>
</tr>
<tr>
<td>8. Psychological issues</td>
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<td>9. Unrealistic expectations</td>
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Anesthetic drop has been placed onto the eye (Fig. 5). The Schirmer strip is removed after 5 minutes with a normal value being between 10 to 15 mm of wetting. If the measurement is significantly less than 10 mm, then the patient has evidence of dry eye syndrome secondary to hyposecretion of tears. Whereas the results of Schirmer’s testing may be inconsistent at times, the test is beneficial to document evidence of severe dry eyes as this may prove to be a contraindication to upper eyelid blepharoplasty as these patients may experience worsening of their dry eye symptoms.

It is not uncommon for postoperative cosmetic blepharoplasty patients to have transient dry eye symptoms, which are typically mild in nature. Patients may note evidence of burning, dryness, stinging, foreign-body sensation, blurry vision, photophobia, itching, and redness. It should be noted that ocular surface lubrication can be influenced by both alteration of the quantitative and qualitative components of the tear film, as well as tear distribution problems secondary to a poor blink reflex mechanism. Quantitative deficiencies result from decreased tear production whereas qualitative problems are secondary to blepharitis/meibomitis affecting the mucous and lipid layers of the tear film, which leads to evaporation of the tear film.

Three components are responsible for normal tearing: production and release of tears from the lacrimal gland and accessory glands, blinking and distribution of tears, and tear pumping into the lacrimal drainage system. The importance of the action of the orbicularis oculi cannot be overemphasized as this muscle is responsible for the second two components for normal tearing. Although the preoperative diagnosis and treatment of dry eye syndrome are important, intraoperative measures such as preservation of the orbicularis oculi muscle and its innervation may allow blepharoplasty to be performed safely in patients with dry eye syndrome. With preservation of the orbicularis muscle and its innervation, the dynamics of eyelid closure, including tear pumping and tear distribution, are not affected. The importance of the preservation of the orbicularis muscle is not only important functionally, but also from a cosmetic standpoint.
Management of Orbital Hemorrhage

The most devastating complication of cosmetic eyelid surgery is an orbital hemorrhage with resulting loss of vision or even blindness. Hass et al reported the risk of orbital hemorrhage to be 1 in 2000 and the risk of orbital hemorrhage with visual loss as 1 in 10,000. Comorbidities for development of orbital hemorrhage include history of hypertension, preoperative aspirin, postoperative vomiting, and postoperative physical activity. The authors also noted an increased risk of orbital hemorrhage during the first 3 hours following blepharoplasty surgery, with the risk decreasing 24 hours after surgery.

Risk factors for orbital hemorrhage, which should be ascertained during the patient's history, include history of hypertension, medications that have antiplatelet or anticoagulant properties including homeopathic or herbal medications, history of abnormal bruising or bleeding, or any underlying disease that may contribute to bleeding. Preoperatively, patients should be provided with a list of medications, which my surgical coordinator frequently updates, that should be discontinued including coumadin, aspirin, nonsteroidal anti-inflammatory drugs, Vitamin E, omega 3 fatty acids, garlic, and other supplements or herbs with blood thinning effects (Fig. 6). Arnica montana, vitamin K, and bromelain can also be implemented preoperatively to limit postoperative edema and ecchymoses.

Intraoperatively, facial cosmetics surgeons should wait 10 to 15 minutes following the administration of the local anesthesia to allow the maximum vasoconstrictive effects of the epinephrine and should also closely control the blood pressure. Meticulous dissection of the orbital fat pads is recommended to decrease the risk of posterior orbital bleeding. Careful attention to cauterization of any pinpoint areas of bleeding from the orbicularis muscle should be completed prior to closure of the skin.

Early detection is critical for the treatment of orbital hemorrhage, therefore postoperative checking of vision is recommended and patients should be encouraged to immediately report any signs of decreased vision, diplopia, pain, or rapidly increasing edema (Table 4). Patients are instructed to avoid bending, lifting, and straining and are encouraged to sleep with their head elevated and to apply ice packs for 2 to 3 days postoperatively. If patients experience any of the previously mentioned signs/symptoms, the surgeon should examine the patient in a timely fashion for evidence of visual loss, proptosis, relative afferent pupillary defect, and/or decreased extraocular motility (Fig. 7). The surgeon's treatment goal is to decrease orbital pressure to restore blood flow to the eye. Initially, the surgeon should open the eyelid incision to identify any active bleeding sites followed by lateral canthotomy and cantholysis (Figs. 8A, 8B). It is extremely important to lyse any adhesions to the orbital rim to allow the lower eyelid to be completely mobile. Active bleeding sites should be meticulously cauterized with subsequent drainage of any hematomas. In very rare circumstances, an orbital decompression may be necessary. Once the patient is stabilized, a tapering dose of systemic steroids can be started and the patient should be referred to an ophthalmologist for assessment of retinal perfusion. If increased intraocular pressure is diagnosed, the ophthalmologist may start a treatment regimen of topical or oral glaucoma agents. The patient should then be monitored for visual acuity, pupil examination, and intraocular pressure.

Botulinum Toxin

During the preoperative consultation, it is imperative that facial cosmetic surgeons obtain the past history of administration of botulinum toxin in our prospective cosmetic eyelid surgery patients as this can affect surgical planning. The specific treated area should be documented and it also should be ascertained whether the patient will continue the use of botulinum toxin following the planned surgery. Complications secondary to botulinum toxin treatments include diplopia, lower lid ectropion, eyebrow ptosis, upper eyelid ptosis, and asymmetrical results.

The most common complication from the administration of botulinum toxin is upper eyelid ptosis, which occurs secondary to migration from periocular injection sites through the orbital septum to the levator muscle of the upper eyelid. Fortunately, the ptosis is typically mild and improves with tincture of time. For the patient who is concerned with the ptosis, the cosmetic surgeon can treat this complication with the administration of apraclonidine 0.5% or a selective α-2 adrenergic agonist, such as Naphcon (Alcon, Fort Worth, TX) or Alphagan (Allergan, Irvine, CA). The mechanism of action of these medications is the resultant effect on Mueller’s muscle to raise the lid 1 to 2 mm. These topical medications can typically be tapered after 6 to 8 weeks as the effect of the botulinum toxin will be decreased at that time frame.
The facial cosmetic surgeon can also utilize botulinum toxin preoperatively to augment surgical results, such as in treating the brow depressors (corrugators, procerus, and lateral orbicularis oculi) 1 to 2 weeks prior to a planned endoscopic brow lift to decrease the action of the brow depressors during the postoperative period. The treatment of brow asymmetry can also be accomplished by the selective administration of botulinum toxin in the brow elevators (frontalis muscle) to lower brow position and in the lateral administration of botulinum toxin in the brow asymmetry can also be accomplished by the selective depressors during the postoperative period. The treatment endoscopic brow lift to decrease the action of the brow lateral orbicularis oculi) 1 to 2 weeks prior to a planned treating the brow depressors (corrugators, procerus, and toxin preoperatively to augment surgical results, such as in injections during facial surgical procedures secondary to the

**Figure 6** List of blood-thinning, including over-the-counter, medications that patients are instructed to discontinue before their cosmetic eyelid surgery.

**Blepharoplasty Complications**

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**Chemosis**

Postoperative chemosis following cosmetic blepharoplasty typically resolves spontaneously in most patients, but a small minority of patients can have moderate to severe symptoms, including foreign body sensation, irritation, pain, redness,
***PLEASE AVOID THESE MEDICATIONS FOR AT LEAST 10 DAYS BEFORE SURGERY***

Orally Administered medications That Increase Bleeding Time
Preparations that contain nonsteroidal anti-inflammatory agents

- 217 Strong
- 4-Way Cold tablets
- Acuprin 81 (aspirin)
- Adult Analgesic pain reliever
- Aggrenox
- Alka-Seltzer
- Analgesic pain reliever
- Anacin
- Anodynos
- Antidol
- APAC Improved
- APO-ASA
- APO-ASEN
- Arco Pain
- Artin
- Arthritis Pain Formula
- Artia SR
- ASA
- Ascriptin
- Aspirin
- Aspirin with codeine
- Aspirin-Low
- Aspir-tab
- Asptab Max
- Astone
- Astrin
- Axotal
- Azdone tablets
- B-A-C tablets
- Bayer Aspirin
- Bayer children’s cold tablets
- BC powder
- BC Tablets
- Buffasprin
- Buffasal
- Buffertin
- Buffets II
- Buffex
- Buffinol
- C2
- Calamine
- Camo arthritis pain reliever
- Carisoprodol compound tablets
- Children’s aspirin
- Cope
- Coryphen
- Damason-P
- Darvon compound
- Darvon compound-65
- Darvon with ASA
- Darvon-N with ASA
- Dasin
- Dolin
- Dolomine
- Dolpin #3 tablets
- Drinophen
- Duradyn
- Easprin
- Ecotrin
- Emagrin
- Empirin
- Empirin with codeine
- Entrophen
- Equagesic
- Equazine-M
- Excedrin
- Fiogesic tablets
- Fiorgen PF
- Fiorinal
- Fiorinal with codeine
- Gelpirin tablets
- Gemnisyn
- Genacide
- Genacote
- Genprin
- Gensan
- Goody’s extra strength
- Goody’s Headache powder
- Halfprin
- Headache tablet
- Heathprin
- Herborprine
- Instantine
- Isolyl Improved
- Kalmex
- Lanoral
- Lorabase with ASA
- Magnaprin
- Marnal
- Meaurin
- Micrain
- Meprobamate and aspirin
- Meprobacges Q
- Midol for cramps, maximum strength
- Midol Original
- Momentum muscular backache formula
- Neogesic
- Nervine
- Night-time Effervescent cold tablets
- Norgesic
- Norgesic Forte
- Norwich extra-strength aspirin
- Novasen
- Orphenagesic
- Orphenegesic Forte
- Oxycodeine and aspirin
- P-A-C
- Pain Aid
- Pain reliever tablets
- Panodynes
- Pepto-Bismol
- Percodan
- Percodan-Demi
- Persistin
- Phenetron compound
- PMS with ASA
- Presilin
- Propoxyphene compound
- Propoxyphene naprosyn with ASA
- Quiet World tablets
- Rhinoces
- Robaxil tablets
- Roxiprin
- Roxiprin tablets
- Salabuff
- Salatin
- Saltro
- Sine-Off sinus medicine tablets
- Slopine
- Soma compound tablets
- Soma compound with codeine
- St. Joseph
- Stanback powder
- Supac
- Synalgesic-DC capsules
- Talwin compound
- Tenol-Plus
- Trigesic
- Tri-Pain
- Ursinus Inlay-Tab
- Valesin
- Vanquish
- Verin
- Wesprin Buffered
- Zorprin

**Figure 6** Continued.

**Table 4** Orbital Hemorrhage Warning Signs/Symptoms

| 1. Orbital pain |
| 2. Loss of vision |
| 3. Diplopia |
| 4. Proptosis |
| 5. Relative afferent pupillary defect |
| 6. Limited extraocular motility |
| 7. Increased orbital pressure/tense orbit |

**Figure 7** Patient presented with postoperative left orbital hemorrhage with pain, proptosis, relative afferent pupillary defect, and limited extraocular motility (► Fig. 11).
epiphora, and blurred vision. Chemosis, which is defined as transudative edema of the bulbar and/or palpebral conjunctiva, presents as a visible yellowish or pink swelling of the conjunctiva.

Multifactorial causes contribute to postoperative chemosis including exposure, prolonged postoperative inflammation, facial and periorbital edema, extensive surgical conjunctival manipulation, and postoperative disruption/dysfunction of the lymphatic system. Periorbital and facial edema can result in secondary regional lymphatic stasis that can both trigger and cause worsening of chemosis, as the lateral half of the eyelid lymphatic system drains to the preauricular node and the medial half drains to the submandibular node. Structural damage that occurs intraoperatively to the lymphatic channels that drain the conjunctiva can also cause lymphatic dysfunction.

Predisposing factors for postoperative chemosis include increased surgical time resulting in increased periorbital swelling and exposure of the conjunctiva as well as lagophthalmos from upper eyelid blepharoplasty and/or brow-lift procedures. For most patients, postoperative chemosis will resolve spontaneously during the early postoperative period, but in some instances, a combination of pharmacological, mechanical, and/or surgical therapies may be necessary for treatment. The facial cosmetic surgeon should focus on the importance of prevention of chemosis following cosmetic blepharoplasty by minimizing intraoperative risk factors with appropriate timely therapeutic intervention for persistent postoperative chemosis.

Recommendations to decrease the risk of chemosis include frequent ocular lubrication intraoperatively, limited surgical dissection, intermittent forced eyelid closure, and temporary tarsorrhaphy suture. Treatment of postoperative chemosis includes medical therapies, mechanical compression, and surgical modalities if needed. Lubrication, topical steroids, head elevation, and eye patching are initiated, and if resolution of the chemosis is not complete, then drainage conjunctivotomy and temporary tarsorrhaphy may be utilized. Putterman advocates the utilization of patient finger compression 4 to 10 times per day as the patient manually elevates the lower eyelid over the chemotic area and applies pressure for ~10 seconds (Fig. 10).

Management of Upper Eyelid Blepharoplasty/Ptosis Surgery/Brow Surgery

To decrease or avoid complications from upper eyelid blepharoplasty, surgeons should strive for a natural, volume-
sparing approach with attention to reestablishment of the upper eyelid. It is beneficial for one to keep in mind Flower’s rule of preserving at least 20 mm of upper eyelid skin for normal lid function. During the evaluation, upper eyelids should be assessed for asymmetry of the lid crease/fold. Asymmetry of the lid crease can be a challenging issue, particularly trying to lower a crease that is too high, which may occur secondary to an iatrogenic cavity from excessive fat removal. Supernatural fixation may be utilized to raise a low crease by placing a three-point suture through the lower lip of the skin/orbicularis muscle incision, through levator aponeurosis, and then exiting through the upper lip of the skin/orbicularis muscle incision.

Intraoperatively, the diagnosis of prolapse of the lacrimal gland, noted to be a firm, fibrous gray structure, can be made and corrected by resuspension to the periosteum of the superior orbital rim. Another potential complication of upper eyelid blepharoplasty is medial canthal webbing, which results from either an improperly placed incision or excessive skin removal. To decrease the risk of medial canthal webbing, the incision is angled slightly superior at the medial extent of the incision without extending past the level of the superior pomatum. Treatment includes massage initially, with surgical procedures such as Z-plasty as necessary.

Included in the evaluation is the assessment for underlying brow ptosis, which can be surgically repaired at the same time as the planned blepharoplasty (Figs. 11, 12). Possible complications of endoscopic brow surgery include alopecia, numbness, facial nerve injury, and asymmetry. Meticulous attention to operating in the correct tissue plane during surgery with limited cauterization of the wound during

Figure 10  (A) Evidence of chronic chemosis following cosmetic lower lid blepharoplasty. (B) To treat chemosis, finger compressions can be performed by manually elevating the lower lid over the chemotic area and applying pressure for ~10 seconds.

Figure 11  (A) Underlying lid ptosis, which should be corrected during the planned blepharoplasty, is evident in addition to dermatochalasis in this woman. (B) Same patient after combined bilateral upper eyelid blepharoplasty and levator advancement.

Figure 12  (A) Underlying brow ptosis and lid ptosis should also be corrected during the planned blepharoplasty. (B) Same patient following combined brow and eyelid surgery.
closure are paramount to achieving superior aesthetic results in endoscopic brow-lift surgery.

Preoperatively, any evidence of upper eyelid ptosis, particularly with secondary brow compensation, should be diagnosed and subsequently repaired during the blepharoplasty surgery. During the upper eyelid blepharoplasty, the surgeon should evaluate for any evidence of ptosis secondary to levator dehiscence and perform correction at that time. It is important for the surgeon to be aware of the close proximity of the levator aponeurosis to the inferior lip of the upper blepharoplasty incision to avoid damage, as this is the insertion point for the levator aponeurosis to the orbicularis muscle/skin. If the surgeon would inadvertently place his incision too deep, then dehiscence of the levator aponeurosis could result in ptosis. To further decrease the risk of iatrogenic damage to the levator aponeurosis, incisions through the orbital septum into the preaponeurotic fat pads should be made near the superior lip of the upper blepharoplasty incision while tenting the orbital septum 90 degrees from the levator aponeurosis.

Multiple etiologies can contribute to postblepharoplasty ptosis, including unrecognized preoperative ptosis, direct levator damage, stretching of the levator, and tethering secondary to the orbital septum being inadvertently incorporated into the eyelid closure. Surgical correction of ptosis is accomplished by either levator advancement or Muller’s muscle-conjunctival resection. In levator advancement repair, the suture is placed in the central 5 mm of the tarsus and in the upper one-third of the tarsus as lower placement may result in ectropion.

**Management of Lower Lid Hollowing**

Lower eyelid hollowing can occur secondary to aggressive lower lid blepharoplasty, aging changes related to soft tissue atrophy, thinning of the skin, soft tissue descent, and/or orbital fat herniation. The goal of treatment is to replace volume in this region through autologous fat, transposition of orbital fat, or dermal facial fillers such as hyaluronic acid (Figs. 14, 15). The placement of the dermal facial fillers should be in a deep, supraperiosteal plane to reduce visibility in this thin tissue. A Tyndall effect can occur from superficial injection of the hyaluronic acid fillers resulting in a bluish color. This complication can be treated by either the injection of hyaluronidase or by using a No. 11 blade to nick the papule. Hyaluronidase can also be utilized for the treatment of any postinjection irregularity or asymmetry (Fig. 16). Nitropaste should be available for the treatment of vascular compromise noted during facial filler treatments.

**Management of Lower Eyelid Retraction/ Lagophthalmos**

Lower eyelid retraction, defined as inferior malposition of the lower eyelid margin without eyelid eversion, is assessed by...
placing upward traction on the lower eyelid. The normal eyelid can be easily raised past the level of the pupil, whereas the lower eyelid with retraction will show evidence of restriction secondary to scarring of the orbital septum to the orbital rim.

Another clue to the diagnosis of lid retraction is that under normal circumstances the lateral canthal complex will move medially with eyelid closure, but with evidence of lower lid retraction, this movement will be decreased or even absent. Lid retraction is characterized by scarring, inflammation, shortening, and tethering of the middle and posterior lamellae resulting in vertical contraction of the eyelid with hollowing as the lower lid fat is pushed posteriorly into the orbit (Fig. 17). Associated problems with lid retraction include scleral show, rounding of the lateral canthal, keratopathy, loss of the almond-shaped eye, and lagophthalmos.

Lower eyelid ectropion, defined as inferior malposition of the lower eyelid margin with eversion from the normal apposition to the globe, can occur independently or in combination with lower lid retraction. Excessive skin removal from a transcutaneous lower lid blepharoplasty can result in cicatricial ectropion, which is characterized by skin tautness with vertical skin tension lines, which worsen with mouth opening. A full-thickness skin graft may be required as part of the surgical correction. Risks of lower lid retraction/ectropion following lower eyelid blepharoplasty can be decreased by using a transconjunctival/pinch technique approach to avoid the orbital septum and therefore minimize possible middle lamellar inflammation/scarring or by emphasizing conservative skin removal if a transcutaneous technique is utilized. Another advantage of the transconjunctival approach is that the orbicularis muscle and its innervation are not compromised, thus dynamics of eyelid closure, including tear pumping and tear distribution are not affected.10

Initial management for lower lid retraction would include massaging the area of scar contraction and the use of lubricating agents and/or steroids. It is important that even if planning reconstructive surgery following complications from prior lid surgery, that the patient is treated with the above medical options while awaiting surgery. Canthopexy, canthoplasty, lateral retinacular suspension, or tarsal strip procedure can be used to correct lower lid laxity.54–84

Figure 15 (A) Before photo of a 50-year-old woman who presented status post (s/p) 4 lid blepharoplasty with evidence of bilateral upper eyelid ptosis and bilateral lower eyelid hollowing. (B) After photo following bilateral upper eyelid ptosis repair and bilateral lower eyelid treatment with hyaluronic acid filler. (Kenneth D. Steinsapir M.D., Inc. is the copyright holder and permission is being granted to use the images.)

Figure 16 (A) Woman status post (s/p) hyaluronic acid dermal filler right lower eyelid; patient is unsatisfied with results from another physician. (B) Same patient after hyaluronidase treatment to right lower eyelid (Courtesy of John Fezza, M.D., with permission.)
Reattachment of the lower lid should be 1.5 mm inside the lateral orbital tubercle. Poor apposition to the globe will result if placed too anterior, if too posterior ocular irritation will may result, and poor cosmesis will occur if too superior or inferior. The surgeon should strive for the following: sharp lateral canthal angles, lid margin position at the level of the limbus, no override, and vertical symmetry with the level being at or slightly above the pupil.

The surgical repair of lower eyelid retraction will require not only correction of the lid laxity, but also the complete release of scar tissue with placement of a posterior lamellar spacer graft. All scarring and adhesions should be released so that the anterior and posterior lamellar are completely mobile to allow the orbital fat to reposition superiorly between the orbital septum and the capsulopalpebral fascia. Posterior lamellar spacer graft materials include auricular or nasal cartilage, porous polyethylene, sclera, tarsus, dermis fat, Enduragen (Stryker, Kalamazoo, MI), and hard palate mucosal and acellular dermal grafts.\(^{85-93}\) (►Figs. 18, 19). Acellular dermal allografts avoid the morbidity of a second operational site, as required with many of the above-mentioned grafts; however, there may be an increased contraction rate noted postoperatively. More severe cases of lower eyelid retraction may also require a midface lift in addition to the above-described procedures.\(^{94-99}\)

**Conclusion**

To avoid complications from eyelid surgery, both functional and/or cosmetic, the surgeon’s examination of the patient should include a thorough evaluation of the brow/upper eyelid region to assess for the presence of brow ptosis, brow/eyelid asymmetry, and eyelid ptosis. The lower eyelid/cheek examination should focus on the diagnosis of underlying negative vector, dry eyes, prominent eyes, ectropion, lateral canthal dystopia, lower eyelid laxity, scleral show, lagophthalmos, chemosis, and lower eyelid retraction. Regarding the patient’s past history, an emphasis should be placed on the previous diagnosis of dry eyes, past facial trauma, past injection of botulinum toxin and facial dermal fillers, and history of previous LASIK and previous facial surgery.

Early intervention during the postoperative period is important to correct any observed functional or cosmetic complications. Medical options should be utilized to treat dry eye syndrome and reduce ocular irritation during the postoperative period, even if the patient is scheduled to undergo revisional eyelid surgery. With upper and lower lid blepharoplasty, it is recommended that conservative skin/fat removal be emphasized with preservation of orbicularis muscle and its innervations. Regarding cosmetic eyelid surgery, the surgeon should strive to avoid skeletonization/hollowing/deflation by repositioning and reinforcing tissue with an emphasis to restore fullness to achieve facial aesthetic balance between the forehead, eyelids, and midface.
