Lower Eyelid Blepharoplasty: Procedure Pearls and Pitfalls

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John D. Siddens

1. If at all possible, a transconjunctival incision is preferable to a transcutaneous incision, especially if the midface is not being addressed.
2. A transconjunctival incision can be performed with a CO_2 laser, a radiofrequency unit, a monopolar tip, or even carefully with a high-temperature cautery.
3. Be conservative when removing herniated orbital fat. Draping or repositioning fat over the rim is often preferable to significant fat excision.
4. Meticulous hemostasis is critical in lower eyelid blepharoplasty. We recommend the clamp, cut, and cautery technique using a small hemostat, Westcott scissors, and the bipolar cautery, respectively.
5. If there is excessive skin laxity in an older patient, skin removal can be useful if done conservatively and in conjunction with a horizontal tightening of the lower eyelid. The fat should still be addressed through a transconjunctival incision. We never remove herniated fat through a transcutaneous incision.
6. Beware of creating a "lateral canthal syndrome" (Fig. 52.1). This is caused by excessive skin removal and/or orienting the lateral skin too vertically.
7. If the patient is a CO_2 laser candidate, this is a preferred way to tighten the lower eyelid skin. Patient selection is critical as this should only be performed on the lighter skin types, and we need to warn the patients of possible persistent erythema or pigment changes.
8. Pretreat CO_2 laser patients with an anti-HSV medication, and avoid performing laser to tan patients.

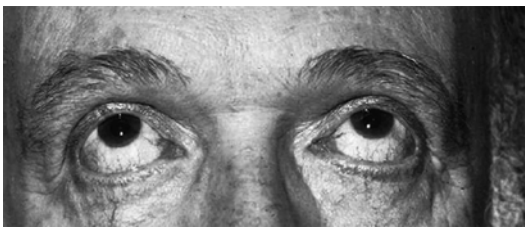

Fig. 52.1 Lateral canthal syndrome

J.D. Siddens, MD
Department of Ophthalmology,
University of South Carolina School of Medicine,
Columbia, SC, USA

M.E. Hartstein et al. (eds.), *Pearls and Pitfalls in Cosmetic Oculoplastic Surgery*,
DOI 10.1007/978-1-4939-1544-6_52, © Springer Science+Business Media New York 2015