SURGICAL PEARL

A minimally invasive approach to lower lid blepharoplasty

Eyal Konstantine Levit, MD,a and Maria Paulina Estrada, MS6b

New York, New York and Medellin, Colombia

Key words: blepharoplasty; complications; L lift; lower lid; rejuvenation; surgery.

SURGICAL CHALLENGE

Over the last decade, there has been a steady increase in the demand for lower eyelid rejuvenation. Still, the danger of side effects when performing lower blepharoplasty has kept many patients and physicians away from the surgery, often choosing fillers to correct the tear trough deformity, sometimes even to the aesthetic detriment of the patient. The side effects prompting this concern range from rare cases of blindness caused by retrobulbar hematoma, ectropion from excessive lower eyelid skin excision, chronic conjunctivitis from the transconjunctival blepharoplasty scar rubbing against the eyelid conjunctiva, and to chronic lower eyelid edema sometimes lasting for more than 3 months.1

SOLUTION

We offer a minimally invasive approach to removing the lower eyelid herniated fat pads, allowing better aesthetic results while avoiding the risk of serious complications. We call this procedure the triple L lift (lower eyelid liposuction), as it helps remove the lower eyelid fat while hiding the incisions as one does in liposuction.

The patient is marked in a sitting position while gazing upward (this allows for a better visualization of the degree of the herniated fat pads). A thin line is drawn with bonnie blue over the fat pad at a length of not greater than 6 mm. The person is then laid in a supine position, and the incision as well as the fat pad are then carefully infiltrated with lidocaine 1% with epinephrine 1:100,000 (Henry Schein, Melville, NY). The area is then sterilized with Hibiclens (Mölnlycke Health Care, Norcross, GA). An incision is carried out with a #15 blade along the marked area down through the skin and muscle, and the fat is gently teased out using a bishop forceps and a curved hemostat (Fig 1). After the appropriate amount of fat is removed, it is excised and its base is cauterized before the fat is allowed to retract back into its pocket. The process is repeated in a similar fashion for all the marked fat pads. A single interrupted 5.0 Ethilon suture (Ethilon, San Lorenzo, PR) is then used to close the incision (Fig 1). The patient is given Aquaphor ointment (Beiersdorf Inc, Wilton, CT) to apply at home and told to sleep elevated and intermittently apply ice to the surgical site. The sutures are removed in 3 to 5 days and a Steri-strip (3M, St Paul, MN) is applied over the incision site.

From Columbia Presbyterian Medical Center, Department of Dermatology, New Yorka and CES University, Medellinb.

Funding sources: None.

Conflicts of interest: None declared.

Correspondence to: Eyal Konstantine Levit, MD, 1220 Avenue P, Brooklyn, NY 11229. E-mail: skin@levitdermatology.com.


0190-9622/$36.00

© 2015 by the American Academy of Dermatology, Inc.

http://dx.doi.org/10.1016/j.jaad.2015.08.029

SCO 5.4.0 DTD ■ YMJD10453_proof ■ 25 September 2015 ■ 11:57 am

e1
If there is any redundant skin left in 4 weeks, we usually offer a fractional ablative resurfacing to further improve the aesthetic result (Fig 2).

Fig 1. A, Conservative amount of fat is removed by placing gentle pressure on the herniated fat pad. B, Immediately after upper blepharoplasty and lower eyelid fat pad removal. (Patient on clopidogrel and coumadin [Bristol-Myers-Squibb, New York, NY].)

Fig 2. A, Before blepharoplasty and B, 6 months after the triple L lift.

REFERENCE