Lower Eyelid and Midface Rejuvenation

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Abstract

Lower eyelid blepharoplasty is one of the most common procedures in aesthetic plastic surgery. Although patients desiring lower eyelid blepharoplasty typically describe their problem as "bags in the lower eyelids," there are many anatomical imperfections that should be assessed. With aging, the youthful single convexity of the lower lid separates into a double convexity with a valley at the intersection of the lower lid and midface. Midface descent further drags this intersection inferiorly, leading to a vertically lengthened lower eyelid. This article discusses how to clinically evaluate lower lid deformities, how to formulate a surgical plan, the preoperative assessment, and surgical markings. The rationale and anesthetic technique for outpatient versus in-office surgery is reviewed, and a detailed step-by-step approach with accompanying figures for lower lid blepharoplasty via a transconjunctival or transcutaneous incision is given. An approach to vertically supporting the lower eyelid is presented.

Keywords

- lower eyelid blepharoplasty
- lower eyelid rejuvenation
- lower eyelid suspension
- midface rejuvenation
- trichloroacetic acid peel

Lower eyelid blepharoplasty is one of the most common procedures in aesthetic plastic surgery. In the past, rejuvenation of the lower eyelid and the midface were divided into separate discussions. In recent years, authors have realized the typical problem causing patients to present for lower eyelid blepharoplasty lies at the intersection of the lower eyelid and midface, making it difficult discussing rejuvenation of the lower eyelid without discussing rejuvenation of the midface.[1] Perhaps less appreciated is the large number of less common problems that lead patients to present for lower eyelid blepharoplasty or that limit the results of lower eyelid blepharoplasty if not addressed.[2]

Defining the Problem

An algorithm for addressing lower eyelid blepharoplasty is listening to the patient's concerns, defining the anatomical problem causing these concerns, discussing which concerns can and cannot be improved, and outlining a plan for improvement. Patients presenting for lower eyelid blepharoplasty typically describe their problem as "bags in the lower eyelids." Despite this uniform description, there are many anatomical imperfections bothersome to patients (►**Table 1**). In youth, the lower eyelid appears as a single convex structure extending from the lower lid margin to the lateral oral commissure. By the time most patients reach their early 40s, the midface tissues begin to visibly descend. The bulkiest of these structures are the suborbicularis oculi fat (SOOF) and the malar fat pad. When these tissues drop, the youthful single convexity separates into a double convexity with a valley at the intersection of the lower lid and midface. The valley is located precisely where the orbital ligament tethers the orbicularis oculi muscle and associated skin to the inferior orbital rim bone, preventing further descent of the structures inferior to the rim.[3,4] The superior convexity is composed of skin, pretarsal and preseptal orbicularis oculi muscle, and eyelid fat pads. The inferior convexity is composed of skin, orbital orbicularis oculi muscle, SOOF, and malar fat. Patients are usually upright and awake, and when illuminated by overhead lighting, the superior convexity casts a shadow into the valley, causing patients to complain of dark circles under their eyes. Midface descent further drags this intersection inferiorly, leading to a vertically lengthened lower eyelid. The double convex contour deformity is present in most middle-aged or elderly patients presenting for lower lid blepharoplasty, so a successful strategy for treating this deformity is necessary to rejuvenate the lower eyelid and midface.

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