

# Pinch Blepharoplasty: A Safe Technique With Superior Results

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The author has refined his lower blepharoplasty technique with the goal of eliminating scleral show and residual skin while maintaining normal eyelid posture. His technique involves fat removal and/or modification through a transconjunctival approach, aligning the lower eyelid globe and canthus with a stitch canthopexy, and measured excision of redundant skin with mastery of the “pinch” technique. (*Aesthetic Surg J* 2007;27:199–203)

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**M**y experience performing lower blepharoplasty suggests the following medical truism: “The more one performs a particular procedure, the more the procedure gains one’s respect.” Surgeons who have critically assessed the results of their skin-muscle flap lower blepharoplasty procedures will heartily agree. In assessing my results, I consistently observed two markers of a less-than-perfect result at the lower eyelid: (1) mild scleral show (Figure 1) and (2) residual crepey skin (Figure 2). Frequently, these same patients had endured weeks of “taping” of the lower eyelid.

I was challenged by these observations and set out to find the *Holy Grail*—a modified procedure that could ensure maximum correction of changes produced by aging and still maintain normal eyelid posture. A review of the literature<sup>1-3</sup> and a personal communication with Dr. Glenn Jelks in 2000 served to confirm my thoughts about modifying the lower blepharoplasty. I elucidated these modifications in the “Pinch Blepharoplasty Revisited” series.<sup>4</sup>

## Technique

It is best to perform the transconjunctival portion of the procedure preceding canthopexy (if planned), to facilitate distraction of the eyelid. Perform a stitch canthopexy through the lateral upper eyelid, using a 5-0 clear nylon suture.<sup>5</sup> If you are planning a prophylactic canthopexy, capture the lateral canthal tissue, using a

fine-tipped, curved mosquito clamp. Make sure that distraction of this tissue up to the orbital rim translates into the desired improved tension of the lower eyelid (Figure 3). For a therapeutic canthopexy, the canthal tissues can be gradually released, as necessary, while putting the mosquito clamp on traction.

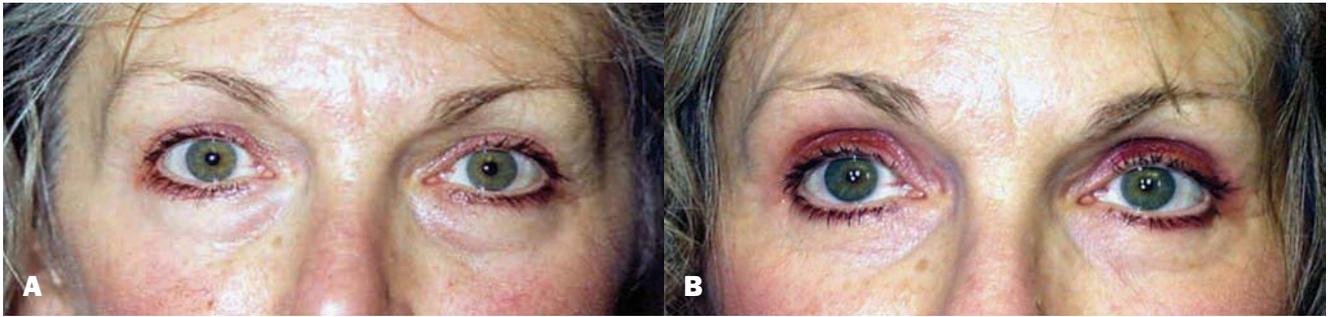
Then, using a pair of fine Brown-Adson forceps, progressively pinch the subciliary skin into a standing “wall” of skin (Figure 4). The endpoint should be the effacement of the wrinkled skin below, while preserving the posture of the lower eyelid margin above. Using a sharp, straight scissors amputate the “wall” at its base, leaving the wound edges “kissing.” Close this wound with a 7-0 nylon suture.

## Discussion

Essentially this modification of the lower blepharoplasty is comprised of 3 maneuvers: (1) fat removal and/or modification through a transconjunctival approach, (2) aligning of the lower eyelid with respect to the globe and canthus with a command of the canthopexy, and (3) measured excision of redundant skin with mastery of the “pinch” technique. Note that a very significant and salutary removal of redundant skin is possible (Figure 5).

It is important to infiltrate the local anesthesia as early and as modestly as possible. Clearly, the less tissue distortion, the more accurate and facile the pinch maneuver. This is particularly germane at the start of your learning curve, and, to this end, it is helpful to, at least, deeply sedate the patient before the pinch.

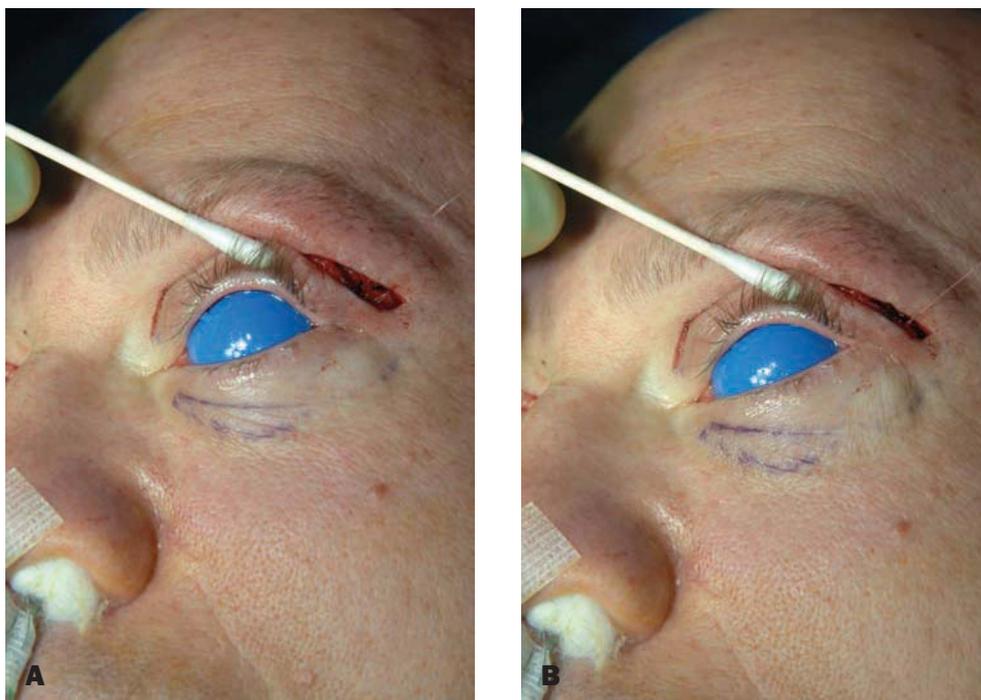
The preoperative decision of whether to add a stitch canthopexy is based on evaluating both the position of the lateral canthus and the posture and tone of the lower eyelid. The action of the canthopexy may be classified as (1) prophylactic (for patients who are aging, have a prominent globe, malar hypoplasia, or “negative” lateral canthal position) or (2) therapeutic (for patients who demonstrate laxity or scleral show).



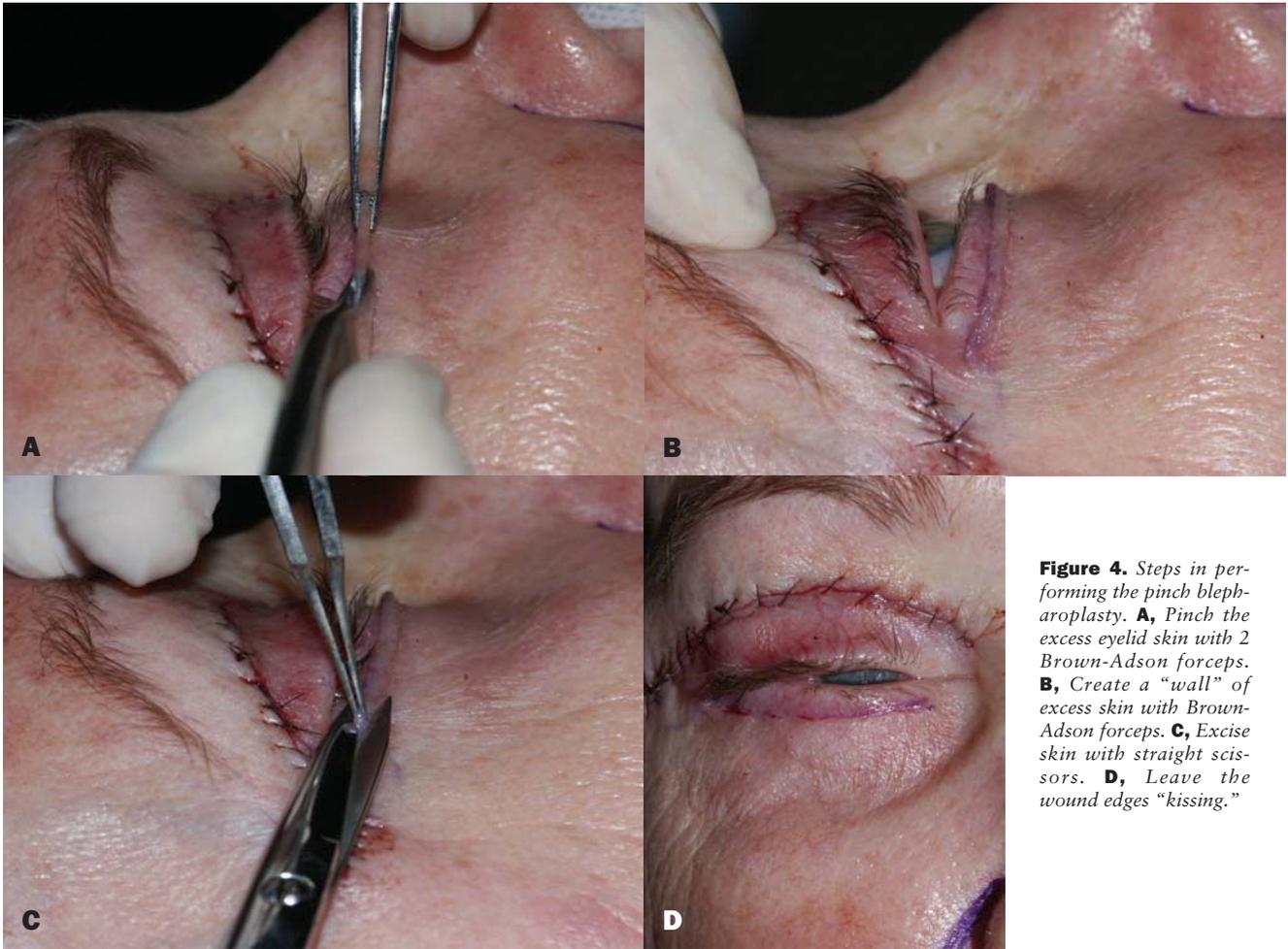
**Figure 1.** **A**, Preoperative view of a 55-year-old woman. **B**, Postoperative view 1 year after a traditional skin-muscle lower blepharoplasty exhibits telltale postoperative scleral show.



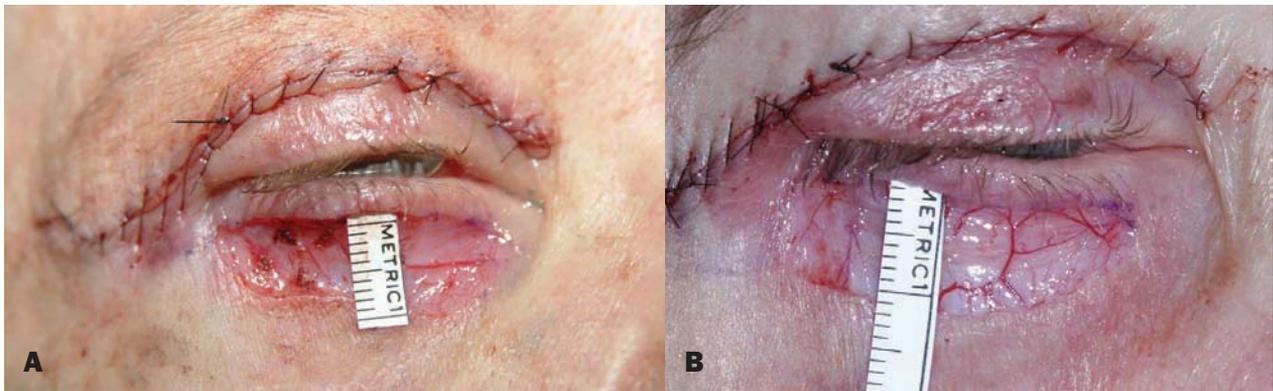
**Figure 2.** **A**, Preoperative view of a 48-year-old woman. **B**, Postoperative view 1 year after a traditional blepharoplasty demonstrates residual crepey skin.



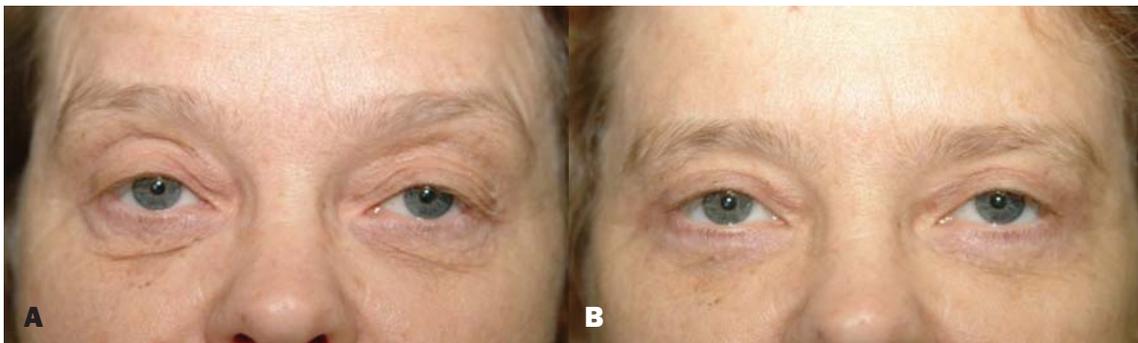
**Figure 3.** **A**, Intraoperative view of the canthopexy with the stitch at rest. **B**, The stitch is shown with tension applied.



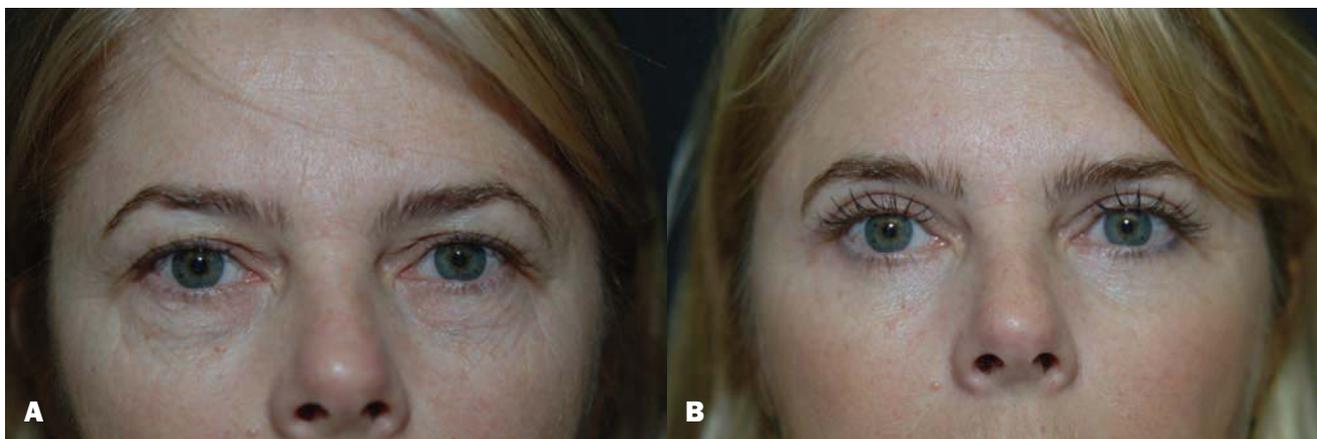
**Figure 4.** Steps in performing the pinch blepharoplasty. **A,** Pinch the excess eyelid skin with 2 Brown-Adson forceps. **B,** Create a “wall” of excess skin with Brown-Adson forceps. **C,** Excise skin with straight scissors. **D,** Leave the wound edges “kissing.”



**Figure 5. A, B,** Examples of extent of skin excision possible with pinch technique (averages from 8 to 12 mm).



**Figure 6.** **A**, Preoperative view of a 52-year-old woman with considerable excess crepey skin. **B**, Postoperative view 8 months after a pinch blepharoplasty demonstrates complete removal of the redundant skin with maintenance of good eyelid posture.



**Figure 7.** **A**, Preoperative view of a 48-year-old woman. **B**, Postoperative view 1 year after correction of lower eyelid aging and upper blepharoplasty while ensuring a normal eyelid posture.

The stitch canthopexy, when judiciously harnessed, empowers the surgeon to take full advantage of the pinch procedure and achieve the most complete removal of redundant skin (Figure 6). As a further benefit, the pinch portion of this technique can be easily repeated under local anesthesia at a later date to treat any residual crepey skin.

It is notable that both the pinch blepharoplasty and the stitch canthopexy techniques require a respectable learning curve. During the learning process, be aware that it is deceptively easy to *over pinch* or to *over pexy*. One layer of initial protection is to pinch a few millimeters further away from the lash margin as compared with the traditional incision. The scar still heals imperceptibly. When first performing the stitch canthopexy, you should not hesitate to replace the stitch if you think there has been an overcorrection; it will not “settle” enough on its own after surgery.

Generally, these modifications will help you to command greater control of the lower eyelid. For me, this technique has been very rewarding. When approaching the lower eyelid, I have the security that I will be able to deliver comprehensive treatment without surgical stigmata (Figure 7). This advantage is particularly apparent when treating a patient who is morphologically compromised (Figure 8). It is notable that I have not performed a skin-muscle flap lower blepharoplasty in more than 6 years. The pinch blepharoplasty has eliminated the need for lower eyelid resurfacing as well as “therapeutic” postoperative taping in most patients. As compared with my experience before using pinch blepharoplasty, I am performing more canthopexies intelligently and excising more skin confidently with consistently faster patient recovery, more accurate canthal and eyelid positioning, and, most importantly, significantly improved aesthetic results. ■



**Figure 8.** **A, C,** Preoperative views of a 49-year-old man with a negative cheek vector, down-turned lateral canthus, and prominent globe. **B, D,** Postoperative views 1.5 years after a pinch procedure with intact lower eyelid shape and upper blepharoplasty.

## References

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