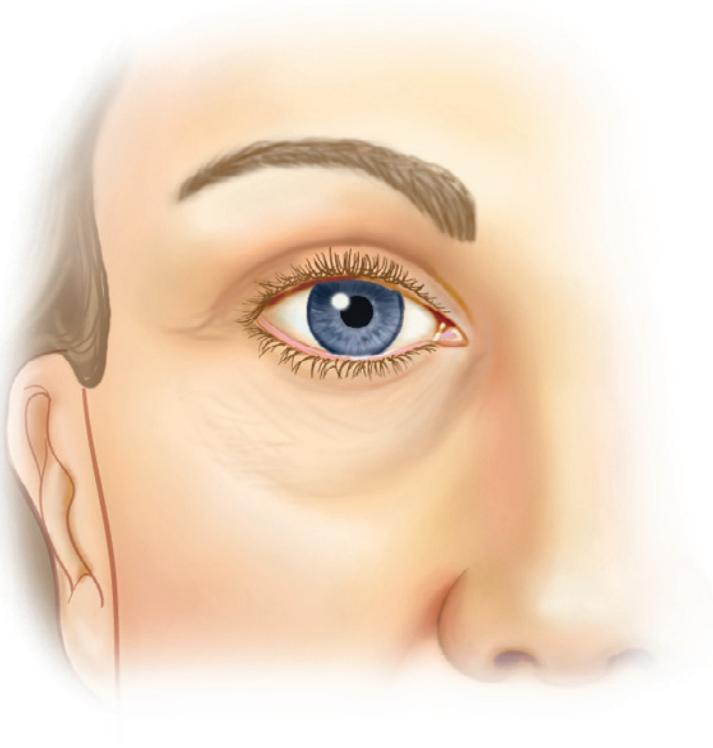


## CHAPTER 32

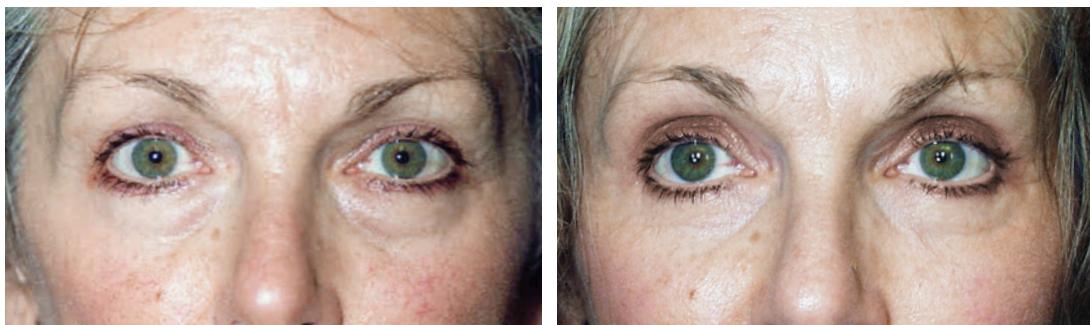


# Lower Eyelid Pinch Blepharoplasty



LORNE K. ROSENFIELD

The lower eyelid blepharoplasty embodies a classic surgical paradox worth revisiting: the more one performs a particular surgery, the more respect it may command. Whereas ignorance may be bliss, knowledge can be quite motivating. Any surgeon who has critically assessed his or her skin-muscle flap lower blepharoplasty results would heartily agree with this statement.



When I examined my own results, I observed, not as infrequently as I would have liked, two particular stigmata of a less than perfect result at the lower eyelid. First, lasting mild scleral show was evident, often preceded by weeks of overly optimistic eyelid taping. This 55-year-old woman, shown preoperatively and 1 year after a traditional skin-muscle lower blepharoplasty, exhibits this telltale postoperative sign of scleral show.



Second, residual crêpey skin was identified, most often after treatment of prodigious fat herniation. This 48-year-old woman, shown preoperatively and 1 year after a traditional blepharoplasty, exhibits this “untreated” redundant skin.

I was compelled by these discomfiting observations to seek an effective solution—a modified procedure that would at once ensure optimal correction of the eyelid deformities and yet maintain normal eyelid posture. And so was born the pinch blepharoplasty series. My personal experience, reported in 2005, confirmed the safety and efficacy of this approach.

Although the true incidence of eyelid malposition after a traditional muscle flap blepharoplasty is not well defined, the plethora of articles on the subject attests to its persistence. Scleral show has been ascribed to multiple causes: excess skin removal, untreated eyelid laxity, denervation of the orbicularis muscle, and scarring of the outer or middle lid lamellae. This postoperative problem may be considered subtle and indeed is often not even acknowledged, but it represents what could also be seen as a glaring example of the “operated” look that we should all strive to avoid. As for the excess skin left behind postoperatively, this problem has been equally neglected in the literature.

## Evolution of Technique

There have been many efforts to reduce the incidence of eyelid malposition following traditional blepharoplasty. As documented by Zarem and Resnick, one approach has been to forego the skin incision entirely, thus preserving the integrity of the outer and middle eyelid lamellae, and to approach the eyelid instead through the conjunctiva only. Although the incidence of scleral show may be less with this approach, there can be a greater chance of untreated excess eyelid skin.

In another effort to avoid the skin incision and still treat the skin, skin resurfacing with a chemical peel or laser, in conjunction with a transconjunctival approach, can indeed reduce the incidence of scleral show. However, unless the skin redundancy is modest and the entire face is treated, resurfacing may not adequately treat the skin redundancy and can otherwise produce distracting lines of demarcation. Additionally, if these therapies penetrate too deeply, undesirable changes in eyelid posture may still occur.

With a skin-muscle flap, a relatively conservative resection of the skin has always been advocated, regardless of the extent of redundancy. Indeed, it is often impressive how little skin is actually removed despite such an aggressive flap dissection. And of course, in a patient with more significant excess skin, this conservatism has surely led to inadequate treatment.

Another adjunctive technique to a blepharoplasty is the canthopexy, particularly in a patient with a lax eyelid. There is no question that this repair helps reduce the incidence of lid malposition, but the results have been frustratingly inconsistent. We have all seen scleral show after a traditional blepharoplasty despite the addition of a canthopexy, even when applied prophylactically. An inadequate canthopexy, coupled with overaggressive skin resection, and the inciting factors of muscle denervation and middle lamellar scarring, probably explain this inconsistency. The deliberate preservation of a wider orbicularis strip of muscle, when conducting a skin-muscle flap approach, may be salutary but has clearly not proved to be the complete answer.

The idea of pinching the excess skin from the lower eyelid is not a new one; in 1973 Parkes et al were the first to suggest the technique. This description, which predated the transconjunctival approach, attenuated its potential benefits by also describing the division of the underlying orbicularis muscle to retrieve the excess fat.

Then in 1992 Dinner et al published a case report on the ultimate combination of the skin pinch with the transconjunctival approach in a “no flap” technique. Ristow, in 1994 in Mimis Cohen’s textbook, included the concept of a direct skin resection with a measured and marked resection.

My impetus to revisit and refine a pinch blepharoplasty came from a personal communication with Glenn Jelks in 2000. The solution became even more lucid when our decades-old standard approach to the upper eyelid blepharoplasty was considered: we “pinch” the eyelid excess to determine the extent of the excision while observing the effect on the eyelash and brow posture. Why not apply the same simple metric to the lower eyelid? So was born the “pinch blepharoplasty” series.

## Advantages

My personal experience of more than 400 pinch blepharoplasties confirms that this approach is indeed capable of producing better, more consistent results than the traditional skin-muscle flap technique. This variation offers two distinctive advantages: more crêpey skin can be safely removed, and an aesthetic eyelid posture is secured.

This rewarding marriage of goals is primarily the result of the inherent accuracy of the pinch technique. The approach enables the surgeon to assess and define in real time the prospective skin resection as well as carefully evaluate its effect on eyelid posture. The pinch technique avoids a heavy skin-muscle flap, which can otherwise create both worrisome vertical traction and more swelling. Additionally, the pinch blepharoplasty eliminates the usual violation of the orbicularis muscle and orbital septum, an action that could lead to denervation, scarring, and poor eyelid posture.

Another possible reason for the improved results is the often seen amelioration of the eyelid-cheek groove with a more youthful vertical shortening of the eyelid, perhaps secondary to the effacing effect of the significant skin resection.

These benefits translate into a more adaptable and consistent blepharoplasty. This advantage is seen particularly and most gratifyingly in morphologically challenging patients with a negative vector and poor lid posture; older patients with poor lid tone; patients with extensive skin or festoons; and younger patients with primary

skin redundancy and nominal excess fat. If there is asymmetrical skin between the eyelids, or even within one eyelid itself, the pinch can be tailored accordingly. Empowered with this versatile tool, the surgeon can now treat the medial eyelid skin, a zone that was traditionally neglected, for an even more complete result. In addition, because the skin excess is more thoroughly treated, the surgeon can avoid the need for regional laser resurfacing of the eyelid, with its added period of healing and attendant, often distracting lines of demarcation.

The advantages of the pinch blepharoplasty can be doubled with a staged reapplication of the pinch to excise even more skin. This “repinch” can be accomplished quite simply, with a local anesthetic. Thus it is feasible that essentially all crêpey skin at the lower eyelid can now be removed.

## Indications and Contraindications

The pinch lower blepharoplasty can comfortably usurp the standard skin-muscle flap technique. Therefore this approach may be offered to the same group of patients. In contradistinction to the standard technique, there is a productive breadth of application, depending on the extent of the patient’s problem. That is, all patients are candidates, but some are better candidates than others. Although results will be superior in all patients, defining the best and worst patient candidates for the pinch most effectively illustrates the nuances of the technique.



The ideal patient has abundant thin, crêpey skin, minimal excess fat, and morphologically advantageous anatomy (such as high cheekbones and almond-shaped eyes). With the application of the pinch and a planned second pinch procedure, if necessary, the improvement achieved in these patients can be dramatic, simply because the surgeon is able to more fully treat the eyelid.



At the opposing end of the spectrum, the imperfect patient is one with thicker, sun-damaged skin, which clearly will not “pinch” well. In these patients, it is best to plan the surgery so that the skin will have the least distortion from local anesthetic and to apply the pinch conservatively. Just as with patients with very thin skin, a thick-skinned patient will equally benefit from a staged second pinch procedure.

Because a dramatic skin resection can be done with this approach, the surgeon must be cautious when applying the pinch to a patient with equally significant redundant fat, because some of this skin must remain to redrape the now less convex lower eyelid. Again, these patients can always undergo a simple second pinch procedure at a later date.

## Pertinent Anatomy

The essence of the pinch technique embodies a key anatomic principle: to violate the eyelid anatomy as little as possible, and if it is compromised by age or genetics, to repair it. Between the transconjunctival approach and the pinch, the pinch touches and takes only what it needs to—the skin—leaving behind the critical neuromechanical support: the orbital septum and the orbicularis muscle and its attendant nerves.

As for the canthopexy, the key anatomic principle is to keep it simple. Because the lateral canthus truly comprises several components and is not easily identified as a distinct structure, the canthopexy has to become a kind of maneuver “on faith”: you can only really feel its presence. That is, rather than trying to dissect and visualize the canthal tissues themselves, the surgeon need only grasp and pull whatever tissue is present in the area to know the “right stuff” has been captured. Then it simply becomes a matter of manipulating this anchor thoughtfully to perform an individualized canthopexy.

## Preoperative Assessment

### History

There are several critical historical points to be gleaned, including a history of eye dryness, tearing, or the need for drops; allergies; Graves' disease; prior eyelid surgery; and previous injection of tissue fillers.

### Physical Examination

The preoperative physical examination should include the same components as for any blepharoplasty. However, the difference is that because the pinch allows one to modify the surgery to match the patient's problem, the value of a detailed analysis is even more rewarding.

The critical elements to evaluate are listed in the box.

#### Critical Factors to Assess in the Physical Examination

- The extent of the redundant skin: If necessary, a second pinch procedure can be planned in advance. This is particularly relevant in a patient with significant "active" skin: exaggerated wrinkling on animation.
- The extent of the redundant fat: Depending on the volume of excess, more or less skin should be pinched to ensure that enough skin is left behind.
- The degree of lid laxity and attendant scleral show (as evaluated by a snap test): This can be treated efficiently with a stitch canthopexy.
- The level of the lateral canthus (canthal tilt): The canthal position can be adjusted relatively precisely with a stitch canthopexy.
- The vector angle of the globe to the malar (positive/neutral/negative): This aids the surgeon in the design of the best application of the pinch and canthopexy components of the surgery.

## Photography

There are several tenets to be followed for photographic evaluation of the eyelids and documentation of the results.

### ***Prevent Parallax Error***

*Parallax* refers to the apparent displacement or difference in the apparent position of an object viewed along two different lines of sight, such as occurs because the lens of a camera and the viewfinder see the subject from a slightly different position. Thus photographs must be taken with the patient and surgeon seeing “eye to eye”; that is, there should be no height discrepancy that could distort the appearance of the posture of the lower eyelid in relation to the globe.

THE PARALLAX EFFECT

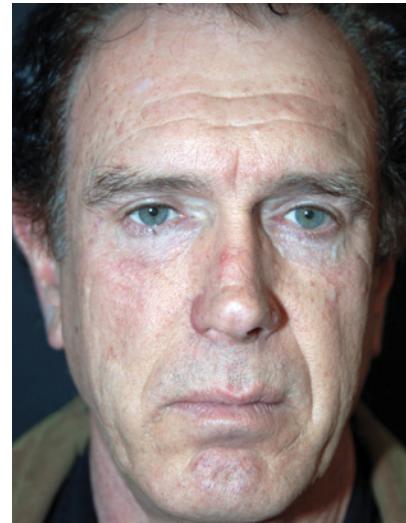


This problem can be manifested when either the patient is not level or the camera is not level. These effects can mask or exaggerate the actual eyelid position.

### *Beware of the Moro Reflex*



Close-up with Moro



Full face without Moro

When a tighter photo of just the eyelids is to be taken, some patients, anticipating the flash's effect, may widen their eyes dramatically. If this is noted, pulling the camera back to include a full-face picture should correct the distortion.

### *Follow the Dermatologist's Credo*



Close-up preoperative photo



Close-up postoperative photo

To accurately document the effects of the pinch procedure, progressively closer pictures of the face should be taken, from full face to just wrinkles at the lower eyelid.

### *Control the Patient's Emotions*

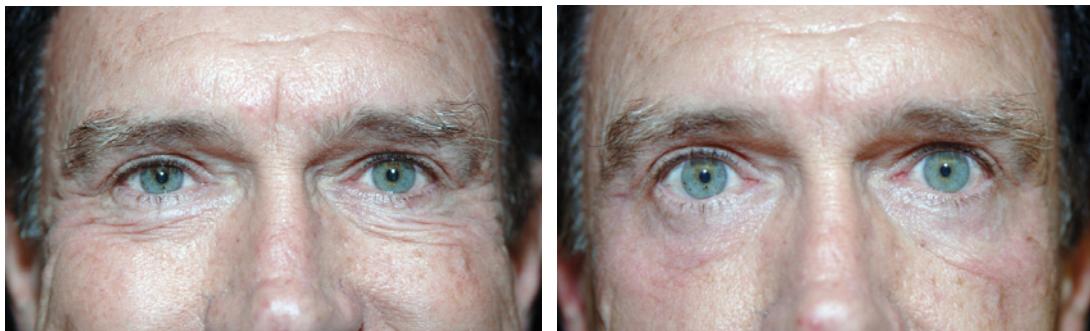
There is a place for both active and passive photographs of a patient's lower eyelid. Photos should be taken of the patient smiling to define the extent of muscle-skin excess.



Patient smiling preoperatively

Patient smiling postoperatively

Often orbicularis wrinkling is the patient's primary concern, and any correction of this problem is a true measure of a technique's efficacy.



Patient's smile hides scleral show

Patient at rest with scleral show

On the other hand, a smile can camouflage an eyelid posture or a scleral show problem.

### ***Compare the Present With the Past***

The patient should be asked to bring photographs from the past (such as college or wedding photos or well-focused candid photos). The insight gained from reviewing such historic images is invaluable not only for observing changes in the characteristics of the periorbital area but also in our attempt to recapture the patient's characteristic expression or persona.

### **Patient Education**

A patient with significant wrinkling must be informed that a second pinch blepharoplasty should be considered, depending on the salutary effects of the first procedure. The goals and actions of a canthopexy should be explained, because the palpebral fissure will become more almond shaped.

## Planning and Technique

Particularly when first attempted, the pinch procedure is best conducted with infiltration of as little local anesthetic as possible. With deeper sedation or general anesthesia, it is both possible and ideal to use no local infiltration. This consideration is critical, because it allows the surgeon to most accurately judge and pinch the skin excess without the potential distortion caused by aggressive local infiltration.

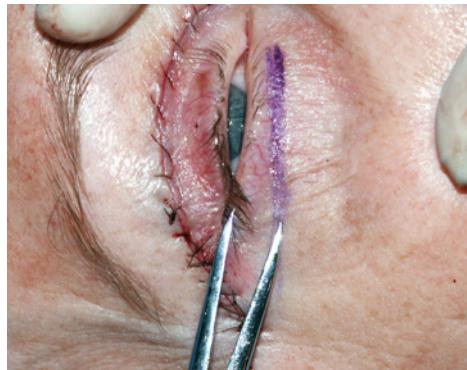


32-1 Pinch blepharoplasty

### Surgical Plan

1. If a local anesthetic must be used, place it in the lower eyelid in the region of the future pinch.
2. Conduct the upper eyelid blepharoplasty, leaving the wound open.
3. Complete the transconjunctival portion of the lower blepharoplasty.
4. Perform a stitch canthopexy through the upper-outer eyelid wound.
5. Close the upper eyelid wound.
6. Perform the lower eyelid pinch procedure and close the wound.

### Marking



The first step is to mark a guiding “pinch line” along the lower eyelid, representing the *uppermost* margin of the future excision. Medially, this line is usually placed within a few millimeters of the ciliary margin, continuing in a straight line laterally, deliberately leaving a progressively enlarging triangular island of intact skin of 4 to 5 mm in minimum height below the lateral eyelid margin. This maneuver further discourages scleral show by lessening the purse-string-like scar contracture that may occur with a curvilinear incision hugging the ciliary margin. However, the latitude of this line can be modified, depending on the location and quality of the excess skin. That is, the pinch line can be moved up or down on the eyelid to facilitate maximal skin removal. If the skin is noticeably thicker, the pinch line should be moved farther away from the ciliary margin to help prevent scleral show.

## Sequencing of Procedures

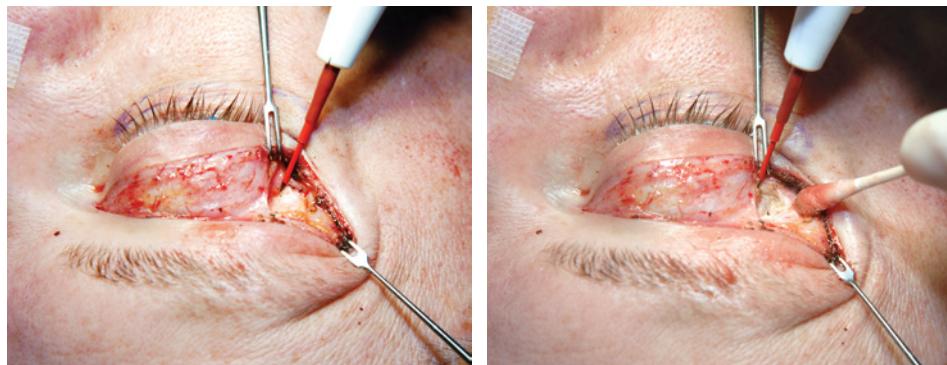
The sequence of operative steps is critical. If an upper blepharoplasty is planned as well, it should be conducted first, with wound closure delayed until after a canthopexy but before the lower eyelid pinch. Thus the lateral upper eyelid wound is available for the canthopexy, and any lower eyelid skin redundancy that may be treated with closure of the upper eyelid takes place before the pinch procedure. On the other hand, if only a lower blepharoplasty is to be performed, to accomplish a pexy a 10 to 15 mm counterincision may be made in the lateral upper eyelid along the path of an upper blepharoplasty.

## Operative Technique

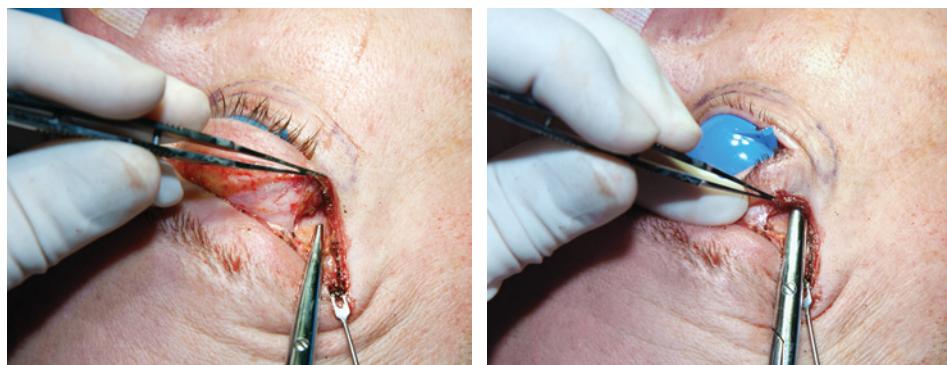
After the markings, the surgeon applies any local anesthetic early and judiciously to minimize the amount of local swelling and maximize its resolution. The transconjunctival portion of the procedure is best conducted preceding a possible canthopexy, lest the surgeon have difficulty distracting or even undoing the tightened eyelid. The canthopexy should be performed before the lower eyelid pinch procedure, because the potential lateral lift of the pexy can treat some of the lower eyelid excess. As for the lower eyelid, the excess fat is trimmed as indicated and the wound reapproximated at its midsection with a 6-0 fast-absorbing catgut suture.

The upper eyelid portion of the blepharoplasty is then performed as premarked. The excess skin and as indicated, excess muscle, are resected. Then the underlying orbital fat is treated, if necessary, with electrocautery and/or excision. Before closure of the upper eyelid wound, the lateral stitch canthopexy is performed.

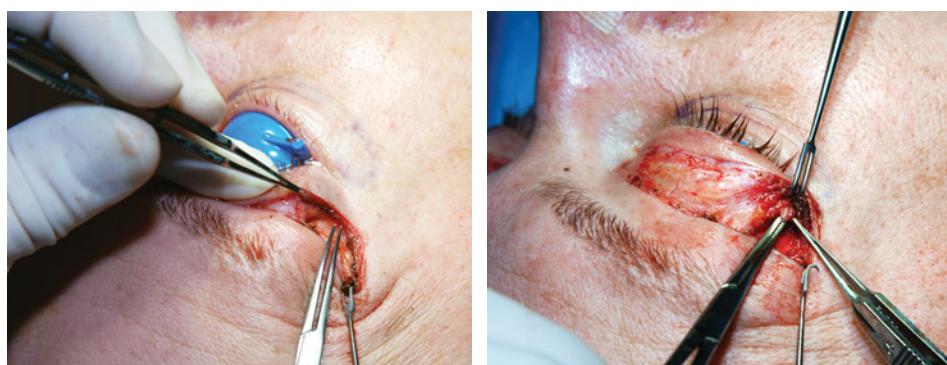
I distinguish two kinds of canthopexy to consider and design: prophylactic and therapeutic. The choice is primarily determined by two factors: the position of the lateral canthus and the posture and tone of the lateral lower eyelid. If the lateral canthus is at or above the horizon and/or the lower eyelid tone is mildly weak without scleral show, a prophylactic pexy is in order. If instead the lateral canthus is below the horizon and/or the lower lateral eyelid tone is weak with scleral show, a therapeutic lateral canthopexy should be performed. Clearly, there is always a gray zone in this arbitrary categorization: there are patients with a normal neutral canthal cant who could have an aesthetic improvement with a slight elevation of the lateral canthus, and as such the canthopexy could be considered not only prophylactic but therapeutic as well. This nuance is particularly relevant in a patient who in youth had an almond-shaped eye.



In either case, the procedure is conducted through the lateral aspect of an upper blepharoplasty incision. First, using the Bovie, a segment of approximately 1 cm of the superolateral inner orbital rim is exposed, with great care to preserve the integrity of the periosteum.



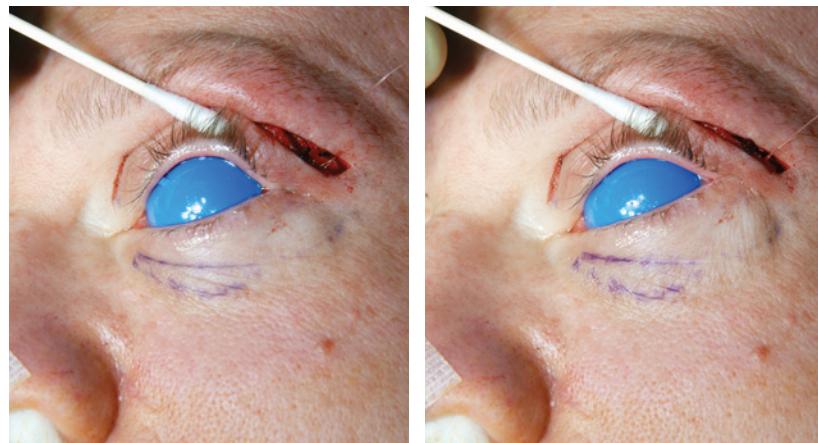
Then a subfascial/submuscular “tunnel” is created between the orbital rim and the lateral canthus using round-tipped iris scissors.



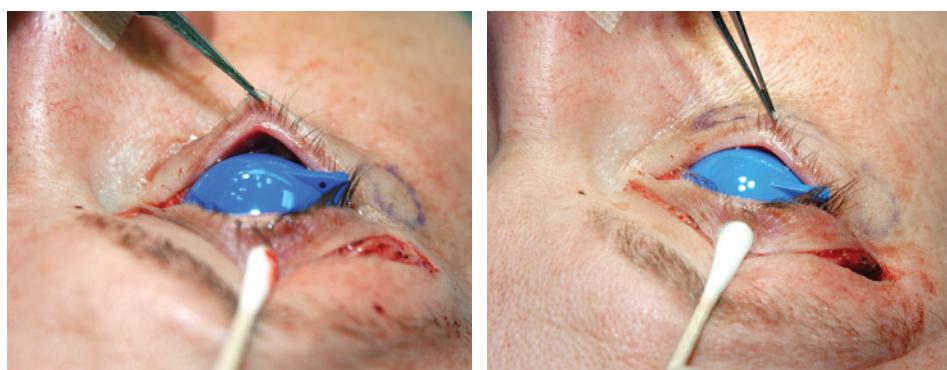
A very fine, curved mosquito clamp is passed down the tunnel, and its very tip is used to capture the lateral canthal tissue.

If a prophylactic canthopexy is planned, the mosquito clamp tip is passed up to the orbital rim to determine the ideal pexy location, which will at once modestly tighten the lower eyelid and maintain the canthal angle. If a therapeutic pexy is desired, the

mosquito clamp is manipulated as needed to produce the desired correction of the eyelid posture and/or canthal position. If necessary, the canthal tissues, still within the grasp of the mosquito, can be gradually released with a scissors or Bovie. This maneuver should be conducted with the mosquito on tension so that the surgeon can proprioceptively conduct adequate liberation of the canthus. At most, a partial release is all that is necessary to properly treat the majority of eyelids and thwart overcorrection.



The canthopexy is sutured in place by taking a double bite of the captured canthal tissue with a 5-0 clear nylon suture and securing this tissue to the periosteum within the orbital rim. The canthopexy is shown before and after it is secured. If desired, transparent scleral protectors may be used, or those shown may be removed, to facilitate placement of the pexy stitch.



The surgeon can evaluate the efficacy of the pexy on eyelid tone by conducting an immediate distraction test. An intraoperative distraction test is shown before and after the canthopexy. The canthal position can also be assessed by sitting the patient upright. NOTE: The suture should be reapplied if the desired lid tightening or canthal positioning effect has either not been achieved or is exaggerated.

## Pinch Blepharoplasty



Then, using a pair of fine Adson-Brown forceps, the subciliary skin is progressively pinched along the premarked line into a standing “wall” of skin. The endpoint should be the maximal effacement of wrinkled skin resting primarily *below* while preserving a normal posture of the eyelid margin *above*.



With a forceps producing linear traction and a straight pair of scissors, the wall is amputated at its base.



The appropriate amount of skin has been removed if the wound edges are close to each other or just kissing. The wound may be opened to electrocoagulate any small bleeding vessels and is then closed with a 7-0 running nylon suture. No taping or other support of the eyelids is necessary.

## Postoperative Care

Patients are started on iced cotton eye soaks during the surgery itself. If the eyes are iced meticulously, there will be less swelling and bruising. The patient performs this same icing routine continually for the first 48 hours, with intermittent breaks to avoid anxiety. Thereafter, icing can be used for comfort as needed.

As an additional proactive effort to encourage faster healing, patients undergo in-office ultrasonic therapy and lymphatic massage within the first postoperative day or two. This is continued for two more sessions over the subsequent week or so. This modality is a natural adjunct to the pinch blepharoplasty's goal of a faster recovery. In addition, herbs (*Arnica montana* and bromelain) to reduce bruising and swelling are given for the first 2 weeks postoperatively. Stitches are removed at 5 days, and no supportive tape is applied. At 2 weeks after surgery, the patient may gradually return to routine exercise over the subsequent 4 weeks.

At 6 months or more after the initial procedure, a planned repinch may be performed. It is usually performed with a local anesthetic and the addition of diazepam (Valium) as necessary. If the patient has lost some of the effect of the first canthopexy or still has a significant amount of redundant skin, planning a repeat canthopexy is prudent.

## Problems and Complications

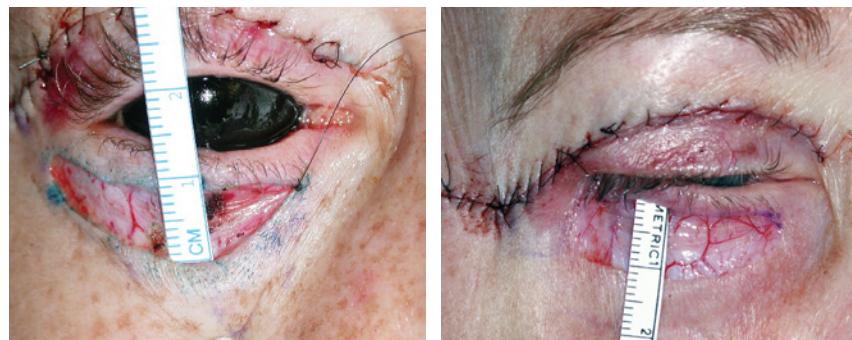
The gratifying essence of the pinch technique is that its entire premise is built on the goal of preventing the routine problems and complications seen with the traditional approach. Thus scleral show and residual eyelid wrinkling are very rare occurrences. However, some issues unique to the pinch blepharoplasty should be noted. If a non-absorbable nylon-type suture is used for the canthopexy, its knot can sometimes be seen postoperatively in a very thin-skinned patient and may need to be clipped. If the pinch is electively performed slightly lower on the eyelid, where the wrinkles often rest, the scar may initially be more visible; however, these scars do uniformly mature inconspicuously. In a patient with a significant amount of excess skin who specifically asks for or prefers a scar aligned with the eyelash, they should be informed of the reduction in wrinkle removal that may result.

When conducting the canthopexy, if there is excessive manipulation of the tissues, a chemosis covering the lateral white triangle of the globe may result. This problem is usually self-limiting but should be supported with lubricating or medicinal eye-drops. To obviate this nuisance effect, it is best to deliberately capture the pexy material with your first bite.

Finally, if performed too aggressively, the canthopexy will produce an overly corrected result. Usually the effect will improve over time. On the other hand, if the pexy is not harnessed adequately, the patient may be left with a canthal or lid deformity. The best preventive maneuver is to critically assess and redo the pexy if necessary in the first place.

## Outcomes

The spirit of this modification of the lower blepharoplasty is defined by a triad of maneuvers: (1) the deliberate preservation of the eyelid's integrity with a transconjunctival incision, (2) the mindful alignment of the lower eyelid with respect to the globe and canthus with the application of the canthopexy, and, pivotally, (3) the proficient excision of the redundant skin with the mastery of the pinch technique.



These examples demonstrate the extent of skin excision possible with pinch technique, averaging 8 to 12 mm. In addition, the patient usually has less bruising and swelling and heals more rapidly.



The typical early appearance of a postoperative patient is shown at 5 days and at 7 days. Together these efforts consistently deliver a salutary removal of redundant skin of the eyelid while still safeguarding its posture. In fact, with greater comfort performing the stitch canthopexy, the surgeon can often go one step further and cre-

ate a subtle, more aesthetic shape to the otherwise normal lower eyelid. On the other hand, particularly in a morphologically challenging patient, the canthopexy may definitively correct the attendant canthal deformity. Additionally, the application of the repinch procedure, best planned for before the first pinch is performed, has reliably contributed to even more satisfying results.

## Results

The following cases were chosen to demonstrate the power of the pinch procedure given various patient presentations—from the best to the more difficult blepharoplasty candidates.

### The Older Patient



This 68-year-old woman is shown preoperatively and 1 year after an upper and lower pinch blepharoplasty. Lower eyelid aging was corrected and a normal eyelid posture was ensured.



This 53-year-old woman with the classic stigmata of aging would previously have undergone a routine blepharoplasty with CO<sub>2</sub> laser or chemical resurfacing. Instead, upper and lower pinch blepharoplasties with prophylactic canthopexies were performed. She is seen preoperatively at age 53, in a historic photo at age 23, and postoperatively at age 54, with an attractive, youthful eyelid posture restored.

## The Younger Patient



This 36-year-old patient presented with modest wrinkling. She underwent only a lower pinch blepharoplasty with full correction, as seen 2 years postoperatively, obviating the need for laser or other resurfacing intervention.

## Orbital Groove



This 42-year-old woman, who requested upper and lower blepharoplasty, demonstrated significant asymmetrical excess of both fat and skin. The pinch blepharoplasty allowed an equally asymmetrical excision and a salutary effacing of the deep orbital groove, as seen 14 months postoperatively.

## Problem: Anatomy



This 45-year-old patient had morphologically challenging anatomy: a triad of a large globe, a negative orbital vector, and lateral canthal cant (*left and center*). In addition to an upper blepharoplasty, she underwent a therapeutic canthopexy and pinch lower blepharoplasty that corrected both the depressed canthus and the eyelid problem itself, as shown 18 months postoperatively (*right*).

## Problem: Anatomy

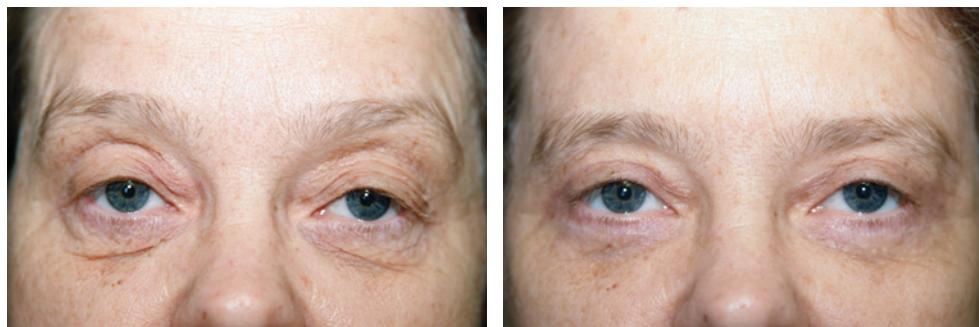


This 58-year-old patient had a spectrum of poor “design” issues: negative cheek and lateral canthus angles and scleral show. He is seen 16 months after upper and lower blepharoplasties with pinch and therapeutic canthopexies (*right*).



This 63-year-old patient had poor morphology and significant, albeit asymmetric redundancy at the lower eyelids, and proper scleral show. He underwent an upper and aggressive lower pinch blepharoplasty with an asymmetrical canthopexy. He is shown preoperatively and (*below*) with results at 7 days and at 6 months.

## Problem: Redundant Skin



This 52-year-old woman had considerable excess crêpey skin. Two years after an upper and lower pinch blepharoplasty, she demonstrates essentially complete removal of the redundant skin; good eyelid posture has been maintained.



This 73-year-old woman was an ideal patient for a pinch blepharoplasty. The photo series reveals the pathway to relatively complete repair of lower eyelid aging. The patient is shown intraoperatively, demonstrating the prodigious pinched wall of skin and wound, with preservation of an attractive eyelid posture. The 1-year postoperative view confirms the rewarding improvement.

## Problem: Persistent Skin Excess Requiring a Repinch Procedure



Preoperative



6 months after first blepharoplasty with canthopexy

This 56-year-old patient presented with advanced sun-damaged skin at the eyelids, so a second pinch procedure was planned. She underwent an upper and maximal lower pinch blepharoplasty with canthopexy. At 6 months postoperatively she demonstrated persistent excess in the upper and lower eyelids.



A revision was performed, with reexcision at the upper and repinch at the lower eyelids. The repinch roll and extent of repinch wound at approximately 10 mm are shown.



At age 20



1 year after repinch procedure

The patient is seen in a historic photo at age 20 and 1 year after the repinch surgery, demonstrating reasonable success at recapturing her youthful look.

## Repinch Procedure



This 72-year-old woman illustrates the power of the repinch procedure. The staged surgery was performed at approximately 6 months. The patient is shown preoperatively and 6 months after the first pinch procedure.



The intraoperative views demonstrate the second pinch roll, the wound kissing, and the pinch wound.



The patient is shown 4 days after the second pinch procedure and 1 year later.



This 68-year-old patient is seen in close-up views of progressive correction: preoperatively, following the first pinch blepharoplasty, and following the repinch surgery, each result 6 months apart.

## Concluding Thoughts

One could say that these modifications empower the surgeon to tame and command greater control of the lower eyelid. Personally, I have found the effects of this technique quite gratifying: I have both a newfound serenity when approaching the lower eyelid with this more reliable means for preventing surgical stigmata and a satisfaction with the results because of the more comprehensive eyelid correction that can be realized.

The procedure's advantages are particularly manifested when one is confronted by challenging morphology. As an endorsement of the efficacy of the pinch blepharoplasty, I have not performed a skin-muscle flap lower blepharoplasty in more than 12 years. The pinch blepharoplasty has eliminated the need for lower eyelid resurfacing in most cases.

In addition, we have abolished the proverbial "therapeutic" postoperative taping. I now perform more canthopexies intelligently and excise more skin confidently. The results of these efforts have included consistently faster patient recovery, more accurate canthal and eyelid positioning, and what is most important, significantly improved aesthetic outcomes.

## Clinical Caveats

- The surgeon should infiltrate the local anesthetic as early and minimally as possible. The less distortion of the tissues, the more accurate and facile the pinch maneuver will be. This is particularly germane at the start of a surgeon's learning curve. To this end, it is often helpful to sedate the patient more deeply just before the pinch procedure.
- The addition of a stitch canthopexy is a preoperative decision predicated on evaluation of 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 either prophylactic (elderly, prominent globe, malar hypoplasia, or "negative" lateral canthal position) or therapeutic (laxity or scleral show).
- Generally, if a patient is deemed to be a candidate for a lower blepharoplasty, at least a prophylactic canthopexy should probably be performed. Thus almost every patient now undergoes a canthopexy. In effect, the stitch canthopexy, when judiciously harnessed, empowers the surgeon to take full advantage of the pinch procedure and perform the most complete removal of redundant skin.
- Both the pinch blepharoplasty and the stitch canthopexy techniques have a notable learning curve. During this evolution, the surgeon should be aware that it is deceptively easy to "overpinch" or "overpexy." As a layer of protection initially, it is prudent to pinch a few millimeters farther away from the lash margin compared with the traditional incision. This scar consistently heals imperceptibly. Also, when conducting a stitch canthopexy, the surgeon should have a low threshold for replacing the stitch if an overcorrection is perceived; it may not "settle" enough on its own postoperatively. Likewise, the pexy should be reattempted if an under-correction is noted.
- The pinch portion of this technique can easily be repeated with the patient under local anesthesia to treat any residual crêpey skin.

## Annotated Bibliography

Dinner MI, Glassman H, Artz JS. The “no flap” technique for lower-lid blepharoplasty. *Aesthetic Plast Surg* 16:155-158, 1992.

*In a case report, the authors described the first lower blepharoplasty with a skin pinch in combination with the transconjunctival approach.*

Parkes M, Fein W, Brennan HG. Pinch technique for repair of cosmetic eyelid deformities. *Arch Ophthalmol* 89:324-328, 1973.

*This is the first description in the medical literature of the pinch technique for skin removal. However, the approach negated some of the benefit of the pinch, because Parkes divided the orbicularis muscle to access the fat.*

Ristow B. Transconjunctival blepharoplasty. In Cohen M, ed. *Mastery of Plastic and Reconstructive Surgery*, vol 3. Boston: Little Brown, 1994.

*Ristow included the concept of a direct excision of skin in conjunction with a transconjunctival blepharoplasty. Rather than pinching the redundant skin, it was measured, marked, and excised in a fashion akin to the traditional upper eyelid skin removal.*

## Suggested Readings

Jelks G. No touch blepharoplasty. In Cardoso de Castro C, ed. *Midface Surgery*. Philadelphia: Elsevier/Saunders, 2009.

Kim EM, Bucky LP. Power of the pinch. *Ann Plast Surg* 60:532-537, 2008.

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Zarem HA, Resnick JI. Minimizing deformity in lower blepharoplasty: the transconjunctival approach. *Clin Plast Surg* 20:317-321, 1993.