Browpexy: Lateral Orbicularis Muscle Fixation as an Adjunct to Upper Blepharoplasty

“Second Thoughts” focuses on ways in which aesthetic plastic surgeons have modified or even dramatically changed their techniques or clinical practice of aesthetic surgery over time to achieve optimal results. Contributors are Aesthetic Society members and other recognized experts.

Disatisfaction with the “traditional” upper blepharoplasty resulted in the development of a procedure to enhance the upper eyelid, which I first wrote about in 1997. During the last 3 years, I have had little reason to modify my approach to this procedure, because it has proven effective in producing the desired results. However, others have sometimes had questions about the technique, which I will address in this article.

Patients who seek a plastic surgery consult with a focus on the eyes are in fact complaining primarily about the effect of brow ptosis. The mildly pigmented and thin upper-eyelid skin must be distinguished from thick brow skin, which has lost its cephalad position over the supraorbital bone. Excising upper-eyelid skin does not address the ptotic brow and further diminishes the youthful eyelid by decreasing the upper-eyelid sulcus.

The need for restoring the upper-eyelid sulcus is apparent to both patient and surgeon if the tissues are simply tucked back in place with a cotton tip while the patient is positioned upright. The effect is immediately obvious, dramatic, and convincing.

Which patients are candidates for this procedure? With rare exceptions, all of the following: patients seeking upper blepharoplasty (Figure), patients dissatisfied with previous blepharoplasty, young and elderly patients, male and female patients, and selected Asian patients.

Once the need for restoring the sulcus is determined, the technique is straightforward. Previous publications have addressed the ptotic brow, but none have specified the need for recreating the upper-eyelid sulcus. It is often appropriate to undertake both brow elevation and browpexy.

I am sometimes asked how the transblepharoplasty browpexy elevates the brow. The answer is that it does not, unless the brow has ptosed below the supraorbital rim. In

Figure. A, Preoperative view of a 50-year-old woman with upper-eyelid redundancy and brow ptosis. B, Postoperative view 3 years after upper blepharoplasty, browpexy, and transconjunctival lower blepharoplasty. Reproduced with permission from Plastic and Reconstructive Surgery (1997;100:1258-1261).
this situation, fixation of the upper portion of the orbicularis muscle to the arcus marginalis will raise the brow and the fixation will prevent further ptosis.

The only potential problem that I have encountered involved a patient who had several previous upper blepharoplasties and complained of persistent “extra” eyelid skin. She had no definable sulcus. Simple browpexy without skin excision restored the sulcus to her satisfaction, but she then complained of dry eye. Although examination revealed that she did have adequate lid closure, it is my assumption that the complaint was the consequence of correcting the ptotic brow and thereby diminishing closure.

Questions are often asked of me that reflect a certain amount of confusion about the technique. Perhaps this confusion stems from use of the (correct) anatomic term *arcus marginalis*, which refers to nothing more than the confluence of the periosteum of the supraorbital rim and the orbital septum. When the orbital septum is incised, it immediately retracts up to the supraorbital rim and thus becomes inconspicuous. The surgeon need only clear the supraorbital rim laterally to identify the periosteum. The absorbable suture is then passed through the free margin of the supraorbital rim periosteum, and the needle is placed through the superior (cephalad) portion of the cut edge of the orbicularis muscle in the lateral third of the brow. By using the muscle, the surgeon avoids dimpling of the brow skin, which has been a problem in the past with techniques that recommended dermal sutures. Usually 2 to 3 sutures are adequate.

One of the advantages of this technique is the immediacy of the effect of the browpexy sutures. The surgeon can visualize the effect as the procedure progresses and thereby modify the suture placement.

My own personal experience, combined with that of colleagues who have adopted the browpexy concept, has not made me aware of any problems associated with the browpexy, with the exception of the questionable one cited above.

**Reference**


Reprint orders: Mosby, Inc, 11830 Westline Industrial Drive, St Louis, MO 63146-3318; phone (314) 453-4350; reprint no. 79/1/112049