Commentary on: Lower Blepharoplasty With Direct Excision of Skin Excess: A Five-Year Experience

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Every plastic surgeon has “backup” procedures that he or she utilizes to address a problem that cannot be handled with a conventional or straightforward operative approach. Certainly, excision of excess skin around the eyes—and around the facial area in general—falls into this category very well. I was pleased to see this article and review the substantial number of cases that have been performed by the author, given the strong results.

I have been employing direct skin excision in the facial area for more than 25 years, including the lower lids, the upper lateral brow area, the perioral area, and sometimes the submental area. These procedures for direct excision have been well received by patients and, for the most part, have been trouble-free. Furthermore, the scars have been nearly invisible. Occasionally, a small pucker or a distortion would show where the scar had been made, but this was not usually the case.

In terms of skin excision in the lower eyelid areas, this has been well documented in articles on transconjunctival lower-lid blepharoplasty with a lateral skin “pinch” (which is another way of saying “lateral skin excision”). In short, there is extensive experience with this in the published literature, and the advantage of minimized scarring as a result of the relaxation of skin and the accompanying skin lines in which a scar could be hidden has been well established. Netscher and Peltier1 published a nice review of 23 patients who had surgical excision of various areas of facial skin, including the nasolabial area, malar bags, and brow skin. These extra excisions enhanced patients’ aesthetic appearance by removing baggy or relaxed skin, elevating the brows, and improving contour. Excision of lower-lid festoons responds well to this technique also, as does excision of a strip of subbrow skin to tighten the upper lids.

With regard to the lower lids themselves, two different approaches can be applied to remove excess skin. Furnas2 described a skin-muscle flap, which tended to pull both layers of tissue up nicely and which allowed suspension to the lateral canthal area for good support. This same operation can also be performed, as I do it, with a separate skin flap and an orbicularis muscle flap suspended to the lateral canthus, followed by redraping of the skin. However, in some cases of festoons of the lower lid, simple skin excision may be best and would put less tension on the lower lid, avoiding lagophthalmos or ectropion, both of which can be complications of the suspension technique. In patients who are mildly or fully anticoagulated, direct excision of the skin (as opposed to elevation of the skin flap) is less invasive and the bleeding is more manageable, so it would be useful in those cases.

The authors have not only excised excess skin tissue in the lower periorbital region, but have also removed fat pads through this procedure. The approach certainly allows direct visualization of the fat pad and easy access, and it does so without disturbing the complex relationship of the pretarsal muscle to the lower tarsal margin. In general, their results are good and serve to reinforce the concept that this is a cosmetically acceptable procedure that can accomplish the desired results.

I recommend that some of the younger surgeons who do not have experience with direct excision of excess facial skin try this approach in the lower eyelids before attempting it in other areas on the face. The incisions are forgiving and the procedure will provide strong experience so that the surgeon will see firsthand just how favorable the results from direct skin excisions can be.

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References


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