Commentary on: Case Studies in Asian Blepharoplasty

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In the abstract for this article, Dr. Takayanagi clearly states that there are many deformities that can result from aging of the Asian eyelid. Each patient represents a unique combination of factors that could include excess skin, sunken eyelids or atrophic tissue in the subbrow area, asymmetric single or double eyelids, ptosis, unilateral or bilateral deformity, and any combination of these. Additionally, it is noted by the author that the operative procedure does not always end in a perfect result and patients may require further procedures to enhance or improve a more moderate result. Skin quality, brow muscle activity, and the patient’s desire for a particular appearance therefore influence the surgeon’s decision about which procedure to perform and exactly how far to pursue the correction. One further factor for Asian patients is that some wish to retain at least a certain aspect of their original Asian eyelid appearance, fearing that they will look unusual to their family or friends by not conforming to the cultural standard in their particular group. Still others clearly wish to change from single eyelid to double eyelid, have open and bright eyes, or completely alter the appearance of their eyelids with operative intervention.

This review of the literature, including examples from the author’s own patients, reflects his many years of experience in attempting to analyze the components or key aspects to correcting deformities of the Asian eyelid. In consulting with these (and all) patients, it is important to accurately ascertain the patient’s desire in terms of a final result. The surgeon must then carefully consider the individual parts of the selected procedure in terms of the final result; each intraoperative maneuver functions as a complex individual procedure that influences the postoperative result.

For example, in one patient, there may be dermatochalasis, pseudoptosis, single eyelid deformity, and asymmetric true ptosis. In this case, the desires of the patient with regard to single or double eyelid, the influence of elevation of the true ptosis on the lid crease position, the amount of skin to be excised, and whether to add fat to the infrabrow area all may need to be considered. If the surgeon selects ptosis repair by levator shortening, excision of skin excess, addition of block fat or injectable fat grafting, and correction of brow ptosis, each component may affect the final result as a single factor. This type of complex surgical algorithm does not lend itself easily to classification, but responds better to compartmentalization of the individual factors, with the end result perceived as an overall harmonious appearance. There is no “one size fits all” in this type of surgery, which the author clearly conveys in his summary of the available techniques.

I think that the take-home message from this article is to analyze every Asian eyelid as an individual complexity of one or more etiologic factors, after which the surgeon should guide the patient through a discussion of exactly what he or she can expect in terms of a postoperative appearance. As with any surgical procedure, this is sometimes challenging since it can be difficult for patients to visualize the “final picture.” With this in mind, it may be helpful to have patients bring in facial photos of themselves when they were younger or photos of what they consider to be the “ideal” aesthetic appearance of their lids.

Levator shortening procedures are slightly more complex with the Asian eyelid, but basically follow the same rules. For minimal ptosis, aponeurosis “tucking” techniques can be useful for 1- or 2-mm corrections. For more significant corrections, or in the case of aponeurosis dehiscence, actually severing of the aponeurosis from its original insertion and replacing it directly to the tarsal plate will correct the ptosis. This should be performed carefully under monitored conditions, so that the eyelid level can be seen clearly at the time of surgery with the patient awake. When the levator shortening is complete, it “compresses” the tissue between the lid crease and the mideyelid area, which appears to lend some bulk to that area. This may eliminate the need for fat grafting in a patient who has atrophy from the mideyelid to the subbrow area.

One of the concerns with surgery on the Asian eyelid is that overresection of skin is nearly impossible to reverse. I believe that this is the most common cause for dissatisfaction in patients who have undergone the “double eyelid” correction. Care must be taken on this point so that overcorrection is avoided. Although these procedures can be challenging and complex, addition or subtraction of tissue and correction of the lid level or eyelid shape can yield good results in the hands of surgeons who take the time to categorize each patient’s specific deformities, treating them both individually and as a total eyelid.

Disclosures

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