DIRECT EYEBROW LIFT

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Before moving to more complex approaches such as the endoscopic eyebrow lift, the surgeon must master the fundamental concepts of preoperative evaluation, indications for surgery, surgical anatomy, and the basic direct browlift procedure.

The direct eyebrow lift is generally performed with local anesthesia and requires excising the tissues adjacent to the superior line of the brow follicles. The advantages of a direct approach include less operating time, less anesthesia, and the ability to address the whole eyebrow or a specific segment of it by manipulating the shape of the excised tissue. In general, the closer the surgery is performed to the eyebrow the more effective it is. The direct browplasty is therefore an excellent option in cases of severe brow ptosis or in patients with a receding hairline or baldness where incisions used for other approaches would leave noticeable scars. The degree of elevation and the long-term results are excellent when compared with other approaches. The major negative aspect is the inferior cosmetic outcome with a supraciliary scar that is sometimes more visible than expected, depending on the healing ability of the patient.
ETIOLOGY

As the aging process continues, the gravitational syndrome occurs at different rates in different people, resulting in sagging or involutional ptosis of the eyebrow with redundancy of skin. Downward displacement of the tissues also takes place as a result of facial overactivity patterns such as squinting and frowning. In these cases the overactive depressor muscles determine the most affected area of the brow. Paralysis of the facial nerve [cranial nerve (CN) VII] or its temporal branch also leads to moderate to severe eyebrow ptosis with blunting of the ipsilateral forehead rhytids due to loss of tone of the frontalis muscle.

PREOPERATIVE EVALUATION AND INCISION MARKINGS

The position of the eyebrows is extremely important when evaluating a patient who complains of superior visual blockage or drooping eyelids. Commonly, patients who present with upper eyelid ptosis or dermatochalasis also have eyebrow ptosis. This sagging of the eyebrow can add fullness and weight that, when combined with an abnormal levator muscle or excessive eyelid skin, can result in more hooding and loss of superior visual field. Recognition is crucial to prevent inadequate surgical management and failure to help the patient.

Gender differences exist, with eyebrows being higher, more arched, and slightly raised laterally in women. Male eyebrows are usually described as T-shaped: They are less inclined and lower, with the inferior border at the level of the superior orbital rim. This baseline difference could be the reason that brow ptosis is more prevalent in men than in women.

The preoperative evaluation is always performed with the patient sitting upright with relaxed frontalis muscle action. A 1:1 lift desired/skin excised ratio is used. The eyebrow is manually elevated to an appropriate position. This amount of lift is measured using a ruler in the lateral, central, and medial aspects of the eyebrow. A fusiform skin incision pattern is usually obtained where the upper line of eyebrow hair follicles dictates the inferior marking, and the superior marking is given by the measurements previously taken for each portion of the eyebrow. As a general rule, the inferior incision line should include a small number of the superiormost brow hairs.