Surgery for Oriental Eyelids: Some Refinements in Technique

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ABSTRACT / Surgery for Oriental eyelids falls into two broad groups. One method uses the conjunctival approach, and the other, the external skin approach. Technical refinements in the skin approach method which the author has developed over the last 10 years are described.

The Oriental eyelid (Fig. 1) has some or all of the following features:

1. The superior palpebral fold is absent.
2. The eyelid is loaded with an excess of fatty tissue.
3. The cutaneous insertion of the levator palpebrae superioris is absent. The eyelid skin hangs down like a curtain and obscures the eyelid margins. This gives a pseudoblepharoptosis.
4. The palpebral fissure is narrow, longish, and tilted laterally.
5. The eyelashes point downward with the eye in forward gaze.
6. The mongolian fold (plica mongolia) is present in approximately 50% of cases.

The most common request nowadays, among Orientals, is for construction of the superior palpebral fold. We do not advise tampering with the mongolian fold because of the high incidence of keloids, hypertropic scars, and depigmented scars. Broadly speaking, two methods are used, i.e., the conjunctival approach (1, 4) and the external skin approach (2, 5). Since my last paper in 1963, I have developed certain refinements in technique which have further enhanced the aesthetic result of the operation (Fig. 2). The principles of the operation have, however, remained the same. The excess fat is removed through the skin incision. This incision will later form the definitive superior palpebral furrow. Then the skin is attached (some authors use the word anchored) to the levator expansion with interrupted silk sutures. The resulting scar between the two anatomic structures simulates the cutaneous insertion of the levator muscle, which is commonly found in the Caucasian. All cases are done under local infiltration anesthesia with sedation.

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The skin incision (Fig. 3) is made approximately 5 to 8 mm from the eyelid margin. A sliver of skin is removed from the medial to the lateral canthus. The amount and pattern of skin removed will depend on the aesthetic sense of the operator. If eyelid skin overhangs the lateral canthus too much, the skin incision can be extended laterally along a wrinkle line and the excess skin trimmed.

The supraorbital fat (Figs. 4 and 5) is easily identified, and as much as possible of this fat should be removed. In the Oriental eyelid a medial pocket is common, but very seldom a lateral pocket is found. These two smaller pockets are noted after the large central pocket is removed. Next, the retromuscular fat must be identified and removed (Fig. 6). This fat is often neglected in the literature. The deposition of fat in the upper eyelid of the Oriental is an interesting study (3). Judicious removal of the retromuscular fat, especially over the lateral portion of the eyelid, further enhances the aesthetic result of the operation.

The fatty tissue and a section of the obicularis oculi are then removed from the lower skin flap. This may cause considerable bleeding, especially when the patient has been taping the eyelids daily to develop a temporary superior palpebral fold. But it is worth the extra effort.

The glistening white levator expansion lies posterior to the supraorbital fat compartment, and it serves as an important landmark (Fig. 5). Failure to identify this structure may lead to failure of the operation. A row of fine (6-0 silk) interrupted sutures (Fig. 7) is used to attach the skin wound to the levator expansion. It is important to pick up the levator at the same level on both sides. Also, sutures must not be attached too high up on the levator expansion, or the patient will have a thyroid stare. The sutures are left in for 5 to 7 days. No pressure dressing is used postoperatively. The results of this operation are satisfying to both patient and surgeon. It is the most common operation used from among the entire range of aesthetic surgical techniques on Orientals (Figs. 8 through 10).