MOPSS

Minnesota Ophthalmic Plastic Surgery Specialists, P.C.

This year marks the **30 year** anniversary of Minnesota Ophthalmic Plastic Surgery Specialists! Our doctors have a combined **55 years of experience** with oculoplastic surgery. We appreciate your trust over the last 30 years. Thank you! It has been our pleasure to take care of your patients. As you know, we provide diagnostic and surgical care for patients with eyelid, orbital and lacrimal issues and offer the latest surgical techniques including small incision and endoscopic approaches. We also have a special interest in aesthetic oculoplastic surgery and offer scarless lower blepharoplasty, endoscopic browlifting and nonsurgical treatments including BOTOX and fillers. We hope you enjoy this newsletter and if you have any questions, please do not hesitate to contact us at 952-925-4161.

Eric Nelson, Andrew Harrison, Meredith Baker

O P H T H A L M I C P L A S T I C A N D R E C O N S T R U C T I V E S U R G E O N S

Dr. Eric R. Nelson

Dr. Meredith Saylor Baker

Dr. Andrew R. Harrison

Battle of the Second Bulge
Management of Malar Mounds & Festoons

Lower Lid Blepharoplasty in a Filler-filled World

Droopy Upper Lids:
More than Meets the Eye

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Eric R. Nelson, MD Ophthalmic Plastic & Reconstructive Surgeon

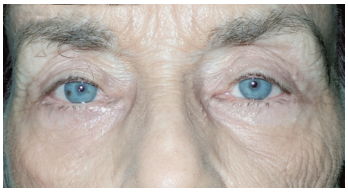
Dr. Nelson founded Minnesota Ophthalmic Plastic Surgery Specialists, P.C. in 1990 and has been in private practice over 20 years.

Battle of the Second Bulge

Management of Malar Mounds and Festoons in Lower Eyelid Blepharoplasty

The majority of patients presenting with lower eyelid esthetic complaints are concerned about their fatty "bags" in the eyelids. Nearly half of these patients additionally have malar edema, malar mounds, or festoons just below the fatty "bags". This second area needs to be addressed or at least discussed with patients in order to achieve a happy post blepharoplasty patient.

Pre-MidFace Lift

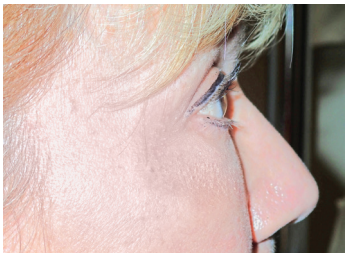


Post-MidFace Lift

Pre-Direct Festoon Excision

Post-Direct Festoon Excision

Before CO_2 Laser



After CO_2 Laser

PHOTOS COURTESY OF ERIC R. NELSON, MD

A malar mound is a soft tissue bulge over the malar eminence, and a festoon is a cascading hammock of lax skin hanging between the medial and lateral canthi. In common usage, festoon describes a festive ornament of flowers, foliage, or fabric hung in a graceful loop between two points. Patients find eyelid festoons to be decidedly unfestive, particularly when they swell postoperatively after upper or lower eyelid surgery. So again, recognition of festoons and pre-operative discussion are key.

I will outline my approach to management of malar mounds and festoons, from diagnosis through treatment. Initially, any cause of facial inflammation or swelling should be recognized and explored. In my experience, rosacea is the most common cause of festoons related to eyelid edema, with thyroid orbitopathy a distant second. Other causes include allergies, medications, and whole body edema due to systemic

causes. Those various entities should be addressed, but management will rarely obviate the need for surgery.

Subcategorizing festoons is very useful when discussing management with the patient. Mild festoon and malar mounds can be managed effectively with the CO2 laser. The laser will tighten the underlying collagen, efface the fullness, and tighten the crepe skin. One caveat is that particular care should be taken in rosacea patients with marked telangiectasia, because laser treatment can make the telangiectasia more prominent. With that exception, laser treatment of mild festoons is extremely effective.

Moderate festoons are associated with both skin redundancy and involvement of deeper tissues. Most of these patients have some degree of midface descent. A midface lift will resuspend the deeper structures away from the eyelid-cheek junction. This can be combined with skin tightening procedures such as laser if needed.

Severe festoons are frequently associated with a large fold of skin at the eyelid-cheek junction, or sometimes “folds upon folds”. Lasers and peels are not capable of producing enough skin tightening to eliminate the folds. Those patients are candidates for direct excision of the festoons. Patients are presented with the option of direct excision with the understanding there will be a discreet scar, and most patients prefer a subtle scar to an obvious fold.

In some cases fillers may be used in place of the above-mentioned procedures, but more commonly can be used to supplement these techniques.

In summary, the management of festoons is dictated by the patient’s own anatomy and aging process. With careful patient selection and thorough discussion, the results can be very rewarding.

Meredith Saylor Baker, MD Ophthalmic Plastic & Reconstructive Surgeon
Dr. Baker is passionate about providing the highest quality clinical and surgical care and educating patients about their conditions.

Lower Lid Blepharoplasty in a Filler-filled World

Management of Lower Eyelid Blepharoplasty Patients with a History of Hyaluronic Acid Fillers

Hyaluronic acid (HA) fillers are increasingly used in facial rejuvenation and periocular volume restoration. With an excellent safety profile, these fillers are currently regarded as the gold standard in the treatment of lower eyelid hollowness or even to mask lower eyelid fat prolapse. In general, patients with prominent tear troughs or infraorbital rim hollowing with little to no orbital fat prolapse are potential candidates for injectable filler treatment, while those with orbital fat prominence are likely better candidates for lower eyelid blepharoplasty.

Despite their excellent track record and gained popularity, HA fillers are not without undesirable consequences, particularly in the lower eyelid blepharoplasty patient. Filler persistence, filler migration, skin expansion from overfilling, contour abnormalities, blue-gray dyschromia, and persistent edema are notable short- and long-term filler-related issues for patients undergoing filler in the periocular area. These consequences are particularly important to recognize prior to surgical intervention, and specifically, prior to lower eyelid blepharoplasty.

Anecdotally, surgeons have recognized the challenging nature of lower eyelid blepharoplasty in a filler-filled world. However, the literature is also now beginning to describe suboptimal outcomes, most commonly persistent edema, in patients who have undergone lower eyelid blepharoplasty in the setting of prior HA fillers. With increased recognition of these undesired issues, surgical outcomes are also improving.

Patients who have received HA injections often require repeat injections or additional treatments prior to surgery. More specifically, most surgeons recommend treatment with hyaluronidase to fully dissolve all filler material prior to any surgical intervention to avoid unwanted or suboptimal outcomes – the most common of which is persistent malar edema.

Due to the immediate results and rare complications of periocular HA fillers when administered by experienced professionals, their increasing popularity is not surprising. With this increased popularity, the awareness of HA filler-related issues is critical. This awareness, in turn, allows for effective pre-operative patient counseling as well as prevention of potential undesired consequences paving the path for excellent outcomes in lower eyelid blepharoplasty patients with prior periocular HA fillers.

Lower Lid Blepharoplasty in a Filler-filled World: Management of Lower Eyelid Blepharoplasty Patients with a History of Hyaluronic Acid Fillers

Andrew R. Harrison, MD Ophthalmic Plastic & Reconstructive Surgeon

Dr. Harrison has practiced oculopastic surgery since 1999 and joined Minnesota Ophthalmic Plastic Surgery Specialists, P.C. in 2000.

Droopy Upper Lids: *More than Meets the Eye*

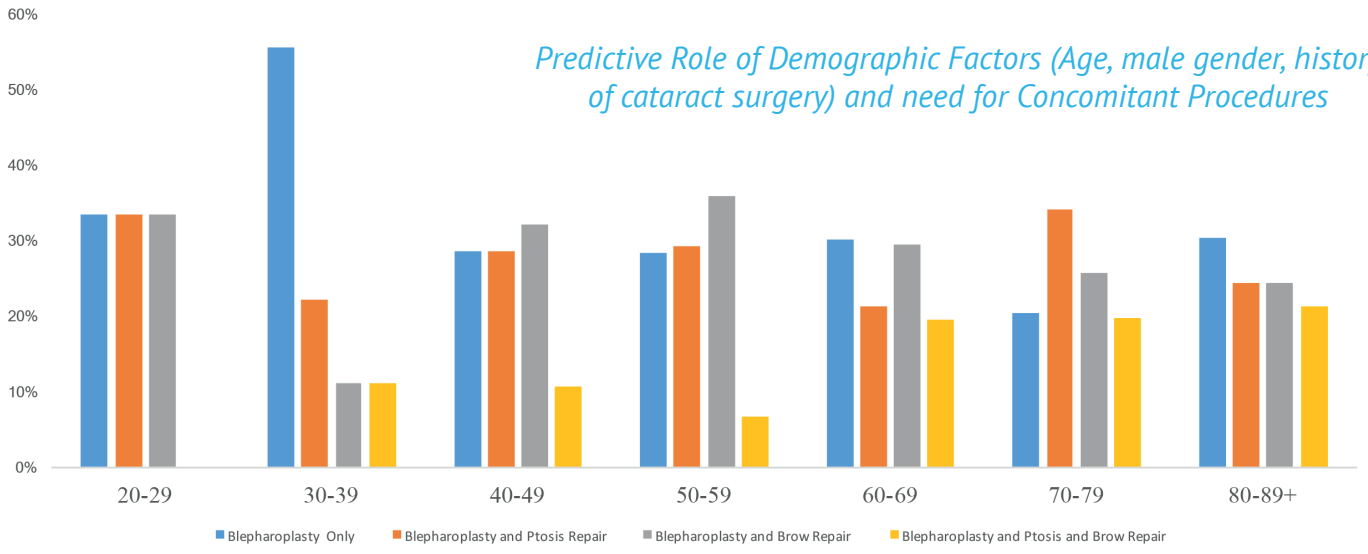
The aging eyelids undergo many changes that can affect vision and visual quality. Patients may present with numerous functional complaints due to upper eyelid dermatochalasis, which, when appropriately addressed, may improve contrast sensitivity, peripheral vision, and quality of life. These patients also benefit from aesthetic improvements. The blepharoplasty surgeon, however, must take care to appropriately diagnose other underlying anatomic changes as unrecognized ptosis or brow ptosis may be unmasked after upper blepharoplasty. I recently conducted a study to identify the frequency of concomitant procedures in upper blepharoplasty patients, and to identify preoperative predictive factors to aid the surgeon in identifying patients that would benefit from an additional procedure. This was the first study of its kind in patients undergoing upper blepharoplasty.

We reviewed over 500 charts of patients who presented for upper lid drooping. The average age of the patients included in this study was 64.6 years old and 61.3% were female. These demographic characteristics are similar to previously published data. A systematic review article on functional blepharoplasty published by Hollander et al. evaluated 24 studies, which showed the average was 55 years old (range: 46–73). Among the 22 studies reviewed that specified the percentage of female patients, 81% of the patient population was female (range: 61-100%). While the study population presented here was slightly older and the patient population included more men, it is well within the range of studies reported in literature.

The data presented in this paper showed that most patients undergoing blepharoplasty required concomitant upper lid ptosis repair and/or brow repair to fully address their functional visual complaints (see figure). Older patients in this population ultimately required more procedures to treat their functional complaints as we expected. Brow ptosis repair was a common concomitant procedure performed in this patient population, particularly amongst males with 58% requiring this procedure in this study. Brow ptosis arises from the effects of gravity, tissue-

laxity, and volume-loss as the patient ages. **Performing an upper blepharoplasty in the presence of unidentified brow ptosis could worsen brow position and lead to an unacceptable aesthetic result and persistent functional changes.** Another factor in our study that was predictive of patients needing additional procedures was a history of cataract surgery. **The development of persistent ptosis after anterior segment surgery is well known, with the incidence of ptosis documented between 4-21%.** While the precise mechanism of blepharoptosis after cataract surgery remains unclear, it is thought to be secondary to speculum placement that occurs during cataract surgery.

In conclusion, the study presented here demonstrates that many patients undergoing blepharoplasty procedures often require additional ptosis or brow ptosis repair to address their upper lid changes. Age, male gender, and a history of cataract surgery all appear to play a predictive role in whether an individual patient may need concomitant procedures. Better understanding of the demographic factors that predisposes patients to benefiting from additional ptosis or brow repair deepens the surgeon's understanding of conditions causing superior visual field obscuration. This in turn allows for further discussion between the surgeon and patient as to which surgical options would best address the patient's visual complaints.



Predictive Role of Demographic Factors (Age, male gender, history of cataract surgery) and need for Concomitant Procedures

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