

THE EYEBROW AND UPPER LIDS

In the Oriental, there is a new conservatism as regards eyelid surgery. In the years following the Second World War, cosmetic surgery gained popularity in Asia and many patients sought westernization of the eyes. Recently, however, there has been movement in the other direction. It has always been my contention that the Asian desire was simply for more * beautiful Oriental lids. Perhaps this was true, but in any case, there is now emerging in the Orient a dislike for procedures that westernize the eyes. The emphasis now is on lid folds that are natural in character and subtle in prominence (which means that the distance between lid fold and lash line stays small).

One way to maintain the natural characteristics of the Oriental eye and avoid any suggestion of surgical alteration is to position the brow upward through a coronal lifting procedure. This freshens and rejuvenates the appearance, and emphasizes the naturally existing lid fold that is usually present. In the Oriental, it is the descent of the thick, juxtabrow tissues in the lateral orbit that gives the eye a tired, weary, and occasionally unhappy appearance. This ptosis of the lateral brow also takes away from the basic Asian design of the orbital region by decreasing the visualized pretarsal portion of the eyelid laterally relative to that in the central or medial portion of the lid. This characteristic is unnatural and rarely occurs in the youthful Oriental. Thus, the person who is interested in only a "refreshing," in other words a very subtle change without a surgically altered appearance to the lids, may be best served by a well-done coronal lift. This is done by resecting primarily from the superior lateral portions of the flap, with very little or nothing removed centrally. Five or six years ago, I presented an essay on the importance of combining coronal lifting procedures with Oriental blepharoplasty in the older person, or one with low positioning of the brow, at an international meeting in Tokyo. This reduction of lateral brow descensus is very important, but coronal lifts should be used very cautiously in patients with *hollowed-out* upper lids. They inevitably increase the visibility and prominence of the hollowed-out, deep-set orbit in the patient with this predilection. When the hollow

is deep and prominent, it may be wisest to delete the coronal lift from the list of procedures to be done, even though it may be desirable from the standpoint of lateral brow descensus. During the planning stage the brow should always be checked mechanically and elevated to see if there is an exaggeration of undesirable features. If there is, it should be deleted. Among Orientals living in Asia and Hawaii, eyebrow tattooing has increased markedly in popularity. Most tattoos are done by non-medical technicians. Often the brows are expertly designed and executed. The popularity of tattooing amongst Orientals no doubt relates to the frequency of scanty brows among their racial types. This allows tattoo artists to position the brow at any point desired, even though the actual brow pad that normally bears the follicles may be resting down on the upper lid. Thus the "brow" may be moored on the forehead skin and, although a coronal lift would improve the appearance of the upper lid and the lid fold, it could cause an abnormally high placement of the new eyebrow. In rare instances, the solution to this may be skin excision just beneath the tattoo's caudal margin.

LID FOLD PROCEDURES

Most Orientals have some degree of fold present during youth. Some young Orientals have a prominent fold on one side and none on the other, which raises interesting anatomic questions. There continues to be much interest in procedures designed to create lid folds. There are those who suggest very simplistic methods of creating them, such as the use of one cutaneously applied nonabsorbable suture running subcuticularly and subconjunctivally, or the simple excision of skin and muscle from the upper lid, or excision of skin and cautery along the muscle. All of the above are invalid methods of obtaining long-term esthetically pleasing lid folds. There remain two basic techniques: the closed method and the open method. Figure I depicts the open method I developed in 1970 and have used since 1972 on virtually all patients. It is increasing in popularity both in the United States and in Asia. Those who have learned the procedure have found it highly effective and it produces consistent and predictably high quality

esthetic results. In the anchor technique that I have proposed, the use of an absorbable suture is important. Even the experienced operator occasionally has a suture that transgresses the conjunctiva. It is comforting to know that these "poaching" sutures eventually absorb and that resultant irritation of the cornea or globe is time-limited. It is also reassuring to know that a Nylon, Dacron, or silk suture will not work through the conjunctiva at some late date after surgery. In my proposed technique the attachment to the tarsus provides an anchor for extra security and checks against lash eversion, which is a common problem after lid fold procedures. Connection to the aponeurosis keeps the pretarsal skin taut. Laterally, where the tarsus dwindles in vertical height, the aponeurosis is attached only to the dermis of the skin Rap. Thus, in the far lateral lid, I revert to the basic technique proposed by Dr. Fernandez in 1960.

It is essential that the lid be flipped over and measured preoperatively because the vertical height of the

Oriental lid cannot be presumed. The Oriental tarsus is usually 9 1/2 to 10 mm, but may occasionally be as small as 7 mm in vertical height, especially in very petite Asians.

It is always essential to define the desired esthetic characteristics of the eye in both Oriental and Caucasian eyelids. A high quality result is unlikely to occur fortuitously in the absence of a precise plan. For me, the features of such a plan continue to be a fold that begins very close to, but just above, a light, medial epicanthal canopy rises to a maximum divergence from the lid margin near the central eye, and then continues at that level across the remaining portion of the eyelid. The suture technique has many variations, but the basic technique is depicted in Figure 2. It can produce a nice fold in the thin lid, but generally yields less permanence than the open technique. It allows for no fat removal, which is often a key element of Oriental lid surgery (the medial compartment should not be ignored).

The medial epicanthus continues to require attention, with the best method being my modification of the Uchida split V-W epicanthoplasty, as illustrated in Figure 3. One must ensure that the upper limb epicanthoplasty in-

cision never joins with the upper lid incision but is significantly above it, thereby avoiding combined contracture. The medial extent of the lid fold incision usually approaches within 2 or 3 mm of the lid margin. The hollowed upper lid produces a dilemma in the Oriental. So far, techniques of injecting autogenous suspensions of fat cells have not been shown to have longterm beneficial effects in the upper orbit. Transposition of the lateral tail of the "lateral" orbital fat to the hollowed out medial section of the lid, together with the occasional use of prominent medial fat transposed laterally (Fig. 4), will be of benefit. Free grafts of fat have proved less effective than the use of free subgaleal areolar tissue grafts from the scalp, harvested during combined coronal lifting type procedures. On the lower Oriental lid it continues to be important to avoid raising skin flaps. Avoidance is aided by the fact that in most young Orientals there is little or no skin to be removed. Since skin incisions on the lower lid are much more prominently displayed in Orientals than in Caucasians, the transconjunctival approach to orbital fat continues to be an often preferred technique.