Patient information

Blepharoplasty and Eyebrow Surgery

Ophthalmology Department – Aintree Hospital

Who is this leaflet for?

This leaflet is for people who are undergoing blepharoplasty and eyebrow surgery for hooded / droopy eyelids and eyebrows.

What is dermatochalasis?

Dermatochalsis is drooping or folding of excess eyelid skin.

It is caused by the skin loosing its elasticity, usually due to age.

It may be associated with prolapse of orbital fat causing the eyelid to bulge (eye bags).

It occurs to a greater degree and at an earlier age in people who have thyroid eye disease.

What is eyebrow ptosis?

Eyebrow ptosis is drooping of the eyebrow. This may contribute to hooding of the upper eyelid skin.

It is often necessary to elevate or fix the eyebrow at the time of blepharoplasty surgery.

It is most commonly caused by ageing, facial paralysis and trauma.

What is Blepharoplasty Surgery?

Blepharoplasty Surgery is the removal of excess eyelid skin.

Depending on an individual the muscle or fat underlying the skin may also be removed or repositioned.

The procedure can be carried out in the upper or lower eyelid.

What is Eyebrow Ptosis Surgery?

Brow ptosis surgery is the fixation or elevation of the eyebrow to overcome the downward descent of the eyebrow that occurs with age or facial paralysis.

Who is eligible for surgery in the NHS?

Surgery is available on the NHS if the dermatochalasis and/or eyebrow ptosis are causing a functional problem such as reduced visual field.

Cosmetic surgery is generally not available in the NHS, unless a cosmetic deformity has been caused by trauma, previous surgery or a specific medical problem, such as Thyroid Eye Disease.

Upper eyelid blepharoplasty:

At the beginning of the operation the amount of skin to remove will be carefully assessed. Marks will be drawn on the eyelid with a sterile marking pen to assist the surgeon during the procedure.

After this, local anaesthetic will be injected under the skin in the upper eyelid.

The skin is removed with surgical instruments. Depending on your particular problem, the muscle beneath the skin may be preserved or partially removed.

If there is fat prolapse in the upper lid this may be treated with partial fat removal.

Sutures are placed to reform the natural skin crease in the eyelid.

The skin edges are sutured together with a continuous suture that is removed one week later or absorbable sutures.

This operation may be carried out under general anaesthesia, local anaesthesia plus intravenous sedation or simply local anaesthesia on its own.

Lower eyelid blepharoplasty:

There are four elements to lower lid blepharoplasty: skin, muscle, fat and eyelid laxity. The procedure you have will be tailored to suit your problem.

Fat prolapse in the lower eyelid gives the appearance of ‘eye bags’.

This fat can be excised or repositioned over the orbital rim to create a smoother transition from the eyelid above into the cheek below.

Surgery on the prolapsed fat may be done without a skin incision from the inside of the eyelid – transconjunctival or via a skin incision just beneath the eyelashes – transcutaneous.

The lower eyelid usually needs to be tightened at the time of surgery. Even a small amount of lid laxity can lead to postoperative lower lid retraction if not addressed at the time of surgery.

This tightening is called ‘lateral canthal suspension’ and involves a permanent suture from the lid to the bony rim of the orbit.

The orbicularis muscle, which lies directly beneath the skin is often tightened by placing sutures from it to the bony rim of the orbit – ‘lateral retinacular suspension’.

Lower eyelid skin is excised in much smaller amounts than in the upper lid. This is to avoid the unwanted side effect following surgery of eyelid retraction.

Internal eyebrow fixation surgery:

Permanent sutures (x1 to x3) are placed underneath the eyebrow, fixing it to the bony orbital rim.

This is performed through the same incision made for the upper lid blepharoplasty.

External direct eyebrow lift:

Skin is removed directly above the eyebrow in a crescent shape to lift a descended eyebrow.

This can only be done in the outer part of the eyebrow so as to avoid damaging nerves that are found under the inner eyebrow.

Before surgery the area to be excised will be carefully assessed with you sat up. Marks will be made on the skin with a sterile marker pen.

This is a more powerful operation than internal brow fixation but has the disadvantage of a skin incision that may be noticeable.

After the excision the skin is sutured together in a deep layer and separate skin layer.

What are the benefits of surgery?

Both eyelid and eyebrow ptosis may reduce the visual field due to the hooding of skin over the eyelid.

In an attempt to raise the eyebrow and eyelid people often use the forehead muscle. Fatigue of the frontalis forehead muscle may cause discomfort, particularly at the end of the day.

What are the alternatives to surgery?

There are no alternatives to surgery in correcting upper eyelid dermatochalasis and eyebrow ptosis.

Some patients weigh up the risks and benefits of surgery and decide to put up with the problem, feeling that the risks of surgery are too great for them – it is an individual decision.

Having dermatochalasis or brow ptosis does not damage the eye, so it is a reasonable option to decline surgery if you wish.

What will happen if I decide not to have surgery?

You will continue to have dermatochalasis and/or eyebrow ptosis, however this will not damage your eye in any way.

What will happen before surgery?

Before the operation you will be seen in the clinic by your consultant or a member of the team.

The doctor will ask you about your problem. He/she will also ask about other medical problems you have and medications you take (bring a list or the tablets themselves with you).

The doctor will examine your eyes and your visual field.

If you are to proceed with surgery the operation will be discussed in detail. This will include any risks or possible complications of the operation and the method of anaesthesia.

You will be asked to read and sign a consent form after having the opportunity to ask any questions.

You will also see a preoperative assessment nurse. You will have blood tests and an ECG (heart tracing) if required. You will be told if and from when you should to starve before the operation.

What should I do about my medication?

In some cases you may be asked to stop or reduce the dose of blood thinning tablets like: warfarin, aspirin, clopidogrel (plavix), dipyridamole (persantin), pradaxa (dabigatran), xarelto (rivaroxaban), and eliquis (apixaban). This decision is made on an individual basis and will be discussed with you before surgery.

Other medication should be taken as usual **unless the pre-operative team instruct you otherwise.**

What are the risks and possible complications of surgery?

Infection might present as increased swelling and redness of the skin. There might also be yellow discharge from a wound. Infection is treated with antibiotics.

Bleeding may present as fresh blood oozing from the site of surgery or a lump appearing near the wound after the operation. Simple pressure on a skin wound is usually enough to control minor bleeding.

Loss of vision: A blood haematoma collecting in the orbit, behind the eye, may compress the nerve of vision and threaten eyesight. It is extremely rare for this to occur. It presents as pain, loss of vision and a bulging forwards of the eyeball and is an emergency. If not treated quickly it can lead to permanent loss of vision.

Scar: Whenever the skin is incised a scar may form. Every attempt is made by the surgeon to minimise and hide scars but sometimes they can be visible.

Further surgery: Your surgeon will take great care to excise the correct amount of skin for your eyelid. It is possible for too much or too little to be excised. Under excision may be addressed by further surgery to excise more. Over excision of skin may cause eyelid retraction and may require further surgery to correct this.

Dry eye: If you have a pre-existing dry eye problem or weakness of the eyelids, these symptoms may be made worse by blepharoplasty surgery. Your surgeon should investigate this prior to surgery.

Skin puckering: If deep sutures are placed, as in internal brow fixation, there is a risk of puckering of the skin above them or discomfort. This is usually temporary but may necessitate further surgery to remove the suture if persistent.

Loss of sensation: After surgery there may be numbness of some of the skin around the incision. This is usually temporary returning gradually over months. Rarely it is permanent and may involve larger areas like the forehead.

What type of anaesthesia will I have?

Three types of anaesthesia are used for these procedures: local anaesthetic alone; local anaesthetic with intravenous sedation; general anaesthesia.

- Local anaesthetic involves an injection just under the skin with a tiny needle. It is similar to dental anaesthesia. Initially the injection is painful but after 10 – 15 seconds the area becomes numb.
- Sedation means that you are breathing for yourself and don't have a breathing tube inserted but you are very relaxed and sleepy and often don't remember the operation or the local anaesthetic injection.
- General means you are completely asleep with a breathing tube inserted.

You should have the opportunity to discuss the risks of anaesthesia with your surgeon or anaesthetist prior to surgery.

What should I expect after surgery?

After surgery you may experience some pain. Simple paracetamol is usually enough to control this.

The eyelids may be a bruised and swollen. Bruising will take up to two weeks to settle. Swelling is greatly reduced after two weeks but may not completely resolve for three months.

Post operative Instructions: Blepharoplasty and Eyebrow Surgery

- If an eye pad is placed it should remain until the next morning when you may remove it.
- Cool compresses should commence as soon as the pad is removed or immediately if there is no pad. 10 minutes, every hour, for the first day. This may be continued less frequently if you find it beneficial.
- Chloramphenicol ointment to skin wounds, three times a day for two weeks.
- For ten days the wound should be cleaned using boiled water that has cooled down and sterile cotton wool balls.
- Viscotears (artificial tears) three times a day to the eyes for one week
- Lacrilube ointment to the eyes at night for one week.
- No hot drinks or straining for 48 hours.
- Sleep at 45 degrees for 48 hours.
- Follow up appointment one week later if suture removal is required or six weeks if absorbable sutures used.

Feedback

Your feedback is important to us and helps us influence care in the future.

Following your discharge from hospital or attendance at your outpatient appointment you will receive a text asking if you would recommend our service to others. Please take the time to text back, you will not be charged for the text and can opt out at any point. Your co-operation is greatly appreciated.

Further information

If you have any questions or concerns please contact

In an emergency

Tel: 0151 529 0186 / 0187
Or
Tel: 0151 525 5980

Pre-op assessment nurses
Tel: 0151 529 0178 / 0179

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