



AMERICAN SOCIETY OF
PLASTIC SURGEONS

Practice Parameter for Blepharoplasty

I. BACKGROUND

Blepharoplasty is performed for both functional and aesthetic reasons. Functional issues include ptosis, floppy eyelid syndrome, blepharochalasis, dermatochalasis, herniated orbital fat, and visual field obstruction.^{1,2} Aesthetic reasons include a desire for a more youthful or less fatigued appearance.

Blepharoplasty is often done in combination with other procedures such as a browlift or facelift. This may be done to restore more complete function or facial expression as well as for aesthetic reasons. Advances in technique, including laser applications, have led to greater patient comfort, fewer complications and more rapid recovery.^{3,4,5}

II. ANATOMY

The upper eyelid is comprised of skin, orbicularis muscle, orbital septum, orbital fat, eyelid retractors, tarsus, and conjunctiva. The orbicularis muscle is divided into orbital and palpebral portions with the palpebral portion further divided into pretarsal and preseptal segments. The orbital septum divides the eyelid into anterior and posterior segments and keeps the orbital fat in its posterior location. The upper eyelid has two fat pads, one nasal and one middle. The eyelid retractors include the levator palpebrae superioris and Müller's muscle. The tarsus and conjunctiva constitute the most posterior layers, respectively.

The lower eyelid is comprised of skin, orbicularis muscle, orbital septum, capsulopalpebral fascia, Müller's muscle, tarsus, and conjunctiva. The orbicularis has the same divisions as the upper eyelid. In the lower eyelid, the orbital septum serves the same purpose. There are three lower eyelid fat compartments: nasal, central and temporal. The temporal compartment may have more than one component.

III. DEFINITIONS

Blepharoplasty is a procedure that reconstructs eyelid deformities, improves abnormal function and/or enhances appearance of the eyelids. *Cosmetic blepharoplasty* can improve a patient's appearance in the absence of any signs and/or symptoms of functional abnormalities. *Reconstructive blepharoplasty* can restore function by transforming abnormal eyelid structures to a more normal state.

Blepharochalasis is a condition in which there is a redundancy of eyelid skin.

Dermatochalasis is characterized by deficient elastic fibers of the skin, which may hang in folds. Skin redundancy and/or muscle laxity involving the eyelids can impair vision.

Ptosis occurs when the eyelid droops more than is considered normal, potentially impairing vision. Ptosis is usually categorized as either "true ptosis," an intrinsic disturbance of the eyelid structures, or as a

"pseudoptosis," a lack of normal eyelid support or the presence of excess lid tissue that "hoods" the eye, restricting the upward gaze and blocking the peripheral and/or forward vision.

IV. DIAGNOSTIC CRITERIA

PREOPERATIVE CONSULTATION

Preoperative consultation should evaluate the patient's reasons for seeking surgery. Patients present with a variety of symptoms or combination of symptoms including edema, visual field defects, hypertrophy of the obicularis oculi, conjunctival inflammation, keratitis, malar festoons, blepharochalasis, dermatochalasis, lagophthalmos, protrusion of orbital fat, eyelid ptosis, and eyebrow ptosis. Medical history should include illnesses, dry eye, medications, allergies, history of eyelid swelling, thyroid disease, heart failure, and bleeding tendencies.

EXAMINATION

The physical examination should include an evaluation of the amount of skin on the upper and lower lids; distribution of orbital fat; vector of the lower eyelid; and physical characteristics of the skin including degree of elasticity and pigmentation. It may be necessary for patients with a history of dry eye to undergo a Schirmer's test (tearing or dry eye test). Ptosis of the upper eyelid is determined by measuring the palpebral fissure width and margin reflex distance. Levator excursion is also assessed. Visual field assessment is required for functional blepharoplasty. The forehead and eyebrow should be evaluated for brow ptosis.

PHOTOGRAPHY

Preoperative photographs may be used in patient assessment. Preoperative photographs may be taken to meet the requirements of both the insurers and surgeons. Additional photographs may include upward and downward gaze as well as oblique views.

LABORATORY TESTS

Laboratory tests, when indicated, should include CBC/SMA-7, bleeding and clotting studies, cardiac evaluation and other tests as indicated. In addition, consultation with an optometrist or ophthalmologist may be arranged for field of vision examination.

V. MANAGEMENT

NONOPERATIVE

Patients with thyroid disease or allergies may be treated medically and may not require surgery. Patients primarily concerned with wrinkles around the lateral eye (crow's feet) can be treated with Botox and/or

resurfacing procedures (laser/peel). Surgery may not be appropriate if the patient's expectations cannot be met by the operative procedure desired.

OPERATIVE

Goals

Operative treatments include various surgical techniques directed at correcting the abnormality found on physical exam. When there is visual field impairment blepharoplasty procedures are considered to be reconstructive.² However, blepharoplasty procedures are most often performed to enhance appearance. The second most common cosmetic procedure in males is lower eyelid blepharoplasty.⁵

Preoperative Instructions

The treating physician should inquire about the patient's use of medications that affect bleeding, bruising, or anesthesia. The treating physician and patient should discuss appropriate discontinuation of these drugs prior to surgery.

Anesthesia

Blepharoplasty may be performed under local anesthesia, local with intravenous sedation, or general anesthesia. The surgeon and anesthesia provider will determine which is appropriate for the individual patient's condition.^{6,7}

OPERATIVE TECHNIQUES

Upper Eyelid

Blepharoplasty is performed to remove excess eyelid skin, muscle and/or protruding orbital fat. When the brow position does not need to be raised and only the eyelid skin and fat are to be addressed, the patient may be marked prior to surgery. The upper lid markings are placed such that the final scar will fall in the supratarsal fold.

The CO₂ laser can be used as the incisional tool as well as for orbicularis tightening and periocular skin resurfacing.^{3,8} Asian eyelids warrant different surgical approaches depending on the desired result due to fundamental anatomic differences.⁹ Transconjunctival approach as well as brow stabilization, levator aponeurosis repair, and lacrimal gland suspension have all been described.^{10,11} The incision can be closed with a variety of techniques: subcutaneous running stitch, absorbable external sutures, nonabsorbable external sutures or tissue adhesives.

Lower Eyelid

Lower eyelid blepharoplasty is generally considered cosmetic and has a high patient satisfaction rate.¹² If there is redundant skin to be removed, the lower eyelid may be marked prior to the procedure and may extend laterally into the skin crease.

When there is skin and muscle excess, the subciliary incision is marked and either a skin or a skin muscle flap is raised. Laterally the orbicularis muscle can be re-approximated with fine absorbable sutures and the skin can be closed in a variety of ways (similar to the upper lid).^{13,14,15,16,17}

If there is only protruding fat and no excess skin in the lower lid, a transconjunctival approach may be utilized.¹⁰

POSTOPERATIVE

Dressings, such as steristrips, can be applied to external incisions. Ophthalmic antibiotic ointment can be used as well. Iced saline gauze or crushed ice packs may be used for the first 48 hours. The patient

should keep their head up and avoid straining or strenuous activity for 7 days. The patient may wash their face in 24 hours and reapply ointment to their eyes. A mild non-aspirin containing analgesic can be prescribed and the patient should be instructed to call immediately if pain occurs which is not relieved with this mild analgesic or if the patient has any visual disturbance.

VI. POSSIBLE SEQUELAE AND COMPLICATIONS^{18,19}

POSSIBLE SEQUELAE

- Chemosis
- Suture tunnels/inclusion cysts
- Persistent rhytids
- Asymmetry
- Dry eye

COMPLICATIONS

- Corneal abrasion
- Inferior oblique injury
- Inferior rectus injury
- Retrobulbar hematoma
- Diplopia
- Blindness
- Infection
- Eyelid malposition – ectropion/entropion
- Ptosis
- Hypertrophic scars/keloids

VII. PROVIDER QUALIFICATIONS

The individual performing this procedure, regardless of the location of the surgical facility, should have approved hospital privileges for the procedure and be qualified for examination or be certified by the surgical board recognized by the American Board of Medical Specialties, such as the American Board of Plastic Surgery.

VIII. DISCLAIMER

Practice parameters are strategies for patient management, developed to assist physicians in clinical decision making. This clinical practice guideline/practice parameter, based on a thorough review of the scientific literature and relevant clinical experience, describes a range of generally acceptable approaches to diagnosis, manage or prevent specific diseases or conditions. This clinical practice guideline/practice parameter attempts to define principles of practice that should generally meet the needs of most patients in most circumstances.

However, this clinical practice guideline/practice parameter should not be construed as a rule, nor should it be deemed inclusive of all proper methods of care or exclusive of other methods of care reasonably directed at obtaining appropriate results. It is anticipated that it will be necessary to approach some patients' needs in different ways. The ultimate judgment regarding the care of a particular patient must be made by the physician in light of all the circumstances presented by the patient, the diagnostic and treatment options available, and available resources.

This practice parameter is not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all the facts or circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. This clinical practice guideline/practice parameter reflects the state of knowledge current at

the time of publication. Given the inevitable changes in the state of scientific knowledge and technology, periodic review, updating and revision will be done.

IX. CODING

<u>Diagnosis</u>	<u>ICD-9 Code</u>
<u>Cosmetic</u>	
Plastic surgery for unacceptable cosmetic appearance	V50.1
<u>Functional</u>	
Other localized visual field defect	368.44
Ptosis of eyelid, unspecified	374.33
Blepharochalasis	374.34
Congenital ptosis	743.61
Congenital deformities of eyelids	743.62
Other specified congenital anomalies of eyelid	743.63

Specific CPT codes alone do not differentiate cosmetic from reconstructive procedures. Categorization of each procedure is to be distinguished by the presence or absence of specific signs and/or symptoms.

<u>Procedure</u>	<u>CPT Code</u>
Blepharoplasty, lower eyelid;	15820
with extensive herniated fat pad	15821
Blepharoplasty, upper eyelid; with	15822
excessive skin weighting down lid	15823
Temporary closure of eyelids by suture	67875
Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	67900
Repair of blepharoptosis; frontalis with suture technique	67901
frontalis with autologous fascial sling	67902
tarso levator resection or advancement, internal approach	67903
tarso levator resection or advancement, external approach	67904
superior rectus technique with fascial sling	67906
conjunctivo-tarso-Müller's muscle-levator resection	67908

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