7.11.6. Blepharoptosis (IV): Treatment

History
- symptoms of dry eye
  - temper blepharoptosis repair in presence of significant dry eye problems
- thyroid eye disease
- previous eye or eyelid surgery
- prior periorbital trauma

Indications for treatment
- functional
  - significant superior visual field loss
  - difficulty with reading
- cosmetic
  - tired or sleepy appearance

3 categories of surgical procedures
- external (transcutaneous) levator advancement
  - In patients with good levator function, surgical correction is generally directed toward the levator aponeurosis
- internal (transconjunctival) levator/tarsus/ Müller muscle resection approaches
- frontalis muscle suspensions
  - if levator function is poor or absent, frontalis muscle suspension techniques are the preferred repair procedures

External (transcutaneous) levator advancement surgery
- indications
  - levator function is normal
  - upper eyelid crease is high
    - levator aponeurosis (its tendinous attachment to the tarsal plate) is stretched or disinserted
- ideally performed under local anesthesia
  - patient cooperation is elicited to obtain optimal lid height and contour
- upper eyelid crease incision
- levator aponeurosis is advanced to the superior tarsal border

Figure 11-15 (© 2020 American Academy of Ophthalmology)

internal (transconjunctival) approach
- directed toward
  - Müller muscle
    - Müller muscle–conjunctival resections (MMCRs)
      - indications
        - minimal ptosis (≤2 mm)
        - adequate upper eyelid position following instillation of a drop of 2.5% phenylephrine hydrochloride
        - useful for maintaining preoperative eyelid contour

Figure 11-16 (© 2020 American Academy of Ophthalmology)

  - tarsus
    - Fasanella-Servat procedure
      - for small amounts of ptosis
      - removal of the superior tarsus with the conjunctiva and Müller muscle
  - levator aponeurosis or muscle

7.11.6. Blepharoptosis (IV): Treatment

Complications
- undercorrection
  - most common complication
  - differentiate true undercorrection from apparent undercorrection resulting from postoperative edema
  - creating symmetry between the two eyelids is the most difficult aspect of ptosis repair
    - adjustable suture techniques
      - early adjustment in the office during the first 2 postoperative weeks
- overcorrection
- unsatisfactory eyelid contour
- scarring
- wound dehiscence
- eyelid crease asymmetry
- conjunctival prolapse
- tarsal eversion
- lagophthalmos with exposure keratitis
  - most common in patients with decreased levator function
  - usually temporary
  - lubricating drops or ointments

frontalis suspension surgery
- indication
  - poor or absent levator function
- technique
  - eyelid is suspended directly from frontalis muscle
    - movement of the brow is efficiently transmitted to the eyelid
  - there is controversy about whether bilateral frontalis suspension should be performed in patients with unilateral congenital ptosis
    - may improve patient's symmetry and stimulate the need to utilize frontalis muscle to lift eyelids
    - subjects normal eyelid to surgical risks
- autogenous fascia lata
  - best long-term results
  - requires harvesting and additional surgery
  - patients ≥ 3 years old or ≥35 pounds in weight
- banked fascia lata
  - may incite inflammation
  - has the theoretic potential to transmit infectious agents
  - poorer long-term outcomes
- synthetic materials
  - silicone rods
  - allow easier adjustment or removal if necessary