

Transcutaneous Blepharoplasty in Blepharochalasis

Blepharochalasis is a rare degenerative disease of skin of lids. We report 3 cases of blepharochalasis, out of which two involved upper eyelids and one involved lower eyelids. All the three cases were treated with transcutaneous blepharoplasty with acceptable cosmetic results.

KEYWORDS: Blepharochalasis, blepharoplasty, ptosis atonica

INTRODUCTION

Blepharochalasis is a rare degenerative disease unique to the skin of the lids, clinically characterized by primary bilateral swelling followed by progressive loss of subcutaneous tissue resulting in fine wrinkling and the skin of the upper lid hangs in thin folds. It is also termed *ptosis atonia*, *ptosis adipose* and *dermatolysis palpebrum*.^[1] Blepharoplasty is the treatment of choice with good cosmetic results.

CASE REPORTS

Case 1

A 24-year-old female presented with history of interference of vision due to laxity of upper eyelids since 6 years. She had several attacks of lid oedema at the interval of 4-6 months which persisted for one day each time since the age of 14 years. For the past 4 years she did not experience lid oedema but developed laxity of skin of upper eyelids. The redundant skin folds extended over the margins of the eyelids.

Case 2

A 23-year-old female presented with right upper eyelid lax skin since the age of 12 years. There was history of on and off edema of right eyelid for one and a half year before the onset of lax skin.

Case 3

A 23-year-old male presented with lax and wrinkled skin of lower eyelid since 4 years. Patient gives history of painless swelling of both eyelids associated with erythema on and off since 13 years. The episodes used to occur daily and used to subside within 2 hours. For the past one year he did not experience any swelling. Patient was a known diabetic (type 1 diabetes mellitus) since 10 years and on treatment.

In all the patients there was no laxity of skin elsewhere on the body. Patient 1 and 2 had levatorpalpebraesuperioris muscle weakness resulted in drooping of upper eyelids. The upper lip and thyroid were normal. Systemic examination revealed no abnormality. Ophthalmic examination was within normal limits. All haematological investigations were within normal limits except for case 3 who was a case of type 1 DM.

Treatment

For all the three patients blepharoplasty was done. For first two patients upper eyelid blepharoplasty was done and case 3 underwent lower eyelid blepharoplasty. Preoperative markings were made with the patient sitting upright in neutral gaze with the brow properly positioned. The upper eyelid was injected with 2% lignocaine with 1:1,00,000 epinephrine and with the help of a NO 15 Bard Parker blade incision was made along the skin markings. The lower limit of excision was made along the eyelid crease, and the lateral extent of the marking was limited by an imaginary line joining the lateral end of the brow to the lateral canthus. The extent of excision was made upto 10 mm from the inferior border of the brow and medial and central fat was excised

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along with skin and closed with 7-0 absorbable suture [Figure 1].

Transcutaneous lower eyelid blepharoplasty was done by giving an elliptical incision 8 mm below the eyelid margin, excess fat and skin was excised and closed by 7-0 absorbable suture [Figures 2-4]. In all the patients there were cosmetically acceptable results.

DISCUSSION

The exact etiology of blepharochalasis is not known. However, the condition being commonly reported during puberty, the role of endocrines is difficult to rule out. In one third of the cases in which the disease starts before the age of 10 years the autosomal dominant heredity probably plays an important role.^[1] Three stages of blepharochalasis are described.^[1-3] First stage is the intermittent painless and transient oedematous swelling of upper lids. In the second stage (atonic ptosis) the skin becomes discoloured, heavily venuled and flabby and hangs over the lashes and the power to lift the eye lid is decreased. In the third stage there is relaxation of the tissues of orbital septum and narrowing of palpebral tissue occurrence which results in interference with vision. The lacrimal gland may be pulled below the orbital margin giving the face tired debauchery. This is

the advanced stage termed as ptosis adiposa.^[1-3] Though the upper lids are commonly involved, lower lid and unilateral involvement may be seen.^[4]

The only effective treatment is correction by plastic surgery after the disease has run its course; otherwise subsequent attacks of lid edema may interfere with the results.^[3] Preoperative patient evaluation for blepharoplasty should document medical and ophthalmologic history. A simple upper or lower eyelid blepharoplasty where only skin or fat is excised can be performed under local anesthesia. For upper eyelid blepharoplasty, preoperative markings should be made with the patient sitting upright in neutral gaze with the brow properly positioned. The eyelid crease is situated above the ciliary margin approximately 8 to 9 mm in women and 7 to 8 mm in men. The lower limit of excision should be along the eyelid crease, and the lateral extent of the marking should be limited by an imaginary line joining the lateral end of the brow to the lateral canthus. A minimum of 20 mm of vertical lid height should be preserved for normal eye closure. The location of fat should be determined and marked preoperatively. The upper lids should be injected superficially, with 2% lidocaine with 1:100,000 epinephrine. Skin incision can be made either with a No 15 Bard Parker blade or the



Figure 1: Before and after photographs of upper eyelid blepharoplasty



Figure 2: Markings in lower eyelid (2 mm below eyelid margin)



Figure 3: Showing excised excess skin and fat with closure of the wound with 7-0 suture



Figure 4: Before and after photograph of lower eyelid transcutaneous blepharoplasty

Empire tip of radiofrequency monopolar cautery. The skin incision can be closed using running or interrupted sutures with various absorbable or permanent material.^[5] Lower eyelid blepharoplasty can be done either through transconjunctival or transcutaneous approach.^[2,5] The advantage of transcutaneous approach is that it corrects excess skin and muscle laxity.^[5]

CONCLUSION

We report 3 cases of blepharochalasis, of which 2 cases involved upper eyelid (1 case was unilateral) and 1 case involving bilateral lower eyelids. Blepharoplasty is a simple procedure which can be done effectively by a dermatologist.

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