

Commentary

Commentary on: Comparison of Efficacy and Complications Among Various Spacer Grafts in the Treatment of Lower Eyelid Retraction: A Systematic Review

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I want to thank the editor for asking me to address the topic of the surgical management of postblepharoplasty lower eyelid retraction (PBLER).

Thanks to the authors for sharing their work with *Aesthetic Surgery Journal*.¹ Lower eyelid retraction following lower blepharoplasty has long been an important topic of interest to aesthetic surgeons, both in terms of its prevention and its treatment. Given the various techniques and numerous types of spacer grafts that have been used, it is obvious that PBLER can be a difficult problem to address. First, it is important to understand that there are various factors involved that can contribute to PBLER. After understanding the possible contributing factors, then one can better understand its treatment.

Surgeon's technique is an obvious reason for occurrence of lower eyelid retraction after lower blepharoplasty, with transcutaneous lower blepharoplasty having far greater risk than transconjunctival lower blepharoplasty.²⁻⁴ In addition, there are certainly some patients that are more prone to developing lower eyelid retraction after blepharoplasty, including those with globe prominence, poorly developed lower orbital rim and maxilla, lower eyelid laxity, volume deficit, or combination of the above. Failure to account for these issues will not only lead to lower eyelid retraction but also prevent successful treatment of it after it occurs. For instance, if the globe is prominent (either from true globe prominence or from poorly developed orbital rim/maxilla), it not only contributes to lower eyelid retraction, it can prevent its treatment. Therefore, lower blepharoplasty has to be done more carefully and conservatively

in these patients and if lower eyelid retraction does occur, these patients may benefit from more favorable globe position (through orbital decompression surgery) and/or additional orbital rim support (through orbital rim or tear trough implant). The type and/or severity of postblepharoplasty lower eyelid retraction will also determine how it needs to be treated. Orbicularis oculi paresis is treated differently than cicatricial lower eyelid retraction. Not all cicatricial lower eyelid retractions are created equal either, both in terms of severity and layer(s) of eyelid involved.

Cicatricial lower eyelid retraction after blepharoplasty has traditionally been surgically addressed with midface lifting to recruit skin, open canthal suspension to suspend and support the lower eyelid, and a posterior lamellar spacer graft to vertically lengthen the lower eyelid and recess the lower lid retractors.⁴ The authors discussed the various types of spacer grafts reported in the literature and discussed their pros/cons. Importantly, they did not find that one type of spacer graft was superior to another. However, they did note limitations of the study (including variability in surgical technique, severity of retraction, and type of retraction) with suggestion for further studies. In

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my opinion, surgeon's technique and treating the contributing factors are much more critical in treating PBLER than the type of spacer graft. In fact, in a recent study published in this journal, I reported that internal eyelid spacer graft is overused and may not always be necessary in treating lower eyelid retraction for various types of lower eyelid retraction, including that of postblepharoplasty, thyroid related, and inherited.⁵ Routine use of lower eyelid spacer graft should be avoided as they may be unnecessary and increase potential complexity and complications.

The need for spacer graft should be determined during preoperative examination with tests including forced upward traction test and smile test. During forced upward traction test, the lower eyelid is manually elevated to determine the severity and layer of the cicatrix present (anterior lamellar shortage vs internal eyelid scarring vs both). Smile test is a similar test as it tests the lower eyelid elevation during smiling with patient's effort rather than manual elevation. If there is anterior lamellar deficit, spacer graft is usually not necessary whereas spacer graft may be necessary with middle lamellar shortage. True middle lamellar shortage is less common than believed, hence the overuse of space grafts.⁵

Given that the type of eyelid spacer graft may not be as important as first thought, then one should select a spacer graft, if necessary, that has least morbidity such as AlloDerm graft. It is again worth mentioning that accounting and treating contributing factors to lower eyelid retraction are critical to achieving a successful anatomic outcome and satisfied patient. In another recent study published in this journal, I reported on use of orbital decompression for patients with nonthyroid prominent globes including performing the procedure on patients with lower eyelid retraction to address relative or actual vertical eyelid shortage, either prior to addressing the lower eyelid retraction or performed concurrently with lower eyelid retraction correction to achieve optimal outcome.⁶ Clearly, this form of surgery requires a different specialized expertise with orbital surgery.

In summary, lower eyelid retraction can be a difficult problem to understand and treat for even oculoplastic

surgeons. The readership should understand not only what spacer graft to use but also when to use it, in addition to factors that can contribute to lower eyelid retraction with sclera show in such patients. Understanding these factors will also help prevent occurrence of lower eyelid retraction, besides its treatment once it occurs.

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