

Procedure Guidelines for Upper Eyelid Plastic Surgery (Blepharoplasty) using Radiofrequency

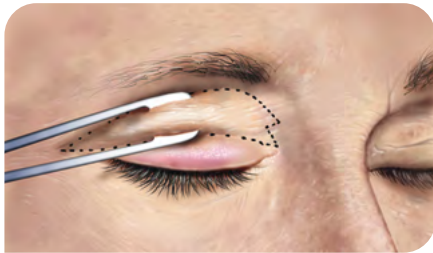


Fig. 1: Surgical upper eyelid incision



Fig. 2: Skin incision and excision of the skin area using the ARROWtip™ monopolar microdissection electrode



Fig. 3: Excision of a small strip of orbicularis oculi muscle



Fig. 4: Removal of prolapsed fatty tissue after exposing the orbital septum



Fig. 5: Before and after an upper eyelid surgery

Disclaimer: These procedure guidelines have been carefully researched and compiled with the help of specialist physicians. They are not meant to serve as a detailed treatment guide. They do not replace the user instructions for the medical devices used. Sutter accepts no liability for the treatment results beyond legal regulations.

Indications / Contraindications

The objective of performing upper eyelid surgery (blepharoplasty) is to correct the loosening of skin (dermatochalasis) over the prolapsing fatty tissue and the periorbital folds. If indicated, low eyebrows may have to be lifted at the same time (eyebrow lift).

Using the radiofrequency technique for the performance of blepharoplasties enables the surgeon to make particularly fine incisions, work with high precision, and cause minimal bleeding. These benefits shorten the operating time and the postoperative trauma.

Patient Preparation

The anatomy of the orbits (eye sockets), eyebrows, periorbital regions and the upper and lower eyelids must be examined and documented using photographic images. In this examination, special attention must be paid to the symmetry of the eyelids and eyebrows. Postoperative asymmetries may be more apparent. Pseudoptosis (false drooping eyelid) due to eyebrow ptosis should be excluded, i.e. it should be considered in the procedure planning (combination of eyelid surgery and eyebrow lift). Upper eyelid surgery is usually performed under local anesthesia (e.g. using 1% Xylorest® plus adrenalin 1:200 000). Before local anesthesia and after skin disinfection (e.g. with Octenisept®) and makeup removal, the surgeon marks the incision line in upright position using a fine marker. If the upper eyelid fold is well-defined, the lower incision will run slightly above the upper eyelid fold. In case the upper eyelid fold does not exist and must be newly defined, the distance between the lower skin incision and the upper lid should be 8 mm without fail. If required, the incision may be extended from the outside past the medial lacrimal punctum without extending it to the thick skin of the nasal slope. W-plasty may be performed in cases of pronounced skin excess (Fig. 1). The lateral incision must be extended into a crow's feet fold, which is located about 6 mm above the outer eye corner. The incision should not extend past the lateral orbital margin. The amount of tissue to be resected is determined as follows: Using blunt forceps, the skin of the closed upper eyelid is gathered to the extent that the eyelid just starts to open. In the process, the forceps are placed caudally in the new eyelid fold. Then the upper margin of the lancet-type skin excision is marked with a pen. It is essential to ensure that the cornea is adequately protected.

Intervention

The respective skin area is excised using the short ARROWtip™ monopolar microdissection electrode (e.g. REF 36 03 21), (Fig. 2). The settings of the CURIS® 4 MHz radiofrequency generator can be adjusted to the incision speed. The electrode should glide through the tissue without any resistance. The output for the incision process may have to be adjusted. Immediately after the incision, bleeding is stopped using the fine SuperGliss® non-stick bipolar forceps (e.g. REF 78 01 48SG) to minimize hematoma formation. As a rule, a narrow strip of orbicularis oculi muscle should also be removed (Fig. 3). This can also be done using the ARROWtip™ monopolar microdissection electrode. Alternatively, the muscle tissue can be "shrunk" by way of bipolar coagulation. In the event a fat prolapse was diagnosed before surgery, bulging fatty tissue is removed using e.g. small scissors while light pressure is exerted on the globe of the eye (Fig. 4). The bulging fatty tissue is removed only after careful bipolar coagulation of all vessels to prevent a parabolbar hematoma. As a rule, the incision is closed using monofilament 6-0 thread for an intradermal suture.



Fig. 6: ARROWtip™ monopolar microdissection electrode, single-use (REF: 36 44 21)



Fig. 7: SuperGliss® non-stick bipolar forceps (REF: 78 01 48SG)

Postoperative Treatment

If at all possible, the patient should lie flat for several hours after surgery while every hour the surgical site is cooled for 15 minutes with a cooling aggregate to prevent edema and hematoma formation. The suture thread may be removed 7 - 8 days after surgery.

Settings* for CURIS® 4 MHz radiofrequency generator (REF: 36 01 00-01)

Valid for the CURIS® with the orange label.



Dermal incision ARROWtip™: CUT 1

Power adjustment: 10-20 watts

Skin preparation ARROWtip™: CUT 2

Power adjustment: 15-20 watts

SuperGliss® non-stick: bipolar PRECISE

Power adjustment: 23 watts



For further accessories see back page.

Dermal incision ARROWtip™: CUT 1

Power adjustment: 30-46 watts

Skin preparation ARROWtip™: CUT 2

Power adjustment: 20-40 watts

SuperGliss® non-stick: PRECISE

Power adjustment: 23 watts



For further accessories see back page.

* Please consider that this information is not meant to serve as a detailed treatment guide. Always start with the lowest settings and adjust them accordingly.

Recommended products for this treatment



134° C
autoklavierbar



SuperGliss® non-stick bipolar Forceps

Qty.	REF	Description
1	78 01 48 SG	SuperGliss® non-stick bipolar Forceps, total length: 15.5 cm, tips: 0.7 mm



ARROWtip™ monopolar microdissection electrode

Qty.	REF	Description
10	36 44 21	ARROWtip™ monopolar microdissection electrode, single-use total length 53 mm



CURIS® 4 MHz radiofrequency generator

Basic set

Qty.	REF	Description
1	36 01 00-01	CURIS® 4 MHz radiofrequency generator (incl. mains cord, user's manual and test protocol)
1	36 01 10	Foot switch two pedals for CURIS® (cut & coag), 4 m cable
1	37 01 54 L	Bipolar cable for CURIS®, length: 3 m
1	36 07 04	Monopolar handpiece (pencil) cut & coag, shaft 2.4 mm, cable 3 m
1	36 02 38	Cable for single-use patient plates, length: 3 m

available patient plates:

1 (x 100)	29 00-5	Single-use patient plate, split, for adults and children, PU 20 x 5 pcs.
1 (x 50)	95 80 04	Single-use patient plate, split, for adults, PU 10 x 5 pcs.
1 (x 50)	95 80 05	Single-use patient plate, split, for children, PU 10 x 5 pcs.
1	36 02 26	Re-usable rubber patient plate



Product availability is subject to regulatory approval in individual markets. Products may therefore not be available in all markets. Lengths for orientation purposes; may vary slightly.



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