

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



Fig. 1: Snap Test



Fig. 2: Dermal incision using the ARROWtip™ monopolar microdissection electrode (REF: 36 44 21)

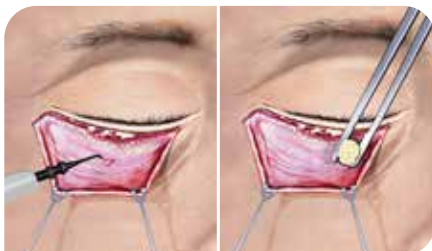


Fig. 3: A skin flap is dissected from the orbicularis oculi muscle



Fig. 4: Removal of fatty tissue



Fig. 5: Only a few millimeters of skin are excised from the subciliary regions while the patient looks upward



Fig. 6: Finally, a small triangular area is excised

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

Lower eyelid surgery is preferably performed under local anesthesia. Aside from correcting excessive skin/wrinkles, the objective of lower eyelid surgery is also the removal of prolapsing orbital fat ("lacrimar or tear sacs"). In general, one large and two small fat compartments appear at the lower eyelid. The large central fat compartment is flanked by the small temporal and medial fat compartments. In old patients, these compartments are almost always confluent and cannot always be distinguished. Relatively large blood vessels run through the fatty tissue. They must be carefully coagulated during surgery to prevent undesired bleeding.

Patient Preparation

It is essential to ensure that the cornea is adequately protected. When planning lower eyelid surgery (blepharoplasty), the functional aspects of the lower eyelid must receive special attention. The lower eyelid must fit completely and firmly against the globe of the eye. Otherwise, there will be a risk of having to deal with an ectropion even after small skin resections. This is an extremely aggravating complication. Before surgery the elasticity of the lower eyelid should be tested (e.g. by way of snap test, Fig. 1); the elasticity should be sufficient to minimize the ectropion risk. These concerns are also ample reason for approaching the necessary skin resection with due caution. Snap Test: The lower eyelid is lifted from the globe and released. The lower lid should immediately snap back. After one second at the latest, the lower eyelid should again tightly nestle around the globe. If this is not the case, it is essential to proceed with increased caution during lower eyelid surgery.

Intervention

The skin incision is performed using a short ARROWtip™ monopolar microdissection electrode (e.g. REF 36 44 21) starting directly underneath the eyelashes and medially at the level of the lacrimal punctum; laterally the incision slants downward and ends in a skin fold (Fig. 2). The electrode should glide through the tissue without any resistance. The eyelashes must be kept out of the way while making the incision. If appropriate, a subcutaneous tunnel may first be formed from the lateral side using scissors. Then, this tunnel will be severed. In the next step, skin of the orbicularis oculi muscle is dissected and prepared (skin flap technique, Fig. 3). The surgeon must be cautious not to dissect the skin too far downward to avoid uncontrollable pitted contractures. The skin-muscle flap technique is the preferable option if for esthetic reasons the dissection must be made far to the caudal side. An incision is made 10 mm below the eyelid margin and the orbital septum is prepared. All bleeding must be coagulated to prevent hematomas in the preseptal space. 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 after careful bipolar coagulation of all vessels (e.g. REF 78 01 48SG). If appropriate, a muscle strip is carefully excised and if necessary the orbicularis oculi muscle may be laterally attached to the orbital margin to guard against an ectropion. Afterward, the excessive skin is carefully resected. For the procedure, the patient is asked to look upward and open the mouth (Fig. 5). Following subtle hemostasis, the incision is closed using 6-0 monofilament thread and intradermal suturing.



Fig. 7: ARROWtip™ monopolar microdissection electrode, single-use (REF: 36 44 21)



Fig. 8: SuperGliss® non-stick bipolar forceps (REF: 78 01 48 SG)

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: 15-23 watts
SuperGliss® non-stick: PRECISE
Power adjustment: 23 watts



For further accessories see back page.

Dermal incision ARROWtip™: CUT 1
Power adjustment: 25-36 watts
Skin preparation ARROWtip™: CUT 2
Power adjustment: 30-50 watts
SuperGliss® non-stick: PRECISE
Power adjustment: 23 watts



For further accessories see back page.

* Always start with the lowest settings to achieve the desired effects. If necessary, increase the settings step-by-step until the desired effect is achieved. This may even be 50 watts or higher. The settings may differ from patient to patient, from tissue to tissue, and have to be adjusted accordingly.

Please consider that this information is not meant to serve as a detailed treatment guide.

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 Equipment

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 with two pedals for CURIS® (cut & coag) with holding bracket, cable length: 4 m
or 1	36 01 14	Foot switch with two pedals for CURIS® (cut & coag) without holding bracket, cable length: 4 m
1	37 01 54 L	Bipolar cable for CURIS®, cable length: 3 m
1	36 07 04	Monopolar handpiece (pencil) cut & coag, shaft 2.4 mm, cable length 3 m
1	36 02 38	Cable for single-use patient plates, length: 3 m
1 (x100)	29 00-5	Single-use patient plate, split, for adults and children, PU 20 x 5 pcs.



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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