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

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). It is essential to ensure that the cornea is adequately protected. Upper eyelid surgery is usually performed under local anesthesia (e.g. using 1% Xylonest® plus adrenalin 1:200000). 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.

Intervention

The respective skin area is excised using the short ARROW*tip*™ monopolar microdissection electrode (e.g. REF 36 44 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 parabulbar 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 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 ARROW*tip*™: CUT 1
Power adjustment: 10-20 watts
Skin preparation ARROW*tip*™: 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.

* 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

90° C

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 (x 100)	**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.

Sutter

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