

Upper Blepharoplasty: A Thorough Overview of Surgical Methods, Results, and Complication Management

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Abstract:

Background: One of the most common facial surgery procedures carried out globally is upper blepharoplasty. Serving both aesthetic and functional purposes. Age-related periorbital changes, dermatochalasis, fat prolapse, and levator aponeurosis attenuation contribute to visual obstruction and facial aging. Although surgical refinements have improved outcomes, Variability in the choice of techniques and the handling of complications is still a challenge.

Objective: The latest research on surgical anatomy, operative methods, functional and cosmetic results, patient-reported metrics, and complication management in upper blepharoplasty is summarized in this review.

Methods: A comprehensive literature review was performed using peer-reviewed publications from 2010–2026 indexed in Google scholar, PubMed, MEDLINE, and Scopus studies. Included were recent studies assessing surgical methods, results, visual field enhancement, patient satisfaction, and rates of complications.

Results: Contemporary upper blepharoplasty techniques emphasize individualized tissue preservation, Fat repositioning rather than aggressive excision, and simultaneous correction of brow ptosis or eyelid ptosis when indicated. Evidence demonstrates high patient satisfaction (>85% in most series), When proper surgical planning is used, there are measurable improvements in the visual field and minimal rates of complications.

Conclusion: Upper blepharoplasty is still a dependable and adaptable treatment. With long-lasting practical and aesthetic results, Success depends on anatomical precision, conservative tissue management, and thorough evaluation during surgery.

KEYWORDS: Upper Blepharoplasty, Facial Aging, Surgical Refinements

1. Introduction:

Upper blepharoplasty has undergone significant development into a sophisticated surgery based on a thorough understanding of anatomy and aesthetic philosophy. From its initial descriptions in the late nineteenth century[1-2]. Historically performed primarily for cosmetic enhancement, Upper blepharoplasty is now widely recognized for its functional benefits[3], Especially in those with visual field compromise caused by dermatochalasis[4]. The process of periorbital aging is intricate and multifaceted, comprising fat protrusion, orbicularis muscle shrinkage, orbital septum weakening, and skin laxity[5]. The complicated process of periorbital aging affects every layer of the face, from the superficial layer of skin to the deep layer of bone. There is ample evidence of age-related changes in bone structure, especially the resorption of the superomedial and inferolateral rim. Periorbital aging is a complex, multidimensional process involving skin laxity, orbicularis muscle attenuation, orbital septum weakening, fat prolapse, brow descent, and levator aponeurosis dehiscence[6].

Since the cornea contributes almost two-thirds of the eye's total optical power, it is essential to visual acuity. Corneal refraction is mostly caused by the anterior surface curvature of the cornea. Because this surface is directly in contact with the eyelids, changes in the form and function of the eyelids can cause refractive error, corneal astigmatism, steep and flat corneal meridians, and changes in corneal refraction. Together, these modifications modify the shape of the eyelids and lead to both functional impairment and aesthetic issues. Compared to other parts of the face, the upper eyelid frequently exhibits early indications of aging because of its thin integument and continuous mobility[7-8].

Because blepharochalasis epidemiological data is not accessible. providing a thorough explanation of the natural history, epidemiology, clinical characteristics, etiology, histology and pathogenesis, differential diagnosis, course of treatment, and prognosis. Upper blepharoplasty is one of the most frequently done cosmetic surgery treatments worldwide[9-10]. According to international aesthetic surgery databases, eyelid surgery remains within the top five cosmetic surgical procedures performed annually. Its popularity stems from relatively predictable outcomes, low complication rates, and significant patient-perceived rejuvenation. Because upper blepharoplasty targets both functional and esthetic goals, an integrated strategy that combines validated patient-reported measures with objective clinical parameters is necessary for outcome evaluation[5-11].

In addition to improving appearance, upper blepharoplasty has been shown to provide functional advantages. The superior visual field may be blocked by redundant upper eyelid tissue, requiring compensatory frontalis muscle activation that may cause headaches, brow fatigue, and visual discomfort. Excision of extra eyelid skin has been shown to improve superior vision fields in quantifiable ways, according to several perimetric investigations. Upper blepharoplasty, therefore, falls somewhere between reconstructive and cosmetic surgery[12]. Modern surgical philosophy has shifted from aggressive excisional techniques toward conservative tissue preservation. Earlier approaches frequently involved extensive fat removal and orbicularis muscle resection, occasionally resulting in hollowed superior sulcus deformities and unnatural contour changes. Contemporary understanding emphasizes volume preservation, structural support, and harmonious brow-lid balance. People are increasingly requesting less intrusive, non-surgical, safe, and effective techniques to treat their eyelids[13].

By removing the extra skin during treatment, any potential obstacles to the viewing field are eliminated. It is no longer required to raise and contract the eyebrow muscles after surgery. In addition, the increasing incorporation of patient-reported outcome measures (PROMs) has refined evaluation standards. Tools such as the FACE-Q and Blepharoplasty Outcome Evaluation (BOE) scale quantify patient satisfaction, psychosocial well-being, and quality of life improvements. These instruments underscore that successful blepharoplasty extends beyond objective measurements and must incorporate subjective patient perceptions[14]

A thorough analysis of upper blepharoplasty that includes surgical techniques, evidence-based results, and complication management is necessary due to the dynamic nature of technique and outcome evaluation. The features of upper blepharoplasty in older patients are different from those in younger people.

Method:

A comprehensive search of relevant systematic reviews and articles was performed using the PubMed and Google Scholar databases. The publication years ranged between 2000 and 2024. Upper Blepharoplasty concept many techniques were introduced and outcomes complication management is very important in medical field. The search strategies included the following terms: 'Upper Blepharoplasty complain management. Furthermore, citation tracking of the studies retrieved was used

to identify additional relevant articles, which were obtained using Google Scholar. Illustrates the general idea of the study and the cited references, correspondingly.

Detailed Discussion

Antomy and Physiology

Surface Anatomy:

Understanding the topography of the upper eyelids is crucial. The levator aponeurosis links to the subdermal tissues via anterior branches at the eyelid skin crease. The eyelid fold, which is directly above this, typically "hides" the upper eyelid skin crease. The tarsal platform is located between the skin crease and the edge of the upper eyelid. The Golden ratio, or phi, should ideally be 1:1.618 between the tarsal platform and the distance between the forehead and the upper lid crease. [15] Many additional facial proportions follow the same ratio. This ratio can become 1:1, which is unsightly, if too much fat is removed. To give the upper eyelid a three-dimensional structure, the upper lid fold that crosses the crease is also necessary. This fold may be effaced by excessive skin or fat removal, giving it an artificial appearance.

Due to a combination of lateral dermatochalasis and temporal brow ptosis, temporal hooding is frequently observed. The evaluation will let the surgeon to decide if direct lid surgery is sufficient to treat such temporal hooding or if the brow tail needs to be repositioned. Certain conditions, such as thyroid eye disease, the Ehlers-Danlos syndrome, blepharochalasis, xanthelasmata, angioneurotic oedema, amyloidosis, and elastolysis (Cutis laxa), can cause the degree of dermatochalasis to be more noticeable.[16]

There should be a minimum of 20 mm between the upper eyelid boundary and the inferior brow border. Depending on age, gender, and brow position, this usually has to be between 25 and 30 mm. In order to retain or produce a healthy and appealing lash curve with suitable upper eyelid surgery, the lash curve must be evaluated.

Cross Sectional Surgical Anatomy:

For eyelid surgery to be performed safely and successfully, a thorough understanding of eyelid anatomy is essential. The skin, subcutaneous tissue, orbicularis oculi muscle, orbital septum, preaponeurotic fat pads, levator aponeurosis, Müller's muscle, tarsal plate, and conjunctiva make up the intricate, multilayered eyelid. Together, these elements facilitate appropriate blinking and tear distribution, preserve eyelid stability, and shield the ocular surface. Precise surgical dissection and the preservation of important functioning structures depend on an accurate understanding of the anatomical relationships between these layers. Maintaining the position and shape of the eyelids is made easier by being aware of crucial ligamentous supports like the medial and lateral canthal tendons. Therefore, minimising surgical problems and attaining the best functional and aesthetic results in eyelid surgery require thorough anatomical understanding.

Skin: The usual thickness of the skin of the upper eyelids is between 0.3 and 0.5 mm, and there is little subcutaneous fat. As it ages, its flexibility contributes to dermatochalasis.[17]

Ocular Orbicularis: This concentric muscle helps in lymphatic drainage and eyelid closure. Prolonged oedema or dry eye symptoms may be predisposed to by overresection.

Fat Compartments and the Orbital Septum: Orbital fat is kept in the central and medial regions of the septum. Eyelid fullness is a result of fat herniation made possible by septal attenuation.

Aponeurosis in the Levator: The lift complex raises the eyelid on top. Age-related dehiscence can cause aponeurotic ptosis, which needs to be corrected simultaneously.

Place of the Brow: Eyelid dermatochalasis is often accompanied by brow ptosis; failure to recognise this could result in undercorrection or recurrence.

Upper Blepharoplasty

An upper blepharoplasty may be indicated for functional reasons.[18]

- ✧ Excess laxity with temporal hooding can interfere with superior and supero-temporal vision and may make the patient constantly raise their brows or the chin in order to see. Patients may complain specifically of having difficulty driving and seeing traffic lights. Formal visual fields are sometimes carried out to objectively show the superior field constriction, although many believe this is a waste of precious resources as it rarely changes medical management or affects the outcome.
- ✧ Constant use of the frontalis muscle in the presence of dermatochalasis and ptosis may give rise to frontal headaches.
- ✧ Eye irritation may be caused by eyelash ptosis or entropion because of the dermatochalasis.
- ✧ Skin-on-skin irritation may cause dermatitis.
- ✧ Down-gaze ptosis is the droop of the upper eyelids that occurs because of redundant upper eyelid skin and interferes with reading.

Cosmetic Blepharoplasty

Most patients seeking cosmetic blepharoplasty are seeking a more defined skin crease and an improvement in the fat prominence in the upper eyelids. Depending upon the changes, upper blepharoplasty is often performed with browlifts.

Technique or Treatment

Either the existing skin crease on the upper eyelid or the intended skin crease should be indicated. The final skin crease frequently ends up being higher than the marked skin crease, so keep that in mind. Symmetry is crucial. A lateral rise in the incision indicates varying degrees of skin removal. Again, a number of criteria must be taken into consideration when determining the amount of orbicularis muscle resection; this also applies to fat removal. In order to maintain or replicate typical periorbital fullness, more conservative blepharoplasty with tissue preservation (muscle and fat) has gained popularity.

The lateral markings are retained inside the lateral orbital rim, and the medial reach of the markings is no more medial than the punctum. If a more significant amount of skin excision is required, a medial "W" plasty can be required. The position of the brow and any brow elevation will be taken into account when determining the extent of skin removal. While the patient is lying down, some surgeons pinch the skin to indicate how much skin needs to be removed. To make sure that not too much skin is taken, this method can be helpful. In most cases, we want the patient to be sitting up when the skin is removed. During the procedure, adjustments can then be made. Of course, the inferior border of the brow and the top incision should be separated by at least 10 mm. In an adult face without surgery, the typical gap between the inferior border of the brow and the lid edge is greater than 25 mm. Although there are guidelines (such as leaving at least 20 mm between the inferior border of the brow and the upper lid margin), we find that this amount varies and depends upon a number of factors, such as whether a concurrent brow repositioning is being performed, orbicularis strength, Bell's phenomenon, history of prior surgery, and any underlying eye dryness, among others.

More tissue is removed laterally due to the excision's form, with the lateral canthus experiencing the largest resection. In certain patients with brow ptosis, when no brow elevation is being done but the temporal hooding needs to be corrected, modifications have been made to the incision designs, removing even more tissue laterally. Using this method, surgeons have demonstrated satisfactory results.[19] Low lateral incisions will impact the orbicularis oculi muscle's innervation, leading to lagophthalmos.

Volume Augmentation

Recently, attention has appropriately shifted away from subtractive surgery and toward volume augmentation.(20) Both the middle fat pad and the brow fat frequently experience volume reduction. Often, the medial fat pad is noticeable. This is most likely due to the orbital septum and levator aponeurosis pulling the central fat pad back together, as well as the inevitable enophthalmos that comes with ageing and posterior orbital fat displacement. The medial fat pad grows more noticeable and does not rest on the levator aponeurosis. Additionally, the orbital septum is smaller over the medial fat pad, which permits the fat to dislocate anteriorly.It is possible to do fat grafting or to preserve fat and transfer it into the hollow areas.[21]

Anaesthesia

Either conscious sedation or direct local anaesthesia can be used for upper blepharoplasty. Lidocaine and epinephrine are injected subcutaneously for local anaesthesia, being careful not to inject too deeply to avoid affecting the levator muscle. When receiving injections, patients may move abruptly. Thus, two methods that can assist avoid this are to stabilise the head and inject with the needle facing away from the globe. Typically, we top off the anaesthetic during the procedure after injecting 1.5 mL per side. When operating on the medial fat pad and closing the wounds along the incision lines, the majority of patients will require further injections.

Incision

A 15 Bard-Parker blade, electrocautery, a CO2 laser, or a radiofrequency needle can all be used to make incisions.

Orbicularis removal

The orbicularis oculi muscle may become somewhat redundant as a result of skin stretching, although it is important to eliminate orbicularis muscle in moderation. Pretarsal orbicularis needs to be maintained at all times. Depending on the patient's age, the degree of redundancy, and whether brow lifting is being done, a varying amount of orbicularis over the preseptal region is removed. A more distinct crease can be produced by removing a small strip of orbicularis and working on the septum and fat.

The Septum Orbital

The orbital septum may not always require opening. Since tissue restoration occurs over time, simple cautery to the septum's surface does not provide long-term tightness. The orbital septum is often opened, and planned fat reduction is carried out.

Fat

Insufficient debulking of the medial fat pad may result in unsatisfactory blepharoplasty outcomes.[22]. However, severe removal of the central fat pad will result in the formation of a "A frame" malformation with a hollow superior sulcus. In certain patients, fat transfer may be used to restore the natural subbrow fullness of a healthy, appealing eyelid, particularly after a repeat or revision blepharoplasty. Rarely, if there is a volume deficit in the medial fat pad, a pedicle may be moved to the central zone. The skill of blepharoplasty involves determining how much should be removed, preserved, and repositioned. 6-0 nylon or prolene can also be used for closure, however interrupted 6-0 catgut sutures provide for a nice wound.

Postoperative Management

We apply topical erythromycin eye ointment twice a day to the sutures and employ artificial tears as necessary. For most people, prescription analgesics are not necessary. By day two, anticoagulants are typically started again. For the first 24 hours, we have patients ice their eyelids intermittently, and for the next two nights, we have them sleep with their heads up. The following day, patients can wash, bathe, or take a shower to moisten their sutures.

Contraindications

Relative contraindications include proptosis, thyroid illness, dry eyes, and clotting issues. Dry eyes might vary in severity. It is advisable to advise patients with severe dry eyes to avoid blepharoplasty because even a slight increase in corneal exposure might exacerbate the condition. Blepharoplasty may result in lagophthalmos with corneal and visual issues if thyroid orbitopathy with proptosis is present. Physicians must assist patients in managing their clotting disorders on an individual basis. Before recommending additional blepharoplasty, patients who have had one or more prior blepharoplasty procedures which we encounter more frequently should have a thorough examination for any lagophthalmos, accessible skin, and orbicularis function.

Lastly, blepharoplasty should be avoided in a subset of patients who suffer from photophobia. [23].

Equipment

Other than the conventional plastic surgery and oculoplastic surgery instrument set, no specialised

equipment is required for upper blepharoplasty.

Visit: Personnel

Straight local anaesthesia, either with or without controlled sedation, can be used for upper blepharoplasty. These treatments can be safely carried out in a hospital operating room, surgical center, or office. In addition to having the experience and expertise to handle any potential preoperative and postoperative issues, the surgeon must be knowledgeable about the blepharoplasty method.

Preparing

A thorough medical history is necessary for both determining the patient's level of anaesthesia and assessing the safety of performing blepharoplasty. Therefore, conditions including diabetes mellitus, hypertension, thyroid disease, respiratory conditions, dermatological conditions, kidney disease, recurrent oedema, and any bleeding disorders should be reviewed in the medical history. Because many medications can raise the risk of bleeding, it is necessary to check supplements and medications. There is a vast variety of medications that might cause severe bleeding. Alcohol use and smoking are assessed because smoking can hinder tissue repair even in relatively straightforward procedures like upper blepharoplasty.

Antiplatelet and anticoagulant medications must be reviewed and discussed with the patient's primary care physician, who keeps an eye on them to make sure it's safe to stop taking them up to one week prior to surgery and up to one week after.

The mental history should be reviewed, and any indications of body dysmorphic illness, narcissistic personality disorder, or a propensity for theatrical behaviour should be noted. The patient should be referred to a psychiatrist or psychologist if necessary.

Historical Ophthalmology

It is necessary to assess prior ocular surgery, including any refractive surgical operations, since many of these patients will be more likely to require lubrication. Meibomian gland dysfunction and blepharitis worsen with age, particularly in patients of Northern European descent; any existing issues and their management should be taken into account. A thorough history and examination are crucial since patients frequently request repeat blepharoplasty but may not recall having had done previously. Patients should be asked if they use artificial tear drops and, if so, how often they need them. They should also be asked about any history or present dryness.

Examination

The forehead, brows, and upper eyelids should always be reviewed when examining the top eyelids. It is also necessary to evaluate underlying ptosis. It is generally known that the position of the brows will descend following upper eyelid surgery, either with or without ptosis treatment, revealing the brow ptosis, particularly in men.[24] It is necessary to measure and record the symmetry or lack thereof of the upper eyelids. It is important to record the amount of excess skin on the upper eyelids, their thickness, any signs of inflammation, and any skin lesions. Finding and recording face asymmetry (brow, eyelid, but also forehead and cheek) is crucial. Epiblepharon may occur in Asians and some other populations; this should be recognised because the location of the upper eyelid incision will influence the final scar and outcome. Patients may have asymmetrical skin wrinkles, either primary, secondary, or tertiary.

It is possible to do a formal Schirmer's test using topical anaesthetic. However, as the results have not been found to be completely dependable, it is no longer deemed required. [25] [26] Nevertheless, evaluation of the corneal tear film, blink, closure, and lower eyelid flexibility (the distraction and snap-back tests) is required. 15% of people will experience a neutral or negative Bell's phenomenon, according to the assessment.

Tarsal platform and eyelid crease:

The formation of an eyelid skin crease, under which lies the tarsal show or tarsal platform, is essential to any blepharoplasty. The orbicularis oculi muscle allows the anterior fibres of the levator aponeurosis to enter the dermis, defining the skin crease. The height of skin creases varies by gender, age, and ethnicity.

In general, men's upper eyelid creases are smaller than women's. However, the height of skin creases vary even within a given ethnic group. To determine whether a patient's skin crease is appropriate, we look at younger patient photos. Due to the orbital septum's significantly lower insertion on the levator aponeurosis and the levator aponeurosis's weaker dermal attachments, Asian races have relatively modest skin creases (1 to 3 mm). Ageing results in a reduction in the flexibility of the skin, a weakening of the aponeurotic attachments to the dermis and tarsal, and a general decrease in periorbital fat, all of which should be evaluated. As people age, they may have "skeletonization" of the orbit, elevation of the skin crease, and hollowing of the periorbital tissues.

In Caucasians, the corneal reflex-lid margin distance is between 3.5 and 4 mm. Ptosis needs to be measured and adjusted if it is less than 3 mm or if there is asymmetry. It is generally advisable to measure the levator's function; it is often greater than 12 mm.

There are medial and central fat pads on the upper eyelid. By lightly pressing on the lower eyelid or the globe while the eyelids are closed, you can draw attention to these fat pads. Although the central fat pad frequently expands laterally, any lateral "bulge" should be interpreted as the lacrimal gland, which may prolapse forward as people age.

A weak septum separates the medial fat pad from the central fat pad, which is lighter in colour and more rounded. It is located medial to the levator aponeurosis. The levator aponeurosis is where the central fat pad is located. The lacrimal gland is located in the superolateral orbit's lacrimal sac fossa. The presence of preseptal retro-orbicularis fat may also be a factor in the fullness of the upper eyelids. A prolapsed lacrimal gland could be the cause of any lateral upper eyelid protrusion. Accurately examining the several bulges on the upper eyelid is made possible by an understanding of these anatomical characteristics.

Evaluation of the brow fat pad and brow posture are crucial. A broad brow makes one appear younger. The brow fat pad rarely needs to be removed. The brow fat (retro-orbicularis oculi fat) may become somewhat drooping due to secondary laxity, which calls for surgical adjustment as opposed to excision.

The following measures and evaluations are done, at the very least:

Brow ptosis can be mild, moderate, severe, or absent. Lateral brow ptosis (which might result in secondary dermatochalasis)

Shape of the brow: MRD-1, or corneal reflex-lid margin distance. The typical measurement is from 3.5 to 4 mm.

- ✧ Levator operation (more than 12 mm).
- ✧ Eyelid height and curvature.
- ✧ Students (any anisocoria).

Ocular motions:

- ✧ Examine the surface of the cornea for pterygia, scars, signs of radial keratotomy or LASIK, conjunctival blebs, and corneal dystrophies.
- ✧ Although Schirmer's test and tear breakup time but are frequently used, their precise reliability is unknown.
- ✧ Bell's phenomena. Conservative blepharoplasty is recommended if the patient exhibits either a negative or neutral Bell's phenomenon.
- ✧ Lagophthalmos: May indicate underlying thyroid disease or prior eyelid surgery.
- ✧ Watch out for underlying blepharospasm, which can produce orbicularis hypertrophy and redundancy, as well as related dermatochalasis and the appearance of ptosis due to the tonic squeezing of the eyelids.
- ✧ Check for floppy eyelid syndrome, or tarsal laxity. Before being lifted, patients' rubbery tarsal plates may need to be shortened horizontally.
- ✧ When a patient exhibits recurring, frequently unilateral eyelid swelling, blepharochalasis should be taken into consideration. There will be related atrophy of the eyelids. Ptosis, steatoblepharon, and extremely thin eyelid skin will eventually occur in patients. Although there is no pathognomonic histological finding, this illness exhibits lymphoedema with epithelial atrophy and loss of elastic fibres.

Patients with kidney failure and those using CPAP machines frequently have fluid retention in the upper and lower eyelids (as well as festoons). Intermittent eyelid swelling should raise the possibility of hereditary angioedema; C1-esterase inhibitor levels are measured.

Complication:

Blepharoplasty complications are rather uncommon. The main problem to take into account is the removal of excessive skin from the top eyelid, which makes it difficult to close the eye. As a result, there is a chance of corneal damage and persistent dry eye problems[27] Complications can arise even with fine surgical technique and cautious preparation, just like with any treatment. Warning symptoms of bleeding, visual loss, compartment syndrome, and infection are examined prior to release. It's critical to comprehend how and why issues arise following eyelid surgery. The majority of postoperative difficulties fall into one of four categories: (27) poor intraoperative assessment, (28) incorrect surgical technique, (29) faulty preoperative evaluation, or (30) idiopathic complications [27-28-30]. The preoperative thickness of the upper eyelid has an impact on these issues as well as the persistence of the double eyelid line following surgery[31]

Disorders of inflammation: Additionally, blepharoplasty is recommended for conditions including Graves' ophthalmopathy and blepharochalasis, which are aftereffects of inflammatory conditions affecting the eyelids and orbits.

Traumatic Events: A functional blepharoplasty may also be necessary in cases of orbital and eyelid trauma.

Other: Blepharoplasty of the upper eyelid is used to remove a tumor, remove a mass, rectify a traumatic or developmental eyelid abnormality, or remove a big xanthelasma.

Summarize Dicussion

The long-term results of upper blepharoplasty are greatly impacted by little technical choices. [32]

A larger paradigm shift in cosmetic surgery toward structural conservation is reflected in the shift from aggressive tissue removal to preservation-focused techniques.[33]

It is impossible to overestimate the significance of thorough preoperative evaluation.[34] Merely removing superfluous skin without addressing underlying structural deterioration may result in a short-term improvement but increase the risk of recurrence or abnormal shape. [35] Similarly, in the past, excessive fat removal resulted in hollowing deformities that went against changing aesthetic standards that preferred delicate volume preservation.[36] Conservative fat management, with repositioning or restricted excision based on individual anatomy, is supported by contemporary literature. [37] Beyond aesthetic improvement, functional results offer compelling support for the operation. [38] In certain patients, objective improvements in visual fields validate upper blepharoplasty's reconstructive legitimacy. The overall effect of periorbital rejuvenation is further supported by patient-reported outcome measures that show significant psychosocial improvement.[39] Careful technique is essential to preventing complications. To stop haematoma formation, haemostasis is essential. [40] Revision rates are decreased by intraoperative symmetry assessment and precise skin marks that minimise overresection. Surgeons have to strike a balance between preserving functionality and aesthetic goals.[41] Prospective, multicenter studies using objective functional assessment and standardised PROM devices should be the focus of future research. [42] Evidence-based practice would also be strengthened by long-term data assessing recurrence rates and revision results.[43]

When anatomical considerations and conservative surgical philosophy are adhered to, upper blepharoplasty continues to be a treatment with predictable, long-lasting results. [44]

Conclusion:

For both functional visual impairment and cosmetic ageing, upper blepharoplasty is a safe and efficient treatment. High patient satisfaction and low complication rates are the results of contemporary surgical techniques that prioritise anatomical precision, tissue preservation, and customised planning.

Comprehensive assessment of surgical success is improved by combining objective metrics with patient-reported outcomes.

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