



**Table 2.** Classification of eyelid lifting muscle function

Function of the lifting muscle	Measure of the excursion of the edge of the upper eyelid
EXCELLENT	>13 mm
GOOD	8–12 mm
WEAK	5–7 mm
POOR	<4 mm

allopurinol from one week before the surgery until 48 hours after skin flap surgery.

### Group A skin flap surgery

The differentiation between patients with congenital or acquired eyelid ptosis is of great importance because their surgical outcomes can differ [3]. Thus, determination of the degree of ptosis and the function of the lifting muscle of the eyelid is essential in selecting the optimal correction method [5, 6, 7].

It is of fundamental importance that the ophthalmologist check the eyes for visual acuity, strabismus, visual field, diplopia, amblyopia, ocular motility, Marcus Gunn and Bell phenomenon, and corneal sensitivity, among others. In almost all cases, correction of the ptosis will cause edema and/or lagophthalmos, even if transitory. Research on the Bell phenomenon is very important because, when absent, the corrective surgery must ensure no corneal exposure, which can lead to complications such as keratitis and even corneal ulcers that, in extreme cases, can result in loss of sight in the affected eye [5].

In the absence of the lifting muscle, other techniques can be applied, such as use of the upper rectus and corrugator muscles and frontal suspension (use of a silicon strip) of the fascia lata [8, 9, 10]. These are the so-called indirect techniques for not acting directly on the lifting muscle.

The objective of this work is to present an alternative to sutures in the correction of light and moderate eyelid ptosis, with continuous suturing for plication and reinsertion of the aponeurosis of the lifting muscle into the tarsus.

### METHOD

A total of 26 patients (16 male, 10 female) with unilateral light or moderate eyelid ptosis underwent corrective surgery [Table 3] between 2006 and 2012 under general or local anesthesia with sedation. The anesthetic solution consisted of lidocaine with a vasoconstrictor at a concentration of 1:100,000; the patients originated from S.U.S. and from the author's private clinic. The average patient age was 43 years (range, 6–80 years).

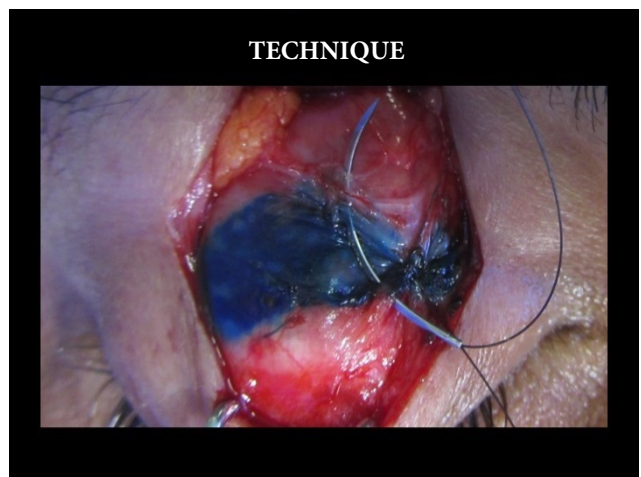
After a cutaneous incision was made in the eyelid fold, the orbicular muscle was divided and the orbital septum was opened. Immediately below the medium fat mass, the aponeurosis of the lifting muscle was accessed and dissected in the cranial direction up to the Whitnall ligament and caudal to the tarsal plaque.

The aponeurosis portion of the lifting muscle was demarcated in the form of an arch using methylene blue and the lower line had a

dimension of 6–8 mm in the central third and 3–4 mm in the lateral and medial thirds. The upper trace corresponded to a line equidistant to the lower trace [Figure 1]. Shortening of the aponeurosis occurred at the expense of a plication in the proportion of 4 mm of shortening for each millimeter of ptosis moving from the medial to the lateral region [Figure 2]. After thread traction was gained, ptosis was corrected and a locking node was made. In the sequence, we used 5-0 monofilament nylon to create a continuous suture in the medial direction that was interlaced with the thread to create suture ends with a figure eight shape. We used 5-0 monofilament nylon for this purpose. We also sutured the edges of the orbicular muscle with 4–5 separate stitches using 6-0 monofilament nylon and closed the skin with an intradermic suture using monofilament nylon 6-0.

**Table 3.** Classification of cases by degree of ptosis

Grau de ptose	Número de pálebras operadas
LEVE	8
MODERADA	18



**Figure 1.** Demarcation of the aponeurosis



**Figure 2.** Suturing technique



