# *Aesthetic Abstracts and Citations*

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**In this Aesthetic Abstract and Citations section, we highlight and briefly discuss recently published manuscripts from other peer-reviewed journals that may be of interest to our readership in oculoplastic surgery. These are just cursory reviews to peak an interest on subjects, which the individual reader may desire to pursue in more detail by reading the manuscript in full.**

Sarwer DB, Spitzer JC. Body image dysmorphic disorder in persons who undergo aesthetic medical treatments. *Aesthet Surg J* 2012;32:999–1009.

This is an excellent summary of current considerations/reports of body dysmorphic disorder (BDD) in patients seeking aesthetic enhancements. It begins with a review of the current popularity (with statistical documentation) and psychological aspects of aesthetic surgery, with elaboration on the concept of body image dissatisfaction—"the internal representation of an individual's external appearance"—and how this plays a role in a number of psychiatric conditions, from eating disorders, to gender identity disorder to BDD. A review of the prevalence, diagnostic and clinical criteria of BDD is presented, in addition to the data available on patients with BDD who both seek (approximately 70%) and have (approximately 60%) cosmetic surgery. Of interest is that 33% of aesthetic surgeons have been threatened legally by a patient with BDD, 2% have been physically threatened, and there are 4 documented cases of surgeons who have been murdered by patients presumed to have BDD. The article concludes with a description of the psychological assessment, motivations, expectations, and psychiatric history and status of patients seeking aesthetic surgery. Of note is that 20% of cosmetic surgery patients report a mental health history and 18% report the use of a psychiatric medication (primarily antidepressant) on their initial evaluation. This is compared with 4% and 5%, respectively, for noncosmetic plastic surgery patients.

**Message:** This is a terrific review with essential and "eye-opening" information for any surgeon who performs aesthetic procedures—surgical or otherwise. I highly recommend reading the article in its entirety.

Kontis TC. Contemporary review of injectable facial fillers. *Jama Facial Plast Surg* 2013;15:58–64.

This is a comprehensive yet concise review of the history of facial filler use in the United States after collagen-based products. The various temporary hyaluronic acid–based products (Restylane, Juvederm, and Perlane), semipermanent materials (Radiesse – calcium hydroxyapatite, and Sculptra – Poly-L-lactic acid), and permanent fillers (Artefill – poly[methyl methacrylate], and LaViv – autologous fibroblasts) are detailed. An excellent historical perspective and chronology of product studies, efficacy, and adverse events is presented. Table 1 lists all injectable fillers (including product trade name/manufacturer and product description) by dates of approval by the US Food and Drug Administration. The 5-point Wrinkle Severity Rating Scale and Global Aesthetic Improvement Scale measures by which filler efficacy was determined are also presented.

**Message:** It is essential for oculofacial surgeons who inject facial fillers to familiarize themselves with the history and product details of the materials they inject. This is a constantly evolving field that can be difficult to stay current with for a busy surgeon. This review nicely simplifies this information to the contemporary applications of these materials.

Kim YJ, Choi KS. Bilateral blindness after filler injection. *Plast Reconstr Surg* 2013;132:289e–99e.

This case details the first report of bilateral blindness (NLP vision OU) after facial soft tissue filler injection. In this instance, the filler was calcium hydroxyapatite for nasal augmentation. The patient is a 30-year-old healthy man. A timetable for presentation after injection was not noted. Findings included NLP vision OU, fixed and dilated pupils, bilateral blepharoptosis, and total ophthalmoplegia. There was bilateral conjunctival injection with multiple emboli along the conjunctival vessels and retinal edema and numerous emboli noted within the retinal vasculature. Externally there was central skin necrosis with a surrounding reddish reticular discoloration along the bridge of the nose and frontal area. The diagnosis included blindness, ocular ischemia, and ophthalmoplegia related to vascular occlusion. Injection techniques to avoid such complications are described.

**Message:** This is valuable reading for any injector of filler materials to the face and periorbital area. I would also strongly recommend the article by Lazzeri et al (Lazzeri D, Agostini T, Figus M, Nardi M, Pantaloni M, Lazzeri S. Blindness following cosmetic injections of the face. Plast Reconstr Surg 2012;129:995–1012), which reviews all reported cases of visual loss following injections and details etiology and management recommendations of such events.

Zhang MY, Yang H, Ding SL, Li CY, Yu YS, Tan WQ. Construction of a double eyelid: an uncut strip of orbicularis removed through three mini-incisions. *Aesth Plast Surg* 2013;37:22–8.

The authors describe their experience with a variant of the mini-incisional technique for eyelid crease formation (double eyelid) in an Asian patient population. The limitations of the closed technique (lack of permanency), open technique (prolonged edema and scarring), and more recently presented mini-incisional procedures (limited excision of subdermal tissue and lack of crease durability) are reviewed. In the procedure described, 3 small stab incisions (temporal, central, and nasal) are made along a predetermined crease demarcation. Through these "mini-incisions," a continuous strip of orbicularis muscle is excised and fed subcutaneously from the temporal to nasal extent of the eyelid and excised. Each stab incision is sutured closed incorporating deeper tissue allowing adherence of the skin to the tarsus/levator with subsequent crease formation. Ninety patients are included in the study (180 eyelids) with only a 4% diminution of the crease at an average 9-month follow up. In 23 patients (46 eyelids) followed >3 years, 17% of patients demonstrated some degree of crease regression. Eyelid edema resolved in 92.6% of eyelids at 3 weeks and 100% of

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eyelids at 4 weeks after surgery. Three immediate postoperative photographs are presented, but only 1 long-term result is photodocumented.

**Message:** A procedure that reduces the extent and duration of postoperative eyelid edema while maintaining a long-term eyelid crease is a useful addition to the Asian blepharoplasty literature. It would have been nice to have had more objective measures of outcome and photopresentation of long-term results. Still, the procedure is an interesting hybrid of the full and more recent mini-incisional crease forming techniques and worth evaluating.

Bellinvia G, Klinger F, Maione L, Bellinvia P. Upper lid blepharoplasty, eyebrow ptosis, and lateral hooding. *Aesthet Surg J* 2013;33:24–30.

The authors describe a 1-year experience (December to January 2008) with 582 upper blepharoplasty procedures with a modified skin ellipse marking/excision whose purpose is to address significant lateral hooding without altering brow position or to give the appearance of an apparent temporal brow lift. No adjunctive "browpexy" or "brow lifting" procedure was added. The upper limb of the skin ellipse begins 5 to 6 mm above the medial canthus and rides high ending well beyond the end of the brow at the height of the medial brow. The lower limb is straight, generally above the natural crease and tails acutely upward 15 to 25 mm above the lateral canthus to meet the upper limb. Laterally, the thicker brow skin is excised, while thinner eyelid skin is preserved. Nice drawings of the markings are presented. Ten and one-half percent of patients had surgery for pure functional reasons and 19.3% for pure cosmetic reasons. The remaining patients had mixed cosmetic and functional concerns. The surgical results were assessed by telephone patient interviews of 100 randomly selected patients performed by office staff personnel. Patients were polled regarding satisfaction with the procedure and degree of visibility of the scars. Eighty-three percent of patients were very satisfied with surgery and 16% were satisfied, while 92% of patients rated their scar as insignificant.

**Message:** This is an interesting incision variant aimed at aggressive lateral skin excision while preserving eyebrow height, which would seem to potentially lead to a more visible temporal scar. This was not an issue in this series as reported by the authors. Eyebrow position pre- and postsurgery was not analyzed in the article. In addition, physician evaluation of results was not included; and surgical results were based on patient satisfaction only. That notwithstanding, the article is worth reading as to stimulate thought regarding varying incision placement during surgery.