



“Droopy Eyelids”: What Can We Do?

Dr Yip Chee Chew, Consultant, Ophthalmology and Visual Sciences, Alexandra Hospital
Head, Oculoplastics, The Eye Institute, National Healthcare Group



“**Droopy eyelids**” is a common concern in the elderly population. The appearance of “droopy eyelids” may be a result of a true droopy eyelid (**ptosis**), lax upper eyelid skin (**dermatochalasis**) and/or droopy eyebrow (**eyebrow ptosis**). Besides affecting cosmesis, it poses functional problems such as visual obstruction, eye tiredness, heaviness of the eyelids and eyebrow ache (due to prolonged use of the frontalis muscle).

Involitional ptosis is due to ageing changes in the levator muscle (attenuation or dehiscence). It presents with high or multiple upper eyelid creases (“double eyelid”) and good levator function. In comparison, **congenital ptosis** is due to maldevelopment of the levator muscle present in early life (evident from the history or old photos), has an absent or poorly formed eyelid crease and diminished levator function. **Neurogenic ptosis** is often associated with neurological diseases such as myasthenia gravis and myotonia dystrophica that may require referral to a neurologist/neuro-ophthalmologist. These conditions often have specific neurological signs such as diplopia, fatigueability, variability, ocular motility deficits, myotonia and motor weakness. **Mechanical ptosis** due to the presence of a heavy mass such as a tumour (benign or malignant) is generally obvious. The treatment of involitional and congenital ptosis with good levator function is **external levator resection** that involves advancing and/or shortening the levator aponeurosis to lift up the upper eyelid via a skin crease incision. Alternatively, with mild/moderate ptosis (less than 3mm), **conjunctiva-muller’s muscle resection** via a trans-conjunctival approach with no skin incision gives a natural contour (**Figure 1**).

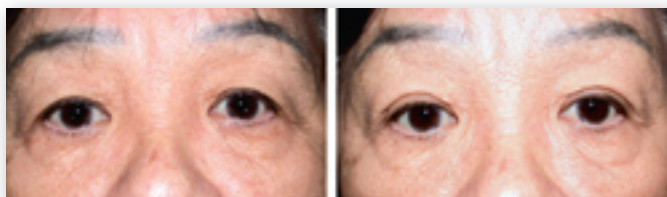


Figure 1 (left): Bilateral involitional ptosis and “eye bags” due to orbital fat prolapse.

(right): One month after upper blepharoplasty, the eyelid crease re-appeared and the heavy sensation relieved.

Dermatochalasis is an increased redundancy of the upper eyelid skin due to skin laxity and ageing. The “redundancy” results in an obliteration of the eyelid crease and visual obscuration. It can be treated with surgical excision of the redundant skin (**upper blepharoplasty**) and conservative orbital fat excision if indicated (**Figure 2**).



Figure 2 (left): Bilateral dermatochalasis causing obliteration of the skin crease.

(right): One month after bilateral conjunctiva-Muller’s resection and lower blepharoplasty. Both upper eyelids are elevated and eye bags ameliorated.

Eyebrow ptosis is due to a loss of structural eyebrow support and gravity. The lateral eyebrow is commonly affected more and presents with lateral hooding (overhanging skin over the eyelid margin). In mild cases, the eyebrows can be medically elevated with **Botox® injection** to weaken the depressor (orbicularis oculi); the eyebrow contour may also be altered by differential relaxation of other facial muscles. Nonetheless, more advanced cases require surgical elevation via a direct approach (**direct or pre-trichial eyebrow lift**) or via small, concealed incisions (**endoscopic eyebrow lift**). The former is simple, easy to perform and has reasonably acceptable surgical scars (**Figure 3**). The latter is a more time-consuming cosmetic procedure that requires special surgical skills.



Figure 3 (left): Bilateral dermatochalasis and eyebrow ptosis with lateral hooding causing visual obstruction.

(right): One month after bilateral upper blepharoplasty and direct brow lift, his appearance is improved.

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