Introduction

The eyes, or more precisely, periorbital tissues, are paramount in facial beauty, exhibiting youth and a plethora of expressions. Unfortunately, this area is also one of the first to show aging from the effects of gravity, ultraviolet radiation, and animation. The hallmarks of the upper third facial aging are: dermatochalasis, lateral hooding, and fat pseudoherniation in the medial aspect of upper eyelids. In the lower eyelids, there may be tear drop deformity, pseudoherniation of the three fat compartments, and rhytides. These changes lead to the so called "double bubble" irregularity, a telltale sign of the aging face ***(Freeman, 2003)***.

Blepharoplasty (in Greek, blepharon, meaning eyelid, and plastos, meaning formed) was originally used by Von Graefe in 1818 to describe a case of eyelid reconstruction that he had performed in 1809. Blepharoplasty can be preformed solely on the upper lids or lower lids or on both. Upper lid blepharoplasty is usually approached from the anterior or skin surface. This procedure concentrates on removal of excess skin and orbicularis muscle with secondary removal of fat if indicated. Lower lid blepharoplasty is nearly always performed for cosmetic purposes and emphasizes removal of herniated fat. Excision of skin and orbicularis muscle is usually secondary. The lower lid may be approached through either an anterior (subciliary) or a transconjunctival incision ***(Baylis et al., 2008)***

The goals of Blepharoplasty are both cosmetic and Functional purposes. Functional blepharoplasty is performed to restore vision.

Excess skin, muscle and fat are removed so that tissue is no longer blocking the visual axis. The goal of cosmetic blepharoplasty is to accentuate the appearance of the eyes with a wider palpebral aperature and greater smoothness and symmetry ***(Della Rocca, 2007)***.

Transconjunctival blepharoplasty and adjunctive CO_2 laser resurfacing represents an excellent alternative to transcutaneous lower blepharoplasty. The procedure addresses lower lid wrinkles, skin redundancy, and fat herniation without a scar and with little risk of lower lid retraction ***(Persing et al., 2008)***.

Lateral canthoplasty and lateral tarsal strip procedures were initially used to correct established lid malposition; however, more recently, it has become an accepted and useful prophylactic measure against lid malposition in cosmetic blepharoplasty ***(Fagien et al., 2007)***.