Effect of Upper Eyelid Surgery on Corneal Topography

Martin S. Zinkernagel, MD; Andreas Ebner, MD; Dagmar Ammann-Rauch, MD

Objective: To compare the effects of different upper eyelid procedures on corneal topography.

Methods: Eighty-two eyes of 43 patients with various degrees of dermatochalasis or ptosis underwent computed corneal topography before surgery and at 3 months after surgery. Patients were divided into groups depending on the extent of surgery. In addition, the thickness of the central cornea was correlated with the change in astigmatism.

Results: There were mean changes in total astigmatism of 0.25 diopter (D) after ptosis surgery ($P = .02$) and 0.21 D after blepharoplasty with reduction of large fat pads ($P = .04$) compared with 0.09 D in patients after skin-only blepharoplasty. In addition, there was a correlation between corneal thickness and change in astigmatism of more than 0.2 cylinders after ptosis surgery ($P < .05$). Postoperative astigmatic axis changes were not systematic.

Conclusions: We found a statistically significant correlation between the severity of upper eyelid abnormality and topographical corneal changes after surgery. These findings emphasize the importance of advising patients, especially those with ptosis and severe dermatochalasis, that upper eyelid repositioning procedures may induce vision changes.

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Dermatochalasis is an age-related change in the eyelids and manifests as excessive folds of skin sometimes with underlying protrusion of fat through the orbital septum of the upper eyelids. Acquired ptosis refers to a thinning of the levator aponeurosis. Ptosis surgery and blepharoplasty are the most commonly performed procedures of the upper eyelid by oculoplastic surgeons. Blurred vision has long been recognized as a potential complication of these procedures. Several studies evaluated the effect of upper eyelid surgery on corneal topography. Most patients who underwent blepharoplasty and ptosis repair had refractive changes measurable by corneal keratometry. However, in view of the rising popularity of blepharoplasty, we investigated whether different surgical strategies involving minor to major resection of tissue, or other factors such as corneal thickness, correlate with severity of corneal topographic change.

METHODS

Patients were recruited from the oculoplastic division of the Department of Ophthalmology, Cantonal Hospital St Gallen, St Gallen, Switzerland, during 16 months from August 1, 2005, to December 1, 2006. The study was approved by the hospital ethics committee. Exclusion criteria were prior intraocular, refractive, or eyelid surgery, as well as existence of corneal surface-altering diseases such as pterygium, keratoconus, or contact lens wearing. Accurate measurement of the upper eyelid position was completed in all patients with the eyebrow fixed in reposition position. Margin reflex distance, defined as the distance from the central light reflex on the cornea to the upper eyelid margin in primary position, was assessed, and a distance of less than 2 mm was generally considered ptosis necessitating surgery.

Corneal topography was recorded using a computed topography system (Orbscan II; Bausch & Lomb, Rochester, NY). The system measures anterior and posterior corneal elevation and surface curvature by using a scanning slit mechanism. Anterior surface elevation maps of the topography system can be considered accurate representations of corneal shape and are reproducible. The central corneal thickness was calculated by measuring the distance between the anterior and posterior surfaces of the cornea. Patients were asked to blink twice to smooth the corneal surface to give a reproducible measurement. Some corneal topographies were recorded twice, and measurements of topographic variables were reproducible. The initial measurement was performed at variable time points before surgery and were repeated at 3 months after surgery following completed wound healing. The analysis of the corneal topographies included simulated keratometry in the 3- and 5-mm zones. The values of the 3-mm zone correspond to Javal-Schiotz keratometry values. A relevant change in astigmatism was defined as a change in cylinder power of at least...
were seen at 3 months after surgery.

Sutures were removed 6 to 8 days after surgery, and patients tral, and sometimes the lateral compartment were resected. roplasty.8,9 In entire fat pad blepharoplasty, the medial, the cen-tral compartment, which is usually deep yellow; a pale yellow compartments have been described in the upper eyelid: a cen-tral compartment, which is usually deep yellow; a pale yellow with medial and lateral ranges of motion. The following 3 fat procedures were performed transcutaneously using a 0.2-mm car-

Forty-three patients were included in the study. Measure-
ments included 24 eyes of 13 patients with involutional ptosis and 58 eyes of 30 patients with dermatochalasis. Of the 58 eyes of 30 patients with dermatochalasis, 17 were from

Table 1. Preoperative and Postoperative Cylinders and Axesa

<table>
<thead>
<tr>
<th>Group</th>
<th>Cylinder, D</th>
<th>Axis, Degrees</th>
</tr>
</thead>
<tbody>
<tr>
<td>All groups (N = 82)</td>
<td>Preoperative</td>
<td>Postoperative</td>
</tr>
<tr>
<td>Pnosis surgery (n = 24)</td>
<td>−0.92</td>
<td>−0.93</td>
</tr>
<tr>
<td>Skin-only blepharoplasty (n = 17)</td>
<td>−1.08</td>
<td>−1.16</td>
</tr>
<tr>
<td>Blepharoplasty with reduction of the medial fat pad (n = 19)</td>
<td>−0.79</td>
<td>−0.82</td>
</tr>
<tr>
<td>Blepharoplasty with reduction of the entire fat pad (n = 22)</td>
<td>−0.87</td>
<td>−0.83</td>
</tr>
</tbody>
</table>

Abbreviation: D, diopter.

Table 2. Relevant Cylinder Power Change

<table>
<thead>
<tr>
<th>Group</th>
<th>No. of Eyes With Relevant Cylinder Power Change/Axis Change</th>
<th>%</th>
<th>Median Decrease, D</th>
<th>Maximum Decrease, D</th>
<th>Maximum Increase, D</th>
<th>Mean ± SD/Median Corneal Thickness, µm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin-only blepharoplasty (n = 17)</td>
<td>2/0</td>
<td>12</td>
<td>0.25</td>
<td>0.20</td>
<td>0.30</td>
<td>526 ± 44/564/562</td>
</tr>
<tr>
<td>Blepharoplasty with reduction of the medial fat pad (n = 19)</td>
<td>7/0</td>
<td>37</td>
<td>0.30</td>
<td>0.80</td>
<td>0.40</td>
<td>532 ± 37/534/547</td>
</tr>
<tr>
<td>Blepharoplasty with reduction of the entire fat pad (n = 22)</td>
<td>11/4</td>
<td>50</td>
<td>0.30</td>
<td>0.80</td>
<td>0.60</td>
<td>543 ± 40/540/541</td>
</tr>
<tr>
<td>Ptosis surgery (n = 24)</td>
<td>15/8</td>
<td>62</td>
<td>0.30</td>
<td>0.70</td>
<td>1.10</td>
<td>539 ± 42/550/550</td>
</tr>
</tbody>
</table>

Abbreviation: D, diopter.

The amount of fat to be resected in upper eyelid surgery was determined before surgery with the patient in downgaze and with medial and lateral ranges of motion. The following 3 fat compartments have been described in the upper eyelid: a central compartment, which is usually deep yellow; a pale yellow medial compartment; and a lateral third accessory compartment, which is a frequent finding during upper eyelid blepharoplasty.8,9 In entire fat pad blepharoplasty, the medial, the cen-tral compartment, which is usually deep yellow; a pale yellow with medial and lateral ranges of motion. The following 3 fat compartments have been described in the upper eyelid: a central compart-

RESULTS

The preoperative and postoperative mean cylinders are summarized in Table 1. The changes in cylinder values and cylinder axis shifts were calculated and were statistically analyzed using 1-way analysis of variance or t test. The mean overall change in simulated keratometry in the 3-mm zone at 3 months after surgery was 0.19 D, with a mean ± SD of 0.09 ± 0.08 D in the SOB group, 0.15 ± 0.20 D in the BMFP group, 0.21 ± 0.20 D in the BEFP group, and 0.25 ± 0.25 D in the ptosis surgery group. We found statistically significant astigmatic changes in the ptosis surgery and the BEFP groups (P < .05 for both) compared with the SOB group.

An analysis of relevant axis changes showed that astigmatic change in 7 of 17 eyes (41%) in the SOB group, in 11 of 19 eyes (57%) in the BMFP group, in 15 of 22 eyes (68%) in the BEFP group, and in 21 of 24 eyes (88%) in the ptosis group. If looking at the amount of astigmatism only, there was a change of 0.2 D or more in 2 of 17 eyes (12%) in the SOB group, in 7 of 19 eyes (37%) in the BMFP group, in 11 of 22 eyes (50%) in the BEFP group, and in 15 of 24 eyes (63%) in the ptosis surgery group (Table 2). In the SOB and BMFP groups, no concomitant axis change was noted, whereas in the BEFP and ptosis surgery groups, the axis rotated more than 10° in 4 of 11 (36%) and 8 of 15 (53%) eyes, respectively. These data were reexamined for the effect of corneal thickness on cylinder power changes following surgery. Corneal thickness was statistically equal among all groups. The mean thickness of corneas with astigmatic change of more than 0.2 cylinder was compared with the mean thickness of corneas with astigmatic change
of 0.2 cylinder or less. A correlation between corneal thickness and change in astigmatism of more than 0.2 cylinders was found only after ptosis surgery (P < .05). In addition, an analysis of corneal topography maps showed a statistically significant increase in astigmatism from the center to the 5-mm zone in all groups. When comparing the 5-mm-diameter-zone mean keratometric values, mean dioptic changes of 0.72 D after ptosis surgery and 0.29 D after blepharoplasty were measured.

Only 1 patient explicitly reported blurred vision at 3 months after surgery. This patient showed an astigmatic change of 1.0 D after ptosis surgery. In all groups, rotation in with-the-rule direction was equally as frequent as rotation in against-the-rule direction.

Studies2-4,10 have investigated the effect of eyelids on corneal shape, mainly in congenital ptosis. Gullstrand11 reasoned that corneal astigmatism was changed by the pressure of the eyelids in with-the-rule direction, attributing this to a flattening of the cornea by the eyelids. When the cornea is flattened peripherally, the central cornea becomes steeper in with-the-rule direction. In addition, various upper and lower eyelid conditions, including hemangiomas, gold weight implants, chalazia, epibulbar dermoids, and involutional ectropion, have been reported to affect corneal shape.2-4,10

In summary, corneal topographic change detected in the present study correlated with the degree of the upper eyelid abnormality and may affect corneal optical function. Our findings provide strong evidence that altered eyelid pressure after ptosis surgery and blepharoplasty with large fat pad reduction may induce notable corneal shape change. Our data suggest that corneal thickness affects the degree of corneal shape change only when there is substantial alteration of eyelid pressure on the cornea, as is the case with ptosis surgery. Corneal topographic changes after blepharoplasty without reduction of large amounts of fat were small and are unlikely to affect visual acuity.

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**REFERENCES**