

Cosmetically favorable scars using the upper blepharoplasty incision

To the Editor:

Approaches to the craniofacial skeleton have been developed to provide good surgical access and to obtain cosmetically favorable scars. The zygomatic complex and the orbit present a significant concern for postoperative scars because of their prominent visibility on the face. A zygomaticomaxillary orbital complex fracture may require exposure of the zygomatic buttress through the buccal sulcus (Keen) approach, infraorbital rim by the subciliary or transconjunctival approach, and the zygomaticofrontal region by either the upper blepharoplasty or lateral brow approach.^{1,2}

The lateral brow incision design provides relatively quick and direct access to the lateral orbital rim of the zygomatic complex. The incision is made parallel to the hair follicles within a lateral brow line to minimize postoperative scarring. A disadvantage of this technique is a visible scar if extended past the brow and more visibility if the patient has a thin or absent eyebrow.³

The upper blepharoplasty incision is not commonly described for access to the zygomaticofrontal region. This approach provides similar exposure compared to the lateral brow incision, but with the advantage of having a camouflaged scar similar to that obtained with a blepharoplasty.

The upper blepharoplasty incision is placed in the upper eyelid skin fold, 8 to 10 mm superior to the lid margin (Figs 1 and 2). The incision is approximately 2 cm in length, which provides adequate exposure of the frontozygomatic region (Fig 3). Blunt dissection



Fig 1. Patient marking in supratarsal crease with eye closed.



Fig 2. Same patient marking with eye opening demonstrating camouflage of incision design.



Fig 3. Intraoperative view of incision used to access the frontozygomatic region in addition to transconjunctival incision for lower rim access.

is performed through the orbicularis oculi muscle in a superior and lateral direction with concomitant retraction of the periorbital tissues so that the periosteum incision is carried out directly over the bone. If dissection is not directed superiorly and laterally, the orbital septum may be encountered, containing the lacrimal gland and orbital fat. The periosteum is incised with a blade, exposing the zygomaticofrontal suture. Subperiosteal dissection can be performed to allow for reduction and rigid internal fixation of the zygomaticomaxillary-orbital complex. Upon completion of fracture reduction and fixation, closure of the upper blepharoplasty incision is performed using a monocryl running subcuticular pullout suture or resorbable ophthalmic gut suture through the skin and muscle layer.⁴

The upper blepharoplasty approach has many advantages, which include a cosmetically acceptable scar that is well hidden in the supra tarsal fold while allowing adequate exposure of the zygomaticofrontal suture for reduction and fixation of orbital zygomatic fractures. The upper eyelid skin is the thinnest in the body, which produces minimal scarring from incisions. Disadvantages of the upper blepharoplasty incision may include encountering the orbital septum with exposure of orbital fat and lacrimal gland. The upper blepharoplasty incision is an excellent alternative for the surgical access to the frontozygomatic region.

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The role of holmium:YAG laser in arthroscopy of the temporomandibular joint

To the Editor:

We have read with great interest the article of Kaneyama et al, "Outcomes of 152 temporomandibular

joints following arthroscopic anterolateral capsular release by holmium:YAG laser or electrocautery" (*Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2004;97:546-51). The authors report their experience with the use of Holmium:YAG laser in temporomandibular joint (TMJ) arthroscopy, a very important and present topic in maxillofacial surgery.

However, the basic concepts and some important aspects reported are really surprising. In fact, we would submit the following statements related to this work.

In the discussion section, the author argues that the clinical efficacy of arthroscopic anterolateral capsular release using Holmium:YAG laser is superior to that achieved through electrocautery. This is a very strange assertion and is not related to the results obtained. They indicate that there were no statistical differences between the laser or electrocautery groups (this finding is reasonable); therefore, the superiority of the laser instrument is not confirmed by the statistical study.

Next, the use of electrocautery in TMJ arthroscopy is related by the authors with thermal damage to surrounding tissues. In our opinion, this assertion is not true. From 1996, we have performed more than 300 TMJ arthroscopies with triangulation, electrocauterization of the posterior ligament, and/or anterior release.¹ In our group, no cases of thermal injury have been observed. The sole condition is the continuous high-flow irrigation with Ringer lactate during the maneuver of electrocauterization. Kaneyama et al justify this complication by a work of McCain et al.² However, McCain et al defend the usefulness of electrocautery and they do not report problems in relation to thermal injury.

Kaneyama reasons that the aim of anterolateral capsular release is to provide sufficient joint space, which is narrowed by the fibrous adhesions. Therefore, the effect of this technique would be to avoid the formation of these adhesions. On the contrary, we believe that the effect of anterior release is to improve the dynamics of the joint. The adhesions should be eliminated by microscissors, forceps, or motorized cutting unit following the criteria of authors such as Tarro.³ Moreover, the presence or not of adhesions is not influenced by the anterolateral release technique.

Finally, 6 patients of the group with poor results were subjected to arthrocentesis in the follow-up. In previous reports, the use of arthrocentesis has been advocated in the treatment of the sudden-onset closed lock.⁴ However, we don't understand what the role of arthrocentesis is after an unsuccessful arthroscopy. Also, the authors do not report the results obtained after this secondary treatment. We think that the recommended