Reconstructions of eyelid defects

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ABSTRACT
Eyelids are the protective mechanism of the eyes. The upper and lower eyelids have been formed for their specific functions by Nature. The eyelid defects are encountered in congenital anomalies, trauma, and postexcision for neoplasm. The reconstructions should be based on both functional and cosmetic aspects. The knowledge of the basic anatomy of the lids is a must. There are different techniques for reconstructing the upper eyelid, lower eyelid, and medial and lateral canthal areas. Many a times, the defects involve more than one area. For the reconstruction of the lid, the lining should be similar to the conjunctiva, a cover by skin and the middle layer to give firmness and support. It is important to understand the availability of various tissues for reconstruction. One layer should have the vascularity to support the other layer which can be a graft. A proper plan and execution of it is very important.

KEY WORDS
Anterior lamella; conjunctiva; eyelid reconstructions; posterior lamella; Tarsal plate

INTRODUCTION
Eyelids are complex structures and pose a challenge for reconstruction. They play an important role in protecting the globe from trauma, excessive light, and in maintaining the integrity of tear films and moving the tears toward the lacrimal drainage system. The beauty and expression to the eye is given by the lids and muscles in it. Upper and lower eyelids have been formed for their specific functions by Nature. To undertake the reconstruction of the eyelids, it is very important to understand few basic anatomical features of the eyelids.

The normal eye [Figure 1] has an elliptical shape with the upper eyelid being more curved due to the shape of the tarsus and adaptation of the lid to the curvature of the globe. The highest point of the curve is just medial to the pupil in primary gaze. The upper lid margin rests at the upper limbus

Figure 1: Normal eye shape. Upper lid margin 1–1.5 mm below the limbus. Horizontal palpebral fissure 28–30 mm. Vertical palpebral fissure 10–11 mm; lateral canthus is 2 mm above the medial canthus
of the cornea in children and 1–1.5 mm below the limbus in adults. The lower lid has a gentle S-shaped curvature with the lowest point being just lateral to the pupil.

Its margin just skirts the corneoscleral junction inferiorly. The width of the eye, the horizontal palpebral fissure, measures 28–30 mm. The vertical palpebral fissure is the distance between the lid margins and is 10–11 mm. The lateral canthus is 2 mm above the medial canthus. The function of the upper eyelid is to protect the cornea and during its excursion it spreads the tears over the cornea to lubricate it. For mobility, it has to be light in weight.

The lower lid is shorter in height, less mobile, and contributes minimally for closure. It helps in pushing the tears toward the punctum to help in lacrimal drainage.

The skin of the eyelid is very unique and is the thinnest in the body. It becomes thicker as it approaches the eyebrow and cheek. It is firmly adherent over the pretarsal area and over the medial and lateral canthal areas due to the absence of subcutaneous tissue. It is lined with the conjunctiva on the inner side and supported in the middle by the tarsal plate. The conjunctiva is firmly adherent over the tarsal plates, loose above it and while lining the fornices. The lid margin is about 2 mm in width and represents the transitional zone of the skin and conjunctiva. This junction is called the grey line and through it the lid can be split into anterior lamella and posterior lamella. The anterior lamella consists of the skin and orbicularis muscle. The posterior lamella consists of the conjunctiva and tarsal plate. The posterior edge of the lid margin is sharper compared to the anterior edge which is rounded. There are two rows of lashes in the lower lid and three to four rows in the upper lid.

The tarsal plates are composed of dense fibrous tissue and give the structural integrity to the lids. They are 28–29 mm long and 1 mm thick. The upper lid tarsus is 10 mm in height centrally and narrows medially and laterally. The height of tarsal plate in the lower lid is 3.5–5 mm. The medial and lateral ends of the tarsi are attached to the orbital rims by the medial and lateral palpebral ligaments also called tendons. In youth, the tarsal plate and canthal tendons hold the eyelids firmly against the globe. With aging, canthal tendons and tarsus may stretch, allowing the lids to be pulled away from the globe.

The medial canthal tendon (MCT) is a fibrous band stabilizing the lid medially. It has anterior and posterior limbs. The superficial head of the pretarsal orbicularis muscle lies anterior to the canaliculi and forms the anterior limb of the MCT. It inserts anterosuperiorly into the lacrimal crest. The posterior limb of MCT along with the deep head of the pretarsal orbicularis muscle inserts into the posterior crest of the lacrimal sac fossa.

The lateral canthal tendon (LCT) is formed by dense fibrous tissue arising from the tarsi. The anterior component inserts into the orbital rim and the deeper component passes laterally deep into the septum orbitale to insert into the inner side of the lateral orbital rim. The orbicularis oculi muscle is a circular striated muscle consisting of the orbital and palpebral part, which is further divided into the preseptal and pretarsal parts. The palpebral part helps in the rapid closure of the eye called blinking, which occurs with stimulus and spontaneous blinking without stimulus. The orbital portion helps in forced closure. It is innervated by the temporal and zygomatic branches of the facial nerve.

The levator palpebrae superioris elevates the upper eyelid. It arises at the orbital apex from the annulus of Zinn, and courses anteriorly along the roof of the orbit. It changes direction from a horizontal to a more vertical direction and ends in an aponeurosis. The aponeurosis inserts into the anterior surface of the tarsal plate.

The blood supply to the upper eyelid is by two arcades. The marginal arcade lies on the anterior tarsal surface, 2–3 mm from the lid margin, and a peripheral arcade lies on the anterior surface of the Müller’s muscle, just above the superior tarsal border. The arcade is formed from the anastomosis of the superior branch of the medial palpebral artery, which is a branch of the ophthalmic artery, and superior branch of the lateral palpebral artery, which is a branch of the lacrimal artery. In the lower eyelid, the marginal arcade lies 2 mm from the lid margin. It is formed from the inferior palpebral artery, a branch from the ophthalmic artery and inferior branch of the lacrimal artery. A branch of the maxillary artery also supplies the lower eyelid.

The lymphatic drainage of most of the upper lid and the lateral half of the lower lid is into the preauricular lymph node. The medial portion of the upper lid and the medial half of the lower lid drain into the submandibular nodes along the lymphatics which follow the angular and facial vessels.

The eyelid defects which need reconstructions are seen in congenital anomalies, posttrauma, and postexcision for neoplastic conditions. Congenital anomalies need an
assessment of other associated defects and need an early repair. Posttraumatic defects need an assessment of tissue loss, associated globe injuries, if any, and accompanying faciomaxillary and head injuries and injuries to other parts of the body.

Careful judgment and planning are required to choose the method of reconstruction in eyelid tumors. The treatment depends on the type of the lesion, its size, location, involvement of other adenexal structures, and health and age of the patient, besides whether he is monocular. The role of alternative and adjunctive methods must also be kept in mind. There are recent reports on the use of topical mitomycin-C in squamous cell carcinoma of conjunctiva. The size of the lesion is reduced by its use and simpler reconstructions are feasible. In selected cases, cryotherapy or radiotherapy may be the preferred method of treatment as the patient is medically unfit or immunocompromised.

In eyelid tumors, the ideal method is excision and simultaneous reconstruction. It is advisable to have a histopathological diagnosis before planning excision when malignancy is suspected. Excision under frozen section control is the choice in most of the centers. It has the advantage of providing a clean surgical defect for reconstruction with tumor-free margins. Moh’s micrographic surgery is a technique which combines tumor extirpation and microscopic examination. A horizontal sectioning of the extirpated tissue is done as opposed to the vertical section in a traditional method. An excellent cure rate for basal cell carcinoma is reported in the western literature.

The basic aim of reconstruction is to restore the anatomy and function of eyelids. There should be normalization of the eyelid position and movements. The internal lining should be smooth. The realistic outcome of the reconstruction must be well understood by the patient and relatives.

**BASIC GUIDELINES FOR RECONSTRUCTION**

For evaluating the site and size of the defect, both the visible and invisible tissue shortage must be evaluated.

For reconstruction, as written by Mustarde, “When the eye is still present, reconstruction of an eyelid or even a part of it requires a minimum of three elements: an outer layer of skin; an inner layer of mucosa; and a semirigid skeleton interposed between them.”

One layer should carry its own blood supply and the other can be a free graft. The reconstructed eyelid must conform to the curvature of the globe. Anchorage both medially and laterally should be to the bony orbit. The horizontal size of the defect which needs reconstruction must be determined by bringing the medial and lateral edges closer under some tension to determine the reduced defect size. The levator palpebrae superioris, orbicularis oculi, and inferior retractor must be respected. Lacrimal drainage reconstruction can be done simultaneously, but if not feasible can be done secondarily. The latent tissue deficiency in the forehead and cheek must be assessed to prevent secondary contracture. This is often seen in burns and faciomaxillary trauma.

**TISSUES AVAILABLE FOR RECONSTRUCTIONS**

Similar tissue should be used for reconstruction [Table 1]. Color match is important for cosmesis of anterior lamella. A full thickness skin graft which can match the color should be chosen. When larger grafts are required, split skin grafts can be utilized. The lining or the posterior lamella coming in contact with the globe should be smooth, capable of producing mucus for lubrication.

Spinelli and Jelks had divided the periocular reconstructions into five zones, with their own anatomic, functional, and esthetic consideration. It is simpler to denote each area by its name.[1]

**METHODS FOR THE RECONSTRUCTION OF UPPER EYELID DEFECTS**

**Upper eyelid**

Upper eyelid reconstruction is much more complex than lower eyelid. Its main function is to protect the globe and

<table>
<thead>
<tr>
<th>Table 1: Donor tissue for reconstruction</th>
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<tr>
<td><strong>Free grafts</strong></td>
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<td>Full thickness skin graft</td>
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<tr>
<td>Vascularized tissue</td>
</tr>
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<td>Nearby area</td>
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<td>Distant flaps and free flaps</td>
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give an aperture for vision. In this process, it moisturizes the cornea by spreading the tears over it. Adequate height and mobility to the reconstructed upper eyelid is important. Most of the upper eyelid skin gets folded and is not visible hence the anterior lamella should be of thin skin and adhere to the orbicularis.

Extra-marginal defects of the upper eyelid would involve only the anterior or posterior lamella. For the defect of the anterior lamella, if limited to the eyelid alone, a full thickness skin graft is recommended. It gives a good color match for cosmesis. But when the areas are extensive and the nearby areas also have to be resurfaced, a split skin graft is preferred. Marginal defects involve full thickness loss of both anterior and posterior lamellae. These defects are classified according to the size [Table 2]:

**Methods of reconstruction of upper eyelid defects**

**Small defects**
- Direct closure
- Direct closure with lateral cantholysis
- Direct closure with a semicircular flap (Tenzel’s)

**Moderate size defect**
- Mustarde’s lid switch flap
- Cutler–Beard reconstruction

**Large size defect**
- Cutler–Beard method
- Mustarde’s lid switch flap

**Other methods**
- Anterior lamella: Fricke’s flap, Lateral temporal flap and midline forehead flap
- Posterior lamella: free mucous membrane graft and Tarsoconjunctival flap

**Small central defects of the upper eyelid**
The lid has some inherent stretch ability due to which primary approximation of small defects can be done. Small central defects can be reconstructed by direct approximation. The defect is converted into a pentagon by making a perpendicular cut up to the upper border of the tarsus. The skin above is excised as an inverted “V.” Closure is done in layers with extra care for the marginal sutures. Notching can occur sometimes. If there is a dog-ear at the upper end it can be corrected with Z-plasty. This method is useful for the correction of congenital simple coloboma of the upper eyelid. If there is some tension, a cantholysis of the upper crus of the LCT can be done. Up to 25% defect of the upper eyelid can be closed in younger individuals and up to 40% in older individuals. Initially, there may be some ptosis which gets resolved in time [Figures 2a–c].

**Small medial defects of the upper eyelid**
Defects of the upper eyelid which are medial and up to 30% in length can be directly approximated. The medial end of the defect must be freshened and the medial end of the tarsus anchored to the periosteum of the posterior lip of the lacrimal bone. Usually, the upper canaliculus is not available. But if the lower punctum and canaliculus is available, it is enough for lacrimal drainage. If there is some tension, a full thickness tarsoconjunctival flap can be advanced and anchored to the medial wall of the orbit. Incision is made through the entire thickness of the lid just above the tarsal plate and it is mobilized medially. The length of the incision is dependent on the extent to which the lid has to be moved. A lateral cantholysis further eases the mobilization. The posterior side of the flap is sutured to the periosteum of the medial wall of the orbit and the anterior side is sutured to the skin in the medial canthal area. [Figure 3 a-b]

**Lateral semicircular flap (Tenzel flap)**
If the central defect cannot be closed directly, a superiorly based semicircular flap can be fashioned from the lateral canthal area. The flap is raised up to the periosteum and moved medially. The conjunctiva in the lateral fornix is dissected and advanced to suture to the margin. The central defect can be closed in layers. Care should be taken to avoid damage to the lacrimal duct. The lateral lid would be devoid of cilia.

**Moderate size defects of the upper eyelid**

**Mustarde’s lid switch**
The defect in the upper eyelid is transferred to the lower eyelid. Its mid point is marked. This forms the hinge (H) of the flap. The flap is designed on the medial or lateral side depending on the availability of the tissue. From the length of the flap, 25% of the lid length should be reduced. The stretchability of the lid allows the primary closure of the lid up to 25% loss. The reconstructed lid should be firm. The mobility would be affected if it is lax. The length of the flap should be at least 7 mm, otherwise it would not survive. The height depends on the height of the defect. The lid is incised full thickness except at the site of the hinge; it should stop 3 mm from the lid margin.

**Table 2: Eyelid defects classified according to size and age of the patient**

<table>
<thead>
<tr>
<th>Size</th>
<th>Young</th>
<th>Older</th>
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<tbody>
<tr>
<td>Small</td>
<td>20-25%</td>
<td>30 %</td>
</tr>
<tr>
<td>Moderate</td>
<td>30-50%</td>
<td>30-60%</td>
</tr>
<tr>
<td>Large</td>
<td>50% and above</td>
<td>60% and above</td>
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on the skin and little less on the conjunctival side. This is to protect the marginal vessel which is 2–3 mm from the lid margin on the anterior surface of the tarsus. The donor area is closed primarily in layers, except at the margin. If there is tension in approximation, lateral lower canthotomy can be done. The switch flap is swung into the defect and sutured in layers. In larger flaps, the levator aponeurosis must be anchored well to the tarsal plate. The bridge flap can be divided anytime after 2 weeks. For larger defects, 75% of the lower lid can be switched along with the reconstruction of the lower eyelid by the cheek rotation flap. The defect is transferred to the lower lid. A quarter of the lid length is marked from the lateral end of the defect. This forms the hinge. The flap is marked on the medial side of the hinge. The size should be the size of the defect minus one-fourth of the lid length. The flap is incised full thickness except at the hinge where it is stopped 4 mm from the lid margin. On the conjunctival side, the incision can be more as the marginal vessel is on the anterior surface of the tarsal plate. The skin lateral to the canthus is raised along with the remnant of the lower lid and mobilized medially. The switch flap is swung into the defect and sutured [Figure 4a-c]. The switch flap is the only method of reconstruction which gives natural-looking lashes to the upper eyelid. The drawbacks are edema which may persist for a long period, and total loss of flap. Extensive dissection is needed if the entire lower lid is to be reconstructed.

Cutler–Beard reconstruction

The Cutler–Beard method of reconstruction is useful for moderate and large horizontal but short vertical height defects of the upper eyelid. The classical method has been modified. In the original described method, the complications occurred due to the lack of tarsal support.

A horizontal incision is made in the lower eyelid 4 mm below the lid margin through the entire thickness of the lid and extended vertically below. The conjunctiva and about 1 mm of tarsus, if available, are raised from the inferior fornix. It is advanced and sutured to the upper eyelid defect with 60 vicryl with knots on the raw surface. Vertical incisions on the skin are extended and a rectangular flap raised. In older patients, the skin flap can be developed well due to the laxity of skin. Burow’s triangle can be excised on either side to give further advancement to the flap [Figure 5a-c]. The skin flap is advanced under the bridge of intact lower eyelid margin and sutured to the skin defect. A cartilage graft from the ear, carved to fit the defect, is sandwiched between the skin.
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The medial and lateral ends of the cartilage should be anchored to the remnants of the upper eyelid tarsus. The levator aponeurosis must also be anchored to the cartilage. In younger patients, skin advancement may not be possible. A full thickness skin graft from the postauricular region along with the cartilage graft can be harvested and used as the anterior lamella [Figure 6 a-e]. The division of the flap is done in 6–8 weeks. This is to stretch the tissues. The skin is incised 1–2 mm below the lid margin to compensate for retraction. The conjunctiva is incised giving extra margin to cover the margin of the newly reconstructed lid. The lower lid donor area skin is undermined and sutured, whereas the conjunctiva is not sutured [Figure 5 a–c].

Shortcomings of this procedure are the time lag for the separation of the lids. Due to this, it is not useful for monocular patients. Entropion and lack of lashes are the other drawbacks. It is an excellent method of reconstruction in defects following the excision of cancer.

Large-sized defects of upper eyelids

Large-sized defects of upper eyelids involving more than 50% of the width of the upper eyelid can be reconstructed with the Cutler–Beard method with modification. The posterior lamella is reconstructed with the tarsoconjunctival flap. For the anterior lamella, there are options. If the vertical height of the defect is not much, the cheek skin can be advanced into the defect provided it is lax. If not, the other options are full thickness skin graft, lateral temporal flap, Fricke’s flap [Figure 7 a-d], or midline forehead flap [Figure 8 a-b] (described later in the details on lower lid reconstruction). If the tarsoconjunctival flap is not feasible, a free graft of the cheek mucosa can be used for lining Mustarde’s total lid switch flap with lower eyelid reconstruction, which is another option. This method needs extensive dissection. It is an excellent method of reconstruction in experienced hands.

METHODS FOR THE RECONSTRUCTION OF LOWER EYELID DEFECTS

Small defects up to 30%
• Direct closure

MODIFICATIONS OF TECHELT METHOD

For the closure of defects which are larger, a Tenzel semicircular flap from the lateral canthal area can be used.
mobilized. A curved incision is made lateral to the lateral canthus and flap raised from the periosteum. The inferior limb of the LCT is cut to allow for further mobilization of the flap. The deeper tissue of the flap must be anchored to the periosteum of the lateral orbital rim. A periosteal flap can be fashioned to give support to the lid margin of the reconstructed flap.

Hughes’ tarsoconjunctival flap
Hughes’ tarsoconjunctival flap is a useful and time-tested method. From the upper eyelid a tarsoconjunctival flap is developed 4 mm above the lid margin. This is needed for the stability of the lid margin. In the original method described by Hughes, the tarsoconjunctival flap was raised from the lid margin, which produced problems. The levator aponeurosis is dissected off the flap. Muller’s muscle is included but divided at the time of the division of the flap. The width of the flap should be less than the size of the defect. The flap is sutured to the inferior edge of the defect to the conjunctiva and to the tarsal plates on the side with absorbable sutures. The anterior lamella is reconstructed by the advancement flap from the cheek, if the skin is lax, or a full thickness skin graft. The division of the flap is done preferably after 6 weeks to allow stretching of tissues [Figure 9] Extra conjunctiva should be retained in the newly reconstructed lid to form the conjunctival lining of the margin. [Figure 9a-c]. Care should be taken to dissect the Muller’s muscle and divide it to prevent lid retraction which can occur [Figure 10 a-b].

Tripier flap
The Tripier flap is a musculocutaneous flap from the upper eyelid transferred to the lower eyelid for reconstructing the anterior lamella. It can be unipedicle or bipedicle like a bucket handle. It can be raised only when there is sufficient lax skin available in the upper eyelid. The advantage in this method is the visual axis which is not covered. The posterior lamella can be a free oral mucosal graft or palatal graft. It is mainly used in reconstructing narrow defects and lid margin [Figure 11a-b].

Mustarde’s cheek rotation transposition flap
This is a very useful flap for reconstruction in larger defects of the lower lid especially in long vertical defects. The flap is marked lateral to the defect extending to the lateral canthal area. It should curve upward and carried down in front of the ear [Figure 12b]. The entire flap is undermined in the subcutaneous layer. It is transposed over the defect. The medial end of the defect should be vertical. This helps in reducing the dog-ear. The medial end of the skin flap should be anchored to the medial wall of the orbit. Laterally, it also must be anchored to the lateral wall. The lining is from the nasal septal cartilage with mucosa. The septal cartilage needs to be thinned and scored to conform to the shape of the globe. The height should be sufficient to form the lower fornix. It should be anchored both medially and laterally to the periosteum to give stability. For the posterior lamella, palatal mucoperiosteum is preferred now. It is easier to harvest and molds better [Figure 12 a-b]. A palatal graft is an excellent source of graft for the posterior lamella. It cannot be used in the upper eyelid, if eye is present. The graft may undergo squamous metaplasia and irritate the cornea.
This flap is a time-tested one and is very useful in specific indications. The drawbacks are the lower lid retraction, dog-ear, dissection of a large area, and sacrifice of the orbicularis of the lower lid. Lacrimal drainage has to be reconstructed secondarily. The preauricular hairline gets distorted.

**Flaps used for defects of upper and lower eyelids and combined areas**

*Lateral temporal forehead flap/Fricke’s flap*

The lateral temporal forehead flap raised above the eyebrow gives a large flap which can be utilized for the upper or lower eyelid or for both. It can also be used in larger defects involving the lateral canthal areas besides the lids. A laterally based skin flap above the eyebrow is raised. The flap should be shaped along the curve of the eyebrow up to the medial end. The donor area is closed directly but it raises the eyebrow. The skin graft to the donor site leaves a perceptible scar. For the posterior lamella, a free mucosal graft or tarsocconjunctival vascularized flap from the lower lid can be used. The skin flap can be divided in 2-week time. The skin is thick and hinders excursion of the lid. The attachment of the severed levator to the dermis of the flap does give some movement to the flap. It may have to be thinned later or replaced with skin graft. The disadvantage in Fricke’s flap is raised eyebrow and scar. It is a useful flap for major defects after the excision of malignancy [Figure 7 a–d]. The asymmetry of the eyebrow can be corrected by excising skin from the opposite side like browplasty. Island flaps based on the branches of the anterior division of the superficial temporal artery can also be used to reconstruct the anterior lamella.

*Median forehead flap*

The median forehead flap is a versatile flap for reconstructing upper, lower, or both eyelids and the medial canthal areas. The flap is thick and the dog-ear in the pedicle needs to be trimmed later. The flap is raised from the center of the forehead depending on the width needed. The donor area is closed directly. The pedicle is returned after 2–3 weeks [Figure 8 a-b] [Figure 13].

**Medial canthal area reconstruction**

Defects in the medial canthal areas may involve the skin alone or MCT and/or the lacrimal drainage system. For the skin defect alone, the *laissez Faire* method which is spontaneous healing of the area is sometimes recommended. Otherwise a full thickness skin graft can be used. If the bone is exposed, a glabellar flap is to be transposed onto the defect. The glabellar flap is a transposition flap raised from the glabellar region. The surrounding area is undermined to allow for the direct closure of the donor area and help in transposing the flap into the defect. The donor area is closed like an inverted “Y”. It brings the medial ends of the eyebrow together. If the defect extends to the lower or upper eyelid, a median forehead flap can be done. [Figure 13a-c]. The MCT and lacrimal drainage system need not be repaired primarily in defects due to malignant lesions. However, in postratricular defects, either MCT or lacrimal drainage reconstruction should be done primarily, and if feasible, both.

**Lateral canthal defects**

Lateral canthal defects may involve only the lateral canthus or upper or lower eyelids or both. If the defect is not involving the lid, the defect can be covered with a skin graft [Figure 14a-b]. If the lateral canthal defect extends and involves full thickness of the upper or lower eyelids, reconstruction can be done by transposing a conjunctival flap from the same lid with the skin graft. For larger defects, a transposition flap from the forehead or an island flap based on the anterior branch of the superficial temporal artery for anterior lamella and mucus membrane graft for lining would be the alternate method. Lateral canthus can be reconstructed by using a periosteal flap from the lateral wall of the orbit and anchored to the remnant of the tarsal plate of the eyelid. A fascial graft from temporalis fascia or palmaris longus tendon can be used. This fascial graft would have to be anchored to the lateral wall...
of the orbit via drill holes made in the bone. Medially, it has to be anchored to the MCT. The fixation of the lateral tendon should be 3 mm above the level of medial canthus.

**Reconstruction of defects of both eyelids**

The reconstruction of full thickness defects in both eyelids is a real challenge to the creativity of the plastic surgeon. The eyelids are unparalleled structures with their structure and mobility. One of the common causes we see in our country is the loss of eyelids due to burns, especially post-acid injuries. The eyes may have escaped injury initially but the cornea may get affected secondarily. To protect the cornea, total tarsorrhaphy by suturing the mobilized conjunctiva from both fornices and covering the anterior surface with a split graft is advised. This is called as the Masquerade procedure [Figure 15a-b].[4] Small holes are left behind for the drainage of tears. Tarsorrhaphy is released once the raw areas over the remaining face have healed well. Mustarde had suggested a midline forehead flap over the sutured conjunctiva. But in acid burns most of the time the forehead is not available. A prefabricated flap lined with mucosa may be the answer.

**CONCLUSION**

There are various techniques available for reconstructions of defects of eyelids starting from the spontaneous healing after excising the lesion. While choosing a method, the specific function of the area of the eyelid has to be kept in mind. The upper eyelid is for mobility. It should be reconstructed with light-weight, pliable tissue. The lower eyelid is for stability along with the canthii. Hence, it must be stabilized well. It is very important to know the various options available for reconstruction. The availability of tissues, technical expertise, and the specific needs of the patient have to be kept in mind before choosing a particular method. As eyes are the focal point of the face, acceptable cosmesis in reconstruction should be a major requisite.

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