As we have become more sophisticated with approaches to the rejuvenation of the lower periorbita, the need for canthal support and fixation has become obvious. The greatly respected and veteran eyelid surgeon Dr. Clinton McCord and his associates have long supported the implementation of canthoplasty with the majority of aesthetic lower periorbital procedures. Several years ago I heard Dr. McCord speak at a plastic surgery meeting regarding canthoplasty where he stated that he performed this maneuver with nearly every blepharoplasty procedure. At that time, this statement was disturbing to many surgeons who were not as familiar technically with these procedures or the merit of their routine incorporation to improve results. Presently, the concept and incorporation of canthal reinforcement to control eyelid function and shape are commonly accepted.

Although the title of Dr. McCord et al.'s article is “Lateral Canthal Anchoring,” references to a host of such procedures are made. However, only a few specific procedures that are performed frequently in his practice are elaborated upon. The authors’ surgical techniques follow an algorithm that is quite influenced by measurements obtained by preoperative assessments, including Hertel exophthalmometry results. The following three canthal anchoring procedures are described in detail: the canthopexy performed on eyes with standard prominence; the cantholytic canthoplasty procedure used in patients with relatively enhanced lower eyelid laxity; and an orbicularis muscle suspension technique utilized when a midface lift is performed via a closed approach. A multitude of other effective canthal techniques (not mentioned) have been described that similarly aim to maintain or improve form and function with lower blepharoplasty.¹⁻⁵ My preference, the lateral retinacular suspension, which I have described,¹ allows for versatility with the same simple procedure without the necessity of canthal division (canthotomy) that can be modified to meet the needs of the individual presentation. The results with most of these procedures, however, are similar, whereby respect for the need to promote

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*FIG. 1. (Above) A 47-year-old woman who presented for upper and lower periorbital rejuvenation. (Below) Four months after upper and lower blepharoplasty. The lower blepharoplasty utilized orbicularis oculi muscle suspension for blending of the lid-cheek junction and lateral retinacular suspension canthoplasty.*

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horizontal lid tension combined with canthal support provides for rejuvenation of the lower eyelid with preserved function and greater aesthetics (Fig. 1).

There are so many valuable pearls to lower blepharoplasty in this article that, like a well-constructed but complicated movie, one must read it again to appreciate what may have been missed in the first pass. Vertical eyelid augmentation with spacer grafts combined with canthal reinforcement in the highly prominent eye, which I, too, often use, is only now just beginning to attract interest. Also, the influence of the globe on eyelid/canthal form and function (and vice versa) has other practical implications that may help to explain some of the postoperative phenomena seen in our patients [e.g., severely symptomatic dry eye and visual fluctuations, especially after laser-assisted in situ keratomileusis (LASIK) operations] and how one can modify the surgical approach to best address these problems.

Dr. McCord’s vast experience with a host of eyelid surgical procedures provides for a greater understanding and appreciation of what is necessary to preserve form and function in a wide variety of aesthetic periorbital procedures from which we can all learn and benefit.

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