



Fig. 1. (Left) Worm's-eye view of native nasal anatomy. (Center) Worm's-eye view of placement and fixation of the extended columellar strut to the anterior nasal spine using the Micro QuickAnchor (red) including fixation of the medial footplates. (Right) Lateral view of the rib graft construct demonstrating fixation of the graft to the maxilla using the Micro QuickAnchor (red).

DISCLOSURE

The authors have no financial interest to declare in relation to the content of this communication.

REFERENCES

1. Gunter JP. Secondary rhinoplasty: The open approach. In: Daniel RK, ed. *Aesthetic Plastic Surgery: Rhinoplasty*. Boston: Little, Brown; 1993:833–847.
2. Gunter JP, Rohrich RJ. External approach for secondary rhinoplasty. *Plast Reconstr Surg*. 1987;80:161–174.

Eyelid Finger Manipulation in the Treatment of Overcorrected Blepharoptosis and Postblepharoplasty Ectropion-Retraction

Sir:

Upper eyelid retraction is an occasional complication of upper eyelid ptosis surgery. If this overcorrection is minimal, it can frequently be corrected by the patient stretching the upper eyelid without secondary surgery. The patient pulls the brow upward with the fingers of the opposite hand while applying the index finger of the hand on the affected side to the area of the lid crease in a horizontal direction (Fig. 1). The index finger pushes inward and downward for several seconds. The index finger is then released while the fingers above the brow continue to hold the brow upward. The index finger is then reapplied to the lid and the patient repeats the inward downward lid stretch. This maneuver is repeated multiple times over 30 to 60 seconds, and is repeated two to six times per day. The patient is instructed that if the upper eyelid reaches a position similar to the level of the opposite lid, or below, the treatment should be discontinued. If the retraction then recurs, the patient is instructed to resume the maneuver.

If the lower eyelid is ectropic, or retracted, following a lower blepharoplasty, a stretching of the lower eyelid can be performed by the patient. The patient is instructed to apply the index finger of the hand on the side of the lower eyelid malposition in a horizontal direction approximately 5 mm below the eyelid margin (Fig. 2). The index finger then pushes inward and upward to stretch the lower eyelid. This is held for several seconds and then the finger is released from the eyelid and the maneuver is repeated multiple times over a 30- to 60-second period. This is repeated two to six times per day and is discontinued when the lower eyelid ectropion, or retraction, is corrected.

Although these techniques seem relatively simple, I have found that most patients end up doing them incorrectly and therefore without results. Also, many surgeons instruct their patients to use other eyelid massage techniques that are ineffective. It is important to demonstrate the techniques with the patients holding a mirror in front of their eyelids and to be sure that they can perform them before leaving the office. Giving the patient a photograph of the technique or a photograph or video of their performing the maneuver can also help compliance.

I have used these techniques for over 40 years with excellent results in the treatment of minor overcorrected upper eyelid ptosis and lower eyelid postblepharoplasty ectropion-retraction cases. I have also found that patients have better acceptance of these complications if they are involved in the correction of them.

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Fig. 1. Demonstration of treating overcorrected upper eyelid ptosis by pulling the brow upward with the fingers on the hand of the opposite side while applying the index finger from the hand on the side of the retracted lid in a horizontal direction, while pushing that index finger inward and downward.



Fig. 2. Demonstration of treatment of lower eyelid postblepharoplasty ectropion-retraction by applying the index finger of the hand on the side of the affected lid in a horizontal direction 5 mm below the eyelid margin and pushing that index finger inward and upward.

PATIENT CONSENT

Patient provided written consent for the use of patient's images.

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Long-Term (24-Month) Safety Evaluation of Poly-DL-Lactic Acid Filler Injection for the Nasolabial Fold: A Multicenter, Open, Randomized, Evaluator-Blind, Active-Controlled Design

Sir:

Many medical devices for antiaging treatment have been introduced into current medical practice. Although hyaluronic acid is the most commonly applied injection device because of its excellent safety and longevity, physicians also prefer to use other fillers such as calcium hydroxyapatite, collagen, and poly-DL-lactic acid.^{1,2} Concerning hyaluronic acid fillers, there are numerous clinical studies with 1-year or even 2-year long-term safety and efficacy evaluation that have been published in the literature.³ However, regarding other types of fillers, there is a relative paucity of scientific data and clinical evidence for long-term safety. Therefore, we have attempted a 24-month, long-term safety evaluation of poly-DL-lactic acid filler for nasolabial fold correction in Korean patients based on a multicenter, open, randomized, evaluator-blind, active-controlled design.

Poly-DL-lactic acid is a U.S. Food and Drug Administration–approved medical material for filler device and can be completely biodegraded into carbon dioxide and water and excreted in the urine. In this study, we have applied poly-DL-lactic acid filler (AestheFill; REGEN Biotech, Seoul, Republic of Korea). The study protocol was approved by the institutional review boards of Chung-Ang University Hospital and Asan Medical Center, Seoul, Republic of Korea. A total of 58 volunteers (seven men and 51 women, aged 37 to 66 years) were enrolled in this study, and 30 patients completed 24-month long-term safety evaluation. Major inclusion criteria were as follows: (1) volunteers older than 20 years (men and women), (2) nasolabial fold with a Wrinkle Severity Rating Scale score of 3 (moderately deep fold; clear facial feature visible at normal appearance but not when stretched; excellent correction expected) or 4 (very long and deep; prominent facial feature; <2 mm visible fold when stretched); and (3) symmetric nasolabial fold scores. For safety evaluation, every side effect such as treatment-emergent adverse events and suspected unexpected serious adverse reactions were also checked. The visiting schedule was a total of five time points (0, 2, 4, 6, and 24 months) and safety check-up parameters were vital signs, physical examination, complete blood count, liver function test, lipid profile, fasting glucose test, electrolytes, blood coagulation test, urinalysis, and urine pregnancy test for female volunteers. Chi-square test and Fisher's exact test were used for statistical analysis.

Clinical trial physical examination revealed four cases of adverse effects at the injection site skin. They were skin discoloration caused by bruising (one case), small transient vesicle formation (one case), and slight mass sensation at the injection site (two cases). They were all mild grade and were restored completely at the 2-month visit. During the 24-month follow-up period, a total of 13 cases of adverse events were identified. However, these were not related to poly-DL-lactic acid filler injection and were