SECOND EDITION

So You Want to Get Your *Eyelids* Done

A Patient's Guide to Cosmetic Eyelid Surgery



Chris Thiagarajah, MD

DENVER EYELID SPECIALISTS

So You Want to Get Your Eyelids Done

A PATIENT'S GUIDE

So You Want to Get Your *Eyelids* Done

A guide to cosmetic eyelid surgery

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So You Want to Get Your Eyelids Done
A Patient's Guide to Cosmetic Eyelid Surgery
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This book is for education. It is not medical advice, and reading it does not create a doctor–patient relationship. Your own examination, and the current instruction sheets you are given, are what you should follow. Medications, fees, insurance rules, and recovery instructions can change. For current practice information, visit **denvereyelid.com** or call the office.

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Dedication

To Erin, Elena, and Charlotte

Erin, I love the life we've built together. I still look forward to telling you the smallest things about my day, just because it's you I get to tell.

Elena and Charlotte, being your dad is my favorite thing about who I am. I love getting to know who you are now, and I look forward to getting to know the women you'll become. I hope you trust your own voices, change your minds when you learn something new, and each build a life that feels like yours.

Years from now, when you think back on our home, I hope you remember how good it felt to walk through the door and hear how happy I was that you were there.

To my mom

You taught me to love unconditionally by loving me that way my whole life. I see your gifts in the way I love my family and in how I try to show up for the people I care about. I hope my daughters feel as sure of my love as I've always felt of yours. So much of who I am began with you. A lifetime of thank-yous would still feel too small.

To my dad

You taught me what it means to be a man. Take responsibility. Take care of the people who count on you. Do what needs to be done and do it well. You taught me these things by living them, quietly, every day. I hope my daughters learn them from me the same way I learned them from you.

To my staff

I couldn't do this without you. I see the care you give our patients when they're nervous before surgery or call afterward because they're worried about how they're healing. You take the time to listen, and people can tell how much you care. Thank you for being there for them and for me.

To my patients

Thank you for trusting me with your care. I know how personal it can feel to sit across from someone and talk about your face, what's changed, and what you hope to feel when you look in the mirror. I'm grateful you've let me be part of those conversations.

Your questions made this book better. They taught me to explain things more clearly, listen a little longer, and pay attention to what matters to you. I wrote these pages with you in mind.

THIS EDITION

A note on the 2026 revision

The first edition of this book was written in 2017 and published with a CreateSpace imprint. A lot of the surgery has not changed: the anatomy is the same, and so is the need for a well-trained surgeon and for realistic expectations. Some of the techniques have changed or shifted.

This revised interior also updates the practical advice around the operation. Icing is now 20 minutes on and 20 minutes off, while awake, for the first week. Incisions are cleaned with a warm washcloth and ointment, not with hydrogen peroxide. Medication holds now include aspirin for seven days, Plavix for five days (with the prescribing doctor's approval), GLP-1 medicines for two weeks, and SGLT2 medicines for three days, along with the usual caution that prescribed blood thinners are not stopped on your own. Upper blepharoplasty can often be done in the office while you are awake. And the non-surgical menu in my practice now includes UltraClear laser resurfacing.

I have also added a clearer discussion of fat in the lower eyelid, of wound healing, of dry-eye screening, of smoking and vaping, and of the difference between extra skin, a drooping lid, and a low brow. A short section after Chapter 3, When insurance may cover eyelid surgery, gathers how coverage is decided, so that discussion is not repeated in every chapter.

This printing also adds a full chapter on brow lifting, a short chapter on what thousands of eyelid surgeries changed about the way I practice, a clearer comparison of laser resurfacing options, color diagrams, a tear-out pre-operative checklist, a one-page recovery timeline, and a page on how to see me. Fees, forms, and hold times can change. The last page of this book points you to the current instruction forms at denvereyelid.com, which is where those details will live when a printed page no longer can.

— C.T., Greenwood Village, 2026

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HOW TO USE THIS BOOK

A short guide to the pages ahead

You do not have to read this book in one sitting, and you do not have to read it in order. Use it the way a good consult should feel: start with what is on your mind, then fill in the rest.

If you are still deciding whether surgery is a good idea

Begin with the introduction and Chapters 1 and 4. Those pages are about expectations, about what a blepharoplasty can and cannot do, and about the times when a non-surgical option, or simply waiting, is the more honest first step. Chapter 3 is about the brow, and about when a lid operation alone may not be enough.

If you already know you want surgery and are choosing a surgeon

Start with the short section Choosing your surgeon, just before Chapter 5, then go to Chapters 5 and 6. Take the questions in those chapters with you. The notes pages at the back of the book are there for the same reason: so you are not trying to remember everything in the parking lot afterward.

If your surgery is already scheduled

Chapters 8 and 9 are the practical ones: what to hold and when, a tear-out checklist, icing, incision care, the recovery calendar and timeline, and when to call. Please treat the current instruction sheets at denvereyelid.com/surgery-forms as the final word if a date or a medicine hold has changed since this edition was printed.

Chapter 2 is the anatomy and the operations, including in-office awake upper blepharoplasty and the ways we treat fat in the lower lid. After Chapter 2, a short section explains how drooping eyelids aren't all the same—extra skin, a lid margin that sits too low, and a low brow—and why determining the problem matters. The Ptosis section that

follows goes over drooping of the lid itself and how it is measured. A short section after Chapter 3, When insurance may cover eyelid surgery, explains when a plan may cover a blepharoplasty, a ptosis repair, or a brow lift. Chapter 7 is a short chapter about what thousands of eyelid surgeries changed about the way I practice. Chapter 10 is for the hard weeks if you are unhappy, and for a plain-language look at risk. Chapter 11 collects the questions I am asked most often. Toward the back of the book there is a page on how to see me, with addresses and a QR code to the practice website.

Throughout, I have tried to write the way I talk in the office: directly, without guarantees, and without asking you to become a surgeon in one afternoon. If a sentence in this book and a sentence from my office ever disagree, follow the office, and then tell us so we can make the next edition clearer.

START HERE

Introduction

I have spent my career on a small, precise part of the face: the eyelids. They are where other people look first, and they are part of the organ that lets you see. Getting them right takes judgment, restraint, and a real love of the anatomy. That is the work I chose, and it is still the work I care about most.

Cosmetic eyelid surgery is among the most common—and most specialized—plastic surgeries performed in the United States. According to the American Society of Plastic Surgeons' 2024 procedural statistics, it is now performed more often than nose reshaping (rhinoplasty). Physicians use the word *blepharoplasty*. Patients may say eyelift, eye raise, or eye job. In this book I use *blepharoplasty* and *cosmetic eyelid surgery* interchangeably, because those are the two terms people hear most often.

I am an oculofacial plastic surgeon in Greenwood Village, Colorado, just south of Denver. Cosmetic and functional eyelid surgery is my area of expertise and focus. This book is a guide for people who are deciding whether to have eyelid surgery, or who have already decided and want to understand the process. It starts with whether surgery is even the right idea, and it goes all the way through recovery. What changed in this 2026 edition is listed in the note at the front of the book; I will not repeat that inventory here.

The book is divided into three parts. The first reviews why people have this surgery, how the eyelids are put together, and the operations—and non-surgical treatments—that exist. The second is about finding a surgeon, getting through a consultation, and what I have learned after thousands of eyelid surgeries. The third concentrates on preparing for surgery, recovering from it, and what to do if you are unhappy with a result.

Three things I look for before I operate

Before I recommend cosmetic eyelid surgery, a patient has to meet three requirements. If they do not, I will not operate, even if the anatomy looks straightforward on a photograph.

First, you have to be a physical candidate. You need enough loose skin or puffiness that you will see a significant improvement. Upper eyelid surgery carries the same kinds of risks whether the extra skin is modest or dramatic. If the amount is only marginal, you are taking on those risks for a change that may not feel worth it. That is a conversation we have together, not something a photograph by itself can settle.

Second, you have to be a medical candidate. You must be medically stable enough for surgery. That includes the eyelids and the eyes themselves, and it includes the rest of the body. Heart disease, poorly controlled blood pressure, a bleeding problem, dry eye that is already significant, or an eye condition that surgery could worsen all matter. Some of these issues can be optimized. Some mean we should wait, or not operate at all.

Third, you have to be a psychological candidate. Cosmetic surgery is not a treatment for depression, a relationship problem, or a life that feels out of control. Patients who are in the middle of a major crisis, or who seem to be asking surgery to fix something surgery cannot fix, are not good candidates, no matter how much extra eyelid skin they have. It also asks something simpler, and harder to fake: can you get through the healing? For a couple of weeks, and sometimes for a couple of months, the lids will be swollen. Vision is usually blurry for the first week after blepharoplasty and after ptosis surgery. Some people move through that calmly. Some do not. You are the person who knows, deep down, which of those you are likely to be. Part of that partnership is being honest with yourself, and with me, about whether you are ready for that stretch—not only for the morning of surgery. It

also means having realistic expectations: a realistic idea of what the final result can be, and a realistic idea of what healing looks like. It is critical to be educated about what cosmetic eyelid surgery can and cannot do.

Patients who meet these three requirements and then have surgery are usually extremely happy with it. Every year I get cards and emails thanking me for a more rested appearance. A large part of that is surgical skill. An equally large part is limiting surgery to people who have satisfied those three requirements.

If you are reading this because you are considering surgery with me, I hope the book makes our consultation more useful, and I hope you feel, by the last page, that you know how I think. If you are seeing another surgeon, I hope it helps you ask better questions. Either way, the examination in the office—and the current forms you are given—always come first.

CHAPTER 1

Why patients have cosmetic eyelid surgery

People come to see me about their eyelids for a short list of reasons, and they often use the same phrases. They look tired, even when they are not. Friends ask if they are angry or sad. Makeup has become difficult to put on. In some patients, extra upper-lid skin actually sits on the lashes and starts to block the upper part of their vision.

This is why I love this surgery, and why I am careful with it. Cosmetic eyelid surgery can be one of the most effective ways to rejuvenate the face, because the eyes are where other people look first. When the lids are heavy or puffy, the whole face can look older or more worn than the person feels. When the lids are lighter and more open, patients often tell me they look more like themselves—not like someone else. That is the change I am after.

It is also a surgery with limits, and I would rather tell you those limits in a book than have you discover them after an operation.

What blepharoplasty can do

An upper blepharoplasty removes extra skin of the upper eyelid, and it may also reduce a pocket of fat at the inner corner. The incision is usually hidden in the natural crease.

My approach: rested, not different

The goal is a more open, rested look—not a different person, and not a pulled look. That is why I am conservative. Removing too much skin or fat, or over-tightening the lids, can lead to trouble closing the eyes (lagophthalmos) and dryness, a hollow look, or a lower lid that pulls down (lid malposition). Those problems are often harder to fix than doing a little more later. I would rather leave something we can address later than take something we cannot put back.

Chapter 7 is about how that approach was shaped by thousands of eyelid surgeries, and about the question I now ask first: what you want me to leave alone.

A lower blepharoplasty addresses puffiness, bags, and, in some patients, extra skin or a hollow at the eyelid–cheek junction. Depending on the anatomy, that may involve removing a modest amount of fat, repositioning fat, tightening the lid, removing a strip of skin, transferring a patient's own fat, or some combination of those steps. I will come back to those choices in Chapter 2.

When the brow has dropped, or when the muscle that opens the eye has loosened, blepharoplasty alone is not the right operation. Those are different problems, with different operations, and mixing them up is one of the more common reasons patients are disappointed after surgery done elsewhere.

What it cannot do

Eyelid surgery will not erase every line around the eye. It will not lift a drooping cheek, tighten the neck, or change the shape of the eyeball. It will not make the two sides of your face identical; faces are not identical to begin with, and surgery does not create perfect symmetry. It will not stop aging. The clock keeps running after the stitches come out.

It also will not fix a life problem that is not about the eyelids. I have had patients hope, quietly, that a more rested appearance would fix a marriage or a job or a feeling they could not name. Surgery is not built for that. When expectations are in the right place, the surgery can be wonderful. When they are not, even a technically good result can feel like a failure.

What a good result means for you

Every patient starts with different anatomy. The position of your brows, the shape of your eyes, and the way your eyelid skin folds all influence how much change surgery can realistically achieve. For one person, a fair result may mean a modest improvement that still feels worthwhile. For another, a good or great result may be a more noticeable change that still looks natural. I'll tell you what I think is realistic for your eyes and what may still look the same. That way, you can decide whether the improvement I expect is enough for you.

Who tends to be a good candidate

The typical patient has extra upper-lid skin, lower-lid bags, or both, is in reasonable health, and understands the recovery. Some patients are in their forties. Some are in their seventies or older. Age by itself is not a reason to have surgery, and it is not a reason to refuse it. The anatomy and the health of the patient matter more than the birthday.

The introduction describes the three things I look for before I operate. The short version is the same here: there has to be enough to improve, you have to be healthy enough for surgery, and your expectations have to be in the right place.

Men have this surgery too, and the planning is a little different: the crease, the amount of skin, and the look we are after are not copied from a female eyelid. Patients who have had eyelid surgery before, and who want a revision, are also a large part of my practice. Revision surgery is its own subject, and I will return to it later.

There are also patients I will not operate on, or will not operate on yet. Uncontrolled medical problems, active eye disease, untreated dry eye that is already significant, a patient who smokes or vapes and is not willing to stop, or a patient whose photograph in their mind cannot be produced by any honest operation—those are reasons to pause.

Another reason people come in is more practical than cosmetic, even when the plan is still self-pay. Extra skin can make it hard to put on eyeliner or shadow. Some patients get a rash in the fold of the lid. Some lift their brows all day without noticing, and then wonder why their forehead feels tired. These are useful things to mention at a consultation. They help me understand what "better" would actually mean for you.

I also see patients who are mainly concerned with one feature—a single bag, a single heavy lid—and are hoping for a very small operation. Sometimes that is exactly what they need. Sometimes the "small" thing they see is sitting on top of a low brow or a drooping lid, and a small operation would miss the point. The consultation is where we sort that out, not a photograph you send in advance and a procedure name you found online.

What cosmetic eyelid surgery alone will not treat

Some of the things people point to in the mirror are neighbors of the eyelid, not the eyelid itself. A blepharoplasty will not fix them, and I would rather say that clearly than let a patient hope the operation will do work it cannot do.

Festoons are swelling or bags of tissue on the upper cheek, below the lower eyelid. They are different from lower-lid fat bags, and a lower blepharoplasty may not fix them. They are hard to treat even in the best hands. Oculoplastic surgeons try to devise different treatments, but long-term results are elusive and unpredictable.

Dark circles under the eyes often come from thin skin, pigment, or the way blood vessels show through, not from extra fat. Removing fat or skin does not reliably fade a dark circle. Skin discoloration can sometimes be helped with skin care, a laser, or time; a blepharoplasty should not be sold as a treatment for it.

Crow's-feet, the lines at the outer corners, come from the muscle that closes the eye. Eyelid surgery does not erase them. A relaxing injection such as Botox can often soften them. If those lines are your main concern, surgery is the wrong tool.

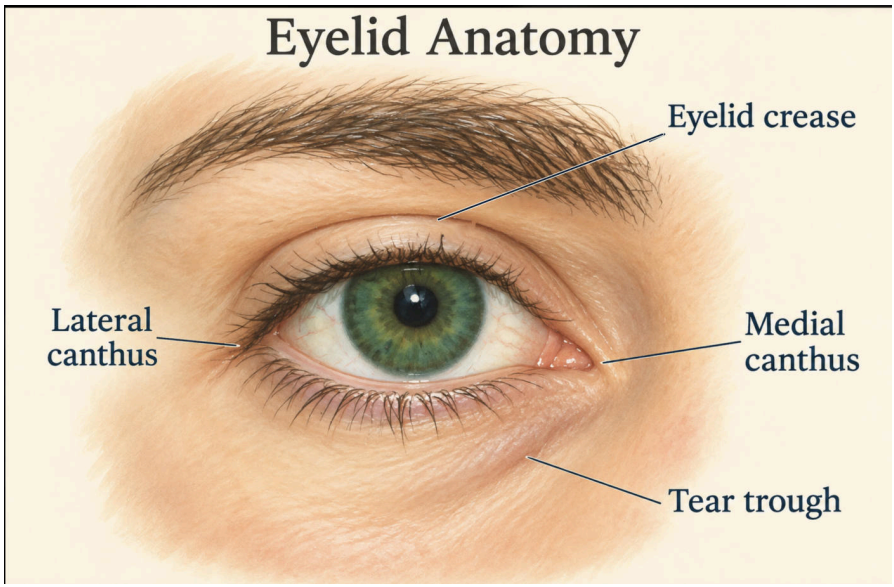
A low brow, as I have already said, needs a brow lift if it is going to be raised. Chapter 3 talks through that decision. A drooping lid needs a ptosis repair if it is going to be raised. The Ptosis section goes over that repair. Extra skin and a bag can be treated with blepharoplasty. Getting these assignments right is most of the planning.

CHAPTER 2

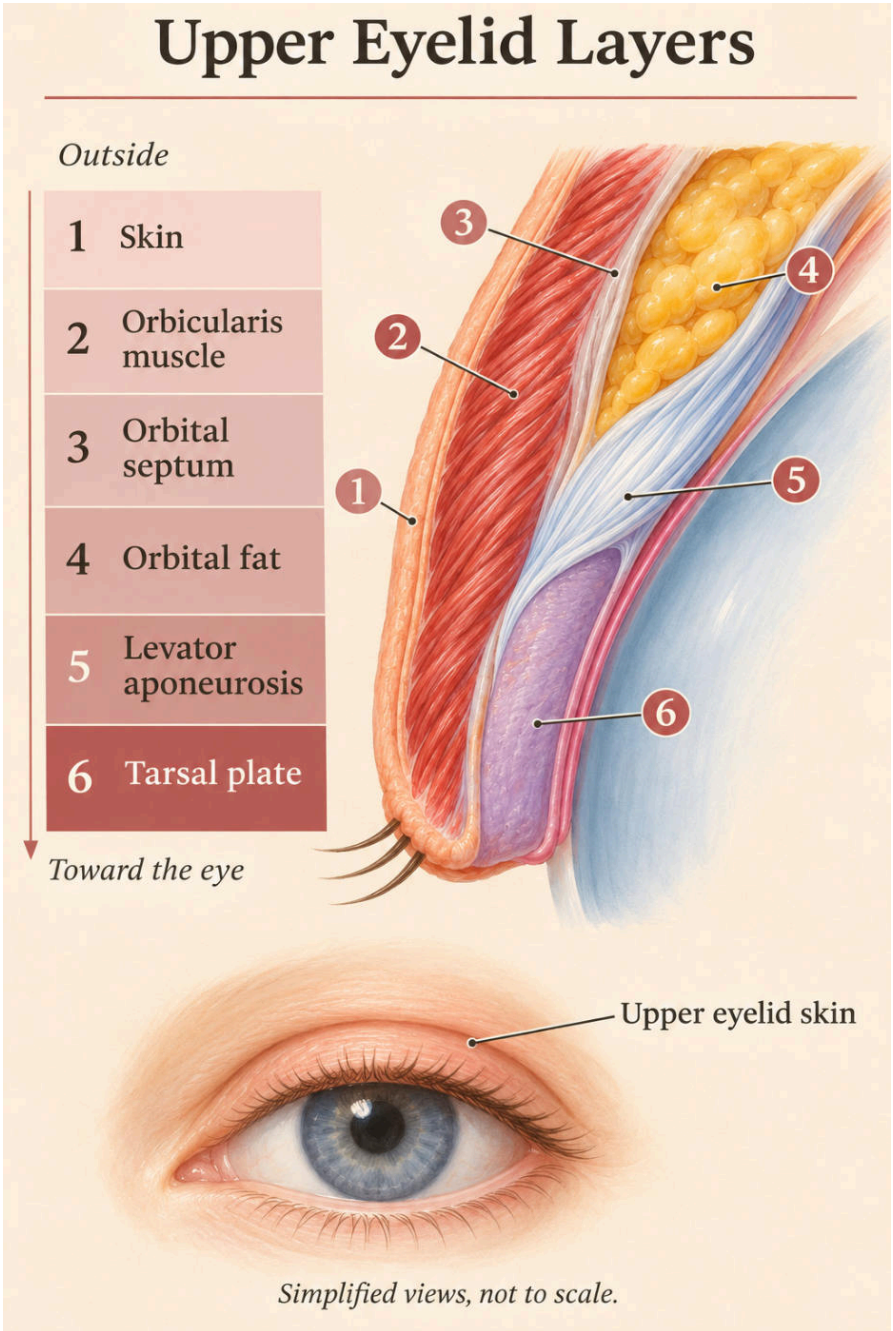
How the eyelids work, and the operations we use

I still get a little excited talking through eyelid anatomy, even after thousands of these operations. The lids are a small space with a lot of important structures in it, and a few landmarks will help you describe what bothers you, ask better questions, and understand the plan.

Basic eyelid anatomy



The main landmarks of the eyelid: the crease, the inner and outer corners (the medial and lateral canthi), and the tear trough. Knowing these names makes a consultation easier.



The layers of the upper eyelid, from the skin on the outside toward the eye: skin, orbicularis muscle, orbital septum, orbital fat, levator aponeurosis, and tarsal plate. These layers are why "just a little skin" is still real surgery: muscle, fat, and the tendon that opens the lid all live in a small space.

The eyelid crease is the fold of the upper lid, and it is where the muscle that elevates the eyelid attaches to the skin. Its position can change in patients who have drooping of the eyelid (ptosis). The fold often gets hidden when there is a lot of extra skin. In some patients of Asian ancestry the crease is lower, or there is no crease, and surgery has to respect that anatomy rather than imposing a crease that does not belong.

The lateral canthus is the outer corner of the eyelids, toward the ear. **The medial canthus** is the inner corner, toward the nose, where the tear-duct entrance sits. Damage there from trauma can lead to chronic tearing.

The tear trough is the hollow under the lower eyelid, at the junction of the lid and the cheek. Some patients are bothered by a shadow there more than by a bag. Fat repositioning or fat transfer may be part of the conversation, depending on the anatomy. Filler is used less often now; Chapter 4 explains why.

Why lids get puffy, and why they get extra skin

The eye sits in the eye socket, cushioned by fat. Puffiness of the upper or lower eyelid is often caused by that fat coming forward over time, as the tissues that hold it back relax. A few diseases can push fat forward as well, and those are worth screening for rather than operating first and asking questions later.

The fat pads around the eyes are different from the fat on the abdomen or the thighs. They are structural fat—more like cushioning and support for the eye than an energy store. In what eyelid surgeons see every week, that fat is not metabolically active in the way body fat is. You do not reliably gain or lose it when you gain or lose weight, including after weight-loss surgery. The rest of the face can change. The jawline and neck may slim, and that can make the undereye area

look more, not less, noticeable. Persistent puffiness of the lids is usually anatomy, fluid, genetics, or age—not leftover body fat waiting on a diet. If the bags bother you, the useful question is whether surgery is the right tool, not whether you have lost enough weight.

Excess upper-eyelid skin is usually a consequence of aging, and it can run in families. Over time the skin can drape over the lashes and, in some patients, begin to block the upper field of vision. That is a different problem from a lid that will not open because the lifting muscle has loosened—and the operation is different too.



Dermatochalasis: loose upper eyelid skin resting on the lashes.

Upper eyelid blepharoplasty

During an upper blepharoplasty, I mark the crease and the skin to be removed. The lids are numbed with an injection. The extra skin is excised, and fat—if it is contributing to fullness, often at the inner corner—is sculpted or reduced. The incision is closed, usually with a suture that is removed about a week later, or sometimes with a stitch that dissolves. The scar typically hides in the crease.



Upper blepharoplasty, before and after. Extra upper-eyelid skin can hide the crease and rest on the lashes. Removing that skin will not, by itself, raise a lid that is truly drooping.

The operation sounds simple, and in experienced hands it is often straightforward. It is also unforgiving. Removing too much skin can keep the eye from closing. Removing the wrong fat, or too much of it, can hollow the lid. Placing the crease in the wrong position can change the expression of the face. This is why I care so much about who does the surgery, and why “just a little skin” is still real surgery.

Upper blepharoplasty is often done by itself. It is also often combined with a lower blepharoplasty, a brow lift, or a ptosis repair when those problems are present. Combining operations can make sense. It also adds time, swelling, and, in some cases, a different setting for the

surgery.

If insurance is being considered, upper blepharoplasty uses the same criteria as ptosis: an MRD_1 of 2 millimeters or less, or, for overhanging skin, a pseudo-MRD_1 of 2 millimeters or less. The short section after Chapter 3, When insurance may cover eyelid surgery, explains that threshold, and that visual field testing is done only once it is met.



Upper and lower blepharoplasty, before and after. The two operations are often combined when both extra upper-lid skin and lower-lid bags are part of what a patient sees.

In the office, awake, or at a surgery center

For many patients, upper blepharoplasty can be done in the office while they are awake, using local anesthesia. You are not put to sleep. You can talk. You will feel pressure and movement, and you will feel the numbing injections, but you should not feel sharp pain once the lids are numb. No fasting is required. Eat a light meal, take your usual morning medicines except those we have asked you to hold, and arrive with a driver. If we have prescribed a relaxing medicine such as Valium, we will tell you when to take it.

The advantages are real. There is no separate facility or anesthesia fee, which is why an in-office upper blepharoplasty is usually less expensive than the same operation at a surgery center. You avoid a trip to a hospital or surgery center, and you go home from a familiar office. Recovery instructions are the same: you still need a ride, and someone should stay with you the first night. An Uber or Lyft is not a substitute for a responsible adult who can take you home.

In-office surgery is not the right setting for everyone. If you are having a lower blepharoplasty, a more involved combined plan, or you simply prefer to be sedated, the operation is done at a surgery center with anesthesia. Lower blepharoplasty in my practice is always done at a surgery center, never awake in the office. Some medical conditions, a high level of anxiety, or a need for deeper monitoring also point toward a surgery center. We will talk about which setting fits you at the consultation, and why.

Questions to ask about setting

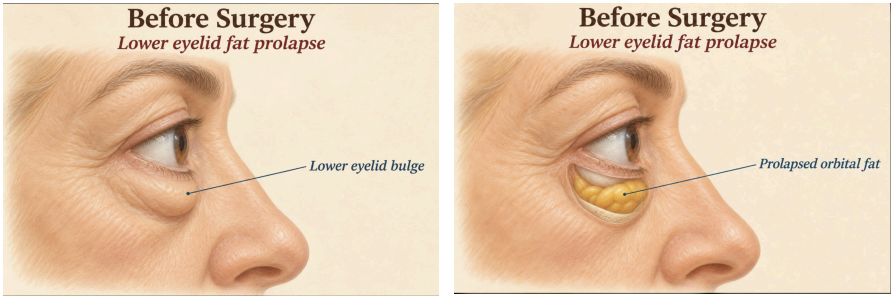
- Can my upper blepharoplasty be done in the office while I am awake, and why or why not?
- If I prefer sedation, what does a surgery-center plan add in time, cost, and recovery?
- Who is with me during the operation, and how is the eye protected?

Lower eyelid blepharoplasty

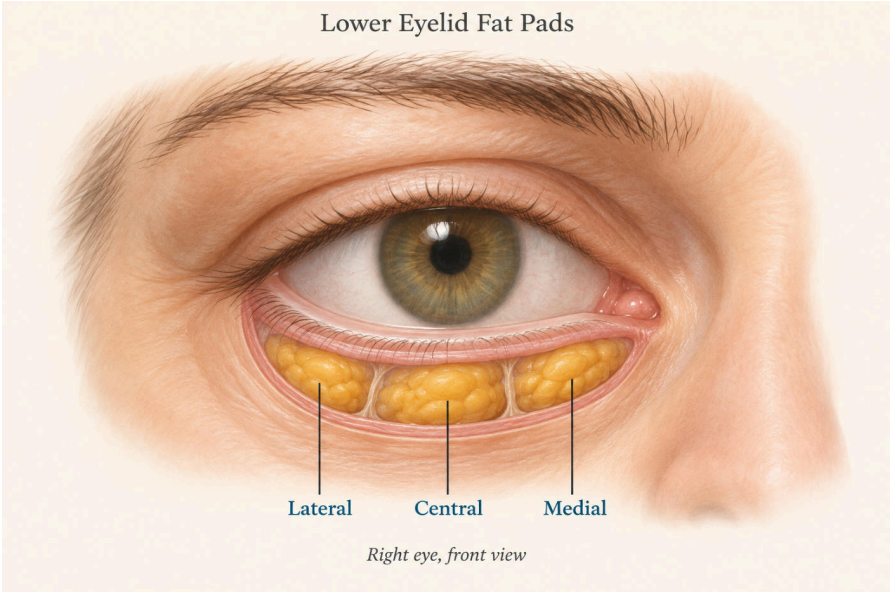
Lower blepharoplasty is a different operation from upper blepharoplasty, with a different recovery. The problem is often a bag—fat that has come forward—sometimes with extra skin, a hollow tear trough, or looseness at the outer corner. The plan has to match the anatomy. A younger patient with an isolated bag and good skin is not treated the same way as an older patient with loose skin, a hollow, and a lid that is already a little lax.



Lower eyelid bags from fat prolapse.



Left: the bulge you see under the eye. Right: the same eyelid with the skin cut away, showing the orbital fat that has pushed forward and causes the bag.



The three lower-eyelid fat pads of the right eye, seen from the front: lateral (toward the ear), central, and medial (toward the nose, also called nasal). A bag may come from one of them or from more than one, which is why the plan is made from an examination, not from the word "bags" alone.



Lower blepharoplasty, before and after. In a younger patient the problem is often a bag of fat with skin that is still in reasonable shape.

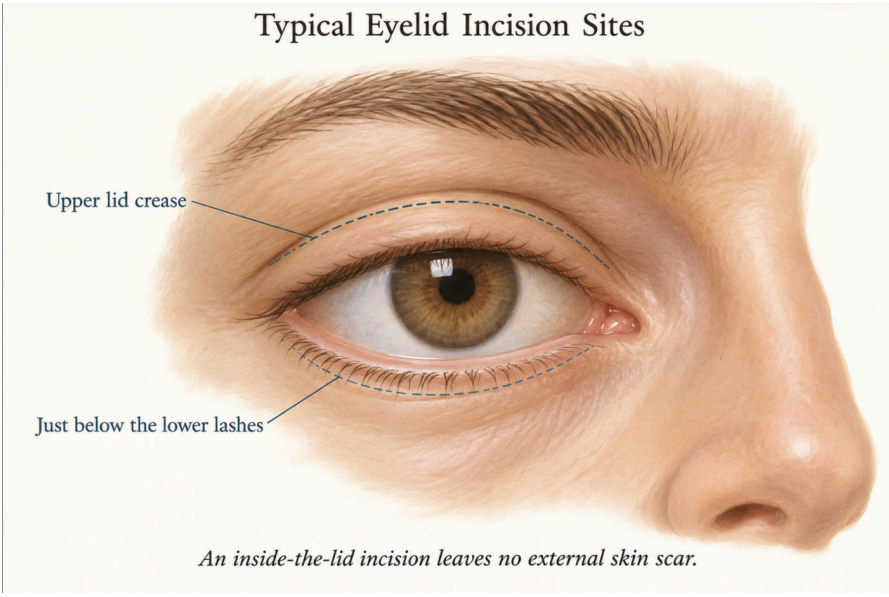


Lower blepharoplasty, before and after. Larger bags are usually fat that has come forward, not fluid that will recede with rest or diet.



Lower blepharoplasty, before and after. Even a more modest bag is usually fat that has come forward, not fluid that rest will clear.

There are two main ways to reach the fat. A **transconjunctival** approach goes through the inside of the eyelid, so there is no skin incision on the outside. That is often a good choice when the main problem is fat and the skin is still in reasonable shape. A **skin** (or skin-muscle) approach uses an incision just under the lashes. That allows extra skin to be removed or redraped, and it may be combined with tightening of the lid. Sometimes both ideas are used in the same operation.



Typical incision sites. The upper incision hides in the crease. A lower skin incision sits just under the lashes. An incision on the inside of the lid (transconjunctival) leaves no external skin scar.

Lower-lid surgery has a longer social recovery than upper-lid surgery for many patients. Bruising and swelling can be more noticeable, and a temporary swelling of the clear membrane over the white of the eye —*chemosis*—is more common after lower-lid surgery than after upper. I will come back to that in the recovery chapter.

When the lower lid needs support

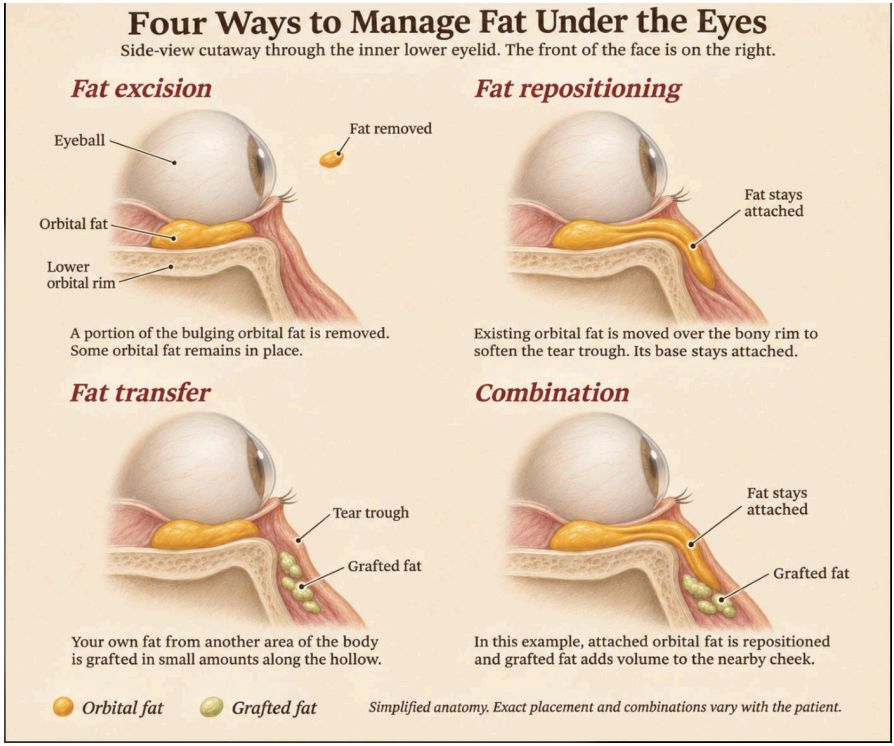
A lower lid that is already a little lax may need tightening or support—a canthopexy or a canthoplasty, in surgical language—to help prevent the lid from sitting too low, or pulling down, after a lower blepharoplasty. Whether that step is recommended is assessed at the consultation, not from a photograph alone. It may be a small part of the plan, or it may not be needed at all. Tightening a lid is not a guarantee that malposition will not occur; it is one of the ways we try to protect the lid's position as it heals.

Approaches to fat in lower eyelid blepharoplasty

When patients ask about lower eyelid surgery, they are often asking about the bags. What they may not realize is that bags, hollows, and shadows are not always treated the same way. Fat in the lower eyelid can be reduced, moved, supplemented with a patient's own fat, or addressed with more than one of those steps in the same operation. The goal is a smoother transition from the eyelid to the cheek, not a hollowed, operated look.

I want to be clear about what this section is and is not. It is a map of the common options I discuss with patients. It is not a promise that any one approach is right for you, and it is not a guarantee of a particular appearance. Faces age in different ways. The plan should follow your anatomy, not a trend.

None of these approaches is designed to treat festoons: swelling or bags of tissue on the upper cheek, below the lower lid, not the fat bags in the eyelid itself. Festoons are hard to treat even in the best hands. Oculoplastic surgeons try to devise different treatments, but long-term results are elusive and unpredictable, and a lower blepharoplasty may not fix them.



Four ways I may manage fat under the eyes: excision, repositioning, fat transfer, or a combination. The choice follows the anatomy, and more than one of these may be used in the same operation.

Simple fat excision

The older, and still useful, idea is to remove some of the fat that has come forward. Through a transconjunctival or a skin incision, a modest amount of fat can be excised so the bag is less prominent. In the right patient—someone whose main problem is a true bulge, with a reasonably supported cheek and not much of a hollow—this can be a clean, effective operation.

The risk of simple excision is overdoing it. Fat that looks like too much when you are thirty-five may be fat you would have been grateful to keep at sixty. Removing too much can deepen a tear trough or leave a hollow, sunken look that is hard to live with and harder to rebuild later. I would rather leave a little fullness than carve a lid into a shadow. When I do remove fat, I am conservative, and I am looking at the whole eyelid–cheek junction, not just the bulge in isolation.

Fat repositioning, or transposition

In many patients the bag and the hollow are two sides of the same anatomy: fat has come forward in one place and a trough has opened just below it. Instead of throwing that fat away, we can keep it attached to its blood supply and move it down, over the bony rim, to fill the trough. This is fat repositioning, sometimes called transposition.

The appeal is obvious. You are using the patient's own tissue, in the same surgical field, to soften a transition that excision alone can make worse. It can be a particularly good option when a bag sits directly above a tear-trough hollow. It is not magic. The fat has to be enough, and it has to reach. Not every trough is best treated this way, and the lid still has to be supported so it does not pull down as tissues heal. Double vision is a very rare but real risk of fat repositioning in particular, which is why I reposition only one fat pad.

Fat transfer, or grafting

Sometimes the lower eyelid and the eyelid–cheek junction need volume that the eyelid fat itself cannot supply. In that situation we may take a small amount of the patient's own fat from another part of the body and place it where it is needed. I typically harvest from the abdomen, the flanks, or the thighs, depending on where a patient has a modest, suitable amount. This is done under general anesthesia, usually at a surgery center, because it is a second surgical site and a different kind of procedure than eyelid surgery alone.

Transferred fat is living tissue, and some of it may not survive. That is a normal part of how this works, not a complication in itself. The amount that remains varies from person to person, and a later touch-up is sometimes needed. Around the thin skin of the eyelids, lumps or small irregularities can appear. I do not promise a particular volume, and I do not treat fat transfer as a substitute for a carefully planned blepharoplasty. It is a tool for volume, used when volume is genuinely part of the problem.

Fat transfer also means more swelling, and a longer time to heal, than eyelid surgery alone. Because a second site is involved, there will be a small harvest-site recovery as well—usually bruising or soreness where the fat was taken. We will talk about that beforehand if fat transfer is part of your plan.

A combination is often the right answer

In practice I often use more than one of these ideas in the same operation. A little fat may be reduced where it truly bulges, some may be repositioned into a trough, and, in selected patients, a carefully placed fat transfer may help a broader hollow or a flat cheek junction. The art is not in having a favorite technique. It is in looking at the lid, the cheek, the skin, and the support of the eyelid, and then choosing a combination that fits.

This is also why a consultation cannot be replaced by a photograph you send in or a procedure name you read online. Two patients who both say "I hate my bags" may need two different operations.

Questions to ask at your consultation

- Is my main problem excess fat, a hollow, extra skin, a loose lid, or a combination?
- Would you remove fat, reposition it, transfer fat, or use more than one of those?
- If fat transfer is on the table, where would you harvest it, and why is general anesthesia needed?
- How will you support the lower lid so it does not pull down as I heal?
- What will recovery look like for the plan you are recommending, compared with a simpler operation?

Brow lift

Drooping of the eyebrows over time is called brow ptosis. When the brow drops, it pushes extra skin into the upper lid and can make a patient look heavy even after a generous blepharoplasty. If I remove that skin and leave a low brow alone, two things can happen: the result looks underdone, or the brow drops a little more and the problem returns sooner than it should.

Many patients can benefit from a brow lift with their blepharoplasty, but this is a separate operation, with its own incision, recovery, and risks. In my practice I perform five techniques: an endoscopic brow lift, a coronal subdermal brow lift, a lateral brow lift (direct), a temporal brow lift (direct), and a browpexy. The choice depends on the height and shape of the brow, the hairline, and what would look natural on that particular face. A brow lift is not automatically better, and it is not automatically cosmetic-only or insurance-covered. It has to be justified by the anatomy.

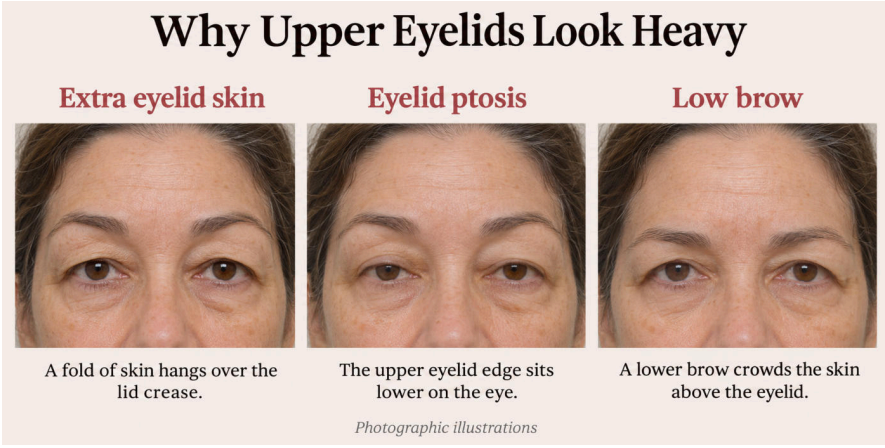
I spend time on this in the consultation because patients often come in asking for eyelid surgery when part of what they are seeing is the brow. Showing you that in a mirror, or with a careful lift of the brow with a finger, is worth a thousand words. Chapter 3 walks through each of those five techniques, including recovery and risks.

Extra skin, eyelid ptosis, and a low brow are easy to confuse, and mixing them up causes real trouble—the wrong operation, or a surprise about insurance. The next section looks at how to tell them apart, because determining the problem is what decides the operation. After that comes a closer look at ptosis itself.

A CLOSER LOOK

Drooping eyelids aren't all the same

Chapter 2 covered the operations. Before we go further, I want to slow down on a distinction that changes the entire plan. Extra skin, a lid margin that sits too low, and a brow that has dropped can all make the upper lids look heavy, and they are easy to confuse. Mixing them up causes real trouble: the wrong operation, or a surprise about insurance.



Extra skin, eyelid ptosis, and a low brow can all make the upper lids look heavy. They are different problems, and they are not treated with the same operation.

How to tell them apart

Dermatochalasis is extra skin of the eyelid. A fold of skin hangs over the lid crease, and sometimes rests on the lashes. An upper blepharoplasty removes or redrapes that skin. It does not raise a lid that is sitting too low because the lifting muscle has loosened.

Eyelid ptosis is drooping of the eyelid itself. The lid margin sits too low on the eye. It has nothing to do with extra skin, even though the two often travel together.

A **low brow** (brow ptosis) is a different problem again. When the brow has dropped, it pushes skin into the upper lid and can make the lid look heavy even if the lid margin itself is in a reasonable place.

Many patients have more than one of these at the same time. Sometimes they need a blepharoplasty. Sometimes they need a ptosis repair, a brow lift, or more than one of those. Getting this distinction right is one of the reasons I believe an eyelid specialist should be the person making that call.

Why the diagnosis matters

The operations are not interchangeable. Removing skin will not raise a lid that is sitting too low, and it will not open the eye. A blepharoplasty and a ptosis repair are different operations, even when they are done at the same sitting.

A brow problem starts higher up. If I remove eyelid skin and leave a low brow alone, two things can happen: the result looks underdone, or the brow drops a little more and the problem returns sooner than it should. That is treated with a brow lift, if a lift is indicated, not with a blepharoplasty or a ptosis repair alone. Chapter 3 is the fuller chapter on brow lifting.

The next section is devoted to ptosis: what it is, how it is measured, how a repair works, and how a plan looks at a ptosis repair and a blepharoplasty.

A CLOSER LOOK

Ptosis

This section is a closer look at eyelid ptosis: what it is, how it is measured, how a repair works, and what recovery and a later adjustment can involve.

What ptosis is

Eyelid ptosis is drooping of the eyelid itself. The lid margin sits too low on the eye.

What causes it, in plain language

In many patients the muscle that lifts the lid, or the tendon that connects that muscle to the lid, has loosened with time. That is what lets the lid margin sit too low. The eyelid crease, which is where that muscle attaches to the skin, can also change position when the lid is drooping.

The repair, in plain terms

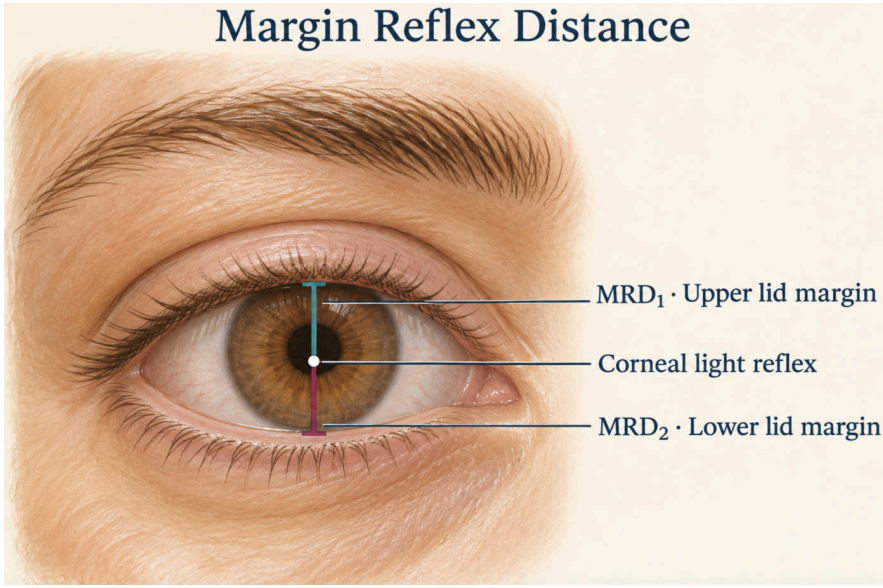
The surgery to fix ptosis repairs or tightens the muscle (or its tendon) that opens the eye, so the lid margin may sit higher.



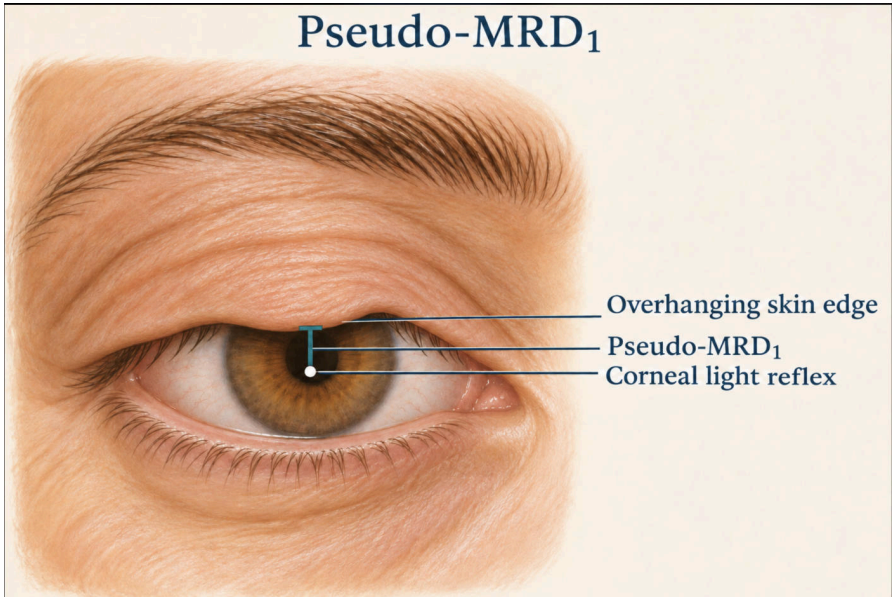
Ptosis repair, before and after. The surgery tightens the muscle that opens the eye so the lid margin sits higher. Removing skin alone will not do this.

How it is measured

MRD_1 is the distance from the center of the pupil's light reflex to the upper lid margin. The measurement is taken from a straight-on photograph made in the office in a standard way. That photograph shows exactly where the lid sits. Squinting or raising the brows cannot change it, and the photo cannot lie.



MRD_1 is the distance from the corneal light reflex to the upper lid margin. MRD_2 is the distance from the reflex to the lower lid margin.



When extra skin hangs over the lid, it can make the lid look lower than it really is (a pseudo-MRD_1). The true MRD_1 is measured to the actual lid margin, which is why the photograph and the exam matter.

If insurance is being considered, the short section after Chapter 3, When insurance may cover eyelid surgery, explains how an MRD_1 or a pseudo-MRD_1 of 2 millimeters or less is used, and how a blepharoplasty, a ptosis repair, and a brow lift are judged separately.

Hering's phenomenon

When we lift one drooping eyelid, the brain may reduce the effort it was using to keep both lids up. This does not happen to everyone. In some patients, a droop that was hidden on the unoperated side becomes noticeable after surgery. This is called Hering's phenomenon (or Hering's law of equal innervation). It may happen in some patients. It is not caused by a mistake in the surgery, and it is not a complication. If it is likely, we will talk about it beforehand, and about whether both sides should be addressed.

Recovery, and the chance of a later adjustment

Vision is usually blurry through the first week after ptosis surgery, as it is after blepharoplasty. Chapter 9 has the fuller recovery calendar, including icing, activity restrictions, and when most people are ready for a restaurant or a social event.

A need for a touch-up is sometimes part of healing. About 10 to 15 percent of ptosis repairs need a second procedure to fine-tune the lid height. I will tell you if that is a realistic possibility in your case. Each eye is its own surgery. If you have sleep apnea, that possibility can be higher; I go over what that means in Chapter 6, under Sleep apnea, eyelid support, and your results.

A revision does not mean it was done wrong

A revision does not necessarily mean the surgery was done wrong. Patients heal differently, and skin relaxes differently in different people. Sometimes a second procedure is simply needed. Chasing perfection is the fastest way to unhappiness island.

CHAPTER 3

Brow lifting

A low or heavy brow can make the upper lids look worse than they are. It is a different problem from extra eyelid skin, and a different problem from ptosis. Getting that distinction right is one of the more common reasons a plan changes in the consultation room.

When the brow is part of what you see

As the brow drops with time, it can push extra skin into the upper lid and give a heavy, tired look. Some people lift their brows all day without noticing, and then wonder why their forehead feels tired. A low brow may also make it harder to show the crease, or make a well-done blepharoplasty look underdone if the brow is left where it is.

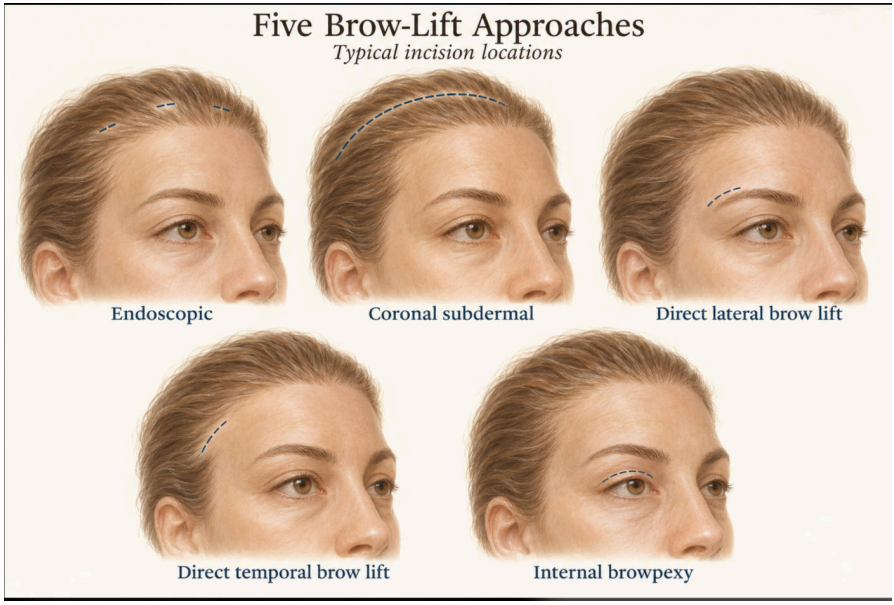
The short section just before this chapter, *Drooping eyelids aren't all the same*, walks through that three-way distinction in more detail. A finger gently lifting the brow in the office is often worth more than a paragraph. If the lid looks much better with the brow supported, the brow may need to be part of the plan. If the lid margin is still low when the brow is held in a natural position, the muscle that opens the eye may be the issue, not only the skin or the brow.

Why operating on the lid alone can backfire

If I remove upper-lid skin and leave a low brow alone, two things can happen. The result may look incomplete, because the heaviness was never only in the lid. Or the brow may drop a little more once the heavy skin that was "propping" it is gone, and the lid can look crowded again sooner than it should. That is not a reason to add a brow lift to every blepharoplasty. It is a reason not to pretend that extra skin is the whole story when it is not.

The brow lifts I perform

In my practice I perform five brow-lift techniques: an endoscopic brow lift, a coronal subdermal brow lift, a lateral brow lift (direct), a temporal brow lift (direct), and a browpexy. I do not use every approach that exists. These are the five I use. The choice among them is made at the consultation, after I examine your brow, your hairline, your forehead, and what would look natural on your face—not from a technique name you arrived with. Sometimes the honest answer is that the brow should be left alone.



Typical incision locations for the five brow-lift approaches I perform. The choice, if a lift is recommended at all, depends on your anatomy, your hairline, and your goals.

Endoscopic brow lift

The incisions are several small ones, placed behind the hairline. A camera is used to work in the forehead and raise the brow. This may suit a patient who needs a broader lift—not only a change at the outer brow—and whose hairline allows those incisions to be hidden.

The advantage is a set of small scars in the hair rather than a long scalp incision or a scar at the brow. The limits are real: it may not be enough for a very heavy brow, and the forehead can feel tight or numb for a time. Hair near an incision can thin a little. This is typically done at a surgery center with anesthesia. Recovery includes swelling and bruising of the forehead and the lids, and the numbness usually improves over weeks to months, though a patch of changed sensation can last longer.

Coronal subdermal brow lift

This uses a coronal incision—typically a long incision along or just behind the hairline, from one temple region toward the other, across the top of the scalp. I work in a more superficial, subdermal plane to raise the brow and the forehead. It may suit a patient who needs a more substantial, or more complete, lift than a limited or endoscopic approach can offer.

The advantage is a single field in which the whole brow and forehead can be addressed. The tradeoffs are a longer scalp incision, a greater chance of numbness, and a possible change in the hair or the hairline near the incision. Recovery is usually more involved than after a limited lift: more swelling, a longer period of tightness or numbness, and more care of a longer incision. This is done at a surgery center with anesthesia.

Lateral brow lift (direct)

The incision sits just above the outer (lateral) brow hairs. This is a direct lift: the skin is adjusted at the brow itself, rather than through a hidden scalp incision. It may suit a patient whose heaviness is mainly at the sides of the brow, and whose inner brow is in a more reasonable position.

The advantage is precision. I can raise the outer brow in a controlled way, and it is a more limited operation than a full forehead lift. The tradeoff is a scar at the outer brow. In some patients it hides well in or at the brow hairs; in some it is more visible. Recovery is usually shorter

than after a coronal or endoscopic lift, with swelling and bruising focused around the outer brow and the lids, and the same gentle incision care I describe for any incision we make.

Temporal brow lift (direct)

This is also a direct approach, focused on the temporal brow—the outer brow toward the temple. The incision is placed in the temple hairline, in a position we choose at the consultation. It may suit a patient whose inner brow can be left alone and whose heaviness is mainly at the sides, when a temporal incision is a better fit than one sitting just above the brow hairs.

The advantage is a targeted lift of the outer brow, without a long coronal incision or a full endoscopic forehead dissection. The tradeoffs are the temple scar, a more limited effect on the inner brow, and, if the incision is in or near the hair, the same possible hair changes that can follow any incision there. Recovery is typically that of a limited lift: swelling and bruising of the temple and the lids, tightness that usually eases, and careful scar care.

Browpexy

A browpexy (an internal browpexy) is done through an upper blepharoplasty incision in the upper lid crease, so there is no additional skin scar. I use it to give a modest lift, or to stabilize the brow so it is less likely to drop after upper-lid skin is removed. It may suit a patient who is already having an upper blepharoplasty and who needs only a modest change in brow position, not a formal forehead lift.

The advantage is that there is no second incision. The limit is the amount of lift: a browpexy is not a substitute for an endoscopic, coronal, or direct brow lift when a larger change is needed. In some patients it can be done in the same setting as the blepharoplasty. Recovery follows the upper-lid operation, with some added tightness or swelling at the outer brow.

Combining a brow lift with blepharoplasty

A brow lift is a separate operation from a blepharoplasty, even when the two are done at the same sitting. Combining them can make sense when both the brow and the lid are contributing to what you see. It also adds time, swelling, and, in some cases, a different setting for the surgery. The amount of lid skin to remove may be less if the brow is being raised, because some of the "extra" skin belonged to the brow all along. That judgment is made in the operating plan, not from a photograph alone.

Anesthesia, in general terms

A browpexy done with an upper blepharoplasty may, in some patients, be possible in the same setting as that blepharoplasty. An endoscopic, coronal, or direct brow lift is typically done at a surgery center with anesthesia. The exact plan depends on the approach, whether other procedures are being combined, and your health. We will tell you where the operation would be done and what kind of anesthesia is planned before you decide.

Recovery

The details vary with the technique, as I have described above. In general, swelling and bruising of the forehead and the lids are expected, and they may last longer than after a blepharoplasty alone. The forehead may feel tight or numb. That numbness usually improves, but it can take weeks or months, and in some patients a patch of changed sensation lasts longer. Incisions—whether at the brow, in the temple, or in the scalp—need the same kind of gentle care as any other incision we make: keep them clean as directed, protect them from the sun, and do not pick at scabs. Activity restrictions are similar in spirit to those after eyelid surgery—no heavy lifting or straining in the early period—and your instruction sheet will give you the timing for your particular operation. Follow that sheet if it and this chapter ever disagree.

Risks

Besides the usual risks of swelling, bruising, bleeding, and infection, a brow lift has some risks of its own. The two sides may not match perfectly; they often did not match perfectly to begin with. Numbness or tightness of the forehead may persist for a time. Scars may be more visible than hoped, especially with a direct incision at the brow or in the temple, or with a longer coronal incision. Hair may thin or the hairline may shift a little near an incision in or at the hair. The brow may be under-corrected, or over-corrected, which can give a surprised look. Injury to the temporal (frontal) branch of the facial nerve is uncommon. That branch moves the brow and the forehead, so if it is affected there can be weakness when you raise the brow on that side. When that happens it may improve, but it may not disappear entirely. We will talk about the risks that apply to the technique under discussion, not to every brow lift in the abstract.

Insurance

How insurance looks at a brow lift—including why coverage for a functional brow lift is difficult to obtain, and how a brow lift, a blepharoplasty, and a ptosis repair are judged separately—is in the short section that follows this chapter, When insurance may cover eyelid surgery.

Non-surgical options

Botox can give a modest lift to the brow, particularly at the sides, and can help crow's feet. It will not fix a significantly low or heavy brow, and it will not remove extra skin. I will say so if I think a few units would be a more honest first step than an operation, and I will also say so if I think it would be a disappointment.

A few misconceptions

"Everyone needs a brow lift." Only if the brow is truly low. A brow lift you do not need, or one that is overdone, can leave a permanently surprised look. That is a risk of a brow lift, not of blepharoplasty, and it is worth weighing when you are deciding whether the brow should be part of the plan. You have probably seen well-known faces with a permanently startled look.

"A brow lift will make me look surprised." Not necessarily. When the brow is truly low and the plan is conservative, the aim is a natural position that fits the rest of the face.

"If I am having my eyelids done, I should have a brow lift too." Not automatically. Many patients have a satisfactory blepharoplasty without one. Adding a brow lift "while you are there" is not a reason to have a second operation you do not need.

IN PLAIN LANGUAGE

When insurance may cover eyelid surgery

Insurance questions come up with upper blepharoplasty, ptosis repair, and brow lifting. The rules belong in one place, rather than repeated in every chapter that mentions a plan.

Insurance, including Medicare, is interested in one question: is the operation being done because the eyelid or the brow is interfering with vision or with the health of the eye, or is it being done to change appearance? Cosmetic surgery is self-pay. A functional operation may be covered, but only if that specific surgery meets the plan's criteria, and only after the plan says so.

A brow lift, an upper blepharoplasty, and a ptosis repair are not interchangeable in an insurer's eyes. Coverage of one is not coverage of the others. They are judged separately. If part of a plan is functional and part is cosmetic—for example, a ptosis repair that meets criteria, done at the same time as a skin removal that does not—we will separate those pieces honestly.

How coverage is documented

A plan typically wants an examination and standardized photographs. Upper blepharoplasty uses the same insurance criteria as ptosis: an MRD_1 of 2 millimeters or less, or, when extra skin hangs over the lid, a pseudo-MRD_1 of 2 millimeters or less. MRD_1 is the distance from the center of the pupil's light reflex to the upper lid margin. A pseudo-MRD_1 is the same kind of measurement, but taken to the overhanging skin fold rather than to the true lid margin. Squinting or raising the brows cannot change what the photograph shows.

I do not perform visual field testing unless that MRD_1, or the pseudo-MRD_1 created by extra skin, already meets the 2-millimeter threshold. The measurement comes first. If it is not there, a visual field test is not done. When the threshold is met, we may then do a visual field test, once normally and once with the lids gently taped up, because a plan often asks for it. That test does not override the photograph. If another eye problem, such as glaucoma or a past stroke, is what is reducing the field, taping the lids will not fix the field, and that test will not support coverage for eyelid surgery.

Insurance plans generally don't cover surgery done to look less tired or to make makeup easier; coverage depends on whether the eyelids measurably block vision (an MRD, or a pseudo-MRD, of 2 millimeters or less). How tired you look, how heavy the lids feel, and how hard it is to put on makeup, are still real reasons people come in.

Insurance coverage for brow ptosis—a functional brow lift—is difficult to obtain. A brow lift done to change appearance is cosmetic.

If part of a plan may be covered by insurance, we will be honest about which pieces are cosmetic and which might be functional, and about the fact that a copay, deductible, and coinsurance can still apply even when a plan says yes. Coverage is never a reason to do the wrong operation. Cosmetic eyelid surgery is paid for by the patient. Insurance may apply only to the functional portion of a plan, and only when that specific surgery meets the plan's criteria. In a mixed plan, the cosmetic portion is self-pay and is prepaid. The cosmetic and functional parts of a mixed plan have separate surgeon, anesthesia, and facility fees. The functional surgeon fee is an insurance estimate. There may also be separate insurance bills for the functional facility and anesthesia fees. We cannot promise that a plan will pay, and we cannot invent a diagnosis to make a cosmetic operation look functional. Current questions are worth checking with the office, because plan rules change. The principle does not: the right operation is the one that matches the anatomy, whether a plan pays for it or not.

CHAPTER 4

When surgery is not the first step

Not every patient who is unhappy with their eyelids needs an operation, and not every concern around the eyes is a surgical one. Some of the most useful visits I have are the ones that end with a plan that does not involve a scalpel—or that puts surgery off until something simpler has been given a fair chance.

This chapter is a map of the non-surgical options I discuss most often. It is not a catalog of every aesthetic treatment on the market, and it is not an argument that these treatments are "just as good as surgery." They are different tools. Used in the right patient, they can be excellent. Used in the wrong one, they disappoint, or they create a new problem.

Fillers around the eyes

Hyaluronic-acid filler can soften a tear-trough hollow or a flatness at the eyelid–cheek junction. For some patients, that shadow is the main thing they see. Filler for the lower eyelids has, however, fallen more out of favor. Filler can migrate, it can be hard to dissolve fully, and it can cause prolonged swelling and edema—a fluid puffiness that may last longer than people expect.

Filler around the eyes is not casual. The skin is thin, the anatomy is unforgiving, and a bump or a bluish tint can happen as well. I would rather underfill than overfill, and I would rather say no than place filler in a lid that actually needs surgery. Filler also does not remove a bag. If the problem is fat that has come forward, adding volume next to it can make the bag look more obvious, not less.

If filler is still a reasonable option in your case, we will talk about what to expect, how long it may last, and what we would do if you did not like it. Hyaluronic-acid fillers can often be dissolved, which is one reason I still prefer them in this area over products that cannot be

reversed, but dissolving is not always complete.

UltraClear laser resurfacing

Surgery changes contours: skin that hangs, fat that bulges, a lid or a brow that has dropped. It does not, by itself, redo the surface of the skin. Fine lines, sun damage, uneven texture, and a crepey quality to the skin around the eyes or on the face are often better addressed with resurfacing than with another millimeter of skin excision.

In my practice I offer UltraClear laser skin resurfacing, including more superficial treatments and more advanced ones. The idea is to treat the quality of the skin—the texture and the sun-worn surface—not to replace a blepharoplasty. If hanging skin is the main problem, a laser will not tuck it out of the way. If the skin itself looks worn, a laser may help in a way surgery will not.

A laser may be done at the same time as eyelid surgery, or later, after the incisions have healed. In my practice I commonly combine UltraClear with an upper blepharoplasty done in the office. That timing is decided at the consultation, looking at your skin and your plan, not from a week-count printed in a book. I will tell you which order I think is more thoughtful, and why.

Patients sometimes ask how UltraClear compares with a traditional carbon-dioxide (CO_2) laser. The short version is below. I offer UltraClear in this practice. I am describing CO_2 as a comparison, so you can understand a conversation you may have heard, not as a treatment I am offering here.

	CO_2 (TRADITIONAL ABLATIVE FRACTIONAL)	ULTRACLEAR
What it is	A traditional carbon-dioxide laser used in a fractional, ablative way.	A cold fiber laser. In my practice, this is the resurfacing laser I offer.
Typical character	Often stronger results, with more downtime and redness.	Adjustable depth. Usually less downtime than a traditional ablative CO_2 treatment.
Skin type	A higher risk of pigment changes in darker skin.	Often considered over a broader range of skin types, though that is still decided case by case.

Downtime depends on the depth of the treatment. A lighter treatment is usually a shorter recovery; a more advanced treatment asks more of the skin in the days afterward and has a more involved aftercare routine, including soaks and diligent sun protection. Numbing cream is used before treatment. For UltraClear, I ask patients to arrive one hour early so the cream has time to work. Patients with a history of cold sores may be given an antiviral medicine in advance. We will give you the current before-and-after instructions if this is part of your plan, because those details matter and they can change.

I do not promise a particular amount of tightening or a particular number of years "turned back." I do tell patients, honestly, when I think a laser, a filler, surgery, or some combination is the more thoughtful order of things.

Skin care, peels, and other office treatments

Daily sunscreen, a simple moisturizer, and, for some patients, a well-chosen prescription cream do more for the skin around the eyes over a decade than any single procedure. I would rather a patient be boring and consistent with sunscreen than enthusiastic and irregular with a complicated routine.

Light peels, medical-grade skin care, and similar office treatments can help texture and tone. They will not lift a drooping lid or empty a bag. If someone is selling you a cream or a "lunchtime lift" as a substitute for a blepharoplasty, be skeptical.

Botox and filler after surgery, and when to stop them beforehand

If you already like the way Botox softens crow's feet, or the way a carefully placed filler helps a hollow, you will often want to continue those treatments after you have healed. They can fine-tune a result. They are not a substitute for a well-indicated blepharoplasty, and they are not something to have immediately before one.

For upper eyelid surgery, I ask patients to stop Botox about three months beforehand, so it has worn off. Botox changes brow position, and I do not want that hidden or exaggerated when I am planning and performing the operation.

For lower eyelid surgery, any filler in the area needs to be completely dissolved first. I need to see your natural tissue. Filler left in place makes it harder to judge what should be moved, reduced, or left alone, and existing filler around the eyes can also cause more swelling after eyelid surgery.

We will go over timing at the consultation and put it on your pre-operative sheet. If you have had filler around the eyes and you are not sure what was used, tell us, because not every product can be dissolved.

When I still recommend surgery

If extra skin is sitting on the lashes, if a bag is a true bulge of fat, or if the lid or brow has dropped, non-surgical treatments usually cannot do the job. It is kinder to say that clearly than to let a patient spend a year and a good deal of money discovering it. The consultation is where we sort this out, looking at your face rather than at a menu of procedures. The next pages are about choosing a surgeon and sitting down for that visit.

A SHORT GUIDE

Choosing your surgeon

Eyelid surgery looks straightforward from the outside. It is not. The eyelids are thin, the anatomy is delicate, and the operation has to protect the eye itself: how the lids close, how they blink, and how they keep the surface of the eye comfortable. A plan that ignores those functions can look acceptable in a photograph and still leave you with a real problem.

Training to look for. An oculoplastic (ophthalmic plastic) surgeon with ASOPRS fellowship training and board certification has spent additional years operating on eyelids, tear ducts, and the tissues around the eye, with protection of the eye as a first principle. That is a strong place to start. It is not the only path to a good result. A surgeon from another background may also be a good choice if they have specific training in eyelid surgery and privileges to perform it at a hospital or a surgery center.

Questions worth asking. How many of these operations do they perform? Who takes care of you if there is a complication? May you see results of work they have actually done? Chapter 5 goes further, including a longer list of questions to take to a consultation.

Price is a poor way to choose. A low fee can look appealing until a problem such as trouble closing the eye, or a lid that has pulled out of position, needs to be repaired. That second operation is often harder, and more expensive, than doing the first one well. Compare training, judgment, and how you are treated—not the number alone.

CHAPTER 5

Choosing a surgeon

The short section just before this chapter covers the essentials: training to look for, questions worth asking, and why price is a poor way to choose. This chapter goes further, because the choice matters more than almost any other decision in this process. I will be direct. A large part of my practice is revising eyelid surgery done elsewhere, and choosing the wrong surgeon is often where the trouble started.

Many kinds of doctors offer eyelid surgery: oculoplastic surgeons, general plastic surgeons, facial plastic surgeons, dermatologists, and others. Some are excellent at this. Some do it occasionally. When something goes wrong, the eye itself can be at risk.

What I think you should look for

Specific training in eyelid surgery. I am biased, and I will tell you why. An ASOPRS fellowship-trained oculoplastic surgeon has spent additional years after ophthalmology residency operating on eyelids, tear ducts, and eye sockets, and has been taught to protect the eye as a first principle. Board certification in ophthalmology, and fellowship training in oculoplastic surgery, are the credentials I would want if I were the patient. They are not the only path to a good result, but they are a strong place to start.

I am also fellowship-trained in neuro-ophthalmology. That is less important for a straightforward extra-skin case, and more important when a droopy lid might not be a simple aging change—when myasthenia, a nerve problem, or something else is in the differential.

A practice that actually does a lot of eyelids. Ask how much of the surgeon's work is eyelid surgery, and how often they revise surgery done by others. A doctor who does beautiful body surgery or excellent Botox is not automatically the right person for your eyelids.

Someone who can handle complications. That includes dry eye, which needs a slit lamp in the office, as well as bleeding behind the eye and lid retraction. If a surgeon cannot care for the eye when there is a problem, I would keep looking.

Someone who talks to you, and who is not in a hurry for you to sign. The decision is personal, and there is no rush. Be wary of pressure to book on the spot, of a consultation that feels like a sales visit, and of a plan that is described before anyone has examined your eyes.

Price is a poor way to choose

Do not choose a surgeon because the price is very low, or because it is very high. Price for cosmetic eyelid surgery is based on demand, cost of living, and sometimes arbitrary factors. A low-priced blepharoplasty is not necessarily the best option; you tend to get what you pay for. The highest-priced blepharoplasty is not always the best either. Some patients assume the most expensive surgeon must be the best. That is, at times, a marketing technique, not a measure of quality.

This is surgery on your eyelids. Now is not the time to be penny-wise and pound-foolish. It is also not the time to assume that a higher invoice is the same thing as a safer pair of hands. Compare training, judgment, and how you are treated—and, when you compare fees, ask what is included.

Questions worth asking any eyelid surgeon

- What is your training specifically in eyelid surgery? Are you an ASOPRS-trained oculoplastic surgeon?
- How much of your practice is eyelids, including revisions?
- Is in-office surgery an option for me, and why or why not?
- How do you handle bleeding, a lid that will not close, or a dry eye after surgery?
- May I see before-and-after photographs?
- What will recovery actually look like, not the best-case version of it?

Warnings I take seriously

A surgeon who will not examine your eyes, or who does not have a slit lamp, is not set up to take dry eye and the surface of the eye seriously. A plan that is quoted before anyone has looked at you, a guarantee of a particular appearance, or pressure to add procedures you did not come in for should make you slow down. So should a consultation where the surgeon never personally examines your eyelids, or cannot explain whether your problem is extra skin, ptosis, or a low brow.

Online reviews are information, not a diagnosis. A long string of five-star comments does not tell you how a practice handles a complication. A single angry review does not tell you the whole story either. Read them, then put more weight on the conversation in the room and on the surgeon's training and judgment.

If you are considering a revision of surgery done elsewhere, bring whatever records and photographs you have. I will tell you honestly whether I think I can help, whether I think time is still doing the work, or whether I think another operation is unlikely to get you where you want to go. I will not pretend that every problem has a tidy surgical answer.

CHAPTER 6

The consultation

The consult is when I decide whether surgery is safe and likely to help, and you decide whether I am the right surgeon for you. It is not a formality, and it is not a sales appointment. If it feels like one, that is useful information.

What happens in the room

I will ask what bothers you, in your words, and what you hope will change. I will examine the eyelids, the brows, the eyes themselves, and how the lids close and blink. I will look at the surface of the eye, because a plan that ignores dryness or irritation is a plan that can make a patient miserable later, even if the photograph looks improved.

I take photographs. Standardized photographs are how I plan, how I talk with you about what I see, and, if insurance is involved, how a plan documents a functional problem. Before-and-after photographs of other patients are useful as illustrations. They are not a menu, and they are not a promise that your result will look like theirs. Your anatomy, your healing, and your plan are your own.

If a functional operation is being considered, we will take the photographs your plan requires. The short section after Chapter 3, When insurance may cover eyelid surgery, explains the criteria, including when a visual field test is and is not done.

Dry-eye screening

I screen for dry eye on purpose, even if you have not complained of it. Blepharoplasty can temporarily worsen dryness, because swelling and a slightly different blink can leave the surface of the eye less comfortable for a while. In most patients this is manageable and improves. In a patient who already has significant dryness, or whose lids do not close well, surgery can make everyday life worse.

Screening may include questions (burning, grittiness, watering, fluctuating vision), an examination of the tear film and the lid margins at the slit lamp, and, when needed, simple tests of tear quantity or quality. If your eyes are already quite dry, we may treat that first, adjust the surgical plan, or, in some cases, recommend against surgery. This is not me being difficult. It is me trying not to trade one problem for a more serious one.

Tell me about eye drops you already use, prior LASIK or other corneal surgery, autoimmune disease, and a feeling that your eyes never feel comfortable. Those details matter more than patients sometimes think.

Other things I am looking for

A droopy lid that fluctuates, double vision, or fat that has come forward in an unusual way can be a sign of something other than ordinary aging—thyroid eye disease, myasthenia gravis, or another medical problem. Simple office tests can help catch these. Operating on a lid whose real problem is not extra skin is one of the faster ways to make a patient worse.

I am also looking at your health more generally, your medications, and whether you are a good candidate in the three ways I described in the introduction: as a physical candidate, a medical candidate, and a psychological candidate. If the answer is no, I will say so, and I will tell you why.

Sleep apnea, eyelid support, and your results

In floppy eyelid syndrome, which is linked to sleep apnea, the eyelid tissue loses elasticity, so the practical issue is how well the lid holds its shape and stays against the eye.

If you have sleep apnea, I pay particular attention to how firmly your eyelids sit against your eyes. Some people with sleep apnea have very loose upper lids that can roll outward against the pillow. You might wake up with one eye feeling gritty or irritated. If I find that kind of looseness, we'll talk about whether tightening the eyelid itself should be part of the plan. That can change what I recommend and what I expect surgery to accomplish.

When we talk about results, I look at how the incision heals, how comfortable the eye feels, and where the eyelid settles. Those are three different things. If we're also repairing a drooping eyelid, I'll explain that getting the two lids to settle at a similar height can be less predictable in patients with sleep apnea. I'll use what I see on your exam to tell you what I think is realistic for your eyes.

In ptosis repair, patients with sleep apnea needed a height adjustment more often—about one in five, compared with about one in eight.

Leaving with a plan

By the end of a good consultation you should know what I think the problem is, what I would do about it, where it would be done, what recovery looks like, and what it costs. You should also feel free to go home and think. I do not need an answer the same day, and I am not offended if you get a second opinion. The next chapter is about what thousands of eyelid surgeries changed about the way I practice—and about the question I now ask first. After that comes getting ready, and the unglamorous details that make the day of surgery safer.

Photographs, and what they are not

I use photographs the way a carpenter uses a square: to see, to plan, and later to compare. I also show before-and-after photographs of other patients when they help illustrate a point. Please do not treat those images as a catalog. Lighting, camera angle, makeup, and the interval after surgery can all change how a result looks on a screen. The honest question is not "can I have that person's eyelids?" It is "does this surgeon understand *my* eyelids, and is the plan a fair match for what bothers me?"

If a functional operation is being considered, the photographs have a second job: they are part of what a plan uses to decide coverage. We take that documentation seriously, and we do not pose it to invent a problem that is not there. The short section after Chapter 3, When insurance may cover eyelid surgery, explains the criteria.

CHAPTER 7

What thousands of eyelid surgeries changed about the way I practice

After more than 12,000 eyelid surgeries, one of the most important questions I ask is this:

What do you want me to leave alone?

People come in ready to tell me what bothers them. They've noticed it in photographs or watched it on Zoom for years. It often takes them a moment to answer when I ask what they *like* about their eyes. Then they'll say something like, "I actually like the shape of my eyes," or, "I just want to look a little less tired." That answer can change the entire plan. It tells me where to stop.

I recommend less when less will do.

When someone comes in asking for upper and lower eyelid surgery, I ask them to show me what made them book the appointment. Sometimes they point to one spot. We look in the mirror together, and it becomes clear that the thing they notice every morning is much more specific than the operation they came in asking for. If a smaller procedure can address what matters to them, that's what I recommend. And sometimes I tell them they can go home and forget about surgery. I'm happy when I can give someone that answer.

I pay more attention to the face between photographs.

A photograph captures your face in one position. In the exam room, I can see what happens when you talk, smile, and let your forehead relax. I pay particular attention to whether you're lifting your eyebrows without realizing it. You may have done it for so long that it feels like your natural resting expression. Watching what happens when your forehead relaxes helps me understand which part of the change you're seeing comes from the brow, the eyelid itself, or the skin above it. That's one reason I take my time examining you before we talk about an operation.

I slow down when "better" could mean two different things.

This comes up especially with revision surgery. Someone may point to a tiny difference between their eyelids that they see every morning. I take that seriously. Then we talk through what it would take to change it and what else could change in the process. A difference can be real, and leaving it alone can still be the best decision. I want you to have enough time to make that choice without feeling pushed in either direction.

My favorite thing to hear after someone has healed is that they've stopped thinking about their eyelids. They get ready in the morning, look in the mirror, and get on with their day. That's the kind of result I have in mind when we sit down for the first time.

CHAPTER 8

Preparing for surgery, and what it costs

Once we have a plan, the practical work starts. A smooth operation begins days and weeks before you arrive. The current pre-operative instruction sheet you are given is the document to follow if anything in this chapter ever disagrees with it. Policies, medication names, and hold times can change. What follows is the practice's typical guidance as of this 2026 edition.

Medications to hold

Some medicines and supplements increase bleeding. Others affect anesthesia, blood sugar, or stomach emptying. Please do not stop a prescribed medicine on your own if it was given to you for a serious reason—especially a blood thinner prescribed after a stent, a clot, a stroke, or a heart-rhythm problem. Call the doctor who prescribed it, and call us, so a plan can be made safely.

MEDICINE OR CATEGORY	TYPICAL HOLD, AS OF THIS EDITION
Aspirin	Stop 7 days before surgery, unless your prescribing doctor has told us otherwise.
Clopidogrel (Plavix)	Stop 5 days before surgery, and only with the approval of the doctor who prescribed it.
Other prescription blood thinners (for example warfarin, apixaban, rivaroxaban)	Do not stop these on your own. Hold times are individualized and must be approved by the prescribing physician. We will coordinate this with you.
Over-the-counter NSAIDs (ibuprofen, naproxen, and similar)	Typically held along with aspirin in the week before surgery; follow the current medication sheet you are given.
Many supplements (fish oil, vitamin E, ginkgo, garlic pills, and others listed on the medication sheet)	Stop 7 days before surgery.
GLP-1 medicines (Wegovy, Ozempic, Zepbound, and similar)	Stop two weeks before surgery.
SGLT2 medicines (Jardiance and similar)	Stop three days before surgery (your sheet may specify a slightly longer hold for a particular drug in this class).
Botox (and similar), before upper eyelid surgery	Stop about three months beforehand, so it has worn off and I can see your natural brow position.
Filler around the eyes, before lower eyelid surgery	Needs to be completely dissolved first, so I can see your natural tissue. Existing filler around the eyes can also cause more swelling after eyelid surgery. Tell us if you are not sure what was used.

Bring a complete list of everything you take, including vitamins and "natural" products. If you are not sure whether a name is on the hold list, ask. It is much easier to sort this out a week or two in advance than the morning of surgery.

Smoking, vaping, and nicotine

Nicotine—whether you smoke, vape, or use another nicotine product—narrows blood vessels and can interfere with healing. It is one of the few habits I ask patients to stop because the tissues I am operating on are thin and need a reliable blood supply. I ask patients to stop smoking and vaping before surgery and to stay off nicotine through the early healing period, following the timing on your instruction sheet.

If you cannot stop, tell me honestly. I would rather know than discover it later, and we can talk about what that means for timing or for whether surgery should wait.

The week before, and the night before

Fill prescriptions early. Set up a recovery spot at home with pillows so you can sleep with your head raised, and get two ice packs or bags of frozen peas and a clean cloth to use as a barrier between the ice and your skin. Arrange a driver, and someone to stay with you the first night. You cannot drive yourself home, even after in-office surgery, and a rideshare is not a substitute for a responsible adult.

If your surgery is at a surgery center, the center (not our office) will call you a day or two beforehand with your arrival time. Nothing to eat or drink after midnight, including coffee, unless you have been given a different instruction. Take usual morning medicines (not blood thinners, and not medicines we have asked you to hold) with a sip of water. If you are on insulin or diabetes pills, ask the doctor who manages that how to adjust.

If your upper blepharoplasty is in the office, no fasting is needed. Eat a light meal, take your usual medicines except those we have held, and arrive with your driver.

What it costs

I am not going to print a menu of surgical fees in this book. Fees change, and a number that is accurate in November 2026 can be misleading a year later. Current fees are available from the office and are posted, when we publish them, at **denvereyelid.com**. At your consultation you will receive a written quote for the plan we discuss.

When you compare quotes, ask what is included. For an in-office upper blepharoplasty, you are typically looking at a surgeon's fee plus an office fee; there is no separate facility or anesthesia bill. At a surgery center, the quote should account for the surgeon, the facility, and anesthesia. Combined surgery (a lower lid, a ptosis repair, a brow lift) is quoted by the pieces of the plan, after an examination. Follow-up visits for the surgery are part of what you should ask about as well.

If part of a plan may be covered by insurance, see the short section after Chapter 3, When insurance may cover eyelid surgery. Coverage is never a reason to do the wrong operation.

Fees change. A written quote for the plan we discuss is the number to rely on, not a figure printed in a book.

What to have ready at home

A little preparation makes the first days easier. I ask patients to have these things on hand before the morning of surgery. The next leaf of this book is a tear-out checklist that gathers the same list, the medicine holds, and the day-of reminders, so you can take it with you.

- Two ice packs or bags of frozen peas, and clean cloths to use as a barrier
- The antibiotic ointment we recommended, and lubricating eye drops if we asked you to get them
- Acetaminophen (Tylenol), unless you have been told not to take it
- Extra pillows so you can sleep with your head raised
- Sunglasses for the trip home and for outdoors afterward (incisions need sun protection for three to four months)

- A responsible adult to drive you and to stay with you the first night

Leave contact lenses out as instructed, and bring your glasses. Do not wear makeup, lotion, or mascara to surgery. Wear a shirt that buttons or zips in front so you do not have to pull clothing over your face on the way home.

The day of surgery

Come on time. Expect to be asked the same safety questions more than once. That is on purpose. **If a case starts late, it is often because another patient needed extra care, as you would want for yourself.**

At a surgery center, arrive at the time they gave you when they called. You will check in for vital signs and paperwork, and you will have an IV if anesthesia is planned. After surgery you will typically spend about an hour in recovery before you go home. If you feel nauseated, say so before you leave; vomiting can increase bleeding. Your eyes will not be patched, so you can watch your vision.

In the office, the rhythm is quieter. You will be settled in a procedure room, the lids will be marked and cleaned, and local anesthetic will be injected. You can talk. Some patients like to hear a little of what is happening; some would rather not. Tell us which you prefer. When we are finished, you will sit for a short while, we will go over the instructions again, and your driver will take you home.

Either way, the first evening is for rest, icing, and a raised head—not for errands, not for reviewing the incisions with a magnifying mirror, and not for deciding how the surgery "turned out." That judgment belongs to a later week.

YOU MAY TEAR OUT THIS LEAF AND TAKE IT WITH YOU

A PRACTICAL PAGE

Before surgery: a checklist

This leaf gathers the usual preparations already described in Chapter 8. If anything here disagrees with your current pre-operative instruction sheet, follow the sheet. Policies, medication names, and hold times can change.

What to have ready

- Two ice packs or bags of frozen peas, and clean cloths to use as a barrier between the ice and your skin
- The antibiotic ointment we recommended, and lubricating eye drops if we asked you to get them
- Acetaminophen (Tylenol), unless you have been told not to take it
- Extra pillows so you can sleep with your head raised
- Sunglasses for the trip home and for outdoors afterward (incisions need sun protection for three to four months)
- A shirt that buttons or zips in front, so you do not have to pull clothing over your face
- Your glasses; leave contact lenses out as instructed

What to stop, and when

Do not stop a prescribed medicine on your own if it was given to you for a serious reason—especially a blood thinner after a stent, a clot, a stroke, or a heart-rhythm problem. Call the doctor who prescribed it, and call us.

- **Aspirin:** stop 7 days before surgery, unless your prescribing doctor has told us otherwise.
- **Clopidogrel (Plavix):** stop 5 days before surgery, and only with the approval of the doctor who prescribed it.
- **Other prescription blood thinners** (for example warfarin, apixaban, rivaroxaban): do not stop these on your own. Hold times are individualized and must be approved by the prescribing physician.
- **Over-the-counter NSAIDs** (ibuprofen, naproxen, and similar): typically held along with aspirin in the week before surgery; follow your current medication sheet.
- **GLP-1 medicines** (Wegovy, Ozempic, Zepbound, and similar): stop two weeks before surgery.
- **SGLT2 medicines** (Jardiance and similar): stop three days before surgery (your sheet may specify a slightly longer hold for a particular drug in this class).
- **Botox** (and similar): stop about three months before upper eyelid surgery, so it has worn off and I can see your natural brow position.
- **Filler around the eyes:** needs to be completely dissolved before lower eyelid surgery, so I can see your natural tissue. Existing filler around the eyes can also cause more swelling after eyelid surgery. Tell us if you are not sure what was used.

BACK OF THE TEAR-OUT LEAF

The day of surgery

- A responsible adult to drive you home and to stay with you the first night. You cannot drive yourself, even after in-office surgery. A rideshare is not a substitute.
- If surgery is at a surgery center: nothing to eat or drink after midnight, including coffee, unless you have been given a different instruction. The center (not our office) will call with your arrival time. Take usual morning medicines (not blood thinners, and not medicines we have asked you to hold) with a sip of water. If you are on insulin or diabetes pills, ask the doctor who manages that how to adjust.
- If your upper blepharoplasty is in the office: no fasting is needed. Eat a light meal, take your usual medicines except those we have held, and arrive with your driver.
- Do not wear makeup, lotion, or mascara to surgery.
- Come on time. Expect to be asked the same safety questions more than once.

After you get home

- Ice the eyelids 20 minutes on and 20 minutes off, while you are awake, for the first week. Use a cloth barrier. Do not put ice directly on the skin.
- Clean secretions with a warm wet washcloth, then apply ointment as directed. Do not use hydrogen peroxide on the incisions.
- Sleep with your head raised about 30 degrees.
- The first evening is for rest—not for errands, and not for deciding how the surgery "turned out."

If a sentence on this leaf and a sentence on your instruction sheet ever disagree, follow the sheet, and then call or text us if you are unsure.

CHAPTER 9

Recovering from surgery, and how wounds heal

The questions I hear most often after a consult are not about the incision. They are about the calendar. When will the swelling go down? When will I look normal again? When can I go back to work, or to a wedding, or to the gym? This chapter is meant to give an honest picture of recovery—not the best-case version, and not a promise that your healing will match someone else's.

Everyone heals at their own pace. A patient who has only an upper blepharoplasty often looks presentable sooner than someone who has upper and lower lids, a ptosis repair, or a brow lift at the same time. Lower-lid surgery usually asks more of the next two or three weeks than upper-lid surgery does. The timeline below is a typical pattern. It is not a guarantee.

Healing is also a little different after a blepharoplasty than after a ptosis repair, and different again if we do both. A ptosis repair tightens the muscle that lifts the lid; a blepharoplasty addresses skin and fat. The swelling and the way the lid height settles are not identical. The Ptosis section explains the repair and the chance of a later adjustment. We will tell you which pattern to expect for the plan we actually do.

Healing is human

I can control the plan and the technique. I cannot control how each person's tissue heals. Genetics, age, skin type, circulation, smoking, medical conditions, medications, and aftercare all play a part. Swelling, bruising, scarring, and even a little asymmetry vary from person to person, and sometimes from one side of the face to the other. That is not a failure of the operation, and it is not a reason to panic in the first weeks. Patience and follow-up matter. I will be honest with you about what I am seeing, and I will not pretend that healing is a switch I can flip.

Icing, and caring for the incision

For the first week, ice the eyelids **20 minutes on and 20 minutes off, while you are awake**. Use a barrier—a clean cloth—between the ice and your skin. Do not ice for long, continuous stretches, and do not put ice directly on the skin. After 72 hours, you may switch to warm compresses if that feels comforting. Stop if they increase swelling or discomfort.

For the incision itself, less is more. Clean secretions with a warm wet washcloth, then apply antibiotic ointment twice a day until the stitches are removed, or as we directed you. Do not use hydrogen peroxide on the incisions. Do not rub, tug, or pick at the stitches or scabs. If a stitch comes loose, call or text us. You can shower, but keep the spray off your face. Hair washing and alcohol are usually all right after 72 hours, unless we have given you a different instruction for your incisions.



A typical recovery kit: a gel ice pack, steri-strips, and a small tube of ointment. Use a cloth barrier between the ice and your skin.

Sleep with your head raised about 30 degrees, so it stays above your heart. Most patients need only acetaminophen (Tylenol) for discomfort. Avoid the over-the-counter anti-inflammatory medicines we asked you to hold unless we have told you they are all right again. Take any prescribed medicines as directed.

> **If this disagrees with a sheet in your folder**
> Follow the instruction sheet you were given on the day of surgery. It is written for your operation and your date, and it takes priority over anything in this book.

A typical recovery calendar

A one-page version of this calendar, from day 1 through month 6, follows this chapter.

Day 1. The lids feel swollen and tight, and vision is often blurry. Vision is usually blurry through the first week after blepharoplasty and after ptosis surgery. This is a day for rest, icing, and a raised head. If you had surgery at a surgery center, you will usually be observed in recovery for about an hour before you go home. Have your driver, and have someone with you overnight.

Days 2 and 3. Swelling often gets worse before it gets better. That surprises people, and it is usually normal. After a lower blepharoplasty, blood-tinged tears are common for several days. Walk around the house, but do not bend, strain, or lift more than about 10 pounds. The icing schedule continues through the first week.

Week 1. Bruising changes color, from purple to green to yellow. Non-dissolvable stitches, if they were used, commonly come out at about one week, in a short office visit. Dissolvable stitches are left to fall out or be absorbed over the following weeks. If you live far away, I can often check in remotely with a photograph you send and a phone call. Sexual activity is typically all right at about nine days. Makeup and the rest of the usual "when can I" times are in the list below.

About 10 days to 3 weeks. Most upper-lid patients return to work in about a week. Lower-lid patients usually need about 10 days. Most people are ready for a restaurant or a social event at about three weeks. You are not fully healed yet—that takes months—but you will not frighten anyone. Clear your calendar of important photographs or events accordingly, and then add a little margin. About 75 percent of the swelling is often gone by two weeks, though every patient is different. Some people lose swelling quickly; for others it lingers and needs time. Human bodies are different. The last bits can take up to six months. Typical times for exercise, contact lenses, travel, and the rest of daily activity are in the list below.

Weeks 3 to 6, and after. Incisions are often at their reddest around six weeks, then fade. Eyelid shape and symmetry keep settling. Most of the swelling has settled by about three months, though the last bits can take up to six months. Numbness can take up to six months to fade. Incisions keep softening for up to a year. I tell patients not to judge the final appearance of an eyelid incision in the first weeks after surgery. How to protect incisions from the sun is in the wound-healing section later in this chapter.

When can I…?

These are typical times from the practice's current guides. Your own instructions may differ, especially if we have combined procedures or used a different incision. When in doubt, ask before you do the thing, not after.

ACTIVITY	TYPICAL TIMING
Ice, 20 minutes on / 20 minutes off	While awake, for the first week
Sleeping position	Head raised about 30 degrees, so it stays above your heart
Walking around the house	The first days are fine. Do not bend, strain, or lift more than about 10 pounds in those early days
Warm compresses, if comforting	After 72 hours
Shower (no spray on the face)	The next day is usually fine
Wash hair, drink alcohol	After 72 hours
Drive	When you are off sedating medicine and your vision is clear enough to be safe—not the day of surgery
Glasses	You may wear them right away. They are often more comfortable than contacts in the first week, when vision is usually blurry and ointment can blur it further
Sunglasses	Outdoors for 3 to 4 months after surgery, to protect healing incisions from UV; they also help with light sensitivity
Over-the-counter blood thinners (aspirin, ibuprofen, naproxen, and similar)	Typically held for two days after surgery, unless we have told you otherwise. If you take a prescribed blood thinner, resume it only as your prescribing doctor and I have directed
Desk work, for many upper-lid patients	About one week
Desk work, for many lower-lid patients	About 10 days
Sexual activity	Typically about nine days after surgery
Makeup, once cleared	Often after the one-week check
Contact lenses	Typically about two weeks, once cleared

ACTIVITY	TYPICAL TIMING
Gym, running, and other vigorous exercise; swimming, yoga, bending, and heavier lifting	Typically about two weeks, once cleared. In the early days, do not lift more than about 10 pounds
Tobacco (smoking, vaping, or any nicotine)	Do not use tobacco in any form for two weeks after surgery
Air travel	Ask us; many patients wait until after the first check, and longer after a more involved operation
Restaurant or social event	About three weeks. You are not fully healed yet—that takes months—but you will not frighten anyone
Important photographs or events	Give yourself more than the three-week social number, especially for a wedding or a portrait

Why no exercise or bending over?

Exercise, bending over, straining, and heavy lifting raise the blood pressure in the head and face, which can restart bleeding in the first days after surgery. Bleeding behind the eye (orbital hemorrhage) is rare but serious, because pressure can build and threaten vision. That is why these restrictions matter. Do not lift more than about 10 pounds in those early days, and wait until about two weeks, once you are cleared, before going back to the gym. If you have sudden, severe pain, a rapidly swelling and tense eyelid, or decreasing vision, call immediately, day or night.

What healing really looks like

Uneven is normal

Early on, one side often looks more swollen or bruised than the other. That is common and does not mean something is wrong; the two sides heal at different rates. It can take weeks, sometimes months, for things to even out.

This patient had eyelid surgery that included a ptosis repair.



Before (top), one week (middle), and four weeks (bottom). Early on can look dramatic; it improves with time. This patient had more bruising and swelling than average. Even so, it settled with time. Most patients bruise less than this.

Eyelid wound healing

When patients have eyelid surgery, they often want a calendar of what the incision itself will look like—not just how bruised or swollen they may be. This section is about the wound: the incision line, the way it changes color, the small bumps that can appear along it, and what is worth calling the office about. Healing is not the same in every patient. The timeline below is a typical pattern, not a promise.

Protect your incisions from the sun

Protect your eyelids with sunglasses outdoors for three to four months after surgery. Strong UV light impairs incision healing. This matters even more at high altitude, like Colorado, where UV is stronger. Sunscreen helps as well on any incision that is exposed. Living at altitude, or visiting the mountains in the first days after surgery, can also make swelling more noticeable than at sea level. If you have a trip to the high country planned, tell us so we can talk about timing.

Days 1 to 3. The first days are often the most uncomfortable, though many patients are surprised that the pain is manageable with the medications they were given. The eyelids may feel tight, heavy, or sticky with ointment. After a lower blepharoplasty, blood-tinged tears are common for several days. A little oozing from the incision can occur as well. This is a time for rest, the icing schedule above, and sleeping with the head elevated.

Week 1. Swelling is often still obvious, and bruising may be changing color. The incision may look pink, slightly raised, or crusted. If you have stitches that need to come out, that is commonly done now. Gentle cleaning should be the warm washcloth and ointment already described—not advice from a video or a well-meaning friend.

Weeks 2 to 6. Swelling and bruising follow the calendar earlier in this chapter; this section is about the incision itself. The line may actually look pinker or more noticeable around the middle of this period than it did at one week. That can be alarming if you are not expecting it, but it is a common part of the way skin incisions mature. They are often at their most red around six weeks, and then they begin to soften. Swelling may still come and go with sleep position, salty food, or a long day.

Three months, then six to twelve months. By about three months, most of the swelling has often settled, and the incision is usually flatter and lighter than it was at six weeks. The last bits of swelling can take up to six months, and by then the result is typically as settled as it will be. Some patients still notice a faint pink line, a little residual puffiness in the morning, or odd sensations as feeling returns. Incisions can continue to fade and soften for many months, even up to a year. A line that still caught the light at three months may be difficult to see later, especially when it was placed in the upper eyelid crease or close to the lower lashes. If a concern is still present at this stage, it is a fair time to review it and talk about whether anything further is worth considering.

Incision redness, and small bumps

The red or pink line of an incision is not a scar "gone wrong." It is the normal appearance of a healing cut. In the upper eyelid, that line is usually hidden in the crease. In the lower eyelid, when a skin incision is used, it is typically just under the lashes or near the outer corner. A transconjunctival incision, on the inside of the eyelid, has no skin scar on the outside. The color may last for weeks and, in some patients, looks most vivid around six weeks before it gradually fades. Avoiding sun exposure to the incisions helps; the note on protecting your incisions from the sun, earlier in this section, is the fuller reminder. Most patients find that, with time, these lines become very inconspicuous. Some may remain slightly visible, especially if the skin tends to mark. A true keloid on the eyelid is uncommon, but it is possible.

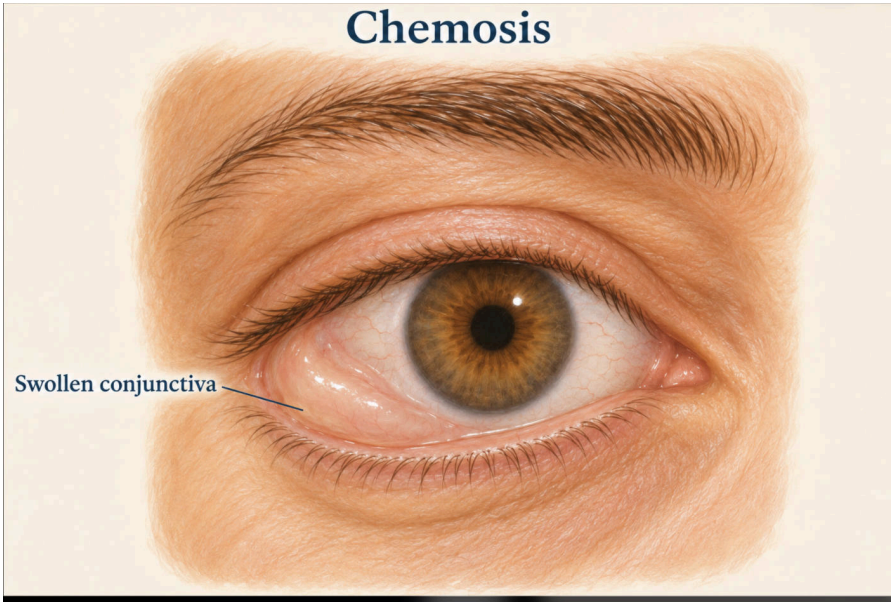
Some patients notice tiny white or yellowish bumps along the incision as it heals. These may be milia, or they may be small inclusion cysts or suture-line cysts, in which a bit of skin or a remnant of suture is trapped under the surface. They can look like whiteheads, and it is tempting to pick at them. I ask patients not to. These bumps often resolve on their own over weeks to months. If they persist, they can usually be managed in the office, sometimes by unroofing or excising

the small cyst. They are a nuisance, not typically a sign that the surgery has failed. Call the office if a bump becomes increasingly red, painful, or drains in a way that worries you, rather than trying to drain it yourself.

Chemosis, and a red patch on the white of the eye

After lower-lid surgery especially—and sometimes after upper-lid surgery as well—the clear membrane over the white of the eye can swell. That membrane, the conjunctiva, is continuous with the inside of the eyelid, which is why eyelid swelling can show up on the surface of the eye. It may look like a clear, jelly-like bulge, or it may have a reddish color. It can blur your vision and feel like something is in the eye. Sometimes the lid does not close fully because of it. This is usually a temporary part of healing, and it typically goes away as the rest of the swelling goes away.

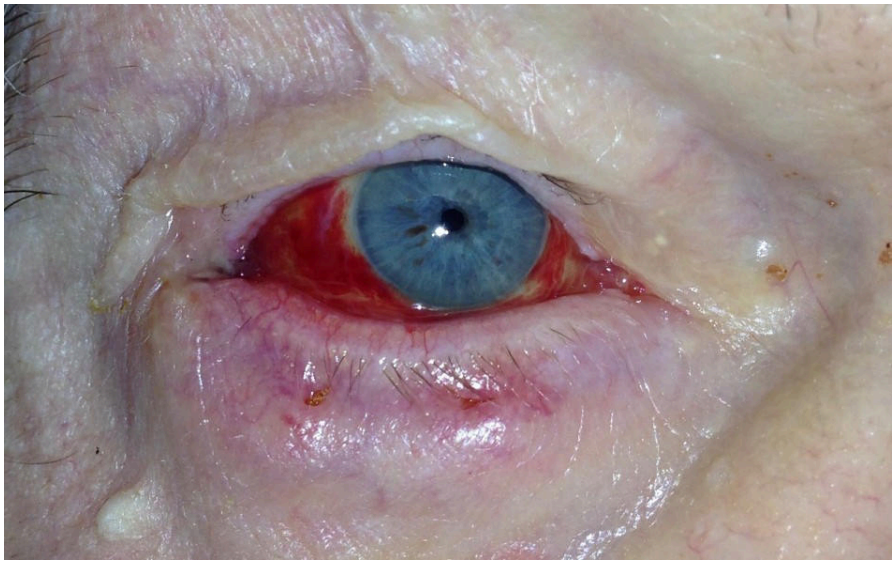
Cool compresses, a raised head, and lubricating drops or ointment as instructed are the usual first steps. In some patients I also use a steroid drop, ointment, or a short course of steroid pills. That is only when I prescribe them, after I have seen you. It is not something to start on your own. If we need a closer look, I can examine the surface of the eye at the slit lamp. Call us if the swelling is getting worse, or if it comes with vision loss, severe pain, or an eye that cannot close or feels very dry.



Chemosis: the clear covering of the white of the eye (the conjunctiva) swells with fluid.



Chemosis of the left eye after lower eyelid surgery: the white of the eye is swollen and reddish, and can look jelly-like. Bruising like this is also common and fades over a couple of weeks.



A red patch on the white of the eye (a subconjunctival hemorrhage) can look alarming. It is fairly common after eyelid surgery and usually clears over two to three weeks, like a bruise under a fingernail.

When to call, and when to go in

Most healing is uneventful, but it is important to know when not to wait. Call the office at **(720) 386-1989** if you have unusual or worsening pain, spreading redness, increasing swelling, excessive discharge, a fever of 101°F or higher, flu-like symptoms, or any vision change that is not simply blur from ointment. If a stitch comes loose, call or text us.

Call immediately, day or night

If you have sudden, severe pain, a sudden decrease in vision, or sudden bulging of the eye, call immediately. If you cannot reach us, go to the nearest emergency room. These can be signs of bleeding behind the eye, which is uncommon but can threaten vision.

A bump along the incision, a pink scar, or swelling that is slowly improving is usually not an emergency. When you are unsure, calling or texting us is a good choice. We would rather hear from you than have you worry at home.

One last piece of advice, which I will keep repeating because it is hard to follow: try not to study the incisions in a magnifying mirror every hour. It is hard not to look. It is also a reliable way to notice things that are still in the middle of healing.

A ONE-PAGE CALENDAR

A typical recovery at a glance

These are typical times from Chapter 9 and from the practice's current guides. Your own instructions may differ, especially if we have combined procedures. When in doubt, ask before you do the thing, not after. Follow the current post-operative sheet you were given if it and this page ever disagree.

DAY 1	The lids feel swollen and tight, and vision is often blurry. This is a day for rest, icing (20 minutes on and 20 minutes off, while you are awake), and a raised head. Have your driver, and have someone with you overnight.
DAYS 2–3	Swelling often gets worse before it gets better; that is usually normal. Chemosis (a jelly-like or reddish swelling of the white of the eye) can appear, especially after lower-lid surgery; Chapter 9 explains what to do. Blood-tinged tears are common for several days after lower-lid surgery. Walk around the house, but do not bend, strain, or lift more than about 10 pounds. Icing continues through the first week. After 72 hours, warm compresses, hair washing, and alcohol are usually all right, unless we have given you a different instruction.
WEEK 1	Vision is usually blurry through the first week after blepharoplasty and after ptosis surgery. Bruising changes color, from purple to green to yellow. Non-dissolvable stitches, if used, commonly come out at about one week. Makeup is usually all right once you are cleared at this visit. Sexual activity is typically all right at about nine days. Many upper-lid patients return to desk work at about one week; lower-lid patients usually need about 10 days. Chapter 9 has the fuller activity list.
WEEK 2	About 75 percent of the swelling is often gone by two weeks, though every patient is different, and the last bits can take up to six months. Gym, swimming, yoga, and contact lenses are typically all right at about two weeks, once you are cleared. Most people are ready for a restaurant or a social event at about three weeks. You are not fully healed yet—that takes months—but you will not frighten anyone.
MONTH 1	Eyelid shape and symmetry keep settling. Incisions may still be pink; they are often at their reddest around six weeks, then fade. Protect healing incisions from the sun with sunglasses outdoors for three to four months; this matters even more at high altitude. Do not judge the final appearance of an incision in these weeks.
MONTH 3	Most of the swelling has settled by about three months, though the last bits can take up to six months. Numbness can take up to six months to fade.
MONTH 6	The last bits of swelling are usually gone by about six months. This is typically your final result. Incisions keep softening for up to a year.

CHAPTER 10

If you are unhappy after surgery

Risks, in plain language

Most patients heal without a serious complication, but every surgery has risks. It's good to review them with every patient, not to frighten anyone out of a good operation, but so you know what to look for and when to call. A large part of my practice is treating problems after eyelid surgery done elsewhere. That work has made me more conservative, not less, in how I operate.

Expected bruising and swelling can look dramatic and can drift toward the cheeks or neck; they almost always clear. Other risks include bleeding, infection, scarring or small cysts along the incision, dryness of the eyes (often temporary, and usually improving over weeks to a few months), trouble closing the eyes, asymmetry, and, very rarely, loss of vision. Bleeding behind the eye is uncommon—it is often quoted at about 1 in 2,000 cosmetic eyelid cases—but it can threaten vision and needs treatment fast. That is why sudden severe pain, sudden vision loss, or a bulging eye is an emergency, day or night.

Aggressive surgery can result in complications. As I said in Chapter 1, removing too much skin or fat, or over-tightening the lids, can lead to trouble closing the eyes, a hollow look, or a lower lid that pulls down. Those problems are often harder to fix than doing a little more later. That is one reason I am conservative, and one reason the goal is a rested appearance rather than a different face.

Asymmetry is not, by itself, a failed operation. The two sides of a face start out different, they swell differently, and they settle differently. We aim for balance. Perfect symmetry is not possible, and I will not promise it.

A need for a touch-up is sometimes part of healing, especially after a ptosis repair. The Ptosis section explains that about 10 to 15 percent of ptosis repairs need a second procedure to fine-tune the lid height, and why a revision does not necessarily mean the surgery was done wrong.

The way to use this list is practical. Know the urgent signs in Chapter 9. Keep the office number where you can find it. And choose a surgeon who can take care of the eye if a problem appears, not only one who can show you a pretty photograph.

Most patients are happy once the swelling has settled. Some are not, or are not yet, and those weeks can feel very long. This chapter is about that period: what usually gets better on its own, when to wait, when to speak up, and when a revision is a reasonable conversation.

Give healing a chance

In the first two weeks, eyelids can look uneven, too tight, too puffy, or simply not like "you." The crease may sit oddly. A lid may not close as well as it will later. Friends may not be as reassuring as you hoped. I have learned that most patients who are unhappy in the first two weeks get a great deal of self-resolution of their problems within three months. The eyelids close better. The crease relaxes toward a more natural position. Mild retraction often improves. It would be largely unwise to perform an adjustment this early for something that is likely to get better on its own.

There are exceptions. If the eyelid retraction or the inability to close the eyes is severe enough to put the surface of the eye at risk, something may need to be done to protect the eye while it heals. That is one more reason to have had the surgery performed by someone who is watching the safety of the eye, not only the photograph. All in all, during this period, most dissatisfied patients improve without an intervention. Wait it out, as hard as that can be. In some cases it is necessary to wait six months, or a full year, for a problem to declare itself as either settled or still in need of attention.

Seeing yourself in 8K

After surgery, many people study their face far more closely than they did before. It is a little like looking at yourself in 8K, while the rest of the world still sees you in 1080. If the only people who notice something "off" are you and very close family—people who may be hesitant to contradict you—be aware that you may have turned up the magnification. That is common, and it does not mean you should keep the worry to yourself. Bring it to me. I will look at it carefully and tell you honestly what I see.

Go back and talk to your surgeon

If you are unhappy with your surgery, go back to your surgeon. That person is the most familiar with your anatomy, how your tissue reacts, and what happened during the operation. He or she will also usually know the best next steps. A few hints, from both sides of the desk:

Be specific. "I don't like that the eyelid crease is high" gives a surgeon something to work with. "I don't like how my eyelid looks" does not. Vague unhappiness is real, but it is hard to treat until it is named.

Be patient, and be fair. Your surgeon generally wants to help you and make you happy. Give him or her a chance to fix a problem, or to reassure you during the healing process. If something should be done, a responsible surgeon will usually say so. If nothing should be done yet, that is also a form of care.

A second opinion is allowed. There is no harm in getting one, and many surgeons will encourage it. Bring your records and your photographs if you can. A good second opinion is an examination, not a conversation about how badly the first surgeon must have done.

Revisions

A revision is sometimes the right next operation, and sometimes it is not. Asymmetry can be improved; perfect symmetry cannot be produced. A hollow from too much fat removal is harder, and may involve fat repositioning or transfer, or a frank conversation about what can and cannot be restored. A lid that will not close, or that has pulled down, is a more serious problem and should be treated as one.

I do a good deal of revision surgery, and I will tell you honestly if I think I can help, if I think time is still the better treatment, or if I think another operation is unlikely to get you where you want to go. I will also tell you if I think the original plan was the wrong operation—for example, a blepharoplasty when the real problem was ptosis or a low brow. That conversation is more useful than blame, and it is the one I would want if the eyelids were mine.

CHAPTER 11

Common questions and misconceptions

I have been asked these questions so many times that I can hear them before they are finished. Here are direct answers, with the usual caveat: your examination comes first, and your instruction sheet comes first if the two ever disagree.

Will I be awake?

For many upper blepharoplasties, yes—you can be awake in the office, with local anesthesia. You will feel the numbing injections and then pressure, not sharp pain. If you prefer to be sedated, or if the plan includes a lower blepharoplasty or a more involved combination, the surgery is done at a surgery center with anesthesia. You still need a driver either way.

How long does the surgery take?

An upper blepharoplasty is often about 30 to 45 minutes of operating time. Adding a lower lid, a ptosis repair, or a brow lift makes it longer. The day itself is longer than the operation: paperwork, numbing, a little time afterward. Ask us for a realistic window so the person driving you is not guessing.

How much pain is there?

Most patients are surprised that the pain is modest. Tightness, swelling, and irritation are more common complaints than sharp pain. Most people need only acetaminophen. Severe or worsening pain is not something to tough out; it is something to call about.

When will I look normal? When can I go back to work?

See Chapter 9 for the calendar and the activity list. The short version: many upper-lid patients return to work in about a week; lower-lid patients often need about 10 days. Most people are ready for a restaurant or a social event at about three weeks. You are not fully healed yet—that takes months, and the last bits of swelling can take up to six months—but you will not frighten anyone. If you have a wedding, a portrait, or a trip, give yourself more room than the earliest number in this paragraph, not less.

Will the scars show?

Upper-lid incisions are usually hidden in the crease. Lower-lid skin incisions sit just under the lashes or near the outer corner; a transconjunctival incision has no skin scar. Incisions are often pinkest around six weeks and then fade, sometimes for many months. Most patients find them very inconspicuous later. I cannot promise that a scar will be invisible. Chapter 9 goes over how the incision itself changes as it heals, and how to protect it from the sun.

Can I have just one side done?

Sometimes, if the problem is truly one-sided. Even then, the two sides of a face are not the same, and a previously hidden droop may become noticeable on the other side after a ptosis repair. The Ptosis section explains this (Hering's phenomenon). It may happen in some patients; it is not a complication.

Is this covered by insurance?

Only if the operation is being done for a functional reason and that specific surgery meets your plan's criteria. Cosmetic surgery is self-pay. Insurance plans generally don't cover surgery done to look less tired or to make makeup easier; coverage depends on whether the eyelids measurably block vision (an MRD of 2 millimeters or less). The short section after Chapter 3, When insurance may cover eyelid surgery, has the fuller explanation.

What about Botox, filler, or a laser instead?

Botox can help crow's feet and, in a limited way, the position of the brow. It will not remove extra skin or a bag of fat. UltraClear and other resurfacing can help the surface of the skin. Filler under the eyes is discussed in Chapter 4. None of these is a substitute for a well-indicated blepharoplasty.

Misconceptions I would like to retire

"Eyelid surgery is a minor procedure." It is common, and it is often done in a short visit. It is still surgery on the tissue that protects your eyes. Treat it that way.

"I should pick the cheapest surgeon, or the most expensive one." Price is a poor proxy for judgment. Compare training, experience with eyelids, and how you are treated, and then compare what a quote actually includes.

"Someone who does great Botox or a great facelift will automatically do a great eyelid." Not necessarily. Ask about eyelids specifically.

"I can go back to a hard workout, a flight, or a big event in a few days if I feel fine." Feeling better is not the same as being healed. Follow the activity timeline you were given, even if you are a fast healer in every other part of your life.

"If I still look puffy at two weeks, something is wrong." Often, nothing is wrong. Swelling is part of the process, and the last of it is slow.

"My eyelids will be perfectly symmetrical after surgery, a mirror image." They will not. Faces are naturally asymmetric—the brows, the bone, the skin, and even the position of the eyes. Surgery aims for balance and improvement, not identical sides. Small differences are normal. They were there before the operation, too.

"I should decide the day of the consultation." You should not feel pressured to. A good plan can wait a night, or a week, while you think.

Can I wear contacts? When can I wear makeup?

Leave contact lenses out until we clear you, often at about two weeks. Glasses are your friend in the first week anyway, because vision is usually blurry after blepharoplasty and after ptosis surgery, and ointment can blur it further. Makeup is usually all right once incisions are closed and you have been cleared at the first visit. Use new or carefully cleaned eye makeup; this is not the week to dig out an old tube of mascara. Typical times for these, and for the rest of daily activity, are in the list in Chapter 9.

What if I have a cold, or my period, or a big deadline?

If you are ill in the days before surgery, call or text us. Some illnesses mean we should postpone, both for your safety and for the way you will heal. A menstrual period is not, by itself, a reason to cancel. A major work deadline or a family event in the first two weeks is a reason to choose a different date, not a reason to tough out a recovery you cannot afford.

Will losing weight shrink my eyelid bags?

Usually not. The fat pads around the eyes are structural fat, not an energy store like the fat on the abdomen or the thighs. You do not reliably gain or lose that fat when you gain or lose weight, including after weight-loss surgery. The rest of the face can slim, and that can make the undereye area look more, not less, noticeable. If the bags bother you, the useful question is whether surgery is the right tool, not whether you have lost enough weight. See Chapter 2.

Will I have to have this done again?

Eyelid surgery does not stop time. I think of it as rewinding the clock. Results last about 10 years on average, but the aging process starts immediately—the day of the surgery. How quickly the lids change after that depends on you: your genetics, your sun exposure, your lifestyle, and how you take care of the skin. That is aging, not a failure of the first operation.

Most patients, even so, only have this surgery once. After the clock has been rewound, the lids often sit a little behind the rest of the face as the years go on. If a gap between the lids and the rest of the face is what drove the first visit, many people do not feel the need to chase that gap again once it is gone.

Some patients, later in life, do have a little more skin to address, or a brow that has dropped farther, or a ptosis that was not there before. A well-done blepharoplasty also should not be repeated casually; there is only so much skin one can safely remove.

Do you operate on patients who have had LASIK, or who have thyroid eye disease?

Sometimes, and sometimes not, and the answer depends on the examination. Prior LASIK or other corneal surgery can go along with a drier eye, which I want to know about before we operate. Thyroid eye disease has its own timing and its own risks; operating too early, or mistaking it for ordinary bags, is a way to make a patient worse. These are exactly the kinds of issues an eyelid specialist is trained to sort out.

A few more misconceptions I hear

"If I have it done now, I will never need eyelid surgery again."
Having a blepharoplasty does not stop the clock. Results last about 10 years on average, but the aging process starts immediately. Most patients choose to have this surgery once, but that is not the same as the eyelids remaining unchanged for the rest of a life.

"Most people have upper and lower surgery at the same time, so I should too." Many people do both, when both are indicated. "What most people do" is not a reason for you to do both. Your anatomy is the reason, or it isn't.

"My upper lids are heavy, so I just need skin removed." I look at three things separately: the skin fold, the height of the eyelid margin, and the position of the brow. Blepharoplasty treats excess skin. Ptosis repair raises the eyelid margin. A brow lift raises the brow.

"The more skin or fat you remove, the better the result." Taking too much upper eyelid skin can make it harder to close the eye comfortably. Taking too much lower eyelid fat can leave a hollow look. Depending on your anatomy, I may preserve or reposition fat.

"Lower eyelid surgery will erase my dark circles and bags." A fat bulge can cast a shadow that surgery may soften. Skin pigment, hollowing, and swelling over the cheek can also contribute to what you see, and each responds differently.

"I'll look like the person in your before-and-after photo." Photos can help us talk about what you like. Your starting brow position, skin, and natural asymmetry shape what's realistic for you. Some asymmetry can remain after surgery.

"It's scarless." An upper blepharoplasty incision usually sits in the natural lid crease, and the scar can take months to fade. Some lower eyelid procedures use an incision inside the lid, leaving no external skin scar from that incision.

"I will be back to normal in a couple of days." That is a recipe for disappointment. Bruising and swelling are usually much improved by about two weeks, not by two or three days. Do not schedule a wedding, a portrait, or a presentation for the week of surgery and hope you will be the exception.

"Once the bruising is gone, I'm seeing my final result." Looking presentable and being fully healed happen on different timelines. Bruising often improves substantially in the first couple of weeks, while swelling and incision appearance can keep changing for months.

"It's a small operation, so my dry eyes don't matter." Comfortable blinking and full eyelid closure matter. Surgery can worsen dryness, so I assess the ocular surface and how well the lids close before deciding how much correction is appropriate.

"Insurance always covers it if my lids feel heavy." Coverage depends on the plan's medical-necessity criteria. The examination comes first: an MRD of 2 millimeters or less, and the photographs that show it. I do visual field testing only when that MRD already qualifies. The short section after Chapter 3, When insurance may cover eyelid surgery, explains how this is documented.

"The antibiotic ointment got in my eye and my vision is blurry, so something is wrong." Vision is usually blurry for the first week after blepharoplasty and after ptosis surgery. Ointment in the eye can also make vision foggy until you blink it away or until the next time the ointment is used. That is expected. It is not the same as a sudden loss of vision, which you should call about immediately.

"Crusting in the morning means I have an infection." A little dried discharge on the lashes in the first days is common. Clean it gently with a warm wet washcloth, then put the ointment back on. Call us if there is spreading redness, worsening pain, thick discharge, or a fever, rather than assuming the worst—or ignoring a real warning sign.

CLOSING

Conclusion

Cosmetic eyelid surgery can be one of the most wonderful procedures for rejuvenating your look. I have made it my life's work: the precision, the way a careful change around the eyes can make someone look more like themselves, and the responsibility of operating so close to the eye.

There are a few important things you can do to increase the chances that you will be happy with it, and they are the same things this book has been about:

Learn the basics of the procedure, and of the procedure you actually need—blepharoplasty, ptosis repair, a brow lift, or something that is not surgery at all.

Pick the right surgeon, with training and judgment that match the operation, and with a willingness to protect the eye, not only to change a photograph.

Know what the procedure can and cannot do for you, and know what healing really looks like in the weeks before a result is ready to be judged.

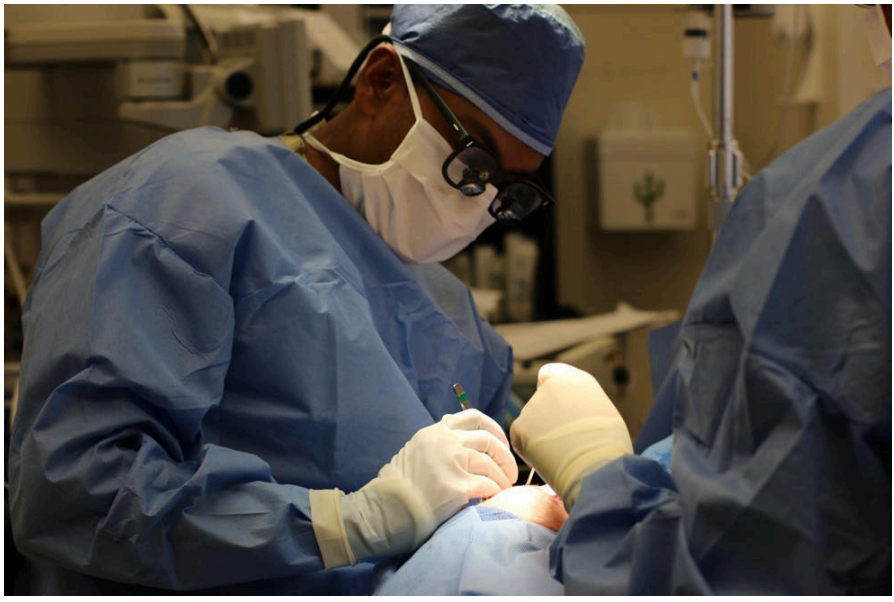
Prepare carefully, follow the current instructions you are given, and give recovery the time it asks for.

Patients are often extremely happy with their appearance once healing is complete. If we decide to operate together, I will be the same person you have met in these pages: careful with the plan, honest about what surgery can and cannot do, and present for the

healing as well as the operation. That is the kind of surgeon I would want for my own family, and it is the kind of surgeon I try to be. If you have questions, the office is at (720) 386-1989, and current information lives at denvereyelid.com. I would be glad to see you.

ABOUT THE AUTHOR

Christopher Thiagarajah, MD, FACS



Dr. Thiagarajah in the operating room. Oculofacial plastic surgery is his area of focus: the eyelids, the tear ducts, and the tissues around the eye.

Dr. Chris Thiagarajah is an oculofacial plastic surgeon and the founder of Denver Eyelid Specialists in Greenwood Village, Colorado. He is board-certified by the American Board of Ophthalmology and is a fellow of the American College of Surgeons. He is the only eyelid specialist in Colorado to have completed fellowships in both oculofacial plastic surgery and neuro-ophthalmology.

Oculofacial plastic surgery is a specialty involving the face with particular regard to the eyelids, tear ducts, and eye sockets. His surgical work includes complex eyelid, tear-duct, and eye-socket operations along with cosmetic surgery of the eyelids, with a high regard for safety.

Dr. Thiagarajah attended medical school and residency at Howard University in Washington, DC, and completed fellowships in Denver and Cincinnati. Before practicing in Colorado, he was at Georgetown University in Washington, DC, where he taught ophthalmology, ENT, and plastic surgery residents in the techniques of cosmetic eyelid surgery.

He sees patients and operates at the offices below.

Denver Eyelid Specialists (surgery and clinic)
8301 E Prentice Ave, Suite 403
Greenwood Village, CO 80111

Vail Valley — Vail Vision
1140 Edwards Village Blvd, Suite B-206
Edwards, CO 81632

Scottsbluff, Nebraska — Oregon Trail Eye
329 W 40th St
Scottsbluff, NE 69361

Call or text **(720) 386-1989**

denvereyelid.com

Current practice information and visiting-clinic details are in the pages that follow.

HOW TO SEE ME

Where I see patients, and how to book

Denver Eyelid Specialists is based in Greenwood Village, just south of Denver. I also see patients, on a visiting schedule, in the Vail valley and in western Nebraska. Current hours and any schedule changes live at **denvereyelid.com**.

Greenwood Village, Colorado — main office

Denver Eyelid Specialists
8301 E Prentice Ave, Suite 403
Greenwood Village, CO 80111

Vail, Colorado — quarterly clinic

Vail Vision
1140 Edwards Village Blvd, Suite B-206
Edwards, CO 81632
I go to Vail roughly once a quarter. Many Vail patients are seen in consultation there and have surgery in Greenwood Village; some post-operative visits can be arranged in Vail.

Scottsbluff, Nebraska — with Oregon Trail Eye

Oregon Trail Eye
329 W 40th St
Scottsbluff, NE 69361
I see patients at this partner clinic for consultations and eyelid care, so that people in western Nebraska do not always have to travel to Denver first.

To make an appointment

Call or text the office at **(720) 386-1989**, or visit **www.denvereyelid.com**.



https://www.denvereyelid.com/

Scan the code, or type the address, to open the practice website. Current hours, locations, and how to get in touch live there.

REFERENCE

A few words defined

Patients are often asked to absorb a lot of new language in a short visit. These are the terms I use most often in this book and in the office, in plain English. They are not a complete medical dictionary, and a word can mean something more precise in a chart than it does here.

Blepharoplasty. Surgery to reshape the eyelids, most often by removing or redraping extra skin and addressing fat. Upper and lower blepharoplasty are different operations.

Dermatochalasis. Extra skin of the eyelid. This is what an upper blepharoplasty is designed to address. It is not the same thing as ptosis.

Ptosis. Drooping of the eyelid itself, so the lid margin sits too low on the eye. The usual repair tightens or reattaches the muscle (or tendon) that opens the eye. Removing skin will not lift a ptotic lid.

Brow ptosis. A brow that has dropped with time. It can make the upper lids look heavier than the eyelid skin alone would suggest, and it is treated with a brow lift, not with a blepharoplasty alone.

Tear trough. The hollow at the junction of the lower eyelid and the cheek. Some patients are bothered more by this shadow than by a bag.

Transconjunctival. An approach to the lower eyelid from the inside, through the pink tissue on the back of the lid, so there is no skin incision on the outside.

Fat repositioning (transposition). Moving a patient's own eyelid fat, still attached to its blood supply, into a hollow such as the tear trough, rather than simply removing it.

Fat transfer (fat grafting). Taking a small amount of the patient's own fat from another part of the body—typically the abdomen, flanks, or thighs—and placing it where volume is thin. In my practice this is done under general anesthesia.

Chemosis. Swelling of the clear membrane over the white of the eye. It is more common after lower-lid surgery, can follow upper-lid surgery as well, may look clear or reddish, and is usually temporary.

Subconjunctival hemorrhage. A red patch on the white of the eye, like a bruise. It can look dramatic and usually clears over a couple of weeks.

Milia, inclusion cysts, suture-line cysts. Small bumps that can appear along a healing incision. They often go away on their own; they should not be picked at.

Hering's phenomenon. After one drooping lid is lifted, a droop that was hidden on the other side may become noticeable in some patients. It is not a surgical mistake and it is not a complication. It may happen in some patients.

MRD_1. The marginal reflex distance: the distance from the center of the pupil's light reflex to the upper lid margin. When extra skin hangs over the lid, it can make the lid look lower than it really is (a pseudo-MRD_1); the true MRD_1 is measured to the actual lid margin. The 2-millimeter threshold used for blepharoplasty coverage is explained in When insurance may cover eyelid surgery, after Chapter 3.

Functional versus cosmetic. A functional operation is being done because the eyelid is interfering with vision or with the health of the eye, and it may be considered by insurance if surgery-specific criteria are met. A cosmetic operation is being done to change appearance and is self-pay. See When insurance may cover eyelid surgery, after Chapter 3.

Oculoplastic (oculofacial) surgeon. A surgeon with specialty training in the eyelids, tear ducts, and eye sockets, usually after an ophthalmology residency and an ASOPRS fellowship. That is my training, and it is the background I would look for if I were the patient.

A PAGE FOR YOU

Notes for your consultation

A consultation goes better when you have already named, in your own words, what bothers you and what you want to ask. These pages are for that. They are not a medical form, and they are not a substitute for the current instruction sheets at denvereyelid.com. They are simply a place to think before you sit down in the exam room.

What bothers me about my eyelids

Write in your own words. "I look tired," "my lid sits on the lashes," "this bag bothers me in photos," and "I have to raise my brows to see" are all useful kinds of answers.

What I hope will change—and what I do not want

Be honest about the look you do not want as well as the one you do: pulled, hollow, surprised, or simply "not like me."

My questions

You might ask about setting (office or surgery center), fat versus skin versus brow versus ptosis, insurance criteria, medication holds, and recovery around a date you cannot move.

A PAGE FOR YOU

After the consultation

If you have already had the visit, use this page while the conversation is fresh. If something is unclear, call or text the office and ask. It is much easier to sort out a question now than the week before surgery.

The plan we discussed

Upper, lower, ptosis, brow, filler, UltraClear, or a combination? In the office or at a surgery center?

Recovery and dates I need to protect

Work, travel, events, and who will drive you home.

Medicines and habits I need to ask about

Aspirin, Plavix, other blood thinners, GLP-1 medicines, SGLT2 medicines, supplements, smoking or vaping.

Current instruction forms: **denvereyelid.com/surgery-forms** · Office: (720) 386-1989

A PAGE FOR YOU

More notes

Use these pages for whatever you do not want to leave to memory: a name, a date, a question you thought of in the car, a medicine you need to mention.

A PAGE FOR YOU

More notes

RESOURCES

Current forms and instructions

Medication holds, recovery instructions, and office policies can change. The sheets in this book's first edition went out of date, and a printed chapter would go out of date again. For that reason, the current pre-operative, post-operative, and related surgery forms live online, not in these pages.



denvereyelid.com/surgery-forms

Scan the code, or type the address above, for the current instruction forms. Consent forms are also available at denvereyelid.com/consent-forms. If a link ever moves, start at **denvereyelid.com** or call the office at (720) 386-1989, and we will point you to the right page.

If you are having surgery with another practice, use the forms and instructions that practice gives you. Their protocols may differ from mine, and you should follow the surgeon who is actually operating.

A PATIENT'S GUIDE

Cosmetic eyelid surgery can be one of the most wonderful operations for the face—if you understand what it can and cannot do, and you choose the right surgeon.

People come in because they look tired when they are not. Friends ask if they are angry or sad. Sometimes extra skin is sitting on the lashes. This book is the conversation I wish every patient could have before they decide.

It explains the difference between extra skin, a drooping lid, and a low brow; when upper eyelid surgery can be done in the office while you are awake; how we treat fat in the lower lid; what recovery actually looks like; and how to prepare, including which medicines to hold.

I wrote it to be clear, honest, and practical—the way I talk in the office. It is a handbook, not a sales brochure.

Christopher Thiagarajah, MD, FACS

Dr. Thiagarajah is a board-certified oculofacial plastic surgeon and the founder of Denver Eyelid Specialists in Greenwood Village, Colorado. He is the only eyelid specialist in Colorado to have completed fellowships in both oculofacial plastic surgery and neuro-ophthalmology.

Denver Eyelid Specialists
Greenwood Village, Colorado
denvereyelid.com