viable cells. Based on our findings, significantly and severely crushed grafts may have heterogeneous regions of cell viability, and thus variable graft survival owing to focal areas of cell death, which may lead to unanticipated contour irregularities. By extension, slightly crushed grafts will have more uniform tissue survival and appearance.

This study was limited by its small sample size and inability to address long-term chondrocyte viability, which is technically challenging to perform with tissue explants. At our institution and in our local area, most surgeons do not perform submucous resection (SMR) in septoplasty surgery and are equally conservative in rhinoplasty operations. Large SMR specimens are also more difficult to obtain, and hence additional specimens for study are difficult to acquire.

Our results support the findings of Cakmak and Buyuklu and Cakmak et al that aggressive morselization reduces chondrocyte viability, although we believe their results likely underestimate the degree of chondrocyte injury. With the Cottle crusher method, there is a tradeoff between crushing cartilage to a clinically useful pliability and maintaining chondrocyte viability in the graft. Thus, the degree and intensity of morselization need to be thoughtfully considered. Other approaches besides the Cottle method may produce the same mechanical changes in cartilage with less graft injury. We advocate performing the least aggressive morselization of cartilage necessary to achieve the desired cosmetic outcome based on our results and experience.

In conclusion, crushed cartilage grafts are often used to soften transitions, conceal irregularities, and fill defects. Increasing the intensity of morselization using the Cottle method results in increased chondrocyte death. Nonviable cells appeared to group in clusters, and these clusters increase with the severity of crushing. Aggressive crushing of cartilage grafts should be avoided because it causes significant chondrocyte cell death and clinically unpredictable grafts. Slight to moderate crushing of cartilage likely results in the most functional and reliable graft.

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**Combined Transconjunctival Release and Midface-lift for Postblepharoplasty Ectropion Repair**

Ectropion associated with blepharoplasty is a clinical challenge for even the most experienced surgeon. The etiology of postblepharoplasty ectropion is multifactorial, and the need for a thorough preoperative blepharoplasty analysis, including checking lower eyelid laxity with a snap test, is critical and can alert the surgeon to the need for an adjunctive procedure at the time of blepharoplasty. Even with a complete preoperative analysis in the most experienced surgeon’s hands, postoperative ectropion may occur, necessitating correction.

There is a relative paucity of grading scales for assessing ectropion. One grading scale, described by Moe and Linder, quantitatively grades ectropion using a numerical scale, simplifying the ability to analyze the effectiveness of a correction technique (see the scale in the “Methods” section).

Postblepharoplasty ectropion is most commonly due to scarring and contracture of the middle lamella, resulting in eyelid retraction and/or aggressive skin excision techniques, and resulting in anterior lamellar deficiency. This often occurs in the absence of preoperative lateral canthal tendon laxity.

Repair of postblepharoplasty ectropion includes many techniques: lateral tarsal strip procedures, lateral canthal repositioning/suspension procedures, skin grafts, spacer grafts, volume augmentation of the lower eyelid, full-thickness lower eyelid excision techniques, and midface-lifting techniques. The lateral tarsal strip procedure was a major advance in the repair of ectropion, but it has drawbacks, including phimosis, trichiasis, ectropion recurrence, lateral canthal rounding, and exophthalmos caused by overcorrection. This led to lateral canthal tendon repositioning and suspension procedures that avoided many of the drawbacks to the lateral tarsal strip procedures. Lateral canthal procedures still have a significant risk of failure with postblepharoplasty ectropion because most of these patients have some degree of middle lamellar scarring with retraction and...
posterolateral subperiosteal transtemporal endoscopic midface-lift to correct anterior lamellar deficiency in postblepharoplasty ectropion repair. We use preoperative and postoperative digital photography analysis and an objective ectropion grading scale.

Methods. We performed retrospective case series review at a tertiary care academic practice (by the senior author [A.A.J.] of 13 consecutive female patients, having had their primary procedure performed by another surgeon, with postblepharoplasty ectropion without lateral canthal tendon laxity undergoing a transconjunctival scar release combined with an extended centerolateral subperiosteal transtemporal endoscopic midface-lift between March 2003 and July 2008. The ectropion was graded according to an ectropion grading scale adapted from a previously developed grading scale by Moe and Linder:¹

0, Normal eyelid appearance and function
1, Normal appearance but symptomatic; eyelid laxity present on examination
2, Scleral show without eversion of lower eyelid
3, Ectropion without eversion of lacrimal punctum
4, Advanced ectropion with eversion of lacrimal punctum from lacrimal lake
5, Ectropion with complication (eg, conjunctival metaplasia, retraction of anterior lamella, or stenosis of lacrimal system)

Statistical analysis was performed using a paired t test, assuming unequal variance to determine the significance of the preoperative and postoperative measurements.

The surgical procedure is as follows: One-half of a cubic centimeter of lidocaine hydrochloride, 1%, with 1:100,000 epinephrine bitartrate mixed in equal parts with bupivacaine hydrochloride, 0.25%, was injected into the fornix. A Colorado tip microbovie was used to make an incision through the conjunctiva approximately 1 cm from the fornix. A scleral protector was used to protect the eye, and an eyelid retractor was used to retract the eyelid downward. Cicatricial release of the lower eyelid was performed with blunt dissection to the level of the orbital rim, after which the subperiosteal plane is entered, and dissection was continued over the maxilla and zygoma.

Next, the midface dissection was performed as described by Quatela and Jacono.⁶ The midface was suspended at the periosteum anterior to the temporal branch of the facial nerve and just lateral to the zygomaticofacial nerve, with a 0 vicryl suture. Two more 0 vicryl suspension sutures were placed, one just above the Pata-
Figure 1. Views of a patient who underwent a transtemporal midface-lift with transconjunctival scar release. A, Preoperative view; B, postoperative view. She had previously undergone blepharoplasty, 3 lateral tarsal strip procedures, and a spacer graft performed by an outside surgeon.

Figure 2. Views of a patient who underwent a transtemporal midface-lift with transconjunctival scar release. A, Preoperative view; B, postoperative view. She had previously undergone blepharoplasty by an outside surgeon.

tropion preoperatively and planning surgery accordingly will facilitate optimal outcomes. We believe that a combined transconjunctival scar release combined with a transtemporal extended subperiosteal midface-lift is an excellent procedure in the armamentarium of postblepharoplasty ectropion repair.

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COMMENTS AND OPINIONS

A Reference Section Update for “Orbicularis Suspension Flap and Its Effect on Lower Eyelid Position”

Our recent article titled “Orbicularis Suspension Flap and Its Effect on Lower Eyelid Position: A Digital Image Analysis”1 had an inadvertent omission in the “References” section. Early in the senior author’s (D.B.R.) surgical training, Norman J. Pastorek, MD, introduced the orbicularis muscle suspension technique in lower lid blepharoplasty and instructed him in the development of such an approach. In addition, Dr Pastorek has published book chapters and peer-reviewed articles describing his well-known lower-eyelid suspension technique.2,3 We wish to credit him with his contribution to our community.

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