

**Abstract from Minimally Invasive Lateral Canthopexy (MILC)
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Inherent laxity of the lower eyelid can result in lower eyelid malposition following a lower eyelid blepharoplasty. This can be avoided by a lateral canthopexy technique which involves securing a suspension suture from the lower eyelid to the periosteum canthopexy of the lateral orbital rim at the level of the superior libmus. Techniques vary in the way in which the lateral retinaculum is captured. Jelks et al. described the inferior retinacular lateral canthopexy in which the lateral retinaculum is dissected from above through an upper blepharoplasty incision. Some place a double-armed suture through the lateral retinacular from the lateral extension of a lower blepharoplasty incision and then pass the suture into the upper blepharoplasty dissection, while others advocate canthopexy entirely through the lower lid dissection after skin/muscle flap elevation. Common to all these techniques is careful identification of the lateral retinaculum for suture placement.

The minimally invasive lateral canthopexy (MILC) described by Eisemann is a modification of the Hamra transcanthal canthopexy. In his modification, a C-1 double armed curved 5-0 Prolene suture is passed through at the site of a #18 gauge needle hole placed through the lateral retinaculum and sutured to the lateral orbital wall periosteum.

It is minimally invasive technique that is simple to perform, especially in the hands of a novice blepharoplasty surgeon. An advantage of this technique is absolute assurance of capturing the lateral canthal tendon. Extensive dissection to identify the tendon is not required which limits operative time and postoperative edema. Furthermore, recreation of the lateral retinaculum and canthal angle as in lateral central reconstruction with cantholysis is obviated. In our series of 26 patients, results have been excellent with no complications.