

# The Management of Festoons

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## KEYWORDS

- Festoons • Oculoplasty • Facial aging • Tired eyes • Aesthetic surgery • Midface aging
- Surgical procedures

## KEY POINTS

- The orbicularis retaining ligament (ORL) is the structure responsible for defining the palpebromalar groove and is a key structure in the appearance of aging of the midface.
- A major anatomic basis for the appearance of festoons seems to be the downward descent of tissues superior to a lax ORL and orbicularis muscle against the resistance of the stronger lower border, effectively creating a surface trough.
- The focus of treating festoons involves addressing the laxity of the ORL along with redistribution of muscle, skin, and fat within the lid-cheek junction to re-establish a smooth and youthful contour.
- Historically, surgical technique addressed maximizing excision of the skin-muscle responsible for the visible appearance of the festoons; currently, surgical approaches involve direct excision of the affected tissue or indirect redraping of the affected soft tissue.

## INTRODUCTION

Aging of the midface and lower lid complex can be evident even in the late 30s, making this one of the earliest detectable areas of facial aging and frequently requested sites for surgical rejuvenation.<sup>1</sup> When present, malar festoons can complicate successful rejuvenation because they present a difficult problem to treat. Festoons occur when portions of the orbicularis oculi muscle attenuate, thereby undergoing a progressive course of sagging muscle that becomes visible to even the most casual observer.<sup>2,3</sup> Beyond aesthetic concerns, severe festoons can cause visual field obscuration on downgaze, leading to difficulty with near-vision tasks.<sup>4</sup> Although typically seen and referred to in the lower eyelid, because the orbicularis oculi encircles the eye, festoons can

occur in the upper or lower eyelid. Because upper eyelid festooning is uncommon and the emphasis in the literature is on lower eyelid festoons, the latter are the focus of this article.

Although a genetic basis for the etiology of festoon formation is suspected, the precise reason why some individuals are susceptible to this condition whereas others are not is largely unknown. When present, festoons can impart the appearance of being excessively tired and when more severe can be deforming, resulting in issues of self-confidence. Every effort should, therefore, be made to improve the appearance of patients with this condition to enhance self-image and social well-being. Limitations in surgical correction are, however, a genuine challenge confounded by their unclear cause.

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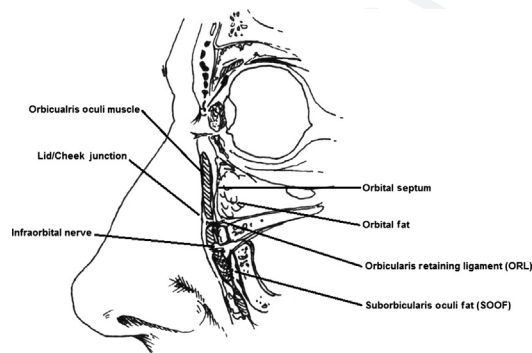
## ANATOMY

The midface is a complex anatomic area that separates the orbital cavity from the oral cavity.<sup>5-8</sup> It is often defined as the area of the cheek medial to a line extending from the frontal zygoma to the oral commissure and the medial border defined by a line extending from the medial canthus to the nasolabial fold. The midcheek is composed of 2 functionally distinct parts<sup>7</sup>:

1. The prezygomatic part that overlies the mid-cheek skeleton
2. The infrazygomatic part that covers the vestibule of the oral cavity

The prezygomatic area can be considered a transition zone where the skeletal attachments of the lower lid, including the ORL, are attached to the upper border of maxillary bone. The ORL (or malar septum) is the structure responsible for defining the palpebromalar groove; the junction between the preseptal portion of the lower lid and the cheek and is a key structure in the appearance of aging of the midface (Fig. 1).<sup>9,10</sup> The ligament acts as a functional and structural barrier defining the lower extent of several clinical entities, including malar mounds, malar edema, periorbital ecchymosis, and malar festoons.<sup>10</sup>

Patients presenting for periorbital rejuvenation commonly complain of eyelid bags with a resulting tired look. The anatomic basis of eyelid bags is multifactorial, where orbital fat prolapse, eyelid fluid, tear trough depression, loss of skin elasticity, orbicularis prominence, and malar mounds and festoons can each contribute to their development.<sup>11</sup> Correct diagnosis of the cause of eyelid bags is, therefore, critical when addressing this



**Fig. 1.** Cross-sectional anatomy of the lower eyelid with graphical representation of the orbital septum, suborbicularis oculi fat (SOOF), and ORL (or malar septum). The ORL extends from the periosteum deep to the skin superficially, is responsible for defining the palpebromalar groove, and is critical in the characteristic appearance of the aged lower eyelid.

problem, with festoons one possible unique clinical entity among the possible causes.

A major anatomic basis for the appearance of festoons seems to be the downward descent of the tissues superior to a lax ORL and orbicularis muscle against the resistance of the stronger lower border, effectively creating a surface trough (Fig. 2).<sup>2,3,8,10</sup> The festoon phenomenon can affect any part of the upper or lower eyelid, with 5 distinct type of festoons described. They are divided by the level of the orbicularis that they affect (Figs. 3-5):

1. Upper eyelid
2. Pretarsal
3. Preseptal
4. Orbital
5. Malar

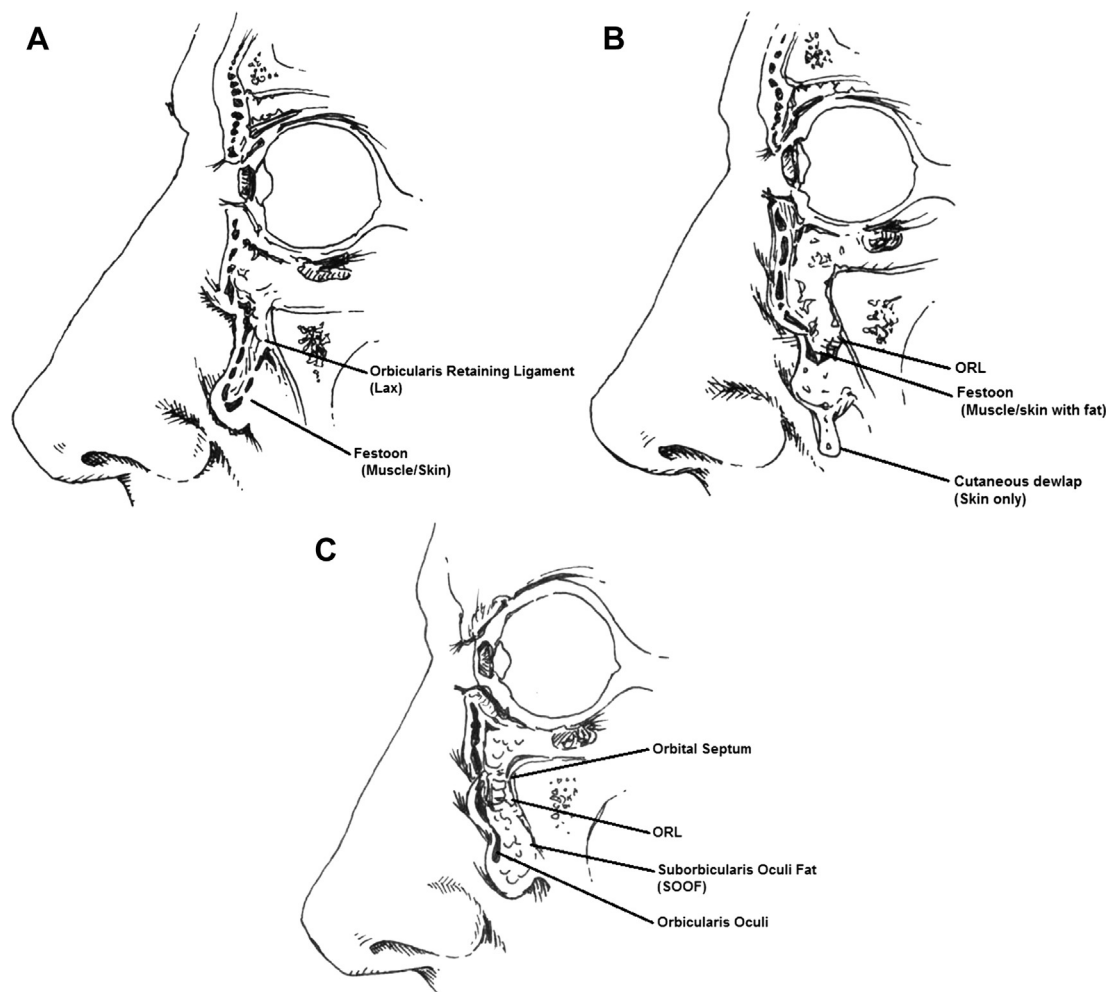
The outward appearance of this process can differ among individuals and can range from the sagging of individual levels in a cascade of festoons with overlapping folds to the coalescence of layers together, sagging into a single festoon.<sup>3</sup> When present in the malar region, a festoon is defined superiorly by the ORL over the previously described prezygomatic area and inferiorly by the stout zygomatico-cutaneous ligament, which is considerably stronger than the ORL.<sup>8</sup> The ORL is also important because it is the inferior boundary of the inferior orbital fat compartment and provides an area of fixation against which the prolapse of fat can lead to the appearance of eyelid bags and be confused with malar festoons.<sup>5,9-11</sup>

The focus of treating festoons involves addressing the laxity of the ORL along with redistribution of muscle, skin, and fat within the lid-cheek junction to re-establish a smooth and youthful contour.

## EVALUATION

Prior to surgical intervention, a full examination of the periorbital and malar contents and anatomy should be performed. Patients should be evaluated with the head in neutral position, while they are either standing or sitting upright in good lighting. Examination should occur initially with the eyes at neutral gaze followed by upward and downward gaze to evaluate for any vision obstruction.<sup>4</sup>

During evaluation, as well as preoperative marking, the surgeon should manipulate the periorbital skin with fingers or forceps. This allows for proper diagnosis as to the level of orbicularis affected and the amount of tension in the skin. Pinching the festoon (the pinch test) allows a surgeon to judge the composition of the festoon (skin muscle or skin only) (see Fig. 2). A lower lid snap test should be performed as well to assure

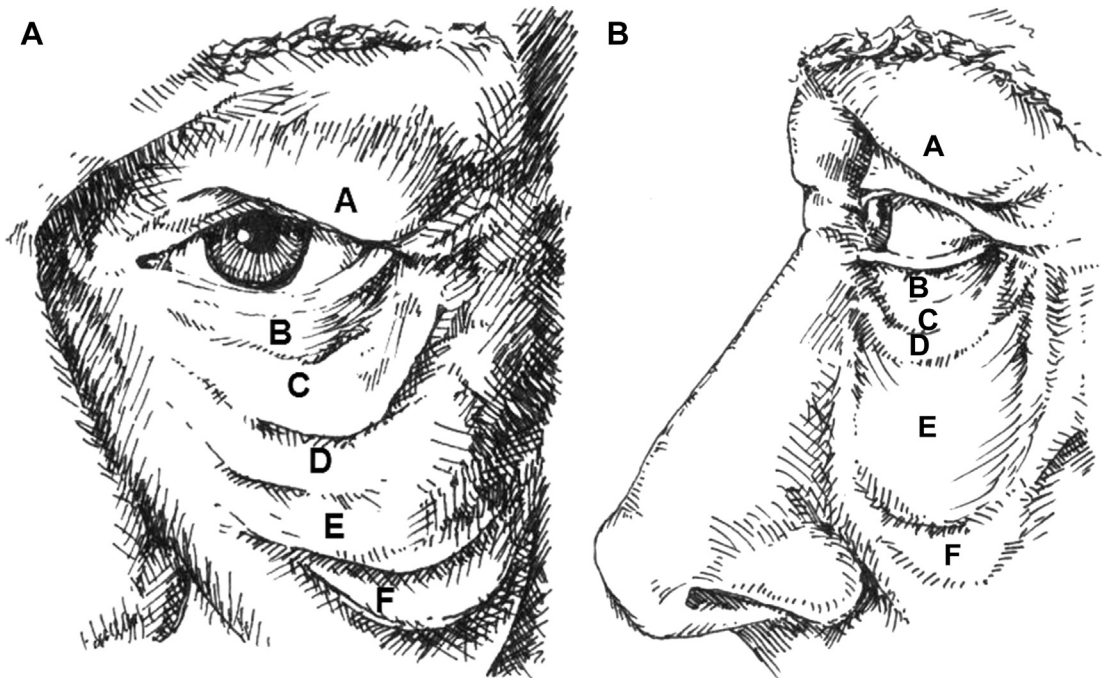


**Fig. 2.** Graphical representation of the pathologic features and different anatomic variations of lower lid festoons. (A) Pure muscle-skin festoon: muscles have gravitated away from orbital septum due to lax skin and muscle creating a simple fold due to descent over the rigid ORL. (B) Muscle-skin festoon with orbital fat and cutaneous dewlap: the orbital septum has sagged into a skin-muscle festoon forming the lining of a pouch. A cutaneous dewlap (skin only) then sags beyond the muscle edge over the ORL. (C) Muscle-skin festoon with suborbicularis oculi fat (SOOF) sagging beyond the edge of the sagging orbicularis muscle over the ORL.

the integrity of the tarsoligamentous complex to determine if a canthoplasty is required. Finally, patients should also be instructed to squinch (the squinch test [ie, tightening and lifting the lower lid]) to determine the integrity of the orbicularis muscle and its relationship to the underlying orbital and suborbicularis fat as well as the laxity of the orbital septum. In cases of lax septum, orbital fat can be seen protruding anteriorly into a separate septal pouch. In these cases, a squinching motion causes orbicularis contraction, which elevates and compresses the fat back into the orbit. It can, therefore, be appreciated how correction of festoons will improve the lower eyelid, whereas correction of the lower eyelid alone will not correct the festoon.

## SURGICAL PROCEDURE

Currently there is no standard treatment of effective management of malar festoons, a fact that reflects the difficulty and dissatisfaction with repair. Nonsurgical options, including radiofrequency thermoplasty, carbon dioxide laser resurfacing, trichloroacetic acid peels, and the use of dermal fillers, have been reported, all with mixed results.<sup>4,12</sup> Historically, operations were designed with the intent of maximizing excision of the skin-muscle responsible for the visible appearance of the festoons.<sup>2,3,13,14</sup> Currently, surgical approaches can be divided into techniques involving direct excision of the affected tissue<sup>2,3,13,14</sup> versus indirect redraping of the affected soft tissue.<sup>4,15-18</sup>



**Fig. 3.** Classification scheme of orbicularis oculi festoons based on the site and composition of the defect. (A, B) Sites of festoons: A, upper lid; B, pretarsal; C, preseptal; D, orbital; E, malar; and F, cutaneous dewlap (no muscle).

These indirect redraping techniques have in common limited skin excision and aggressive tightening as opposed to excision of the lax orbicularis muscle to optimize results with variations on those themes reported.<sup>4,15-18</sup>

### **Direct Excision**

Excisional correction procedures have historically been used as a means of festoon correction as a result of the belief that the sagging of muscle resulted in excess muscle and skin that require removal for treatment.

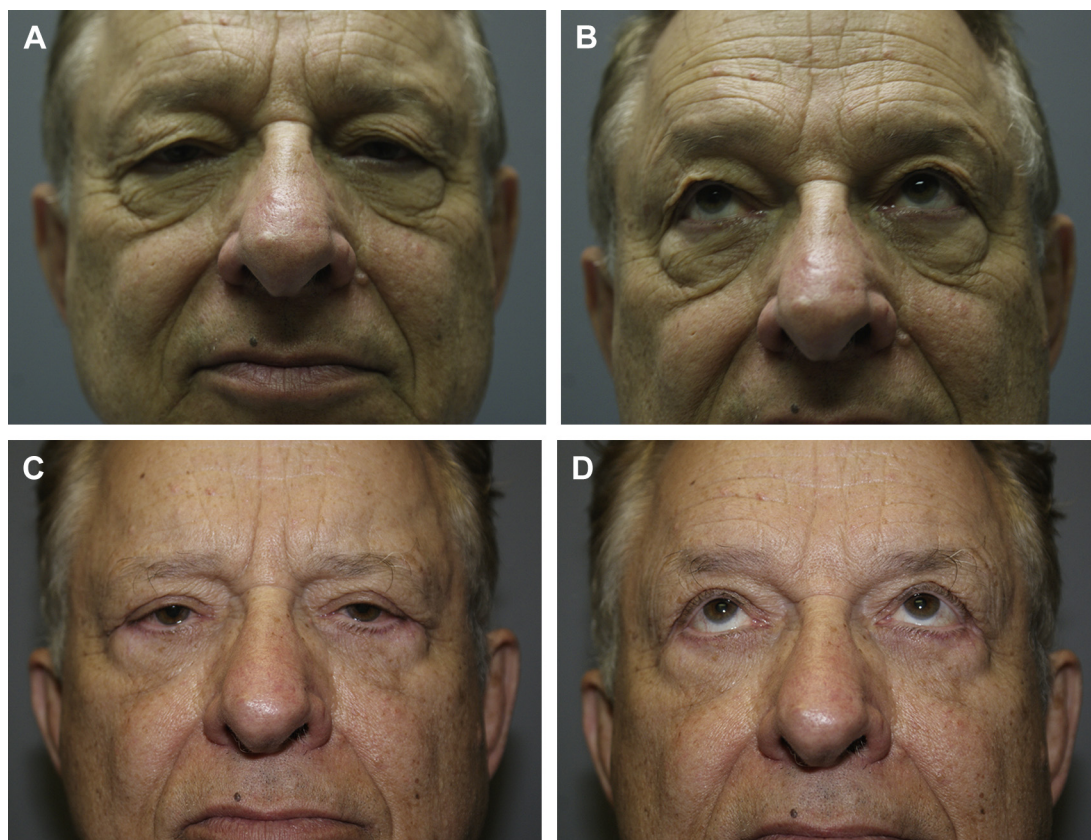
- The procedure begins with a subciliary incision 2 to 3 mm below the lid line followed by creation of a split-level flap consisting of a skin-only flap laterally and a skin-muscle flap medially.
- The lateral skin-only flap is dissected from the orbicularis muscle until the pretarsal orbicularis is reached wherein elevation of the skin-muscle flap is begun using blunt dissection and proceeding downward with wide exposure of the orbital septum. Any identified excess fat is excised off the flaps during this dissection.
- Excision of a portion of the orbicularis muscle is then planned and designed to be perpendicular to the direction of the muscle fibers.

- The muscle is gathered and folded along the proposed myomectomy axis and the optimal pattern (rectangle, trapezoid, triangle, and so forth) is chosen for the myomectomy and marked.
- The muscle is excised layer by layer until only a thin layer of muscle fibers and posterior fascia remains. The remaining muscle and fascia act as a protective layer for the underlying facial nerve branches.
- The cut edges of the orbicularis muscle are then joined with simple and horizontal mattress sutures and the upper border of the orbicularis is anchored to the periosteum or deep fascia of the lateral canthus.
- Excess skin is excised next in the form of a wedge resection guided by the initial skin markings.
- A trial suture is placed subcutaneously to close the skin wedge, and the tautness of the lid and level of the lid margin are adjusted as necessary.
- The lateral wedge is resected and closure is completed with fine absorbable suture.

### **Indirect Redraping**

More recent recognition of the effect that gravitational migration has on the formation of festoons and midface descent has resulted in a paradigm





**Fig. 4.** Orbitomalar festoons composed purely of muscle and skin, corrected by extensive subperiosteal dissection, with obliteration of the ORL followed by aggressive tightening of the orbicularis muscle and limited skin excision (see Fig. 5 for operative views). (A, B) Preoperative appearance of patient. (C, D) Postoperative result.

shift that has focused more on enhancing lower lid–cheek shape and contour rather than simple elevation and tissue removal.<sup>4,15–18</sup> Where segmental myectomy and myorrhaphy of the orbicularis previously dominated treatment plans, now extensive dissection with aggressive redraping of the muscle and limited skin excision are key elements of surgical management and the preferred techniques of the senior authors (SB and SD). Variations of these techniques have been reported in the literature and are described.

The extensive dissection necessary to address festoons involves some form of subperiosteal midface lift to properly correct the gravitation descent of all involved structures while creating an aesthetically pleasing eyelid and midcheek unit.

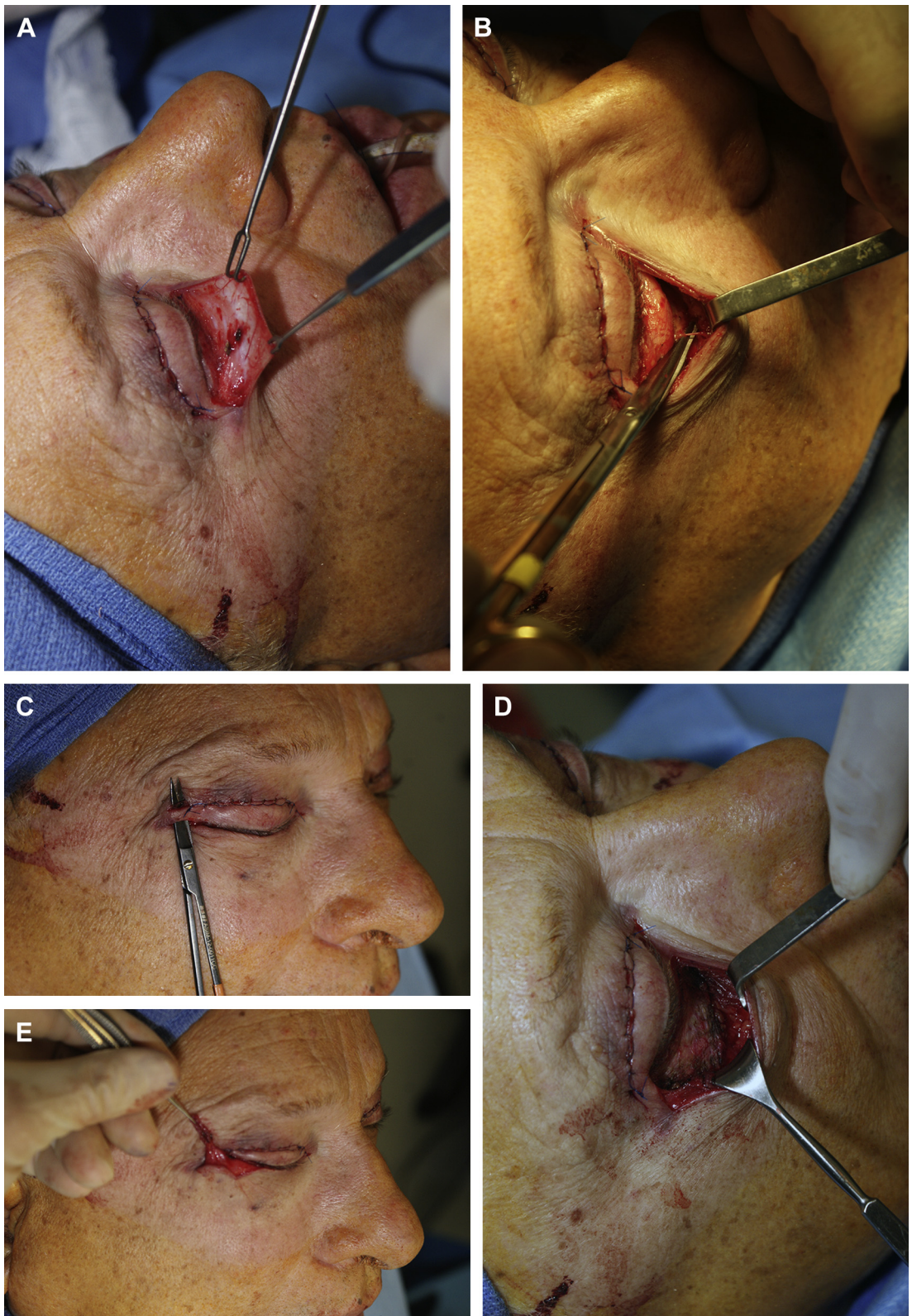
- These techniques begin with a subciliary incision followed by creation of either a skin-only or skin-muscle flap. The senior authors' preferred technique is use of a skin-only flap initially, with the amount of elevation based on how much skin excision is planned, followed by a skin-muscle flap.

- Once elevation to the level of the orbital rim is complete, an incision is made in the orbicularis oculi muscle lateral to the lateral canthal angle down to the level of the bone.
- A subperiosteal dissection is then carried inferiorly to at least the inferior border of the festoon and can extend to below and around the zygomaticofacial nerve and vascular complex.
- The ORL is released during this dissection and care is taken to avoid injury to the neurovascular bundle.
- Once the dissection is complete and mobility confirmed, redraping of the soft tissue is performed through a variety of techniques.

#### SOFT TISSUE REDRAPING

Patipa<sup>19,20</sup> begins with tightening of the lateral canthus via the use of a canthotomy of 3 mm and cantholysis followed by vertical elevation of the midface via the lateral orbicularis oculi muscle. The muscle and malar fat pad are then sutured to the periosteum from deep to superficial where they





**Fig. 5.** Festoon correction through indirect redraping. Operative technique (operating room pictures of patient pictured in Fig. 4). (A) A skin-only flap is developed through a subciliary incision and elevated for 6 to 8 mm. (B) An incision is made in the orbicularis oculi muscle down to the level of the orbital rim and a subperiosteal dissection carried inferiorly to the inferior border of the festoon, releasing the ORL while avoiding injury to the neurovascular bundle. (C) Muscle and malar fat pad are sutured to the periosteum from deep to superficial elevating the midface and simulating the orbitomalar ligament. (D) Lateral canthotomy and cantholysis are performed. (E) The orbicularis oculi muscle is pulled above the lateral canthal angle and sutured to the lateral orbital rim periosteum.

654 overlap the inferior lateral rim, effectively elevating  
655 the midface and simulating the orbitomalar liga-  
656 ment. Finally, the orbicularis oculi muscle is tight-  
657 ened in a superolateral direction, pulled above  
658 the lateral canthal angle and sutured to the lateral  
659 orbital rim periosteum, which effectively eliminates  
660 the festoon.

661 Krakauer and colleagues<sup>4</sup> describe subperios-  
662 teal dissection to the inferior extent of the festoon,  
663 followed by periosteotomy of the elevated flap  
664 from the deep dissection to the subcutaneous  
665 plane. Once the festoon is dissected, they perform  
666 a standard tarsal strip procedure, attaching a  
667 myocutaneous flap to the lateral orbital wall peri-  
668 osteum and excise excess muscle, thereby repair-  
669 ing the festoon.

670 These procedures are then completed by limited  
671 skin excision as with conventional lower lid bleph-  
672 aroplasty, followed by closure.

673 Another variation on the redraping technique  
674 uses an extended subperiosteal vertical midface  
675 lift to resolve the festoons by freeing cheek tissue  
676 from the bone and repositioning the malar  
677 septum.<sup>15</sup> In this procedure, extensive subperios-  
678 teal dissection is performed over the frontal pro-  
679 cess of the maxilla, along the inferior and lateral  
680 orbital rim up to the level of the lateral canthus  
681 and over two-thirds of the zygomatic arch through  
682 both a subciliary and buccal incision.

- 683 • Elevation of the midface begins by taking a  
684 deep bite of soft tissue through the buccal  
685 incision at a predetermined fixation point  
686 defined by the intersection of a vertical line  
687 extending down from the lateral canthus and  
688 a transverse line from the lowest aspect of  
689 the alar groove at its intersection with the lip.
- 690 • Sutures are then advanced up to a short scalp  
691 incision by the temporal fossa and fixed into  
692 the deep temporal fascia at the desired  
693 position.
- 694 • A laterally based transposition orbicularis  
695 muscle flap is then developed and advanced,  
696 allowing transmission of traction to the lower  
697 lid without the need for a canthoplasty or  
698 canthopexy.
- 699 • Redundant lower lid skin is resected and the  
700 buccal sulcus closed with interrupted sutures.

## 703 KNOWLEDGE OF COMPLEX ANATOMY

704 The surgical correction of lower eyelid festoons  
705 has evolved from simple excision of the offending  
706 structures, skin and orbicularis muscle, to exten-  
707 sive dissection of the soft tissues of the face with  
708 redraping and more limited excisions. Regardless  
709 of the chosen technique, a surgeon must have a  
710

711 thorough understanding of the complex regional  
712 anatomy as well as pathologic features of this  
713 hard-to-treat condition prior to undertaking any  
714 of the procedures described in this article.  
715

## 716 AFTER CARE

717 Care after surgical correction of festoons is  
718 consistent regardless of technique used. As with  
719 most eye surgery, the authors recommend antibi-  
720 otics ointment twice daily, topical steroid drops  
721 for swelling, and cool compresses to minimize  
722 swelling. Additionally it is recommended with  
723 many of the redraping and canthal tightening pro-  
724 cedures to place a frost suture at the time of sur-  
725 gery as another technique to minimize swelling.  
726 A 4-0 silk is placed through the lower eyelid margin<sup>q11</sup>  
727 in a double-armed fashion and the 2 ends either  
728 placed through the brow or simply taped to it for  
729 2 to 4 days. Skin sutures are typically removed af-  
730 ter 7 days to minimize scarring.  
731

## 732 COMPLICATIONS

733 Surgical treatment of festoons is associated with  
734 few additional complications beyond those typi-  
735 cally seen with lower eyelid blepharoplasty. The  
736 most common problem associated with surgery  
737 is persistent or recurrent festoons.<sup>3</sup> Causes  
738 include inadequate resection or undermining of  
739 skin, failure to release the orbicularis attachments,  
740 hyperextensibility of skin and muscle, or inade-  
741 quate elevation or lift in cases of muscle or skin  
742 redraping. Another possible complication is dam-  
743 age to the zygomaticofacial nerve during dissec-  
744 tion, which can lead to decreased or absent  
745 sensation in the area over the malar prominence.  
746 Ultimately, correct diagnosis is key not only in  
747 determining the optimal treatment approach but  
748 also in preparing patient expectations.  
749

## 750 SUMMARY

751 The management of patients with festoons is a  
752 highly challenging undertaking with potential to  
753 drastically alter the appearance of those afflicted.  
754 Traditional teaching has focused on excision and  
755 tightening of the pathologic muscle with subse-  
756 quent removal of excess skin. Recognition of the  
757 interactions between all subunits of the face has  
758 resulted in a recent shift in focus, with the new  
759 trend being techniques aimed at redraping the  
760 soft tissues with the intent of reproducing a more  
761 natural rejuvenation of the lower lid–cheek inter-  
762 face. Where direct excision techniques simply  
763 remove the deformed tissue, redraping techniques  
764 actually elevate the midface soft tissues and  
765 tighten the pathologically lax orbicularis muscle,  
766  
767



thereby counteracting the downward descent associated with the aging process. The optimal treatment is as yet unclear but seems to be a combination of elevation of soft tissue, tightening of orbicularis muscle, and removal of excess skin and or muscle to properly address all the manifestations of this interesting process.

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