

Surgical treatment of xanthelasma using blepharoplasty

Tratamento cirúrgico do xantelasma com técnica de blefaroplastia

ABSTRACT

Xanthelasma is a frequent complaint in dermatology, especially among women. Clinically, the condition has the appearance of flat or slightly raised yellowish plaques in the eyelid region. There are several procedures described for treating this condition. Blepharoplasty is the most commonly used technique to correct extensive xanthelasmas, particularly in patients with excess skin.

Keywords: xanthomatosis; blepharoplasty; surgical procedures, elective.

RESUMO

O xantelasma é queixa frequente nos consultórios de dermatologia, principalmente entre as mulheres. Clinicamente apresenta-se como placas amareladas, planas ou ligeiramente elevadas, na região palpebral. Há diversas modalidades descritas no tratamento dessa condição, sendo que, para correção de xantelasmas extensos, particularmente em pacientes com excesso de pele, a técnica mais utilizada é a blefaroplastia.

Palavras-chave: xantomatose; blefaroplastia; procedimentos cirúrgicos eletivos.

Xanthelasma (from the Greek xanthos = yellow and elasma = metal plate) is a frequent complaint in dermatologic practices, especially among women. It is the most common type of plane xanthoma, and can indicate possible abnormalities in serum lipoprotein levels (occurring in approximately 50% of cases). There is deposition of xanthomatous cells in the superficial dermis, associated with inflammation and fibrosis.¹ Clinically, it has the appearance of yellowish plaques, flat or slightly elevated, in the eyelid region.

Case Report

Authors:

Poliana Santin Portela¹
Felipe José da Cruz Oliveira²
Daniel Fabiano Ferreira³

¹ Post-graduate Candidate in Dermatology, Dermatology Service of the Hospital Naval Marcílio Dias (HNMD), Rio de Janeiro (RJ), Brazil

² Post-graduate Candidate in Dermatology, Dermatology Service of the Hospital Naval Marcílio Dias (HNMD)

³ Plastic Surgeon; Instructor at the Dermatology Service of the Hospital Naval Marcílio Dias (HNMD)

Correspondence:

Dr. Poliana Santin Portela
Rua Visconde de Sepetiba, 935 - sala 605,
Niterói - RJ, Brazil
CEP: 24012-900
E-mail: polidermato@hotmail.com

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Figure 1: Bilateral eyelid xanthelasma affecting the upper and lower eyelids; an hypochromic area is observed in the right upper eyelid, a site which has previously undergone TCA application and electrosurgery.



Figure 3: Immediate post-operative with primary running suture of the lesions using 6-0 nylon monofilament thread

CASE REPORT

A 36-year-old female patient experiencing bilateral xanthelasma for three years (Figure 1). Previously treated with punctual electrocoagulation and application of 70% trichloroacetic acid (TCA), developing into residual hypochromia, she underwent surgical removal of the lesions through the blepharoplasty technique, with local anesthesia and removal of skin only, leaving the subcutaneous tissue untouched. Primary closure was carried out without the need to rotate the flap or implement grafts (Figures 2, 3, and 4). The procedure was performed without complications.

Several therapeutic options have been described for the treatment of xanthelasma. It is a difficult to manage condition because each method may be associated with undesirable side effects, such as hyper- or hypochromia, recurrence, persistence, and hypertrophic scarring. The most frequently used modalities are the chemical cauterization, fractional electrocoagulation,



Figure 4: Two months after the procedure.



Figure 2: Marking of lesions with narrow margins; a small amount of lesion was left in the lower eyelids to help maintain their functional closing movement.

laser therapy, cryosurgery, and surgical excision.^{1,3-8}

Blepharoplasty – the generic term used to describe the surgical intervention carried out to remove excess skin of the upper and/or inferior eyelids – is the most commonly used technique to correct extensive xanthelasmas, particularly in patients with excess skin.³ The vast majority of procedures are carried out for aesthetic reasons – in order to reverse the effects caused by the aging of the skin⁹ – nonetheless the technique has been employed to correct skin lesions located on the eyelids. The closure can be primary or, in the most exuberant cases, through flaps and grafts.

A rigorous assessment as to the amount of excess skin, texture, and laxity must be made from the outset, in order to achieve the correct surgical marking. The presence of scars, nevi and palpebral bags must also be taken into account.¹⁰ The surgical markings must not surpass the orbital region.

In the present surgical procedure, the marking was carried out narrowly and with precision, bilaterally around the xanthomatous lesions. Anesthesia (2% lidocaine with vasoconstrictor) was applied locally, with the incision being carried out with the removal of the skin only, without the subcutaneous tissue and fat pads. After conducting local hemostasis, 6-0 nylon monofilament thread was used to carry out the primary running suture, with the stitches being removed five days after the procedure. As the patient presented only a small amount of excess skin, it was possible to carry out the procedure without the need for rotation flaps or grafting. There was no functional compromise, only residual hypochromia, which did not prevent the patient classification of the procedure as yielding excellent results. There was a high level of patient satisfaction, with reports of improvement in self-esteem and social inclusion. ●

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