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Effectiveness of Using Silicone Tape for Blepharoptosis in Children

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Annotation: Blepharoptosis (BP) is a common disease - from 2% to 9% of patients in ophthalmological hospitals (Atamanov V.V. 2003). Drooping of the upper eyelid, along with a significant cosmetic defect, is the cause of decreased vision and the development of amblyopia , due to the forced position of the head leads to curvature of the spine. According to a number of authors, BP ranks first among congenital eyelid pathologies in children and is one of the causes of childhood disability (M.T. Aznabaev , 1965; S.A. Barkhash , L.D. Pikalova, V.P. Khrinenko , 1975; S.A. Barkhash et al ., 1981).

Relevance.

The etiology of BP is associated with weakening or absence of activity of the muscle that lifts the upper eyelid, and can be of congenital or acquired genesis. The emerging growth of this pathology is associated with an increase in the number of environmental and social disasters, which, in addition to post-traumatic ptosis, leads to an increase in the number and aggravation of congenital syndromes of eyelid pathology, including those associated with the manifestation of drooping of the upper eyelid.

Treatment of BP is mainly surgical. Despite long-standing experience in treating this pathology and the existence of a huge number of different methods and modifications, this problem remains relevant, and the results of most known methods of correcting ptosis remain unsatisfactory. They are due to the following reasons:

Blepharoptosis is a pathological drooping of the upper eyelid, which is a significant problem of both functional and aesthetic nature. Children with blepharoptosis have limited visual functions, which can lead to amblyopia and other visual disorders. Traditional treatment methods do not always provide stable results, and in some cases are accompanied by complications. The use of silicone tape as an innovative approach to the treatment of blepharoptosis in children remains poorly understood and requires detailed analysis. This study is aimed at assessing the clinical efficacy and safety of using silicone tape to correct blepharoptosis .

The aim of the study: to evaluate the effectiveness and safety of using silicone tape for the correction of blepharoptosis in children.

Materials and methods of the study . The study was conducted in the eye diseases department of the multidisciplinary clinic of the Samarkand State Medical University in the period from 2020 to 2024. The study included 20 patients diagnosed with congenital blepharoptosis . The age of the patients ranged from 7 to 16 years, 9 of them were boys and 11 were girls.

Patients' condition before surgery:

1. All patients had a pronounced degree of drooping of the upper eyelid, which impeded visual functions.
2. In 14 patients (70%), a decrease in visual acuity in the affected eye was observed, caused by mechanical closure of the pupil.
3. In 10 patients (50%), initial stage of amblyopia was diagnosed , associated with prolonged occlusion of the visual field.
4. Six patients (30%) complained of aesthetic discomfort, which caused psychological difficulties.
5. All patients had limited upper eyelid mobility, which was confirmed by mobility tests.

Diagnostic methods included:

- *Ophthalmological examination:* visual assessment of the position of the upper eyelid, testing the mobility of the muscle that raises the upper eyelid.
- *Measurement of the upper eyelid height:* was carried out using a millimeter ruler in the primary gaze position.
- *Upper eyelid mobility tests:* determination of the range of active upper eyelid movements when looking up and down.
- *Assessment of visual functions:* testing of visual acuity using standard tables and determination of the visual field using the perimeter.
- *Photographic documentation :* was carried out before surgery, 1, 3 and 6 months after the intervention for visual assessment of changes.

Treatment method:

1. Patients underwent silicone tape installation under general anesthesia, which ensured minimal trauma and comfort for children.
2. The tape was fixed in the soft tissues of the orbit, creating reliable support for the upper eyelid in a physiological position.
3. After surgery, patients were kept under observation in the hospital for 24 hours to monitor their condition.
4. The rehabilitation period included local application of antibacterial and anti-inflammatory ointments, as well as regular examinations, and moisturizing eye drops were used to prevent dry eye syndrome.

Inclusion criteria:

- ✓ Congenital blepharoptosis of moderate to severe degree with absence of function of the muscle that lifts the upper eyelid.
- ✓ Age from 7 to 16 years.
- ✓ Parental consent for surgery to eliminate blepharoptosis .

Exclusion criteria:

- ✓ Concomitant severe systemic diseases.
- ✓ Inflammatory processes in the eye area.
- ✓ Previous upper eyelid surgery.

Patients were followed up at 1, 3 and 6 months after the intervention. The main focus was on assessing the functional and aesthetic results, as well as the presence of possible complications, such as conjunctival irritation, tissue inflammation and migration of the silicone tape.

Results and discussion

In the study, all 20 patients had successful correction of blepharoptosis using silicone tape. The results were assessed according to the following criteria:

1. **Functional indicators:**

- ➢ Restoration of the normal position of the upper eyelid was noted in 90% of patients.
- ➢ In 16 patients (80%), visual field limitations were completely eliminated.
- ➢ Visual acuity improved in 12 patients (60%), which was associated with the elimination of mechanical obstruction to vision.

2. **Aesthetic indicators:**

- ➢ All patients showed satisfactory aesthetic results. The patients' parents positively assessed the child's appearance. The eye socket became symmetrical, the upper eyelid position became identical to the second healthy eye.

3. **Complications:**

- ➢ One patient (5%) experienced conjunctival irritation, which was resolved by adjusting the tape tension.
- ➢ No other serious complications such as inflammation or tape migration were noted.
- ➢ Hypo and hyper effects were not observed in any cases.

The results of the study confirm the high efficiency and safety of using silicone tape for the correction of blepharoptosis in children. Compared with traditional treatment methods, this approach showed less trauma and more stable functional and aesthetic results.

RESEARCH MATERIALS

The study consisted of observation of 120 patients operated in the first eye department of the State Budgetary Healthcare Institution of the Samara Region Regional Clinical Hospital No. 1 for BP during the period 1999-2011. The patients were divided into two groups: the main group (60 people operated using the MRLVV method developed by us) and the control group (60 people who were operated using the SRLVV method (V.P. Khrinenko , born in 1957)).

The etiological structure of ptosis in the patients included in the study included five types of ptosis: congenital, involutional, myasthenic , neurogenic and traumatic. The average age of the examined patients in the main group was 46.1 ± 2.5 years, of which 32 were men and 28 were women; in the control group 45.6 ± 2.4 years, of which 34 were men and 26 were women. 2.1 - research methods

Examination of patients in both groups included: collection of anamnesis, external examination: assessment of posture to determine the degree of compensation of BP, assessment of the degree of drooping of the upper eyelid of both eyes, determination of: levator function and the degree of its impairment, rate of levator fatigue , degree of mobility of the eyeball, sensitivity of the cornea.

The clinical examination of a patient with blepharoptosis began with a detailed anamnesis, which allowed differentiating between congenital and acquired types of ptosis. In case of questionable anamnestic data, in some cases old photographs, including childhood ones, were useful, which often allowed establishing the approximate age of ptosis development. During the survey, an idea was also obtained about such manifestations of the disease as fluctuations in the severity of ptosis during the day, rapid fatigue and double vision.

During the general examination, attention was paid to the position of the head, in particular, the chin, which made it possible to indirectly assess the degree of limitations in daily activity and the development of ptosis. A standard ophthalmological examination was mandatory, with special attention

Attention was paid to the balance of the extraocular muscles and pupil function. The combination of anisocoria with unilateral ptosis suggested either Horner's syndrome or paralysis of the P1 pair of cranial nerves. Bilateral deficits in the function of the extraocular muscles were observed in the ocular form of myasthenia, oculopharyngeal myopathy, and Grave's disease .

Specific examination for ptosis began with an assessment of lacrimal function. Assessment of baseline secretion using local anesthetics and Schirmer strips is still the best way to determine tear secretion. Xerophthalmia was diagnosed when 10 mm or less of the strip became wet.

Upper eyelid ptosis was determined by measuring the edge-reflex distance. The normal palpebral fissure width was about 10 mm. The edge-reflex distance (ERD) is the distance between the corneal light reflex in the center of the pupil and the edge of the upper eyelid when looking straight ahead.

RKR-1 is the distance from the light reflex to the edge of the upper eyelid, normally it was 4-5 mm. For example, if RKR1 OB = 1 mm, and OB - 4 mm, then this indicated ptosis of the left upper eyelid of 3 mm. RKR 2 was measured as the distance from the pupillary light reflex to the edge of the lower eyelid. This distance made it possible to identify retraction or elevation of the lower eyelid.

RESULTS OWN RESEARCH

The main group included 75 patients, of which 46.7% were men (35 patients) and 53.3% were women (40 patients). Age of patients V basic group varied from 48 to 82 years And V average compiled

63.6 ±8.1 years. Patients of the main group were divided into two subgroups: patients with a positive (“+”) response to the PE test (37 patients, 50 eyelids) and with a negative (“-”) or weakly positive (“+/-”) response to the PE test (38 patients, 53 eyelids).

The comparison group included patients who underwent surgical treatment for blepharoptosis from January 2016 to September 2017. The comparison group consisted of 24 patients (35 eyelids), of which 37.5% were men (9 patients) and 62.5% were women (15 patients). The age of the patients ranged from 46 to 80 years and averaged 65.7 ± 10.1 years. Within this group, a retrospective analysis of surgical correction of blepharoptosis was conducted .

Indicator	Group With «+» answers to the FE test (n -50)			Group with "-" and "+/-" answers on FE test (n - 53)		
	M±SD	Min	Max	M±SD	Min	Max
Degree of ptosis to operations (mm)	3.3±0.9	2	5	3.54±0.86	2	5
FE test (mm)	2.18 ±0.38	2	3	0.61±0.49	0	1
MRD 1 (mm)	0.82± 0.95	- 1	3	0.52±0.88	- 1	2
F-ya MPVV(mm)	13.42±2.04	10	18	13.68±1.74	10	16
Length VTM (mm)	14.76±3.37	9	23	14.1±2.68	10	20
Mobility white lines (mm	1.78±1.06	0	4	2±0.69	1	3

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Tarsal plate height (mm)	8.16±1.1	5	10	7.76±1.25	5	10
Size TMV resections (mm)	12.82±3.4	7	21	12.26±2.65	8	18
Result resections VTM (mm)	2.74±1.0	1	5	2.46 ±0.66	2	4

Table №1. Distribution analyzed data V subgroups

Analysis influences various factors on result phenylephrine test

IN subgroup With «+» answers on FE test average meaning FE test - 2.18 ±0.38 mm, in the subgroup with "-" and "-/+" responses - 0.61±0.49 mm. In the course of the work, we assessed the dependence of the FE test on the degree of blepharoptosis , the function of the MPV, the length of the TMV, and the mobility of the white line.

According to the function of the MPVS, patients were divided into 2 groups: with excellent (≥ 13 mm) and good (8-12 mm) (Anderson RL, 1979). According to the data obtained, patients with excellent MPVS function showed a significantly better response on the FE test (1.94 ± 0.4 mm) compared with the group with good function (1.34 ± 0.6 mm), (p = 0.048).

According to the degree of blepharoptosis, patients were divided into 3 groups (S. Beard et al ., 1989): mild (MRD 1: 3-4 mm); moderate (MRD 1: 2-3 mm) And expressed degrees (MRD 1: 0-2 mm). Results FE test V groups were 1.5 ±0.5, 1.86 ±0.5 and 1.48 ±0.7, respectively, and did not differ significantly from each other (p=0.28).

There were no significant correlations between the results of the FE test and the length of the TMV and the mobility of the white lines received Not was (R = 0.145; p = 0.143 And R = 0.115; p = 0.24 respectively).

According to the obtained data, only the MPVV function has a significant effect on the result of the FE test (p=0.048), while the degree of blepharoptosis , as well as the length of the TMV and the mobility of the white line, do not have a significant effect (p>0.05).

Analysis influences various factors on mobility white lines

The mobility of the white line in the subgroup with "+" responses to the FE test varied from 0 to 4 mm And V average compiled 1.78 ±1.06 mm, in subgroup With "+/- " and "-" FE test varied from 1 to 3 mm and averaged 2.0±0.69 mm (p>0.05). IN In the course of the work, we assessed the dependence of the mobility of the white line on the length of the TMV and the function of the MPV.

The correlation analysis revealed the influence of the TMV length and the MFV function on the white line mobility. However, the relationship with the MFV function is moderate and only in patients with "+" responses to the PE test (p < 0.05). A high and noticeable inverse relationship was found from the TMV length in both subgroups, i.e. the longer the TMV, the lower the white line mobility and vice versa (p < 0.05).

Analysis of the dependence of the result of resection of the superior tarsal muscle on FE test, white line mobility, absolute length of the TMV and MPVV function

The result of TMV resection in the subgroup with "+" responses to the FE test varied from 1 mm to 5 mm And V average compiled 2.74±1.0 mm, V subgroup With "+/- " and "-" FE test varied from 2 to 4 mm and averaged 2.46±0.66 mm (p>0.05).

We selected the following factors as factors that could influence the outcome of TMV resection: PE test, white line mobility, absolute TMV length (in mm), and MV function. IN in the course conducted correlation analysis revealed:

- presence of moderate dependencies (By Chaddock scale) resection of the TMV (in mm) from the FE test (R=0.31, p=0.03 in the subgroup with “+” responses to the FE test and R=0.33, p=0.018 in the subgroup with “-” and “+/-” responses to the FE test);
- the presence of a high dependence of the result of resection of the TMV (in mm) on mobility white lines V subgroup With "-" and "+/-" answers to FE test (R=0.72, p=0.0005) and the absence of dependence in the subgroup with “+” responses to the FE test (R=0.02, p=0.99);
- no influence of the absolute length of the resected TMV (in mm) (R=- 0.01, p=0.945 for “+” responses to the PE test and R=-0.24, p=0.081 for “-” and “+/-” responses to the PE test) and the MPVV function (R=0.042, p=0.77 for “+” responses to the PE test and R=0.15, p=0.274 for “-” and “+/-” responses to the PE test) on the result of TMV resection in both subgroups.

Like this in this way, FE test has moderate correlation With result of resection VTM outside dependencies from character answers on him. Based on from received results, follows turn attention on high correlation of white line mobility and the result of TMV resection in the subgroup with “-” and “+/-” responses on FE test. Costs Also to note absence influences absolute length of the resected TMV (in mm) and the function of the MPVV on the result of TMV resection. *Evaluation of the functional results in early postoperative period performing a modified resection of the superior tarsal muscle*

Evaluation of functional results in the early postoperative period period we performed within the main group. For this we used the following indicators: the degree of ptosis, the width of the palpebral fissure in the center, along the lateral And medial limbo (V volume number And their difference), MRD 1 And MRD

2. All indicators evaluated to operations, A Also through 3 months after operations.

Table 2. Results of modified resection of the TMV in the main group after 3 months (van der Waerden criterion) (n-number of eyelids)

Indicator	To operations, (n=103)	3 months p/o, (n=102)	r
Degree ptosis , mm	3.4±0.9	0.35±0.7	<0.0001
Width eye cracks in the center, mm	5.6±0.9	8.7±0.75	<0.0001
Width eye cracks By lateral limbo (MMD T), mm	4.2±0.9	7.6±0.8	<0.0001
Width eye cracks By medial limbo (MMD N), mm	3.1±0.8	6.3±0.9	<0.0001
MMD difference T and MMD N , mm	1.08±0.8	1.34±0.9	0.87
MRD 1, mm	0.6±0.9	3.7±0.7	<0.0001
MRD 2, mm	4.8±0.4	5	0.98

As can be seen from the table, 3 months after the operation, a significant increase in the width of the palpebral fissure in the center, along the lateral and medial limbi, the MRD1 index, and a decrease in the degree of ptosis were achieved (p <0.05).

Evaluation of functional results in the late postoperative period performing a modified resection of the superior tarsal muscle

The functional results in the late postoperative period were assessed within the main group. The following parameters were used for this purpose: the degree of ptosis, the result, the width of the palpebral fissure in the center, lateral and medial limbo (V volume number their difference), MRD 1 and MRD

2. All indicators were assessed before surgery, as well as 6 months and 1 year after surgery.

Table 3. Results of modified resection of the TMV in the main group after 6 months and 1 year (van der Waerden criterion) (n-number of eyelids)

Indicator	To operations , (n=103)	6 months p/o, (n=102)	1 year p/o, (n=96)	r
Degree ptosis, mm	3.4±0.9	0.2± 0.6	0.22±0.45	<0.0001
Width eye cracks in the center, mm	5.6±0.9	8.8±0.6	8.7±0.6	<0.0001
Width of the palpebral fissure lateral limbo (MMD T), mm	4.2±0.9	7.6 ±0.7	7.5±0.7	<0.0001
Width of the palpebral fissure medial limbo (MMD N), mm	3.1±0.8	6.5±0.6	6.4±0.7	<0.0001
MMD difference T And MMD N , mm	1.08±0.8	1.1±0.6	1.1±0.6	1.0
MRD 1, mm	0.6±0.9	3.8 ±0.6	3.7±0.56	<0.0001
MRD 2, mm	4.8±0.4	5.0	5.0	0.89

At 6 months and 1 year after surgery, we observed a significantly reduced degree of blepharoptosis and increase width eye clefts in the center, along the lateral and medial limbus, and MRD 1.

Thus, complete elimination of blepharoptosis was achieved in 91.6% of patients (65 patients, 88 eyelids). Repeated surgery was required only in 1.4% of patients (1 patient, 1 eyelid). A residual degree of ptosis of 1 mm was observed in 5.6%. patients (4 patients, 6th century), V 2 mm - at 1 patient (1 eyelid), hyper effect V

1 mm was observed in 1.4% of patients (1 patient, 1 eyelid). Moreover, modified STM resection did not contribute to changes in the upper eyelid contour.

Comparison of results when performing resection of the superior tarsal muscle modified and standard methods

To evaluate the results, we assessed such parameters as the degree of ptosis, the width of the palpebral fissure in the center, along the lateral and medial limbs (their difference), MRD 1, MRD 2, and the result of STM resection 1 year after the operations. All compared data are presented in Table 4.

Table 4. Data results surgical treatments V groups

Indicator	Main group , (n=96)	Group control , (n=35)	r
Degree ptosis , mm	0.22±0.45	0.12±0.8	0.12
Width eye cracks in the center, mm	8.7±0.6	8.8±0.8	0.2
Width eye cracks By lateral limbo (MMD T), mm	7.5±0.7	7.7±0.8	0.88
Width eye cracks By medial limbo (MMD N), mm	6.4±0.7	6.6±0.7	0.89
MMD difference T and MMD N , mm	1.1±0.6	1.1±0.6	1.0
MRD 1, mm	3.7±0.56	3.8±0.9	0.2
MRD 2, mm	5.0	5.0	1
Result resections VTM, mm	2.6±0.8	2.0±0.6	0.035
Result operations , mm	3.4±1.0	2.0±0.6	<0.0001

At first glance, all the parameters are similar. However, the structure of hypo- and hypereffects is fundamentally different (Table 5). Thus, in the targeted analysis, in the group where the standard technique of STM resection was performed, the frequency of hypo- and hypereffects was 29.1%: 4 patients (5 eyelids) with residual blepharoptosis of 1 mm, 1 patient (1 eyelid) - residual ptosis of 2 mm, 2 patients (2 eyelids) with a hypereffect of 2 mm. Whereas in the group where the modified STM resection was performed, the frequency of hypo- and hypereffects was 8.4%: residual ptosis of 1 mm was observed in 4 patients (6 eyelids), 2 mm - in 1 patient (1 eyelid), the hypereffect of 1 mm was in 1 patient (1 eyelid).

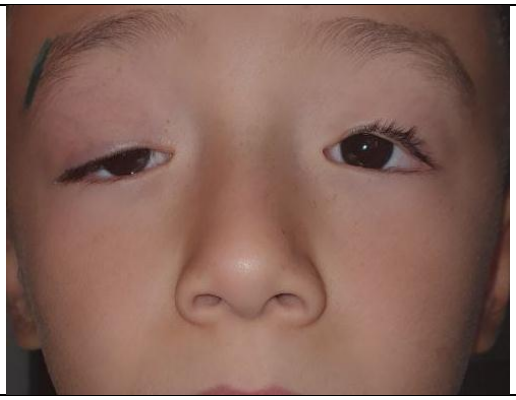
Unevenness of the contour (difference in the width of the palpebral fissure along the lateral and medial limbi ≥1.5 mm) was observed in 2 patients of the main group (2 eyelids, 2.8%) and in 1 patient of the comparison group (2 eyelids, 4.2%).

Table 5. Comparison of the frequency of hypo- and hypereffects in groups (n - number of patients)

Indicator	Main group (n=71)	Group control (n=24)	r
Hypoeffect	5 patients (7.0%)	5 patients (20.8%)	0.0001
Hyper effect	1 patient (1.4%)	2 patients (8.3%)	0.0001
Unevenness contour of the upper centuries	2 patients (2.8%)	1 patient (4.2%)	0.0001

Certainly, the modified resection of the TMV presented in this work allows for a more predictable outcome with a lower incidence hypo - And hyper effects . To others important aspect is

the possibility of performing modified resection of the TMV in patients not only with "+" but also with "-" and "+/-" results of the FE test. According to the analysis, modified resection of the TMV has proven itself as a reliable method for correcting mild to moderate blepharoptosis , provided that the function of the MVV is excellent and good (8 mm or more) with any result of the FE test.



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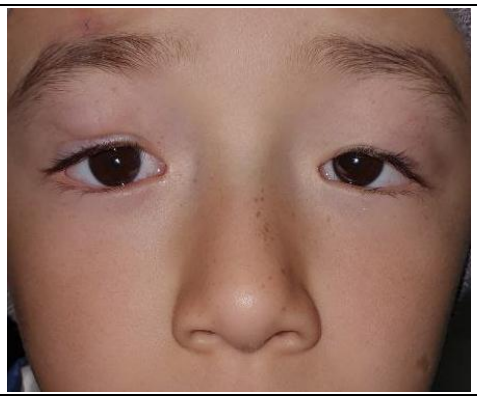

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Photo: 1 – before surgery 2 – after surgery

Conclusions

1. The use of silicone tape for the treatment of blepharoptosis in children is an effective method that ensures the restoration of the functional and aesthetic state.
2. The technique is characterized by a low level of complications and good tolerability by patients.
3. The results of the study confirm the need for further study of the use of silicone tape for the treatment of blepharoptosis in children and the development of standardized recommendations for clinical practice.

Practical significance

The development of a patient selection algorithm and a silicone tape installation technique will allow this treatment to be introduced into everyday ophthalmological practice, which will improve the quality of life of patients and reduce the risk of complications. Further studies with an expanded patient sample and an increase in the observation period will contribute to the improvement of the technique.

Conclusion. The study showed that the use of silicone tape for the correction of blepharoptosis in children is a promising method with high potential. The technique demonstrated high efficiency in restoring the function of the upper eyelid, improving visual indicators and achieving satisfactory aesthetic results. Minimal trauma and low complication rates make this technique preferable for use in children with congenital blepharoptosis . The introduction of this technique into clinical practice will expand the range of available surgical methods for the treatment of blepharoptosis , especially for younger patients.

A 0.25% solution of dicaine is instilled into the conjunctival sac . A 1 % solution of novocaine is injected subcutaneously along the upper edge . Then novocaine is also injected along the line of the supposed direction of the silicone thread, namely: from the outer corner of the eye slit upwards to the eyebrow and then from the inner corner of the same slit upwards to the eyebrow. Finally, novocaine is injected subcutaneously in the supraorbital region.

A large surgical needle (3BI— 1.3 x 70) is used to insert the silicone thread. Its thickness and length ensure free movement of the silicone thread over fairly long distances following the needle.

The pattern for inserting the silicone thread is shown in Fig. 105. The first needle prick is made in the skin of the palpebral part of the upper eyelid, 5-7 mm from the outer corner of the eye and 3-4 mm from the ciliary edge. The needle with the thread is inserted along the free edge of the eyelid under the muscle layer, directly along the cartilaginous plate of the eyelid. To prevent damage to the cornea (in case of a through puncture of the eyelid), it is necessary to insert a Jaeger plate under the upper eyelid . The needle prick is made in the skin of the palpebral part of the eyelid, 5-7 mm from the inner corner of the eye. The total length of this first "stitch" reaches 16-18 mm. Then the needle is removed from the thread and the end of the thread that extends from the prick site to the outer corner of the eye slit is threaded into the eye.

Using an operating microscope or a binocular loupe, the needle is inserted exactly into the first puncture site and passed subcutaneously upwards to the eyebrow area, slightly deviating outwards. The puncture site is marked with the tip of the needle above the eyebrow at a distance of 10 mm from it . Before the needle is removed, the puncture site in the skin must be widened to 2-3 mm with the tip of a Graefe knife. The inner end of the thread is passed through the thickness of the eyelid in a similar manner (after preliminary threading it into the needle). Then, as can be seen in the diagram, the needle is inserted into the area of one and the other superciliary incisions and passed towards each other, slightly rising upwards. In the junction area, before removing the needle and bringing the silicone thread to the surface, it is necessary to make an expanding skin incision 3 mm long and 4-5 mm deep subcutaneously.

This incision will allow you to carefully immerse the future bundle of the ends of the thread. When both ends of the thread are brought together in the median incision of the skin above the eyebrow, proceed to adjusting the position of the upper eyelid. The ends of the thread are pulled up one by one until the edge of the eyelid is evenly positioned along the upper edge of the limbus (when the patient looks straight ahead). Usually, a slight hypereffect is achieved on the operating table. Both ends of the silicone thread are fixed in the wound with a mosquito net, slightly pulled out and tied with a supramid thread (6.0) with a clamp. In this case, both ends of the silicone thread are wrapped three times with a supramid thread, tied twice with a single knot and a third time with a triple knot. This is necessary to prevent the supramid suture from untying. The ends

of the silicone thread are cut at a distance of 8-10 mm with a supramid suture. Using anatomical tweezers, the silicone thread is inserted into the wound to completely immerse the supramid nodal constriction. The patient is asked to make light blinking movements, while the eye slit remains uncovered by 2-3 mm. Then they are asked to tightly squeeze the eyelids; the eye slit should completely close. A supramid suture is applied to the skin wound, between the edges of which the tied ends of the silicone thread are located. It is tied into a loop. The protruding ends of the silicone thread and the surrounding skin are additionally lubricated with a solution of brilliant green. The ends of the thread and the wound are covered with a small napkin and sealed with an adhesive plaster.

The next day or the day after, as the eyelid swelling disappears, the patient's upper eyelid position is assessed in the dressing room for correctness. The patient is then taken to the operating room, the ends of the threads and the skin are lubricated with a brilliant green solution. The skin suture loop is untied. If the upper eyelid position is correct, the ends of the silicone thread are pulled up until a supramid suture appears. The ends of the silicone thread are cut off at a distance of 1 mm from the supramid suture. The ends of the silicone thread are inserted into the skin wound with anatomical tweezers.

If there is a hypo or hyper effect , the supramid thread is cut and the constriction is created below or above its original position.

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