Cosmetic

Surgical Anatomy of the Ligamentous Attachments of the Lower Lid and Lateral Canthus


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Description of the surgical anatomy of the superficial fascia of the face must include its deep attachments. These attachments have been mapped out for the forehead, temple, and cheek as retaining ligaments. The deep attachments of the orbicularis oculi of the lower lid and lateral canthus have long been recognized in canthopexy surgery but have yet to be properly defined. Six fresh cadavers were dissected with histologic support, and the results were correlated with surgical observations. The fascia of the deep aspect of the orbicularis is attached to the periosteum of the orbital rim by an orbicularis retaining ligament. This attachment is weakest centrally and tightest over the inferolateral orbital rim. The retaining ligament fuses with an expanded fibrous attachment beyond the lateral canthus, the lateral orbital thickening, which extends over the lateral orbital rim onto the adjacent deep temporal fascia. Aging changes are associated with attenuation of the ligamentous support provided by the orbital thickening and the orbicularis retaining ligament, which then allows inferior displacement of the lower boundary of the lid and contributes to the typical effects of age in this region. The superficial fascia of the lateral orbital region has a continuous connective tissue structure linking the temporoparietal fascia and orbicularis fascia to the lateral canthal tendon by means of the tarsal plate connection. Release of the deep ligamentous attachments (lateral orbital thickening and orbicularis retaining ligament) of the orbicularis fascia is important in some canthopexy and in rejuvenation procedures. The release allows effective redraping and upward mobilization of the orbicularis of the lower lid and the premalar soft tissues. (Plast. Reconstr. Surg. 110: 873, 2002.)

As surgical approaches to rejuvenation of the midface and periorbital regions become more numerous and complex, the need for precise and detailed descriptions of the surgical anatomy of these areas becomes increasingly manifest. To be of use to the surgeon, anatomic studies should describe the anatomy as the surgeon might encounter it in the operating room. To this end, significant and elegant contributions to the literature have been made by a number of authors, including Mitz and Peyronie,1 Bosse and Papillon,2 Furnas,3 Thaller et al.,4 Stuzin et al.,5 Knize,6 Byrd and Andochick,7 and others.8–17

It is now well recognized that when the superficial fascial system of the face (superficial musculoaponeurotic system [SMAS]) is used as the basis for rejuvenation surgery, specific anatomic attachments (ligaments, septa, and adhesions)17 to the periosteum and deep fascia must be defined and released to allow unrestricted mobilization and redraping of the SMAS.18 The definition of these anatomic attachments in the temple has recently been published.17 This study on the lower lid and lateral canthus, and the subsequent article in this issue on the anatomy of the midcheek19 represent further investigations from the standpoint of applied surgical anatomy.

Because the orbicularis oculi is an integral part of the SMAS, the question arises as to what, if any, ligamentous attachment must be released to effectively redrape the orbicularis for midfacial and periorbital rejuvenation. It has been our surgical observation that adequate mobilization of the lower orbicularis oc-
uli muscle requires the release of a definite attachment of this muscle to the inferolateral orbital rim; without specific knowledge about this attachment, we had named it the orbicularis retaining ligament. These observations were bolstered by the extensive experience of Byrd,7,20,21 who approached the suborbicularis plane endoscopically from the temple and who described the importance of the release of this attachment. Regardless of the surgical approach, the existence of a stout attachment of the orbicularis to the inferolateral orbital rim is beyond clinical question. But what is the anatomy of this attachment?

There have been few detailed descriptions of the anatomy of the attachments or retaining ligaments of the orbicularis in the lower lid and lateral canthal region. As recently as 1996, Kikkawa et al.22 described an “orbitomalar ligament,” which takes origin from the orbital rim and passes through the orbicularis oculi into the overlying dermis. Pessa et al.16 described a “malar septum,” a thin membrane also originating from the orbital rim. However, this structure is described as inserting into the cheek skin approximately “3 cm below the lateral canthus,” and it seems to be a different structure from that described by Kikkawa et al.

Given the lack of a satisfactory anatomic description to account for our clinical observations of the attachment of the orbicularis oculi to the orbital rim and the inconsistency of the few reports in the literature, we sought to characterize this structure and to define its attachments and relations to the orbital rim, orbicularis oculi muscle and fascia, and lateral canthus.

METHODS

Six fresh cadaver heads ranging in age from 48 to 89 years were subjected to dissection and histologic examination. Eleven facial halves were dissected; one entire facial half was submitted for histologic examination without dissection. Anatomic observations were systematically recorded, sketched, and photographically documented. These data were correlated with the anatomic observations from hundreds of intraoperative dissections performed in the course of temple lift, brow lift, and rhytidectomy procedures (B.C.M.).

Dissection was performed according to a standardized protocol using 3.5X loupe magnification. In three specimens, dissection was performed from both the inferior margin of the orbicularis and from a subciliary approach. In three other specimens, a temporal approach to the lower lid suborbicularis plane was combined with an inferior periorbital approach. In each specimen, the arcuate expansion of the orbital septum and the orbicularis retaining ligament were identified. The distance from the orbital rim to the ligament was measured. The thickness of the ligament and its length (the distance from its periosteal attachment to the underside of the orbicularis) were measured along the orbital rim, and the orbicularis oculi was divided at the 8 o’clock position (right side) in line with the arcuate expansion. The medial and lateral limits of the retaining ligament were also determined. Finally, the dimensions of the lateral orbital thickening and the frontal process of the zygoma were measured.

Four specimens were submitted for histologic analysis: three wedge-shaped en bloc resections from skin to periosteous of the lower lid-midcheek region (subciliary to infrazygomatic) and a fourth histologic specimen derived from an entire undissected facial half. All specimens were fixed in formalin. The fourth specimen was decalcified. All sections were stained with hematoxylin and eosin and trichrome and were reviewed with a pathologist.

RESULTS

Anatomic Dissections

The orbicularis oculi has a direct muscle attachment to the inferior orbital rim from the anterior lacrimal crest out to approximately the level of the medial corneoscleral limbus. Lateral to this point, the attachment of the orbicularis to the rim is indirect through the orbicularis retaining ligament (Fig. 1). The ligament spans from the periosteous, just outside the orbital rim, to the fascia on the underside of the orbicularis, here separating it into the preseptal and peripheral parts (Fig. 2). The periosteal attachment continues around the inferior orbital rim to the lateral canthal region. The orbicularis retaining ligament was found to have a variable length at different positions along the inferior orbital rim.

Above the levator labii superioris, the orbicularis is closely attached to the orbital rim. The length of this attachment then increases to a maximum centrally, at about the level of the arcuate expansion of the septum orbitale, here measuring between 10 and 14 mm (the dis-
tance from the orbital rim to the orbicularis) and 1.5 to 5 mm in thickness. The length of the orbicularis retaining ligament then diminishes further laterally until it becomes negligible at the lateral orbital thickening. The laxity of the retaining ligament creates a V-shaped deformity (Fig. 3).

In the lateral canthal region, the orbicularis retaining ligament merges with the lateral orbital thickening, which is a triangular condensation of the superficial and deep fasciae that crosses the frontal process of the zygoma onto

Fig. 1. Dissection within the prezygomatic space. The upper border is indicated by the blue line. Medially, the orbicularis oculi (OO) originates directly from the orbital rim above the origin of the levator labii superioris (LLS). More centrally, the orbicularis has an indirect attachment to the orbital rim by means of the orbicularis retaining ligament (ORL), which courses directly on the orbital side of the zygomatico-facial nerve (ZFN). At the lateral orbital rim, the ligament merges into the lateral orbital thickening. Sub–orbicularis oculi fat (SOOF) lines the undersurface of the prezygomatic orbicularis (pars orbitalis). Zmaj., zygomaticus major muscle; Zmin., zygomaticus minor muscle.

Fig. 2. Concept of the orbicularis retaining ligament (ORL), which indirectly attaches the orbicularis oculi (OO) at the junction of its pars palpebrarum and pars orbitalis to the periosteum of the orbital rim and, consequently, separates the prezygomatic space from the preseptal space.

Fig. 3. The length of the orbicularis retaining ligament is demonstrated by traction. It is negligible mediially, increases to a maximum centrally, and then diminishes laterally. Its laxity creates a V-shaped deformity (dotted lines).
the deep temporal fascia (Fig. 4). In this region, the retaining ligament is thicker and less distensible. In the five older cadavers aged (77 to 89 years) the lateral orbital thickening measured approximately 11 to 12 mm vertically along the frontal process of the zygoma and 12 to 29 mm in transverse width as it crossed the frontal process (13 to 14 mm wide) and extended onto the deep temporal fascia for 14 to 15 mm. However, in the 48-year-old cadaver, the dimensions of the orbital thickening were considerably greater: 35 mm along the frontal process of the zygoma and 30 mm in transverse width (Fig. 5). These findings are concordant with our clinical observations at surgery that younger patients typically have a greater dimension of the orbital thickening than do older patients.

The orbicularis retaining ligament is a bilaminar membrane (Fig. 6). On the orbital side, the membrane is derived from a reflection of the septum orbitale, whereas the caudal membrane is derived from a continuation of the membrane covering the preperiosteal fat over the zygoma. Thus, the caudal leaflet of the bilaminar membrane that makes up the retaining ligament also forms the cephalad boundary of the prezygomatic glide plane space (Fig. 1) (see companion article). Between these membranes is a layer of fat. The thickness of the retaining ligament varies in accordance with the thickness of the intervening fat layer.

The orbicularis retaining ligament consistently lies directly cephalad, or on the orbital side, of the zygomatico-facial nerve and foramen (Fig. 1). The nerve is a reliable surgical landmark for the location of the retaining ligament. Access to the ligament may be gained through the prezygomatic space.

The orbicularis retaining ligament is in continuity with the lateral orbital thickening at the inferolateral orbital rim immediately below the lateral canthal region. A clinically relevant anatomic relation is evident in this region. Specifically, the retaining ligament, orbital thickening, and lateral palpebral raphe form an anatomic unit. Moreover, this unit is connected to the deep head of the lateral canthal tendon by the orbicularis fascia on the deep surface of the orbicularis oculi muscle and its fascial connections to the tarsal plate (Figs. 7 over an orange background, has a separate orbital attachment. Zmaj, zygomaticus major muscle; Zmin, zygomaticus minor muscle.
and 8). Thus, release of the retaining ligament/orbital thickening from the orbital rim periosteum allows movement of all the above structures as a unit. The lateral palpebral raphe is difficult to identify as an isolated or discrete anatomic structure. Rather, it seems to merge into the confluence of fibrous tissue that makes up the lateral orbital thickening.

In these fresh cadaver specimens, untethered redraping of the preseptal orbicularis oculi was not possible until the retaining ligament and lateral orbital thickening were completely released.

**Histologic Findings**

The retinacula cutis fibers between the orbicularis oculi and dermis were most concentrated where they directly overlay the inferior orbital rim (Fig. 9). This is in contrast to the lesser dermal attachments of the preseptal orbicularis and the coarser fibrous attachments of the prezygomatic orbicularis to the thicker layer of subcutaneous fat (Fig. 10). Evidence of a fibrous connection between the orbital rim and the orbicularis oculi was also found; however, we were unable to capture a complete cross section of the orbicularis retaining ligament between the rim and the orbicularis in any single histologic section.

**DISCUSSION**

The retaining ligaments of the cheek and their significance in facial rejuvenation surgery have been elegantly described. However, the plastic surgery literature does not include a similarly detailed description of the retaining ligaments or attachments of the orbicularis oculi in the lower lid and lateral canthal region. This deficiency has remained despite the mention of a significant attachment of the orbicularis to the orbital rim by several authors in the descriptions of their classic canthopexy techniques. The lack of this anatomic detail is also remarkable given the growing importance of orbicularis oculi redraping in rejuvenation surgery of the periorbital and midface regions using dissection in the suborbicularis plane. An understanding of lateral canthal anatomy has also become more important because of the increased attention given to lateral canthal support in lower lid blepharoplasties of various types, and also because of the increased burden placed on the lateral canthus with some of the recent rejuvenation procedures (most particularly, subperiosteal midcheek lifts and laser resurfacing of the lower lid).

As far back as 1975, Hinderer described the necessity for a wide undermining of the inferolateral orbicularis off the orbital rim in his canthopexy technique. Flowers mentioned the importance of the “division of tethering bands of orbital septum and caudal reflections of the lateral canthal tendon to facilitate easier upward canthal location” and to secure a lasting canthopexy. Whitaker also described the surgical release of a “distinct band, being a combination of periosteum and orbicularis muscle, which extends inferiorly and medially from the lateral canthus,” and whose release is necessary to allow a superior and lateral shift of the palpebral fissure in canthopexy. These authors all observed an attachment of the orbic-
ularis to the inferolateral orbital rim because of the need for its release.

The description of the anatomy of the lateral canthus in the classic ophthalmology texts provides minimal detail on the lateral palpebral raphe and the lateral orbital rim periosteum. The lateral palpebral raphe is merely mentioned as a fibrous intermingling of upper and lower preseptal fibers. Gioia et al. clarified the anatomy of the lateral palpebral raphe as being located medial to the orbital rim and consisting of pretarsal fibers. Zide and Jelks demonstrated a thickening of the periorbital at the lateral extent of the lateral canthal tendon, whereas Isse referred to the thickening of the preperiosteal tissue lateral to the insertion of the lateral canthal tendon as the “precanthal web” and noted that it must be released to modify the lateral canthus. Moss et al. described the anatomic relationships of the thickened area of the lateral orbital rim periosteum designated the “lateral orbital thickening,” and Knize referred to the horizontal condensation in the fascia lateral to the lateral canthus as the superficial leaf of the lateral canthal tendon. The anatomic details of this region are particularly pertinent to periorbital rejuvenation when using the suborbicularis plane from the temporal approach and from the traditional lateral face lift approach.

This study further defined the lateral orbital thickening and quantitated its attachment between the orbicularis fascia and periosteum, and the extension of the attachment onto the adjacent deep temporal fascia. The orbital thickening attachment extends further on the deep temporal fascia than on the underside of the orbicularis. The ligamentous density of the orbital thickening is less than that of some specific localized retaining ligaments, such as the main zygomatic ligaments or the lateral canthal tendon proper. In addition, it seems

**FIG. 7.** The attachments of the orbicularis retaining ligament (ORL) to the orbital rim (including the lateral orbital thickening [LOT]) have been released. This allows the lid to be rotated 180 degrees around the lateral canthal tendon (LCT), which is the only intact attachment. X and X’ indicate the lateral extent of the orbital thickening on the deep temporal and temporoparietal fascia (TPF), respectively.

**FIG. 8.** The superficial fascia, or superficial musculoaponeurotic system, is a continuous unit composed of the temporoparietal fascia (TPF) and the orbicularis muscle fascia. It attaches to the skeleton (1) along the orbital rim, by the lateral orbital thickening (LOT) in continuity with the orbicularis retaining ligament (ORL); and (2) to the lateral orbital tubercle by means of fibrous connections of the orbicularis fascia with the tarsal plates (TP), and from there to the deep head of the lateral canthal tendon (LCT).
that the density of the structure is not uniform; it is weaker peripherally, where it undergoes attrition with aging. This is reflected in the reduction of the peripheral extension of the orbital thickening, which recedes from the deep temporal fascia and persists better where closer to the lateral canthus. Reduction of the lateral orbital rim attachment of the orbicularis would contribute to the increased mobility of the superficial tissues around the lateral canthus and lower temple seen with aging.

It is now apparent that the lateral orbital thickening and its inferior extension, the broader-based and more resistant inferolateral part of the orbicularis retaining ligament, are the structures specifically mentioned by several surgeons in their canthopexy techniques. For a surgical release to be effective, it must release only the part of the retaining ligament that provides resistance to redraping of the orbicularis. The more distensible central part of the ligament (see discussion of retaining ligament below) does not create a “downward drag,” which is the reason the release along the inferior orbital rim need not extend medial to the pupil.

Moss et al. described the lateral orbital thickening as being located immediately superolateral to the lateral canthal tendon insertion, where it retains the deep surface of the orbicularis oculi muscle fascia. Furthermore, they described a structure “continuous with...the lateral orbital thickening” that they termed the “periorbital septum” and that “gains origin from three-quarters of the circumference of the orbital rim, extending from the corrugator origin around to the inferomedial bony origin of the orbicularis oculi.” Because this structure is generically similar to other retaining ligaments of the face, we prefer the term orbicularis retaining ligament for the periorbital septum of the lower lid.

The retaining ligament is a distinct and, in
part, substantive structure in the form of a bilaminar membrane that connects the fascia on the underside of orbicularis oculi to the orbital rim periosteum and merges laterally with the lateral orbital thickening. The ligament was significantly longer than we had anticipated, which may have been related to the advanced age of our specimens. Lengthening of this retaining structure allows the descent of bulging orbital fat behind an attenuated septum orbitale. It is the orbicularis retaining ligament, not the septum orbitale, which defines the lower limit of the descent and the shape of lower lid fat bulges (Fig. 11). The distension of the ligament is not uniform across its length. Fat bulges are most prone to develop centrally, where the ligament is weakest and becomes most distended. The minimal inferior displacement of the bulging fat of the medial lower lid correlates with the minimal length of the ligament here, where it is reinforced by the direct orbicularis muscle origin along the medial extent of the inferior orbital rim. Lateral compartment fat bulges are initially situated higher, near the lateral canthus, because the septum orbitale is least distensible near the inferolateral orbital rim. Because the retaining ligament is strongest over the inferolateral orbital rim, it further resists the tendency for lateral fat bulges to prolapse over the rim, at least until a more advanced stage of degeneration.

Because the upper part of the orbicularis is relatively fixed, it is the preseptal segment of the orbicularis muscle and its fascia that undergoes elongation with the downward displacement of the lid-cheek junction. This distension accounts for the significant thinning of the orbicularis and the separation of preseptal muscle bundles. Such attenuation of the preseptal orbicularis is associated with a weakened function and reduced ability to contribute to the support required to maintain the lower lid fat in its position. This may explain the frequent association of bulging lower lid fat in people who have a significant descent of the lid-cheek junction.

The orbicularis retaining ligament is the boundary separating the preseptal space of the lower lid (above) from the prezygomatic space (below). Accordingly, when distension of the ligament is present, allowing preseptal fat to extend into the upper part of the prezygomatic space, this constitutes a direct hernia.

The differential laxity of the retaining ligament with aging is associated with an altered appearance. The greater descent of central lid fat and the laxity of the lid-cheek junction form a V-shaped downward angulation, which also contributes to the development of the nasojugal groove (Figs. 3 and 12). The descent of the lid-cheek junction produces a redundancy of the soft tissue immediately below. This laxity of the superficial fascia in the roof of the prezygomatic space contributes to the appearance of malar mounds (Fig. 13) (see companion article). Furnas described an “orbit-cheek fold” (which defines the upper border of the malar mound) and a “mid-cheek fold” (which defines the lower border of the malar mound). He was prescient in his hypothesis that the orbit-cheek fold might be formed “by a line of fusion between the superficial and deep layers of facial fascia that in turn attach to the orbital rim.” This is the level of attachment of the orbicularis retaining ligament, first described by

![Fig. 11. Comparison between the youthful and aged lid. The blue line overlies the bony orbital rim. In the aged lid, the peripheral extent and shape of the bulging lid fat are determined by the distended orbicularis retaining ligament. The preseptal orbicularis undergoes elongation associated with the extension of the “lid” beyond the orbital rim.](image-url)
Kikkawa as the orbitomalar ligament and shown histologically to attach to the overlying dermis. The components of the “orbit-cheek fold,” the nasojugal and palpebro-malar grooves, should not be confused with the mid-cheek or (malar) groove or furrow, which is the same as the “mid-cheek fold” described by Furnas. This location correlates with that described for the termination of the “malar septum” into the cheek skin “approximately 3 cm below the lateral canthus.” It may be that the “malar septum” is a reflection of the membrane covering the preperiosteal fat and caudal boundary of the prezygomatic space.

In surgery, once the lateral orbital thickening and the restraining part of the orbicularis retaining ligament have been released, the sole remaining skeletal attachment of the superficial fascia (which includes the anterior lamella of the lid) is the lateral canthal tendon. The fibrous connective tissue structure of the superficial fascia has a continuity that comprises the temporoparietal fascia and the orbicularis muscle fascia, both external to and internal to the orbital thickening, and is linked by the attachment to the tarsal plates and to the deep head of the lateral canthal tendon (Fig. 8). Accordingly, after the superficial fascia is completely mobilized from the periosseum of the orbital rim, an effective redraping of the superficial fascia, including the entire orbicularis, can be performed without traction against resistance (Fig. 12). Effective redraping of the orbicularis, made possible by release of the orbital thickening and retaining ligament, allows “clearing” of redundant accumulated lax tissue in the lower lid-cheek region and elevation of the ptotic lid-cheek junction. It also counteracts the senile tendency for lower lid malposition and scleral show.

Release of the orbicularis attachment at the lateral orbital thickening also allows for modification of the lateral canthus because of the attachments of the orbicularis fascia to the deep lateral canthal tendon and the continuity

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**Fig. 12.** Aging changes result from laxity and displacement of the underlying structures. The grooves overlie ligamentous attachments, and the bulges overlie “spaces.” The nasojugal and palpebro-malar grooves overlie the orbicularis retaining ligament. The midcheek groove or furrow overlies the zygomatic-cutaneous ligaments. Downward displacement of the lid-cheek junction contributes to the development of malar mounds. On the patient’s left side, the changes are more advanced because the lid bulge has become confluent with the bulge of the malar mound, with loss of the intervening palpebral-malar groove.

**Fig. 13.** Surgical application. Intact ligaments of the lateral and inferolateral orbital rim (LOT and ORL) restrict the ability to redrape the orbicularis over this area. Traction, applied through the temporal approach, is resisted by these attachments so that distortion results because the limited movement that does occur is not in the direction of the traction force (right panel). After release of the attachments to the orbital rim, a tension-free and undistorted redraping of the entire orbicularis ensues. The displacement is in the direction of the traction force and affects the tissues medial and lateral to the lateral orbital thickening and the orbicularis retaining ligament.
of the periorbital SMAS with the anterior lamella of the lower lid (Fig. 8). The tarsal-ligamentous support of the lower lid may be affected by this redraping of the superficial fascia. This may occur indirectly, from an unloading of downward gravitational drag of the cheek on a poorly supported lower lid. Alternatively, a degree of direct improvement on the lateral commissure may result from the redraping by means of the previously described fibrous interconnection through the orbicularis fascia to the tarsal plates and lateral canthal tendon. Thus, the lateral canthus may be treated without performing a formal canthal procedure. Sutures can be placed in the released superficial part of the orbital thickening (i.e., the reinforced orbicularis fascia) to further accentuate the change in the lateral canthus, as described by Byrd and Andochick\(^7\) and Byrd.\(^20\) The release associated with this approach also allows the placement of deeper sutures to directly modify the deep lateral canthal tendon.

The general principles of SMAS flap surgery are no less applicable to this area of periorbital SMAS.\(^18\) Accordingly, for orbicularis (SMAS) redraping to be effective, there must be a complete release of all restraining deep attachments between the area requiring correction and the point of fixation so that the redraping is not placed under tension; hence the need for release of the lateral orbital thickening and orbicularis retaining ligament. For fixation to be most effective, it should be close to the area requiring correction, which in this situation means either the arcus marginalis along the inner aspect of the orbital rim or the deep temporal fascia adjacent to the posterior border of the orbital rim.

**Conclusions**

- The orbicularis retaining ligament (previously termed the orbito-malar ligament or orbicularis retaining septum) is a bilaminar septum–like structure attaching the orbicularis oculi to the inferior orbital rim.
- The attachment of the retaining ligament is broader and stronger inferolaterally than centrally.
- Aging changes of the retaining ligament are associated with distension, elongation, and thinning. Initially, these changes are more apparent on the central than on the lateral lid.
- Aging of the preseptal orbicularis oculi is associated with considerable distension and thinning of this strata, with separation of muscle bundles.
- The lateral orbital thickening is continuous with the expanded lateral end of the retaining ligament.
- The orbital thickening is a fibrous fusion between the orbicularis fascia of the peripheral part of orbicularis oculi and the underlying deep fascia (periosteum and deep temporal fascia.)
- The orbital thickening extends across the entire width of the frontal process of the zygoma and onto the deep temporal fascia for a variable distance.
- Aging changes of the orbital thickening are associated with a reduction of its area.
- There is continuity of the connective tissue supporting structures medial to the orbital thickening. The orbicularis fascia of the preseptal and pretarsal orbicularis continues with the tarsus and the lateral canthal tendon.
- Release of the orbital thickening and the thicker lateral part of the orbicularis retaining ligament results in complete detachment of the superficial fascia from the orbital rim.
- Once mobilized, the superficial fascia forms a continuous connective tissue structure, namely, the temporoparietal fascia, orbicularis fascia laterally (pars orbitalis) and over the lid (pars palpebralis), tarsal plate, and deep head of the lateral canthus ligament (the sole remaining bony attachment).
- Redraping of the peripheral part of this continuous fibrous supporting structure has a beneficial effect on the more central (lid) part of the structure.

**REFERENCES**

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