Re: “Mullerectomy Procedure with Skin Crease Preservation”

To the Editor:

Szamocki and Shah-Desai described a Mullerectomy procedure with skin crease preservation, which they advocated because of their good results and faster healing time, compared with a Mullerectomy with skin resection.

When I first described the Muller muscle conjunctival resection ptosis procedure, it was also done without any skin excision or crease reconstruction. However, it became apparent that in most of my patients, this led to a lower crease and a greater skinfold that they found unacceptable, as it made one part of them look better by raising their upper eyelids and another part worse by increasing their skinfolds. (This was due to patients no longer having to raise their brows to compensate for their ptosis, as well as the advancement of the levator aponeurosis by the procedure that brought the levator orbicularis skin attachments lower.)

Therefore, in selected patients, I began advocating removal of upper eyelid skin and reconstruction of the eyelid creases in addition to the Muller muscle conjunctival resection ptosis procedure. I found that I was able to determine candidates for this skin crease procedure by doing a preoperative phenylephrine test. By instilling several drops of 10% phenylephrine into the upper fornix, the patients were able to look at themselves in a mirror several minutes later and see what they would look like with a higher upper eyelid and the effect it had on increasing their skinfold. If they found this skinfold increase to be unacceptable, I would recommend a skin excision and crease reconstruction in addition to the Muller muscle conjunctival resection.

I hope this additional information is helpful for surgeons considering the technique described by Dr. Szamocki.

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The author has no financial or conflicts of interest to disclose.

REFERENCES


Re: “Outcomes of Orbital Blow-Out Fracture Repair Performed Beyond 6 Weeks After Injury”

To the Editor:

We read with great interest the recent article by Scawn et al. on outcomes of delayed repair of blow-out fractures of the orbit. In the developing countries, patients with orbital fractures may often present late for treatment due to multiple logistical reasons. This article assumes special significance for us in this context. The authors have addressed a particularly contentious area regarding management of orbital fractures. It is extremely encouraging to note that they have reported markedly improved functional and cosmetic outcomes in their set of patients. We would like to take this opportunity to share some of our concerns and issues related to delayed orbital blow-out fracture repair.

In their study population, the authors have included patients with pure orbital floor blow-out fractures as well as those with combined floor, medial/lateral wall, and roof fractures. To the best of our understanding based on our clinical experience, we tend to believe that an isolated orbital floor blow-out fracture and one that involves orbital walls in addition to the floor behave slightly differently from each other. This could possibly be attributed to the larger expansion in orbital volume if multiple orbital walls are fractured. As also seen in the authors’ series, the maximum enophthalmos has been documented in these patients. In our hands, such patients have more often tended to have less than optimal outcomes on delayed fracture repair. More specifically, correction of hypoglobus has been better compared with that for enophthalmos. It has been reported that the overall volume of herniated orbital contents correlates significantly with the enophthalmos. Multiple orbital wall fractures can lead to a greater volume of tissue herniation, displacement and over time to potentially greater amounts of tissue fibrosis and atrophy. This could be a possible contributor to suboptimal correction of enophthalmos. It may be more informative to compare outcomes between groups with isolated orbital floor fractures and multiple wall fractures. Currently, however, in our practice, we continue to be more guarded in predicting the cosmetic and functional outcomes in delayed orbital fracture repair in patients with multiple orbital wall fractures.

Apart from its retrospective nature and small sample size as noted by the authors themselves, the study also lacks a control group. It may be more informative to look at similar outcome parameters in patients with orbital fractures undergoing early repair (within 6 weeks of injury) versus those undergoing delayed repair (beyond 6 weeks of injury). Comparable outcomes between these groups would lead to a more robust conclusion of good cosmetic and functional outcomes in delayed orbital fracture repairs.

Despite significant advances made in surgical techniques and imaging, we still have several limitations in predicting the cosmetic and functional outcomes of orbital fracture repair, ostensibly more so in cases of delayed repair. Meanwhile, our understanding of the use of imaging technology and the dynamics involved in orbital tissue trauma and fractures for clinical decision making continues to evolve. The authors current attempt will certainly take us a step in the direction where we are better equipped to quell the apprehensions regarding cosmesis and functionality of those of our patients who present to us with delayed orbital fractures expecting a good surgical outcome.

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REFERENCES

Letters to the Editor

To the Editor:

We were delighted with the interest shown by Drs. Panda and Tripathy in our article, “Outcomes of orbital blow-out fracture repair performed beyond 6 weeks after injury.” We thank the authors for bringing forth discussion of several points pertaining to fracture complexity, surgical timing, and use of a control group.

Anatomic fracture complexity is certainly an important factor influencing clinical outcome. As suggested by Drs. Panda and Tripathy, we did compare the pre- and postoperative enophthalmos, hypoglossus, and ocular motility between the 10 patients with isolated floor fractures and the 10 patients with multiple fractures. The only statistical difference detected between these 2 small subgroups was in the preoperative ocular motility, that showed greater impairment in those with fractures extending beyond the floor (Mann–Whitney; \( p = 0.03 \)). However, postoperative outcome measures were not significantly different between subgroups.

Although we considered the use of a control group undergoing earlier surgery, we were not attempting to address the question regarding the optimum time for fracture repair. There already exists a number of high quality publications that serve as historical controls. Our goal was instead to analyze outcome data in patients presenting outside the typical presentation period experiencing late functional or aesthetic complications.

We again thank Drs. Panda and Tripathy for their comments and hope that our study provides some input for surgeons and patients considering orbital fracture repair months to years after injury.

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Periorbital Sclerotherapy Caution

To the Editor:

Drs. Stacey, Gemmete, and Kahana provided an excellent review of the multimodality treatments for periocular and orbital vascular lesions, which historically have been among some of the most difficult problems to manage. Incorporation of endovascular techniques has greatly improved both outcome and safety.

While we have frequently used and also endorse the endovascular techniques reviewed, we raise a cautionary flag on the casual use of sclerosing agents for the treatment of cosmetically unacceptable prominent periorbital veins. We have seen 3 cases of sudden thyroid eye disease-like presentations referred to us within 2 weeks of periorbital sclerotherapy with varying degrees of eyelid retraction, chemosis, conjunctival injection over the insertions of the medial and lateral recti, lagophthalmos without von Graefe’s sign, and mild exophthalmos. No visual or motility deficits were present. There was no personal or family history of thyroid imbalance and thyroid function and autoimmune antibody testing was normal. CT in 2 cases demonstrated mild enlargement of the extraocular muscle bellies with eventual total normalization on repeat imaging months later. All cases spontaneously resolved over 4 to 6 months with supportive treatment only. The sclerosing agents were chromated glycerin (chemical irritant) in 2 cases and sodium tetradecyl sulfate (detergent) in 1 case.

While the pathogenesis of these cases is uncertain, we hypothesize a venous etiology, similar to the venous and orbital congestion of thyroid eye disease. The lower eyelid veins drain into the inferior orbital vein and ultimately into the cavernous sinus. Conceivably our patients experienced a low-grade retrograde thrombophlebitis or other orbital venous system disturbance following sclerosing treatment, which precipitated a partial thyroid orbitopathy type effect. If this hypothesis is correct, then it is fortuitous that a more permanent adverse event did not occur.

As with all rapidly evolving medical technologies, an appropriate temptation is to seek novel and disparate applications. However, we should remind our colleagues, especially those from other disciplines, about the powerful impact (both negative and positive) that alterations of the periocular vascular flow may have.

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REFERENCE


Re: “Periorbital Sclerotherapy Caution”

To the Editor:

We thank Mr. Patrinely and Dr. Soparkar for their thoughtful comments regarding our article. We completely agree that sclerosing therapy of orbital vascular anomalies should never be undertaken “casually.” The risks of sclerosant injection in orbital vascular anomalies in which draining vessels are abnormally...