to show that both small-incision levator advancement and conjunctival-mullerectomy blepharoptosis repair yield excellent outcomes.

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The authors have no financial or conflicts of interest to disclose.

Proprietary interest statement: Julian D. Perry, M.D. – Elsevier.

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REFERENCES

Reply Re: “Comparison of Fasanella–Servat and Small-Incision Techniques for Involutional Ptosis Repair”

To the Editor:

We were pleased to review the recent findings by Dr. Choudhary et al.1,2 complementing the results of our previously published study3 comparing the outcomes between the Fasanella–Servat and small-incision external levator advancement techniques for ptosis repair.

We agree with the authors that eyelid contour is a critical outcome measure in ptosis repair, the absence of which was a limitation of our original study. We thank the authors for using a previously developed method for evaluating eyelid contour4 to support our findings that internal and external approaches to ptosis repair lead to comparable outcomes with shorter operating times using the former technique.

While our results, like the authors’, revealed similar improvement in postoperative margin-to-reflex distance (MRD1) between the internal and external approaches, our patients had a lower average preoperative MRD1 in both groups (–0.83 and –0.29 mm vs. 2.12 mm and 1.61 mm for internal and external approaches, respectively). The difference may be attributable to the authors’ exclusion of patients with negative MRD1 patients in their studies. Also of note, the authors’ technique for internal ptosis repair involved an algorithm to determine whether tarsal resection is necessary depending on the presence of undercorrection after phenylephrine testing,1 while our approach uniformly involved tarsal resection (average 2.93 mm).

The authors’ algorithm suggests that adding resection of the tarsal plate increases the degree of eyelid elevation, and perhaps the greater average change between our preoperative and postoperative MRD1 measurements in the Fasanella–Servat group was attributable to the standard resection of tarsus in all our cases.

We thank the authors for sharing their important findings, which support our results that the internal approach remains an excellent and highly relevant alternative for correcting visually significant aponeurotic ptosis in patients without prior eyelid surgery with shorter average operating time. Future studies may benefit from prospective comparisons over a longer postoperative follow-up period, including the association between changes in eyelid position and contour and the amount of tarsal resection.

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REFERENCES


To the Editor:

McConnell et al.1 report 3 cases of body dysmorphic disorder and point out “patients with body dysmorphic disorder are likely to seek care from oculoplastic surgeons, but to date, little has been written about the condition in the ophthalmic or oculoplastic literature.” They cite no references from the ophthalmic or oculoplastic literature other than an abstract by Massry who reviewed an article on this subject matter from the “Aesthetic Surgery Journal.”1,2

I would like to inform the authors that although body dysmorphic disorder was originally called “imagined ugliness syndrome” as they state, it has also been called “body image dysmorphic disorder,” “body dysmorphia,” “dysmorphic syndrome,” as well as “dysmorphophobia.”1,2 The first article describing the various features of dysmorphophobia (body dysmorphic disorder) and its importance appeared in our...
“oculoplastic literature” (Ophthalmic Plastic and Reconstructive Surgery) in 1998 by Mawn and Jordan. A second article on the same topic, by the same authors appeared in the “ophthalmic literature” in 2003. Within these articles, Jordan and Mawn describe the salient features of the body dysmorphic syndrome also described by McConnell et al. in their recent article. The purpose of these two early articles by Jordan and Mawn was for the same reasons McConnell et al. elected to write their report, i.e., “little has been written about the condition in the ophthalmic or oculoplastic literature.” This was highlighted in the abstract section of Mawn and Jordan’s initial paper, “treatment of patients with dysmorphophobia has not previously been addressed in the ophthalmic literature.”

It is essential all of our colleagues seeing cosmetic patients are aware of this entity. I would like to thank Dr. McConnell et al. for re-emphasizing its importance to our community.

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

REFERENCES


To the Editor:

We would like to thank Dr. David Jordan for bringing attention to the term dysmorphophobia and its use as a synonym for body dysmorphic disorder (BDD). The articles by Dr. Jordan with Dr. Louise Mawn published in OPRS in 1998 and the Canadian Journal of Ophthalmology in 2003 are well written pieces presenting an additional 3 cases of patients with BDD in the oculoplastics clinical setting.

We have learned quite a bit about the structure of medical search engines and the use of controlled vocabularies from our investigation of how the articles were not encountered during what we believed was a thorough search of the literature on BDD. A medical librarian conducted the search using the following search strategy in PubMed: (“Body Dysmorphic Disorders”[Mesh] OR “body dysmorphic disorder”[tiab]) where [MeSH] is Medical Subject Heading and [tiab] is the tag used for searching terms in the record’s title and abstract. Search results were further narrowed using an eye terminology search hedge with over 100 eye-related keywords and phrases (including such terms as “ophthalmic plastic,” oculoplastic, eyebrow, eyelid, ocular, and other eye-related terms) and a list of over 200 vision science journals. We further restricted the search to “human” and English language articles.

“Body dysmorphic disorder” was added as a MeSH term in 2010. Before that time it was indexed as the broader term “somatoform disorders” from 1981 to 2009 and, even more broadly, “mental disorders” before that. Thus, even searching the author names and BDD will not find the articles. We have reported the need for a cross-reference of the terms BDD and dysmorphophobia to the NCBI help desk at the National Library of Medicine. Our University of Iowa Department of Ophthalmology librarian was unaware of the term “dysmorphophobia,” whether or not she should have been aware of the term, how she might have discovered it, and modifications of her general protocol for database searching are items for an article she will be preparing for publication in the medical library literature.

We hope that this letter to the editor will serve to link the term dysmorphophobia and its associated publications to the term BDD so future readers with an interest in this important subject will have access to all of the relevant articles.

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REFERENCES

Image Guidance for Orbital Surgery

To the Editor:

I have the good fortune of being an integral part of both skull base and craniofacial surgery teams. My collaboration with neurosurgeons and otolaryngologists has exposed me to the application of image-guided technology (IGT) for intraoperative navigation of the craniofacial region.

From this, I now use IGT for resection of certain neoplasia localized to the orbit and for orbital bone decompression