

Blindness following blepharoplasty

Sir

We wish to draw the attention of your readers to two further cases to illustrate the value of preoperative assessment by a consultant ophthalmologist when patients are being prepared for blepharoplasty. This operation has many potential ophthalmic complications and not all are as disastrous as the blindness which may follow orbital haemorrhage. Pre-existing problems may be exacerbated or merely brought to the patient's notice. In the latter event the patient may erroneously blame the operation. Callaghan's paper (Callaghan, 1986) may be added to the useful bibliography given by Mahaffey and Wallace (1986), again emphasising the precautions to reduce the risk to vision.

We report two illustrative cases.

Case 1

A 37-year-old woman was referred to an ophthalmologist 2 years after bilateral upper and lower blepharoplasty. A good cosmetic result had been achieved but the patient complained of watering and recurrent "conjunctivitis" which she dated from the time of the operation. Enquiry revealed a long history of acne rosacea with blepharitis and recurrent meibomian gland cysts which had responded to treatment with systemic tetracycline. Her recent problem was that of puffy eyelids in the morning accompanied by nasal obstruction and sneezing. In fact she already knew of her allergic nasal reaction to feathers and household polish but she did not associate this with her eye symptoms. With some scepticism she accepted the explanation that her eye symptoms were caused by a combination of ocular rosacea and acute allergy. Only when a dramatic response to treatment with systemic tetracycline and antihistamine confirmed the diagnosis was her anxiety and that of her plastic surgeon relieved.

Case 2

A 43-year-old woman was referred for routine ophthalmic examination prior to bilateral upper blepharoplasty. There was no history of past eye disorder and her visual acuity was good (6/6 Snellen) in each eye without glasses. The ophthalmologist was surprised to find a cluster of small round retinal holes in the equatorial fundus of the right eye at the 1 o'clock meridian. There was a localised area of shallow detachment of the retina in this zone with extension down the nasal periphery to the 4 o'clock meridian. There was no other retinal abnormality in either eye. The patient therefore required retinal detachment surgery which was performed a few days later under

general anaesthetic. Cryotherapy was applied to the area of hole formation and the treated area was supported by indentation with a radial plomb of silastic sponge. Subretinal fluid was not released and the detachment settled within two weeks. The retinal detachment might well have extended in the period immediately after blepharoplasty and it would have been difficult, considering the configuration of the retinal hole, to refute an allegation that this had been caused by inadvertent needle puncture of the sclera during blepharoplasty.

We hope these cases may serve to illustrate the importance of ophthalmic examination before blepharoplasty. Even if no defect is found, it reminds both patient and surgeon that the operation is not without risk to vision when excess fat is removed through the orbital septum.

Yours faithfully

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References

- Callaghan, M. A. (1986). Prevention of blindness after blepharoplasty. *Ophthalmology*, **90**, 1047.
Mahaffey, P. J. and Wallace, A. F. (1986). Blindness following blepharoplasty. *British Journal of Plastic Surgery*, **39**, 213.

Sir

I enjoyed reading the comprehensive review by Mahaffey and Wallace on blindness following cosmetic blepharoplasty and commend the authors on their scholarly work.

In the 30 years since I have been routinely performing cosmetic blepharoplasties and removal of intra-orbital fat I have not had any alarms involving loss of vision following this procedure. Could this be because of purely technical reasons? The procedure I employ is as follows. The patient is premedicated in the usual way, 2% xylocaine with 1:100,000 adrenaline being injected very superficially under the eyelid skin so as to avoid any haematoma formation. The intra-orbital pads of fat are exposed by cutting parallel to the orbicularis oculi fibres and thereafter through the orbital septum. By applying light pressure on the eyeball the fat pads become more prominent. They are gently grasped with fine forceps and, employing a low cutting diathermy current at the base of the pad of fat, the excess fat is removed. Should there