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

by any residual bleeding points, these are caught with the fine forceps and, using a low diathermy current, are coagulated. At this stage one proceeds to the opposite eyelid and at the end of the same surgery on this side, one returns to the original side to coagulate any possible bleeders to ensure complete haemostasis. Finally, excess skin is excised and the skin margins are sutured.

Only occasionally do patients complain of pain when the fat is being removed and their remonstrations are momentary while the diathermy is being used. It is interesting that skin anaesthesia alone suffices for this procedure and my experience confirms that of Dr N. Robbe in his letter to the Editor (*British Journal of Plastic Surgery*, **40**, 107).

The use of haemostats for grasping the base of the pad of fat is avoided for fear of causing traction on the deeper feeding vessels.

Perhaps these few remarks may be of interest to your readers.

Yours faithfully
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The significance of incomplete excision in patients with basal cell carcinoma

Sir

Richmond and Davie's article appearing in the January number (*British Journal of Plastic Surgery*, **40**, 63) confirmed all of the findings in our paper (Taylor, G. A. and Barisoni, D. Ten years' experience in the surgical treatment of basal cell carcinoma. *British Journal of Surgery*, 1973, **60**, 522). I assume that the authors' omission of our article from their otherwise appropriate list of references was a simple oversight.

I would commend our article to them as one of the first attempts to correlate various factors, including the presence of residual tumour in the margin of the resected specimen, with recurrence. Since our article appeared various authors, most of whom are mentioned in Richmond's reference list, have attempted to establish guidelines upon which management of these difficult cases can be based. My philosophy of management is still based upon the conclusions which appeared in my 1973 article and heretofore I have seen nothing in the literature, including the article in question, which would encourage me to change that philosophy.

Yours sincerely
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Reply from Mr Richmond

Sir

I first read G. Allan Taylor's paper whilst preparing my own: its omission from my "otherwise appropriate list of references" was, however, not an oversight.

Dr Taylor reviewed various factors which affect recurrence after surgery for basal cell carcinoma. The problem of incomplete excision is indeed discussed but in over half of his patients the pathology reports did not state whether or not the tumour had been completely excised: in those where excision was known to be incomplete it was not stated which margins were involved. The importance of this information and its possible role in determining further therapy was dismissed as "... such an approach is neither possible nor practical in the majority of centres". It is also difficult to know what was considered as "recurrent disease" as the paper in question states "Lesions appearing many months or years after removal can hardly be called recurrent".

My own paper was a review of cases known to have been incompletely excised and looked at the influence of various factors on the likelihood of recurrence and time taken for the recurrence to become clinically manifest. In addition, problems of offering supplementary treatment at that stage were discussed.

In short, the omission of G. Allan Taylor's paper from my bibliography was intentional. Little in the paper was of direct relevance to my own review—and the areas which were germaine were better documented in the papers which were cited.

Yours faithfully
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