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Letters to the Editor

The use of gold weights in the upper eyelid

Sir,

Recently there has been a plethora of articles in the plastic surgery literature discussing a small and troubling incidence of complications in the use of gold weights in the upper eyelid to correct or improve the lagophthalmos of facial palsy.

In the September 1992 issue, Pickford, Scamp, and Harrison report another series in which an unacceptable frequency of extrusion is reported. As a consequence of an even more discouraging report by Kelly and Sharpe in *Plastic and Reconstructive Surgery*,[1] I asked MedDev Corporation who design and distribute Gold Lid Loads of my design to conduct an inquiry of its customers to ascertain, approximately, the incidence of infection and extrusion among this population.

700 customers were solicited. 168 replied, representing an estimated accumulative experience of just over 2000 operations. The incidence of infection in this group was 0.3 percent, extrusion, 2.6 percent. This is a considerable improvement over the figures cited in the above referenced reports of considerably smaller series.

The recommended method of insertion is identical to that suggested by Pickford *et al.*, except that the consistent difference from the circumstances in both reports is that the loads are placed 4 to 5 mm above the lid margin and they are perforated with 1 mm holes through which they are secured in position with sutures. Ultimately fibrous tissue grows through these holes.

It is my belief that securing the loads in position with a suture or two prevents motion and reduces the problems causing this discussion.

I shall be happy to provide more information about these lid loads and the related techniques, or the inquiry mentioned above, if asked.

Yours faithfully,

Richard Jobe, M.D.,
Division of Plastic and Reconstructive Surgery,
Stanford University,
Stanford, CA 94305, USA

Reference

Kelly S A, Sharpe D T. Gold eyelid weights in patients with facial palsy: a patient review. *Plas Recon Surg* 1992; **89**: 436–440.

Morbidity after gold weight insertion

Sir,

We read with interest the paper by Pickford *et al.* (*British Journal of Plastic Surgery*, **45**, 460–464) on the morbidity after gold weight insertion in facial palsy. The authors place the gold weight in a pocket between the tarsal plate and the orbicularis oculi muscle rather than suture it to the tarsal plate. The study is of particular importance as it is the only large series of patients so treated. Many oculoplastic surgeons have converted to using gold weights with holes (Figure). This allows fixation of the gold weight using 6-0 nylon sutures passed partial thickness through the tarsal plate. It has been our experience that this rigid fixation results in the formation of a pseudocapsule of fibrous connective tissue.

A major concern in the use of any lid-loading material is the rate of extrusion and migration. Pickford *et al.* had an extrusion rate of 5/41 (12%) and migration of 3/41 (7%). The results of a literature review on tarsus-sutured gold weights are presented in Table 1. A total of 277 patients are included. The overall extrusion and migration rates were 2% and 2.7% respectively. We have had similar results in our practice. Pickford *et al.* state that they have made the gold weight longer and flatter in an attempt to reduce the rate of extrusion. Our data suggest that suturing the gold weight to the tarsal plate significantly reduces the rate of extrusion and migration. A complication not mentioned by Pickford *et al.*, which is familiar to oculoplastic surgeons, is astigmatism induced by the gold weight resting on the superior cornea.

Bhupendra C. Patel, FRCS, FCOphth, MD, Clinical Instructor,
Patrick Flaharty, MD, Assistant Professor,
Richard L. Anderson, MD, Professor,
Division of Ophthalmic Plastic Reconstructive and Orbital Surgery,
University of Utah,
1002 East South Temple,
Suite 308, Salt Lake City,
Utah 84102,
USA

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2. Soll D.B. New surgical approaches to the management of ocular exposure secondary to facial paralysis. *Ophthalmic Plast Reconstr Surg* 1988; **4**: 215–219.
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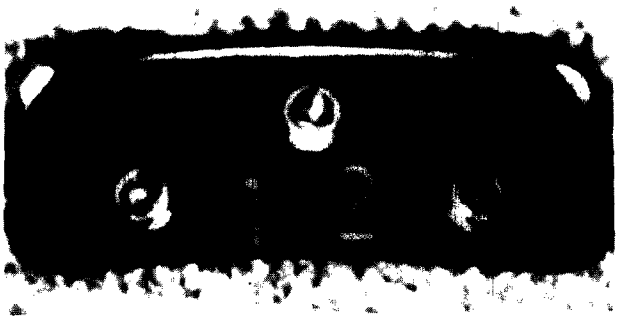

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