Classic Reprint

CORRESPONDENCE

81 Harley Street, London, W.1,
19th September 1949.

Dear Sir,

Slitting the Lower Canaliculus

Recent papers and discussion by plastic surgeons on the treatment of epiphora in cases of facial palsy have prompted me to comment about the revival of the old practice of slitting the canaliculus from the punctum to the medial canthus, as recommended in these communications.

I think the reasons against slitting the canaliculus right up to the medial canthus are these:—

1. Nature has placed the entrance to the lacrimal drainage channels apposed to the bulbar conjunctiva. The collection of tears from an opening, however large, medial to the plica semilunaris is almost always a poor affair. After the operation of conjunctivo-dacryo-cystostomy, which I described some years before the war, it is often possible to pass a No. 8 Cowper's probe with ease into the opening in the lacus lacrimalis; but, despite this, epiphora continues in some of these cases.

The drainage of tears is not merely a mechanical affair of an adequate opening to collect tears and a patent canal for their flow. I do not think that capillary attraction is the main feature.

2. When the canaliculus is slit up to the medial canthus the opening is overhung by the caruncle. In facial palsy the gutter of the slit canaliculus may become choked with mucopus and débris.

3. If occlusion of the canaliculus occurs later at the medial canthus it is very rare for a reconstruction of the canaliculus at this site to succeed. Reconstruction of a patent canaliculus in its subconjunctival course between the punctum and the medial canthus is difficult but possible.

I think it is the position and not the size of the opening into the lower canaliculus that matters. It is essential for the ectropion to be corrected, either by the diathermy puncture operation or excision of an ellipse of conjunctiva or a Z-plasty, so that the opening into the canaliculus lies against bulbar conjunctiva.

At Moorfields since 1901 Sir John Parsons and Sir William Lister and their successors have taught generations of young eye surgeons that the only justification for extensive slitting of the lower canaliculus is the presence of a streptothrix, and that in the treatment of epiphora the slitting of the full subconjunctival length of the canaliculus achieves no more and often less than a small slit of 3 mm as in the "3 snip" operation.

Yours sincerely,
H. B. Stallard.