External (Subciliary) vs Internal (Transconjunctival) Involutional Entropion Repair

EDITOR:
WE READ WITH INTEREST THE ARTICLE BY BEN SIMON AND associates,1 who we felt that the title and “purpose” of the article were slightly misleading. The transconjunctival entropion repair, the procedure which was first described by Dresner and Karesh in 1993,2 included not only retractor reinsertion, but also a lateral tarsal strip procedure,3 as well as excision of a strip of the preseptal orbicularis oculi. The authors’ surgical technique included retractor reinsertion primarily, either with or without a lateral tarsal strip, but no orbicularis myectomy was performed, which was a significant modification to the original technique. The preseptal orbicularis myectomy is integral to the success of the transconjunctival entropion repair and may explain their recurrence rate of 15%.

When the transconjunctival entropion repair (TCER) is performed, as originally described, with a preseptal orbicularis myectomy, retractor reinsertion, and lateral tarsal strip procedure, the recurrence rate is much lower than the authors’ 15% recurrence rate on 20 eyelids for transconjunctival retractor reinsertion. Khan and Meyer4 reported results on a slightly modified TCER which included preseptal orbicularis myectomy, retractor plication with two Quicksert sutures, and lateral tarsal strip, and they reported a recurrence rate of 2% on 114 lower eyelids with no postoperative eyelid retraction or overcorrection. Cook and associates5 reported results on a considerably modified TCER which included preseptal orbicularis myectomy, retractor reinsertion, and a periosteal flap technique for lateral canthal fixation. With a periosteal flap as a considerable modification to the TCER, Cook reported a poorer recurrence rate of 8.3% on 36 lower eyelids with no overcorrections. In our experience with TCER, our recurrence rate is 2.9% on 170 lower eyelids, and with no postoperative eyelid retraction or overcorrections (data submitted for publication). In our experience, the complications of TCER are mild conjunctivochalasis, occasional cilia loss, and rare recurrence.

The authors conclude that internal and external approaches have similar outcomes. There was, however, a higher recurrence rate with internal repair (15% vs 3.4%, internal vs external) and a higher rate of postoperative entropion with external repair (0% vs 10%, internal vs external), although neither were statistically significant. Mild lower eyelid retraction was a complication in an additional three cases, which, we are left to assume, occurred from the external approach. It is important to note that the complication from internal repair, namely recurrent entropion, is relatively easy to correct. The complication from external repair, namely lower eyelid retraction and/or cicatricial ectropion, may be more difficult to correct and may require canthoplasty, full thickness skin graft, hard palate or alloglomer graft, or midface lift for correction.

The reasons to perform the transconjunctival entropion repair are similar to the reasons to perform a transconjunctival lower eyelid blepharoplasty over a transcutaneous blepharoplasty. The complications are rare and are easier to repair; it circumvents the risk of lower eyelid retraction, and the cosmesis is superior.

MELANIE H. ERB, MD
STEVEN C. DRESNER, MD
Santa Monica, California

REFERENCES

REPLY
WE AGREE WITH DRS ERB AND DRESNER THAT THE CONJUNCTIVAL approach is superior overall in the treatment of involutional entropion. However, in approaching the eyelid conjunctivally we are not trying to avoid the skin incision itself. There is minimal morbidity or scar related to incising...
and carefully closing the eyelid skin. Instead, the morbidity in the cutaneous approach, whether it is for blepharoplasty, orbital surgery, or eyelid rotation, relates to the orbicularis sepal complex. Hematoma, inflammation, and scarring in this middle lamellar plane can result in eyelid retraction or volume deflation.

Lower eyelid entropion surgeries accomplish their anatomic goal by creating a scar between the lower eyelid retractors and the anterior tarsal fibrous tissue. This scar both transfers the force of the retractors to the anterior lamella and creates a mechanical stiffness that inhibits inward rotation of the margin. Trying to get the right amount of scar tissue is a delicate balancing act, subject to the inconsistencies of the biology of wound healing. Too little scar, and the entropion will recur. Too much scar, and overcorrection or eyelid retraction will result. Understanding the anatomy, physiology, and wound healing biology of the various available surgical manipulations provides the surgeon with an artist’s palate. The accomplished surgeon individualizes each surgery based on subtle differences in anatomy, trying to accomplish just the right amount of intervention (and recognizing that undercorrection is more easily managed than overcorrection.)

Drs Erb and Dresner are likely correct that surgery to the orbicularis sepal complex increases the success rate of transconjunctival entropion surgery (although comparison of the retrospective studies that they reference is not scientifically valid, and a randomized prospective study would be required to prove their point). On the other hand, aggressive treatment of the orbicularis sepal complex increases the complication rate and, indeed, turns the conjunctival approach into essentially a full thickness approach, which is what we started out trying to avoid. Unnecessary surgical reduction of eyelid volume also has negative aesthetic consequences. The orbicularis sepal complex is always manipulated to some extent in the process of exposing the anterior tarsus, but we suggest that debulking of orbicularis should be individualized and graded based on the degree of scar tissue needed to stabilize the margin and on the aesthetic goal of the surgery.

GUY J. BEN SIMON, MD
Melbourne, Australia

JOHN D. MCCANN, MD, PhD
Los Angeles, California

ROBERT A. GOLDBERG, MD

Natural History of Asymptomatic Clinical Retinal Detachments

EDITOR:
WE READ THE ARTICLE BY STEVEN COHEN ON NATURAL history of asymptomatic clinical retinal detachments with interest.1 We agree with the author that asymptomatic clinical rhegmatogenous retinal detachments (RDs) can probably be safely observed periodically for many years, though the management options depend on many factors, like patient’s age, size, and location of the subretinal fluid, the causative lesion and presence of demarcation lines, as well as on patient’s personality. Some patients accept self-monitoring and the need for frequent follow-up examinations, while others may not. Also, since presence or absence of symptoms is a totally subjective phenomenon, potential vision-threatening conditions might occur in some patients, depending on their observational powers and cognitive function, who are unaware of any ocular symptoms.2

The study did not define the presence of a partial or complete posterior vitreous detachment (PVD), which we feel might play a role in progression of the detachment. Also, since most of the cases had retinal detachments located temporally and inferiorly and were associated with demarcation lines, we feel the conclusions cannot be extrapolated to a rapidly progressive superior retinal detachment, which might lead to visual impairment sooner than later.

We agree with the author on the many potential complications that can result from a retinal detachment surgery, but these surgeries have had some impressive results over the years. Obviously, the risks and benefits of each management option have to be discussed with the patient. Also, some of these patients can be managed with the newer surgical techniques like 25-gauge vitrectomy systems.

Management of these patients with clinical retinal detachments continues to be debatable. Davis reported six (30%) out of 20 eyes with asymptomatic subclinical retinal detachments progressing to clinical retinal detachments,3 while Byer reported 0.8% risk of progression of a subclinical retinal detachment.4 He also recommended treating patients with subclinical retinal detachments that progress to become clinical detachments. Moreover, the progression of the retinal detachments was not associated with symptoms. The present study followed up eighteen eyes of 16 patients with asymptomatic RD over an average of 46 months; none of them became symptomatic during follow-up.

We feel that the decision to manage surgically in this subgroup of patients depends on wide range of factors. Most patients can be managed conservatively, with a thorough explanation to the patient, followed by a regular follow-up and documentation of findings. Once progression occurs, surgery may be required. With special reference to the countries where retinal specialists may not be available close to the patient, the treating physician may have to consider surgery in the first