REPLY: 'RESULTS OF SURGICAL PROCEDURES FOR THE CORRECTION OF FOOT-DROP AND LAGOPHTHALMUS DUE TO LEPROSY'

Sir,

In *Lepr Rev* (1994) **64,** 282–3, Margreet Hogeweg expresses deep dissatisfaction with the results of temporalis transfer for the correction of facial paralysis with lagophthalmos.

As a plastic surgeon with extensive training in ophthalmology and more than 30 years' experience with reconstructive surgery in several countries, both Asian and African, I strongly disagree with this.

It is quite true that many, possibly most of the patients who come for correction of facial paralysis have a loss of corneal sensation. I have never considered this a contraindication to temporalis transfer. It is obvious that pre-existing corneal opacities will remain unchanged. It is also perfectly obvious that recent paralysis, traditionally of less than 6 months' duration, should receive full treatment with corticosteroids, even if no other evidence is present of reversal reaction.

Possibly Dr Hogeweg has encountered operations which were performed with a less satisfactory technique. It is important that the transferred strip of temporalis muscle reaches the outer canthus in an oblique direction, so that the lower lid will be lifted in the closure. It is also important that the facial strips after passage through the lids, close to the margin are crossed deep to the canthal ligament, thus pressing punctum lacrymale against bulbus so that the tear pump may be reactivated. It is equally obvious that it must be ensured that tear passages are open before the operation, and that any infections have been dealt with. The traditional wedge excisions of the lower lid to correct the frequently overslack and drooping lower lid are in fact often unsatisfactory, not least because the resultant scar tissue on the lid irritates the cornea. Instead I use a wedge excision away from the eye and a lateral transposition of the lid obliquely upwards.

Both of these procedures, that might be performed in a single session, are not unduly complicated or difficult for a trained surgeon. They do not require complicated surgical or anaesthetic equipment.

I grant her that competent postoperative physiotherapy is necessary, but even if the cornea is completely anaesthetic, it is possible to create a new reflex arc, using visual stimulus as the afferent branch and the temporalis muscle as the effector. Even if this is not possible, the results are generally good. Nearly all patients have permanently reduced palpepral fissure and closed eyes during sleep. Detailed descriptions of these techniques are given in *Lepr Rev*, **34** and *Brit J Plast Surg*, **14** and **31**.

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