

COMMENT: CURRENT CONCEPTS IN THE SURGICAL MANAGEMENT OF LAGOPHTHALMOS IN LEPROSY

Sir,

The article by Paul Courtright and Susan Lewallen in *Lepr. Rev.* (1995) 66, 220–23 calls for a response from an African surgeon. Under *Results* they state that in Africa surgeons rely on tarsorrhaphy almost exclusively in the management of lagophthalmos. First-line treatment is of course, to suppress the ‘reaction’, which often will bring back adequate eye closure. Only then is surgery indicated.

It is not possible for me to know if they surveyed the unit where I worked from 1954 to 1982. Unfortunately, I have no exact figures, but I know we performed a good number of temporalis transfers after obtaining the proper tendon tunneler in about 1965. I think we would have performed at least 30 of that procedure. Without exception patients obtained satisfactory closure when told to clench their teeth. But the number who initiated closure of their eye(s) was very small. We concluded that only those patients less than 30 years of age and who had retained sensory perception of the cornea would initiate closure spontaneously.

For that reason we resorted to doing both a nasal and temporal tarsorrhaphy as depicted in the diagrams. The nasal ‘Z’ plasty is of limited value, as it cannot be very extensive without injury to the lacrimal puncta. It should be used along with a temporal tarsorrhaphy. To determine where to extend the incision to point ‘A’ in the second illustration, pinch the lids shut laterally as in Figure 1. After completing the procedure as outlined in Figures 1 and 2, close with interrupted sutures, leaving a few long to tie over small gauze rolls that may be impregnated with Tr. benzoin to repel flies. This dressing makes it possible to keep the eye(s) uncovered. The sutures are removed after a week.

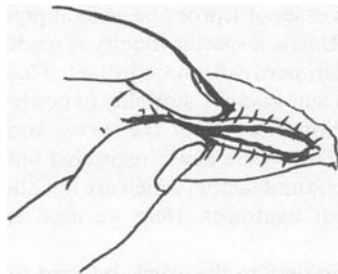


Figure 1. Extent of tarsorrhaphy: Test how much passive closure of the lids is needed to cover the cornea.

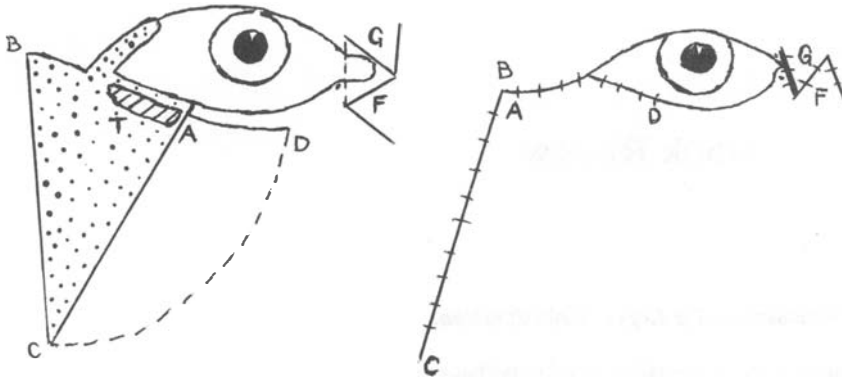


Figure 2. Tarsorrhaphy for lagophthalmos of right eye. Lateral tarsorrhaphy: The dotted triangle of skin, the lateral part of the tarsal plate and the mucocutaneous junction beneath the lashes of the upper lid are removed. ACD is undercut, and A is sutured to B. 'T' is the tarsal plate. Medial tarsorrhaphy: Two v-shaped flaps (F & G) are raised, the intervening skin and mucous membrane are removed, and the flaps interposed and sutured. The puncta are spared.

Remove the temporal $\frac{1}{3}$ rd of the upper lid margin taking care to excise the lash hair follicles completely.

It is impossible to recall how often we carried out this procedure, but it was done far more frequently than the temporalis transfer—possibly 100 times or more. I recommend this technique both because it is technically simpler than the temporalis transfer, and because functionally the results are much to be desired.

Although I cannot be specific, I am quite sure there have been several other institutions in Africa using the temporalis transfer for lagophthalmos during the past 40 years.

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