Intraoperative Adjustment of Eyelid Level in Aponeurotic Blepharoptosis Surgery

Dear Editor:

We read with interest the article titled "Intraoperative Adjustment of Eyelid Level in Aponeurotic Blepharoptosis Surgery" by Yabe et al.[1] We congratulate the authors for enriching literature by contributing their observations. The authors have suggested that intraoperatively the lid height should be located above the pupil but within the cornea while the patient gazes up. We, however, believe that this is an oversimplification because there are many variables at play here.

The authors mention that along with the skin, orbicularis was also excised. Orbicularis oculi is the sole protractor of the upper eyelid. Any insult in the form of surgery or anesthesia results in reduced action and reduced force of contraction of the orbicularis oculi as is evident by lagophthalmos which is seen intraoperatively on asking the patient to close his or her eyes. The amount of lagophthalmos is a good indicator of the amount of action of the orbicularis muscle, when observed intraoperatively. In our experience, upon wearing off of the anesthesia and complete wound closure, the orbicularis tone returns, albeit partially and the palpebral fissure height reduces. Furthermore, the amount of orbicularis excised as mentioned by the authors, varied from 5 to 10 mm. One does not expect uniform results when there is such variation in the amount of orbicularis oculi excised.

In our practice, during ptosis correction surgery, the overhead operating lights are moved completely away from the surgical field by the circulating nurse and only then is the patient asked to open the eyes and straight ahead, that is, primary gaze, *not* upgaze; while in the supine position. With a bright operating light overhead, patients often squeeze their eyes and are unable to completely open their eyes; as a result, the true corrected lid height is not observed.

Furthermore, at times, augmentation of local anesthesia in the form of infiltration into the surrounding orbicularis and the levator aponeurosis is required depending on the patient's pain threshold—all of which can contribute to change in the intraoperative lid height noted after tying the central cardinal suture.

Finally, the authors have mentioned that in their study, the lid height was observed when the patient was asked to look upward. This requires further qualification with regard to the degree of upgaze. This is relevant because it has been observed that the interpalpebral fissure height varies with vertical meridian gaze amplitude.[2]

Oculoplastic surgery, especially ptosis surgery, has a steep learning curve and is far from an exact science. None of the presently available algorithms are absolute and precise as surgeons, we often find intuition and experience guiding us rather than tables and charts. Therefore, we congratulate the authors in their commendable attempt to standardize ptosis surgery.

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Tissue Expander Complications Predict Permanent Implant Complications and Failure of Breast Reconstruction

Sir:

We read with great interest the article entitled "Tissue Expander Complications Predict Permanent Implant Complications and Failure of Breast Reconstruction."[1] We congratulate the authors on finding that women with complications after placement of a tissue expander are at significantly increased risk for both complications and reconstructive failure after placement of a permanent implant.

According to the authors' data, there were 196 patients undergoing mastectomy. One hundred eight patients underwent bilateral mastectomy (and 216 tissue expander placement), 88 patients received unilateral mastectomy (and 88 tissue expander placement). Therefore, the total number of tissue expander-based breast reconstructions were 304 (216 plus 88). Over half of the patients got bilateral breast operations, which should be taken into consideration.

The authors used number of patients developed complications as a parameter for the calculation of complication rate. We suggest the authors use the number of tissue expander/implant besides the number of patients. For example, if a patient got bilateral operation and just one of them developed complication, the complication rate would be 100% (1/1) with number of patients as parameter. However, if the complication rate is calculated by number of tissue expanders with complication divided by number of tissue expanders placed, then the complication rate would be 50% (1/2). Furthermore, for certain therapeutic modalities, such as radiation, unilateral or bilateral radiation related complication should also be taken into account.

Tissue expander-based breast reconstruction–related complications is important in plastic surgery, we hope there will be larger-scale prospective investigations in this field.

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