CLINICAL HISTORY OF AN OPERATION FOR CICATRICAL ECTROPIUM WITH ADVANCEMENT OF THE LEVATOR PALPEBRÆ.

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CLINICAL HISTORY OF AN OPERATION FOR CICATRICIAL ECTROPIUM WITH ADVANCEMENT OF THE LEVATOR PALPEBRÆ.[1]

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On the 23d of October, 1896, Dr. Charles J. McFadden, of Pittston, in this State, brought an eight year old boy to me at my clinic at Wills' Eye Hospital, with the history of having had the left upper eyelid hooked and torn by a cow's horn four weeks previously. The lacerated tissues were united and stitched into position as well as possible under the circumstances, by Dr. Lewis H. Taylor, of Wilkes-Barre.

When first seen there were two irregular curvilinear cicatrices extending from a broad break in the inner extremity of the ciliary margin up and out to the middle of the lid, from which a long curved superficial skin scar, almost reaching the outer border of the lid, extended.

The outer two-thirds of the lid were completely everted with an almost absolute hernia of the thickened cul de sac. The tarsus itself was so split and cicatrized, and the skin tissues were so firmly bound together along the superficial cicatrices, that it was impossible to either bring the lid into proper position or to lift it from the ciliary border of the underlying lower lid. Just above the cicatrices a long strip of loose tissue seemed to be devoided of the support of any underlying tarsus.

The eyeball was intact and the lower lid was uninjured.

Two days later, whilst the patient was under the anesthetic influence of ether I exercised as much as possible of the hypertrophic

[1] Read before the January, 1897, meeting of the Section on Ophthalmology of the College of Physicians of Philadelphia.

conjunctival tissue, leaving a horizontal lozenge-shaped area, the edges of which were united by a series of fine interrupted sutures. The superficial and deep cicatrices were carefully recut and trimmed to a sufficient distance to allow the lid to be inverted into its proper position, and a number of interrupted sutures were so placed as to practically mat the skin, muscle, tarsus and conjunctiva into their normal relations.

The field of the operation was dressed by an ordinary occlusive antiseptic bandage. There was but little reaction, which was kept in abeyance by the judicious use of ice compresses and thorough cleanliness.

Although the lid seemed in good position, yet on the 4th of November, by reason of the appearance of a large wedge shaped piece of hypertrophied conjunctiva into the palpebral fissure just above the position of the upper canaliculus, the entire area between the two original cicatrices with the bulging hypertrophied conjunctiva that extended through the lid, was excised. The edges were neatly freshened and brought together, leaving a lid, which, with the exception of the marked drooping, looked exactly like its fellow. The wound was dressed in a similiar manner as was done at the first operation.

After healing had established itself in several days' time, it was determined to endeavor to find the levator palpebræ and, if possible, to attach it to the remaining rim of tarsus a couple of millimeters above the ciliary border.

On November 27, with the kind assistance of Drs. George C. Harlan and William F. Norris, a long curvilinear incision parallel with the ciliary border about half way up the lid was made through the skin and underlying tissues down to the orbicularis muscle. The fibres of the muscle were carefully teased apart, and, after much free dissection up and in under the orbital margin, the fan-shaped sheath of the levator was found and secured by two sutures and held by an assistant while the muscle was dissected loose from a mass of false cicatricial tissue.

After the levator had been freed, and could be easily pulled down, its free extremity was trimmed and attached to the upper edge of the central position of the remaining tarsus by carrying the threads through the tarsus and making two deep sutures, thus allowing by resection and advancement, the muscles to act upon the lower and fixed part of the upper lid. This being done, the orbicularis fibres were smoothed into position, the gaping wound was thoroughly flushed with warm sterile water, and its edges brought together by several fine superficially placed sutures.

A few days later the stitches were removed, it being necessary to etherize the patient in order to remove the deep ones without injury to the field of operation.

In three weeks' time the patient was discharged from the hospital with a lid which, in appearance, could not be differentiated from its fellow, and which enjoyed as free movement.

REMARKS:—The case is interesting not only from the peculiarity and comparative rarity of the character of the accident, but is instructive in showing the various steps of

operative procedure pursued to overcome a deformity that would have been both permanent, and probably, sooner or later, detrimental to the functional activity and power of the eye itself.

The almost complete eversion of the upper lid, the dense and irregular cicatrices binding the skin-surface of the lid together, and the almost entire loss of the tarsus, were complications that at first sight might appear insurmountable.

The drooping and immobility of the repaired lid from having lost its attachment to its levator muscle offered, as it did more than a quarter century ago to Dr. John Green of St. Louis, in an almost identical case, an opportunity of making useful a perfectly healthy misplaced muscle in performing its proper functions.

For these reasons, and to stimulate other surgeons when confronted with the same character of disturbance to pursue similiar or better and improved methods, have been the reasons that I have thought well to make a brief résumé of the case.