MINI REVIEW

Adjustable sutures in squint surgery

Despite widespread attention in the ophthalmic literature the use of adjustable sutures in squint surgery remains limited in the United Kingdom. This review examines the advantages of adjustable sutures, surgical indications, and operative techniques.

The concept of adjustable suture surgery was originally developed more than 50 years ago, but it was not until the mid 1970s that the technique was popularised by Jampolsky following work on squint surgery under topical anaesthesia with on table adjustment. A one stage procedure with adjustment under general anaesthesia has been described, but ocular alignment depends solely on examination of the corneal light reflexes. Furthermore, the resting position of the eyes is affected by general anaesthesia, although attempts have been made to estimate the 'true' position and predict optimal postoperative alignment. The majority of surgeons now opt for a two stage procedure; initial surgery being carried out under general anaesthesia, with postoperative adjustment under topical anaesthesia.

Indications

Adjustable sutures are intended primarily to facilitate more accurate ocular alignment and decrease the need for reoperation. In patients with fusion an optimal position within the fusional range can be selected, minimising postoperative diplopia and maximising the functional field of binocular single vision. In cosmetic procedures the most appropriate ocular alignment is more easily attained.

Indications for the use of adjustable sutures vary widely – 'a horizontal or vertical deviation requiring a weakening or strengthening procedure on a rectus muscle in a cooperative patient' being proposed by the more enthusiastic. The advantages of an adjustable technique are most apparent when the results of conventional surgery are unpredictable, particularly as a result of tethering, scarring, or contracture of extraocular muscles. Specific indications include reoperations, large angle squints, thyroid eye disease, blow-out fractures, diplopia following retinal detachment surgery, paralytic squints, and combined horizontal and vertical muscle procedures. A possible limitation of the technique is that it is difficult to perform vertical transposition in conjunction with horizontal muscle surgery although this is not universally accepted.

Preoperative assessment

A full explanation of the procedure, including details of the adjustment, is mandatory. To gauge the suitability of a patient for adjustment, topical anaesthesia is applied and a cotton bud used to manipulate the bulbar conjunctiva. Patients tolerating the 'cotton bud test' are likely to cooperate with adjustable surgery. In our experience this includes most adults and some children as young as 8 years.

The two stage approach

The anaesthetist should be aware that an adjustable procedure is planned so that the patient is as alert and cooperative as possible in the early postoperative period. Day case surgery is ideal, the operation being performed in the morning and adjustment carried out later the same day. Adjustment is possible with recession or resection, on horizontal or vertical muscles, on two muscles of the same eye and on both eyes in a bilateral procedure. Adjustment may be performed as soon as the patient is sufficiently alert to cooperate, usually within 6 hours of surgery. Waiting until the following morning is an acceptable alternative, but difficulty may be encountered as some muscles adhere firmly to the globe within 24 hours.

Limbal, Swan, and fornix incisions are practised. We prefer the limbal approach which has the advantage of good exposure, allows conjunctiva to be resected in cases of restriction and is generally favoured in re-operations. Difficulty may be encountered when contact lenses are worn and required at the time of adjustment; in such cases a Swan or fornix incision is preferred.

Two principal techniques of muscle reattachment have been described, the 'bow tie' and the 'sliding knot'. In the bow-tie technique the arms of the suture are passed through scleral tunnels starting near each end of the insertion and emerging 1.5 mm apart, advancing nearer to the limbus to facilitate adjustment. A double throw is placed, with the muscle correctly positioned and secured with a loop. Fells passes both arms of the suture through the insertion twice, each time from posterior to anterior to form two 'Z' configurations. The position is maintained by friction alone and only a loose bow need be tied. When a sliding knot is to be employed, the two arms of the suture are brought out parallel and close together at the insertion, and lassoed with a second piece of 6/0 vicryl. This is tied tightly around the muscle suture and snugged down to the insertion. If the muscle is then pulled anteriorly as far as the insertion, the distance between sliding knot and insertion can be measured, and will be equal to the amount of recession performed. This technique allows accurate estimation of the final muscle position following adjustment, but tends to leave a larger knot. In a final variation, Campos leaves the two ends of the vicryl suture completely untied allowing the muscle to hang back freely, thereby committing himself to adjustment.

Subsequent adjustment in all cases is eased by the ability to fix the globe, which is best done with the aid of a 'bucket handle' suture, such as 6/0 vicryl (Polyglandin 910), placed in the sclera at or anterior to the insertion.

A key factor in the success of adjustable sutures has been the use of the double armed 6/0 vicryl suture on spatulate needles. Despite its gauge, 6/0 vicryl has remarkable tensile strength and little tendency to snag. Identification at the time of adjustment is eased by using a dyed suture and the handling characteristics may be improved by coating with bone wax. A tendency for 'tissue drag' to occur between conjunctiva, Tenon's capsule, and muscle can be reduced by lubrication with Healon although this is rarely necessary.

Some surgeons deliberately over-recess at operation as it is easier to advance rather than resect a muscle at the time of adjustment. Such a strategy inevitably increases the number of cases requiring adjustment, and it is our policy to recess the exact amount required. When resecting a muscle, it is usual to resect slightly more than the estimated amount, and then leave the muscle recessed to allow adjustments either way. Excess resection, however, would increase both the risk
of restriction and the documented incidence of muscle slip-page, making adjustable resection in general a far less popular option.

Several strategies have been proposed for dealing with the conjunctival flap following a limbal incision. In the 1970s, problems were encountered with irritation from the non-absorbable sutures used at that time but this is much less apparent with vicryl. It should be remembered that some squint operations are cosmetic, and that the handling and repair of conjunctiva is an important part of the operation. Jampolksky originally advocated leaving the knot exposed on bare sclera, and excising it 2 to 3 weeks postoperatively. We routinely close conjunctiva, with a loosely recessed flap allowing access to the bow. Alternatively, sutures may be placed through the corners of the flap and corresponding lateral conjunctival fornix.

Complications are uncommon, complications are rare. Nausea may be induced by adjustment, but careful handling of the globe minimises both this and the risk of bradycardia. Breakage of the suture is very uncommon, as is the inability to achieve a satisfactory alignment. Parks has questioned the use of any form of ‘hang loose’ suture, stressing both the tendency for the muscle width to collapse and the potential uncertainty of the final position of attachment of muscle to sclera. Inferior rectus is prone to slip postoperatively as a consequence of its attachments to Lockwood’s ligament and inferior oblique: Kushner has advocated the use of a non-absorbable adjustable suture in this situation.

Results

The recognition of any new surgical technique as successful is best made with reference to prospective studies comparing the newly proposed procedure with a previously accepted technique. Such information is not available, but results have been published and should be considered carefully. The absolute criterion for failure in squint surgery is the need to reoperate. Two retrospective studies have shown a decrease in the reoperation rate comparing adjustable sutures with conventional surgery.21 Other authors have examined their reoperation rates following adjustable techniques, quoting figures of 5–8%.17 18 Alternatively, considering ‘success’ to be a final deviation of less than 10 prism dioptries horizontally or 5 prism dioptries vertically, Kraft and Jacobson typify published results with a success rate of 85% for primary procedures and 78% for reoperations. Their ‘adjustment rate’ of 40% is similar to that of other studies.17 24–26

Conclusion

Success in ocular motility surgery depends on many factors. The adjustable suture technique is designed to minimise variability in one of these factors, namely the idiosyncratic response of an individual patient to a stereotyped surgical procedure. Adjustable sutures have been employed across the whole spectrum of squint surgery, from the cosmetic correction of a divergent blind eye to the functionally complex Harada–Ito procedure.27 28 Each surgeon must base his practice on his own results, the particular needs of the individual patient and the time and resources available. The techniques outlined above are simple to perform and take up no more theatre time than conventional squint surgery. Although adjustable suture surgery is not at present regarded as routine, the simple objective of avoiding large post-operative ocular misalignment in unpredictable cases should endear this procedure to all squint surgeons.
Adjustable sutures in squint surgery.

R J Morris and A J Luff

Br J Ophthalmol 1992 76: 560-562
doi: 10.1136/bjo.76.9.560