clinical curio which they are unlikely to encounter. It does, however, offer potential insight into the mechanisms of initiation and propagation of uveitis and other autoimmune disease, and confirms the importance of the CD4+ T cell in this process. The explanation as to why some individuals develop malignancy and others autoimmune disease is eagerly awaited.

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Changing concepts in ptosis surgery

In this issue of the journal, the article by J R O Collin and B A O’Donnell draws our attention to a changing concept in the surgery for blepharoptosis. There are many and various techniques for the management of the adjustment of lid height, either for practical optical reasons or for purely cosmetic reasons.¹

An initial foray into the literature allows an easy understanding of the principles behind lid height management, and to the uninitiated the procedures appear to be relatively straightforward. Line diagrams, cadaver dissections, and the occasional prepared coloured slide give a general overview of the work of the ptosis surgeon and an appreciation of its apparent simplicity.

However, in reality there are many frustrated junior and senior doctors who are being confronted with the ‘Red Sea’ of blood that despite many a prayer does not part, and the final surgical result is for the management of uncorrected postoperative lid height. Surgeons who specialise in lid and periorbital procedures have often quite varied approaches to what appears to be a common end result, but despite personal differences and often heated discussion, one constant requirement remains – that is, knowledge of anatomy, which must be combined with a consistent dissecting technique and the ability to know where one is within the ‘lid sandwich’. Once this has been mastered, then the various surgical doctrines can be adapted to suit virtually any surgeon. Precise repositioning of a retracted levator aponeurosis or the precise excision of levator and Müller muscle are the features of a successful surgical technique.

However, despite relative consistency, there are patients who do not conform to the standard pattern, and many of the pathologies listed in the article by Collin and O’Donnell exemplify this problem. Such conditions range from degenerative and dystrophic extraocular muscle pathologies to endocrine imbalance resulting in dysthyroid ophthalmopathy. The upper lid can vary in position quite dramatically and with abnormal muscle function the standard ground rules of levator surgery often have to be abandoned.

The adjustable suture technique described offers an expansion in the range of options that the surgeon can call upon when controlling lid height. This is not a new concept, because when the archives are dusted down and examined it is easy to find theories on adjustable suture techniques encompassing all the extraocular muscles dating back a substantial amount of time.² It is relatively recently that the strabismus surgeons have presented the profession with consistent repeatable and successful adjustable suture techniques. The main difference between their current success and their predecessors’ failure is the quality and standard of material available.

The current article underlines the success obtainable with modern equipment, which we often take for granted. The particular style of alloy needle coupled with absorbable strong, yet sleek running suture material is very much a modern development, and I think many of our predecessors would have been well pleased to have had this type of material at their disposal. It is therefore much easier to adopt the principle of postoperative manipulation of soft tissue in an expanding group of patients. The technique, however, may be limited to the patients who are responsive, cooperative, andrelaxed and, although the pathology may indicate adjustable suture technique as being the most favourable form of surgery for a reasonable outcome, we must not forget the patients and their wishes and demands. The adjustable suture ptosis surgery technique undoubtedly adds to the surgeon’s armoury for lid work.

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