of Professor Meller, "There is no one way of treatment in medicine that is the best. It is for each to select the particular line of treatment that seems best to him and perfect himself in it, and he will then get as good results with that method as somebody else elsewhere is getting with his particular method."

CORRECTION OF PTOSIS BY TWO STRIPS OF FASCIA LATA

BY

J. A. MAGNUS

BIRMINGHAM

MANY operations have been designed for the correction of ptosis. To instance a few, there are Everbusch's operation, in which the levator palpebrae muscle is advanced; Hess's operation in which three sutures are employed; Motais' operation in which a narrow tongue of the superior rectus is attached to the upper border of the tarsus, and Derby's operation in which a hammock of the fascia lata is used to pull the upper lid upwards.

The great disadvantage common to all is the more or less tortuous lagophthalmos with which the operator has to deal at the end of the operation, and therefore the necessity of protecting the cornea from ulceration. This, however, is avoided by the method described by Lexer of Munich in 1923.

Lexer employs two strips of fascia lata to pull the lid up in a manner similar to that in which Hess uses his sutures. The advantage of Lexer's technique is that a direct connection is made between the frontalis muscle and the lid margin by a tissue which can be left in place. This, in due course, will undergo a natural contraction and so emphasize the effect of the operation. Since this method is apparently not well known in this country, and since I have had some experience in this operation on the Continent as well as in England, it may be of service to outline briefly the main points:

I. Preparation: The day before the operation the eyebrow is shaved and its position delineated with silver nitrate stick. The skin of the thigh and face is prepared as for any other operation.

II. Operation:

(1) Two per cent. novocaine with adrenalin is used for local injection. The thigh below the great trochanter is incised for a distance of about 8 cms. and the fascia lata exposed. Two parallel incisions 2.5 cms. long are made in the fascia 6—8 mms. apart. The portion of the fascia is separated and transferred to a basin

warm saline lotion. The fascial gap is closed with catgut and the skin sutured in the ordinary way.

(2) The graft is freed from fat and cut into two strips measuring 25 by 3 mms. Silk sutures are passed through each end, that for the lower being double armed.

(3) Two incisions 1 cm. long are made in the line of the eyebrow; the inner being at the junction of the inner and middle thirds, while the outer is between the middle and outer thirds. The

FIG. 1.

skin is undermined upwards with blunt scissors for 6—8 mms. to expose the frontalis. Two tunnels are now made between the skin and the orbicularis in a downward and converging direction towards the lid margin where a counter incision is made at about 3—4 mms. above the margin (Fig. 1).

(4) An aneurysm needle is passed from above downwards through this tunnel and threaded with the suture of the graft. The aneurysm needle is withdrawn with the strip, and the latter left in position (Fig. 1).

(5) The lower end of the graft is sutured to the margin of the skin wound, and the latter closed with the same suture (Fig. 1).

(6) The upper ends of the strips are pulled so that a palpebral furrow is formed and the margin of the lid brought to within 3 mms. of the upper margin of the cornea, with the eye in the primary position. The upper lid is retained in the desired position by stitching the strips with double armed catgut sutures to the lower end of the frontalis muscle (Fig. 2).

(7) The ends of the strips are then trimmed and the wound closed with silk sutures (Fig. 3).

FIG. 2.

FIG. 3.

It is important to see that the upper lid is not pulled up too high. I usually find it sufficient if the lid margin is on a level with the upper fifth of the pupil (taking the average pupil as 6 mms. in diameter) and never above it, since as the strips contract, there is a further shortening effect of at least 1 mm.; but it is not produced for 2—3 weeks. Should the upper limbus have been exposed in the first instance, overcorrection with its dangers of exposure to the cornea will result.

It is not necessary to take special precautions for the protection of the cornea, as it is moistened by blinking and fully covered when

the eye is closed. During sleep there is a gap of about 1–2 mms. between the lids through which the sclera can be seen, but the cornea is completely protected, as the eyeball is rotated upwards.

It will be found by the end of 4–6 weeks that the upper lid margin is within 2 mms. of the limbus above. The patient is able

FIG. 4

FIG. 5

to move his upper lid with the help of the frontalis and there is a slight palpebral furrow due to the pulling of the strips. The upper scars cannot be seen, as they are covered by the eyebrow, while the lower, near the lid margin, disappear in the palpebral furrow.

I have successfully used this operation, also, in those cases where the levator was not completely paralysed, and have found this easier than the advancement of that muscle.

Full surgical asepsis is of particular importance as any infection will vitiate the result.

In conclusion, I have to thank Mr. Alabaster for the use of his clinical material (Fig. 4, 5).

REFERENCES

- Lexer.—Ptosisoperation, Herstellung der Oberlidfalte und des Unterlides durch Fascienzügel. *Klin. Monatsbl. f. Augenheilk.*, p. 464, 1923.
 Derby.—Correction of Ptosis by Fascia Lata Hammock. *Amer. Jl. of Ophthalmol.*, p. 352, 1928.
 Meller.—Ophthalmic Surgery.

A MODIFICATION IN BIFOCALS

BY

F. A. WILLIAMSON-NOBLE

LONDON

THE commonest complaint of the wearer of bifocals is difficulty in going downstairs, stepping up curbs, etc.

This is due, not so much to the different power in the reading portion as to its centering. In the ordinary bifocal glasses the centres

FIG. 1

Ordinary solid ground bifocal.