CASE NOTES

PARTIAL RESECTION OF THE UPPER EYELID AND ITS REPAIR*

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CASES that need partial resection of the upper or lower eyelid for lesions requiring surgical removal are not often encountered in daily practice. The plastic repair of the defects remaining after resection is not easy, especially when the lesion occupies half the lid or more, and is moreover located in the upper lid. The following operative procedure, first advocated by Wheeler (1939), and modified by Reese (1944), can be used to repair a defect involving the entire lower lid, though it is not adequate to repair more than one half of the upper lid.

CASE REPORT

Y.H.A., 55 years of age, works as an Imam of a mosque; he was referred to the Giza Memorial Ophthalmic Laboratory from Esna Ophthalmic Hospital, on October 22, 1950, for the treatment of a tumour of the right upper tarsus suspected to be malignant. The condition, according to the patient, had started 8 years before as a small swelling in between the lashes of the middle of the right upper lid. The swelling had been removed twice but recurred after each removal, and had continued to grow until it reached its present dimensions. No specific history was given by the patient.

Examination.—Left eye normal, with uncorrected vision 6/18. Right globe normal, with uncorrected vision 6/24. A swelling in the centre of the upper lid occupied more than half the breadth of the lid and all its length (Fig. 1). Externally it was lobulated and hard, and the skin, although tense, was not infiltrated. The swelling was about 2 cm. in height, by 1.25 cm. in breadth, by 0.75 cm. in thickness. When the lid was everted, the tumour was seen to occupy the whole length of the tarsus, including the lower border of the lid (Fig. 2), and the conjunctival surface was also lobulated in a cauliflower appearance. The tumour occupied the middle of the lid, leaving less than one-quarter of the breadth unaffected on each side. One small submaxillary lymph node was palpable on the right side. The condition was considered clinically malignant, and it was decided that complete removal of the tumour mass was necessary.

Operation.—This was done on October 25, 1950. Local block and infiltration anaesthesia with novocaine 2 per cent. solution with adrenaline was used. The edges of the lid outside and inside the tumour were split with a sharp knife for 2 to 3 mm.,

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FIG. 1. Outside of eyelid before operation.

FIG. 2.—Inside of eyelid before operation.

starting beyond the limit to which the lesion extended. By this splitting, the skin and muscle remained in the anterior flap and the tarsus and conjunctiva in the posterior. The lid was then everted and the conjunctiva above the lesion incised and dissected as far up into the fornix as possible. Two double-armed sutures were inserted into the edge of the posterior conjunctival flap and left for future use.

The part to be excised was then outlined on the skin and conjunctival surfaces, and first the medial vertical cut and then the horizontal cut were made with strong scissors. A canthotomy was then done and the blade of the scissors was passed up to cut the upper limb of the external canthal ligament so as to free the upper lid completely.

The sliding flap from the skin of the temple was marked out, the incisions diverging so that the flap had a broad base. The principles used in pedicle grafts were observed here, the width of the flap being at least one third of its length so as to ensure sufficient nourishment. The flap was then undermined, the dissection going deeper the farther it went laterally, so that the outer portion would be thicker than the inner. The vertical lateral incision of the area of the lid to be removed was made and the whole tumour mass excised.

The anterior flap (skin and muscle) of the split area of the inner part of the lid was then excised, and the posterior flap (tarsus and conjunctiva) of the split area of the outer part of the lid similarly treated. The two ends of the cut edges of the lid were approximated and that part of the sliding flap that was intended to lie in front of the outer border of the bony orbit was marked out. A catgut suture was then passed into the periosteum of the outer border of the bony orbit, and subcutaneously into the area or point already marked on the skin, and knotted (this is one of the most important steps of the operation for it is this suture that will hold the two flaps of the lid together, so that no tension will be exerted on the skin-to-skin sutures).

The conjunctiva of the fornix was then pulled down and stitched to the back of the newly-formed lid (this step should be done at this point and not at the end of the operation as in lower blepharoplasty, because it is very difficult, and even dangerous, in upper-lid repair to evert the lid after the two flaps have been sutured together).

The two flaps of skin were then stitched together by double-armed sutures, and all the skin incisions were sutured with silk (great care must be taken in locating and stitching the new outer canthus).

A binocular bandage was then applied, the first dressing being done after 48 hours. The bandage was retained for about 10 days, and changed every second day.

FIG. 3.—Condition after treatment.

Tumour.—Histopathologically the tumour proved to be an adeno-carcinoma of a Meibomian gland and the sections showed that the tumour has been completely excised.

Post-Operative Course.—The case ran smoothly with no complications, and the bulk of the newly-formed lid was well preserved (Fig. 3). A small notch seen 10 days later at the lid border at the site of junction was easily repaired by simple stitching. One month after the operation healing was complete. The lashes that were present in the outer non-affected part of the lid, and which now were located in the middle, were turned in, so that I was obliged to excise them to avoid injury to the cornea. I would have grafted a new row of lashes, but the patient did not mind about the appearance and could not stay any longer in hospital. He was discharged on December 9, 1950, with a good functional and cosmetic result.

SUMMARY

A case of adeno-carcinoma of a Meibomian gland affecting more than half the right upper lid is described. The tumour was excised and the lid successfully repaired by a sliding flap.

REFERENCES

- REESE, A. B. (1944). *Arch. Ophthalm., Chicago*, **32**, 173.
 WHEELER, J. M. (1939). "Collected Papers", pp. 338-342, Columbia Univ. Press, New York. *Quoted by Reese.*

NOTE

FACULTY OF OPHTHALMOLOGISTS

At a meeting of the Council on Friday, April 13, 1951, the following were elected officers:

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