BLASKOVICZ OPERATION*

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THE Blaskovicz operation is the best surgical procedure so far devised for the correction of ptosis. The following observations are based on the experience of 35 cases of congenital ptosis in which this technique was used. In each case the function of the superior rectus muscle was normal (Table).

TABLE
RESULTS IN 35 CASES FOLLOWED-UP FOR AT LEAST 3 MONTHS

Result		No. of Cases	Lid Lag		Incomplete Closure		Retraction on Abduction	Retraction on Occlusion of Sound Eye
			Pre-sent	Not Tested	Pre-sent	Not Tested		
Perfect		10	7	3	7	3	—	—
Near Perfect	Over-correction	3	2	1	2	1	—	—
	Under-correction	9	5	4	5	4	—	—
	Arching of Lid	4	2	2	2	2	—	—
Fair (Insufficient Resection)		4	—	—	—	—	—	—
Poor	Loose Bandage and Cutting through of Sutures	1	—	—	—	—	—	—
	Gross Under-correction	1	—	—	—	—	*1	*1
Not Traced		3	—	—	—	—	—	—
Total		35	16	10	16	10	1	1

* Case 3

Case Reports

Case 1.—In a man with complete ptosis on the right side (Fig. 1a), the operation resulted in an excellent cosmetic appearance (Fig. 1b), though the defect was slightly over-corrected. The principle of over-correction at the time of operation, as advocated by Berke (1952), was strictly followed and at the time of the first dressing the over-correction was regarded as offering a good ultimate prognosis.

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Three years after the operation, however, this defect has not improved at all. In sleep the eye remains open, and the worried patient recently returned seeking restoration of his ptosis. Even a forceful effort of the orbicularis muscle does not cause complete closure of the palpebral aperture, and on looking down there is a marked lid lag of the pseudo-Graefe type (Fig. 1c).

Case 2.—Sutures through the frontalis muscle failed to lift the lid to the desired extent, and the Blaskovicz technique was used (Fig. 2a). There was arching of the lid (Fig. 2b) and the palpebral aperture could not be completely closed (Fig. 2c). On looking down there was a lid lag of the pseudo-Graefe type (Fig. 2d).

Case 3.—After the present author's observations on synkinetic lid retraction (Jain, 1957), this case, like the others, was examined particularly with the aim of discovering any peculiar pre-existing associations, but none was found.

After the Blaskovicz operation had been performed, the result was under-correction in primary position (Fig. 3a). There was no lid lag on looking down (Fig. 3b), and the lids could be completely closed (Fig. 3c). On abduction, which was normal, the right lid retracted, making a wider palpebral aperture (Fig. 3d). This phenomenon is identical with that of Fuchs (1895), which is seen after partially-recovered ophthalmoplegias. On occlusion of the left eye, lid retraction with residual ptosis was seen (Fig. 3e) and the palpebral aperture was widened.

Discussion

Two difficulties were encountered during the operation:

(1) The dissection of the conjunctiva from the underlying levator was not always easy, particularly where the conjunctiva was cicatrized and adherent on account of trachoma. This gave rise to button-holing and tearing of the conjunctiva, or to the dissection of levator fibres with the conjunctiva.

(2) The traction sutures through the muscle insertion gave way, either because the muscle fibres had been partly damaged in the process of dissecting the conjunctiva, or because the muscle was fragile.

Instead of separating the muscle insertion from the tarsal plate, the piece of tarsus bearing the muscle insertion and intended for ultimate excision was cut and mobilized in all directions first. Traction sutures were passed through the tarsal piece, and the muscle strip was separated from the underlying muscle of Muller and from the orbicularis oculi along the embryonic plane of cleavage. This made mobilization of the levator band easier with no risk of losing the grip on the muscle.

Lid Lag and Incomplete Closure of the Lids.—Of the 35 cases, 26 gave a good result. Although Dunnington (1941) and Malbrán (1941) state that lagophthalmos is negligible, sixteen cases tested out of the 26 with a good result showed lagophthalmos and incomplete closure of the eyelids. It appears, therefore, that the ptosis should be slightly under-corrected.

Lid Arching.—This is reported to be rare by Dunnington (1941) and Malbrán (1941), although Scott (1952) found four cases and there were four in the present series. To avoid arching of the lid, two precautions were taken:

(1) The central suture was passed through the levator muscle a little distal to the side sutures, thus slightly under-correcting the centre only,

(2) The side sutures were passed through the skin of the upper lid well to the outside both medially and laterally.

Summary

35 cases of ptosis operated by the Blaskovicz technique are reported. The wisdom of fully correcting the defect is debated.

Case 3 shows of a rare post-operative type of lid retraction.

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