PLASTIC RECONSTRUCTION OF THE UPPER EYELID*†

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RECONSTRUCTION of the upper lid aims to give movement to the lid and protection to the eyeball. Wherever possible the levator muscle must be used to permit the lid to move (Stallard, 1958).

In the following case three-quarters of the upper eyelid were excised and the cut margin of the levator was utilized to give mobility to the reconstructed lid.

Case Report

A man aged 45 years was admitted to the Government General Hospital, Guntur, with mechanical ptosis due to tumour of the left upper eyelid. The lid covered the eye completely and the patient was not able to open the palpebral aperture. The swelling had been present for a year and was gradually increasing in size (Fig. 1).

FIG. 1.—Meibomian carcinoma of left upper eyelid before operation.

Examination.—There was a nodular oval swelling of the left upper lid, measuring $1\frac{1}{2} \times 1$ ". The skin was smooth and not adherent to the tumour, which was firm in consistency. On the conjunctival surface, the growth was ulcerated. The pre-auricular and sub-maxillary nodes were not enlarged.

The clinical diagnosis of meibomian carcinoma was confirmed by histological examination.

Treatment.—The whole tumour along with 0.5 cm. of healthy skin around it was excised. From the incised margin of the upper lid the cut levator muscle was carefully dissected and mobilized. An incision was made along the grey line in the lower lid, and the tarsus with the palpebral conjunctiva was separated from the rest of the lid up to the lower fornix. Two vertical cuts were made 1" apart in the separated tarsus in the lower lid up to the fornix. The tarsus of the lower lid along with the palpebral conjunctiva was sutured to the upper fornix with 0000 silk (continuous stitch) and the ends of the stitch were brought out through the healthy skin.

The mobilized edge of the levator palpebrae superioris was brought forwards and sutured to the tarsus of the lower lid.

To provide skin for the upper lid by a sliding graft, two parallel horizontal incisions $\frac{3}{4}$ " apart and 2" long were made in the left temporal region starting from the orbital margin. The undermined skin-flap was slid medially and sutured to the cut edges of the skin of the upper lid. The lower margin of this grafted skin-flap was stitched to the margin of the lower lid. A pressure bandage was applied.

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Post-operative Treatment.—The patient was given penicillin daily for 10 days. The first dressing was done on the fourth day. The sutures of the skin-graft were removed on the seventh day. The continuous suture fixing the upper fornix to the lower tarsus was removed on the tenth day. The tarsorrhaphy sutures were removed on the fourteenth day. The lids were separated after 3 weeks. The skin and the conjunctiva were carefully incised along the tarsorrhaphy. At the end of one month the patient was able to open and close the lids (Figs 2 and 3). The reconstructed upper lid had normal movement and was lined on the inner side by conjunctiva.

FIG. 2.—Both eyes open after operation.

FIG. 3.—Both eyes closed after operation.

Summary

This reconstruction of the upper lid achieved a good cosmetic and functional result. This operation was based on the technique of Hughes (1954), but because the patient was not willing to undergo repeated operations the work was all done at the same time instead of in several stages. For this reason the reconstructed lid-margin could not be provided with eyelashes.

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