



ORIGINAL RESEARCH PAPER

Ophthalmology

CONGENITAL PTOSIS: A GOOD COSMETIC OUTCOME

KEY WORDS: congenital ptosis, frontalis sling surgery, lagophthalmos.

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ABSTRACT

congenital ptosis is the drooping of upper eyelid since birth, corrected mostly with frontalis sling surgery and likely to have postoperative lagophthalmos i.e. inability to close the eyelids completely. Here we discuss a case of 6 years old male child having congenital ptosis operated by frontalis sling surgery with no postoperative lagophthalmos, highlights good cosmetic and surgical outcome in experienced surgical hands.

Case summary:

Six years old male child presents with his parents complaining of drooping of right upper eyelid since birth. It is non progressive, no diurnal variation, not affected by jaw movements. No history of ocular trauma, surgery, allergic eye disease or any systemic illness. On examination there was drooping of right upper eyelid covering half of the cornea, absence of upper eyelid crease with slight chin elevation. Best corrected visual acuity was 6/6 both eyes with normal anterior and posterior segment of eye. On ptosis evaluation, margin reflex distance was -2mm (normal is 4 mm) i.e. severe ptosis, vertical fissure height 3mm (normal is 9-10 mm), upper eyelid crease absent, levator action 2 mm (normal is 15mm to 18 mm) i.e. poor levator function, lid lag on downgaze, good bell's phenomenon, no marcus gunn jaw winking phenomenon with normal corneal sensations and shirmer's test. He diagnosed as right severe congenital ptosis with poor levator function and frontalis sling surgery (using silicon sling), fox procedure done under general anesthesia after taking informed consent for overcorrection, under correction, lagophthalmos, lidlag, need of resurgery. Postoperatively there was good cosmetic outcome with no lagophthalmos. There was no recurrence reported in 3 years of follow up period.

DISCUSSION:

Congenital ptosis is present since birth and characterized by absence of lid crease, poor levator function, chin lift, amblyopia, marcus gunn phenomenon and higher ptotic eye on downgaze due to inability of fibrosed levator muscle to relax. 1 Levator function is poor in 71.8% of congenital ptosis patients. Congenital ptosis is unilateral in 64.7% - 75% patients. 1,2 Unilateral congenital ptosis with poor levator function continues to be a surgical challenge for the oculoplastic surgeon. Levator function and severity of ptosis guides the type of surgical treatment for congenital ptosis. 3 Levator muscle function is categorized into three groups depending on amount of lid excursion: good (excursion >8mm), fair (5-7 mm) and poor (0-4 mm). 4 Several surgical procedures demonstrated to treat severe unilateral congenital ptosis with poor levator function with variable outcomes and complications. Two main surgical options are frontalis suspension and maximal levator resection. Frontalis sling surgery is the most successful surgical option for correcting congenital ptosis with poor levator function of <4 mm. 5,6 Effective material for use in frontalis suspension is silicon rod because of its elasticity and ease of adjustment. 5 Cosmetic outcome graded as 0= excellent (<1 mm difference in height between the eyelid of both eyes with acceptable crease and contour), 1= good (>1 mm difference in eyelid height or an asymmetric crease) and 2= poor (>2 mm difference with poorly defined eyelid crease and contour asymmetry). 6,7 Most common complication post frontalis sling surgery is lagophthalmos, others are overcorrection, undercorrection, suture granuloma, sling exposure, late recurrence of ptosis. 7 in our case there was no postoperative lagophthalmos with good cosmetic outcome and no recurrence observed in 3 years of follow up.

CONCLUSION:

Good cosmetic outcome needs good clinical evaluation and surgical experience.

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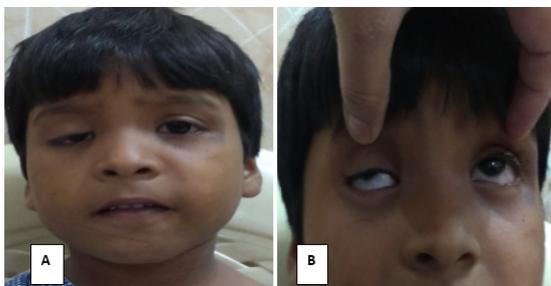


Figure A shows right upper eyelid ptosis, absence of right upper eyelid crease, small vertical fissure height. Figure B demonstrating good bell's phenomenon

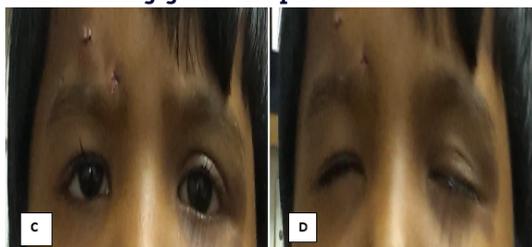


Figure C shows correction of right upper eyelid ptosis. Figure D demonstrating that there is no lagophthalmos.