• Comment and Response •

Comment on "Anterior lamellar recession for management of upper eyelid cicatricial entropion and associated eyelid abnormalities"

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Dear Editor,

I read with great interest the article by Gawdat *et al*[1]. The authors evaluated the functional and aesthetic outcomes of upper eyelid cicatricial entropion correction using anterior lamellar recession (ALR) combined with procedures addressing the associated conditions including dermatochalasis, brow ptosis, blepharoptosis, and lid retraction. ALR was carried out for the correction of a mild to moderate upper lid entropion.

The ALR procedure involves complete splitting of the lid from the grey line or posterior to the more posterior aberrant eyelashes and keratinized lid margin and subsequent recession of anterior lamella 3-7 mm posterior to the lid margin. Interlamellar separation can be performed through lid margin approach (Figure 1), eyelid crease approach as performed in this series, or both.

Several complications have been reported following ALR including: anterior lamella necrosis, madarosis, lid margin deformity, and trichiasis[1-2]. This procedure is aesthetically unacceptable, especially in young patients. I think ALR procedure is too invasive for treatment of mild and moderate cicatricial entropion without keratinized lid margin and major trichiasis.

One of the most important factors affecting the success of a specific procedure for the correction of cicatricial entropion and associated eyelid abnormalities is the selection of the appropriate surgery. The severity of entropion and the association of misdirected eyelashes and severity of lid margin abnormality should be considered for the selection of the appropriate surgical procedure[3]. For mild to moderate cicatricial entropion without lid retraction, anterior lamellar repositioning with or without lid splitting, and tarsal fracture might be the procedures of choice[3-4]. In moderate cicatricial entropion with lid retraction and keratinized lid margin, ALR could be used[2,4].

According to our review of literature the indications of ALR could be summarized as followings[2]: severe lid margin abnormality with keratinized lid margin and aberrant lashes; presence of major trichiasis (>5 eyelashes); moderate to severe entropion with lid retraction; entropion and trichiasis in auto-immune conjunctival diseases, where conjunctival incision may aggravate the disease.

For a lesser degree of cicatricial eyelid changes, simpler procedures should be used. In mild entropion with or without trichiasis (<5 eyelashes) and without lid margin keratinization, anterior lamella reposition with or without epilation is recommended respectively. In moderate entropion with or without trichiasis (<5 eyelashes) and without lid margin keratinization, tarsal fracture procedure with or without epilation may be the procedure of choice. Both of these procedure could be combined with procedures addressing associated lid problems including dermatochalasis, brow ptosis, blepharoptosis, and lid retraction.

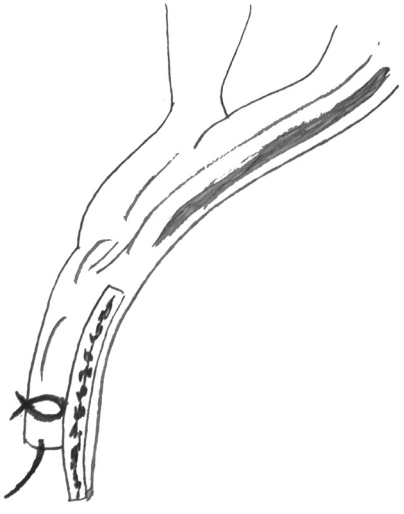

Figure 1 Anterior lamellar recession procedure.

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Conflicts of Interest: Owji N, None.

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Author Reply to the Editor

Dear Editor,

We thank the author for his valuable observations on our article. We advocate the use of anterior lamellar recession (ALR) for all severities cicatricial entropion even in marginal subtype. ALR keeps the integrity of the meibomian glands and avoids iatrogenic dry eye, this seems especially important in trichiasis caused by trachoma[1-3]. This technique has the added advantage that the surgery is performed on structures anterior to the tarsal plate, thereby avoiding incising the conjunctiva and tarsus[2]. We agree that there is marginal thickening with abnormal appearance in the early postoperative period; however this tends to soften with reversion to normal skin color in approximately 6wk. In addition, concurrent correction of associated lid problems further enhances the postoperative aesthetic appearance (Figure 1)[1,4-5]. Anterior lamellar repositioning without lid split will not overcome the underlying cicatricial force at the lid margin. The anterior lamella should be recessed without tension to have an effective long-term result[1,4].

We avoid any technique involving direct conjunctival incision as in BLTR and PLTR or tissue excision as in tarsal wedge resection. We believe that this may often trigger conjunctival inflammation and further cicatrisation, which can lead to surgical failure even in trachoma[6-7].

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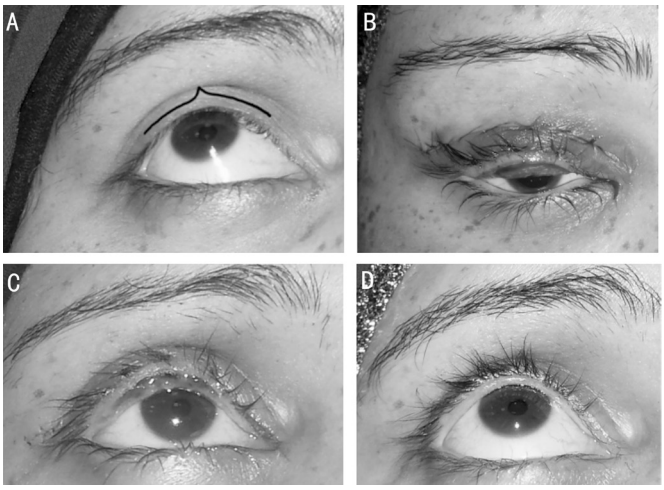

Figure 1 ALR of right upper lid in a 19-year-old female patient

A: Preoperative appearance of the patient; B: At the end of the procedure; C: Postoperatively at 1wk; D: Two months after surgery, showing rapid healing and softening of the lid margin with perfect apposition of the lid to the globe. The patient was satisfied with the functional and cosmetic improvement.

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