VIDEO PRESENTATIONS

V1. Endoscopic Upper Face Lifting

MB Kashkouli

Eye Research Center, Iran University of Medical Sciences, Tehran, Iran

Aim: To demonstrate 6-step Endoscopic Upper face Lifting technique

Material & Methods: Marking was made to highlight the site of incisions as well as the probable course of the nerves and vessels. After making 5-incision sites behind the hairline, drilling of lateral ports was performed using 5-mm stop drill tip. Subsequently, optical pocket was created. Subperiosteal dissection was then performed under the endoscopic view. Lateral conjoint tendon and canthal raphe release were firstly addressed. Corrugator muscle dis-insertion was the performed in the majority of cases. Hemostasis was achieved through irrigation. Two 13-mm screws were put on the lateral sides and all the incisions were finally closed with stapler.

Results: Dressing was removed 2-3 days after the surgery when topical antibiotic and steroid creams were commenced and continued for 2-3 weeks. Staples and screws were removed 2-3 weeks later. An overcorrected eyebrow and forehead elevation was observed in the first 2-3 months after lifting.

Conclusion: Endoscopic Upper face Lifting is an option for not only addressing the forehead droopiness but to proportionally elevate the eyebrows and smoothen the frown lines.

V2. Sutureless transcutaneous blepharoplasty

G.U. Aimino[1], L. M. Francone[1], G. Davì[2]

[1]Istituto di Ricerca in Oftalmologia I.R.I.O., Ivrea, Turin, Italy, [2]Studio Oculistico Valdobbiadene, Milan, Italy

The authors present a surgical technique of upper and lower blepharoplasty transcutaneous without application of sutures.
In the cases presented in the video a biological glue (2-Octyl-Cianoacrylate) is spread along and below the cutting line and in the most traction points are applied Steri-strip, only after slight compression and complete drying of the skin flaps. This adhesive does not leave traces or marks on the skin, has a large holding power, and causes an antimicrobial barrier through a protective film that allows a humid environment healing, rapid cicatrization and reduction of the pain after surgery. In selected cases in which this procedure has been carried out, 12 patients for a total of 28 eyelids, no significant complications were observed.
In one patient it was necessary to apply a short suture the day after surgery for detachment of a small part of the skin incision of the upper eyelid. Another patient presented, only in a lower eyelid, an inflammatory reaction with production of a subepithelial cordon along the cutaneous scar that was reduced after one month. Howewer in all cases the surgical scar appeared little evident. In conclusion, the application of biological glue instead of sutures in selected cases has proved effective, well-accepted by patients, with few complications, rare side effects, and good aesthetic result, but certainly can be improved.

V3. Managing the damaged nasolacrimal duct during craniofacial surgery- innovative technique in an unusual situation!

C. Senthilnathan
Ramana Eye Centre, Chennai, India

Aim: To demonstrate the technique of managing the cut Nasolacrimal duct(NLD) which accidently occurred while performing cranio facial surgery for a patient with Crouzon's syndrome.

Materials & methods: A patient with Crouzon's syndrome was posted for orbital expansion and translocation with a Kawamoto's distractor. Following bicoronal flap creation and reflection the NLD"s were cut bilaterally during medial orbital dissection. This was identified and silastic tubes were passed from the puncta and intubated across the cut ends of the NLD which was identified under direct visualization and brought out through the nose under endoscopic guidance and knotted in the inferior meatus.

Results: The patient did well following surgery and did not have complaints of watering postoperatively. The tubes were removed at the end of 6 months and the ducts were patent on syringing.

Discussion: Damage to the Nasolacrimal apparatus is not uncommon during craniofacial surgery. Early identification and appropriate management leads to good results with minimal morbidity to the patients.

V4. Small Incision Surgery for Upper Lid Retraction

CT Choo

Singapore National Eye Centre

Aim: Upper lid retraction is usually caused by thyroid eye disease. However postoperative or traumatic cause is not uncommon. Scarring of middle and or posterior lamella result in lid retraction. Surgical indications for upper lid retraction are ocular exposure and cosmetic. The challenge of surgery is postoperative long term lid level stability. This video demonstrates small incisional approach and its postoperative management.

Methods: After local anesthetic infiltration, double eversion of upper lid exposes the tarsoconjunctiva and puts the upper tarsal border superiorly. Small conjunctival incision is made to expose the levator aponeurosis. It is detached and recessed from the tarsal surface in graded fashion. Small skin incision is used for fat reduction in thyroid eye diseases and for scar lysis in postsurgical or traumatic cicatricial lid retraction. Intraoperative mitomycin C is applied to scar lysis site. Traction suture maintains lid stretching till satisfactory lid level is achieved within first postoperative week.

Results: 5 postsurgical unilateral and 3 bilateral thyroid lid retractions treated with this approach were reviewed. Targeted lowered lid level was achieved in all cases at three months follow up.

Conclusion: Levator recession, fat reduction or scar lysis, intraoperative mitomycinC application can be performed through small conjunctival and skin incision. Postoperative lid stretching suture help to achieve the lid level and maintain long term stability.

References:

Ben Simon GJ etal. Transconjunctival Müller muscle recession with levator disinsertion for correction of eyelid retraction associated with thyroid-related orbitopathy. Am J Ophthalmol. 2005 Jul; 140(1):94-9.

Putterman AM etal. A simplified levator palpebrae superioris muscle recession to treat overcorrected blepharoptosis. Am J Ophthalmol. 1974 Mar; 77(3):358-66.

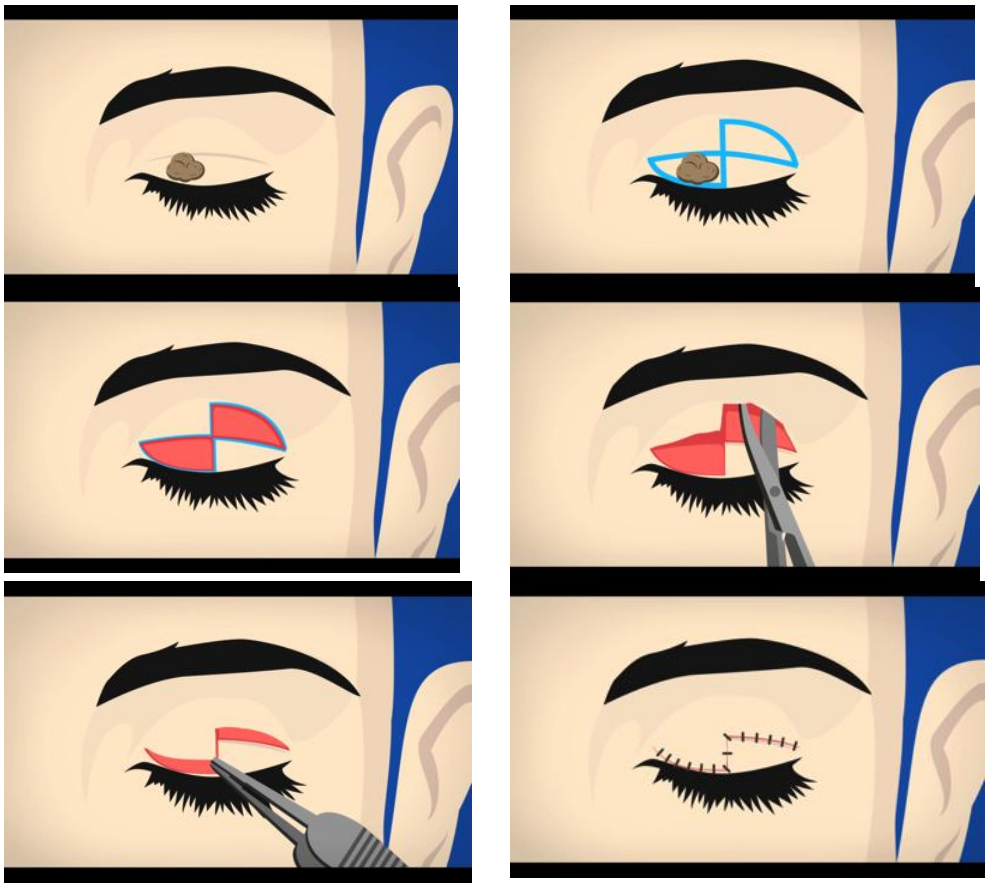
Kinast RM etal. Concentration Accuracy of Compounded Mitomycin C for Ophthalmic Surgery.

JAMA Ophthalmol. 2016 Feb; 134(2):191-5.

V5. The blepharoplasty flap

K. McVeigh

Department of Ophthalmology, Bristol Eye Hospital, Lower Maudlin Street, Bristol, UK



V6. The use of new monocalicular stent for canalicular laceration repair

E. Farah, M. Zmuda, O. Galatoire[1]
Oculoplastic Department, Rothschild Foundation Hospital, Paris, France

Aim: Using master K silicone tube as a new technique for canalicular laceration repair
Material & Methods: Video of upper canalicular laceration repair of a 15 years old patient after a blunt trauma
Results:.the stent was maintained 3 months , a good functional and anatomical results after the removal of the stent
Conclusion : The use of master K silicone tube for reconstructing traumatic canalicular laceration is a safe and simple method with minimal risk of extrusion and a high functional success rate.

V7. Orbital Implant Exchange. Hydroxyapatite implant replaced with autogenic dermis-fat graft

H. Aral
LidMed, Cologne, Germany

Background: A 27 year old female patient with an anopthalmus after left eye enucleation due to Iris melanoma was primarily supplied with a hydroxyapatite orbital implant. After 3 years rejection with exposed implant, inflammation and pain was seen. The patient was not able to use her ocular prosthetics anymore.
Methods: We exchanged the exposed hydroxyapatite implant with an autogenous dermis graft-fat into the orbital cone by saving the rectus muscle functions, followed by new ocular prosthetics.
Results: After exchange surgery orbital inflammation and pain were healed. The surgical procedure, functional and aesthetic results are presented in our video.
Conclusion: If complications with artificial implants are seen, a replacement with autogenous dermis-fat is graft a good alternative. An improvement in aesthetics as well as prevention of socket shrinkage can be achieved.

V8. Orbital fibromyxoma excision with transconjunctival incision

S. H. Uğurbaş[1], B. Bahadır[2]
[1]*Department of Ophthalmology,* [2]*Pathology Department, Bülent Ecevit* University, *Zonguldak, Turkey*

Abstract: True orbital fibromyxoma is a rare tumor of soft tissue and its diagnosis is complicated by the large number of soft tissue tumors that can have myxoid appearance. Herein, we report a case of orbital fibromyxoma in a 9 year old girl who presented with a solid nontender, palpable mass at the inferolateral orbital rim. Magnetic resonance imaging (MRI) showed a round, partly enhancing isointense mass with a pitting in the maxillary bone. Surgical exploration with lower conjunctival fornix incision showed a yellowish white firm mass surrounded by a thin fibrous capsule indenting the adjacent maxillary bone. The tumor was completely excised. Histopathologic analysis was consistent with the diagnosis of fibromyxoma. To our knowledge, this is the first case of orbital fibromyxoma reported in children and only second to a previously reported case located on lacrimal fossa.