**An operation for trichiasis due to cicatricial entropion / by W. Odillo Maher.**

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# AN OPERATION FOR TRICHIASIS DUE TO CICATRICIAL ENTROPION.[1]

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AN operation I have found give the most satisfactory results in cases of trichiasis and districhiasis, due to cicatricial entropion, consists in thoroughly dividing the tarsal cartilage from the under surface of the lid from end to end at about two and a half millimetres from its free edge, as in a Burow, and fixing with sutures between the edges of the divided cartilage a piece of mucous membrane the length of the tarsal cartilage and about two or three millimetres broad.

I perform the operation in the following manner:

Standing behind the patient, who is anæsthetized, I evert the lid, and make a puncture with a Beers knife through the tarsal cartilage, at the outer canthus if operating on the right lid, and at the inner canthus if operating on the left, and divide the cartilage and all structures of the lid to the skin from end to end, parallel with and about two and a half millimetres from its free edge, with a straight, blunt-pointed scissors, by passing one blade through the puncture, and subcutaneously along the length of the cartilage. The lower lip is now clamped with a Snellen entropion clamp to prevent hemorrhage, and a flap of mucous membrane the length of the incision in the cartilage, and from two to three millimetres broad, is marked out by two parallel cuts with

[1] A paper read before a meeting of the N. S. Wales branch of the British Medical Association, at which cases were shown.

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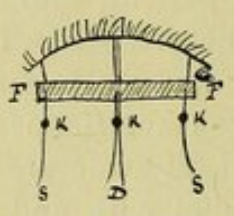
a Beers knife, and removed by a few snips of a scissors. The mucous-membrane flap is then laid on the tip of the forefinger of the left hand, and any submucous tissue snipped off with scissors. Three silk sutures, two single and one double, with knots about two centimetres from the ends, are used. The single sutures are passed through the ends of the flap from its mucous surface, and then through the ends of the cut in the cartilage, coming out on the cutaneous surface of the lid near the canthi and a few millimetres from its free edge. The double suture is now passed through the middle of the flap from its mucous surface and through the middle of the cut in the cartilage, coming out on the cutaneous surface of the lid midway between the canthi and a few millimetres from its free edge. By drawing on these sutures, the knots pull the flap of mucous membrane well in between the cut edges of the cartilage. An assistant now applies with his finger a little traction on the skin of the lid, so as to cause the edge of the lid to evert and the wound in the cartilage to gape. The sutures are then tied. Either the two single or end sutures are tied together across the lid parallel with its free edge, and between the two threads of the double suture, which are tied over them, or the single end sutures may each be tied to a thread of the double central suture. I consider the latter the better way of tying




F. F. Flap of mucous membrane.
K. K. K. Knots in the sutures.
S. S. Single sutures.
D. Double suture.

the sutures, as the former sometimes causes the middle edge of the lid to evert a little too much. The edges of the wound in the lip, which causes very little inconvenience, are brought together with sutures, and it heals by first intention. The eyelids are dressed with an antiseptic dressing smeared with iodoform ointment, and left undisturbed for

thirty-six hours, when the sutures are removed. The object of having the knots a couple of centimetres from the ends of the sutures is to facilitate their removal. The eyes are kept bandaged for a few days, so as to prevent any disturbance of the flap, *which takes readily.*

This operation was first performed by me in April, 1896, and during the following twelve months I operated on sixty-one cases. In two cases only the operation was a partial failure, as a few hairs on the outer canthi were touching the globe some weeks after the operation. The cause of these two partial failures was that the cartilage had not been divided up to the outer canthus. All the others were highly satisfactory, and some I have seen nine months after the operation. A special feature about this operation is that no tissue is removed from the lid, but tissue added to replace cartilaginous tissue at that part where it has undergone absorption. It produces no disfigurement, and the results are most satisfactory. The effect of the operation can be enhanced by a subcutaneous division of the outer canthus.