

Ptosis operations / by Freeland Fergus.

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Ptosis operations.

By A. FREELAND FERGUS, M.D.

OPERATIONS for the relief of ptosis are very numerous and are based on certain definite lines which admit of simple classification. In the first place there are those in which an attempt is made to produce cicatricial contraction by the introduction of sutures. Of this form, the operations of Dransart and Pagenstecher may be taken as examples. Secondly, there are operations by ligature, a metallic thread or a piece of kangaroo tendon being inserted in the tissues so as to ligature the eyelid permanently in a suitable position. The well-known operations of Mules, of Harman, and of Worth, may be taken as illustrative of this group of operations. Thirdly, attempts have been made at advancement. The operation previously described by myself of advancement of the occipito-frontalis may be taken as illustrative of this class of procedure, and attempts have also been made (Motais) to attach a portion of the superior rectus muscle to the upper eyelid. Other surgeons again have endeavoured to advance what they believe to be the levator palpebræ superioris. Fourthly, there are operations which are perhaps best described by the word "plastic." We may take the well-known operation of Panas as typical of these procedures.

It seems to me that operations which attempt to remedy the defect by the gradual tightening of sutures tied over pieces of india-rubber tubing, and the ends of which are exposed, are in their very essence bad operations. It is difficult to conceive how anyone possessed of a modern surgical training can employ such a method. To begin

with, a thread which is absolutely sterile will not produce any permanent cicatricial contraction. If it does set up an inflammatory reaction so as to cause cicatrisation in the tissues, that to my mind is proof positive that the suture employed has not been absolutely sterile, and therefore is one which ought not under any circumstances to have been introduced into the tissues. Moreover, the ends of threads left projecting on the skin surface, unless very carefully protected, are apt to be channels of septic invasion. For these reasons it is probably not far off the mark to say that stitch operations should never be employed.

Those forms of procedure which I have classed together under the heading of ligature operations are in the main good, and I think reliable. The chief objections to them are that to some surgeons they are rather difficult of performance. They leave the lid without much mobility, and the success of the operation depends upon the permanency of the metallic or tendinous suture. Still they are essentially good operations.

As regards advancement operations, I am satisfied with that of the occipito-frontalis. Of recent years, however, I have always found it advisable to make a very much larger incision than that described in my first communication. When I attempt to do this operation now I make an incision right along the eyebrow, and then continue it for an inch and a half or two inches upwards and outwards, and thus I am enabled to reflect the skin very thoroughly and get a large and broad strip of the occipito-frontalis muscle. Where trouble has been taken to insure the asepticity of the skin, and when the operation has been performed in an aseptic manner, there is no fear of any well-marked cicatrix disfiguring the patient in after life.

I have no experience of attempts at advancement of the levator palpebræ superioris, but it is to be remembered that there are many cases of ptosis in which that muscle does not seem to be developed at all. About the year

1887 I saw Professor Snellen, with his usual dexterity and skill, do one of these operations. After he had finished he remarked to me that probably what he had effected was an advancement, so to speak, of the strong fibrous tissue which unites the tarsus to the periosteum of the bone.

I have not attempted any advancement of the superior rectus, nor do I intend to do so, for if the field of fixation of a person afflicted with ptosis be accurately measured it is almost invariably found that there is great weakness in elevation. It would seem therefore to be a dangerous proceeding to weaken further a muscle which is probably already too weak. If a pure advancement is to be made I am still of opinion that it ought to be that of the occipito-frontalis muscle.

Recently I have had marked success by an operation which is probably very similar to that of Gillet. The method, in brief, is the shortening or rather the excision of a large portion of the tarsus. The eyeball is protected by an ordinary metal spatula. A skin incision is made parallel with the edge of the eyelid and across its entire extent: it is situated a few millimetres above the free border of the lid. Another incision is made in the following manner: it begins at one end of the primary incision and curves upwards over the eyelid and then downwards so as to terminate at the other end of the same incision. The portion of skin thus isolated is next dissected up and all the tissue down to the conjunctiva is removed, although the conjunctiva itself may be left intact. Two sets of sutures are employed. The one set is placed deeply and consists of three points, one in the middle and one at either side. The deep sutures attach the portion of the tarsus still left in the eyelid to the strong fibrous tissue which comes down from the occipito-frontalis to the top of the tarsus. The others are merely superficial skin sutures. The first set must of necessity be formed of some kind of catgut which will absorb. Generally speaking I use van Hoorn's

.00 gut, which will take ten days in absorption. The skin sutures may also be made with this material or with silk.

The form of operation which has here been described lifts the eyelid easily to the required amount, and what is more remarkable still, puts it completely under the voluntary control of the occipito-frontalis muscle. The patient by voluntary effort can open his eye nearly, if not quite, as widely as under normal circumstances, and can close it tolerably well although not completely. If the skin

FIG. 1.

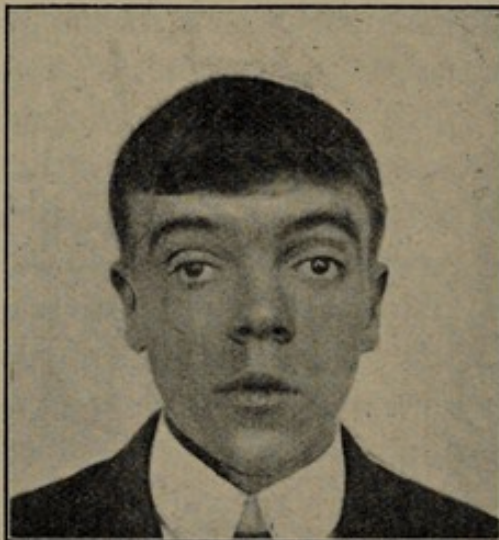


FIG. 2.



The left eye of this patient has been operated on for unilateral ptosis by the resection of the tarsus.

The same as Fig. 13, with the left eye shut.

incisions are properly arranged they give to the eyelid the appearance of the furrow at the top of the tarsus which is normally present, and consequently there is no disfigurement but rather an improvement in the appearance of the eyelid.

My most recent case is that of J. F—, æt. 67 years, a house painter, who was operated on for paralytic ptosis in the month of March, 1908. This patient had been treated for double ocular paralysis in the month of December, 1902. At that time there was a limitation of the

movements of the right eye outwards, inwards, and downwards.

On the left side there was a certain degree of ptosis and the movements of the left eye were restricted inwards. The responses of the pupils were active both to light and to attempts at convergence. The fundi were normal in appearance. There was no specific history but there was a history of injury to the head as a consequence of a fall some ten months before. Such was his condition when I saw him in December, 1902. It is to be observed

FIG. 3.

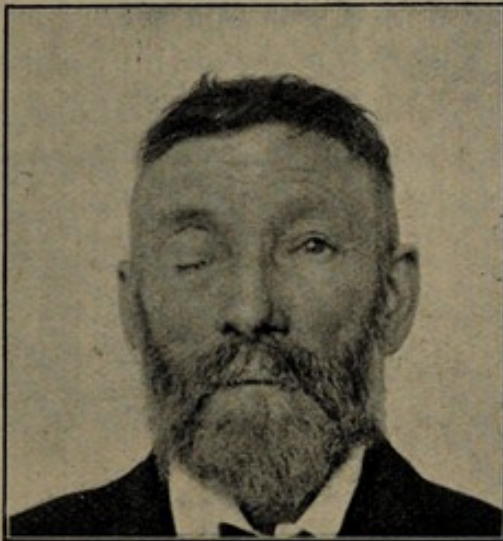
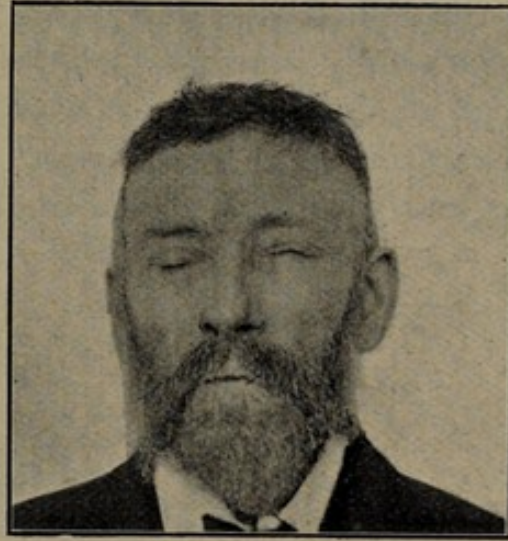


FIG. 4.



The patient after operation by a resection of the tarsus of the left eye.

The same patient with both eyes shut.

that this patient was a house painter and that possibly his malady might be connected with his occupation. He, however, never had had any lead palsy of the ordinary type nor any lead colic, and the state of the gums was as in health. When I saw him late in February or early in March of this year I found that there was almost complete paralysis of all the external muscles of each eyeball. There was only a slight movement of each eye inwards and of the right slightly upwards; the pupils, however, were not in the least dilated and responded fairly well to differences of illumination.

This case was operated on much in the way described, with the exception that after the primary incisions and the laying bare of the tarsus, I resected the lid throughout its entire structure, for I found it impossible to separate the tarsus from the conjunctiva; I therefore went right through the lid and removed a considerable portion of it.

The upper edge of that portion of the tarsus which was left in the lower part of the lid was stitched high up to the fascia which comes down from the frontal portion of the occipito-frontalis. In this way I put the movements of the eyelid as far as the opening of the eye is concerned under the influence of the occipito-frontalis muscle.

The photographs, I think, show that the operation has been amply successful; indeed, so satisfactory is the result that in future I do not propose to take the trouble of separating the tarsus from the conjunctiva but intend regularly to resect the lid completely. (*May 7th, 1908.*)