Figure 1 A newborn neonate with bilateral eyelid imbrication syndrome. Large and elongated upper lids/tarsal plates overlapped the lower lid margins by over 1 mm. The upper eyelids were 'floppy' and could be everted with minimal effort or did so spontaneously with forceful orbicularis oculi contraction.

birth were unremarkable apart from minimal olighydramnios noted at 20 weeks gestation. Ocular examination of the child asleep showed elongated upper lids and tarsal plates overlapping the lower lid margins by more than 1 mm (Figure 1). Horizontal and mid-point vertical dimensions of the upper lids were 25 and 8 mm respectively. In addition, the upper eyelids were 'floppy' and could be everted with minimal effort or did so spontaneously with forceful orbicularis oculi contraction. The subtarsal conjunctiva showed minimal hyperaemia and few papillae. Conjunctival swabs showed no microbial growth. The patient was managed with topical lubricants and antibiotic prophylaxis. At 2 months postpartum there was marked improvement in lid position with reduced overriding and absence of spontaneous eversion.

Comment

Eyelid imbrication is typically acquired in adults over the age of 40, with only one previous report of the condition in a neonate.[1,2] Here we describe a second congenital case, which in addition displayed spontaneous upper lid eversion on forceful contraction of orbicularis oculi. This striking feature is reminiscent of floppy lid syndrome, and was notably absent from the case reported by Rumelt *et al*.[1] In both cases of congenital imbrication, natural resolution occurs with apparent tightening of the upper canthal ligaments. Congenital eyelid imbrication syndrome is thus an unusual, apparently isolated and transient eyelid abnormality, which resolves within the first few months of age. Surgical management of this condition is not required.

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Sir,

Expanding role of local anaesthesia in vitreoretinal surgery

We read with interest the above analysis of local anaesthetic (LA) usage for vitreoretinal (VR) surgery in Southampton and wish to make several comments. The paper describes a 20.2% sedation rate (35.9% in ages under 35 years). A retrospective database analysis of our last 500 VR cases from mid-2003 shows 380(76%) performed under LA without an anaesthetist present, 55(11%) with an anaesthetist present, and 70(14%) under general anaesthetic. Our LA method is an 8 ml 50 : 50 mix of lignocaine 2% and bupivocaine 0.5% administered with a blunt cannula into the subtenon space. We have found this to provide excellent analgesia and akinesia without any need for sedation. This also reduces the risk

of globe perforation inherent in sharp-needle intraconal injection (although this was not encountered in Southampton). Clearly we make great efficiency savings by being less reliant on anaesthetic cover, especially when providing theatre time for acute surgical VR work.

The paper goes on to state that 51.7% of the cases included in the study are 'retinopexy +/− vitrectomy'. This could be interpreted as a significant proportion in the LA group simply receiving retinopexy for retinal tear.

Clarification on the above will be welcomed.

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Sir,

Response to Goldsmith *et al*

We were interested in Goldsmith *et al*'s comments on our recent paper.[1] We are aware that subtenons anaesthesia is used for VR surgery;[2] however, to achieve a rate of 87%, under local anaesthesia, is certainly impressive. The authors are not clear on their own use of sedation. In some units nearly all patients are sedated, and in others it is rarely used. We have tailored our use to measured patient satisfaction outcomes performed over the last 5 years,[3–4] and clearly have a lower threshold for their use than Goldsmith *et al*. This may be because we have access to an experienced anaesthetist for our VR lists.

The Royal College of Ophthalmologists 2004 guidelines on cataract surgery do not specify the necessity of anaesthetist presence where blunt needle subtenons anaesthesia is required, such anaesthetic cover is recommended where sharp needle anaesthesia and/or sedation is required.[5] Arguably in VR surgery anaesthetic cover is more important given the longer and more unpredictable nature of the surgery.

We note with interest Goldsmith *et al*'s comment that grouping all retinopexy patients may bias the results. However, our previous work showed that the laser and cryopexy were more important determinants of discomfort during vitrectomy than other aspects of the surgery, and so these were analysed as one group.[2]

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Sir,

The urgency and site of retinal detachment surgery

Four letters in the correspondence section of The Journal prompt me to join the debate about the setting in which retinal detachment surgery is undertaken, both with respect to urgency and surgical facility.[1–4] This is an ongoing debate and has been discussed in This Journal before.[5]

The first fallacy that needs to be highlighted is about the urgency of management of macula-on detachments. Although it is taken for granted that all macula-on detachments should be operated on within hours of