

Sir,
I was very interested in the clinical algorithm for the management of facial nerve palsy from an oculoplastic perspective by Sadiq and Downes.¹ The basic principles of the algorithm are unexceptionable. However, I have stopped using botulinum toxin injections to produce a protective ptosis. I have now observed four cases of permanent vertical diplopia due to superior rectus weakness as a result of botulinum toxin injections into the levator muscle. Although two of these cases have been managed by prisms in spectacles, two have required squint surgery. I think this is an unacceptable complication. Recently I have employed tantalum eyelid weights that may be applied externally with tape (Med Dev Corporation, Palo Alto, CA). The patients have found these much more acceptable than eyelid surgery when the long-term prognosis for the facial nerve palsy is uncertain.

References

1. Sadiq SA, Downes RN. A clinical algorithm for the management of facial nerve palsy from an oculoplastic perspective. *Eye* 1998;12:219-23.

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Sir,

We thank Mr Sarkies for his interest in our paper. Our algorithm was designed for use on the neurosurgical ward in our institution so that they would be able to manage simple cases of post-surgical facial palsy by themselves, and refer

only those patients with corneal exposure to the on-call service, or those requiring surgery directly to the oculoplastic clinic. The scheme has certainly been useful in helping to reduce unnecessary workload for the ophthalmologist on the neurosurgical ward.

We do agree that certain patients may have permanent diplopia following botulinum toxin A (BTXA) injections. This has been noted by others in the past,¹ whilst a few patients even go on to require corrective strabismus surgery.² We do advise patients that diplopia may occur as a complication of BTXA injection, but we feel that corneal protection is our primary goal in order to preserve vision. To try to reduce the incidence of complications further, we have more recently been administering BTXA into the levator via a transconjunctival route (paper submitted). We are hoping that this study will be published in the near future.

Eyelid weight loading is excellent for patients with residual upper eyelid retraction despite previous levator recession, and also for the subgroup with associated trigeminal neuropathy for whom we aim to achieve a much narrower vertical palpebral aperture. However, using tape to apply these weights for anything other than diagnostic testing in the clinic setting in our opinion would render them unstable and prone to loss, along with resultant skin reaction to the adhesive tape.

References

1. Adams G, Kirkness C, Lee J. Botulinum toxin A induced protective ptosis. *Eye* 1987;1:603-8.
2. Heyworth P, Lee J. Persisting hypotropias following protective ptosis induced by botulinum neurotoxin. *Eye* 1994;8:511-5.

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Sir,

I congratulate Sabri *et al.*¹ on their review of corneal abrasion management but I note that the references in support of the tenet that topical anaesthetics impede healing are all more than 20 years old and only one (from 1944) or possibly two (the German study) looked at clinical as opposed to animal or *in vitro* models.

While not wishing to be heretical, perish the thought, should we now consider a limited clinical study using a modern topical anaesthetic in low dosage for corneal abrasion and begin to quantify any delay in healing and balance it against the benefit of a possible improvement in pain control?

Reference

1. Sabri K, Pandit JC, Thaller VT, Evans NM, Crocker GR. National survey of corneal abrasion treatment. *Eye* 1999;12:278-81.

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ERRATUM

Lawry J, *et al.* Simultaneous cell cycle and phenotypic analysis of primary uveal melanoma by flow cytometry. *Eye* 1998;12:431-9.

On the title page of the above paper the name of the third author should read 'M.A. Parsons'.