

CORRESPONDENCE



Comment on: Recurrent upper eyelid trichomatous entropion repair: long-term efficacy of a five-step approach

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TO THE EDITOR:

Diab and Allen [1] report excellent outcomes using their approach to repair of recurrent trichomatous upper eyelid entropion. We share their approach and principle of conjunctival-sparing surgery. We would, however, question the validity of their definition of anterior lamella laxity (ALL) in this cohort. Having never encountered true ALL in such cases, we wonder whether they are simply observing relatively less contraction involving the anterior lamella compared to posterior lamella. We have frequently identified *horizontal* anterior lamellar contraction, easily identified by persistent per-operative anterior lamella lash-line in-turning despite complete separation of anterior lamella from tarsus. Horizontal lengthening can be achieved through “sphincterotomy” incisions to the posterior surface of the anterior lamella, close to the margin, as shown in Fig. 1. Regarding the possibility of true ALL, we would welcome any data the authors have regarding lid margin to brow distance (LMBD), or asymmetry in anterior lamellar skin suggesting true laxity was present. Reviewing the photographs they present, we would suggest laxity is not present. The authors direct readers to figures 3 and 4 to demonstrate ALL, however, in figure 4, the LMBD appears approximately 20–25 mm. In figure 3, there appears a fold in pre-tarsal skin; in our

experience, this often occurs with persistent posterior lamella retraction following cicatricial entropion surgery. We wondered if the authors would consider this possible given the apparent 20 mm LMBD.

Our concern over the level of skin excision performed in these patients is the minimal residual LMBD. Tissue resection in cicatricial pathologies should be minimised, particularly as these patients often have underlying dry-eye disease [2]. We congratulate Diab and Allen on raising the debate of aetiological factors in patients with upper eyelid cicatricial margin entropion and support their approach in redirecting the retractors’ pull to the anterior lamella whilst allowing recession of the posterior lamella inferiorly. However, we caution any emphasis on anterior lamellar resection under the misguided assumption that ALL exists in trichomatous cicatricial margin entropion.

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REFERENCES

1. Diab MM, Allen RC. Recurrent upper eyelid trichomatous entropion repair: long-term efficacy of a five-step approach. *Eye*. 2021;35:2781–6. <https://doi.org/10.1038/s41433-020-01306-y>
2. Ross AH, Cannon PS, Selva D, Malhotra R. Management of upper eyelid cicatricial entropion: Upper eyelid cicatricial entropion. *Clin Exp Ophthalmol*. 2011;39:526–36. <https://doi.org/10.1111/j.1442-9071.2011.02503.x>

AUTHOR CONTRIBUTIONS

SH wrote and submitted the article. RM drafted contents of article and made revisions.

COMPETING INTERESTS

The authors declare no competing interests.

ADDITIONAL INFORMATION

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Fig. 1 Intra-operative anterior lamellar sphincterotomies being performed to address horizontal contraction.

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