

CORRESPONDENCE



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

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Eye (2022) 36:1851–1852; <https://doi.org/10.1038/s41433-021-01882-7>

TO THE EDITOR:

We appreciate the comments from Hunt and Malhotra on our study [1] and agree that there is the potential for confusion with regards to the term “anterior lamellar laxity (ALL)”. It may be a semantics argument, but we agree that the distinction should be made between relative anterior lamellar laxity (RALL) and true or absolute anterior lamellar laxity (AALL). In our manuscript, we used ALL without qualification.

Absolute ALL is observed in dermatochalasis. Causes of AALL include involutinal and after episodes of repeat oedema or mechanical trauma. It is difficult to determine the amount of AALL in trachoma patients without having reference measurements made prior to the process. Although a minimum vertical measurement between the lower cilia of the eyebrow and eyelashes should be 18–20 mm, all surgeons have measured values greater or less than this in the normal population. One could imagine that the patients in our report have a component of AALL secondary to age and history of episodes of oedema/mechanical trauma associated with the trichomatous process. Without previous reference measurements, it would be difficult to determine with certainty the amount of AALL.

Relative ALL is secondary to posterior lamellar contraction. In the trichomatous process, this is likely the main contributor. Ultimately, this process results in *lamellar dissociation*, with an excess of anterior lamella relative to the posterior lamella. With regard to horizontal anterior lamellar contraction noted intraoperatively by Hunt and Malhotra, we think that the contraction is limited to the lid margin structures, but superior to this, the anterior lamella is lax.

We defined ALL in our report as an overhanging skin fold beyond the lid margin and/or pretarsal skin laxity, not defining absolute or relative. When correcting this ALL, we do not remove an excessive amount of skin; instead, we use the force of the upper lid retractors to tighten the anterior lamellas by redirecting the pull of the upper lid retractors from the tarsal plate to the recessed anterior lamella. In addition, the upper edge of the wound is taken up by the deep crease obliterating any overhanging skin fold. Figs. 1 and 2 demonstrate ALL. Consent was obtained from patients for use of their photographs in published media.

In trachoma patients, there is likely a component of both AALL and RALL, but a predominance of RALL. The five-step approach in our report addresses this process through a conservative blepharoplasty, lamellar splitting, and eyelid crease formation. We are in full agreement with Hunt and Malhotra that resection of anterior lamella through a blepharoplasty should be conservative and respect retaining 18–20 mm of vertical anterior lamella. As Hunt and Malhotra appropriately note, excessive



Fig. 1 Representative case 1 of anterior lamellar laxity. Preoperative photograph of a 60-year-old woman with right upper lid recurrent entropion following bilamellar tarsal rotation shows both pretarsal laxity (white arrow) and overhanging skin fold (black arrow).

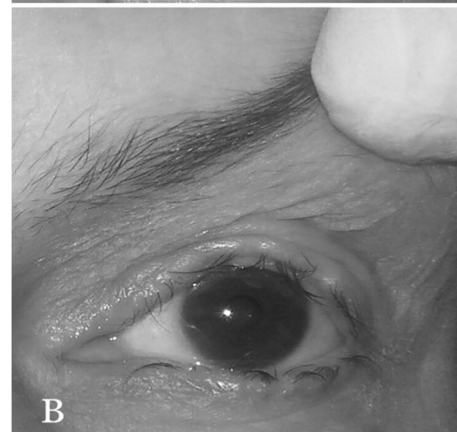
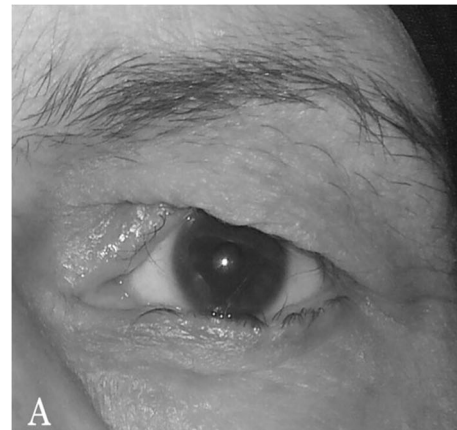



Fig. 2 Representative case 2 of anterior lamellar laxity. An overhanging skin fold extends beyond the lid margin (A) masking an underlying pretarsal laxity (B) in a 51-year-old woman having recurrent entropion following anterior lamellar recession.

resection of anterior lamella may worsen eyelid closure. We are intrigued by the use of sphincterotomy and look forward to utilising this in our patients.

We thank Hunt and Malhotra for their interest in our report and noting the potential for confusion and possible mismanagement of this challenging group of patients.

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1. Diab MM, Allen RC. Recurrent upper eyelid trichomatous entropion repair: long-term efficacy of a five-step approach. *Eye*. 2021;35:2781–86. <https://doi.org/10.1038/s41433-020-01306-y>

AUTHOR CONTRIBUTIONS

DMM and ARC have made contributions to the conception of the work and wrote the letter to the editor.

COMPETING INTERESTS

The authors declare no competing interests.

ADDITIONAL INFORMATION

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