WELCOME TO FOURTH YEAR FOR EYE CLASSES
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DISEASES OF LID

*BRIEF REVIEW OF ANATOMY & PHYSIOLOGY*.
Cross-section of the lower lid

Gland of Moll
Cilium
Lash follicle
Gland of Zeis
Sweat gland

Duct of meibomian gland
Meibomian gland
Anterior lamella
Posterior lamella
Anatomy of the levator complex and lower lid retractors
FUNCTIONS

1. Cosmetic
2. Protection from Injurious ones
3. Tear Film Formation
4. In Photophobia
5. Drainage of Tears
TRICHIASIS

1. Def: Misdirected Lash

DISTICHIASIS

1. Def: Aberrant Lash
Congenital distichiasis
CAUSES

1. Chronic Blepharitis (Trichiasis)
2. HZO (Trichiasis)
3. Trachoma (Trichiasis)
4. Burn (Distichiasis)
5. S-J Syndrome (Distichiasis)
6. OCP (Distichiasis)
TREATMENT

1. Epilation (Temporary)
2. Electrolysis (Recurrence 40%)
3. Cryo (Skin Necrosis, de-pigmentation & MGD)
4. Argon Laser Ablation
5. Surgery
Chronic Marginal Blepharitis

1. Anterior Blepharitis
   A. SEBORRHOEIC
   B. STAPHYLOCOCCAL

2. Posterior Blepharitis
Telangiectasia of the anterior lid margin and scales in staphylococcal blepharitis

Foam in meibomian seborrhoea

Fig. 1.34
Diffuse inflammation around meibomian gland orifices in meibomianitis
Fig. 1.32
Capping of meibomian gland orifices with oil in posterior blepharitis
Complications of ch. blepharitis

- Trichiasis, madarosis and poliosis.

- Lid margin may get scarred, notched or hypertrophic. Infection may spread to glands of Moll/Zeis leading to Stye (acute hordeolum externum) or to mebomian glands (internal hordeolum).

- Secondary changes include: papillary conjunctivitis, PEE, marginal keratitis, phlyctenulosis, recurrent attacks of ac. bact. conj and tear film instability.

- Seborrhoeic dermatitis, acne vulgaris and acne rosacea, atopic keratoconjunctivitis and contact lens intolerance.
TREATMENT OF BLEPHARITIS

- Lukewarm water and soft soap wash
- Topical Antibiotic preparations e.g. chloramphanicol, Sulphacetamide, tobramycin, Ofloxacin, moxifloxacin, etc.
- Topical steroid e.g. fluoromethalone, prednisolone, beta/dexamethasone
- Systemic antibiotics in some cases
HORDEOLUM EXTERNUM
Fig. 1.39
Chalazion
Fig. 1.41
Incision of chalazion
ENTROPION

- Rolling in of lid margin (up/down)
- Types:
  - 1. Involutional (senile)- [Horizontal lid laxity, vertical lid instability, overriding]. Lid everting sutures, weise procedure, Jones procedure.
  - 2. Cicatricial (trachoma, trauma , St-j S, OCP) Tarsal plate fracture/ nasal septum + buccal mucosal graft.
  - Spastic (lubricants, antibiotic + steroid, treat underlying cause if any)
  - Congenital
ECTROPION

- Rolling out of lid margin

- TYPES:
  1. Involutional (horizontal lid laxity + med and lat canthal tendons laxity, disinsertion of lower lid retractors) Medial Conjunctivo-Tarso Plasty, Horizontal lid shortening, modified Kunht – Szymanowski.
  2. Paralytic (Medical cantho plasty, lateral tarsorrhaphy)
  3. Cicatricial (Z – Plasty)
  4. Mechanical (Removal of the mass)
Fig. 1.96
(a) Generalized ectropion without excess skin; (b) horizontal lid shortening.
Fig. 1.98
Cicatricial ectropion due to trauma
PTOSIS

- Dropping of the upper eye lid
- MRD – less than 4mm
- Types:
  - Myogenic e.g. MG, Myotonia, Simple Myogenic, Blepharophimosis syndrome
  - Neurogenic e.g. 3rd N. Plasy, Horner’s Syndrome, Misdirected 3rd N., Marcus Gunn Jaw Winking Synd.
  - Apponeurotic e.g. Involutional, Post-operative
  - Mechanical. e.g. Big Chalazion, Tumor.
Fig. 1.112
Left pseudoptosis due to ipsilateral hypotropia
Fig. 1.122
Marcus Gunn jaw-winking syndrome. (a) Normal position showing a mild left ptosis; (b) retraction of the left eyelid on moving the jaw to the contralateral side.
Marcus Gunn jaw-winking syndrome. (a) Normal position showing a moderate left ptosis; (b) retraction of left eyelid on opening the mouth.
MANAGEMENT

1. History: Age of onset, Variability of ptosis, abnormal head posture/forehead creases, Antenatal and perinatal history, any other developmental/ milestone abnormality

2. Examination
   A. MRD, Levator function, vertical palpebral fissure height, Upper lid crease.
   B. VA & Refractive Error, Extra Ocular Movement especially elevation, bell’s phenomena, jaw winking, corneal sensitivity and evidence of increased innervation.
Fig. 1.115
Margin–reflex distance. (a) Normal; (b) mild ptosis; (c) moderate ptosis; (d) severe ptosis
Fig. 1.116
Measurement of vertical fissure height
Fig. 1.117
Measurement of levator function
1. **Indications**
   
   A. Amblyopia prevention
   
   B. Cosmetic

2. **Options**

   A. Medical treatment available for MG rest of the condition need surgery.

   B. One of the Surgeries:
      
      1. Fasanella – Serwat (1 – 2mm elevation good for mild ptosis of simple myogenic & horner’s syndrome)
      
      2. Levator resection: upto 3mm elevation.
      
      3. Frontalis Brow suspension good for all ptosis when severe
Fig. 1.131
Fasanella–Servat procedure

Fig. 1.132
Levator resection

Fig. 1.133
Frontalis suspension
Tumors of eye lid

- Benign cysts and nodules:
  (chalazion, epidermoid cyst, cyst of Zeis, cyst of Moll, milia)

- Benign tumors:
  (squamous cell papilloma, basal cell papilloma, inverted follicular keratosis, actinic keratosis, keratoacanthoma, congenital and acquired melanocytic naevus, capillary haemangioma, port-wine stain, pyogenic granuloma, xanthelasma, and neurofibroma)
Malignant tumors: [xeroderma pigmentosum, immunosupression, retinoblastoma survival and albinism] BCC, Squamous cell carcinoma, sebaceous gland carcinoma, melanoma, Merkel cell carcinoma, kaposi sarcoma
Extensive capillary haemangioma

Small capillary haemangioma
Fig. 1.63
Large capillary haemangioma
Fig. 1.64
Progression of skin changes in naevus flammeus. Darkening from red (a) to purple (b); (c) hypertrophy and nodularity
Fig. 1.138
Epicanthus palpebralis and pseudo-esotropia
THANK YOU