A 63-year-old woman presented with a 15-year history of gradually increasing proptosis of right eye. Ocular examination revealed proptosis of 9 mm with decreased visual acuity in her right eye. CT scan showed a well-circumscribed and enhancing orbital mass filling almost the entire right orbit. The tumor occupied the superolateral, superomedial, and inferomedial intraconal space, enveloping the optic nerve. Complete excision of two large intraconal tumors was performed successfully via a vertical lid split orbitotomy. Histopathologic examination confirmed the diagnosis of cavernous hemangioma. There were no intraoperative or postoperative complications. The patient achieved a satisfactory cosmetic outcome 1 year after surgery.
orbitotomy was performed to remove the tumor. The larger tumor was firmly attached to the smaller tumor with fibrous band and the optic nerve was located between two tumors. Careful dissection was performed, so as not to damage the optic nerve. After all fibrous adhesions between two tumors were released, the larger tumor was removed successfully and then smaller tumor was removed safely. The lid incision was repaired with a similar method used for repair of a full thickness lid margin laceration. The masses measured $5 \times 3 \times 1$ cm and $3 \times 1 \times 1$ cm, respectively. Histopathologic examination confirmed the diagnosis of cavernous hemangiomas (Figure 2). There was no intraoperative complication, and the patient's recovery was uneventfully. At postoperative 6 months, best corrective visual acuity of the right eye was improved to 20/50. There was satisfactory cosmesis with no eyelid dysfunction. CT scan of the orbit showed no residual tumor in the orbit (Figure 3).

### 3. Discussion
Several surgical approaches for intraconal orbital tumor have been described in relation to the location and size of the lesion...
Lateral orbitotomy has been the preferred method to excise the cavernous hemangiomas as they are usually located intraconally and laterally. The removal of large cavernous hemangiomas in the medial intraconal space is challenging for complete excision without complications because visualization of tumor is limited and there are high density of critical normal structures often associated with substantial attachment to the tumor [2–4]. An anterior orbitotomy via an upper eyelid crease incision requires transection of the levator aponeurosis and Müller’s muscle to reach to the intraconal space. In addition, disinsertion of medial rectus muscle is also needed in the medial approach. Transcranial approach or circumferential pan-orbitotomy is invasive procedure and spends much operative time [3].

Byron Smith reported the vertical lid split orbitotomy for removal of superonasal anterior orbital tumors [5]. Kersten and Kulwin described the detailed procedure of the vertical lid split approach [6]. This approach provides excellent exposure of the superomedial orbit and is a very useful approach to access lesions that lie in medial to the optic nerve [7].

In our case, the larger tumor was located at the superomedial part of the orbit and attached to another tumor laterally, enveloping the optic nerve. With its close proximity to the optic nerve, dissection of the tumors was challenging. We excised the tumors completely via vertical lid split orbitotomy and saved operation time. The patient recovered fast and had an uneventful postoperative period.

In conclusion, the huge intraconal cavernous hemangiomas could be safely removed via vertical lid split orbitotomy. Postoperatively, it maintains the normal eyelid function and yields good cosmetic outcome. It is an excellent alternative approach to extract large intraconal, well encapsulated tumor which is superomedially located in the orbit.

Conflict of Interests

The authors declare that they have no conflict of interests regarding this paper.

References

[1] J. A. Shields, C. L. Shields, and R. C. Eagle, “Cavernous hemangioma of the orbit,” Archives of Ophthalmology, vol. 105, no. 6, p. 853, 1987.
[2] G. J. Harris and N. Perez, “Surgical sectors of the orbit: Using the lower fornix approach for large, medial intraconal tumors,” Ophthalmic Plastic and Reconstructive Surgery, vol. 18, no. 5, pp. 349–354, 2002.
[3] J. Rootman, B. Stewart, and R. A. Goldberg, Eds., Orbital Surgery: A Conceptual Approach, Raven, Philadelphia, Pa, USA, 1st edition, 1995.
[4] R. W. Pelton and B. C. K. Patel, “Superomedial lid crease approach to the medial intraconal space: a new technique for access to the optic nerve and central space,” Ophthalmic Plastic and Reconstructive Surgery, vol. 17, no. 4, pp. 241–253, 2001.
[5] B. Smith, “The anterior surgical approach to orbital tumors,” Transactions of the American Academy of Ophthalmology and Otolaryngology, vol. 70, no. 4, pp. 607–611, 1966.
[6] R. C. Kersten and D. R. Kulwin, “Vertical lid split orbitotomy revisited,” Ophthalmic Plastic and Reconstructive Surgery, vol. 15, no. 6, pp. 425–428, 1999.
[7] V. Prabhakaran and D. Selva, “Vertical lid split approach for optic nerve sheath decompression,” Indian Journal of Ophthalmology, vol. 57, no. 4, pp. 305–306, 2009.