Letters to the Editor

Orbital Metastasis

To the Editor:

I was intrigued by the article by Glazer et al. (1) that appeared in the December 1991 issue of the Journal.

Their 64-year-old woman presented with periorbital induration of 6 months duration and a biopsy of the orbicularis muscle, and the preaponeurotic fat pad demonstrated infiltrating carcinoma. Finally, a 1 cm subareola breast mass was diagnosed highlighting the fact that orbital metastasis presented before the diagnosis of breast cancer.

I had a similar case of a 62-year-old woman who presented to her ophthalmologist with ophthalmoplegia showing marked restriction of motion in the right eye. She also noticed decreased visual acuity in that eye. The patient denied any other significant medical history. A CT scan showed marked infiltration of the medial rectus muscle and the orbital fat with neoplastic tissue. The patient was seen by her internist for a possible metastatic workup and was told that she had no signs of any disease. A chest radiograph was normal as was a CT scan of the abdomen and lower pelvis. The patient was then brought to the operating room where she was again examined for preoperative medical clearance. I was told that she was cleared for surgery.

Her biopsy, through a conjunctival approach, revealed an infiltrating schirrus carcinoma. This was compatible with schirrus carcinoma of the breast. On her first postoperative visit, a foul odor was noted emanating from the patient’s chest. I asked the patient to remove her bra and noticed a large ulcerated lesion of the right breast that measured approximately 3–4 cm and had areas of ulceration and inflammation. This was obviously the site of a large infiltrating schirrus carcinoma of the breast. The patient, subsequently, underwent chemotherapy for a metastatic lesion.

It was of great interest to us that this patient presented first to an ophthalmologist and then to an oculoplastic surgeon before the diagnosis of breast carcinoma was made. More importantly, two internists examined this patient without removing her brassiere and declared that she was free of any tumor and that she was clear for surgery.

When subsequently questioned, the patient was under the impression that what she had on her breast was an infection and neglected to even mention that to her internist.

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Reanimation of the Paretic Eyelid

To the Editor:

An article by Gilbard and Daspit (1) from the June 1991 issue of this journal came to our attention. The authors described good results with implantation of gold weights for reanimation of the paretic eyelid, but did note problems with extrusion in four of 61 procedures. In all four extrusions, the weight was ≥1.4 g.

We have been using gold weights for the last 5 years, and early in our experience had also encountered problems with extrusion. This occurred only when weights >1 g were placed. It was our conclusion that this was caused by the larger size and exaggerated curvature of the larger weights, and in response we began to divide the total weight implanted in the lid into two smaller weights when a weight >1 g was required. (For example, we placed two 0.6 g weights side by side, rather than a single 1.2 g weight. See Fig. 1.) Since initiating this approach, we have performed >50 procedures in this fashion without encountering a single extrusion.

We note that we have not felt it necessary to perform a Mullerectomy in the upper eyelid and
that postoperative ptosis was not a frequent problem. On the other hand, we rarely find it necessary to place a weight >1.2 g.

We have found gold weight implantation an excellent method for reanimation of the paralytic eyelid and would encourage placement of two smaller weights when >1 g is required to adequately load the upper lid.

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1. Gilbard SM, Daspi CP. Reanimation of the paretic eyelid using gold weight implantation. A new approach and prospective evaluation. Ophthalmic Plast Reconstr Surg 1991;7:93–103.