



OUT OF FRYING PAN INTO THE FIRE : SHOCKING POST-OPERATIVE PTOSIS IN A PATIENT OF OSSN- A RARE CASE REPORT

Ophthalmology

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ABSTRACT

A 70 year old man presented with growth in superotemporal quadrant of bulbar conjunctiva(2cm x 1cm x 1cm size)close to limbus in right eye; not associated with pain; had watering. Provisional diagnosis of OSSN was confirmed by CIC & HP study of the excised mass.On the first postoperative day, unexpected severe ptosis was seen . The patient underwent ptosis correction using frontalis sling surgery (conventional fox pentagon technique).

KEYWORDS

ocular surface squamous neoplasia , conventional fox pentagon technique

CASE REPORT

A 70 yr old man complained of painless growth in superotemporal quadrant of bulbar conjunctiva close to the limbus not associated with redness and discharge ,since 1 month. The growth was 2cm x 1cm x 1cm in size , gelatinous , soft in consistency , smooth and raised surface and well defined margin , pale pink to salmon in colour, mobile, feeder vessels seen on the surface .

There was no significant past history of any similar episode , systemic illness , trauma .

On ocular examination , his best corrected vision was found to be 6/12 in right eye and 6/9 in left eye .Growth seen in superotemporal quadrant in bulbar conjunctiva of right eye, encroaching upto 3mm of the corneal surface with translucent , greyish and frosted appearance . Bulbar conjunctiva was injected with engorged and tortuous vessels [figure1] [figure2]. Posterior segment evaluation and CT scan brain were normal . Conjunctival impression cytology revealed dysplastic squamous cells.

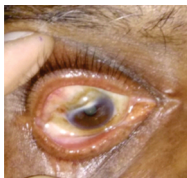


Figure 1 Growth seen in superotemporal quadrant in bulbar conjunctiva of right eye, encroaching upto 3mm of the corneal surface

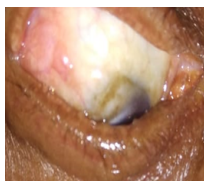


Figure 2

Excisional biopsy with 4mm clear border was done & HP study revealed keratin pearls – concentric keratinocytes , with increasing keratinization & parakeratosis at the centre . Tumor cells arranged in nests and sheets , in between cells, the prominent intercellular bridges indicate well differentiated squamous cell carcinoma.

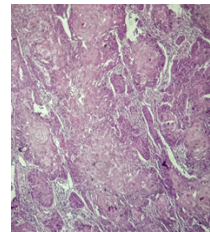
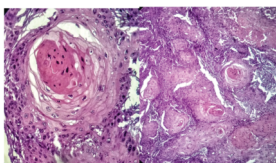


Figure 3 : presence of keratin pearls , concentric keratinocytes with increasing keratinization & parakeratosis at the centre
Figure 4 : pleomorphic cells, round to polygonal with abundant eosinophilic cytoplasm , centrally placed distinct nuclei

Routine hemogram & peripheral blood smear were normal.

On the first postoperative day, the patient presented with severe ptosis of right eye with extraocular movements free and full in all directions .

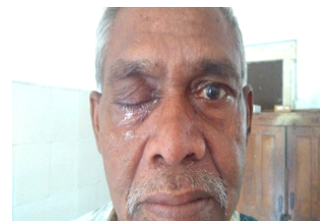


Figure 6 : 1st postoperative day with severe ptosis

The ptosis was managed after 1 month by conventional fox pentagon frontalis sling surgical technique .



Fig8 : 5th postoperative day after ptosis surgery

DISCUSSION :

Ptosis can be divided into its etiologies, including myogenic, aponeurotic, neurogenic, mechanical or traumatic[1]

Myogenic ptosis	Myotoxic effects of anesthesia
Aponeurotic ptosis	Bridle suture or rigid speculum causing dehiscence of levator aponeurosis

Neurogenic ptosis	Prolonged effects of anesthetic on neuromuscular junction. Susceptibility of anteriorly located terminal twigs of the oculomotor nerve to local anesthesia infiltrated in the eyelid in a Van Lint block [3]
Mechanical ptosis	Edema or hematoma in the eyelid [2]
Traumatic ptosis	Blunt or sharp trauma to levator aponeurosis
Transient ptosis (ptosis that improves over the postoperative period)	eyelid edema, hematoma formation (both intraorbital and eyelid), foreign body reaction, ocular inflammation and anesthesia effects.
Persistent or chronic ptosis (ptosis doesn't improve over postoperative period)	Damage to levator aponeurosis or scarring to levator complex – grasping superior rectus during passage of bridle suture[5] , lid speculum , prolonged lid edema [2] .Traction on the superior rectus/levator complex while the upper lid is rigidly fixated with a speculum can cause marked dehiscence of the aponeurosis.[4]

Superior approach to surgery may have a greater risk of ptosis compared to a temporal approach, since vertical traction of the globe during a superior approach may cause dehiscence of the aponeurosis, whereas a temporal approach has no vertical vectors applied to the globe.

In this case , the presenting picture of the growth arouse the suspicion of OSSN which was later confirmed by the histopathological findings. Complete ptosis was seen on first postoperative day after the excision of the conjunctival growth .

“OUT OF THE FRYING PAN INTO THE FIRE” – clearly describes this rare case report. Operated for OSSN & astonishingly turned up with severe ptosis on the first postoperative day.

Ptosis after ocular surgery is amenable to repair via an external approach through the lid crease and repair of the aponeurotic dehiscence or a transconjunctival approach with Müellerectomy for minimal ptosis. Patients with a dehisced levator will have an increased lid crease height and a superior sulcus defect secondary to retraction of the preaponeurotic fat pad. In our case ptosis was managed by conventional fox pentagon technique , after 1month when the patient turned up. He was then referred to the oncologist for further management.

Conflict of interest : There are no conflicts of interest

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