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Case report

Distichiasis following transconjunctival approach to the inferior orbital rim and orbital floor

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ABSTRACT

Zygoma fractures are often associated with orbital floor fractures, which can be approached through a transconjunctival or transcutaneous incision. The transconjunctival approach has gained popularity over the transcutaneous one for its overall lower complication rate. We describe a patient with a zygoma fracture where the inferior orbital rim and orbital floor were exposed, reduced and fixated through a transconjunctival incision. Postoperatively, the patient developed a row of eyelashes posterior to the normal lash line, a condition termed distichiasis, causing corneal irritation and ulceration. This is believed to be caused by the postoperative eyelid inflammation induced by the transconjunctival incision. The condition was treated by electrolysis with no recurrence of symptoms. This condition has never been described as a postoperative complication of a transconjunctival approach to an inferior orbital rim and orbital floor fracture.

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Introduction

Zygomato-maxillary complex (ZMC) fractures are among the most common fractures of the facial skeleton because of the exposed position of the zygoma in the midface. They involve the inferior orbital rim and the zygoma with its zygomato-maxillary and zygomato-frontal buttresses and are often

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associated with an orbital floor fracture. Most of these fractures require open anatomic reduction and rigid internal fixation to re-establish aesthetically pleasing malar projection and facial symmetry, correct orbital volume and restore maxillary stability for mastication.¹

The inferior orbital rim and orbital floor can be exposed through a transconjunctival or transcutaneous (subciliary or subtarsal) incision.^{2,3} The transconjunctival approach was initially described by Bourquet in 1924 for cosmetic lower eyelid blepharoplasty and was later popularized by Tessier for exposure of the orbital floor in congenital craniofacial anomalies and trauma.³ Both preseptal and retroseptal approaches have been described with or without lateral canthotomy to increase orbital floor exposure.^{2,3} This incision has gained popularity over the transcutaneous approaches because of its inconspicuous scar and decreased risk of postoperative ectropion and scleral show.^{2,3}

We describe the treatment of a zygoma fracture in which the inferior orbital rim and orbital floor fractures were exposed with a transconjunctival incision. In her postoperative course, the patient developed an accessory row of lashes near the Meibomian gland orifices in the operated eyelid, a condition termed distichiasis. To our knowledge, this has never been described in the literature as a potential complication of a transconjunctival incision.

Case report

We describe the case of a 32 year-old female who presented to the emergency room after sustaining a fall down a flight of twelve stairs while being inebriated. She complained of pain in her left hemiface and presented with mild left malar depression and trismus. A facial computed tomography demonstrated a left zygoma tetrapod fracture (Figure 1) associated with a left orbital floor fracture (Figure 2). The patient's preoperative ophthalmologic exam was within normal limits.

Her surgery consisted of a left zygoma and orbital floor open reduction and internal fixation. A left superior gingivobuccal sulcus incision was performed to approach, reduce and fixate the zygomatico-maxillary buttress and to reduce the zygomatic arch fracture. The zygomatico-frontal buttress was reduced and fixated through a left lateral eyebrow laceration that the patient had sustained during her fall. The inferior orbital rim and orbital floor were approached via a transconjunctival incision and a preseptal dissection. A lateral canthotomy was not performed. The inferior orbital rim was fixated with a miniplate and the orbital floor was reconstructed with a titanium plate. At the level of the transconjunctival incision, the periosteum was closed with a 5-0 polyglactin suture, then the conjunctiva was reapproximated with a subconjunctival suture.

One week postoperatively, the patient did not have any visual complaints or diplopia. Two months postoperatively, she presented to the emergency room complaining of a two-week history of left eye pain and photophobia. An ophthalmologic exam revealed normal eyelid position (Figure 3), but present were distichiasis, secondary conjunctivitis and corneal ulceration (Figure 4). She was treated with topical antimicrobial ointments and later underwent electrolysis for the treatment of the distichiasis.

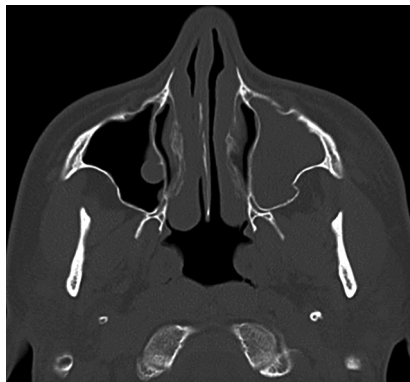


Figure 1. Axial view of left zygoma fracture.

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