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President Message: Hirohiko Kakizaki

Dear APSOPRS colleagues,

Season's greetings during mid-summer! It has been 2 years since the new council started, and now at the last corner.



The first thing we did was the move of the secretariat from Singapore to Japan. The most important matter was managing the members. At the time, the number of the official members were only 77, which means only 77 members paid the fee to the society. The society had 197 past (unpaid) members, though. I was very surprised at this reality as the APSOPRS is the representative society in this area and an affiliated society of APAO. In addition, the APSOPRS has been a reciprocal society of the ASOPRS. This matter was simply caused by the bothersome payment system. We before had only two methods of payment: one was the direct payment at a conference venue and the other was via bank transfer, the latter of which needs a complicated procedure. We therefore simplified the payment system using the Paypal via web. As a result, the number of the paying members has increased to 112 by now. This is not enough, of course, so please invite your colleagues and try to catch up with the ASOPRS and ESOPRS!

In relation to this membership management, we have launched the "life membership" system. This has been long proposed by Dr. Ganga Sunder in Singapore and came true at last with his endeavor. Once 500 USD is paid, in addition to the entrance

fee (100USD), no renewal procedure is needed to have the membership status continuously. By now, 77 members have registered as a life member.

By the way, what is the merit as a member of the APSOPRS? To attend a meeting biannually? To make an international relationship with colleagues? These are one aspect of the advantage though, I believe the most important is the “education”, which means “level up of oculoplasty” in our vast Asia-Pacific region. We have continuously held the biannual conference since 2000, but this is not enough, of course. More frequent meeting may be a countermeasure, but this is not a realistic as there are a lot of other conferences such as APAO, AAO, WOC, ASOPRS, ESOPRS, in several of which we have APSOPRS sessions. We will, therefore, start a web-education system for the members. Log on the APSOPRS homepage and log-in to the member only page, you can show surgical videos and various lectures. We are now brushing up this system and will soon deliver them soon.

The biannual APSOPRS meeting will be held on 26th and 27th of August in Osaka, Japan. Our Japanese team is warmheartedly preparing for the meeting. Many well-known doctors will lecture you with fruitful contents and more than 60 poster presentation will give you novel information.

This is the last president message of mine and I appreciate your kind contribution during the presidency. However, our APSOPRS is still developing. We need your continuous support to achieve prosperous future of the APSOPRS.

Warmest regards,

Hirohiko Kakizaki, M.D., Ph.D.
Professor & Chairman, Department of
Oculoplastic, Orbital & Lacrimal Surgery, Aichi
Medical University Hospital.
The presidents of Asia-Pacific Society of
Ophthalmic Plastic & Reconstructive Surgery, and

Japanese Society of Ophthalmic Plastic &
Reconstructive Surgery.

Editorial Note

Dear friends and colleagues,

Warm greetings to all! Our biennial meeting is almost upon us and we are looking forward to a terrific meeting in Osaka helmed by our President, Prof Hirohiko Kakizaki. The programme looks exciting and it will be a good opportunity for our younger colleagues to learn new angles and approaches from the more experienced ones in our oculoplastic community. And as always, we will likely be bowled over by the kind hospitality of our gracious Japanese hosts.



We have a few interesting articles for our readers this issue. We could, however, do with more contributions so that the outlook remains more regional and relevant to all. To this end, we shall directly approach each country’s representative to contribute at least 2 articles per year. I hope for everyone’s participation so that all can be proud of this newsletter that we can call our very own.

See you all soon in Osaka!

Sincerely,

Adj Assoc Prof. Audrey Looi
MBBS, M.Med (Ophth), FRCS (Ed), FAMS
Senior Consultant
Oculoplastic Department
Editor, APSORPS
Singapore National Eye Centre



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CASE HIGHLIGHTS (1)

Surgical management of unusual eyelid swelling

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A 57 year old female presented with persistent left upper lid swelling for three years. She has a history of carcinoma of tongue that was treated with hemiglossectomy with post-operative radiotherapy. She then developed a gradual onset of left upper lid swelling causing visual disturbance because of secondary mechanical ptosis. Ophthalmic examination disclosed left upper lid swelling with secondary mechanical ptosis, the left eye MRD was 0 mm, palbrebral fissure was 4 mm, levator function was 9 mm. The left upper lid swelling was non tender, there was no erythema or signs of inflammation (Figure 1). The pupils were equal and reactive, the extraocular movement, tear film, Bell's reflex were normal. Her visual acuity, intraocular pressure and fundi were unremarkable. The left side face is slightly larger than the right side. There was no palpable cervical lymph nodes and no signs of recurrence of carcinoma of tongue.

The diagnosis was left upper lid lymphedema, probably related to previous radiotherapy. She then received left upper lid blepharoplasty and ptosis correction with excision of excessive left upper lid skin muscle flap, debulking of the orbital septum and preaponeurotic fat pad, resection of levator muscle, followed by reforming of skin crease (Figure 2). Patient was satisfied with the cosmetic and functional outcome. She remains well 4 years after the surgery with no recurrence.

Lymphedema occurs as a result of impaired lymphatic drainage, accumulation of protein-rich interstitial fluid with subsequent inflammation and fibrosis. It can be congenital or acquired. Common causes of head and neck lymphedema are inflammatory, trauma (surgery and radiation), neoplasm and infection.

Eyelid lymphedema is a nonpitting edema which leads to bulky eyelid. In severe cases with "solid" swelling, it can cause visual field loss and disfigurement. Eyelids lymphedema is usually progressive, in contrast with blepharochalasis, and seldom gives rise to skin thinning.

Ocular involvement in rosacea is common in form of blepharitis, meibomianitis or conjunctivitis. Though rare, eyelid lymphedema is also seen in cases with rosacea^{1-4,7}, and indeed, rosacea is the most commonly reported association with eyelid lymphedema. Morbihan disease is characterized by persistent severe edema and erythema of the upper two-thirds of face, including the eyelids². It is considered as a late complication of rosacea though the pathophysiology is not well understood. There are few cases of eyelid lymphedema reported developing after neck dissection, surgery or radiation⁵⁻⁷. Edema of face and neck region is common especially in cases with bilateral lymphatic disruption and usually transient, but again, isolated eyelid lymphedema is rare. It is difficult to isolate the cause of the lymphedema since these cases usually underwent resection of the head and neck tumour together with reconstructive surgery with or without radiotherapy.

Chalasanani et al also reported a case of eyelid lymphedema secondary to post-vitreotomy silicon oil leak in his series.

In general, lymphedema can be managed with manual lymphatic drainage, compression garments, lymphatic exercise and skin care ⁸. Medical therapies reported, especially in cases associated with acne rosacea, include tetracycline, systemic steroid or intralesional steroid injection but they were of limited efficacy in the presence of eyelid lymphedema ^{1-2, 4}. Surgical debulking was found to be effective and the use of split thickness skin graft was reported with favorable result ^{1, 7, 9}. In the current case, in addition to surgical debulking, levator resection was also performed for the mechanical ptosis due to the long standing edema. The absence of recurrence may be due to presence of scar tissue of which is less likely for edematous fluid to accumulate.



Figure 2

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Figure 1

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granulomatosis with involvement of her brain, lungs, abdominal lymph nodes, spinal cord and breasts, which had been in remission for 6 months. She had undergone 18 weeks of chemotherapy 16 months prior with high-dose methotrexate, vincristine, rituximab, procarbazine and cytarabine. She also had a history of well-controlled scalp psoriasis.

Examination

On examination, there was an indurated 3.5cm by 2cm discharging abscess at her left medial canthal area, which was erythematous, warm and tender on palpation, with bilateral medial epiblepharon and lash-corneal touch. The rest of her eye examination was otherwise unremarkable. Her systemic examination was also unremarkable. She was afebrile, and her vital signs were within normal ranges.

Investigations

Preliminary blood tests were unremarkable. A CT of her brain and orbits was performed to rule out progression of lymphomatoid granulomatosis as a cause of suspected nasolacrimal duct obstruction causing dacryocystitis. This showed a thick-walled rim-enhancing collection in the left preseptal space that involved the left medial canthus, inferior eyelid and nasolacrimal duct compatible with left dacryocystitis with early abscess formation. It also showed a decrease in size of multiple enhancing foci in her brain. Specimen sent from the discharging abscess showed a gram stain of 3+ polymorphs and 1+ gram negative bacilli, and positive cultures for haemophilus influenzae. Blood cultures taken were negative.



CASE HIGHLIGHTS (2)

High-dose methotrexate implicated in nasolacrimal duct obstruction

Authors:

Amy Chan, BMed, MD¹; Tiffany Tang, MBBS, BMedSci, MMed (Int Med), MRCP (UK)²; Audrey Looi, MBBS, MMed (Ophth), FRCS (Ed)¹

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2. Singapore National Cancer Centre, Singapore

History

The patient was a 24-year-old female who presented with left lower eyelid redness and discharge for 1 week, with a lump at the left medial canthus. There was no history of trauma or insect bite, and no report of fever, chills or rigors. She had a past medical history of lymphomatoid

Management

She was treated for left dacryocystitis and commenced on intravenous vancomycin, aztreonam and levofloxacin eye drops. After the results of positive cultures for haemophilus influenza, which were sensitive to ciprofloxacin, her systemic antibiotics were subsequently changed to oral ciprofloxacin. Her care was managed in conjunction with Infectious Disease specialists and with her primary Oncology physician. She had slow resolution of her left dacryocystitis and an early dacryocystorhinostomy (DCR) was offered to the patient to aid complete resolution. DCR through an endoscopic approach was performed successfully.

Discussion

Given her age and absence of other aggravating factors, her nasolacrimal duct obstruction (NLDO) was thought to be related to the chemotherapy (Table 1), she had received 16 months prior to presentation.

Table 1: Chemotherapy regimen

Week	Methotrexate (g)	Vincristine (mg)	Procarbazine (mg)	Rituximab (mg)	Cytarabine (g)
1	5.2	2	150	-	
3	5.2	2	-	600	
5	5.4	-	-	600	
7	5.4	2	-	600	
9	5.7	2	150	600	
11	5.7	2	-	600	
13	5.6	-	-	600	
16					4.5 (2 days)
18					4.5 (2 days)

NLDO is most commonly associated with fluorouracil, docetaxel, cyclophosphamide and paclitaxel. However, literature is scarce and comprises case reports predominantly¹⁻⁷.

To date, there has been one case report on NLDO due to combination therapy involving methotrexate, along with cyclophosphamide and fluorouracil⁸. However, there have been no case reports on methotrexate alone resulting in NLDO. Vincristine, rituximab, procarbazine and cytarabine have not been previously reported to be associated with NLDO. This case suggests that high-dose methotrexate may have the potential to cause NLDO, perhaps due to levels of methotrexate accumulated in tears that are similar to levels in

plasma 24-48 hours after high doses of systemic methotrexate (>30mg/kg)⁹.

Notably, the patient had lymphomatoid granulomatosis, which bears features of Wegener's granulomatosis, a cause of secondary NLDO. However, lymphomatoid granulomatosis has been found to be its own distinct entity and has not been reported with NLDO¹⁰⁻¹¹. Thus, we propose that patients on high-dose methotrexate be informed of this potential complication and consider prophylactic stenting with silicone tubing.

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ANNOUNCEMENTS

Event : 9th APSOPRS & 4th JSOPRS Joint Meeting in Osaka
Date : 26 to 27 August 2016
Venue : International House Osaka



Harmony with the World

9th APSOPRS & 4th JSOPRS JOINT MEETING in OSAKA
Asia Pacific Society of Ophthalmic Plastic & Reconstructive Surgery
Japanese Society of Ophthalmic Plastic & Reconstructive Surgery

Date | Friday 26- Saturday 27 August 2016

Venue | **International House Osaka**
2-6 Uehommachi 8-chome, Tennoji-ku Osaka-shi, Osaka, 543-0001, Japan
URL: <http://www.ih-osaka.or.jp/english/>

Keynote
Raman Malhotra (Queen Victoria Hospital, U.K.)
Peerooz Saeed (Netherland)
Anthony Tyers (Salisbury District Hospital, U.K.)
Yutaka Ogawa (Kansai Med University, Japan)
Reiko Arita (Japan)
Robert Goldberg (U.S.)
Don Kikkawa (U.S.)
JongHak Lim (Kairos Aesthetic Surgery, Korea)
Koh Inoue (Inoue Eye Clinic, Japan)
Dinesh Selva (Australia)

Emeiritus
Yasuhisa Nakamura (Aichi Medical University)

Host
The 9th Meeting of Asia Pacific Society of Ophthalmic Plastic & Reconstructive Surgery (APSOPRS)
President: Hirohiko Kakizaki, Professor of Department of Oculoplastic, Orbital & Lacrimal Surgery, Aichi Medical University Hospital.
The 4th Meeting of Japanese Society of Ophthalmic Plastic & Reconstructive Surgery (JSOPRS)
President: Hidenori Mito at Ide-Ganka Hospital

Contact The Office of the Joint Meeting of APSOPRS & JSOPRS
c/o 206 Welllife Uehommachi Clinic Plaza, 5-52, Fudegasakicho, Tennoji-ku Osaka-shi, Osaka, 543-0027, Japan

<http://apsoprs.org/meeting/2016/>

Event : 32nd Asia-Pacific Academy of Ophthalmology Congress
Date : 1 to 5 March 2017
Venue : Suntec Singapore Convention and Exhibition Centre in Singapore.

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APAO 2017 Congress Secretariat: apao@apaophth.org

EVENT : SNEC Oculoplastic Cadaveric Dissection Workshop
Date : 28 February to 1 March 2017
Venue : Academia, Singapore

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GUIDELINES

Below are the formats for the different categories of articles:

Invited Articles

(no more than 1600 words; include images where appropriate)

Case Highlights

This refers to the written presentation of an interesting or challenging case in the following format:

- History (no more than 100 words)
- Examination (no more than 150 words; include clinical photos)
- Investigations (include imaging where appropriate)
- Management (no more than 100 words; include pathology images where appropriate)
- Discussion (no more than 200 words; including challenges encountered in diagnosis or management)

Operative Pearls

This refers purely to advice that allows the reader to improve on his or her intraoperative technique and can include immediate post-op advice (no more than 600 words; include images where appropriate)

Meetings or Social Visits

All meetings organized by APSOPRS members as well as social visits to each other's' centers are eligible for inclusion in the newsletter (no more than 1000 words for the main APSOPRS biennial meeting and no more than 500 words for other meetings or visits).

Philosophical Notes

No more than 800 words; include images where appropriate