President Message: Hunter Yuen

Dear APSOPRS colleagues,

The biennial meeting of the Asia-Pacific Society of Ophthalmic Plastic and Reconstructive Surgery (APSOPRS) will be held at Hong Kong Convention and Exhibition Center 15-16 Dec 2018.

Throughout the past years, APSOPRS has been very active in enriching the oculoplastic knowledge and surgical skills in the region. This year, we are honored to have Prof Geoffrey Rose from UK and Prof Don Kikkawa from USA to be our featured speakers. Aside from them, our program is fully packed with excellent presentations with a wide coverage of clinical and research in ophthalmic plastic and reconstructive surgery, as well as general ophthalmology. We are expecting more than 100 invited speakers and more than 800 delegates.


APSOPRS AGM and now council election will be held from 0700 to 0900 on 16 Dec 2018 at the convention center during the conference. Nominees are reminded to attend this and eligible members can vote during the AGM. Please be reminded that we only accept onsite voting only.

Hong Kong is a modern, dynamic and vibrant city where the east meets the west, as well as the gateway to China. Aside from the scientific program, there are plenty of places that are truly worth exploring.
On behalf of APSOPRS, COHK and HKOS, I welcome all of you again. May all esteemed overseas guest have a wonderful and memorable stay in Hong Kong and I wish you all found this symposium enjoyable and fruitful. Thank you.

Warmest regards,

YUEN Kwok Lai Hunter
MBChB, FRCOphth, FRCS(Ed), FCOphthHK, FHKAM (Ophthalmology), DipClinDerm (London)
Clinical Associate Professor (Honorary), Department of Ophthalmology and Visual Sciences, The Chinese University of Hong Kong (CUHK)
Consultant, HKEH

Editorial Note

Dear friends and colleagues,

Warm wishes to all as we head towards our biennial meeting and AGM in Hong Kong in December! The end of the year always prompts personal reflection and plans for the new year as the old gives way to the new. At APSOPRS, we are grateful to our President for the past two years, Prof Hunter Yuen, for his excellent leadership and guidance. We have seen strengthened links with ASOPRS and ESOPRS as well as emerging relationships with various oculoplastic societies in the Asia-Pacific region. Our ex-co nomination processes have been streamlined into an orderly online system with many thanks to our Secretary-General, Dr Mary Rose Peyos aka Mayos. We did not have to pay taxes this year, thanks to our Treasurer, Dr Sunny Shen! We can indeed be so proud of our Society that has grown so much since its inception.

Following the AGM, we will see a new team on board. This will, sadly, be my last issue as Editor-in-chief of iPlastic. It has been an honour and privilege to serve in this role since I was assigned the task during Dr Ashok Grover’s term as President five years ago. At this point, I would like to take the opportunity to thank all my department secretaries and fellows who have helped out in one way or another. Good job with this last one, Kai Ling! I look forward to passing on the torch to the next Editor and wish him or her all the best in continuing this effort to record our Society’s journey and the excellent work of our members. And I certainly hope for all your continued support as I look towards serving the Society in other ways.

Wishing all members a lovely holiday season ahead and those who celebrate Christmas, a very Jolly and Merry Christmas!

Best regards,

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

<table>
<thead>
<tr>
<th>Case Highlights</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A Foreign Body in Orbital Apex Nearby Internal Carotid: A Case Report</strong>&lt;br&gt;By David Honglei Liu</td>
<td>4</td>
</tr>
<tr>
<td><strong>Lid anthropometry and its co-relation with Primary Angle closure Glaucoma</strong>&lt;br&gt;By Jayantha Kumar Das, Prafulla Sarma, Harsha Bhattacharjee, Pooja Gupta, Shyam Sundar Das Mohapatra, Shahinur Tayab, Chengchira A. Sangma</td>
<td>6</td>
</tr>
<tr>
<td><strong>Rhomboid Flap in Periorbital Reconstruction</strong>&lt;br&gt;By Mary Rose Pe Yan</td>
<td>10</td>
</tr>
<tr>
<td><strong>Clinical Analysis of Hyaluronic Acid Injection to Correct Enophthalmos after Orbital Fracture</strong>&lt;br&gt;By Pengsen Wu, Don O. Kikkawa, Wei Lu</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Philosophical Notes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incoming President Dr. Raoul Henson Attends the Midyear Class of the APAO Leadership Development Program in Singapore</strong>&lt;br&gt;By Raoul Henson</td>
<td>14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Announcement</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>APSOPRS Hong Kong 2018</td>
<td>16</td>
</tr>
<tr>
<td>ITEDS Meeting 2019</td>
<td>18</td>
</tr>
<tr>
<td>ITEDS-SNEC Cadaveric Dissection Course 2019</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>iP lastic e-Newsletter Paper Contribution Guidelines</td>
<td></td>
</tr>
</tbody>
</table>
A Foreign Body in Orbital Apex Nearby Internal Carotid: A Case Report

David Honglei Liu

ABSTRACT

A 19-year-old male patient, his glasses was hit by a big umbrella yesterday and then his right eye couldn’t see anything. On surgical exploration we retrieved a plastic cap of a big umbrella sized 3.5cm X 1.5cm from orbit apex nearby internal carotid without patient hemorrhage.

INTRODUCTION

The incidence of intra-orbital foreign bodies reported is 2.9 %. Orbital foreign bodies are commonly observed in males and in younger patients. Occupational accidents, gunshot injuries and road traffic accidents are common causes for penetrating orbital injuries. The history of orbital injury or penetrating eyelid injury should raise the suspicion of foreign body. Based on the material, foreign bodies can be classified into (1) metallic, like steel; (2) non-metallic, such as glass, stone, plastic; and (3) organic, such as wood. They can cause structural and functional damage. The clinical presentation includes pain, redness, swelling, limited eye movement, infestation, optic nerve compression even vision loss. The severity of these damages depends on the foreign body’s property, size, position and the state of being injured. CT scan is the better than ultrasonography, MRI and X-ray in locating foreign body. In this article we present a case report of foreign body in orbit apex—nearby internal carotid, which was retrieved successfully without hemorrhage.

CASE REPORT

A 19 years old male patient, his glasses was hit by a big umbrella blown down by the high wind yesterday and then his right eye couldn’t see anything. He went to the local hospital, the doctors did eyelid debridement and suturing and took two foreign bodies like glasses out of his eyelid, but they couldn’t take out of a green string embedded in the conjunctiva. Then he came to our hospital in order to take the green string out.

Visual acuity in right was NLP. Ophthalmologic examination revealed upper eyelid wound sutured, conjunctival congestion, chemosis in the right eye, ocular movements were limited in every direction, total ptosis, haze of corneal epithelium, chamber depth is deeper than the other one, tyndall, herniation of vitreous, mydriasis, cataract, vitreous opacity, fundus examination revealed blurred. The left eye was normal. CT scan showed the fracture of medial wall, inferior wall and sphenoid bone in the right eye, extraocular muscle and optic nerve contusion, periorbital soft tissue contusion.

Radiographic findings did not reveal any conclusive diagnosis to this severe damage, so we decided to intervene surgically under general anesthesia. At the beginning, only a green string can be seen embedded in the conjunctiva. The other end of the string couldn’t be seen from Tenon’s capsule deep into central space through transconjunctival approach. Because of big resistance, the green string couldn’t be pulled out. Looked at CT over and over again, we found an oval low density, in which there was lower density like air, located orbit apex stretching into sphenoid sinus (Fig.1) MRI showed an oval low signal located in orbit apex (Fig.2).

![Fig.1 axial CT view](image1)

Then we decided to change the approach to lateral orbitotomy. When we made blunt dissection towards orbit apex, we found a tiny hole in the periorbita (Fig.3) and then cut the periorbita before superior orbital fissure. A green foreign body was exposed and stuck in the orbit apex. We made the foreign body exposed step by step, then we found it was a green wafer plastic (Fig.4).
Clamped it and dragged it out, there was still big resistance. Try to revolve 360 degree, we saw the foreign body became loose and found it was a torus plastic (Fig.5). At last, the foreign body was taken out entirely. As expected, the torus plastic and the green string was linked together. The torus plastic moved as dragging the green string. The torus was 3.5cm X 1.5cm and the total length of the two were 11cm (Fig.6). After packing hemostasis and oppressing eyeball several minutes, we restored bone flap with absorbable plate and nails, sew the incision.

DISCUSSION

Orbit foreign bodies dislike cataract, strabismus, retinal detachment and so on. Each of them has their own characteristics. Retrobulbar foreign bodies of the orbit are either associated with double perforation of the globe or traverse the orbital septum through the lids and peribulbar tissues. Plain film radiography is useful to localize radiopaque objects. However, plain films lack the capacity to demonstrate the object details, their exact location in relation to surrounding structures and tissue response or damage. Standardized ophthalmic ultrasonography requires a specific expertise and technology that is not available in many institutions and is time consuming. Magnetic resonance imaging should be avoided when there is the suspicion of metallic foreign body, as the magnetic field may lead to the movement of the metallic structure. Hence CT scanning is
considered to be gold standard for diagnosing intraorbital foreign bodies.\(^7\) Imaging plays a very important role in locating foreign bodies. But it’s often difficult to find organic foreign material like wood, it was also not very clear in our case. Combining the defect of imaging, the history of injury becomes crucial in clinic. In our case, the patient said his glasses were hit by a big umbrella blown down by the high wind. Through examination, we only found two wounds, one in upper eyelid and the other in conjunctiva, which exhibited minimal surface damage which couldn’t cause vision loss. His orbital apex syndrome revealed that it was not what it looked like. Severe problem may be hidden in orbital apex. So operation was needed, and we found the answer in the surgery. Surgical intervention in a case with intraorbital foreign body is usually indicated in the presence of a sharp foreign body, signs of infection, proptosis, restricted motility, palpable orbital mass, optic nerve compression, abscess, suspicion of organic material, fistula formation, or when adjacent structures are compromised.\(^6,9\)

Another horrible thing in our case is the foreign body’s place, which located orbit apex, stretching into sphenoid sinus and nearby internal carotid. If a blood vessel was burst, that would result in serious consequences like hemorrhagic shock even death. So careful reading of CT is also important for a surgery. If we did the operation with neurosurgeon, that would be safer. In addition, we shouldn’t cut the green string, because the big one would be left in patient’s orbit, which may cause damages like infection, abscess, fistula etc. It tells us that we should check the foreign body’s integrity and then end the surgery.

CONCLUSION

Any penetrating injury to the orbit should cause everyone’s attention on foreign body. A detailed medical history, careful reading of imaging, clinic experience are essential to diagnose. Patience and skilled at anatomy will make the surgery more easier.

REFERENCES


Lid anthropometry and its co-relation with Primary Angle closure Glaucoma

Jayantha Kumar Das
Prafulla Sarma
Harsha Bhattacharjee
Pooja Gupta
Shyam Sundar Das Mohapatra
Shahinur Tayab
Chengchira A Sangma

ABSTRACT

Objective: Primary angle-closure glaucoma (PACG) is a major cause of world blindness today. Studies have found that South Asians, ethnic Chinese, and Inuit Eskimos are at significantly higher risk for angle-closure glaucoma. There are very few studies aimed at elucidating the epidemiological factors. In this study we aim to identify the any co-relation between upper lid anthropometry and high incidence of PACG in North-East Indian population.

Methods: A case control study was carried out in North-eastern region of India from January 2012- Dec 2017. In study group, a total of 180 patients of above 40 years old with primary narrow angle and PACG were included, controls were frequency matched with the cases on age, sex and ethnicity. Apart from standard clinical examination and investigation, Gonioscopy and measurement of horizontal length of lid, vertical fissure height, lid crease distance and tarsal plate height were measured in both side and data were analyzed by paired t-test for statistics.

Results: Male: female ratio was 0.55:1 in both groups. The mean ages of study and control groups are 58.17 and 57.86 years respectively. The mean horizontal length was 27.93 and 28.08 (p<0.01); vertical height 8.4 and 8.71 (p=0.15); tarsal plate height 7.77and 8.67 (p<0.01); lid crease distance 7.53 and 8.05 mm (p<0.01) in study and control group respectively. The P value was <0.01 in tarsal plate height, lid crease distance and horizontal length which is significant at 1 % level of significance.
Conclusions: The study highlights the significant relation between lid anthropometry and high incidence of PACG, would put forward the possibility of less tarsal plate height and less lid crease distance are significant contributing factor of PACG in some Asian countries.

INTRODUCTION

Worldwide, 60.6 to 79.6 million people are estimated to be affected from glaucoma in a duration of 10 years from 2010 to 2020. Among those detected with glaucoma, one quarter (around 26%) are estimated to have primary angle closure glaucoma (PACG) but PACG is responsible for around 50% cases of blindness due to glaucoma.

In previous studies, PACG was found to be much more prevalent in Asia compared to other continents of the world. Prevalence was highest (2.7%) in northwest Alaska, followed by Myanmar (2.5%) and rural Japan (2.2%).

There is a large variation in prevalence of PACG in different parts of India. In rural West Bengal it was found to be around 0.23% whereas in southern India it ranges from 0.5% to 4.3%. In Eastern India it ranges from 0.97% to 1.03%. However, majority of PACG cases are asymptomatic and remain undiagnosed. So, identification of risk factors and early diagnosis of PACG is of utmost importance for prevention of sight threatening complications.

Known risk factors for PACG include age, female gender and ethnicity. Prevalence is 0.4% in white subjects, 1.4% in Chinese and 2% to 8% in Eskimos. Risk factors related to eyeball anatomy include small corneal diameter, shallow anterior chamber, thicker lens with increased anterior curvature and short axial length of eyeball. Genetic makeup of an individual is also a known risk factor for PACG. The heritability for a narrow angle (on gonioscopy) is approximately 49% whereas heritability for a shallow anterior chamber is as high as 93%.

Literature search has not shown any study on role of eyelids in causing PACG. Authors hypothesize that since eye lids are in direct contact with cornea, pressure affect from lids can cause narrowing of anterior chamber angle. This can lead to more resistance to aqueous outflow and hence PACG in severe cases. Hence, this comparative study was carried out to record anthropometric measurements of upper eye lid in PACG patients and normal subjects.

AIM

To identify co-relation between upper lid anthropometry and high incidence of primary angle closure glaucoma in North-East Indian population.

METHODS

A prospective study was carried out in North-Eastern region of India from January 2012- Dec 2017. In study group, a total of 180 patients were included, controls were frequency matched on age, sex and ethnicity. All the cases were subjected to standard clinical and detailed ophthalmic evaluation. In addition, gonioscopy and detailed lid evaluation was carried out as per below mentioned protocol.

On gonioscopy - 360-degree anterior chamber angle was evaluated to look for iris attachment on sclera.

Lid evaluation
1. Palpebral fissure width (PFW) - Distance between medial and lateral canthus. (Fig 1)
2. Palpebral fissure height (PFH) - Distance between superior eyelid margin and inferior eyelid margin over the pupil. (Fig 1)
3. Tarsal plate height- Upper lid was everted and height of tarsal plate was measured. (Fig 2)
4. Lid crease height- vertical distance of the superior lid margin from the natural lid crease in down gaze (normal 8-10 mm). (Fig 3)
Enrolment Criteria:

Enrolment criteria for study group:
The cases were identified directly by the investigators who reported above said hospital.
Age more than 40 years
Narrow angle or angle closure glaucoma patients.

Enrolment for control group: age and sex matched volunteers were included for control with the same geographical locality and demographic profile, fulfilling similar criteria with cases.

Data collection and consent: verbal and written consent was taken from participants before the study.

Data analysis:
Null hypothesis- There is no relation between lid anthropometric findings and PACG.
We performed Pearson Chi-square test for the analysis to establish or reject our null hypothesis.

RESULTS

Male: female ratio was 0.55:1 in both groups. The mean ages of study and control groups are 58.17 and 57.86 years respectively.

<table>
<thead>
<tr>
<th>Eye lid parameters</th>
<th>Study group</th>
<th>Control group</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>58.17 yrs</td>
<td>57.86 yrs</td>
<td>&gt;0.01</td>
</tr>
<tr>
<td>Palpebral fissure width</td>
<td>27.93mm</td>
<td>28.98mm</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Palpebral fissure height</td>
<td>8.4mm</td>
<td>8.71mm</td>
<td>0.15</td>
</tr>
<tr>
<td>Tarsal plate height</td>
<td>7.77mm</td>
<td>8.67mm</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Lid crease distance</td>
<td>7.53mm</td>
<td>8.05mm</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

The table showing the measurement of different parameters in both study and control group.

The mean palpebral fissure width was 27.93 and 28.98 (p value <0.01).

The palpebral fissure height 8.4 and 8.71 (p value 0.15).

The tarsal plate height 7.77 and 8.67(p value <0.01).
**CONCLUSION**

For identifying people more prone to develop PACG, gonioscopy etc. These measurements can be used as screening tool for identifying people more prone to develop PACG. Since this a pioneer study, more data from different parts of the world is required to establish the results. These anthropometric measurements can be easily done in rural population where skilled glaucoma specialists are not available for detailed glaucoma evaluation which includes anterior chamber depth, tonometry, gonioscopy etc. These measurements can be used as screening tool for identifying people more prone to develop PACG.

**REFERENCES**


Rhomboid Flap in Periorbital Reconstruction

Mary Rose Pe Yan

ABSTRACT

Primary closure with simple suturing is often the first choice in reconstruction of facial defects. However, size of the defect is a common deterrent to primary closure. The type of closure of a skin defect depends on the defect size and the characteristics of the surrounding tissues. Facial reconstruction of defects that cannot be closed by direct approximation is best treated with skin flaps from adjacent tissues.

CASE SUMMARY

A 63-year-old female who underwent excision and post-operative radiation of a Sphenoid Wing Meningioma WHO Grade I on the left 23 years prior, and re-excision of a recurrent mass 4 years prior, presented with a 10-mm circular area of tissue necrosis lateral to the left lateral canthus, exposing the zygomatic bone (Picture 1). Best corrected visual acuity for both eyes was 20/30, with lens opacities on slit lamp examination. A CT scan revealed bone changes consistent with a previous craniectomy and surgically absent sphenoid bone in the lateral orbital wall. An area of hyperdensity in the lateral orbit was considered as fibrosis.

Lid reconstruction by undermining and advancement of skin edges of the defect was done. One week post-operatively, there was wound dehiscence, re-exposing the zygomatic bone. She then underwent reconstruction using a rhomboid flap.

DISCUSSION

In 1946, Alexander Limberg designed a protocol for transposition of a rhomboid flap. The advantage of this method is that it maintains continuity of color, texture, and vascularity with the adjacent tissue. The superior aesthetic outcome of rhomboid flaps over skin grafts is due to the intact dermal-subdermal vascular plexuses in the pedicle of the flap. The blood supply of a rhomboid flap is random; although the presence of extensive collaterals in the face makes this aspect less important.

The skin defect is excised in the shape of two adjacent equilateral triangles that merge at the base to form a rhomboid (Picture 2). A rhomboid has opposite sides that are equal, and has 2 pairs of opposite angles that are 60 degrees and 120 degrees. For any rhomboid-shaped defect, there are 4 possible rhomboid flaps that can be created. The rhomboid flap has 3 sides: (1) the first flap side is along the axis that bisects the 120-degree angle and the same length as the base of the triangles that form the rhomboid; (2) the second flap side is the adjacent side of the defect; and (3) the third flap side is the same length and parallel to the second flap side. The choice of flap depends on local skin availability, taking into consideration skin tension lines, skin texture, and defect location (Picture 2, blue arrows). The rhomboid flap is transposed towards the defect, with a 60-degree rotation. The main restriction of the rhomboid flap is that the secondary defect should be closed directly. The line of maximum tension in a rhomboid flap is at the corner of the defect most distant from the flap donor site.

The high success rate of rhomboid flap is due to the excellent vascularity of the head and neck. Despite maintaining adequate blood supply through the pedicle, flap necrosis can still occur due to tension at the distal end of the flap. In the face, the maximum length-to-width ratio of the pedicle is 2:1; whereas the ratio is 1:1 in other parts of the body with poorer circulation.

In addition to the cutaneous (skin) flap, a musculocutaneous flap, composed of skin, subcutaneous tissue, fat, and muscle, can adequately replace deficient tissue in irradiated wounds. The rhomboid flap in this case involved left lower lid skin, orbicularis oculi muscle, and sub-orbicularis oculi fat, resulting in resolution of surface and volume deficiency (Picture 3).
Clinical Analysis of Hyaluronic Acid Injection to Correct Enophthalmos after Orbital Fracture

Pengsen Wu, Don O.Kikkawa, Wei Lu

Orbital fractures are frequently encountered in traumatic injuries to the peri-orbital region. While enophthalmos is a main manifestation after orbital fracture. Enophthalmos may affect patients' visual function and appearance greatly [1]. Nowadays the majority of enophthalmos are repaired surgically. For sake of severe damage to the patients, more complications and high cost, this method is not widely accepted [2]. Hence there is an urgent need of new method to solve this problem. Our research introduced a new method to correct enophthalmos by hyaluronic acid injection.

Clinical data of 21 orbital fractures were retrospectively analyzed. All received hyaluronic acid injection to correct enophthalmos.

**Inclusion Criteria**

1. Diagnosed as orbital fracture through the clinical manifestation and CT scan.
2. Manifestation of enophthalmos ≥ 2 mm.

**Major drugs**

Hyaluronic acid, Resylane 2, Q-Med Company.

**Injection procedure**

Place the patient in supine position, after sterilizing the skin of the inferior orbital rim, insert the syringe at the 1/3 of the inferior orbital rim, go vertically about 1.5 cm then go inferiorly and deeply. When the needle reaches behind the equator of the eyeball and between orbital peristeme and extraocular muscle core. Pumping back if no blood flow back into the needle, then inject the hyaluronic acid into the unique position. According to the position of the eyeball and preoperative assessment, decide the amount of hyaluronic acid to inject.

REFERENCES

Post-injection Outcomes

There was no statistic difference in visual acuity. Before injection, the average measurement of enophthalmos for 21 patients is 2.67 (±0.53) mm, 1 week after injection, 20/21 (95.2%) cases of enophthalmos were totally corrected, the average degree of enophthalmos is 0.48 (±0.60) mm, 6 months after injection, 4/21 (19.1%) cases of enophthalmos recurred; in 17/21 (80.9%) cases, the hyaluronic acid was absorbed partly, the average degree of enophthalmos is 1.48 (±0.52) mm. After injection, 5 patients complained nausea, recovered after a break. The manifestation of diplopia or eyeball movement limitation was not recorded. After injection the CT scan shows the position of the hyaluronic acid was proper. No case of infection or rejection was recorded.

Enophthalmos is the eyeball shifting backward caused by various reasons, while the eyeball volume is normal. If the difference of two eyes' projection is more than 2 mm, then can make the diagnosis[3]. Hyaluronic acid injection to correct enophthalmos can avoid surgical repair. Compared with conventional method[4], this method has the benefit of minimally invasive, practical also can avoid the risk of graft exposure, infection and rejection. During injection, we can prevent the interference of the factors like orbital contents swelling, also can estimate the degree of enophthalmos correction directly. It is convenient to control the amount of hyaluronic acid to inject, therefore can correct enophthalmos more precisely. Due to the abundant orbital blood supply[5], the injection of hyaluronic acid should be very cautious.
to prevent the hyaluronic acid going inside the arteries as embolus, consequently lead to severe complications like tissue ischemia, necrosis and visual loss[6]. In short, intra orbital hyaluronic acid injection to correct enophthalmos provides a new method to solve this problem.

REFERENCES


Philosophical Notes

Incoming President Dr. Raoul Henson Attends the Midyear Class of the APAO Leadership Development Program in Singapore

Raoul Henson

The Leadership Development Program (LDP) was instituted by the Asia-Pacific Academy of Ophthalmology to provide systematic orientation and professional development skills for future leaders in ophthalmology in the Asia-Pacific region. The participants are leaders and representatives from different countries and subspecialty societies. During the mid-year master class, LDP participants undertake team-building activities and workshops detailing communication skills, ethics, project management, working with an executive team, advocacy, working with industry and organizational skills. At the end of the program each participant needs to complete a sustainable project that can help their respective societies achieve its goals and visions.

Chosen by the APSOPRS for the 2018-2019 LDP class was our incoming president, Dr. Raoul Paolo D. Henson. He was able to participate in all the activities during the midyear class which was held at the prestigious Singapore National Eye Centre. There were a number of oculoplastic surgeons who also attended the learning activities. They were Dr. Gangadhara Sundar (Singapore – representing the Asia-Pacific Ophthalmic Trauma Society - APOTS), Dr. Fairooz Manjandavida (India), Dr. Mutmainah Mahyuddin (Indonesia), Dr. Youn-Shen Bee (Chinese Taipei), Dr. Gillian Teh (Singapore) and Dr. Kailing Yong (Singapore). The LDP project of Dr. Henson will be “The Establishment of a Permanent Secretariat for the Asia-Pacific Society of Ophthalmic Plastic and Reconstructive Surgery.” His plan is to establish the permanent secretariat in the Philippines. He is now at the beginning stages of the project and his time table is to finish the secretariat before the 10th APSOPRS meeting in Hongkong this coming December. With the success of the LDP, Dr. Henson proposes to send one APSOPRS member participant each year in order to develop more leaders for our society.

During his stay in Singapore, Dr. Henson was also able to meet up and have dinner with fellow APSOPRS office bearers Dr. Sunny Chen, Dr. Audrey Looi, Dr. Ganga Sundar and past president Dr. Choo Chai Teck. He expounded to them his plans for the society and gave his detailed exploits on how to fast track the permanent secretariat in the Philippines. A few topics that were also discussed were membership, website, marketing, research, fellowship and committee issues. Finally, Dr. Henson wants to impart his plans on visiting as many Asia-Pacific countries during his term as president of the society.
Team Jose Rizal
From Left to Right: Dr. Raoul Henson, Dr. Kavin Vanikieti (Thailand), Dr. Kailing Yong (Oculoplastics - Singapore), Dr. Gillian Teh (Oculoplastics - Singapore), Dr. Amir Samsudin (Malaysia)

Our master class boat ride around Singapore.
Welcome Message

Dr YUEN Kwok Lai Hunter
- ASM Organizing Committee Chairman
- President, Asia-Pacific Society of Ophthalmic Plastic and Reconstructive Surgery (APSOPRS)
- Past President, Hong Kong Society of Ophthalmic Plastic and Reconstructive Surgery (HKSOPRS)

It is my great pleasure and honor to welcome you to the biennial meeting of the Asia-Pacific Society of Ophthalmic Plastic and Reconstructive Surgery (APSOPRS), which will be held in conjunction with 30th Annual Scientific Meeting (ASM) jointly held by The College of Ophthalmologists of Hong Kong (COHK) and the Hong Kong Ophthalmological Society (HKOS).

COHK and HKOS have jointly organized our Annual Scientific Meeting (ASM) since 1989. This annual conference is the most important platform for our ophthalmologists in Hong Kong to share our newest developments and research in ophthalmology. This is the first time for our annual scientific meeting held in conjunction with APSOPRS conference.

Throughout the past years, APSOPRS has been very active in enriching the oculoplastic knowledge and surgical skills in the region. This year, we are honored to have Prof Geoffrey Rose from UK and Prof Don Kikkawa from USA to be our featured speakers. Aside from them, our program is fully packed with excellent presentations with a wide coverage of clinical and research in ophthalmic plastic and reconstructive surgery, as well as general ophthalmology. We will have plenty to learn with a programme grace by the top speakers in the Asia-Pacific Region and the world. Hong Kong is a modern, dynamic and vibrant city where the east meets the west, as well as the gateway to China. Aside from the scientific program, there are plenty of places that are truly worth exploring.

On behalf of APSOPRS, COHK and HKOS, I welcome all of you again. May all esteemed overseas guest have a wonderful and memorable stay in Hong Kong and I wish you all found this symposium enjoyable and fruitful. Thank you.
The 30th Annual Scientific Meeting
Hong Kong Ophthalmological Symposium 2018
in conjunction with
The 10th Conference of Asia Pacific Society of
Ophthalmic Plastic & Reconstructive Surgery

Dec 15-16, 2018
Hong Kong Convention and Exhibition Centre

Abstract Submission Deadline: August 30, 2018
Early Bird Registration Deadline: September 30, 2018

For online registration and abstract submission, please visit:
www.apsoprs-asmhk2018.com
The ITEDS Symposium will come to Asia for the first time and it will be held in Singapore. Themed “Current Perspectives in the Management Thyroid Eye Disease: East Meets West”, the symposium will be helmed by world-renowned experts specially gathered to share their expertise and years of experience. There will be something for everyone: medical student, allied health specialist, physician, endocrinologist, ophthalmologist and orbit surgeon.

**ITEDS-SNEC Cadaveric Dissection Course**
20 February 2019

**Pre-Congress Teaching Course**
21 February 2019

**ITEDS Main Symposium**
22 – 23 February 2019

**Venue:** Academia
Singapore General Hospital
20 College Road, Singapore

To Register: Please email the Academy of Medicine at iteds@ams.edu.sg or visit www.iteds2019.com
Surgical Rehabilitation of Thyroid Eye Disease: Orbital Decompression and Eyelid Surgery

This course is led by Professors Peter Dolman, Jonathan Dutton, Geoffrey Rose, Wen-Chang Wu and David Verity in conjunction with regional and local faculty. External and endoscopic approaches for orbital decompression and procedures for patients with Thyroid Eye Disease will be demonstrated. Participants will have ample opportunities for hands-on practice after each demonstration and experienced instructors will be available to provide personalised guidance at every step.

- Orbital Decompression Technique:
  - Lateral Wall Decompression
  - Medial / Floor Decompression (External and Endoscopic Approach)

- Surgery for Correction of Eyelid Retraction
  - Mullerectomy
  - Blepharotomy

Registration Fee: SGD 2,000

PRE-Congress Teaching Course, 21 February 2019 • 8.00AM - 5.30PM

Session 1: ABCs of Thyroid Eye Disease
Session 2: A Multi-Pronged Approach to the Disease
Session 3: Medical Management
Session 4: Surgical Management

Main Symposium Programme, 22-23 February 2019 • 8.00AM - 5.30PM

There will be didactic and interactive sessions on various aspects of Thyroid Eye Disease including: Patients’ Perspectives, Clinical Manifestations, Pathogenesis, Genetics and Epidemiology, Medical and Surgical Management, Novel Treatments, Biomarkers and New Research.

<table>
<thead>
<tr>
<th>Delegate Category</th>
<th>Registration Type</th>
<th>Early Bird Fee (till 31st October 2018)</th>
<th>Regular &amp; On-Site Fee (From 1st November 2018 to 23rd February 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegate (Clinician / Physician)</td>
<td>Full Registration</td>
<td>SGD 675</td>
<td>SGD 775</td>
</tr>
<tr>
<td></td>
<td>Pre-Congress Only</td>
<td>SGD 325</td>
<td>SGD 425</td>
</tr>
<tr>
<td></td>
<td>Main Congress Only</td>
<td>SGD 575</td>
<td>SGD 675</td>
</tr>
<tr>
<td>Fellow of Academy of Medicine, Singapore (FAMS)</td>
<td>Full Registration</td>
<td>SGD 575</td>
<td>SGD 675</td>
</tr>
<tr>
<td></td>
<td>Pre-Congress Only</td>
<td>SGD 275</td>
<td>SGD 375</td>
</tr>
<tr>
<td></td>
<td>Main Congress Only</td>
<td>SGD 475</td>
<td>SGD 575</td>
</tr>
<tr>
<td>Resident / Allied Health / Nursing</td>
<td>Full Registration</td>
<td>SGD 375</td>
<td>SGD 425</td>
</tr>
<tr>
<td></td>
<td>Pre-Congress Only</td>
<td>SGD 150</td>
<td>SGD 200</td>
</tr>
<tr>
<td></td>
<td>Main Congress Only</td>
<td>SGD 300</td>
<td>SGD 350</td>
</tr>
<tr>
<td>Medical Student</td>
<td>Full Registration</td>
<td>SGD 250</td>
<td>SGD 275</td>
</tr>
<tr>
<td></td>
<td>Pre-Congress Only</td>
<td>SGD 100</td>
<td>SGD 125</td>
</tr>
<tr>
<td></td>
<td>Main Congress Only</td>
<td>SGD 200</td>
<td>SGD 225</td>
</tr>
</tbody>
</table>

IMPORTANT DATES!!

- Registration for Cadaveric Dissection Course opens 1st May 2018
- Early Bird Registration for ITEDS Symposium Main Meeting opens 1st May 2018
- Early Bird Registration closes 31st October 2018
- Call for Abstracts opens 1st May 2018
- Abstract Submission closes 31st August 2018

Do not miss this wonderful opportunity. Send your abstracts to iteds@ams.edu.sg or visit www.iteds2019.com
ITEDS—SNEC
CADAVERIC DISSECTION COURSE
20 FEBRUARY 2019
ACADEMIA, SINGAPORE

This course is led by ITEDS (International Thyroid Eye Disease Society), international experts and SNEC faculty. We will demonstrate the external and endoscopic approaches of orbital decompressions as well as common thyroid related eyelid procedures with hands on practice.

Registration Fee: SGD2,000
For Details and Registration, visit www.sneceeetings.org

Professor
Peter Dolman
Clinical Professor
University of British Columbia, Canada
Past President, ITEDS

Professor
Geoffrey Rose
Consultant
Ophthalmic Surgeon
Moorefields Eye Hospital, United Kingdom

Professor
Timothy Sullivan
Professor of
Ophthalmology
University of Queensland, Australia

Professor
Jimmy Uddin
Consultant
Ophthalmic Surgeon
Moorefield Eye Hospital, United Kingdom
Past President, ITEDS

Professor
David H Verity
Consultant
Ophthalmic Surgeon
Moorefields Eye Hospital, United Kingdom

Professor
Wencan Wu
Director
Wenzhou Medical University, China
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