President Address

Dear APSOPRS colleagues,

Greeting from Japan! We are now wholeheartedly preparing the biannual APSOPRS meeting in Osaka held on 26th and 27th of August. Please log on the page in detail (https://apsoprs.org/meeting/2016/index.html).

We will invite several renowned speakers inside or outside the APSOPRS. The most noted is the memorial lecture and the key note lectures. The memorial lecture is done by Prof. Yasuhisa Nakamura, the president emeritus of this meeting and one of the founding members of the APSOPRS. The keynote lecturers are by Mr. Raman Malhotra (UK:“Facial Nerve Palsy”), Dr. Peerooz Saeed (Netherland:“Orbital Tumour”), Mr. Anthony Tyers (UK:“Eyelid Tumour”), Prof. Yutaka Ogawa (Japan:“Socket Reconstruction”), Dr. Reiko Arita (Japan:“Meibomian Gland”), Prof. Robert Goldberg (US:“Thyroid Eye Disease”), Prof. Don Kikkawa (US:“Ptosis & Entropion”), Dr. JongHak Lim (Korea:“Asian Aesthetic Surgery”), Dr. Koh Inoue (Japan:“Dacryoendoscopy”) and Prof. Dinesh Selva (Australia:“DCR”).
Many educational lectures are also planned. In addition, we make preparation of travel grant to poster presentations. There are several rooms still remaining. You can enjoy the Osaka meeting as well as the culture of OSAKA!

I would like to refer to the new secretariat as well. We launched our new secretariat since last year and the office is in Tokyo, Japan. The secretariat chief is Miss Miho Tohyama, She has worked very hard and kindly performed every task. The duties in main are management of the members and web hosting. The web hosting is performed by Mr. Hiroyuki Tanino, a well-known web designer. You can see the renewed and easy-to-understand web pages of the APSOPRS (https://apsoprs.org/). Their endeavor has improved the APSOPRS as an organization.

The aim of our society is to promote and to spread the oculoplasty in the Asia-Pacific Region. We need your continuous support to fulfil this mission.

Warmest regards,

Prof. Hirohiko Kakizaki
President, APSOPRS
Aichi Medical University

Editorial Note

Dear Friends and Colleagues,

Here in the Asia-Pacific region, we marked a milestone in the last quarter of 2015 with the inaugural HKSOPRS conference hosted by Profs Kelvin Chong and Hunter Yuen. The excellent meeting is well documented in this issue and we look happily forward to more editions in the coming years. Our heartfelt congratulations to the team in Hong Kong for their significant achievement. It certainly encourages the Oculoplastic community here in Singapore to continue our efforts to evolve from our current Special Interest Group to a more formal structure which has thus far met with resistance at the local College level.

In the coming months, we look eagerly towards the 31st APAO / 57th Ophthalmological Society of Chinese Taipei meeting in March in Taipei, Taiwan, and our own 9th APSOPRS / 4th JSOPRS meeting in Osaka, Japan. Certainly, we can expect updates in the latest developments in the Oculoplastic arena and to learn new tricks and surgical techniques. For the Taipei meeting, our APSOPRS ex-co team has set up Young APSOPRS sessions allowing us to get to know our younger colleagues. So, see you all in Taipei!

Sincerely,

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Case Highlights

Orbital Lymphangioma Treated with OK-432

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Introduction

Lymphangiomas are benign, unencapsulated, hamartomatous tumours that may occur in the conjunctiva, eyelids, oropharynx or sinuses. They usually occur during the first decade of life and may have an aggressive nature. They are hemodynamically isolated from the systemic circulation. Bleeding into the lumen may occur, which can present as abrupt proptosis or as a mass lesion. Lymphangiomas are frequently observed, but persistent symptoms or visual impairment may necessitate treatment. Surgical resection is usually the first line treatment, but prove to be difficult due to the high recurrence rate, difficulty of complete excision, and risk of injury to adjacent structures. Intralesional injection of sclerosing agents have been proposed as an alternative to surgical excision. We report a case of a 16-year-old female with orbital lymphangioma who underwent intralesional injection of OK-432.

Case Report

A 16-year-old female presented with the complaints of abruptly increased swelling of the left upper lid and decreased vision in the left eye of one-week duration. She was diagnosed at age four with lymphangioma involving the left cheek, palate and orbit, which manifested as swelling of the left side of her face, which was treated with two doses of ethanol sclerotherapy at age five and four intralesional injections of OK-432 at age seven by general surgeon at the vascular surgery clinic. She developed left upper lid swelling and proptosis at age five, which did not compromise vision and was observed. Orbital lymphangioma remained stable for 10 years without changes in her best corrected visual acuity (BCVA), which was 20/20 right eye and 20/25 left eye. One week ago her left eyelid swelling and decreased vision occurred, and came to our orbital clinic through ER. On ocular examination, the left eye showed 9mm of proptosis(Fig 1. A,B), visual acuity of 20/40, intraocular pressure of 34mm Hg, restriction of eye movements in all directions, reduced colour vision and a RAPD suggesting recent hemorrhages into the cyst compromising the optic nerve. Fundus examination was normal. The right eye showed normal findings.

Magnetic resonance imaging (MRI) of the orbit showed left proptosis with multiiloculated cystic masses with high signal intensity on T2-weighted scans, containing fluid-fluid levels in both the intraconal and extraconal space with extension to the eyelid (Fig 2. A, B) and compression of the optic nerve. MRI also showed extensive involvement of the left temporalis muscle, masticator space, pterygoid muscle, pterygopalatine fossa, mandible, palate and nose.

The patient was treated with 12 doses of 250 mg intravenous Methylprednisolone given every 6 hours for 3 days, but without improvement. Therefore, the patient underwent aspiration (12 ml of chocolate colored fluid) and injection of 2ml of 0.02 mg/ml of OK-432 under general anesthesia. The following day, the BCVA had improved to 20/25, the proptosis decreased to 3mm, with resolution of eye movement restriction. However, two weeks after injection the patient re-presented with left upper lid swelling, worse proptosis (7mm) and eye movements and reduced BCVA (20/30). A second aspiration (5.5ml of hemorrhage) and injection of 1ml of 0.02mg/ml of OK-432 were performed under general anesthesia. The proptosis, vision and eye movements returned to post-first injection levels(Fig 1. C, D). Orbital MRI demonstrated decreased extent of the venolymphatic malformation in the left orbit (Fig 2. C, D). The patient has remained stable clinically and radiologically at 4 years after sclerosing agent injection. (Fig 2. E, F).
Discussion

Orbital lymphangioma usually enlarge slowly, producing progressive proptosis, restriction of eye movements, or vertical globe displacement. However, these symptoms may manifest abruptly because of hemorrhage. Spontaneous hemorrhage is the most feared occurrence in orbital lymphangioma and may lead to eyelid ecchymosis, subconjunctival hemorrhage, acute proptosis, and occasionally, optic nerve compression.\(^8\)

The main indications for treatment are preservation of vision and cosmetic appearance.\(^8,9\) Intralesional injection of sclerosing agents have been proposed as an alternative to surgical excision.\(^5,7\) Sclerotherapy has been found to be effective in tumor debulking and to date has not been reported to cause vision-threatening complications. Numerous sclerosing agents have been used for sclerotherapy including OK-432, bleomycin, doxycycline, Ethibloc, sodium tetradeceyl sulfate, and ethanol. OK-432 is a sclerosing agent derived from a strain of Streptococcus pyogenes that is of low virulence\(^7,10-13\) and has been used as an anticancer drug since 1975. Ogita et al first introduced the use of OK-432 as treatment for lymphangioma in the right scapular region of a 4 month-old-girl with the cytotoxic effect being presumed to be the mechanism of action in cystic lymphangioma.\(^7\) OK-432 induces production of cytokines that act on the endothelium to enhance permeability, accelerating lymph drainage and increasing lymph flow leading to shrinkage.\(^9\) Cytokines related to fibrotic change may also be involved in the regression.\(^12\)

OK-432 injection is not without complications; increased intraocular pressure, fever, and local inflammatory reaction have been reported, and has been used with caution for diffuse intraconal lymphangiomas surrounding optic nerve for this reason. The classic treatment for our case might have been the emergent surgical drainage of hemorrhage through a lateral orbitotomy approach to relieve the compressive optic neuropathy. We successfully treated with aspiration of blood and injection of OK-432 without significant side effects and had no recurrences 4 years after injection. Our case highlights that intralesional injection of OK-432 may be considered as a simple, safe and effective treatment for sight threatening hemorrhage from orbital lymphangioma.

References


**Figure 1** Photographs (A&B) showing marked proptosis of left eye. C&D. One year after injection.

**Figure 2**
On orbital MRI, T2-weighted axial(A) and Gd-enhanced coronal(B) images showing multiloculated cystic masses containing fluid-fluid level occupied entire orbit. The left globe is markedly proptotic and the optic nerve is stretched and compressed by the cystic masses. MRI taken 3 months after OK-432 injections showing markedly decreased venolymphatic malformation in the left orbit (C, D). MRI taken 4 years after injection showing no significant recurrent lesions in the left orbit (E and F).

**Managing Marcus Gunn Ptosis- Our approach**

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Marcus Gunn Ptosis is the most common form of congenital synkinetic ptosis. It constitutes about 4-5% of all congenital ptosis\(^1,2\) (12% in our series at a tertiary referral centre). An inverse Marcus Gun phenomenon is also known.
Management of the condition depends on the
1. Severity of ptosis
2. Excursion of jaw winking
3. Associated ocular motility problems

Objectives of surgery
- To correct ptosis
- To eliminate Jaw winking (where significant)

Need to tackle ocular motility problems when present, before ptosis surgery, to allow for elimination of pseudoptosis and to improve Bell's phenomenon.

*Mild Jaw winking*- Where jaw winking is not severe the choice of procedure is dictated by the amount of ptosis and the levator action, as in any case of congenital simple ptosis by procedures like Fasanella Servat surgery and levator resection. However, larger resections may be needed if levator surgery is performed and undercorrections may be commoner²,³,⁴.

*Significant jaw winking* - Options for management include:
- Unilateral levator excision with frontalis sling
- Unilateral levator excision with bilateral frontalis sling
- Bilateral levator excision with a frontalis sling surgery

A sling procedure done unilaterally results in lagophthalmos and lid lag, giving rise to an asymmetry between the both eyes in downward gaze.

Unilateral levator excision with bilateral sling removes asymmetry but may result in apparent undercorrection of the involved eye, due to inadequate use of Frontalis. Bilateral levator excision with bilateral frontalis sling removes the asymmetry in down gaze and sleep. It is the authors’ procedure of choice.

Material of choice for Frontalis sling
- Autologous- Fascia lata is the first choice in all cases where a bilateral sling is performed.
- Where patient opts for a unilateral procedure, the choice of material is silicone rod.

*Surgical technique for Fascia Lata Sling surgery*

All cases are done under general anaesthesia.. Infiltration with 2% xylocaine and adrenaline is done in the region of the proposed incision in the thigh, eyelid and the eyebrow region.

*Harvesting of fascia lata*

A line joining the lateral condyle of femur to the anterior superior iliac spine is marked.

A lower thigh incision about 5cm above the lateral condyle on the marked line is the site of incision (fig 1a). The incision may be made in the middle of the marked line. Our current choice, as it provides better access to both the superior and inferior ends of the fascia. The skin incision is deepened through the fat till the glistening fascia is visible (fig 1b).

The fascia is cleared of the overlying tissue for a length of about 10 cm. A 12 to 15 mm incision is given at the lower end of the exposed fascia lata. Dissection is carried out beneath the fascia lata separating it from the underlying muscle along the entire length. Two linear vertical incisions are made along the length of dissection using a long scissors. The superior end of the fascia is made free by a horizontal cut using a long bladed scissors while the assistants retract the skin and the subcutaneous tissues (fig 1c). The subcutaneous tissue is closed using 4 – 0 Vicryl and the skin is closed using 4 – 0 nylon sutures(fig 1d).
Fig 1a - A 10cm marking is made in the line joining the lateral condyle of femur to the anterior superior iliac spine starting 5cm above the lateral condyle.

Fig 1b - A 2.5cm incision is given at the lower end. The skin incision is deepened through the fat till the glistening fascia is visible.

Fig 1c - The fascia lata strip being removed.

Fig 1d - Closure is done in two layers.

Fig 1e - The fat is trimmed from the fascia lata strip.

Fig 1f - The fascia lata strip is divided into four pieces each of about 3 mm width by a scalpel blade.

Fascia Lata sling suspension
Three traction sutures are passed along the lid margin. Four incisions are made 2-4mm above the...
margin. The placement of these determines the position of lid fold. The two central incisions are on either side of the center of the lid while the other two are at the junction of middle and lateral thirds and middle and medial thirds of the lid. An incision is also made at the proposed site of lid crease. The eyebrow incisions are marked next. They are made on a line perpendicular to two lateral eyelid incisions and the two medial incisions while the eyelid is in the desired corrected position. A third mark is made on the forehead between the first two marks but 4-6 mm higher than the first two. The eyelid crease incision is given through skin and orbicularis. The skin and the orbicularis are dissected from the underlying orbital septum. Any dissection on the surface of the tarsal plate is scrupulously avoided. The orbital septum is cut completely across exposing the preaponeurotic fat. Fat is retracted posteriorly to reveal the underlying tendinous aponeurosis. The levator is dissected from the adjoining structures. The lateral and the medial horn are cut. Excision of a large segment of levator aponeurosis is carried out. (fig 2a).

The eyelid incisions are made down to the tarsus and the brow incisions are made upto the Frontalis. Blunt dissection is carried out to make pockets for the fascial knots.

The fascia lata strip is passed between the two outer eyelid incisions. The Wright fascia lata needle is passed in the submuscular plane from the lateral eyebrow incision to emerge from the lateral incision in the lid. The fascia is threaded through the eye of the needle and is pulled through. The Wright’s needle is again passed from the lateral incision to the second eyelid incision threaded with fascia and drawn up. The procedure is repeated on the medial side (Fig.2b,c). A single tie is made of the lateral and medial ends to place the eyelid margins as high as possible without lifting the eyelid from the globe. After a single tie the position and contour of the eyelid are assessed. Required adjustments are made. Presence of good lid crease is ensured at this stage. A second tie is made. The knots are then secured using 5-0 vicryl (Fig 2d).

One end of fascial strip from each brow incision is pulled through the central brow incision. Knots are tied and secured (Fig. 2e). All the knots are buried in the pockets prepared for them. The excess of skin created by shortening of the posterior lamina is judged and excised by removing a spindle of skin from above the eyelid crease (Fig 2f). Eyelid incisions require no closure. The brow incisions and the eyelid crease incision are closed with 6 – 0 nylon.

Patients are prescribed oral antibiotics and anti-inflammatory agents.
Fig. 2(c): Fascial strips pulled from both medial & lateral brow incisions

Fig. 2(d): Knots is secured using 5'0 vicryl

Fig. 2(e): One end of fascial strip passed through central brow incision and tightened

Fig. 2(f): Strip of skin excised

Fig. 3a, b shows a patient with Marcus gunn phenomenon with severe ptosis with post operative photograph of the same.

Fig. 3a: A 5 yr old boy with severe ptosis with Marcus Gunn phenomenon in left eye

Fig. 3b: Post operative photograph showing good correction and elimination of jaw winking phenomenon after bilateral levator excision with bilateral fascia lata surgery

A Retrospective analysis of 165 patients with significant (2 mm or more) jaw winking ptosis was carried out from 1994 to 2014. Seventy three patients had undergone unilateral levator excision
with bilateral fascia lata sling while in 92 patients bilateral levator excision with bilateral fascia lata sling was carried out. Elimination of jaw winking was achieved in 96.2% of all cases. Good results was defined as asymmetry of habitual MRD of two upper eyelid of 1 mm or less and fair results was defined as asymmetry of habitual MRD between 1.5-2mm between the two upper eyelid.

Good results were achieved in

- Unilateral excision group 20.6%
- Bilateral excision group 68.3%

Good or fair results were achieved in

- Unilateral excision group - 65.7%
- Bilateral excision group – 91.1%

Bilateral levator excision with bilateral fascia lata sling provides the most consistent elimination of jaw winking and improvement in ptosis.

Khwarg et al reported the results of 24 patients who underwent frontalis suspension using fascia lata after levator excision for moderate-to-severe jaw-winking ptosis. Five patients underwent bilateral frontalis suspension and levator excision only on the involved side, final results were good in two patients (40%) and poor in three (60%). Of the 19 patients who underwent bilateral levator excision, final results were good in 13 (68.4%) and fair in 6 (31.6%-between good and poor)³.

Demirci H et al reported 88% good results in 26 patients who had undergone unilateral levator excision with bilateral fascia lata sling and 75% in 4 patients who underwent unilateral levator excision with unilateral frontalis sling⁶.

References:


Meetings

Inauguration meeting of Hong Kong Society of Ophthalmic Plastic and Reconstructive Surgery (HKSOPRS) 2015

The 1st Symposium of Hong Kong Society of Ophthalmic Plastic and Reconstructive Surgery and HKSOPRS inauguration Ceremony was held on 12 Dec 2015 in the Hong Kong Convention and Exhibition Centre. The HKSOPRS's establishment marks an important milestone in the development of Hong Kong's ophthalmic plastic and reconstructive surgery, heralding a new phase of societal and academic development.

Under the founding presidency of Dr George CHENG, HKSOPRS sets out to promote research and education, to serve as an interest group for academic assembly and discussion in the field of ophthalmic plastic and reconstructive surgery.

It is an honor in the HKSOPRS Symposium to have renowned international experts (Prof Geoffrey ROSE, Dr Chai-Teck CHOO, Prof Shu-Lang LIAO, Prof Xian-Qun FAN, Prof Lay-Leng SEAH, Prof Ashok GROVER, Dr Damayanti SISWOYO, Prof Reynaldo M. JAVATE, Prof Timothy John SULLIVAN, Prof
Yoon-Duck KIM, Prof Chee-Chew YIP and Prof Dong-Mei LI) to share excellent and inspiring lectures to the participants.

The inauguration ceremony was officiated by Dr George CHENG, the founding President of Hong Kong Society of Ophthalmic Plastic and Reconstructive Surgery after the symposium. Our renowned advisors Dr Kin-chor AU YEUNG, Dr John CHANG, Dr Raymond TSE and the Trainer of the Year 2015 Dr Carol YU also attended the ceremony and offered congratulatory remarks.

With HKSOPRS’s inauguration, Hong Kong now has an official organization to provide development and training in Ophthalmic Plastic and Reconstructive Surgery. HKSOPRS is composed of ophthalmologists in Hong Kong and each of them has provided outstanding contributions to the advancement of ophthalmology in Hong Kong.

**Philosophical Notes**

**Passing on the baton at SNEC**

2015 was a hugely significant year for all Singaporeans. In this 50th year of independence, we held a year-long series of SG50 events to celebrate the successful journey that we had undertaken as a nation amidst great uncertainty. The passing of our Founding Prime Minister, Mr Lee Kuan Yew, stirred and united the nation in a way that may never be experienced again in this island nation. Such is the admiration and gratitude we all feel for Mr Lee. Over at the Singapore National Eye Centre, we were happy to have hosted our 25th SNEC Anniversary with an Oculoplastic Symposium and Cadaveric Dissection Course which was described in our last issue.

On a personal level, I will also remember 2015 as my last year as Head of the Oculoplastic Department in SNEC. As I pass the baton on to Dr Sunny Shen, it is difficult not to reminisce a little over the glories and challenges faced over the past 8 years. For those of us who may think private practice is the only way to go, I can only say that it has been my utmost honour and pleasure to have served in this position.

I remember vividly the day I was asked to take on the role and being surprisingly excited at the opportunity to shape the department further in a way that would encourage greater professionalism, the highest level of academic interaction and of course, improve the quality of clinical care. We have achieved a high quality of teaching with our monthly Orbital Imaging Rounds, quarterly Clinico-Pathology Conference and participation in CME residency programmes. Our Clinical Audit and Tissue Audit processes ensure a high quality of our clinical work and our Morbidity and Mortality rounds allow us to learn from our mistakes, which fortunately, have been few and far between. Overall, I am most proud of our team of six Oculoplastic surgeons who have received training from masters of the field all over the world, as well as our International Fellows who now work in the
region and whom we are always delighted to meet at conferences.

Of course, there are the usual frustrations with administrative duties. But these simply do not take away from the privileges of Headship and the opportunity to work with other Heads to achieve excellence for the Centre. So, Sunny, I wish you all the best as you take on this special role. And to my colleagues in APSOPRS, thank you for your years of support which I sincerely hope you will kindly extend to my friend and colleague, Sunny Shen.

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