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Coloboma of upper eyelid: its repair A new approach

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Coloboma of upper eyelid manifests as defects of various sizes and shapes primarily affecting the lid margin. Several procedures have been advocated for repair of different types of lid coloboma. Here we have a case of seven months old child with coloboma in both upper eyelids. A new approach for its repair in one eye has been made based on principles of Abbe's flap with flap rotation technique. In this procedure a full thickness lid flap, with blood supply maintained through its narrow pedicle, was raised from lower lid and after rotating it to almost 180 degrees, it was grafted to colobomatous site in upper lid. Three weeks later final lid margin adjustments were done after detachment of the pedicle from lower lid.

Key words : Lid coloboma, associated anomalies, reconstruction, Abbe's flap, flap rotation technique.

Introduction:

A simple coloboma manifests itself as a defect in the lid affecting primarily the margin. Several procedures have been advocated for the repair of lid coloboma like direct closure of the defect with V-Y operation, modified Wheeler's operation, lateral canthotomy, cantholysis and orbicularis myotomy or Tenzel – type semicircular flaps. Larger defects can be cosmetically cured with tarsal conjunctival flap and skin graft for lower lid and Mustarde's operation for reconstruction of the upper eyelid.

In the present case a new approach for the repair of coloboma in right eye has been made based on principles of Abbe's flap with flap rotation technique.

Material and Methods:

A seven months old male child was brought with congenital defect in upper eyelids of both the eyes. In right eye the defect was in form of triangular notch with base at the lid margin situated to the inner side of mid line involving about one third of the lid and in its full thickness. The defect on the left side was a smaller one, somewhat irregular in shape and was also in its full thickness.

Surgical procedure

The general condition of the child was assessed and was investigated for fitness to undergo surgery under general anaesthesia.

The defect in left eyelid was repaired in a single sitting under general anaesthesia by carving out straight edges from irregular margins and closing the wound in layers. No lateral canthotomy or grafting was needed. The stitches were removed after seven days and the result was satisfactory. (Fig. 1).

In the right upper lid, where the defect was more than one third of the lid, required full thickness replacement from the lower lid.

Under general anaesthesia, a triangular, full thickness lid flap, medially pedicle based (with its blood supply maintained through the narrow pedicle,) was taken up from the lower lid. The cut margins of the lower lid were approximated in layers. The coloboma margins were freshened in full thickness to accommodate the triangular flap raised from the lower lid, which was rotated by almost 180 degrees upwards. The flap was stitched in layers (Fig. 1). The eye was dressed after antibiotic ointment application.

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