Anterior and Nasal Transposition of the Inferior Oblique Muscle for Iatrogenic Superior Oblique Palsy

The reflected tendon of the superior oblique (SO) muscle lies in close proximity to the medial horn of the levator palpebrae superioris aponeurosis in the superomedial aspect of the upper eyelid, placing it at risk for inadvertent damage during surgery in that area. However, although levator resection or excision procedures are commonly performed, this complication is rarely reported.1,2 Kushner and Jethani1 reported a superior oblique palsy in 4 cases and Brown syndrome in 3. We describe various types of eyelid procedures, which led to SO palsies4 as well as those with missing SO tendon. Stager et al.3 It has been reported to be useful in patients with severe or recurrent SO palsies as well as those with missing SO tendons.3 The IO is transposed nasal to the inferior rectus insertion. This converts the IO from an extorter and elevator in adduction to an intorter and antieverter in adduction. Although the effects are more pronounced in upgaze owing to neurological activation of the IO in attempted upgaze and inhibition in downgaze,

Comment. Anterior and nasal transposition of the IO is a relatively new procedure devised by Stager et al.3 It has been reported to be useful in patients with severe or recurrent SO palsies as well as those with missing SO tendons.3 The IO is transposed nasal to the inferior rectus insertion. This converts the IO from an extorter and elevator in adduction to an intorter and antieverter in adduction.3,2 Although the effects are more pronounced in upgaze owing to neurological activation of the IO in attempted upgaze and inhibition in downgaze,

Figure 1. Preoperative results. A, Photographs showing left hypertropia, overelevation in adduction, and underdepression in adduction. B, Fundus photographs showing excyclotorsion (left eye [OS] > right eye [OD]). C, Preoperative measurements in prism diopters. LHT indicates left hypertropia; XT, exotropia; and ET, esotropia.

Additional Contributions: Ata Siddiqui, FRCR, helped with the radiological imaging.


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the procedure is effective in correcting overrelevation and underdepression in adduction as well as ex cyclotorsion. Our case had profound loss of SO function, and one surgical option was an ipsilateral IO anterior transposition combined with contralateral inferior rectus recession. However, the large amount of ex cyclotorsion, especially on down gaze, was unlikely to be eliminated even if the IO was placed adjacent or anterior to the inferior rectus insertion.6 Dealing with residual torsion would have been difficult as the SO tendon damage precluded SO transposition surgery. Although horizontal transposition of the vertical recti was an alternative, this technique effectively corrected both the vertical and torsional components in 1 step, with sparing of the ciliary circulation and a more predictable result.

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Primary Orbital Melanoma With Poliosis and a Palpable Mass

Poliosis, defined as the depigmentation of hair, has been linked with several inflammatory conditions such as blepharitis, herpes zoster, idiopathic uveitis, Vogt-Koyanagi-Harada syndrome, sarcoidosis, vitiligo, Marfan syndrome, and tuberous sclerosis.1 To our knowledge, we report the first case in the English-language ophthalmic literature of eyelash poliosis as one of the manifesting signs of primary orbital melanoma.

Report of a Case. A healthy 60-year-old white man had swelling above the left eyeball and whitening of the left upper eyelid lashes for 3 months. Visual acuity was 20/20 OD and 20/20 OS. No afferent pupillary defect was detected. He had eyelash poliosis of the left upper eyelid with a mobile, nontender, firm mass in the left anterior orbit superonasally (Figure 1). There was no proptosis, and he had normal ocular surface examination, anterior segment examination, and fundus examination results. Examination results of his right eye were unremarkable. Magnetic resonance imaging with contrast revealed a well-circumscribed, diffusely enhancing mass in the superonasal region of the left anterior orbit (Figure 2). Excisional biopsy of the mass was achieved through an eyelid crease incision. A histopathologic report revealed solid sheets of spindle cell neoplasm. Melan-A immunohistochemical staining showed cytoplasmic immunoreactivity in the neoplastic cells. The histopathologic findings were consistent with the diagnosis of orbital melanoma. No inflammatory cells were seen in the mass.

An extensive systemic evaluation showed no evidence of distant metastasis or primary tumor elsewhere. The mass was diagnosed as primary orbital melanoma, although primary tumor elsewhere cannot be totally ex-