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Letters to the Editor

The use of gold weights in the upper eyelid

Sir,

Recently there has been a plethora of articles in the plastic surgery literature discussing a small and troubling incidence of complications in the use of gold weights in the upper eyelid to correct or improve the lagophthalmos of facial palsy.

In the September 1992 issue, Pickford, Scamp, and Harrison report another series in which an unacceptable frequency of extrusion is reported. As a consequence of an even more discouraging report by Kelly and Sharpe in *Plastic and Reconstructive Surgery*,[1] I asked MedDev Corporation who design and distribute Gold Lid Loads of my design to conduct an inquiry of its customers to ascertain, approximately, the incidence of infection and extrusion among this population.

700 customers were solicited. 168 replied, representing an estimated accumulative experience of just over 2000 operations. The incidence of infection in this group was 0.3 percent, extrusion, 2.6 percent. This is a considerable improvement over the figures cited in the above referenced reports of considerably smaller series.

The recommended method of insertion is identical to that suggested by Pickford *et al.*, except that the consistent difference from the circumstances in both reports is that the loads are placed 4 to 5 mm above the lid margin and they are perforated with 1 mm holes through which they are secured in position with sutures. Ultimately fibrous tissue grows through these holes.

It is my belief that securing the loads in position with a suture or two prevents motion and reduces the problems causing this discussion.

I shall be happy to provide more information about these lid loads and the related techniques, or the inquiry mentioned above, if asked.

Yours faithfully,

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Reference

Kelly S A, Sharpe D T. Gold eyelid weights in patients with facial palsy: a patient review. *Plast Reconstr Surg* 1992; **89**: 436–440.

Morbidity after gold weight insertion

Sir,

We read with interest the paper by Pickford *et al.* (*British Journal of Plastic Surgery*, **45**, 460–464) on the morbidity after gold weight insertion in facial palsy. The authors place the gold weight in a pocket between the tarsal plate and the orbicularis oculi muscle rather than suture it to the tarsal plate. The study is of particular importance as it is the only large series of patients so treated. Many oculoplastic surgeons have converted to using gold weights with holes (Figure). This allows fixation of the gold weight using 6-0 nylon sutures passed partial thickness through the tarsal plate. It has been our experience that this rigid fixation results in the formation of a pseudocapsule of fibrous connective tissue.

A major concern in the use of any lid-loading material is the rate of extrusion and migration. Pickford *et al.* had an extrusion rate of 5/41 (12%) and migration of 3/41 (7%). The results of a literature review on tarsus-sutured gold weights are presented in Table I. A total of 277 patients are included. The overall extrusion and migration rates were 2% and 2.7% respectively. We have had similar results in our practice. Pickford *et al.* state that they have made the gold weight longer and flatter in an attempt to reduce the rate of extrusion. Our data suggest that suturing the gold weight to the tarsal plate significantly reduces the rate of extrusion and migration. A complication not mentioned by Pickford *et al.*, which is familiar to oculoplastic surgeons, is astigmatism induced by the gold weight resting on the superior cornea.

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Figure

Table 1 Rates of extrusion and migration in sutured gold weights

Study	*No of eyes*	*Extrusion*	*Migration*
Chapman & Lamberty[1]	19	0	1
Soll[2]	14	0	0
Neuman *et al.*[3]	68	3	3
Sobol & Alward[4]	18	0	0
Seiff *et al.*[5]	17	0	0
Kartush & Linstrom[6]	37	0	0
Gilbard & Daspit[7]	61	4	0
O'Connell *et al.*[8]	20	0	2
Townsend[9]	23	1	0
Total (%)	277	8 (2.9%)	6 (2.2%)

4. Sobol S.M., Alward P.D. Early gold weight lid implant for rehabilitation of faulty eyelid closure with facial paralysis: an alternative to tarsorrhaphy. *Head and Neck* 1990; **12**: 149–153.
5. Seiff S.R., Sullivan J.H., Freeman L.N and Ahn J. Pretarsal fixation of gold weights in facial nerve palsy. *Ophthal Plast Reconstr Surg*, 1989; **5**: 104–109.
6. Kartush J.M., Linstrom C.J., McCann P.M. and Graham M.D. Early gold weight eyelid implantation for facial paralysis. *Arch Otolaryngol Head Neck Surg*, 1990; **103**: 1016–1023.
7. Gilbard S.M., Daspit C.P. Reanimation of the paretic eyelid using gold weight implantation. *Ophthalmic Plast Reconstr Surg* 1991; 7: 93–103.
8. O'Connell J.E., Robin P.E. Eyelid gold weights in the management of facial palsy. *J Laryngol and Otolog*, 1991; **105**: 471–474.
9. Townsend D.J. Eyelid reanimation for the treatment of paralytic lagophthalmos. Historical perspectives and current applications of the gold weight implant. *Ophthalmic Plastic and Reconstructive Surgery*, 1992, **8**: 196–201.

Morbidity after gold weight insertion—reply

Sir,

In response to Dr Richard Jobe and Dr Patel *et al.*'s letters regarding fixation of the gold weights, I would concur. To some extent we had been trying to make the gold weights less apparent by making them thinner and over a broader area of the tarsal plate. Most extrusions have related to previous surgery with surrounding fibrosis, but there is no doubt that the gold weights can be persuaded to shift and it may well relate to rubbing the eye, with the irritation of epiphora. For the last year we have inserted two holes in the gold weight and have sutured it to the upper edge of the tarsal plate with 6/0 nylon. It is a little early to say whether or not this has been entirely successful but judging by the two foregoing letters, it would appear to be a distinct improvement.

Regarding the final comment about astigmatism, this is certainly a complication if the gold weight is inserted insufficiently bent to the curvature of the cornea. With a rather thick flat weight it will press on the surface of the cornea, distorting it, and in consequence produce astigmatism. The thin weights that we employ are very easy to bend to the correct shape and ensure that this complication does not arise.

Yours faithfully,

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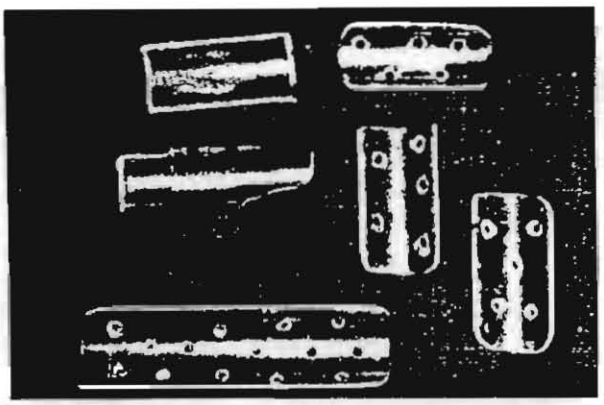
Finger injury splints

Sir,

Finger injuries are the commonest of hand injuries and most of them require some kind of splintage for a period of time We have found 'used' disposable syringes helpful for splinting fingers with various lesions. These are easily-made, convenient, non-traumatic, light in weight and practically free of cost. The size of the syringe required depends on the size of the finger. Usually 20 cc for adults and 10 cc for children are suitable. They are best used as gutter splints, which are easily prepared by longitudinally splitting the syringe with a pair of stout scissors. The ends and corners are rounded off to prevent irritation and pressure. A number of small holes are made with a hot large-bore needle to allow for evaporation of sweat and prevent sogginess, which is necessary in our tropical climate (Figure). The splints are easily secured with simple adhesive plaster tape.



Figure

We have used these successfully over a period of one year in patients with finger-tip lacerations, phalangeal fractures (particularly middle and distal phalanges) and dislocations, mallet and boutonniere deformities and for splinting the fingers after small grafts and flaps for finger-tip defects

Yours faithfully,

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Open tibial fractures

Sir,

The paper of Small and Mollan (*British Journal of Plastic Surgery*, **45**, 571–7) was directed to the readers of the BJPS and thus may not be brought to the attention of orthopaedic surgeons, for whom the message is just as pertinent. The message of encouraging early cover of compound fractures with appropriate soft tissue should be stressed to orthopaedic surgeons, who are usually the first involved at the onset of management of such injuries. Despite the problems caused