

tained the millennium when there will be no disease and no suffering.

Let us then be up and doing,
With a heart for any fate;
Still achieving, still pursuing,
Learn to labor and to wait.

Original Articles.

A MODIFICATION OF PANAS' OPERATION FOR PTOSIS.

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Panas' operation for ptosis probably yields better results, on the whole, than any other operation, and yet its various steps are not always clearly understood by

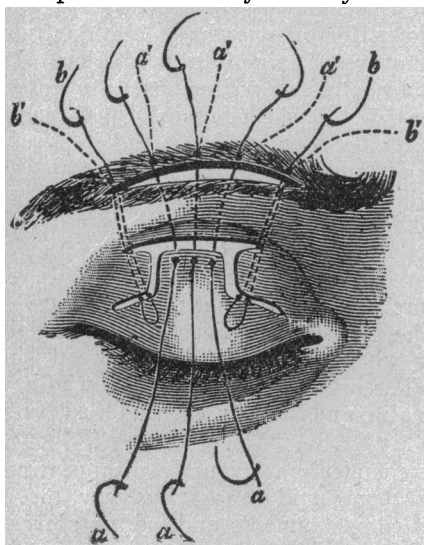


Fig. 1.—Panas' operation for ptosis. (After Panas.)

operators, and it possesses some glaring defects that have served to render it rather unpopular. It is for the purpose of clearing up these misunderstandings and

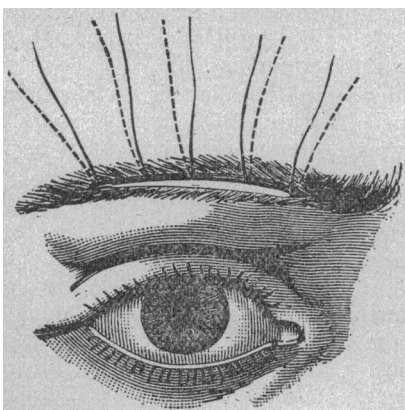


Fig. 2.—Appearance after the operation is completed. (After Panas.)

remedying the defects that I have ventured to offer this communication.

I will first reproduce the drawings usually given to clarify the written description of Panas' operation, and it will be seen that they do not entirely clear up some of the points in the ordinary description.

I think that the addition of a plain schematic drawing would better demonstrate the different steps in the opera-

tion, and for this purpose at my clinics I draw a plan like Figure 3.

The line indicated by 1 represents the first incision, which should be in the eyebrow and extend to the bone. The line indicated by 2 represents the second incision, which should be just below the eyebrow, and should extend also to the bone. The bridge of tissue between these two incisions should not be more than 5 or 6 mm. in width. The line marked 7 represents the palpebral margin of the upper lid. The line marked 3 represents a short incision in the lid at about the upper margin of the tarsal cartilage, and should be from 8 to 10 mm. long, and should pass completely through the skin. The line marked 4 represents another similar incision in the opposite angle of the lid. The lines marked 5 and 6 represent two incisions passed completely through the skin and uniting 3 and 4 with 2. While incisions 3, 4, 5 and 6 are being made, the horn spatula should be placed underneath the lid, both to facilitate the making of the incisions and to avoid accidents to the underlying eyeball. The tissue between incisions 5 and 6 should be about 15 mm. in width.

Figure 1, as given by Panas, shows all the lines, etc.,

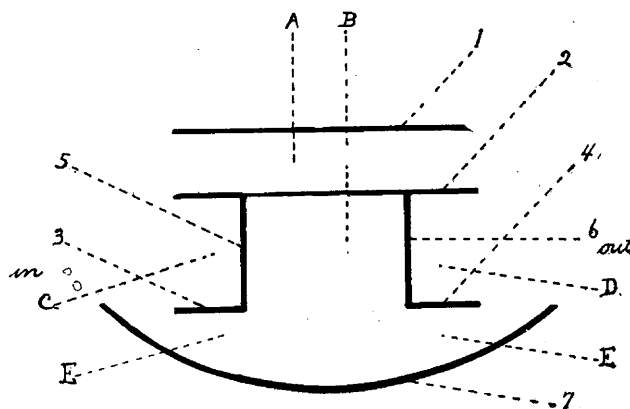


Fig. 3.—1. First incision. 2. Second incision. 3. Third incision. 4. Fourth incision. 5. Fifth incision. 6. Sixth incision. 7. Edge of upper lid. A. Bridge flap. B. Tongue flap. C. Nasal flap. D. Temporal flap. E. Palpebral flap (nasal side). E. Palpebral flap (temporal side).

to be beautifully curved in outline, but in practical work these curves are not feasible, and I believe straighter incisions can be much more accurately made, and will not detract from the efficiency of the operation.

The original drawing of Panas (Fig. 1) is misleading, as it shows the two threads in the five needle holes in the superior portion of the eyebrow incision, both coming out of the same needle hole, whereas they should be shown as coming out of separate needle holes, side by side and close together, as shown in Figure 4, which I would suggest as in every way a plainer drawing than Figure 1.

The description as given by Panas is also not explicit concerning the sutures 4 and 5, which are placed to prevent a tendency to ectropion induced by the traction effect of sutures 1, 2 and 3. These sutures should include the tissues of the lid except the skin and tarsal cartilage, and should be inserted in the spaces between the skin flaps. One of the needles of a double-needled thread should be inserted directly through the lid from within outwards, just above the upper edge of the tarsal cartilage, and pulled through, after which the other needle should be inserted through the tissues, also from within outwards, and brought out close to the first point of entrance of this suture, leaving the loop of the suture on the conjunctival surface of the lid. The lid should

be held well away from the eyeball either with the fingers or forceps during the entire placing of these sutures, so that the operator may look under the lid and see what is transpiring, and so that the needle may not injure the eyeball. The sutures should then be passed up under the bridge flap, and through the superior margin of the brow incision and firmly tied.

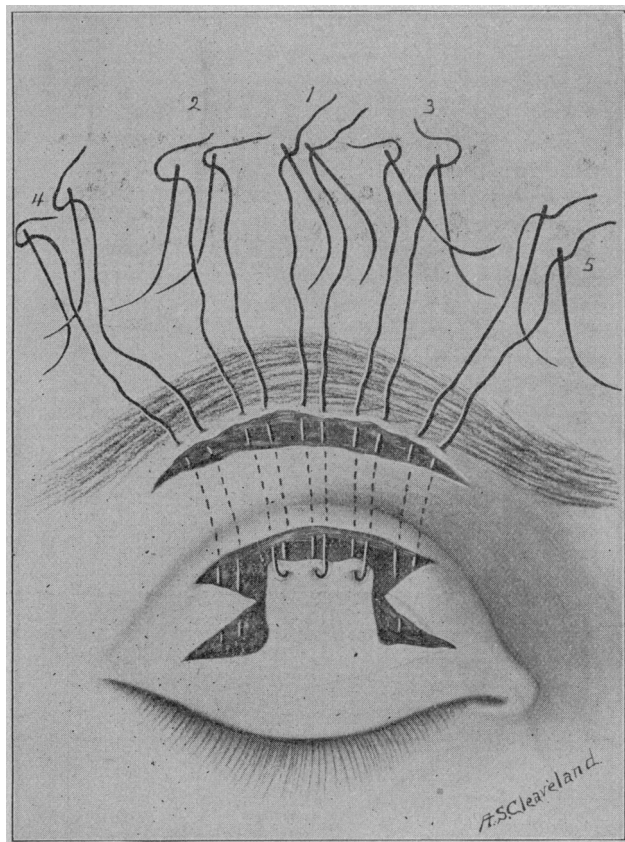


Fig. 4.—1. First suture. 2. Second suture. 3. Third suture. 4. Fourth suture. 5. Fifth suture.

One great objection to the operation is the fact of the non-adherence between the flap marked B (Fig. 3), which I will call the tongue flap, and the flap marked A (Fig. 3), which I will call the bridge flap. The upper surface of the tongue flap is unbroken skin, that of the

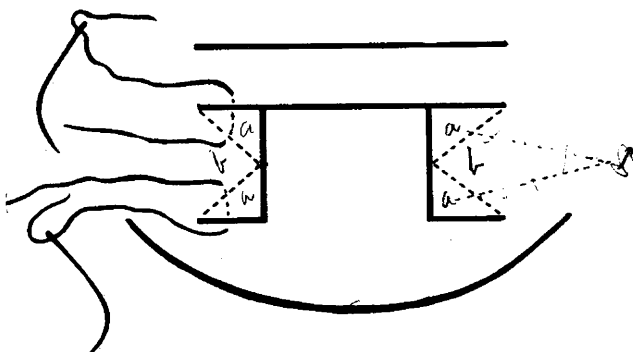


Fig. 5.—1. Corners cut from flap.

under surface of the bridge flap is connective tissue, fat, etc., and the two do not heal together, which leaves a pocket or cul-de-sac between the two for the permanent accumulation of various forms of debris, which is both unsightly and unhealthy, as well as being a distinct defect in the operation. This objection I remedy by thoroughly scarifying the skin surface of the tongue

flap by criss-cross incisions, and then removing most of the dermal epithelium by delicate forceps and scissors. This procedure is accomplished before the tongue flap is dissected from the underlying tissue, as the flap is then firm, and can be handled easier than after it is lifted. The sutures are then placed and the tongue flap drawn up under the bridge flap and tied, and in a few days perfect adhesion will take place. Another objection to the operation is the thick, lumpy appearance of the bridge flap, which never entirely disappears. This objection I minimize by making the bridge flap as narrow as possible, never more than 5 or 6 mm. in width, and also making it as thin as possible by stripping it of all possible tissue beneath the true skin.

The last objection to the operation is the two pieces of skin at the angles of the lids marked C and D in Figure 3, which pucker up and look permanently bulky

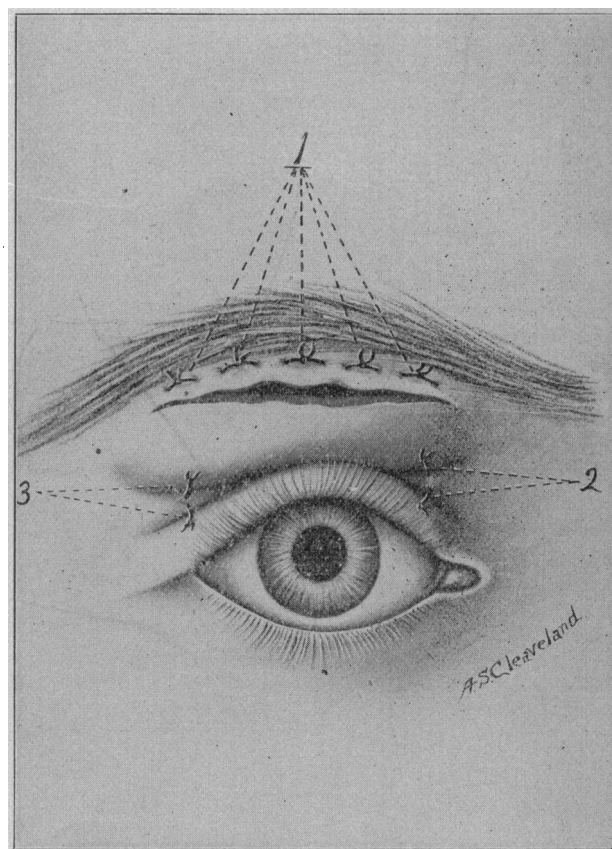


Fig. 6.—1. Sutures 1, 2, 3, 4, 5, after being tied. 2 and 3. Sutures in flaps C and D after being tied.

and unsightly. This I remedy by cutting off the corners as seen in the dotted lines of Figure 5, and then thinning the under sides of flaps C and D (Fig. 3) by removing all possible tissue except the true skin. Flaps C and D (Fig. 3) are then sutured to flaps E and E (Fig. 3) and flap A (the bridge flap) by four sutures, which makes the entire field of operation present a smooth and finished appearance and adds much to the cosmetic effects of the operation, as shown in the completed operation of Figure 6.

I have performed the operation as thus outlined a number of times, and have not failed to obtain satisfactory results.

Crystallized Wisdom on Epidemics.—In these days there are no excuses for epidemics of filth diseases; there are only explanations of them.—"N. Y. Times."