Comment on: Upper eyelid levator-recession and anterior lamella repositioning through the gray-line – Avoiding a skin-crease incision

Sir,

We congratulate the authors for publishing their excellent work.[1] It reminds us the old technique. We will be happy if author can explain in detail the following queries.

Is there any specific pathology for meibomian gland inversion (MGI) in two patients with facial nerve palsy?

Was upper lid retraction present preoperatively in all patients? It would have been appreciable if author could have written the marginal reflex distance 1 for all patients to compare the postoperative ptosis which was significant in two patients with 3 mm of droop in which one patient had trichiasis also.

What is the cause of trichiasis in one case, was it postoperative droop of anterior lamella or was it an unrecognized scarring of posterior lamella?

In this study out of 11 eyes, 2 eyes had increase in lid retraction and one had no change in retraction. A study by Gawdat *et al*. showed that out of 97 eyelids with upper lid cicatricial entropion, 18 patients underwent upper lid retractor recession with good results.[2] Barr *et al*. assumed that the high recurrence rate observed (21%) in their study following anterior lamellar recession was due to not performing concurrent levator recession.[3] Would there will be a recurrence if levator recession had not been performed in this group of patients.

Of the 11 eyes operated, five (45.5%) needed further treatment. As concluded in this study, a long-term follow-up with a considerable number of eyes will clear us the necessity for doing levator palpabrea superioris (LPS) recession.

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Conflicts of interest

There are no conflicts of interest.

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