Editorial

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Perspectives on the management of eyelid burns

Baljit Dheansa, Consultant Burns and Plastic Surgeon
Queen Victoria Hospital, East Grinstead, UK
Email: b.dheansa@nhs.net

The impact that facial burns can have on patients is significant, and burns around the eyes in particular can have a major impact both physically and psychologically, as highlighted by Lymperopoulos et al.[1] It is interesting to note that the 'base' specialty of the literature quoted covers burns, plastic surgery and ophthalmic/corneoplastic surgery. This is particularly relevant as any discussion on the best way to manage a condition should cover not just what is done but who should be involved. Unfortunately, this is an area that is all too often missed and therefore can lead to the loss of an opportunity to work collaboratively with colleagues who have overlap with our own interests.

This is especially the case with eyelid burns where ophthalmic surgeons have a vested interest in avoiding any secondary injury to the cornea. Having a combined approach with an interested colleague should be encouraged as early management can reduce long-term visual problems significantly.[2]

It is often the case that active surgical measures for eyelid protection may only be required 2–3 weeks after injury but it is important to have a plan and approach before then with clear indications for when further treatment may be required. With large burns involving the face it behoves the team to understand what and when any eyelid reconstruction will be required, especially if skin is in very short supply.

The authors discuss their experience of using a particular technique of temporary tarsorrhaphy and clearly some thought has gone into modifying previous approaches.[1] However, I think the readership would have gained more if they had been able to review the broader literature on tarsorrhaphy and temporary tarsorrhaphy for eyelid burns with a view to understanding the best timing, comparing various techniques in terms of complications, need for further surgery and indications. There is clearly a paucity of high level evidence in this area but before one can establish good quality trials it is important to have a good understanding of the available knowledge in the field. Conditions that arise infrequently are often treated in a variety of ways with very little guidance or consensus on the best approaches to take. I would encourage the authors to follow up this paper with a more detailed analysis of the literature on tarsorrhaphy/temporary tarsorrhaphy to enable burns clinicians to have better information.

Another aspect of eyelid burns that needs further clarity is whether our approaches to sedated and ventilated patients should be different to those that are not. The drawstring temporary tarsorrhaphy[3] may, for example, be acceptable and effective in a sedated patient but not in an awake patient when they have bilateral eyelid burns.

Although there is much discussion about the effectiveness of permanent tarsorrhaphy in this area this is often because it is considered the only treatment.[4,5] A more relevant question may be whether permanent tarsorrhaphy and formal reconstruction is less likely to give long-term scarring or visual problems compared with temporary tarsorrhaphy and reconstruction.

Clearly from a reconstructive perspective the authors' review of the literature on burns ectropion treatment once it is established is helpful especially as it suggests that many different approaches may be useful. However, in light of their focus on their new technique, it may have also been beneficial to look at the effectiveness of initial reconstruction in preventing long-term sequelae.

As the focus of much of our research changes toward more patient-focused outcomes, it will be essential for all of us to determine what patients want from their long-term outcome before embarking on research in this field. In their paper, the authors allude to a lack of standardised assessment that makes it more difficult to make sense of the available literature.

I would hope that the authors will continue looking into this field, help provide clarity where there is a lack of clear guidance and produce a body of evidence that we can utilise for the better management of our patients.

References

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