The surgical management of severe congenital blepharoptosis in pediatric patients continues to evolve. Results are often less than ideal regardless of the procedure used. This accounts for the numerous reports of proposed improved techniques and modifications of frontalis suspension and maximal levator muscle resection surgical procedures. A recent improvement in the frontalis suspension procedure is the incorporation of tarsal fixation of the suspensory material. This procedure includes an eyelid crease incision with dissection to the tarsus. This technique may preclude slippage of the suspensory material and recurrence of the ptosis. Although this increases surgical time, the improved long-term results make the extra time invested well worth it.

The choice of the suspensory material to be used in a frontalis sling procedure can be difficult. Most ophthalmologists prefer to avoid harvesting autogenous fascia lata, although this may be the ideal material. Formation of granuloma and rejection of foreign materials are well-recognized complications. The introduction of banked prepared fascia lata has reduced, but not eliminated, the incidence of foreign body rejection in many cases. One thing is certain—the material used must be buried deep in the brow incisions with multilayer closure of the frontalis muscle and overlying skin.

In this issue of the Journal of Pediatric Ophthalmology & Strabismus, Hersh and colleagues compare their results using Silastic and banked fascia lata in pediatric frontalis suspension surgery. It is instructive to read that surgeons in Australia encounter the same difficulties with this surgery as surgeons in other parts of the world. The authors found no difference in initial results or granuloma or infection rate. They did find a statistically significant difference between the two materials in terms of ptosis recurrence (35.3% for fascia vs 13% for Silastic). There is, however, conflicting evidence in the literature regarding the ideal suture material and surgical technique. Until a superior surgical procedure for severe pediatric ptosis is clearly demonstrated, these reports of short- and long-term results are extremely useful. Information garnered from the experiences of many can be used to refine the approach of individual surgeons.

Rudolph S. Wagner, MD
Editor