

Blepharoptosis and Floppy Eyelid



Dear Editor:

We read with interest the recent article by Ezra et al¹ concerning the associations of floppy eyelid syndrome (FES). FES is not uncommon in our own clinical practice and, as previously reported,² many cases we encounter were previously misdiagnosed or considered unspecified chronic ocular surface inflammations. Taking into account the important systemic associations of FES, such as the obstructive sleep-apnea syndrome and the risks they carry, the early recognition of the condition is of high clinical value. Accordingly, we would like to add a comment concerning a clinical association of FES we observe frequently, which we believe may assist clinicians in recognizing this condition.

The authors report that FES patients in their series displayed significantly lower palpebral aperture scores than controls.¹ This finding is in conformity with previous studies reporting an association between blepharoptosis and FES.³ However, blepharoptosis is a common disorder, and its presence may not be sufficient to direct the attention toward the presence of FES. Moreover, many FES patients do not present with frank blepharoptosis. What we frequently notice though, in many FES cases, is a disruption of the upper eyelid contour with predominantly lateral upper eyelid ptosis. We also notice that this deformity of the lateral aspect of the upper eyelid may be present in FES despite a normal or near-normal marginal-reflex distance score for the upper eyelid. Four characteristic examples of patients with FES presenting with lateral upper eyelid ptosis are presented in Figure 1 (available at <http://aaojournal.org>). The ptotic lateral part of the upper eyelid is presented in Figure 1A, C, E, and G. Levator function (LF) was normal or only slightly compromised in these cases. The mean LF score reported by Ezra et al¹ for their test group was also quite high (16.9 mm).

The localized contour defect of the lateral eyelid observed in some FES patients may possibly be attributed to a greater exposure of this part of the eyelid to repeated mechanical stress, compared with the medial or central eyelid,

resulting in a local aponeurotic defect. Tarsal damage, often in the form of linear tarsal deformities, may also be evident upon eyelid eversion. Such tarsal defects are presented in Figure 1B, D, and F. Interestingly, these patients displayed severe lateral canthal laxity but only moderate medial laxity for the upper eyelid. Ezra et al¹ also report that in their case series the association between upper lid lateral canthal laxity and FES approached but did not exceed statistical significance ($P = 0.07$), whereas the association between medial canthal laxity of the upper eyelid and FES was statistically not significant.¹ This finding supports the concept that the lateral part of the upper eyelid may be more severely affected in many FES patients, compared with the medial one, contradicting a previous report on the presence of predominantly medial upper eyelid laxity.⁴ That report suggested medial tightening of the upper eyelid to correct FES,⁴ whereas the concept of a predominantly lateral upper eyelid destabilization may possibly direct surgical correction to the lateral aspect of the upper eyelid, as also previously suggested.⁵ Moreover, we believe that the lateral upper eyelid ptosis may serve a useful clinical marker for FES diagnosis.

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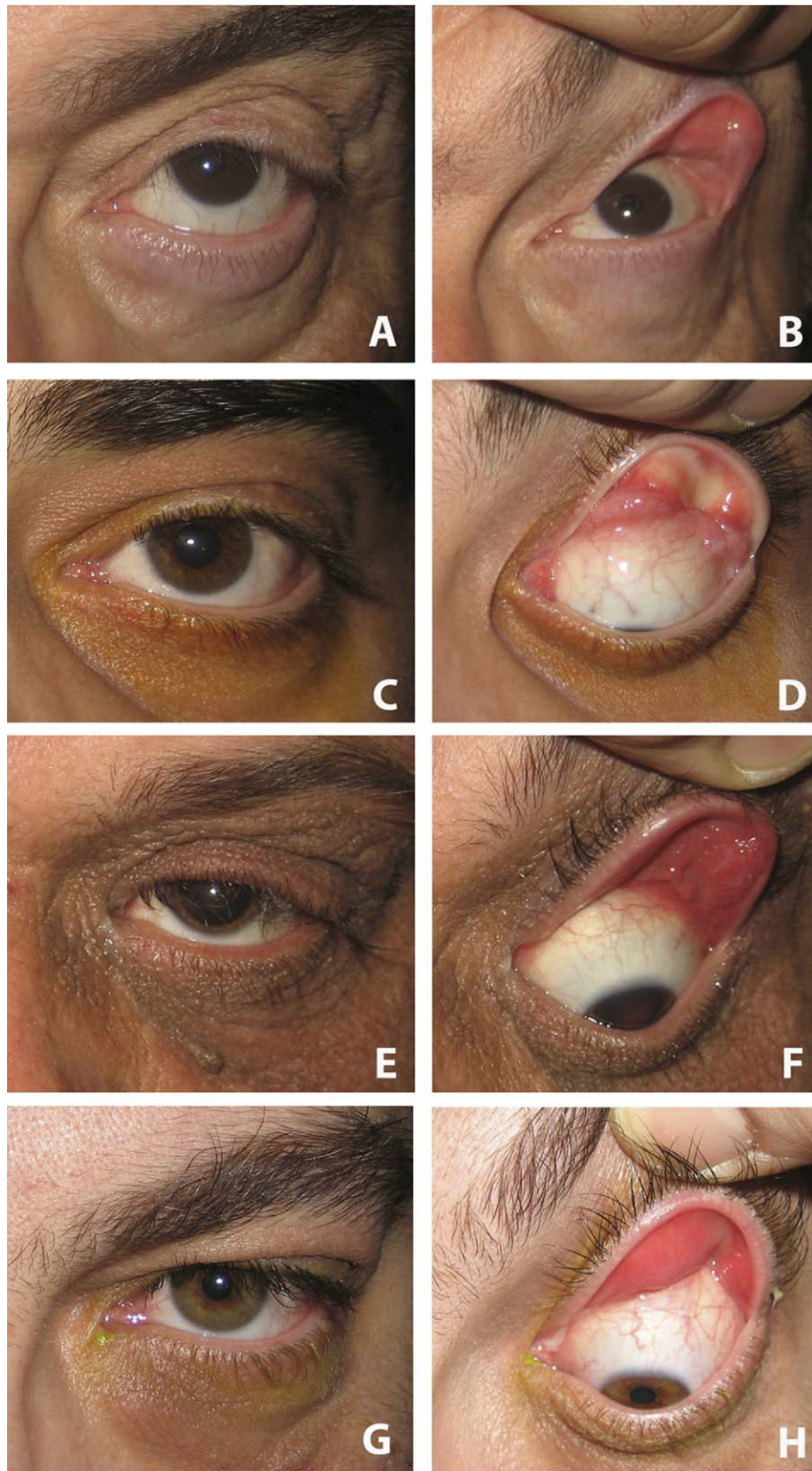


Figure 1. Characteristic cases of floppy eyelid syndrome (FES) with lateral upper eyelid ptosis (A, C, E and G). Upper eyelid eversion reveals severe tarsal deformities at the lateral aspect of tarsus (B, D, F).