IDIOPATHIC LOSS OF LATERAL TARSAL SUSPENSION

DESINSERCIÓN TARSAL LATERAL BILATERAL IDIOPÁTICA

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ABSTRACT

Case: A 53-year-old man who showed a loss of tarsal suspension in the lateral third of both lower eyelids underwent lateral canthoplasty with a good post-operative result.

Discussion: Disinsertion of the union of the inferior tarsus with the lateral canthus, of unknown cause, is a very uncommon finding that has almost never been reported in the world literature. There are two cases described of eyelid elastolysis with loss of lateral tarsal suspension, as in our case, but both showed eyelid skin atrophy and had histopathologic confirmation. Our case did not have skin atrophy (Arch Soc Esp Oftalmol 2007; 82: 369-372).

Key words: Canthoplasty, canthopexy, elastolysis, tarsal strip, cutis laxa.

INTRODUCTION

We describe herein a case of deinsertion of the lower eyelid tarsus for both eyes at the lateral canthal ligament. This is a relatively frequent condition after certain palpebral surgeries, such as the tarsal strip. However, in the present case it occurred in an idiopathic and bilateral fashion.

CASE REPORT

A 53-year-old male, asymptomatic, without a relevant personal history, reports the loss of eye lashes in the last third of both lower eyelids progressing for several months. He does not report any trauma, surgery, or chronic eye scratching. The exploration revealed the absence of the tarsus in the last third of
both lower eyelids, while the free palpebral rim remained attached by means of an extremely thin skin bridge (fig. 1). He also presented a descent in both lower eyelids and slight blepharoptosis, not confirmed by the patient. Upon the patient’s request, surgery included lateral canthoplasty with canthopexy to correct the tarsus deinsertion. The anatomopathologic study of the adjacent skin did not provide any relevant data. The postoperative progressed favorably, improving the descent of the lower eyelid and palpebral contour (fig. 2). The patient later rejected the proposed ptosis surgery.

**DISCUSSION**

Configuration of the palpebral fissure is maintained by the medial and lateral canthal tendons, which are inserted into the tarsal plates (1). The eyelids’ retractor muscles and the orbicular muscle also contribute to the said fissure. Thus, in physiological conditions, the characteristic almond-shaped palpebral contour results.

The patient presented loss of the lateral canthal angle with a blunt and rounder appearance, absence of eyelashes in the deinsertion area, since the free rim was formed by skin and the canthal subcutaneous tissue; the descent of the lower eyelid, which we attribute to the effect of the lower eyelid’s retractor muscle lacking the opposition exerted by the necessary horizontal palpebral tension.

Deinsertion of the union between the inferior tarsus and the lateral canthus, of unknown cause, is a very uncommon finding that has almost never been reported in the literature. Two cases have been described regarding the cutis laxa with palpebral involvement with the associated absence of lateral tarsal suspension (2). Ptosis and atrophy of the palpebral skin were also present. This rare disease involves the skin’s elastic tissue, so-called elastosis, characterized by the selective loss of elastic fibers at the dermis media. It may be congenital or acquired, and localized or diffuse. The skin appears to be prematurely aged, with the formation of wrinkles and flaps (3). At the palpebral level, it may progress with dermatochalasis, cutaneous atrophy and aponeurotic ptosis. Diagnosis is obtained by means of a cutaneous biopsy of the area involved. Nevertheless, in the present case no cutaneous atrophy was observed, and the anatomopathologic study did not reveal any alteration of the skin’s elastic component.

The insufficient laxity of the lower eyelid did not allow for a conventional tarsal strip technique, since in order to suture it to the lateral orbital rim it would have been necessary to perform a peristomeum flap. Thus, the lateral canthus was reformed by joining the lateral end of the inferior tarsus and the superior branch of the lateral canthal tendon. Subsequently, a canthopexy was performed in order to avoid the narrowing of the horizontal palpebral fissure. Performing a small incision in the upper eyelid’s cutaneous flap, the tissues were

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**Fig. 1:** Pre-surgical lateral view. The arrow points at the limit for the deinserted tarsus. The thin skin bridge joining the lower and upper eyelids can be noticed.

**Fig. 2:** Comparison before and after surgery. The descent of the lower eyelid and the lateral canthus contour have improved.
dissected to isolate the lateral canthal tendon, which was sutured to the lateral orbital rim’s periosteum, similarly to the way that cosmetic blepharoplastias are performed on certain occasions to elevate the canthus (4).

Finally, it is worth mentioning the significance of anatomopathologic studies in similar cases in order to discard the associated cutaneous diseases, as pointed above.

Likewise, it is worth noting the technique used as a valid alternative to the tarsal strip in cases like this one, where performing a tarsal strip without additional procedures is not feasible.

REFERENCES