Re: Young et al.: Conservatively treated orbital blowout fractures: spontaneous radiologic improvement
(Ophthalmology. 2018;125:938-944)

TO THE EDITOR: We read with interest the study by Young et al., which presented data demonstrating spontaneous clinical and radiologic improvement in conservatively managed orbital blowout fractures. The study has several strengths including its prospective design, detailed radiologic analysis, and inclusion of follow-up computed tomography scans for all patients. However, we would like to make several comments on the study’s results.

In their study, Young et al. found isolated blowout fractures of the medial orbital wall to be 3 times more common than those only involving the orbital floor (61.4% vs 18.2%, respectively). This finding stands in contrast with the majority of studies that suggest floor fractures as more common, and indeed represents a higher proportion than previously reported in a large study of a similar patient population. Although this study makes a worthy contribution to the literature on medial wall fractures, these patient characteristics are unusual and may limit the study’s generalizability to other populations.

Second, the reported mechanisms of injury suggest that the majority of patients sustained a low-energy traumatic insult with almost one-half of the patients presenting owing to an assault or a fall at ground level. Additionally, as the authors note, few patients presented with significant diplopia or ocular motility restriction. These features may indicate a relatively low-severity population. It would be interesting to know the proportion of patients who sustained other significant facial fractures or significant injuries (as a marker of the severity of the initial injury). Our experience in a high-volume, high-intensity trauma center has been that a significant proportion of patients do present with diplopia or motility restriction, a reasonable proportion of whom do improve with conservative management.

Third, the mean duration from injury to initial computed tomography scan was 6.5 days and earliest scan was at 2 days. It would be interesting to explore the reasons for this delay; in our experience, almost all suspected orbital fractures presenting to our institution would undergo computed tomography scanning within 24 hours. A longer duration to initial scan may suggest a significant proportion of delayed presentations, again suggesting a low-impact injury cohort.

Overall, we applaud the authors’ challenge to the established dogma of more aggressive surgical management; however larger, more generalizable studies are needed before the optimal approach is clear.

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The authors of the original article declined to reply.

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References