Re: Kersten et al.: Orbital ‘blowout’ fractures: time for a new paradigm
(Ophthalmology. 2018;125:796-798)

TO THE EDITOR: We read with interest the editorial by Kersten et al.1 The authors address the difficult issue of timing of repair of orbital floor fractures, and their argument is 2-fold: (1) immediate surgical repair of “trapdoor fractures with marked vertical limitation of ductions” and (2) “prolonged observation” in all other patients. The first point, with which we agree, is noncontroversial among ophthalmologists and oculofacial plastic surgeons. The second point argues against the prior recommendation proposed by Burnstine2 to repair a subset of orbital blowout fractures within 2 weeks.

A paradigm is defined as the “worldview underlying the theories and methodology of a particular scientific subject” and a paradigm shift requires a scientifically substantiated theory that is widely applicable and inclusive based on the available literature.3 There is reasonable disagreement among clinicians about the indications for surgical repair. We agree the 2-week observation period is arbitrary and welcome the authors’ persuasive argument for several months of observation in most patients owing to reports of resolution of diplopia with observation alone and rarity of significant enophthalmos.

However, we believe the authors’ argument to observe all fractures other than classically entrapped trapdoor fractures is an oversimplification of a nuanced, complicated, and controversial topic. There are rare but important groups of patients Kersten et al1 do not address that require urgent surgical repair: those with a nonresolving oculocardiac reflex4 and those with large fractures allowing for globe subluxation into the maxillary sinus.5 Observation of these patients could have serious cardiac or visual implications.

The authors also fail to address the grey area in patients with diplopia, motility deficits, and clinical and radiographic evidence of orbital soft tissue entrapment that does not improve with time. Furthermore, the references cited in the editorial do not advocate as clear a picture as Kersten et al describe. The authors point to studies of good outcomes of observed orbital fractures to support their theory of prolonged observation. However, many of these studies are victims of selection bias, confounded by the fact that patients who met Burnstine’s criteria for early surgery were surgically repaired, and those with milder presentations were observed.

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References