INTRODUCTION

Various direct integrated implants were developed by such men as Cutler, Hughes, Rolf, Iliff, House, Stone, Johnson, and Dr. Jack S. Guyton. Certainly, their intention was noble; to improve the welfare of the anophthalmic patient by providing better movement to the artificial eye. These implants featured an exposed face with a female receptacle which was designed to accept a male peg attached to the back of an artificial eye. Because they were "semi-buried" they were more prone to chronic infection as well as migration problems. To their credit, they pointed the way to the more successful buried integrated implants such as the Allen and Iowa implants. They also challenged ophthalmologists to improve the technique used for sphere implants.

This may not be a typical case presented here, nevertheless, there are a few interesting things one may can learn from it. Improvisation to ones fitting technique must be considered and this method may be used in other unusual cases. Secondly, the psychological aspect was a compelling factor.

PROBLEM SOCKET

A 67 year old caucasian male came to the office wearing the same prosthesis he had been fit with in 1950 following orbital reconstruction with implanation of a Guyton implant. (Figure 1) True to their design, the implant and prosthesis moved extremely well. However, over the years a number of problems had developed; the
implants had migrated forward and tilted nasally and the inferior fornix was very shallow, meaning the prosthesis was retained in the socket by the peg. (Figure 2) Another problem was the appearance of a gap in the lateral canthal area. (Figure 3) Along with all these problems, the patient had frequent infections (and chronic mucus drainage) of the eye socket.

The initial treatment reaction was to strongly urge the patient to look into surgery to have the implant removed and to reconstruct the socket. The patient was aware of this option and in fact had recently talked to two different surgeons. However, he stated that he was extremely reluctant, in fact, frightened, of any surgery due to a bad experience he had years ago. It became apparent that if he did not fit a new prosthesis he would wear the old one indefinitely. After thoroughly discussing the potential problems, a new, replacement prosthesis was started.

The first fitting attempt was to empirically design a wax model for the new eye, but this was not retained to the eye socket. As an alternative, a duplicate of the old prosthesis (Figure 4, left) was made and then modified. To duplicate the shape, a stone casting was made and a white
plastic shape was fabricated. Much of the anterior of this shape was removed to permit attaching an aluminum iris button (for the iris positioning) with wax. The periphery of the new shape was extended with wax, especially in the nasal and temporal areas. From this fitting shape the new prosthesis was fabricated. (Figure 4, right) The final result was an improvement, and for now at least, the patient circumvented further surgery. (Figure 5)

CONCLUSION

As ocularists, we often face less than ideal fitting situations. Sometimes the best course to take is referral for oculoplastic surgery. However, if this does not prove viable we should be ready to try a creative approach to achieve the best results possible.

REFERENCES


FIGURE 5: While ptosis is still present, the new prosthesis shows significant improvement in the patients appearance over the old prosthesis, and eliminates ‘gaping’. The new prosthesis also provides reasonable movement, and circumvents surgery.