Greater Manchester Shared Services

Greater Manchester EUR Policy Statement

Title/Topic: Correction of Eyelid Ptosis
Reference: GM047
Date: December 2014
Last Reviewed: January 2016

Greater Manchester Shared Services
Hosted by NHS Oldham CCG
on behalf of the Greater Manchester CCGs

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VERSION CONTROL

Version	Date	Details	Page number
0.1	24/04/2014	Initial draft	N/A
0.2	29/05/2014	Amendments made by GM EUR Steering Group on 21/05/2014:	
		Removal of "covers Blepharoplasty and Levator Aponeurosis" from the title of the policy.	1, 3 & 11
		Removal of Levator Aponeurosis Dehiscense from Mandatory Criteria.	8
		Addition of Levator Aponeurosis Dehiscense paragraph under Policy Exclusions.	8
		Draft policy approved for consultation following the above amendments.	N/A
		Policy published for consultation from 09/07/2014 to 03/09/2014.	N/A
0.3	25/09/2014	Amendments made by the GM EUR Steering Group on 17/09/2014 following review of the feedback from the consultation:	
		Amendments to the section 4, mandatory criteria:	
		First paragraph – insertion of 'for adults', i.e. 'Blepharoplasty is only commissioned **for adults** where….'	3 & 8
		Second paragraph – insertion of 'of visual field loss, i.e. 'All possible underlying causes **of visual field loss** need to….'	3 & 8
		Third paragraph – inclusion of Estermann visual field test and definition.	3 & 8
		Inclusion of children in the policy exclusion section, as this policy is specifically for adults; children should be managed as clinically appropriate.	3 & 8
	17/09/2014	Policy approved by GM EUR Steering Group subject to the above amendments.	N/A
0.4	08/10/2014	Branding change following creation of North West CSU on 1/10/2014.	All
0.5	10/10/2014	Inclusion of criteria related to Wick Syndrome.	8
1.0	16/10/2014	Policy approved virtually by GM EUR Steering Group	N/A
2.0	20/01/2016	Policy reviewed by GM EUR Steering Group. No additional evidence reviews or commissioning guidance were found. No material changes necessary to the policy.	
		The following sections were added under Section 2 - Definition of the	10

		policy:- • Cosmetic symptoms • Function symptoms • Examination <u>Section 4 - Criteria for Commissioning</u> The Mandatory Criteria has been reworded for clarity and sections added on conservative treatment and surgical treatment The visual field test requirement in the policy changed from: *"Applications should be supported by an Estermann visual field test showing the degree of obstruction to be less than 120 degrees on the horizontal in the monocular field and a significant defect in the binocular field which encroaches within 20 degrees of fixation above or below the horizontal meridian in accordance with DVLA guidance for driving."* To: *"Applications should be supported by a monocular field tests showing the degree of obstruction carried out by a community optometrist (as for a general sight test) with a supporting letter from the optometrist describing the likely effect of the visual field loss on the individual's ability to function in their day to day life e.g. risk of falls, impact on driving etc."* Paragraph under policy exclusions relating to Levator Aponeurosis Dehiscence re-worded for clarity. *Added to Policy Exclusions that "Care as part of an externally funded trial or as part of a locally commissioned pathway is excluded from this policy."* Section 9 - Funding Mechanism updated. Wording for date of review changed.	11/12 4 &12 12 12 4 & 13 4 & 14
2.1	05/04/2016 19/04/2016	List of diagnostic and procedure codes in relation to this policy added as Appendix 2. Policy changed to Greater Manchester Shared Services template and references to North West Commissioning Support Unit changed to Greater Manchester Shared Services. Bolton CCG funding mechanism for Dermatochalasis with symptoms and signs of ocular surface disease despite conservative treatment changed from Monitored Approval to Individual Prior Approval.	18 N/A 5 & 13

POLICY STATEMENT

Title/Topic:	Correction of Eyelid Ptosis

Issue Date:	December 2014

Reviewed:	January 2016

Commissioning Recommendation:	Blepharoplasty procedures will not be commissioned for aesthetic reasons. Blepharoplasty is only commissioned for adults where the condition is symptomatic and conservative management has failed. All possible underlying causes of visual field loss need to have been excluded or treated prior to requesting surgical intervention. Applications should be supported by a monocular field tests showing the degree of obstruction carried out by a community optometrist (as for a general sight test) with a supporting letter from the optometrist describing the likely effect of the visual field loss on the individual's ability to function in their day to day life e.g. risk of falls, impact on driving etc. Levator Aponeurosis Dehiscence is excluded from this policy and should be referred via the normal route. Prior funding approval is not required. Children under the age of 18 are excluded from this policy and should be managed as clinically appropriate. **See Section 4: Criteria for Commissioning**

Date of Review:	One year from the date of approval by Greater Manchester Association Governing Group thereafter at a date agreed by the Greater Manchester EUR Steering Group (unless stated this will be every 2 years).

Prepared By:	Greater Manchester Shared Services Effective Use of Resources Policy Team

Approved By	Date Approved	Funding Mechanism
Greater Manchester Effective Use of Resources Steering Group	16/10/2014	GM EUR Steering Group recommended funding mechanism: Individual Prior Approval for Dermatochalasis with symptomatic visual field defect demonstrated on formal testing. Monitored Approval for Dermatochalasis with symptoms and signs of ocular surface disease despite conservative treatment. (Except for Bolton CCG) Individual Prior Approval for other symptoms relating to dermatochalasis - Wick syndrome, symptoms or headaches due to frontalis overaction, periocular dermatitis, reduced vision due to lash ptosis, symptoms of ocular surface discomfort in the absence of signs. Individual Funding Request by exceptionality for co-existing brow ptosis requiring surgery. No approval required for Blepharoplasty as part of levator aponeurosis advancement surgery.
Greater Manchester Chief Finance Officers / Greater Manchester Heads of Commissioning	15/11/2014	N/A
Greater Manchester Association Governing Group	29/12/2014	N/A
Bury Clinical Commissioning Group	04/03/2015	GM Recommended Funding Mechanism
Bolton Clinical Commissioning Group	27/03/2015	As GM Recommended Funding Mechanism except: Individual Prior Approval for Dermatochalasis with symptoms and signs of ocular surface disease despite conservative treatment.
Heywood, Middleton & Rochdale Clinical Commissioning Group	16/01/2015	GM Recommended Funding Mechanism
Central Manchester Clinical Commissioning Group	05/03/2015	GM Recommended Funding Mechanism
North Manchester Clinical Commissioning Group	11/03/2015	GM Recommended Funding Mechanism
Oldham Clinical Commissioning Group	29/12/2014	GM Recommended Funding Mechanism

Salford Clinical Commissioning Group	29/12/2014	GM Recommended Funding Mechanism
South Manchester Clinical Commissioning Group	14/01/2015	GM Recommended Funding Mechanism
Stockport Clinical Commissioning Group	25/02/2015	GM Recommended Funding Mechanism
Tameside & Glossop Clinical Commissioning Group	27/05/2015	GM Recommended Funding Mechanism
Trafford Clinical Commissioning Group	17/03/2015	GM Recommended Funding Mechanism
Wigan Borough Clinical Commissioning Group	04/03/2015	GM Recommended Funding Mechanism

CONTENTS

Policy Statement

The Greater Manchester Shared Services (GMSS) has developed this policy on behalf of Clinical Commissioning Groups (CCGs) within Greater Manchester, who will commission surgery for the correction of eyelid ptosis in accordance with the criteria outlined in this document.

In creating this policy the GMSS has reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population of Greater Manchester.

Equality & Equity Statement

The GMSS/CCG has a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved, as enshrined in the Health and Social Care Act 2012. The GMSS/CCG is committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, the GMSS/CCG will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

In developing policy the GMSS policy team will ensure that equity is considered as well as equality. Equity means providing greater resource for those groups of the population with greater needs without disadvantage to any vulnerable group.

The Equality Act 2010 states that we must treat disabled people as *more equal* than any other protected characteristic group. This is because their 'starting point' is considered to be further back than any other group. This will be reflected in GMSS evidencing taking 'due regard' for fair access to healthcare information, services and premises.

An Equality Analysis has been carried out on this policy. For more information about the Equality Analysis, please contact policyfeedback.gmscu@nhs.net.

Governance Arrangements

Greater Manchester EUR policy statements will be ratified by the Greater Manchester Association Governing Group (AGG) prior to formal ratification through CCG Governing Bodies. Further details of the governance arrangements can be found in the Greater Manchester EUR Operational Policy.

1. Introduction

This commissioning policy has been produced in order to provide and ensure equity, consistency and clarity in the commissioning of blepharoplasty for the correction of eyelid ptosis by Clinical Commissioning Groups in Greater Manchester. When this policy is reviewed all available additional data on outcomes will be included in the review and the policy updated accordingly.

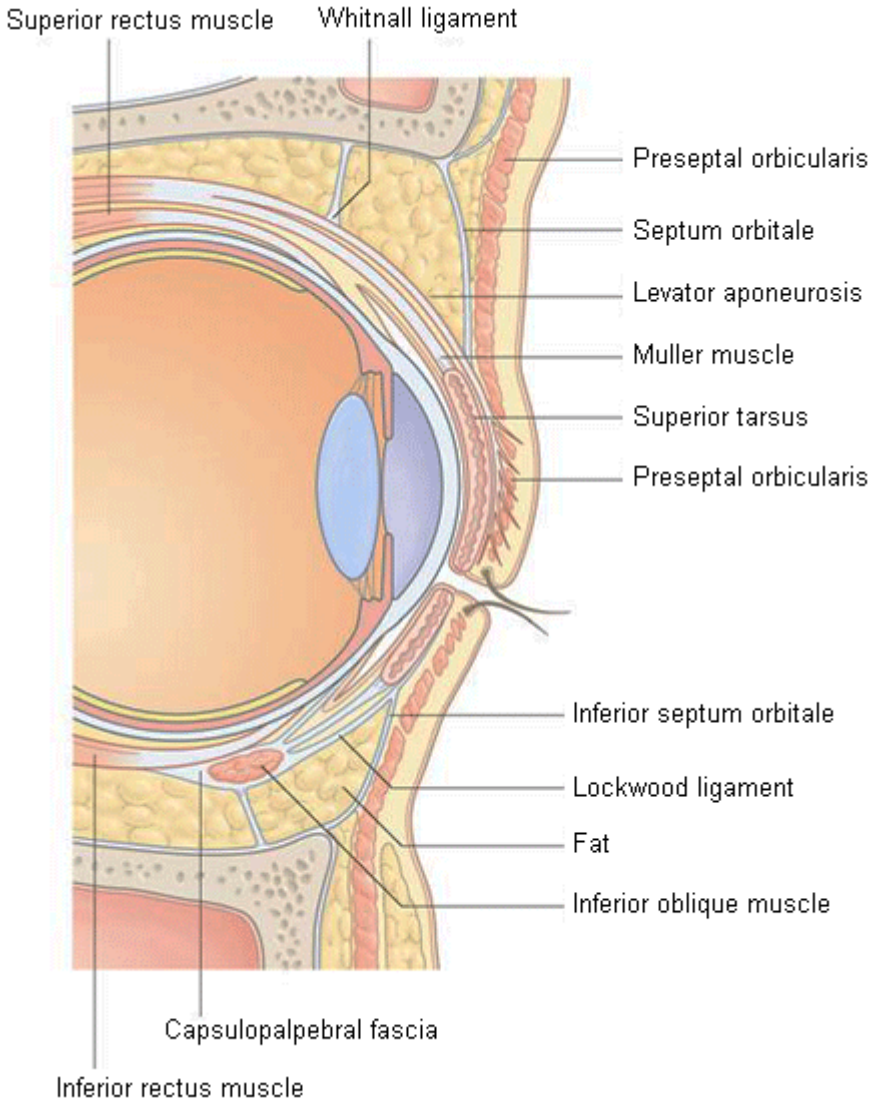
In this document dermatochalasis refers to the condition characterised by excess laxity of the skin and subcutaneous tissues of the upper eyelid (ptosis). The skin of the upper lid may hang down over the lid margin causing a variety of symptoms, both cosmetic and functional.

Dermatochalasis is frequently associated with brow ptosis, and blepharoptosis, and occasionally with lacrimal gland prolapse.

Correction of eyelid ptosis is frequently requested for aesthetic reasons; however, it is occasionally needed to address functional issues with the visual fields or to correct dehiscence of the upper lid levator muscle (in these cases a Levator Aponeurosis advancement is needed).

2. Definition

Correction of eyelid ptosis covers any procedure correcting drooping of either eyelid and repair of the levator aponeurosis.



Ptosis is a term applied to drooping of the eyelid. It can be unilateral or bilateral, complete or incomplete, acquired or congenital. Lid lag means delay in moving the eyelid as the eye moves downwards. It is a common finding in thyroid disease, when it is known as Graefe's sign.

Blepharoplasty: surgical repair or reconstruction of an eyelid.

Levator aponeurosis: a thin, tendon-like sheath that connects the eye's main opening muscle, the levator muscle, to the upper eyelid's supporting structure (tarsal plate) and skin.

Cosmetic symptoms

- Alteration in the appearance of eyes
- Sagging of the upper eyelid
- Change in shape of palpebral aperture
- Disruption of skin crease, pretarsal lid hidden by overhanging skin
- Difficulty applying eye make up

Functional symptoms

- Superior visual field loss – patients may struggle to articulate the effect on vision, but often have particular problems with reading (mechanical ptosis more noticeable in downgaze) and driving. They may have a feeling of heaviness, or need to hold the skin out of the way.
- Frontalis overaction leading to headache or tiredness.
- Reduced visual acuity or contrast sensitivity due to lash ptosis (looking through eyelashes).
- Sore skin around the eye (periocular dermatitis).
- Wick syndrome – watering (epiphora) from lateral canthus or along upper lid skin crease
- Burning/itching/grittiness due to blepharitis causing evaporative dry eye and / or keratitis
- Ocular surface discomfort and pain due to upper eyelid entropion

Examination

Should include:

- Visual field (where suspected loss of visual field is the only significant symptom)
- Description / drawings of:
    - Frontalis action / overaction
    - Brow position
    - Dermatochalasis
    - Upper lid margin position and contour
    - Presence / absence of lacrimal gland prolapse
    - Skin crease
    - Lower lid position / laxity
    - Orbicularis function
- Measurement of:
    - Skin crease
    - Marginal reflex distance
    - Levator function
    - Tear meniscus
    - Tear break up time
- Presence / absence of:
    - Dermatitis
    - Blepharitis
    - Upper lid entropion
    - Lash ptosis
    - Floppy eyelid syndrome
    - Lagophthalmos
    - Bell’s phenomenon

- Corneal staining
- If a field defect is present:
  - Intraocular pressure
  - Fundoscopy

3. Aims and Objectives

Aim

This policy document aims to specify the conditions under which procedures for the correction of eyelid ptosis will be routinely commissioned by Clinical Commissioning Groups in Greater Manchester.

Objectives

- To reduce the variation in access to procedures for the correction of eyelid ptosis
- To ensure that procedures for the correction of eyelid ptosis are commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness.
- To reduce unacceptable variation in the commissioning of procedures for the correction of eyelid ptosis across Greater Manchester.
- To promote the cost-effective use of healthcare resources.

4. Criteria for Commissioning

Mandatory Criteria

Conservative treatment

Symptoms / signs of ocular surface disease should be treated conservatively before consideration of surgery. (In the presence of upper eyelid entropion secondary to dermatochalasis, it may be necessary to arrange more urgent surgery).

Conservative management may include:

- Eyelid hygiene
- Warm compress with massage
- Tear replacement therapy
- Omega 3 oil

Surgical treatment

Skin only, or skin – muscle blepharoplasty may be performed in the presence of a symptomatic visual field defect, if other causes of field defect have been excluded. In some instances, there may be a clear history of reduction of vision in specific circumstances (e.g. when driving, reading or when tired), even in the absence of a formally demonstrated visual field defect.

When symptoms of ocular surface disease or other symptoms persist despite conservative measures, a skin (+/- muscle) blepharoplasty may be undertaken, if it is likely that they are attributable to the presence of dermatochalasis.

Pre- and post-operative clinical photos should be taken.

There is no indication for lower lid or fat blepharoplasty within this policy.

Blepharoplasty procedures will not be commissioned for aesthetic reasons.

Blepharoplasty is only commissioned for adults where the condition is symptomatic and conservative management has failed.

All possible underlying causes of visual field loss need to have been excluded or treated prior to requesting surgical intervention.

Applications should be supported by a monocular field tests showing the degree of obstruction carried out by a community optometrist (as for a general sight test) with a supporting letter from the optometrist describing the likely effect of the visual field loss on the individuals ability to function in their day to day life e.g. risk of falls, impact on driving.

Applications should be accompanied with a description of symptoms and findings on examination as well as, for cases where conservative management was indicated, a timeline showing which conservative measures were tried, when and for how long.

Policy Exclusions

Where there is significant aponeurotic blepharoptosis, surgery such as levator aponeurosis advancement may be required these are excluded from this policy and should be referred via the normal route. Prior funding approval is not required as this is commissioned but on monitored approval.

This policy excludes children under the age of 18 years, who should be managed clinically as appropriate.

Care as part of an externally funded trial or as part of a locally commissioned pathway is excluded from this policy

This procedure/treatment is commissioned in accordance with the above criteria. Funding outside of the criteria may be considered on an individual patient basis, if there is evidence of clinical exceptional circumstances.

Clinicians can submit an Individual Funding Request (IFR) if they feel there is a good case for exceptionality.

Exceptionality means 'a person to which the general rule is not applicable'. Greater Manchester sets out the following guidance in terms of determining exceptionality; however the over-riding question which the IFR process must answer is whether each patient applying for exceptional funding has demonstrated that his/her circumstances are exceptional. A patient may be able to demonstrate exceptionality by showing that s/he is:

- Significantly different to the general population of patients with the condition in question.

and as a result of that difference

- They are likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.

5. Description of Epidemiology and Need

Eyelid ptosis is a common condition. The incidence increases with age. There is no race or gender predilection. Acquired eyelid ptosis can occur at any age. Congenital eyelid ptosis usually presents at birth but is sometimes detected within the first year of life.

6. Evidence Summary

Evidence of effectiveness is limited in availability as this is an established procedure carried out for both aesthetic and medical reasons. For aesthetic reasons it is considered a procedure of low clinical value.

It is an effective procedure and should be commissioned where there is a medical indication or significant impairment of the visual field causing functional issues

Full details of the Evidence Review are contained with Appendix 1.

7. Rationale behind the Policy Statement

Eyelid ptosis is a common problem and most blepharoplasty procedures are aesthetic in nature. This policy has been developed to ensure that GM NHS funded interventions for the correction of eyelid ptosis are targeted to those cases where there is a medical need for the procedure or a clearly documented functional problem e.g. impaired visual field.

8. Adherence to NICE Guidance

NICE have not currently issued guidance on this treatment.

9. Mechanism for Funding

Clinical Commissioning Group	Funding Mechanism
Bury Heywood, Middleton & Rochdale Manchester Central Manchester North Manchester South Oldham Salford Stockport Tameside & Glossop Trafford Wigan	Individual Prior Approval for Dermatochalasis with symptomatic visual field defect demonstrated on formal testing. Monitored Approval for Dermatochalasis with symptoms and signs of ocular surface disease despite conservative treatment. (Except for Bolton CCG) Individual Prior Approval for other symptoms relating to dermatochalasis - Wick syndrome, symptoms or headaches due to frontalis overaction, periocular dermatitis, reduced vision due to lash ptosis, symptoms of ocular surface discomfort in the absence of signs. Individual Funding Request by exceptionality for co-existing brow ptosis requiring surgery. No approval required for Blepharoplasty as part of levator aponeurosis advancement surgery.
Bolton	As GM Recommended Funding Mechanism except: <u>Individual Prior Approval</u> for Dermatochalasis with symptoms and signs of ocular surface disease despite conservative treatment.

10. Audit Requirements

There is currently no national database. Service providers will be expected to collect and provide audit data on request.

11. Documents which have informed this Policy

- Greater Manchester Effective Use of Resources Operational policy.

12. Links to other Policies

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

13. Date of Review

One year from the date of approval by Greater Manchester Association Governing Group thereafter at a date agreed by the Greater Manchester EUR Steering Group (unless stated this will be every 2 years).

14. Glossary

Term	Meaning
Blepharoplasty	Surgical repair or reconstruction of an eyelid.
Congenital	Present from birth.
Dehiscence	Release of material by splitting open of an organ or tissue.
Epiphora	Excessive watering of the eye
Levator Aponeurosis	A thin, tendon-like sheath that connects the eye's main opening muscle, the levator muscle, to the upper eyelid's supporting structure (tarsal plate) and skin (see diagram above).
Lid Lag	Delay in moving the eyelid as the eye moves downwards.
Ptosis	A term applied to drooping of the eyelid. It can be unilateral or bilateral, complete or incomplete, acquired or congenital.
Visual field or Field of Vision	The entire area that a person is able to see when their eyes are fixed in one position.
Visual field test	Test that maps out an individual's visual field.
Wick syndrome	The misdirection of tears laterally or along the upper eyelid skin crease causing epiphora.

References

N/A

Appendix 1 – Evidence Review

Title/Topic: Correction of Eyelid Ptosis
Ref: GM047

Search Strategy

Database	Result
NICE	Nil found
NHS Evidence and NICE CKS	• Ptosis and lid lag, Patient.co.uk (not cited) • NHS Modernisation Agency: Information for Commissioners of Plastic Surgery) (not cited)
SIGN	Nil directly related found
Cochrane	Nil directly related found
York	Nil found
BMJ Clinical Evidence	Nil directly related found
BMJ Best Practice	• Section on diagnosis and management of Blepheratosis (Ptosis) (not cited) • **Ptosis: causes, presentation, and management** Finsterer J. Aesthetic Plast Surg. 2003 May-Jun;27(3):193-204. Epub 2003 Aug 21.
General Search (Google)	• Numerous provider websites – not cited • Occuloplastic Surgery (Google e-book) (not cited) • ***Association of Upper-Eyelid Dermatochalasis and Tearing*** *Inbal Avisar, MD; Jonathan H. Norris, FRCOphth; Dinesh Selva, FRACS, FRANZCO; Raman Malhotra, FRCOphth Arch Ophthalmol. 2012;130(8):1007-1012*
Royal College Websites	• Royal college of Opthalmologists website: Current issues and opportunities – Oculoplastic Surgery

Summary of the evidence

Evidence of effective is limited in availability as this is an established procedure carried out for both aesthetic and medical reasons. For aesthetic reasons it is considered a procedure of low clinical value.

It is an effective procedure and should be commissioned where there is a medical indication or significant impairment of the visual field causing functional issues.

The evidence

Levels of evidence	
Level 1	Meta-analyses, systematic reviews of randomised controlled trials
Level 2	Randomised controlled trials

Level 3	Case-control or cohort studies
Level 4	Non-analytic studies e.g. case reports, case series
Level 5	Expert opinion

1. LEVEL 5: EXPERT OPINION

Ptosis: causes, presentation, and management

Finsterer J.

Aesthetic Plast Surg. 2003 May-Jun;27(3):193-204. Epub 2003 Aug 21.

Abstract

Drooping of the upper eyelid (upper eyelid ptosis) may be minimal (1-2 mm), moderate (3-4 mm), or severe (>4 mm), covering the pupil entirely. Ptosis can affect one or both eyes. Ptosis can be present at birth (congenital) or develop later in life (acquired). Ptosis may be due to a myogenic, neurogenic, aponeurotic, mechanical or traumatic cause. Usually, ptosis occurs isolated, but may be associated with various other conditions, like immunological, degenerative, or hereditary disorders, tumors, or infections. Besides drooping, patients with ptosis complain about tired appearance, blurred vision, and increased tearing. Patients with significant ptosis may need to tilt their head back into a chin-up position, lift their eyelid with a finger, or raise their eyebrows. Continuous activation of the forehead and scalp muscles may additionally cause tension headache and eyestrain. If congenital ptosis is not corrected, amblyopia, leading to permanently poor vision, may develop. Patients with ptosis should be investigated clinically by an ophthalmologist and neurologist, for blood tests, X-rays, and CT/MRI scans of the brain, orbita, and thorax. Treatment of ptosis depends on age, etiology, whether one or both eyelids are involved, the severity of ptosis, the levator function, and presence of additional ophthalmologic or neurologic abnormalities. Generally, treatment of ptosis comprises a watch-and-wait policy, prosthesis, medication, or surgery. For minimal ptosis, Müller's muscle conjunctival resection or the Fasanella Servat procedure are proposed. For moderate ptosis with a levator function of 5-10 mm, shortening of the levator palpebrae or levator muscle advancement are proposed. For severe ptosis with a levator function <5 mm, a brow/frontalis suspension is indicated. Risks of ptosis surgery infrequently include infection, bleeding, over- or undercorrection, and reduced vision. Immediately after surgery, there may be temporary difficulties in completely closing the eye. Although improvement of the lid height is usually achieved, the eyelids may not appear perfectly symmetrical. In rare cases, full eyelid movement does not return. In some cases, more than one operation is required.

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2. LEVEL 5: GUIDANCE FOR COMMISSIONERS

Modernisation Agency Information for Commissioners of Plastic Surgery Services

Surgery on the upper eyelid (Upper lid blepharoplasty)

This procedure will be commissioned by the NHS to correct functional impairment (not purely for cosmetic reasons)

As demonstrated by:

- Impairment of visual fields in the relaxed, non-compensated state
- Clinical observation of poor eyelid function, discomfort, e.g.. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow

Rationale: Many people acquire excess skin in the upper eyelids as part of the process of ageing and this may be considered normal. However if this starts to interfere with vision or function of the eyelid apparatus then this can warrant treatment.

Surgery on the lower eyelid (Lower lid blepharoplasty)
This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin.

Rationale: Excessive skin in the lower lid may cause "eyebags" but does not affect function of the eyelid or vision and therefore does not need correction. Blepharoplasty type procedures however may form part of the treatment of disorders of the lid or overlying skin.

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3. LEVEL 5: EXPERT OPINION

Royal College of Opthalmologists website: Current issues and opportunities - Oculoplastic Surgery

PCTs generally decline to provide funding for surgical procedures which are judged to be "cosmetic", or provide funding only in exceptional circumstances. Brow lifts, blepharoplasty, ptosis correction, removal of benign eyelid or skin lesions and procedures to treat watering eyes are often included on lists of procedures for which PCTs do not routinely provide funding.

Although this is an understandable response to difficult economic times, it is important that it does not hinder prompt assessment and treatment where there is a likelihood of malignancy, or where eyelid malposition threatens the ocular surface (eg where eyelashes are abrading the cornea or where the ocular surface is exposed). There should also be provision for treatment where brow droop or ptosis reduce the field of vision to the point where the ability to drive is compromised.

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4. LEVEL 4: CASE SERIES UPPER-EYELID WICK SYNDROME

Association of Upper-Eyelid Dermatochalasis and Tearing

Inbal Avisar, MD; Jonathan H. Norris, FRCOphth; Dinesh Selva, FRACS, FRANZCO; Raman Malhotra, FRCOphth

Arch Ophthalmol. 2012;130(8):1007-1012

Objective: To highlight a case series of patients manifesting epiphora and misdirection of tears laterally or along the upper-eyelid skin crease. This association has been termed *upper-eyelid wick syndrome*.We describe the clinical features and outcomes of management of these patients.

Methods: A retrospective review of patients referred to 2 oculoplastic centers during a 6-year period for epiphora, who were considered to have misdirection of tears related in some way to upper-eyelid dermatochalasis.

Results: Nine patients (7 women and 2 men; mean [SD] age, 61.2 [11.3] years, range, 41-76 years) with bilateral epiphora and lateral spillover (100%), occasionally combined with upper-eyelid wetting (n=2). All patients had upper-eyelid dermatochalasis. Five patients had uppereyelid skin obscuring and in contact with the lateral canthus (type 1), and in 4 the lateral canthus was only partially obscured by upper-eyelid skin (type 2). Five patients (56%) had linear excoriation of skin in the lateral canthus. All patients underwent upper-eyelid blepharoplasty, 3 combined with ptosis repair and 3 combined with eyebrow-lift. All patients achieved 80% to 100% improvement in epiphora following surgical intervention to the upper eyelid. Themean (range) follow-up was 2.8 (1-6) years.

Conclusions: We defined *upper-eyelid wick syndrome* as the misdirection of tears laterally or along the uppereyelid skin crease causing epiphora, related in some way to upper-eyelid dermatochalasis. In all cases, epiphora improved with treatment of upper-eyelid dermatochalasis. Although recognized among physicians, this has never been formally described in the ophthalmic literature, to our knowledge.

Appendix 2 – Diagnostic and Procedure Codes

(All codes have been verified by Mersey Internal Audit's Clinical Coding Academy)

GM047 - Correction of Eyelid Ptosis Policy	
Blepharoplasty of both eyelids	C13.1
Blepharoplasty of upper eyelid	C13.2
Blepharoplasty of lower eyelid	C13.3
Blepharoplasty NEC	C13.4
Other specified excision of redundant skin of eyelid	C13.8
Unspecified excision of redundant skin of eyelid	C13.9
Correction of ptosis of eyelid using levator muscle technique	C18.1
Correction of ptosis of eyelid using frontalis muscle technique	C18.2
Correction of ptosis of eyelid using sling of fascia	C18.3
Correction of ptosis of eyelid using superior rectus muscle technique	C18.4
Correction of ptosis of eyelid using aponeurosis technique	C18.6
Other specified correction of ptosis of eyelid	C18.8
Unspecified correction of ptosis of eyelid	C18.9
With the following ICD-10 diagnosis code(s):	
Ptosis of eyelid	H02.4
Exceptions (ICD-10); the following in a primary or secondary diagnostic position:	
Other disorders affecting eyelid function (*although not specific to Levator Aponeurosis Dehiscence)*	H02.5
Keratopathy (bullous aphakic) following cataract surgery	H59.0