Letters

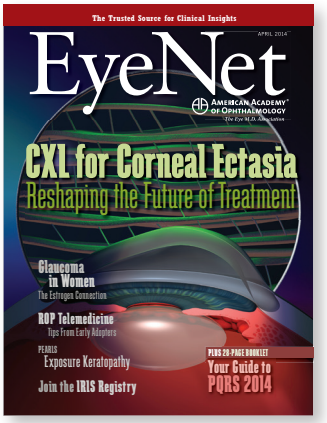
Orbital Floor Fracture

I write in response to "Orbital Floor Fracture Repair: When Less Is More" (Clinical Update, February). As an ophthalmology resident at the California Pacific Medical Center in the early 1970s, I was assigned rotating call for all of the hospitals in the north San Francisco Bay Area, including one in the East Bay, to evaluate orbital floor fractures managed by oral surgery (OS) residents. Hungry to operate, the OS residents slept in the hospital and were assigned exclusive management of all orbital and facial fractures.

In one case, a man who had been struck in the left orbit/globe by a baton presented with a classic orbital floor fracture proven by CT. Fortunately, hospital protocol required that an ophthalmology resident be called to evaluate the status of the eye.

When I arrived, the patient was under general anesthesia and was surrounded by a team of OS residents—with no attending staff member. The group was attempting to elevate the globe out of the maxillary sinus with various crude retractors and elevators. The chief resident asked me who I was and why I was called. I replied, "I'm here to protect the eye." He wasn't impressed but allowed me to examine the status of the retina and the integrity of the globe for a few minutes. After they had wedged a rigid implant into the orbital floor "for support," I asked to reevaluate the status of ocular blood flow to the retina and have a cursory look at freedom of movement of his globe. The chief again challenged my concerns. I finally blurted, "How will you answer if he wakes up blind or with double vision and learns that a dentist operated on his eye?"

Samuel R. East, MD
Ketchum, Idaho



Past issues are available at www.eyenet.org/archives.

WRITE TO US Send your letters of 150 words or fewer to us at *EyeNet Magazine*, AAO, 655 Beach Street, San Francisco, CA 94109; e-mail eyenet@aao.org; or fax 415-561-8575.