Letters

An Insulin Emergency

I read "Prepare for In-Flight Medical Emergencies" (Clinical Update, January) with interest, as it reminded me of a scenario that I happened to encounter on an airplane 30 years ago.

I was flying out of Los Angeles International Airport on the red-eye and was delayed 2 hours before boarding and 2 hours on the tarmac waiting for clearance. Shortly after takeoff and a quick meal—they still served them in those days—I was thinking only about sleep when I heard the announcement "Is there a doctor on the plane?" It was a 747, and, yes, I was the only physician or health care provider on board the aircraft!

I was led to the back of the plane by a very frightened flight attendant to find a nicely dressed middle-aged man, rigid and straight as a board, wedged in his seat in the very last row. It is hard to recall my precise thought process 30 years later, but it is not hard to remember that I was pretty terrified. The gentleman could not speak, but there was a briefcase under his feet, and inside I found a vial of insulin and syringes. He must have administered insulin in the airport anticipating a meal shortly after boarding. There were no medical kits on planes in those days; no stethoscopes or blood pressure cuffs, let alone defibrillators; and certainly no dextrose solution. Oral was out of the question, so my treatment options were limited to recommending an emergency landing to the flight attendant. Minutes after landing, my "patient" was awake and alert and no doubt wondering what he was doing in an ambulance on the way to the hospital.

Thirty years later and 30 minutes after leaving the Academy's 2015 annual meeting in Las Vegas behind, I heard the exact same announcement—it turned out that a business class passenger had a syncopal episode. I was in the process of extricating myself from my seat when it was announced that an EMT was nearby and had matters in hand. The patient spent a few minutes supine in the aisle and then was back in his seat and enjoying peaceful notoriety for the rest of the flight.

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Entropion Repair: Another Method for Consideration

I read with interest "Diagnosis and Management of Involutional Entropion" (Ophthalmic Pearls, February), by Drs. Lo and Glavas. This article accurately notes the condition's multifactorial etiology and describes some general principles of entropion repair.

The article states that a number of factors contribute to this condition, including horizontal laxity of the tarsus and/or canthal tendons, disinsertion of the lower lid retractors, and overriding preseptal orbicularis. It should be noted that entropion may also develop postoperatively after cataract extraction,[1] and might well be overlooked as the patient postoperatively complains of nothing more than "scratching or nonspecific ocular irritation."

Various surgical treatments are noted by the authors, including the Quickert procedure, lower lid retractor reinsertion, and lateral canthal tightening along with tightening of the tarsus. One often effective, but possibly underutilized, treatment for spastic entropion is described by Dr. David H. Saunders[2]—with reference to articles by Tores[3] and Bick[4]—as the "corn crib" technique. In this particular method, the specific "horizontal shortening of the skin, muscle and tarsus brings the lid and globe into tighter apposition" and the "posterior support of the globe helps eliminate the margin from rotating."[2]

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With the specific tightening of the inferior tarsal border, even without further dissection/specific advancement of lower lid retractors, entropion development or recurrence is much less likely to occur. Mauriello[5] described a modified corn crib procedure that adds a Quickert suture "2 to 3 mm lateral to the punctum to plicate the dehisced lower eyelid retractors," but in my experience I have found this additional step unnecessary.

Dr. Saunders found a 3.4% recurrence rate with 58 corn crib lids (followed for an average of 17 months).[2] This indeed has been my experience over the past 25 years of using this alternative approach to entropion repair, which has often allowed me to avoid the need to horizontally dissect and advance the retractors.

This procedure is quite straightforward and applicable to most spastic or senile entropion patients with an often excellent result.

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1 Levine MR et al. *Ann Ophthalmology.* 1992;24(5):195-198.

2 Saunders DH. *Advances in Basic Oculoplastic Surgery Course* [syllabus]. Presented at: Rush Medical College; April 26, 1986; Chicago.

3 Tores LT et al. *Am J Ophthalmol.* 1972;74(2):327.

4 Bick MW. *Ophthalmology.* 1966;75(3):386.

5 Mauriello JA et al. *Ophthalmology.* 1997;104(3):504-507.