Oculoplastics: an evolving specialty

BY RAMAN MALHOTRA

Consultant Ophthalmic and Oculoplastic Surgeon **Raman Malhotra** provides an insight into this increasingly popular subspecialty of ophthalmology.

Oculoplastic surgery refers to plastic, reconstructive and aesthetic surgery of the eyelids, the surrounding facial areas, orbits and lacrimal system. Its scope has extended over the last two decades to the forehead and midface region, mainly due to the recognition that eyelids should be managed by specialists in this region and cannot always be treated in isolation to the face. In fact, as an aesthetic discipline it may be thought of as oculo-facial surgery. This transformation has resulted in a subspecialty of ophthalmology to be now considered a specialty in its own right, certainly by those seeking aesthetic treatment in the eyelid region. At the turn of this century, ophthalmic trainees considered simple ptosis surgery, dacryocystorhinostomy and correction of eyelid malposition to be core competencies of ophthalmic specialty training. However, many of these are now procedures only undertaken following fellowship training in oculoplastics. Factors to explain this include an evolution in our understanding of orbito-facial diseases and the factors that need addressing in such disorders, as well as the expansion of technique repertoire and complexity.

The specialty has undergone a paradigm shift to include non-surgical modalities. Ophthalmology was the first specialty to use botulinum toxin as a therapeutic agent and hyaluronic acid as a viscoelastic expander. Oculoplastics has embraced both of these for both functional, as well as aesthetic indications. Lacrimal surgery has evolved to include endoscopic endonasal approaches, both for children and adults. Orbital decompression surgery as been honed to minimally-invasive and individually-tailored approaches. Techniques in aesthetic rejuvenation now cross over for therapeutic indications. Rehabilitation for conditions such as thyroid eye disease and facial palsy are now aimed at restoring natural appearance, with interventions at thresholds now significantly lower than for sight-threatening indications. The management of periocular malignancies has improved with a deepening evidence-base. Some form of margin-controlled excision of tumours in order to minimise the unacceptable occurrence of incomplete excision now forms the mainstay of tumour removal. However, non-surgical modalities are available either as adjuncts or alternatives. The use of Mohs excision is another example of the cross-speciality reach of oculoplastics. Nowadays, periorbital and oculo-facial reconstruction can involve co-management with ENT, maxillofacial, plastic and even neuro-surgery. As a trainee, I still remember the words of one of my mentors: "I like oculoplastics, because it gets you out the eye."

What are the best places to learn reconstructive and orbital surgery and which can be recommended to learn lid surgery?

Organising a trainee selected component (TSC) in oculoplastics (previously known as advanced specialist training opportunity – ASTO) is always a good start. This is a formalised period of training vetted and monitored by the Royal College of Ophthalmologists.

A listing of available UK oculoplastic fellowships may be found at http://www.bopss.co.uk/fellowship-listings/ The exposure to orbital surgery is indicated for each fellowship.

In some respects, my first response to such a question would be "To what level do you wish to learn?" and "What are your career goals, interests and personal commitments?" Simply put, there is no point seeking tertiary-referral level orbital training if you wish to pursue a career in ophthalmology in a geographical region where only secondary care is provided. Conversely, the pursuit of a tertiary-referral specialist practice as a long-term goal may prove difficult if you are unable to travel beyond your training region. It is always useful to speak to oculoplastic consultants and fellows for advice. Do not be put off by the lack of jobs advertised at this point in time. The situation regarding available consultant posts is incredibly fluid and ever-changing. If you enjoy your subject, then you should remain passionate towards maintaining the highest standards in your training. This in itself will ensure your skills and achievements. Competition for selection has been tough, not only for medical school, but then for ophthalmology and beyond that, for a fellowship in oculoplastics. It then defies logic to opt for career choices based upon perceived lack of competition for consultant posts. If a career in oculoplastics interests you, then go for it!

With planned changes to NHS funding and accreditation, will the spectrum of procedures performed at district hospitals be limited to lid surgery (for oculoplastic surgeons)?

It is certainly foreseeable that some of oculoplastics may be considered lower-priority and accordingly be affected by NHS funding. It behoves us to continue clinical audit and evaluation with QoL and PROMs to demonstrate the functional benefit of procedures. Many

eyelid, orbital and lacrimal disorders will have sight-threatening potential and we need to ensure the design and quality of NHS research in oculoplastics helps establish and / or reinforce the need for treatment of these disorders. This is a crucial question that needs to be asked from the outset when embarking upon a research project in oculoplastics.

What affected your career choice?

My priorities for a desirable ophthalmic sub-subspecialty included:

- Need for a good breadth of surgical repertoire.
- Crossover with neuro-ophthalmology, ocular surface and strabismus.
- Involvement of systemic health and disease.
- Ability to undertake both adult and paediatric care.
- The ability to apply a creative approach to my work.

What is the best way to get a fellowship? What makes the perfect candidate?

In my opinion, fellowship training begins the day you decide to pursue a subspecialty interest in oculoplastics. At that moment, trainees should read all oculoplastic papers that appear in the main ophthalmic journals. Concentrate on the discussion, not just the abstract! This provides valuable insight into the background and controversies of each topic. Knowledge is the foundation of your learning and does not begin the day you commence your first fellowship, it is cemented at that stage. Aim to familiarise yourself with every procedure you are exposed to during your basic ophthalmic training. Make notes the same evening with specific attention to steps, how instruments were held, specific equipment used, pitfalls and difficulties highlighted or encountered. Try and visit oculoplastic consultants in your study sessions, or even take leave to observe them. Become involved in on-going research projects. Be prepared to devote your spare time in doing so. Most importantly, complete what you start!

The perfect candidate demonstrates their interest rather than simply expresses it.

Is it worth considering fellowship abroad?

Yes, for life experience. A particular centre overseas may provide additional specialist expertise that may be limited or unavailable in the UK.

How would you design the perfect ASTO? Would you involve other specialties?

The perfect ASTO should not just be considered an introduction to a sub-specialty. It can be a phenomenal opportunity for an intense period of enhanced training. Clear achievable aims and objectives should be set at the outset and both parties should be held accountable for its delivery. A curriculum should be set out and minimum standards to achieve established. The case mix should be broad and involve direct supervision during outpatients and theatre.

In outpatients, trainees should present new cases as long cases and be prepared to justify plans of management. In the operating theatre, a trainee should come prepared, knowing how to carry out a procedure even if they have not seen one before. In the era of internet, Youtube, electronic media etc. it is hard to justify the absence of literature available to facilitate this. Having such a proactive approach will fast track your learning. Trainers should also supervise surgery to ensure basic surgical techniques, including tissue handling, identifying tissue planes and anatomy etc. is excellent.

What oculoplastic courses and other resources can you recommend?

Attend all RCOphth seminars and symposia in oculoplastics and consider attending the American Academy of Ophthalmology annual meeting, particularly with a view to taking the courses in oculoplastics (need to book early).

Valuable video tutorials are available at:

- http://oculoplastics.info/
- https://www.youtube.com/

In addition to reading journal articles, you should obtain major reviews on all major topics in oculoplastics and familiarise yourself with the background, history and evolution of each topic. Also familiarise yourself with seminal papers on each topic. Lastly, obtain one or two good textbooks, but consider this a basic knowledge. Do not rely upon this as your core basis of knowledge. This is merely an introduction and within a few years will no longer be sufficient even as a reference source.

How do you think the subspecialty is likely to change over the next 10 years?

Oculoplastics will continue to evolve into a speciality in its own right, within the discipline of ophthalmology. Areas such as periocular tumour management, thyroid orbitopathy and, to a degree, facial palsy management already have a multidisciplinary team approach in order to optimise outcomes. This will continue to develop and become established. Oculoplastics will increasingly dominate aesthetic medicine as a specialty to manage the eyelid region; however, this requires continued enthusiasm and skill from within our current generation of peers. Lastly, oculoplastics will always remain the ideal linchpin for an individual wishing to combine ophthalmology, paediatrics, plastic surgery, neuro-ophthalmology, strabismus, ocular surface care and general medicine.

Acknowledgement
Questions posed by Katarzyna Klodnicka, Manchester Royal Eye Hospital.

Raman Malhotra,
Consultant Ophthalmic and Oculoplastic Surgeon, Queen Victoria Hospital, East Grinstead, UK.
E: raman.malhotra@qvh.nhs.uk

Declaration of Competing Interests
None declared.