

## Where can I get more information and can I make contact with fellow sufferers?

Many people find the changes in appearance with thyroid eye disease very distressing and contact with other sufferers who have been through the same thing is very helpful. You can make contact with other people through the Thyroid Eye Disease (TED) self-help group. There may be a local TED group near you.

**Thyroid Eye Disease (TED)** Head Office, Solstice, Sea Road, Winchelsea Beach, East Sussex TN36 4LH UK

e-mail: [tedassn@eclipse.co.uk](mailto:tedassn@eclipse.co.uk)

Phone/Fax 01797 222 338

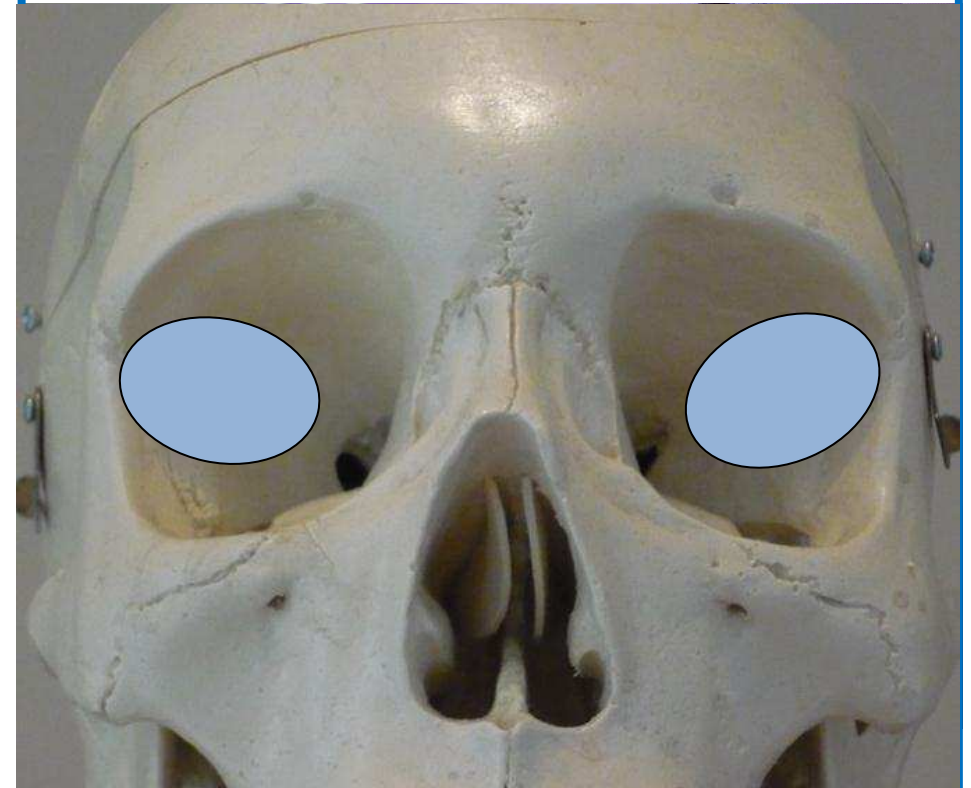
## References

If you require a full list of references for this leaflet please email [patient.information@ulh.nhs.uk](mailto:patient.information@ulh.nhs.uk)

The Trust endeavours to ensure that the information given here is accurate and impartial.



If you require this information in another language, large print, audio (CD or tape) or braille, please email the Patient Information team at [patient.information@ulh.nhs.uk](mailto:patient.information@ulh.nhs.uk)



# Lateral Wall Decompression

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Royle Eye Department, Pilgrim Hospital  
01205 445626  
[www.ulh.nhs.uk](http://www.ulh.nhs.uk)



## **Aim of the leaflet**

This leaflet aims to tell you what lateral wall orbital decompression is and who might need this surgery.

## **What is lateral wall decompression and why might I need this operation?**

Lateral wall orbital decompression is undertaken to increase the space in the orbit (the bony socket that contains the eyes); this is usually carried out in patients with thyroid eye disease.

Thyroid eye disease can result in the eyes protruding forward (proptosis). Once your thyroid eye disease is no longer active and has been stable for a number of months it is possible to have lateral wall decompression to help the eyes move back into place. This reduces the staring appearance and can help dry eye symptoms, ache behind the eyes and sometimes lid retraction (this is where the whites of your eyes are visible above and below the coloured part of your eyes).

The results of the operation can vary according to individual factors. If the orbital fat is very scarred it may not move (prolapse) through the new space created. If you have very enlarged muscles, shallow orbits or very large eyes, such as in people who are extremely short-sighted, these factors can have an effect on the final surgical result.

Orbital decompression is usually the first step in a number of rehabilitative operations to treat the result of your thyroid eye disease. If you need squint surgery this is usually carried out second, followed by lid surgery, which may include removing excess skin or fat around the eyes or treating lid retraction. These operations can take many months and sometimes over a year to complete.

## **What happens after the operation?**

Your eye will be padded overnight. You will need to stay in hospital overnight and your pad and drain will be removed in the morning.

It is normal to have swollen lids initially; this will gradually improve. Contact your GP or relevant eye department listed below if you have severe pain, increasing swelling, redness or significant discharge. This could be a sign of infection.

Resolution of post-operative swelling and bruising can vary between patients. Bruising will usually resolve over 2-3 weeks. Swelling takes longer but most will resolve over 6 weeks. The main effects of the operation are seen over the first 3 months but there can be small changes for up to a year.

Try to avoid strenuous activity for 2 weeks after surgery. Many people need at least 2 weeks off work.

## **Contact details**

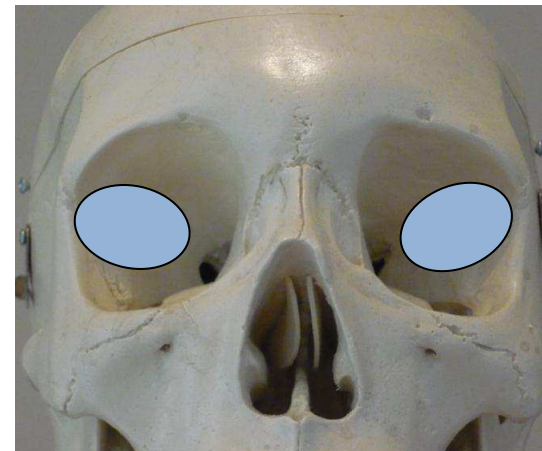
If you have any questions about any of the information contained in this leaflet please contact the Royle Eye Department on 01205 445626.

- **Infection** – this can usually be treated with antibiotics.
- **Asymmetry** – the human face and eye region are normally asymmetrical. There can be variation from one side to the other following surgery.
- **Further surgery** – occasionally it is necessary to have a further operation.
- **Loss of sensation** – any incision can cut through nerves, it is possible to have some numbness around the incision site. This usually resolves over a number of months; occasionally it may be permanent.
- **Allergic reactions** - in rare cases local allergies to tape, suture material, ointments or drops have been reported. Systemic reactions (reactions involving the whole body), which are more serious, may occur to drugs used during the operation and to prescription medicines. Allergic reactions may require additional treatment.
- **Wobble of vision** – rarely some patients report a very slight wobble of vision whilst chewing.

There is also an operation called a medial wall orbital decompression: this can be carried out as an emergency operation for optic nerve compression, which can lead to loss of vision. Alternatively it can be used to treat proptosis in patients with inactive thyroid eye disease who are very proptosed, in addition to a lateral wall decompression. This operation has higher risks attached to it and is not carried out in this department. However, if this operation is the appropriate treatment option for you, you will be referred to a department in the hospital that provides this operation.

### **Surgery – what happens during the procedure?**

This operation is done under a general anaesthetic so that you are asleep. You will have a skin incision at the outside corner of your eye. This allows access to the bone of the lateral orbital wall. Bone is removed to create a window so that the tissue inside the orbit can prolapse through it, to increase the orbital space; see picture below.



The blue ovals represent the area of bone that is removed during lateral orbital wall decompression.

The incision is then stitched and a plastic drain is placed where the bone has been removed in order to catch any bleeding; the drain is visible.

## How should I prepare for surgery?

You will need to have a CT scan of your orbits prior to surgery, which allows planning of the operation. This will be booked for you. You will have a pre-assessment appointment prior to the operation to ensure that you are fit for surgery.

If you are taking aspirin or any other blood thinners you will need to inform your surgeon as you may need to stop these. This decision is made on an individual basis and you should only do so if it is safe and you have been instructed by your GP, surgeon or anaesthetist. This will be discussed with you before surgery.

Some anti-inflammatories such as ibuprofen and nurofen can also make you more likely to bleed; you should stop these two weeks prior to surgery. If you cannot stop blood thinners it may not be appropriate to go ahead with surgery.

All herbal medicines should be stopped at least 14 days before surgery.

Smoking impairs healing and if possible you should try to stop 6-8 weeks prior to surgery.

If you have high blood pressure ensure that this is well controlled as it will make you more likely to bleed and bruise.

You should bring a list of your current medications and any allergies with you.

You will not be able to drive yourself home after the procedure. Please arrange for someone to accompany you home.

## Surgery – what are the complications?

- **Bruising and swelling** – this happens after the operation in everyone.
- **Blurred vision** – this is often due to the ointment used on your wounds.
- **Chemosis**—swelling of the clear covering of your eye (conjunctiva) which can last a few weeks.
- **Watering** – this is common and occurs due to irritation of the eyes.
- **Corneal abrasion** – a scratch to the front of the eye; this can be painful but it will normally heal very quickly.
- **Scarring** – wounds heal very well in the majority of people. However, abnormal scars may occur both within the eyelid and the deeper tissues. Scars may be unattractive and of a different colour to surrounding skin.
- **Haematoma** – a sudden bleed around the eyeball; the eye is pushed forward, the vision often reduces and it is usually painful. This is very rare but a bleed can crush the optic nerve and cause loss of vision long term. This needs urgent treatment.
- **Loss of vision** - any orbital surgery carries a very small risk of permanent loss of vision. This could be due to damage to the optic vision during the procedure or bleeding after the operation.
- **Double vision** - any orbital surgery carries with it a small risk of double vision. In most cases it is temporary but rarely it is permanent. Permanent double vision may usually be corrected with surgery or prisms in spectacles.