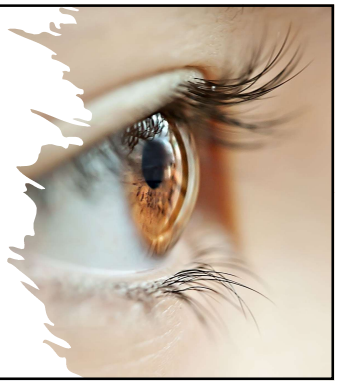
Advances in Eyelid Lesion Management and Lacrimal Procedures for Optometrists



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No financial disclosures

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Learning Objectives

1. Understand the anatomy of the skin, eyelid, and lacrimal system as it pertains to lesion formation.
2. Differentiate between various epidermal, dermal, follicular, and glandular eyelid lesions.
3. Recognize the distinguishing clinical features of chalazion differentials such as sebaceous carcinoma and preseptal cellulitis.
4. Review the process and technique for infiltrative injections, lesion excisions, and suturing.
5. Learn proper surgical techniques for treating lesions, including incision and curettage and radiofrequency excision.
6. Understand conservative and surgical treatment modalities, risks, and informed consent discussions.
7. Gain foundational knowledge of appropriate post-operative care and follow-up protocols.
8. Acquire a basic understanding of billing and coding for minor surgical procedures in optometric practice.

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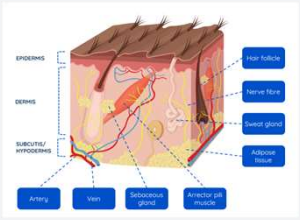
Anatomy of the Skin



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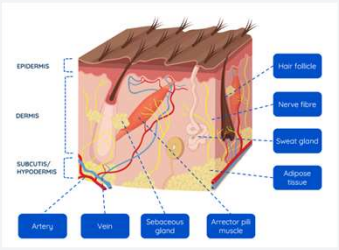
Epidermis

- Actinic Keratosis
- Basal cell carcinoma
- Keratoacanthoma
- Melanoma
- Molluscum contagiosum
- **Papilloma**
- Seborrheic keratosis
- Squamous cell carcinoma



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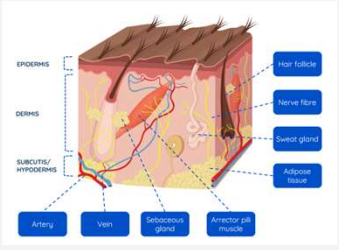
Dermis

- Abscess
- Amyloidosis
- Cellulitis
- Fibrocytic tumors
- Merkel cell carcinoma
- Sarcoidosis



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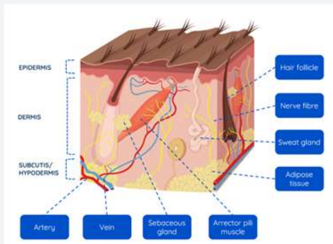
Hair Follicle



- **Epidermoid cyst**
- Trichilemmoma
- Trichilemmal carcinoma
- Trichilemmal cyst

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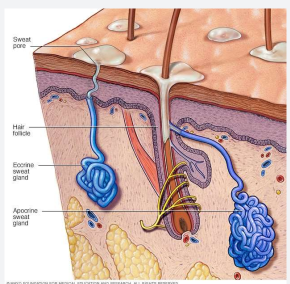
Sweat Glands

- Apocrine gland
    - **Apocrine hidrocystoma**
    - Apocrine adenoma
- Eccrine gland
    - **Eccrine hidrocystoma**
    - Eccrine adenoma



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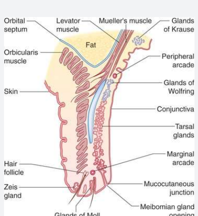
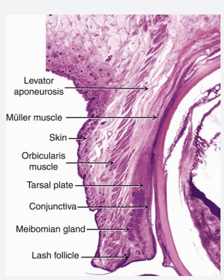
Eyelid Anatomy

- Orbicularis Oculi
- Tarsal Plate
- Meibomian Glands
- Hair Follicles
- Glands of Moll
- Glands of Zeiss





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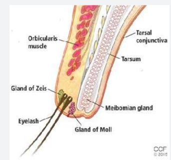
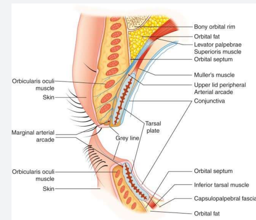
Eyelid Cross Section

- Eyelid skin is thinnest skin in the body
    - Allows for quicker healing and less scarring





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Surgical Anatomy Terminology

- Considered in lamellar layers
- Upper eyelid
    - Anterior lamella
    - Middle lamella
    - Posterior lamella
- Lower eyelid
    - Anterior lamella
    - Posterior lamella

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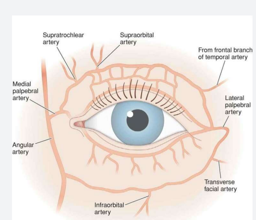
Vascular Supply of the Eyelids

- **Marginal Arcades**
    - Ophthalmic and lacrimal arteries branch into medial and lateral palpebral arteries
    - Travel through the septum and anastomose to form the tarsal arcades
        - Located between orbicularis and tarsal plate
        - Then anastomose with the superficial temporal, transverse facial, and infraorbital arteries
- **Peripheral Arcades**
    - Upper eyelid has secondary peripheral arcades
        - You will have more bleeding in procedures of the upper eyelid!
    - Superior branch of medial palpebral arteries
        - Supply orbicularis, skin, conjunctiva, and tarsal glands



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Sensory Innervation of the Eyelids

OPHTHALMIC DIVISION (V1) OF TRIGEMINAL NERVE

- Lacrimal
  - Innervation of lateral upper lid
- Frontal
  - Supratrochlear
    - Innervation of medial upper lid
  - Supraorbital
    - Innervation of central upper lid, forehead, scalp
- Nasociliary
  - Infratrochlear
    - Innervation of medial aspect

MAXILLARY DIVISION (V2) OF TRIGEMINAL NERVE

- Zygomaticofacial
  - Innervation of lateral lower lid
- Infraorbital
  - Forms the external nasal, internal nasal, and palpebral branches
    - Innervation of lower eyelid and conjunctiva

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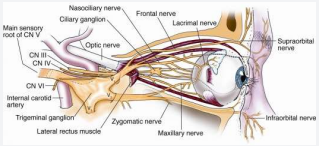
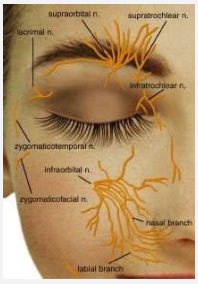
Sensory Innervation of the Eyelids





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Injectable Anesthetics

- Lidocaine 2% (shorter acting), bupivicaine (longer acting)
- Epinephrine addition
  - Vasoconstricts
  - Keeps anesthesia more local
  - Less bleeding
  - Some risk in heart disease
- Sodium bicarbonate addition
  - Increases pH
  - Causes less sting and can improve diffusion of bupivicaine
  - Does decrease shelf life of anesthetic
- For optometric procedures we commonly use lidocaine
- For longer ophthalmic procedures bupivicaine is considered

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Application of Infiltrative Anesthesia

Pre-tarsal subcutaneous block

Anesthesia to anterior lamellae
- Skin, orbicularis, septum, anterior tarsal plate

Subcutaneous injection

Retrotarsal block

Anesthesia to posterior lamella
- Posterior tarsal plate, palpebral conjunctiva

Sub-conjunctival injection

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Infiltrative (Anesthetic) Injections

Prepare Medication	• 1 mL syringe with 27-gauge ½ inch needles • Draw up to a full mL (dependent on size of lesion)
Patient Asepsis	• Wipe area with either alcohol or betadine
Insert Needle	• Pull patient's skin taut for better accuracy • Insert needle bevel up at 15-degree angle
Injection	• Slowly inject medication • Pro tip: pause after small amount of medication is injected to allow for better patient comfort
Withdraw Needle	• Safely withdraw needle and immediately dispose into sharps container
Apply Pressure	• Apply light pressure to injection site and softly massage • Too much pressure/massage may cause vasovagal response

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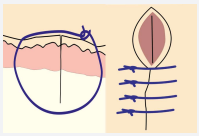
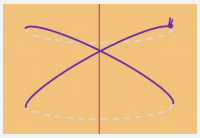
Suturing 101

- Occasionally, you will need to close a wound
- Simple interrupted suture
- Figure 8 (or Figure X) suture
- Alternatives to suturing
  - Wound closure adhesive
  - Steri-strips





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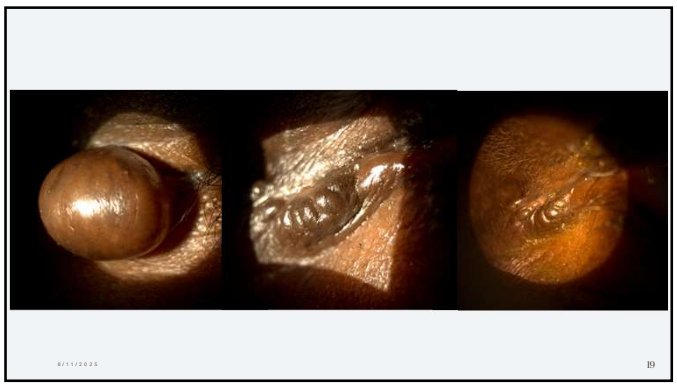

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Drainage Versus Total Excision

DRAINAGE

- Less painful as no infiltrative injection is needed
  - Like draining a blister
- More likely to recur since cyst wall is not removed

TOTAL EXCISION

- Less likely to recur since cyst wall is removed
- Higher risk of post-operative complications
- Requires use of infiltrative (anesthetic) injection

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HIDROCYSTOMA

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Drainage Procedure

Pre-Operative

- Blood Pressure and pulse
- Informed consent

Procedure

- Asepsis
- Utilize bevel of small gauge needle to insert into lesion and make a vertical "cut"
- Utilize cotton tipped applicators or forceps and gauze to drain
- Apply abx ung to area

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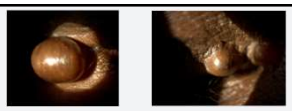
Hidrocystoma Classifications



- Smith versus Robinson
  - Smith (solitary)
    - Skin-colored, dome-shaped
    - Usually along lower lid and canthus
    - Females = males
  - Robinson (multiple)
    - Smaller in diameter
    - Females > males
    - Associated with hyperhydrosis, high humidity environment, Graves disease

- Apocrine versus Eccrine
  - Apocrine (originates from apocrine sweat glands)
    - Usually adjacent to hair follicles
    - Firm, dome-shaped, blue/grey-hued or milky
    - Proliferative
    - Do not increase in size due to humid/hot weather
    - Found: upper/lower eyelids, eyebrow, canthi, periorbital
  - Eccrine (originates from eccrine ducts)
    - Considered a retention cyst
    - Small and translucent (will transilluminate!)
    - Made worse by hot/humid weather and excess sweating
    - Mainly found medial or lateral canthi

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Total Excision of Hidrocystoma

Pre-operative

- Obtain blood pressure and pulse
- Informed consent

Procedure

- Asepsis
- Infiltrative injection
- Create incision or utilize scissors
- Drain lesion
- Remove cyst wall
- Suture (if applicable)
- Apply abx ung

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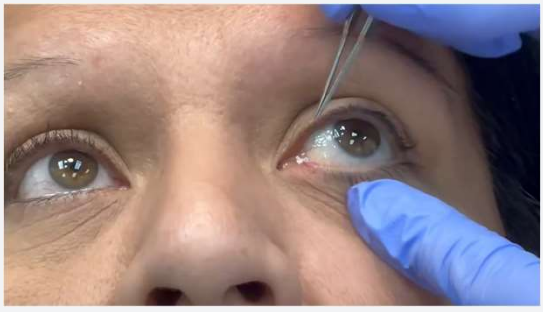

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Post-Operative Care of Hidrocystoma

- Re-measure blood pressure and pulse and ensure patient is safe to leave the clinic
- Educate on potential post-operative complications
- Have patient apply abx ung twice daily for 7-10 days
- Follow up as needed for observation/suture removal

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EPIDERMOID CYST

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Epidermoid Cyst Attributes

- Benign, slow growing cyst
- Usually solitary, round, elevated, and freely mobile
- Contents appear "feta cheese-like"
- Usually painless, but can become infected and inflamed
- Cause: buildup of epidermal cells (dead skin cells) in a confined space

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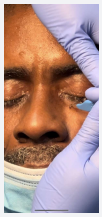
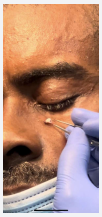
Excision of the Epidermoid Cyst

- Begin with obtaining blood pressure and pulse and informed consent
- Patient asepsis
- Anesthetize area **underneath** the lesion
- Make a small incision
- Utilize tissue forceps, cotton tipped applicators, and surgical scissors to remove all contents
- **MUST** remove cyst wall or the cavity will refill
- May need to suture if the wound is 3mm or larger





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Post-Operative Care of Epidermoid Cyst Excision

- Same as hidrocystoma!
- Re-measure blood pressure and pulse and ensure patient is safe to leave the clinic
- Educate on potential post-operative complications
- Have patient apply abx ung twice daily for 7-10 days
- Follow up as needed for observation/suture removal

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PAPILLOMA

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Papilloma Classifications

- Sessile
  - Attached directly by the base
  - Wound size will be the size of the full lesion
- Pedunculated
  - An elongated stalk of tissue

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RADIOFREQUENCY OR TRADITIONAL EXCISION?

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Radiofrequency (RF)

- Works by generating heat using high-frequency waves to simultaneously cut and coagulate tissue
- Must be used on wettened skin
  - Unit heats up the water molecules between the probe and the grounding plate
- Minimally invasive and more precise than a scalpel

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Traditional Excision

Procedure

- After local anesthetic, a blade or pair of surgical scissors can be used to excise papilloma
- Goal is to shave or cut as close to the base as possible
- Traditional methods are easier to perform on pedunculated papillomas

Post-operative care

- Hemostasis with sterile gauze
- If no contraindications, may cauterize with RF unit (but WHY???)

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Radiofrequency Excision

Procedure	• After local anesthetic, radiofrequency can be used to excise a papilloma
	• There are different electrode shapes, each serving a different cutting or excision style
	  • Circular loop electrode easily removes a pedunculated papilloma, aimed at the base of the lesion
	  • A ball electrode better removes a sessile papilloma, ablating the lesion layer-by-layer

Post-operative care	• RF has minimal to no bleeding post excision • Immediate post-operative application of steroid cream • Minimizes risk of scarring
Contraindications	• Use of oxygen tank or similar equipment • Use of pacemaker • History of keloid or hypertrophic scarring

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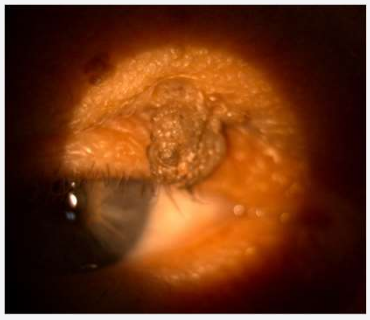

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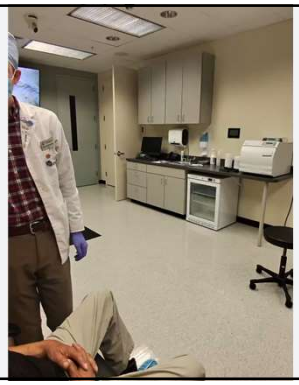

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CHALAZION AND ITS DIFFERENTIALS

HORDEOLUM, PRESEPTAL CELLULITIS, ORBITAL CELLULITIS, SEBACEOUS CARCINOMA

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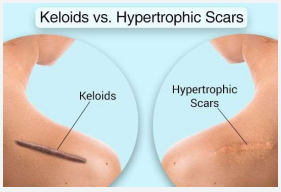
Complications of Papilloma Excision

- Bleeding if lesion is vascularized
- Scarring
  - Mitigated with immediate s/p application of abx/steroid with RF
  - Hypertrophic – continual collagen production causing visible scar
  - Keloid – thicker and more disorderly arranged excess collagen
- Lid notching
- Recurrence
  - Especially if not fully excised



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HORDEOLUM

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Post-Operative Care of Papilloma Excisions

- Repeat blood pressure and pulse
- Achieve hemostasis
  - Either sterile gauze and pressure or use of RF unit
- Steroid cream application, if applicable
- Have patient apply abx ung twice daily for 7-10 days
- Follow up as needed for observation/suture removal

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Chalazion versus Hordeolum

HORDEOLUM

- Acute
- Inflammatory or infectious
- Painful to touch
- Can become a chalazion

CHALAZION

- Chronic
- Inflammatory
- Not painful, firm to the touch
- Can become further inflamed or infiltrated by a pathogen

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Treatment of Hordeolum

- Surgical intervention is NOT recommended in cases where active infection is present
  - As infection subsides may be removed with incision and curettage
- Palliative methods are the standard
  - Warm compresses
  - Oral antibiotics

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Augmentin

- Penicillin based antibiotic that targets the cell wall
- Amoxicillin PLUS clavulanic acid (penicillinase inhibitor)
- Better gram (-) coverage
- MOA: inhibit transpeptidase (linking of peptidoglycan)
  - Prevents bacteria from growing
  - Clavulanic acid prevents bacterial resistance
- Small chance of hypersensitivity

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Azithromycin

- Commonly used as a Z-Pak
  - 5-day course of azithromycin
- Macrolide antibiotic
- MOA: inhibits bacteria from making protein
  - Binds to the 50s subunit of the ribosome
- Safe for pregnancy!

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Doxycycline

- Tetracycline antibiotic
- More side effects
  - Teeth discoloration
  - Bone growth retardation
  - IIH
- Contraindicated in pregnancy and children
- MOA: inhibits bacteria from making protein
  - Binds to the 30s subunit of the ribosome

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PRESEPTAL AND ORBITAL CELLULITIS

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Preseptal Cellulitis

- Eyelid or adnexal infection
- Usually has accompanying redness and chemosis
- May spread from existing lid lesion or adjacent sinuses

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SEBACEOUS CARCINOMA

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Treatment of Preseptal Cellulitis

- Oral antibiotic to prevent further infection or worsening of condition
- Has an opportunity to worsen to orbital cellulitis

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Sebaceous Carcinoma

- Cancerous lesion of a sebaceous gland
- Mainly seen in adults over the age of 60
- VERY rare, but aggressive
- Often present similarly to a chalazion
  - However, these WILL recur – a clinical indicator of malignancy
- Associated with madarosis

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Preseptal versus Orbital

Differ in:	Location:	Severity:	Symptoms:	Treatment:
Location, severity, symptoms, and treatment	Preseptal: limited to soft tissue in front of orbital septum Orbital: spread behind orbital septum • Affects orbit, EOMs, adipose tissue	Preseptal <<<<<< Orbital	Orbital will have severe eye pain, painful and/or restricted EOMs, proptosis, fever, blur/loss of vision	Orbital requires treatment with IV antibiotics versus oral antibiotics for preseptal

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Statistics of Sebaceous Carcinoma

Incidence	• Rare, accounts for <1% of skin cancers • Higher prevalence in Asian populations
Location	• 75% occur in eyelid
Recurrence Rate	• Up to 30% after surgical removal
Metastasis Risk	• 20-25% develop regional lymph node metastasis • 5-10% metastasize to lungs, liver, or brain

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Diagnosis and Treatment of Sebaceous Carcinoma

REQUIRES CONFIRMATION VIA BIOPSY

COMPLETE SURGICAL EXCISION CRUCIAL TO PREVENT METASTASIS

MANY TIMES, EXCISION IS FOLLOWED UP WITH RADIATION AND/OR CHEMOTHERAPY IN CASES WHERE BIOPSY MARGINS ARE POSITIVE OR THERE IS EVIDENCE OF METASTASIS

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What is a Chalazion?

- Chronic lesion that is considered lipogranuloma
  - Aka a nodule of granulomatous material
- Occur due to stagnant materials and secretions in tarsus
- Singular or multiple
- Recurrent
- Benign!!!
- Affect all ages, frequent adult population more
- More likely to occur on upper eyelid

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Morbidity and Mortality

Mortality rate

- 5-year survival rate is 50-90%
- Higher mortality rate in cases with metastasis (up to 50%!)

Morbidity

- Significant due to aggressive nature
- Local tissue damage
- Vision impairment
- Metastasis

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Complications of a Chalazion

Irritation, inflammation, eyelid deformities → Cosmetic disturbances

Mechanical ptosis
- Mainly in larger lesions

→ Blurry vision
- Induced astigmatism secondary to lesion pressing on cornea

Can become further inflamed or infiltrated by a pathogen → Can cause a conjunctivitis or even cellulitis

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CHALAZION

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Treatment Methods

- Conservative
- Intralesional injection
- Intense pulsed light therapy (IPL)
- Incision and curettage
- Combination Therapy

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Conservative Treatment of the Chalazion

EYELID HYGEINE

WARM COMPRESSES

ANTIBIOTICS NOT USUALLY INCLUDED

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Intralesional Injections

- Effective due to anti-inflammatory action of steroid medications
- Possess vasoconstrictor properties
- Great option for difficult lesions, cautious patients, or those with contraindications for other therapies
- May cause hypopigmentation is patients with African-American descent
- Use caution in patients that are or could be steroid responders

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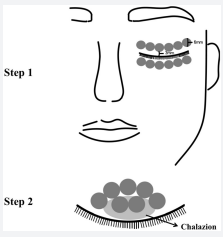
Intense Pulsed Light Therapy

- Brief pulses of non-coherent and polychromatic light to obtain antimicrobial and anti-inflammatory effects
- Usually performed in conjunction with meibomian gland expression
- Great option for those intolerant or unable to injections or surgical excision
- Has shown to have similar efficacy to incision and curettage
  - Acute lesions respond quicker than chronic lesions
  - May require multiple sessions 2-4 weeks apart
- Extra benefit of improving meibomian gland function
- Technique:
  - Topical anesthetic and corneal shield placement prior to procedure
  - Apply thin layer of ultrasound gel
  - Two passes of traditional MGD treatment followed by 2-3 pulses directly on top of lesion



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Incision and Curettage

- Usually indicated for large lesions that are creating ptosis or inducing astigmatism
- Indicated if a biopsy of the lesion is warranted
- Begins with local anesthetic
- Utilizes clamp placement to access lesion from the palpebral conjunctiva
- Small incision created and contents disrupted using curette and cotton-tipped applicators
- Wall of lesion must be removed to prevent recurrence

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Pre-Operative Care

Obtain informed consent

Review potential risks and complications

Obtain vitals

BP/pulse

Describe the procedure

Answer any questions the patient may have

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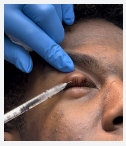

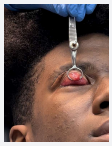

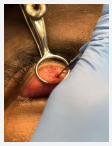

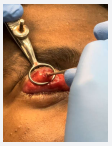

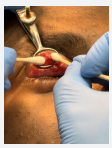

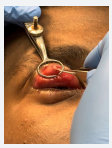

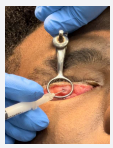

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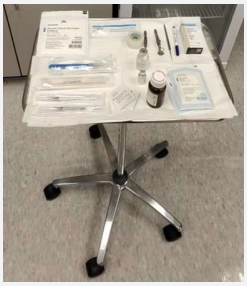
Surgical Tools Utilized



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Perform Thorough Curettage

- Using a properly sized curette, aggressively scramble the contents of the chalazion to loosen them from the surrounding wall

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Clamp Placement

- Once anesthetic is verified administer a drop of proparacaine 0.5%
  - Makes the placement of the clamp much more comfortable for the patient
- Apply clamp with the ring facing the globe
- Thoroughly tighten the clamp so the lid is secure when everted
- Evert lid to expose the chalazion from the palpebral side

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Express Contents

- Can use curette and/or cotton tipped applicators
- Important to express the entirety of the contents of the lesion

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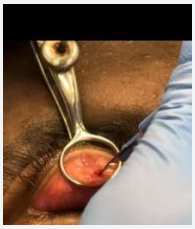
Make Initial Incision

- Locate chalazion within the clamp
- Using a scalpel, make initial incision
  - Usually 1-3 mm wide – remember a larger wound may require sutures!
  - Ensure you continuously tighten the clamp as the lid volume will decrease
  - 11-blade versus 10-blade



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Remove the Wall

Using tissue forceps and surgical scissors remove full chalazion wall to prevent recurrence

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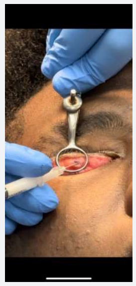
Optional Combination Steroid



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Post-Operative Care of Incision and Curettage


THE EYE CENTER

Post-Operative Patient Handout

Wound care:

- ☐ If pressure patched, remove pressure patch after 1-2 hours
  - A little bit of blood on the pad is normal
- ☐ Do not scrub or pick at removal site
- ☐ Clean gently with soap and water to remove any dried blood or crust
- ☐ Apply prescribed (____________) to the area twice daily for one week
- ☐ Perform warm compresses as much as you can tolerate over the next 2-3 days
- ☐ If tolerated, you may take Tylenol for pain. Avoid aspirin or Motrin, as these medications can increase the risk of bleeding.
- ☐ Take oral antibiotic (____________) (____) times per day for (____) days.

When to Contact the Office:

- **Excessive bleeding**
  - Apply pressure to the area 5-10 minutes. If bleeding continues, continue holding pressure and contact The Eye Center at SCO.
- **Signs of infection**
  - A small area of redness and swelling is normal post procedure. If you experience increased redness, swelling, pain, pus, or abnormal draining, contact The Eye Center at SCO.
- **Fever**
  - Temperature greater than 100.5 for more than 24 hours

- Achieve hemostasis
- Flood eye with antibiotic or antibiotic/steroid ointment
- Pressure patch eye
  - Patient may remove patch after 1-2 hours
- Advise on warm compress use for 2-3 days
- Antibiotic ointment versus ointment and oral antibiotic therapies post-procedure

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Combination Therapy Considerations

Combination of I&C with steroid injection
- Reduces recurrence rate
- Decrease in healing time
- Ability to use transpalpebral approach
  - Lessens risk of hypopigmentation

Combination of I&C with IPL therapy
- Shows decrease in healing time
- Aids in prevention of new chalazia
- Aids in structural improvement of meibomian glands

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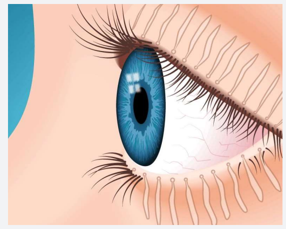
Meibomian Glands Impacted by I&C?



- Meibography used in study in 2022
  - Reveals global improvement of the meibomian gland (MG) health post I&C
- Earlier intervention shows significant restoration of MG architecture
- Additionally other dry eye syndrome parameters improved
  - TBUT, OSDI scores
- Specific mechanisms still unknown

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Billing and Coding for Lesions

If billing procedure on same day of an exam remember your –25 modifier!

- ICD 10 Codes
  - Chalazion
    - Right U/L H00.11/H00.12
    - Left U/L H00.14/H00.15
  - Papilloma D23.1x
    - Do not use skin tag!!!
  - Eyelid Cyst
    - Right U/L H02.821/H02.822
    - Left U/L H02.824/H02.825
  - Benign neoplasm skin/eyelid D23.1xx
- CPT Codes
  - Excision of lesion eyelid 67840
  - Chalazion
    - Single 67800
    - Multiple 67801
  - Intralesional injection 11900
    - Modifier if additional to I&C (-59)
  - Incision and drainage
    - Single lesion 10060
    - Multiple lesions 10061
  - IPL 17999
  - Anterior Segment Photography 92285

Global Period = 10 days

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Dilation and Irrigation

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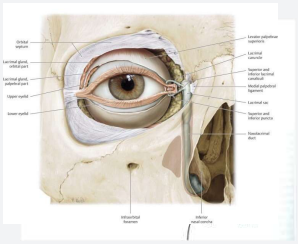
Lacrimal System Review

- Responsible for ocular comfort, resistance to disease, and optimal visual function
- Excretory system
  - Drains 90% of tear film
  - Puncta
  - Canaliculi
  - Lacrimal sac
  - Nasolacrimal duct



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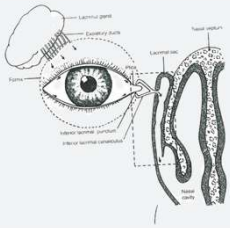
Puncta

- At the lacrimal puncta there will be slight elevation of the tissue
  - Changes with age
- Forms the junction of lacrimal and ciliary portion of the eyelid
  - Lacrimal portion: nasal to punctum
    - 1/6th of the total area of the lid margin
  - Ciliary portion: temporal to punctum
    - Remaining 5/6th of the lid margin
- Tear drainage
  - Around 60% is through lower and 40% through upper punctum
    - This is debatable and varies by source
    - Some sources state only 90% of tears are drained and 10% is evaporated



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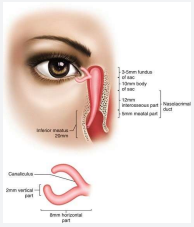
Canaliculi

- Elastic tissue surrounded by orbicularis muscle
  - Pumping mechanism to create suction
- Vertical portion
  - 2mm with slight dilation at the ampulla (base)
- Horizontal portion
  - 8mm
- Common canaliculus
  - Upper and lower join to advance to the lacrimal sac



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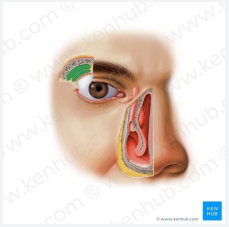
Lacrimal Sac

- Located within the fossa of the medial orbital wall
- Surrounded by fascia
- Medial palpebral ligament straddles the lacrimal sac
  - Creates tension to create the suction
- Check ligaments of the medial rectus lie behind lacrimal sac



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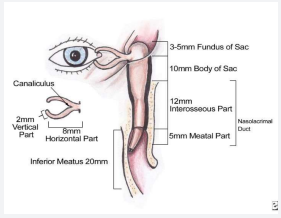
Nasolacrimal Duct

- Lacrimal sac then empties into the nasolacrimal duct at the nasolacrimal canal within the maxillary bone
- Duct runs vertically approximately 15mm
- Duct terminate at the inferior meatus
- Opens at the Valve of Hasner
  - Mucosal tissue that prevents fluid movement up into the nasolacrimal system
  - Up to 50% (!!!) of babies have a blocked Valve of Hasner



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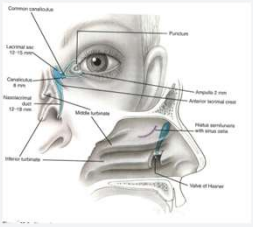
Evaluation of Lacrimal System

- Observe puncta
- Apply gentle pressure to lacrimal sac/ canaliculi area
- Observe nasal cavity
- Jones Testing
  - Jones 1
    - Dye disappearance test
    - Instill NaFl into cul-de-sac and wait 5 minutes
    - Positive test = patency
  - Jones 2
    - Dilation and irrigation
    - Diagnostic and can be therapeutic



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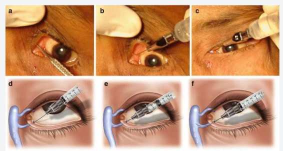
Process of the Dilation and Irrigation Procedure

- Anesthetize inferior punctum with 0.5% topical proparacaine or liquid lidocaine
- Dilate punctum
- Insert lacrimal cannula on 3cc syringe
  - Start vertically than rotate horizontally to follow anatomy of cannula
- Inject sterile saline
- Patient should report tasting saline and be triggered to swallow
- Positive = patency



8/11/2025 HTTPS://WWW.REVIEWOFOPTOMETRY.COM/ARTICLE/LEARN-HOW-TO-IRRIGATE-THE-LACRIMAL-SYSTEM 91

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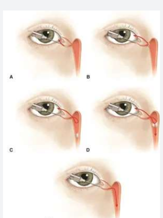
D&I Procedure Outcomes



1. Reflux through same punctum
   - Obstruction within the inferior canaliculus
   - "Total canalicular obstruction"
2. Retrograde flow through opposite punctum
   - Obstruction of the common canaliculus
3. Flow through opposite punctum with distention of lacrimal sac
   - Total obstruction of the nasolacrimal duct
4. Flow into nose, tasted by patient
   - Patent lacrimal system
   - Positive Jones II test

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Billing and Coding for Dilation and Irrigation

ICD-10 Codes

- H04.56x - Punctal stenosis
- H04.22x - Epiphora d/t insufficient drainage

CPT Code

- 68801 – Dilation of lacrimal punctum

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Conclusions

- There are many procedures an OD can perform in select states
- It is important to have a thorough discussion with your patient about their diagnosis and all treatment options
- Even if you do not perform these procedures, it is important to recognize these lesions and be able to educate your patients and make an informed referral

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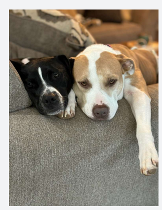

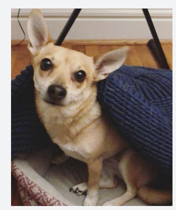

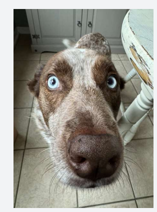

THANK YOU!

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