1. Following surgical preparation, the patient’s eyelids were grasped with towel clamps and closed to minimize contamination of the surgical field.
2. The eyelids were sutured together using a simple continuous pattern, and the ends left long. The ends of the sutures were used to put traction on the eye throughout surgery.
3. A transpalpebral incision was made around the orbit, leaving as much normal tissue as possible. The incision was 1 cm from the margin of the eyelid. Blunt dissection was used around the orbit continuing down to the caudal aspect of the orbit, but avoiding entrance through the palpebral conjunctiva.
4. As the blunt dissection deepened into the orbit, it was difficult to release the globe until the medial and lateral canthal ligaments were transected. To locate the medial broad ligament, a finger was passed along the medial aspect of the orbital rim while placing upward tension on the lids by using the long ends of the suture. The scalpel was directed halfway between the eyelid incision and orbital rim and the ligament was cut.
5. Using Metzenbaum scissors, a plane of dissection was created to release the globe from the remaining tissues that were attaching it to the orbital rim.
6. Traction on the extraocular muscles stimulates a vagal reflex. Excessive force, twisting, or traction was not used because these actions can damage the optic chiasm. The optic nerve and surrounding blood vessels were clamped before dissection. The optic nerve and posterior ciliary arteries were severed by using curved Metzenbaum scissors.
7. Once the globe was removed the orbit was packed with gauze, and pressure applied for at least five minutes.
8. Closure consisted of a subcutaneous layer of simple continuous sutures using an absorbable suture material and a interrupted horizonal mattress pattern using a nonabsorbable suture material on the skin.