



Letter to the Editor Re: “Bilateral Asynchronous Infraorbital Masses in a Patient Denying Dermal Filler Injection”

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Dear Editor,

I read with interest the case report by Arıcı et al.¹ and would like to share my thoughts about the lesion description and surgical approach.

The authors report en bloc excision of a lesion within the orbital fat at the infraorbital nerve and extraocular muscle level, following subperiosteal dissection in the inferior orbit. However, both magnetic resonance images show the lesions anterior to the inferior orbital rim, in a pre-periosteal position. There is no evidence of intraorbital extension or a mass suitable for en bloc excision. Also, the authors also reported palpation of a firm mass in the tear trough region, and the patient's external photograph shows subcutaneous fullness. Therefore, the clinical and radiographic findings are inconsistent with the surgical description and do not support the migration of a filler material into the orbit.

The article title emphasizes that the patient denied a history of dermal filler injection. However, the patient later on admitted having undergone such a procedure. Highlighting the denial in the title may be misleading for readers.

Keywords: Dermal filler, tear trough, intraorbital migration, treatment, surgical technique, case description

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Reference

1. Arıcı C, Aksoy B, Mangan MS. Bilateral asynchronous infraorbital masses in a patient denying dermal filler injection. Turk J Ophthalmol. 2025;55:234-236.

Reply

We gratefully acknowledge the opportunity to address the concerns raised in the letter and to clarify specific aspects of our study.¹ We also extend our sincere thanks to the authors for their interest in our work and for taking the time to provide their thoughtful observations.

The lesion was located in the medial part of the tear trough region and demonstrated a firm consistency on palpation. During surgical excision, a subciliary incision was made, and dissection was carried out between the orbicularis oculi muscle and the orbital septum to expose the inferior orbital rim. The mass was found to be attached to the periosteum; therefore, a periosteal incision was performed. The lesion was not entirely located anterior to the inferior orbital rim surgically, as it extended into the inferior orbital region. The mass was removed as a single piece (en bloc). Evidence of intraorbital extension was observed in the right orbit on the coronal section of the magnetic resonance imaging of the same patient (Figure 1).

Despite repeated inquiries during the initial ophthalmic examination, the patient consistently denied any history of filler injection; this denial was not due to forgetfulness. Therefore, we

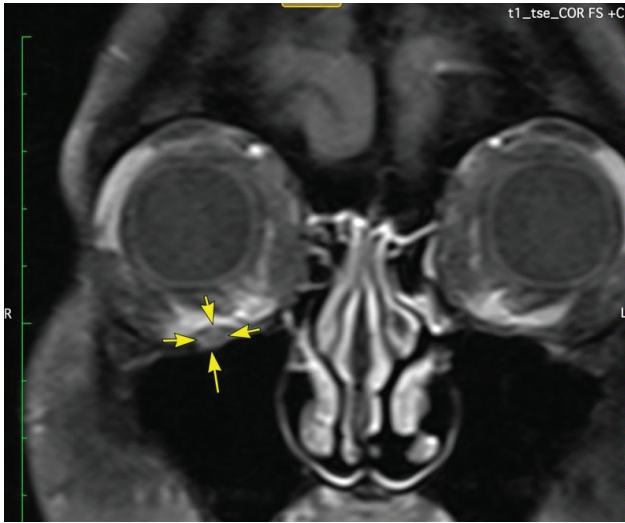


Figure 1. Coronal section on magnetic resonance imaging showed evidence of intraorbital extension in the right orbit

highlighted the patient's denial in the title. It is important to clarify that the patient's denial does not imply the absence of filler but rather a refusal to acknowledge previous filler injection. Upon further discussion, the patient admitted to having received bilateral hyaluronic acid filler injections in the lower eyelids approximately 10 years prior but chose not to disclose this information initially because the procedure was performed without family consent.

In summary, we sincerely appreciate the considerable interest shown in our article.

Ethics

Informed Consent: Written informed consent was obtained from the patient.

Declarations

Authorship Contributions

Surgical and Medical Practices: C.A., Concept: C.A., B.A., M.S.M., Design: C.A., Data Collection or Processing: C.A., B.A., Analysis or Interpretation: C.A., B.A., M.S.M., Literature Search: C.A., B.A., Writing: C.A., B.A., M.S.M.

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