Fractures of the Orbital Roof

G.M.		Bleeker
T.H.		Oei
J.P.A		Gillissen
H.H.		Verkerk
H.J.F.		Peeters

Orbitacentrum, Eye Clinic, Neurosurgical Clinic, Oral Surgery Clinic, ENT Clinic, Radiological Department, University Hospital Wilhelmina Gasthuis, Amsterdam

H. J. F. Peeters, Ruimzicht, 322 Torenwijk, Osdorp, Amsterdam (The Netherlands)

Round about 1955 the active treatment of blow-out fractures of the orbit received much interest. The treatment of zygoma fractures had been already well known, but insufficient attention had been given to the position and the motor function of the eye; since then these areas have been sufficiently made up. Outside the neurosurgical literature, little is to be read about fractures of the orbital roof, or the floor of the anterior cerebral fossa [Van der Werf, 1968; Hötte, 1969]. We were of the opinion that much could still be done for these fractures and in the past year we have seen eight patients, in collaboration with the neurosurgeons Prof. W. Noor-denbos, Dr. A. J. M. Van der Werf and Dr. H. A. M. van Alphen.

Our starting principles are known to you: (1) the orbit is entirely filled with soft parts, and (2) if the shape of the orbit changes, the position of the bulbus changes.

Symptoms: (1) Displacement of the roof downwards causes exophthalmus. (2) Sagging of the floor causes enophthalmus. (3) A combination of the first two causes enophthalmus or exophthalmus, dependent on increase or decrease of the orbital volume.

It has been shown that fractures of the orbital roof also require treatment and that the results are encouraging, and that again, the therapy should be started as early as possible and, again, in collaboration with several disciplines.