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ABOUT COVER

Editorial Board Member of *World Journal of Clinical Cases*, Dr. Iva Brčić finished medical studies at the Medical University of Graz and received her MD degree in 2003. She received her doctoral degree in 2006 at the same institution. In 2007, she enrolled in the pathology residency program at the University Hospital Center Zagreb. In 2012, she passed her board exam and, until 2015, worked as a staff pathologist at the University Hospital Center Zagreb. From 2015, she is working as the University Assistant at the Medical University of Graz. At the end of 2017, she joined the bone and soft tissue team and spent 4-mo observership at the University of Miami, FL, USA. Her ongoing research interests include bone and soft tissue neoplasms.

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Observational Study

Diagnostic value of orbicularis oculi muscle electromyography in functional epiphora

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Abstract

BACKGROUND

Functional epiphora is a clinical condition which is not due to an anatomic defect. Most studies agree that it involves the action of the orbicularis oculi muscle, particularly its deeper segment (Horner's muscle), but the exact mechanism is not clear.

AIM

To evaluate the orbicularis oculi muscle in functional epiphora patients using electromyography (EMG).

METHODS

A total of 8 Chinese patients (16 eyes) with functional epiphora were enrolled in this study, and ten volunteers (10 eyes) were included as normal controls. Five epiphora patients (five eyes) with facial palsy served as positive controls. Quantitative EMG was performed in the deeper segment of orbicularis oculi muscle. The average duration of each EMG waveform was measured.

RESULTS

The average duration of EMG waveforms in the normal control group, the functional epiphora group, and the facial palsy group were 6.39 ± 0.73 ms, 9.39 ± 1.32 ms and 11.2 ± 1.42 ms, respectively. The duration of EMG waveforms was significantly longer in the functional epiphora group than in the normal control group ($P < 0.05$), and shorter than that in the facial palsy group ($P < 0.05$).

CONCLUSION

These data indicate the presence of neurogenic orbicularis oculi muscle damage in

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epiphora patients, which may be the cause of functional epiphora. The etiology of neurogenic damage in the orbicularis oculi muscle requires further investigation.

Key words: Functional epiphora; Electromyography; Orbicularis oculi muscle; Neurological damage; Etiology; Treatment

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Core tip: Functional epiphora is a clinical condition which is not due to an anatomic defect, and the cause of functional epiphora is not very clear. In this study, we used electromyography as a valuable tool to evaluate the orbicularis oculi muscle, and the results suggest neurogenic muscle motor neuron disease in functional epiphora patients. This study reveals a possible new approach for the treatment of functional epiphora.

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INTRODUCTION

Epiphora is a bothersome clinical condition, which may require extensive diagnostic efforts. The patient's history and/or clinical signs, which may include lacrimal hypersecretion, canalicular (presac) obstruction or stenosis, nasolacrimal (postsac) obstruction or stenosis, or even a functional (nonanatomic) defect, which might be due to "lacrimal pump" failure, can provide critical information in identifying this disorder^[1]. Functional epiphora is a clinical condition which is not due to an anatomic defect, and the cause of functional epiphora is not very clear^[2,3]. Although some controversy exists concerning the exact mechanism of functional epiphora, most studies agree that it involves the action of the orbicularis oculi muscle, particularly its deeper segment (Horner's muscle), which inserts on the lacrimal sac.

Electromyography (EMG) is a supplement to clinical examination, which can distinguish myopathic from neurogenic muscle wasting and weakness. To determine the etiology of muscle weakness in functional epiphora, we used EMG to evaluate the orbicularis oculi muscle, in order to provide an approach for the diagnosis of functional epiphora.

MATERIALS AND METHODS

Subjects

A total 8 Chinese patients (16 eyes) with functional epiphora were included in this study, 3 males and 5 females aged between 48-68 years, with a mean age of 62.5 years. Five epiphora patients (five eyes) with facial palsy served as positive controls, including 2 males and 3 females aged between 50-70 years, with a mean age of 59.0 years. Patients with chronic lacrimal canaliculitis, previous lacrimal canalicular laceration, congenital absence of lacrimal puncta and canaliculi, or canalicular mass were excluded from the study. Ten volunteers (10 eyes), with a mean age of 62.2 years, without any eye diseases or epiphora symptoms were included in this study as normal controls (Table 1). This study complied with the Declaration of Helsinki and was approved by the Ethics Committee of the Zibo Central Hospital. All subjects gave written informed consent.

Methods

The patency and caliber of the lacrimal puncta was assessed by slit lamp biomicroscopy. Drainage to the ipsilateral nasal cavity was assessed by probing the canalicular system. Quantitative EMG of the orbicularis oculi muscle was performed. EMG response was recorded by a disposable concentric facial EMG needle electrode^[4]

Table 1 Clinical characteristics of the study patients

	Normal control group	Functional epiphora group	Facial palsy group
Age, yr	62.2 ± 7.8	62.5 ± 8	59.0 ± 6.5
Male/female	4/6	3/5	2/3
Subjects (eyes)	10 (10)	8 (16)	5 (5)
Duration of EMG (ms)	6.39 ± 0.73	9.14 ± 1.32	11.0 ± 1.41

EMG: Electromyography.

(25 mm × 0.33 mm, 30G, Alpine Biomed), which was inserted into Horner's muscle (Figure 1), while the muscle was maintained under slight voluntary contraction. The parameters of the motor unit potential were measured by isolating the discharge of single motor units as achieved by triggering and delaying their display^[5-7]. The duration of motor unit potentials was measured. Filter settings were set from 1000 Hz–10000 Hz.

Statistical analysis

For each eye, the mean duration of the EMG waveform was used in the calculations, and measurements were available from left and right sides. A one-way ANOVA was used to compare the average duration of the EMG waveform in the normal control group, functional epiphora group and the facial palsy group. A *P* value ≤ 0.05 was considered statistically significant.

RESULTS

EMG waveforms in the normal control group, the functional epiphora group and the facial palsy group are shown in Figure 2. The average duration of each EMG waveform was measured. The average duration of each action potential was calculated from 7-10 different action potentials. Our data showed that the average duration of the EMG waveform was 6.39 ± 0.73 ms, 9.39 ± 1.32 ms and 11.2 ± 1.42 ms in the control group, the functional epiphora group and the facial palsy group, respectively. The duration of EMG waveforms in the functional epiphora group and facial palsy group were significantly longer than those in the normal control group (*P* < 0.05), indicating the presence of neurological damage in functional epiphora patients (Figure 3).

DISCUSSION

Epiphora may present as a watery (usually due to punctual or canalicular causes) or mucous (the so called "sticky eye") condition^[8,9]. Watery epiphora can significantly affect the patient's quality of life and may be more difficult to treat than mucopurulent discharge^[2]. However, the exact reasons underlying epiphora remain unclear. According to Jone's theory, contraction of Horner's muscle may cause expansion of the sac and creation of a negative pressure resulting in tear suction^[8-10]. Alternatively, the Rosengren Doane theory postulates that the elastic expansion of the lacrimal papillae that occurs upon eyelid opening aspirates tears into the sac and the subsequent contraction of the orbicularis oculi creates a positive pressure gradient that may drive tears along the nasolacrimal duct into the nose^[8-10].

The causes of muscle wasting and weakness can be divided into myopathic and neurogenic mechanisms, which can be distinguished by EMG. EMG represents an obligatory tool for assessing myopathic from neurogenic muscle motor neuron disease to demonstrate the widespread denervation and fasciculation required for a comprehensive diagnosis. EMG can detect abnormalities such as chronic denervation or fasciculation, which may not be apparent in clinically normal muscle. Isolating the discharge of single motor units as achieved by triggering and delaying their display, enables parameters of the motor unit potential to be measured. Amplitude and duration were measured, and these motor unit parameters varied with the muscle examined. Chronic re-innervation was associated with long duration motor unit potentials with a normal number of phases. Generally, the amplitude of motor unit



Figure 1 Electromyography of the orbicularis oculi muscle: A disposable concentric facial electromyography needle electrode was inserted into Horner's muscle.

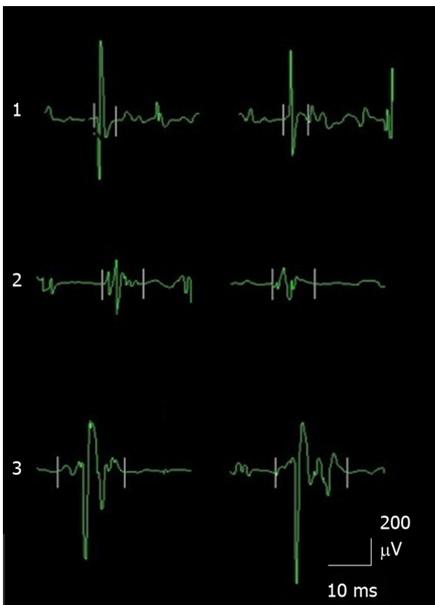


Figure 2 The electromyography waveforms in the subjects. The time between the two vertical white bars is the duration of the electromyography waveform. 1: The normal control group; 2: The functional epiphora group; 3: The facial palsy group. The bar represents 10 ms.

potentials was less than 2 mV, and the durations were 10–5 ms with 3–4 phases. Intramuscular sprouting and re-innervation can occur in chronic partial denervation, and the amplitudes might be 10–20 mV and durations might increase to 20–30 ms. In primary muscle disease, only slight motor unit amplitude potentials of short duration were observed; typical amplitude and duration values would be 0.5 mV and 5–10 ms, respectively^[11].

A recent study revealed that EMG of the orbicularis oculi muscle is very sensitive in patients with ptosis^[12]. In this study, we used EMG to evaluate Horner's muscle and its relation to functional epiphora. Amplitude and duration were measured, and these motor unit parameters varied with the muscle examined. In general, high amplitude and long duration motor unit potentials with a normal number of phases in EMG suggest chronic re-innervation. Facial palsy is definitely a neurogenic muscle motor neuron disease; therefore, we included facial palsy patients as positive controls in this study. The results demonstrated that the duration of the EMG waveform in the facial palsy patients was significantly longer than that in the normal controls. Consistent with the data from the functional epiphora patients, the duration of the EMG waveform was significantly longer than that in the normal controls, which suggested that chronic denervation in the orbicularis oculi muscle, particularly in the lower segment (Horner's muscle) may contribute to this condition. It is noteworthy that the extent of increase in the duration of the EMG waveform in the facial palsy patients was more significant as compared to that in the functional epiphora patients, and this may be due to a different degree of neurogenic muscle motor neuron disease.

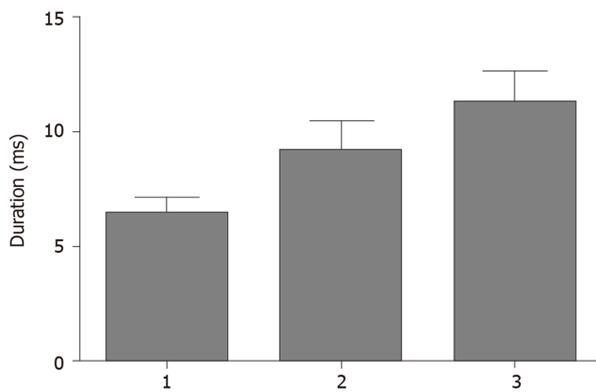


Figure 3 The duration of the electromyography waveform in the different groups. The durations in group 2 and group 3 were significantly longer than that in group 1 ($P < 0.05$). 1: The normal control group; 2: The functional epiphora group; 3: The facial palsy group.

Thus, longer duration might mean chronic partial denervation, which suggests neurogenic muscle motor neuron disease in the functional epiphora patients, which might help us to treat functional epiphora in another way.

According to previous studies, lacrimal scintigraphy, can identify treatment strategies for functionally acquired epiphora^[13,14]. For example, a horizontal shortening of the lower eyelid may be present which can then augment the action of the lacrimal “pump” (as lower eyelid laxity has been associated with decreased lacrimal pump function^[13]). However, if the cause of functional epiphora is chronic denervation in the orbicularis oculi muscle, lacrimal scintigraphy may not be good enough to identify treatment strategies for this disease.

In addition, the cross-sectional study method used should be taken into account, the small number of patients included in the study and the lack of a control group for analysis of treatment decision specificity, require further investigation. Our results revealed that EMG of the orbicularis oculi muscle is a valuable tool for identifying treatment approaches for functional epiphora. The etiology of neurogenic damage in the orbicularis oculi muscle requires further investigation.

ARTICLE HIGHLIGHTS

Research background

Functional epiphora is a clinical condition which is not due to an anatomic defect, and the exact causes of epiphora remain unclear. In this study, we used electromyography (EMG) to evaluate the orbicularis oculi muscle, and the results suggested neurogenic muscle motor neuron disease in functional epiphora patients.

Research motivation

Most studies agree that functional epiphora involves the action of the orbicularis oculi muscle, particularly its deeper segment (Horner’s muscle), but the exact mechanism is not clear. In this study, we used EMG to evaluate Horner’s muscle and its relation to functional epiphora, which may provide a new way to evaluate orbicularis oculi muscle-related disease.

Research objectives

The objective of this study was to evaluate the orbicularis oculi muscle in functional epiphora patients using EMG. The data indicated the presence of neurogenic orbicularis oculi muscle damage in epiphora patients, which might be the cause of functional epiphora.

Research methods

Three groups were included in this study: Functional epiphora, normal controls and facial palsy patients who served as positive controls. Quantitative EMG was performed in the deeper segment of the orbicularis oculi muscle. The average duration of each EMG waveform was measured. A one-way ANOVA was used to compare the average duration of the EMG waveform in the three groups. A P value ≤ 0.05 was

considered statistically significant.

Research results

The duration of EMG waveforms in the functional epiphora group and facial palsy group were significantly longer than those in the normal control group ($P < 0.05$), indicating the presence of neurological damage in functional epiphora patients. The small number of patients included in the study and the lack of a control group for analysis of treatment decision specificity, require further investigation.

Research conclusions

The cause of functional epiphora is not clear; however, orbicularis oculi muscle weakness might be related to functional epiphora. To determine the etiology of muscle weakness in functional epiphora, we used EMG to evaluate the orbicularis oculi muscle, in order to provide an approach for the diagnosis of functional epiphora. EMG was a valuable tool in evaluating the orbicularis oculi muscle, and the results suggest the presence of neurogenic muscle motor neuron disease in functional epiphora patients, which might help us to treat functional epiphora in another way.

Research perspectives

EMG of the orbicularis oculi muscle is a valuable tool for identifying treatment approaches for functional epiphora. The etiology of neurogenic damage in the orbicularis oculi muscle requires further investigation.

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