**Enucleation**:

Suture:
Absorbable sutures (e.g. polyglecaprone No 0) should be utilized for any ligation or subcutaneous procedure. Skin should be closed with an appropriately sized non-absorbable suture (e.g. Nylon No 3 or polymerized caprolactam No 6) placed in a Ford-interlocking suture pattern or tension relieving suture patterns (e.g. cruciate pattern).

A ***transpalpebralablation technique*** is utilized to remove the eye. The upper and lower eyelids are sutured closed or alternatively, eyelids can be closed using multiple towel clamps. A circumferential skin incision is made approximately 1cm from the edges of the eyelids. Using a combination of blunt and sharp dissection, Mayo scissors are used to dissect through the orbicularis oculi muscle, fascia, and subcutaneous tissue surrounding the eye. The interior of the bony orbit is used as a guide. The medial and lateral canthal ligaments are sharply transected to allow access to the caudal aspect of the orbit. As there is a large vessel associated with the medial canthus, transection of the medial canthal ligaments is best left until necessary. Complete excision of orbital tissue is necessary in most cases of eye removal. The retrobulbar musculature and the optic nerve sheath should be transected as far caudally as feasible. vascular clamp can aid in hemostasis while additional excision of remaining orbital tissue is undertaken. In cases where neoplastic infiltration of the bony orbit has occurred, affected areas of ocular periosteum should be thoroughly excised. An orbitotomy may be necessary to remove affected areas of orbital bone; however radical resection of orbital bone and associated lymph nodes is an extensive procedure not recommended except in tertiary care setting.

The skin incision can be closed in a variety of patterns with a nonabsorbable suture such as No. 3 nylon. Common patterns include the Ford interlocking, cruciate or simple continuous. An interrupted suture should be placed in the medial canthal portion of the skin closure to allow for facilitation of drainage if necessary. If a cosmetic result is desired, a “trampoline” suture can be employed to reduce the hollow appearance of the orbit. However it is not recommended in cases where there is periorbital infection or neoplasia present. Placement of a trampoline suture is done by grasping the periosteum on the dorsal and ventral rim of the orbit using a simple continuous pattern with No2 polypropylene or equivalent nonabsorbable suture. The sutures are tightened to allow for support of the overlying ocular skin. The skin is subsequently sutured using a Ford interlocking, cruciate, or simple continuous pattern and No. 2 or No. 3 nylon suture. The skin sutures are removed routinely in 14 to 21 days, leaving the underlying trampoline sutures in place as a permanent support.