**EXENTERATION**

Patients with life-threatening malignancies or infections are typically under the care of a team of physicians at the time of exenteration. A complete systemic evaluation is required before surgery to establish the extent of the disease process and to determine the patient's prognosis following any surgical and/or medical treatment. Preoperative imaging should also be performed to help identify the extent of the orbital involvement and to aid in surgical planning. Obvious extension outside the orbit mandates the need for surgical consultation with a Mohs' surgeon, head and neck surgeon, or neurosurgeon. Often in cases of secondary orbital tumors, an interdisciplinary surgical approach is required. Consultation with a tumor board often proves valuable in formulating an overall treatment plan for the patient. Some tumors benefit from preoperative chemotherapy, whereas others require postoperative radiation therapy. In cases in which extensive systemic disease is found, a major disfiguring surgery might be contraindicated and palliative care might be undertaken instead. A definitive tissue diagnosis using permanent histopathology material is always required before exenteration.

After general anesthesia is induced, an initial incision line is marked just inside the orbital rim. Intravenous broad-spectrum antibiotics are given. The area is infiltrated with local anesthesia with 1:100,000 unit of epinephrine injected subcutaneously. A 4-0 silk suture placed through the eyelid margin is used to close the eyelids and provide a means of traction during the procedure. An incision is then made using a no. 15 blade through skin and into superficial orbicularis muscle fibers along the previously marked incision line. The dissection is then continued in the suborbicularis plane using scissors or unipolar cautery to the bony orbital rim. If possible, the septum should be left intact. The periosteum is then cut just outside the orbital rim around the entire orbit. The periosteum is dissected from the orbital rim and elevated along the orbital walls towards the apex using a Freer periosteal elevator. Adequate suction and a headlight are essential for proper visualization. The zygomaticofacial and zygomaticotemporal neurovascular bundles along the lateral orbital wall are cauterized and cut. The periorbita elevates easily from most surfaces of the orbit. Firm attachments are seen at the lateral orbital tubercle, the trochlea, and in the inferomedial orbit near the nasolacrimal duct and inferior oblique muscle attachment. When the inferior and superior orbital fissures are encountered, incremental cautery followed by cutting with large scissors facilitates the dissection and decreases bleeding. Care must be taken when dissecting the periorbita from the medial orbital wall to prevent breaking the bone. Penetration into the sinuses may result in the formation of sino-orbital fistulas. After the periorbita has been elevated to the apex, the apical stump is transected using enucleation or Metzenbaum scissors. The specimen is removed; cottonoids soaked in dilute epinephrine, Afrin, or thrombin are placed over the remaining orbital tissue; and the socket is firmly packed with 4- × 4-in. gauze sponges. After 5 minutes, the packing is removed and hemostasis is achieved with bipolar cautery to the stump. Inspection of the orbit is then performed for any evidence of abnormal tissue. Frozen section monitoring should be used to ensure complete resection in areas where the tumor approaches the surgical margins. Extension into the cranial vault or sinuses requires the expertise of a neurosurgeon and head and neck surgeon to ensure adequate removal of tumor.