1.

A 16 yr old seeks help for acute onset esotropia. He is about to take his entrance exams and obviously is in trouble! He has no past history of strabismus. Although he offers no history of other problems, there is a suggestion of ataxia on his exam.

1. What tests would you order?
2. What is the d dx of esotropia with late onset?
3. How would you treat his problem?
4. What if the scan is normal? Can a tumor etiology be dismissed?

2

A Case of Symptomatic Glare and Strabismus

A 68-yo woman with a history of childhood strabismus and amblyopia of the right eye was referred from her comprehensive ophthalmologist after experiencing binocular diplopia and light sensitivity following uncomplicated phaco with IOL OD. Her postop BCVA's were 20/100 OD and 20/50 OS. The PC IOL was well centered OD and the retina appeared normal. OS had a 2+ NSC. Her sensorimotor exam showed an incomitant RHT of 14 PD, increasing to 20PD in downgaze and decreasing to 2 in upgaze. She had 1-2 degrees excyclo on DMR testing.

	2RHT	
10RHT	12RHT	10RHT
16RHT	20RHT	20RHT

1-2 excyclotorsion in primary

	-1
-1	+1

Thinking that the problem might be due to primary surgery on the non-dominant eye causing issues of fixation-switch rivalry, I recommended phaco OS

Following uneventful phaco OS her acuity OS was better and the binocular diplopia was essentially gone…but the glare was not. Incidentally, the glare was significantly improved with either eye occluded.

Could her strabismus be the cause of the glare/light sensitivity? What would you do?? She had strabismus surgery as a child but didn't know the details.

3.

61-year-old

Slow onset right 6th nerve palsy, diplopia began 1996
- MRI brain and orbits w and wo contrast, 2003, WNL, reviewed
- MG testing WNL normal.
- Hx of 3 previous procedures
-- 2003 RMR recess 3.5 mm, RLR resect 4.5 mm
-- 2004 RMR re-recess, found at 4 mm and recessed to 6 mm, LMR recess 2 mm with posterior fixation suture

-- 2007 RMR re-recess, from 6 to 8 mm on adjustable suture. No adjustment
-- Briefly saw single, then return of diplopia/ET in primary.
-- 2008, seen by me in Houston, TX. 15PD ET, RE mod abduction deficit. Fusing w R lens 8 BO prism w small right face turn.
-- 2021, finds me in Austin, TX… “Can you help me?”
-- now uses extreme right face turn sees single to drive, even with prism specs

Exam:

Dcc 35-40 RET
Ncc 35 RET

Diagnostic Gaze Positions

___ ___	___ 40	___ ___
___ ___	___ ___	___ ___
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55 ET ___	___ 35 RET	Flick E ___
___ ___	___ ___	___ ___
----------	----------	----------
___ ___	___ 40ET, Fl LHT	___ ___
___ ___	___ ___	___ ___

Ductions and Versions

	Right Eye				Left Eye	
0	___	0		0	___	0
-5	___	-0.5		0	___	0
0	___	0		0	___	0
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Panel: Any plans for patient prior to intubation?

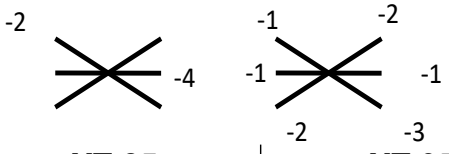
4.

-
- Our patient is an alert 75-year old retired school teacher with well-controlled atrial fibrillation.
-
- The orthoptist charted a history we have all seen many times.
-
- “She had surgery at about age 4 for early childhood strabismus, after which she was placed in glasses that made her eyes look big. She hated them. For many years her eyes looked straight in glasses or contact lenses, and then she no longer needed to wear the glasses to maintain straight eyes.
-

- About five years ago she noted that her eyes “became lazy again”. Her optometrist said- “We can fix this these days” and referred her in. She is bilaterally pseudophakic, using reading glasses only.
-
- I walked in expecting a straight-forward case of partially accommodative esotropia treated with surgery and hyperopic correction who had experienced inevitable progression to consecutive exotropia.
-
- However, her sensorimotor exam was more complex than this.
- How would you proceed?
-

Presenting Sensorimotor Exam

Acuity excellent, no RAPD



XT 30 **LHT 15**	**XT 25** **RHT15**	**XT 35** **RHT 15**
XT30 **LHT 20**	**XT 25** **LHT 20**	**XT 40** **LHT20**
XT 30 **LHT 30**	**XT 20** **LHT 30**	**XT 35** **LHT 35**

Exotropia -- with poor adduction OD and some elevation deficit. Mild elevation deficit OS and notable infra-duction deficit OS
No binocularity and no diplopia. No anisocoria. Symmetric senile ptosis

-

5.

A. • 7 mos: CC: OD not opening, OS wandering “all over”, chin up posture. Mom grew up near Chernobyl.
• Ptosis OD, smaller pupil OD
• limited elevation, depression and adduction OD
• XT and LHT
• Alternates but prefers OD, using L face turn, L tilt and chin up
• Dysconjugate vertical pendular nystagmus, larger amplitude OD
• Large dysmorphic optic nerve OD, small OS
• -1.00 +4.00 x 105

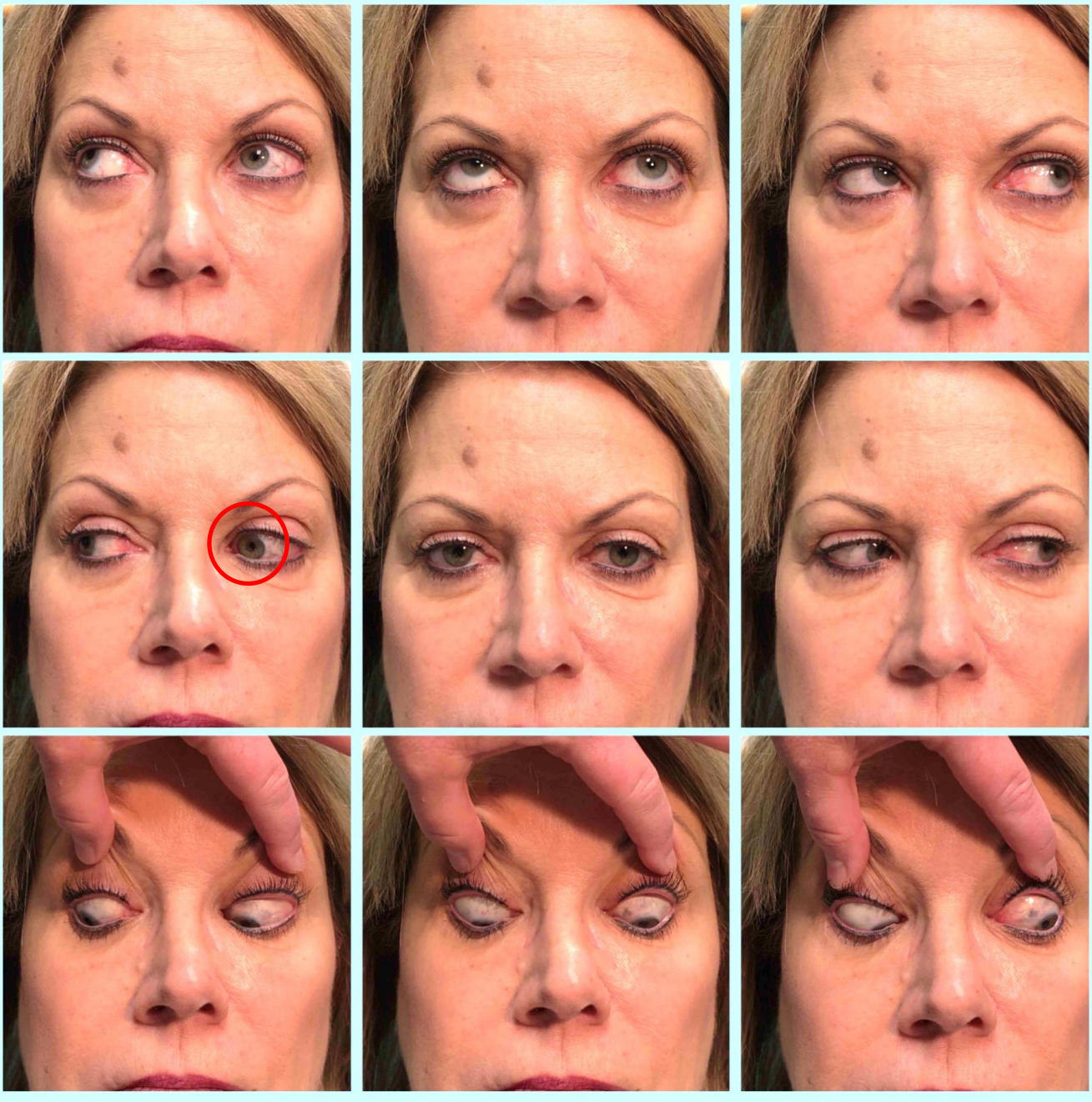
1. Plano +2.00 x 060

B.• 9 mos: poor F/F OS; start patch OD 2 hrs/day
• 11 mos: Nystagmus resolved
• -4 elevation, depression, and adduction OD
• Alternates - uses OD when interested.
• REF LXT 70, LHT 20
LEF smaller XT, similar LHT
• Rx for anisometropia
-5.50 +3.00 x 105
-1.50 +0.50 x 0

6.

56 yo RD with S

- Has had Botox inj to LLR q6-8 wks for 15 years (>100 injections!!)
- Has moved to Indiana – wants to know if she can get botox here
- Very self conscious of XT appearance
- Va – R- 20/25 , L - CF



What shall w

- More botox?
- Offer surgery?
  - –Without removing buc
  - –Remove buckle?
- Send her back where
- Something (nothing) e

7.

60 yr old with globus fixus: vision is 20/80 or so but she can't use the eye (right eye)
Surgery: 5-0 permanent suture 7.mm posterior to insertion of SR and LR to tie the muscles together:
Technical problems: suture keeps breaking

Eventually the eye is brought up to 20 deg below midline
Now what?
Options?:

Strabismus case
Evelyn Paysse, M.D.

HPI: 8-year old girl with Crouzon syndrome with poorly controlled large intermittent exotropia with over-elevation in adduction and under-depression in adduction.

PMH
Hydrocephalus S/P VP shunt,
Remote VP shunt malfunction with papilledema
Moderate obstructive sleep apnea

Exam
Va sc 20/20 OU
PERRLA
IOP normal OU
External: shallow orbits with exophthalmos and inferior scleral show OU
SLE: inferior scleral show, cornea, AC, iris and lens normal OU
Fundus: normal disc, macula, vessels and periphery OU
CR plano + 0.50 x 090 OU

Orbital CT: Small caliber of the bilateral superior oblique muscle. Shallow orbits. Excyclorotation of EOMs

Presented to discuss strabismus surgical approach and outcome.