

been considered in the differential diagnosis. In a retrospective study Ing *et al.*<sup>2</sup> found that 3 of the 43 acquired cases (7%) were attributed to migraine, but Keith<sup>3</sup> has observed only one case of migrainous origin in the 28 reported palsies of his series. We have also come across two such cases in children within the last year, one of which was a recurrent oculomotor palsy with full recovery without treatment. A similar observation has been reported by Amit and Benezra<sup>4</sup> in an infant.

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Sir,

I thank Dr Karabatsas for his comments. We presented a typical case of a child with painful third nerve palsy to highlight the pitfalls in using the rules of third nerve palsy when assessing for aneurysmal compression in children. The diverse differential diagnosis of third nerve palsy was therefore not discussed in detail in our paper. Dr Karabatsas is right in emphasising the importance of ophthalmoplegic migraine in the diagnostic work-up as it is a diagnosis of exclusion. After excluding the more

common causes of painful nerve palsy such as trauma, infection, inflammation or non-aneurysmal compressive lesions, the remaining differential diagnosis in such cases is often between an aneurysm and ophthalmoplegic migraine. The diagnosis of migraine can be clinched if there is a previous history of a similar episode of migraine associated with ophthalmoplegia, but in a first attack it is still prudent to investigate for an aneurysm unless complete ophthalmoplegia in the presence of total sparing of pupil (third rule) is observed.

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Sir,

We read with interest the recent paper by Potamitis *et al.*<sup>1</sup> on astigmatic decay following suture removal in 34 cataract patients. This paper confirms our study on 50 post-operative cataracts published in *Eye* a year ago.<sup>2</sup>

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