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Sir,  
**Inferior oblique myectomy vs recession—its clinical significance**

We read with great interest and would like to congratulate Shipman and Burke for their paper comparing the results of inferior oblique myectomy and recession.<sup>1</sup> The homogeneity of their sample population adds strength to their findings. Their results confirm the efficacy of single muscle surgery, but we would like to question their interpretation of the results and the conclusion that ‘inferior oblique muscle myectomy may be the procedure of choice giving a better and more predictable long term outcome.’ While a 1-year difference between 1.75<sup>Δ</sup> and 3<sup>Δ</sup> may be statistically significant, we wonder how clinically significant this is likely to be, given that a difference of 1.25<sup>Δ</sup> can entirely be attributable to a small change in head positioning.<sup>2</sup> Furthermore, we question the basis of concluding that

myectomy has a more predictable outcome. They have shown in Table 2 that the range of hyperdeviation in contralateral gaze at 12 months was much more in the myectomy group (–5 to +16) as compared to the recession group (0 to +9). This should make recessions more predictable. We are also concerned that there have been some patients with overcorrection in the myectomy group that might represent a group of very unhappy patients, their new eye position going against their long-term head posture. We feel the conclusions have been overstated.

## References

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Sir,  
**Reply to letter on inferior oblique paper**

Patients with symptomatic unilateral right inferior oblique overaction/superior oblique underaction may describe diplopia that is initially confined to levo-elevation or levo-depression, and eventually can progress into primary position. The goal of surgery is to achieve as large a field of diplopia-free vision as is functionally possible without the need to assume a compensatory head position. Ideally, this surgical outcome should not then recede with time.