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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.[1] The homogenicity 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^{Δ} and 3^{Δ} may be statistically significant, we wonder how clinically significant this is likely to be, given that a difference of 1.25^{Δ} can entirely be attributable to a small change in head positioning.[2] 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.

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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.

One of the interesting observations noted in the subgroup of patients with preoperative moderate/marked inferior oblique overaction and binocular single vision, was the observed trend in postoperative inferior oblique muscle overaction in the inferior oblique recession and inferior oblique myectomy groups between 2 months and 12 months postoperatively.[1] There was a greater likelihood of a recurrence of some inferior oblique muscle overaction in patients who underwent an inferior oblique muscle recession. Should this trend continue, then this could lead to not only a clinical but a functionally different long-term outcome between these two procedures in this subgroup of patients with overacting inferior obliques. The anatomical differences between the described myectomy and recession procedures may well be one explanation for this observational difference.

We fully agree with Shankar and Thompson that a difference of 1.25 prism dioptres, while statistically significant, is not likely to be clinically significant in this group of patients who are expected to have normal/supranormal vertical fusion ranges.

The statistically significant differences between the two groups, as a whole, is very much more likely to be genuine rather than attributable to small changes in head positioning as all the measurements in the three gaze positions for the recession and myectomy patients were carried out under the same clinical conditions by the same experienced orthoptist. None of the patients in either group were unhappy postoperatively.

While Table 2 indicated that a single case had a measurable but functionally asymptomatic contralateral inferior oblique muscle underaction, Table 3 reflected the changes that occurred in the hyperdeviation after the immediate postoperative period, namely from 2 weeks to 12 months postoperatively. This table demonstrated the variability in the range of primary position and contralateral gaze measurements in the myectomy and recession groups. These data do not support the view that recessions are more predictable. Accordingly, we disagree with Shanker and Thompson: our conclusions have not been overstated.

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Sir,

Acute glaucoma in the unoperated eye after macular hole surgery

We read with interest the article by Bansal *et al*[1], and would like to report another case of angle closure glaucoma following pars plana vitreous surgery. This, however, occurred in the unoperated eye of a 68-year-old man following macular hole surgery.

Case report

The patient was initially referred 8 years earlier with a persisting inferotemporal retinal detachment in his right eye, following an unsuccessful buckling with cryotherapy a month earlier. A vitrectomy with gas and oversewing of the buckle was performed. The retina was attached but within 2 months developed an epiretinal membrane that was peeled. His vision improved from 6/60 to 6/12. At 3 years following this procedure, he was discovered to have raised intraocular pressure (IOP) in his right eye, with a narrow but open angle. His left IOP was normal and his angle was slightly narrow. He was commenced on a topical beta -blocker to his right eye. After 4 years, he developed a symptomatic cataract in the right eye and underwent phacoemulsification with an intraocular lens implantation. Over the next few months, he developed right metamorphopsia and his vision fell from 6/9 to 6/36 and was found to have developed a macular hole.

Therefore, a right internal laminar membrane peel was performed. An internal search revealed a retinal break at 12 o'clock that was lasered. An air/16% C3F8 exchange was performed. The postoperative instruction was to lie face down.

On the first postoperative day, the patient was found to have an IOP of 45 mmHg in his right eye with an attached retina. Systemic acetazolamide and topical beta blockers and alpha agonists were given and the IOP fell to 38 mmHg. The patient, however, complained of feeling unwell and of an ache over his forehead, which he blamed on pressure on his forehead from posturing.