LETTERS TO THE EDITOR

Sir,

A recent article on the outcome of strabismus surgery in childhood exotropia[1] raised some interesting questions.

This paper differentiated intermittent distance exotropia into true and simulated types using a prism cover test. These types of exotropia, however, appear identical on simple cover testing, the differences appearing only when the AC/A ratio is measured.[2] The AC/A ratio is normal (e.g. 3:1) in patients with true intermittent distance exotropia, but is larger (e.g. 7:1) in the simulated type. Imprecise categorisation of exotropia may affect the type of surgery and therefore outcome in these patients.[2–4]

Secondly, all patients within this study were managed with a unilateral recession and resection procedures. Others suggest[2–4] that true intermittent distance exotropia is well managed with bilateral lateral rectus recession. However, there is no comment as to the authors' choice within the paper.

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Sir,

We thank Tomlin *et al.* for their interest in our article and for their comments.

The problems associated with performing a retrospective study is that one often finds the complete data set is not available on every patient. The vast majority of our patients with simulated distance exotropia showed equalisation of their deviation if the distance measurement was done through −3.00 lenses. Conversely, the vast majority of our true distance exotropias showed no such variation. However, these measurements were not available on every patient and, therefore, we chose our definitions to comply with the information available. Where both pieces of information were available, no patient initially classified as true distance exotropia (on the basis of having a deviation more than 10 dioptres greater in the distance than for near) was re-classified as a simulated distance exotropia.

Since the outcome of surgery in both groups was the same, our results would suggest that, certainly in terms of management, distinguishing between the two types plays no major role in achieving a successful outcome.

The choice of surgery in true or simulated distance exotropia is commonly based on personal experience and the good outcome experienced in our group suggests that our choice was reasonably made. In our hands (and I know in others) bilateral lateral rectus recessions have proved disappointingly unpredictable and, therefore, we choose to rely rather on recession/resection with a greater amount of the surgery being performed on the recessed lateral rectus.

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Sir,

We read with interest the recent paper by Baer, Aylward and Leaver concerning the surgical management of cataracts that develop after the use of intravitreal liquid silicone.[1] The authors point out that for some of these patients, the silicone oil may

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