
LETTERS TO THE EDITOR

Sir,

A recent article on the outcome of strabismus surgery in childhood exotropia¹ 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 suggest²⁻⁴ 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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References

1. Keenan J, Wilshaw H. The outcome of strabismus surgery in childhood exotropia. *Eye* 1994;8:632-7.
2. Mein J, Trimble R. Diagnosis and management of ocular motility disorders, 2nd ed. Oxford: Blackwell Scientific, 1991:230-1.
3. Carta A, Pinna A, Aini MA, Carta AJ, Carta F. Intermittent exotropia: evaluation of results on the basis of different treatments. *J Fr Ophtalmol* 1994; 17:161-6.
4. Taylor D. Pediatric ophthalmology. Oxford: Blackwell Scientific, 1990:629.

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

already have been removed, or the oil is planned for removal at the same time as cataract surgery. In these circumstances, they advocate a planned extracapsular extraction, with particular attention being paid to careful hydrodissection of the nucleus prior to expression, because of the loss of vitreous pressure consequent upon prior vitrectomy. Alternatively, a posterior infusion cannula can be used to induce positive vitreous pressure at the point of nucleus expression.

We are surprised that no mention was made of phacoemulsification as a means of cataract extraction in these circumstances. This technique is now firmly established in the management of cataract, and amongst many other advantages it obviates the need for nucleus expression. We feel that 'post-vitrectomy cataracts' may indeed constitute a specific indication for the use of this technique when cataract surgery is needed.

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Reference

1. Baer RM, Aylward WG, Leaver PK. Cataract extraction following vitrectomy and silicone oil tamponade. *Eye* 1995;9:309-12.

Sir,

In response to the letter from Mr Roger Gray and Mr Bradley Horsborough we entirely agree that phacoemulsification techniques are well suited to the removal of cataractous lenses after, or at the time of, silicone oil removal. This is particularly the case now that phacoemulsification is undertaken through a corneal pocket, rather than a scleral one. (Because of the amount of conjunctival and sub-conjunctival scarring associated with previous retinal re-attachment surgery, in eyes treated with intravitreal silicone oil, a scleral pocket is not ideal.)

We are currently removing silicone oil through a posterior capsulorhexis, following phacoemulsification via a corneal pocket, and this has proved a very satisfactory method. Likewise, phacoemulsification in eyes from which silicone oil has previously been removed has proved highly effective. During the period in which the cases reported in our paper were operated, however, phacoemulsification via a corneal pocket was not in routine use.

We are grateful to Mr Gray and Mr Horsborough for their helpful comments.

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