

fore, like to emphasise the advantages of routinely employing limbal stay sutures during strabismus surgery:

(1) Placement of stay sutures at the 12 and 6 o'clock position at the limbus provides a fixed landmark and accurate reference point when determining the location and position of a muscle during surgery. This is particularly important when locating a muscle during reoperation, as well as aiding the identification of congenital anomalies of insertion, thereby minimising the risk of operating on the wrong muscle. Stay sutures are also useful in aiding accurate positioning of the globe when operating on muscles other than the horizontal recti, and in particular for procedures on the inferior oblique.

(2) Limbal stay sutures also facilitate accurate and reproducible traction testing. Forced duction tests performed at the start of the procedure are aided by gentle anteropulsion of the globe (produced by tension on stay sutures), thus resisting retropulsion which may give rise to a false negative response. Once the conjunctiva is opened, traction testing assesses the conjunctival and muscle components of any mechanical restriction. Equally, in the reverse situation, following reattachment of muscle and conjunctiva, traction testing with limbal stay sutures will identify mechanical restrictions due to tight conjunctiva or muscle. The gauging of a conjunctival recession is facilitated by using the stay sutures to maintain the eye in the direction opposite to the muscle being operated on.

(3) During the procedure of muscle recession, selective tension on the upper stay suture facilitates the placement of the upper muscle suture by creating a space between the muscle insertion site and the muscle hook, and likewise for the lower suture. Also, during muscle resection, when reattaching the muscle to the eye, stay sutures are used to maintain the eye in a position opposite to the muscle being operated on, so allowing the surgeon to gauge accurately whether any mechanical restrictions are being caused by the resection procedure. This helps to avoid the common complication of causing mechanical restriction of abduction, following a medial rectus resection.

Finally, in view of the many advantages incurred by the use of limbal stay sutures, we would strongly recommend that they be used as standard practice in strabismus surgery.

A. M. McElvanney
A. M. Ansons

Manchester Royal Eye Hospital
Oxford Road
Manchester M13 9WH
UK

Sir,

We are grateful to A. M. McElvanney and A. M. Ansons for their comments on our recent paper 'A novel conjunctival incision for horizontal strabismus surgery'. They draw attention to the many advantages of limbal stay sutures.

We wish to stress that our technique is advocated only for routine, primary strabismus surgery, and would not be considered in complicated cases.

In answer to some of their specific comments, we point out that the 2 and 10 o'clock positions marked by the extent of our conjunctival incision provide excellent landmarks for orientation during surgery.

An inferior peritomy allows direct visualisation of the Tenon's sheath surrounding the inferior oblique muscle if surgery on this muscle is planned.

There are many descriptions of forced duction testing in the literature. The forceps which grasp the sclera during the test may be used to provide anterior traction prior to rotation of the globe. This method is preferred by the authors.

During horizontal strabismus surgery we find that a combination of gentle manipulation using St Martin's forceps on bare sclera and traction on muscle hooks provides excellent exposure for identification and cleaning of muscles. A small degree of rotation of the muscle hook about the axis of its shaft aids easy placement of sutures prior to recession.

We recognise that the surgical details of strabismus surgery should vary according to individual preference. However, we are happy to say that we have found no reason to return to the routine use of stay sutures since adopting the technique that we describe.

A. B. Calliar
E. M. Eagling

Birmingham and Midland Eye Hospital
Church Street
Birmingham B3 2NS
UK

Sir,

The first individual I know of who reported that nasally sited filtration resulted in lowering intraocular pressures was Christina Raitta, who did an elegant study in *Ophthalmic Surgery* which reported this phenomenon.

Vernon and Spencer noted the same phenomenon in their interesting article on intraocular pressure control following micro-trabeculectomy.¹ A procedure similar to one they described has been performed at the Glaucoma Service of the Wills Eye Hospital for the last five or so years. Indeed, several of our surgeons utilised scleral flaps that are

about 1.5 mm × 1.5 mm, with appropriately smaller sclerectomies. We agree entirely with the authors that this is the preferred technique. Clearly, the less tissue that is traumatised, the less the inflammation and the more tissue there is for subsequent surgery. We congratulate the authors on their important contribution.

George L. Spaeth, MD

William & Anna Goldberg Glaucoma Service
Wills Eye Hospital
900 Walnut Street
Philadelphia, PA 19107
USA

Reference

1. Vernon SA, Spencer AF. Intraocular pressure control following microtrabeculectomy. *Eye* 1995;9:299–303.