CORRESPONDENCE

When is acute onset concomitant esotropia a sign of serious neurological disease?

EDITOR,—We read with interest the paper by Hoyt and Good in which they outlined the differences between patients with acute onset concomitant esotropia with and without central nervous system pathology and those who were otherwise neurologically intact.1 We fully agree with the authors that the vast majority of cases will have no obvious underlying neurological cause, making it of utmost importance to have good clinical criteria for use in the selection of those patients who will need immediate neurological and neuroradiological investigation. As the authors state, the patient who presents with diplopia should prompt careful consideration of whether the strabismus is a sign of serious central nervous system pathology. The ophthalmic history (especially that of previous strabismus and occlusion therapy) and neurological findings (such as headache, papilloedema, clumsiness, etc) are helpful in distinguishing ophthalmic from neurological causes of strabismus. Enquiry about previous head trauma is most important.2 The authors reach the quite correct conclusion that the presence of nystagmus in cases of acute concomitant esotropia should be considered an abnormality that warrants neurological investigation.

Furthermore, we do not agree that a history of monocular visual loss need cause little worry for the clinician. Unilateral reduced visual function is one of the various factors that may be a cause of concomitant esodeviations.3 Both tumours of the optic nerve and chiasmal procedure. It appears to be safe, especially when compared with other refractive surgical procedures, etc'. This statement is unrefere-enced. The only comparable procedure for low degrees of myopia with which there is a fair comparison for photorefractive keratectomy (PRK) is radial keratotomy (RK). The data on RK are much more extensive in time than data for PRK, and the 10 year PERK study4 shows at least comparable results with the 1–6 dioptre range for PRK. I note that patients when interviewed with regard to the potential treatment for their myopia were only offered the one solution! I further note that nowhere in the article is cornual topography mentioned, neither preoperatively nor post-operatively, when the results can be monitored.5 The author therefore shows disregard for the comprehension of cornual shape when a professional attitude is a dreadful way to present a surgical technique to the public.

CORRESPONDENCE

Reply

EDITOR,—We thank Cruysberg, Draijer, and Sellar for their thoughtful and important comments on our paper. We do not disagree with the concern about the early esotropia associated with afferent visual pathway disease. However, we were only addressing acute esotropia presenting with diplopia. Our experience has been that the esotropia associated with monocular visual loss and tumours of the optic nerve and chiasma is more indeterminate in its onset and rarely associated with diplopia. This is not meant to minimise the importance of these tumours and the associated esotropia, but to say that this group of patients usually falls outside the clinical profile that we were addressing. We thank the authors again for their comments.

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Refractive and visual results and patient satisfaction after excimer laser keratotomy for myopia

EDITOR,—I would like to take issue with some of the points raised in the paper by Brett L Halliday.1 In the discussion there is a statement ‘Excimer laser surgery is still a relatively new procedure. It appears to be safe, especially when compared with other refractive surgical procedures, etc’. This statement is unrefere-enced. The only comparable procedure for low degrees of myopia with which there is a fair comparison for photorefractive keratectomy (PRK) is radial keratotomy (RK). The data on RK are much more extensive in time than data for PRK, and the 10 year PERK study4 shows at least comparable results with the 1–6 dioptre range for PRK. I note that patients when interviewed with regard to the potential treatment for their myopia were only offered the one solution! I further note that nowhere in the article is cornual topography mentioned, neither preoperatively nor post-operatively, when the results can be monitored.5 The author therefore shows disregard for the comprehension of cornual shape when a professional attitude is a dreadful way to present a surgical technique to the public.

CORRESPONDENCE

Reply

EDITOR,—I wholeheartedly agree with Mr Rosen’s attitude; we seem to share a similarly circumspect view of the excimer laser.

Time will ultimately prove the safety or otherwise of the excimer laser. My statement that the procedure ‘appears to be safe’ is based on the results reported in my paper. Inadvertent corneal perforation and subsequent surgical intervention for all the reasons stated. Mr Rosen may not realise that the patients reported in this paper were treated over a 17 month period starting in 1991. At that time cornual topography was in its infancy and Klyce’s excellent paper did not appear until 1994.

I agree that high spending laser clinics need to treat large numbers of patients in order to generate profit. In comparison, low budget keratotomy never became very popular. This was not because radial keratotomy was perceived by the public as dangerous or unpredictable, but that, in the absence of massive capital investments, there was no need for the professionally generated, high profile, media campaigns and expensive advertising which have become the hallmark of so many private laser clinics. This promotional attitude is a dreadful way to present a surgical technique to the public.

CORRESPONDENCE

Low vision

EDITOR,—We read with interest the editorial ‘Low vision: a parochial view’.1 As Dickinson said, it is becoming increasingly recognised that the use of the hospital eye service prescrip-

