

Inferior oblique overaction is not always the same

Hatem Marey , MD.

Ex. fellow of pediatric ophthalmology and strabismus unit,
Japanese pediatric hospital, Cairo University, El-Sayda
Zainab, Cairo, Egypt.

Ex. fellow of pediatric ophthalmology and strabismus unit,
Augenlinik, Universtat Libeg and Marburg, Giessen,
Germany.

Ghada Rajab, MD.

Menoufia University

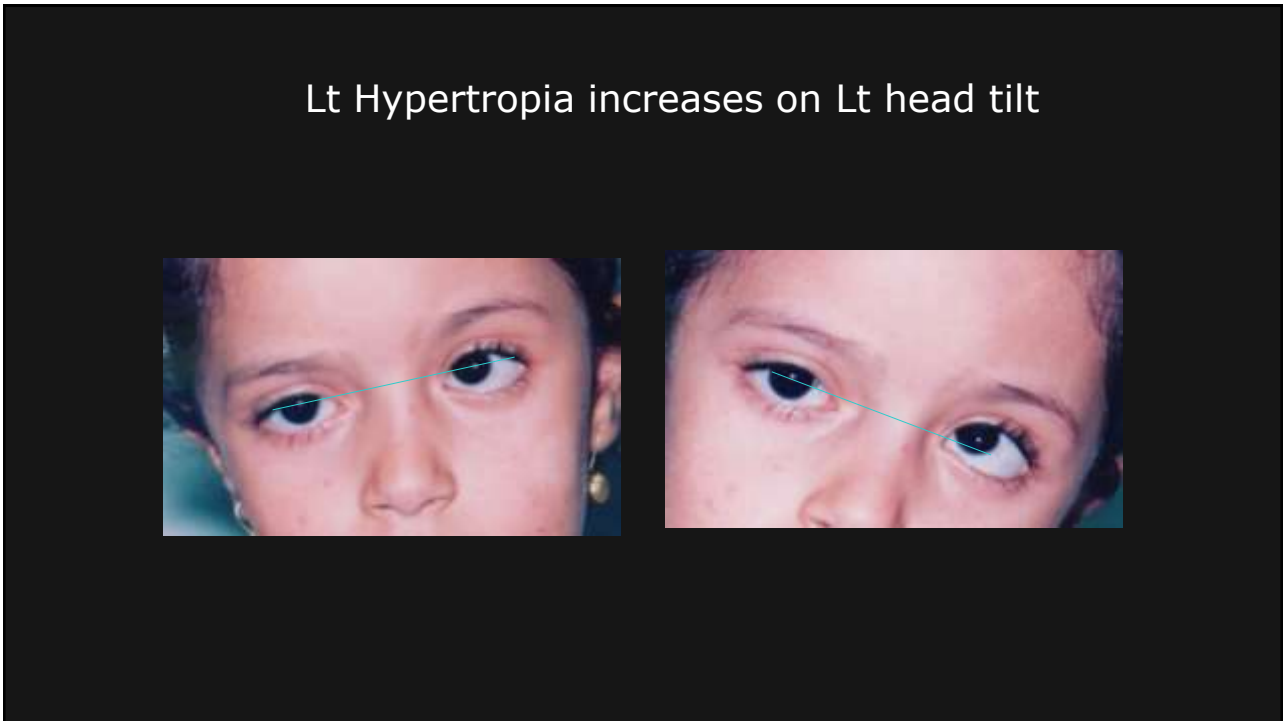
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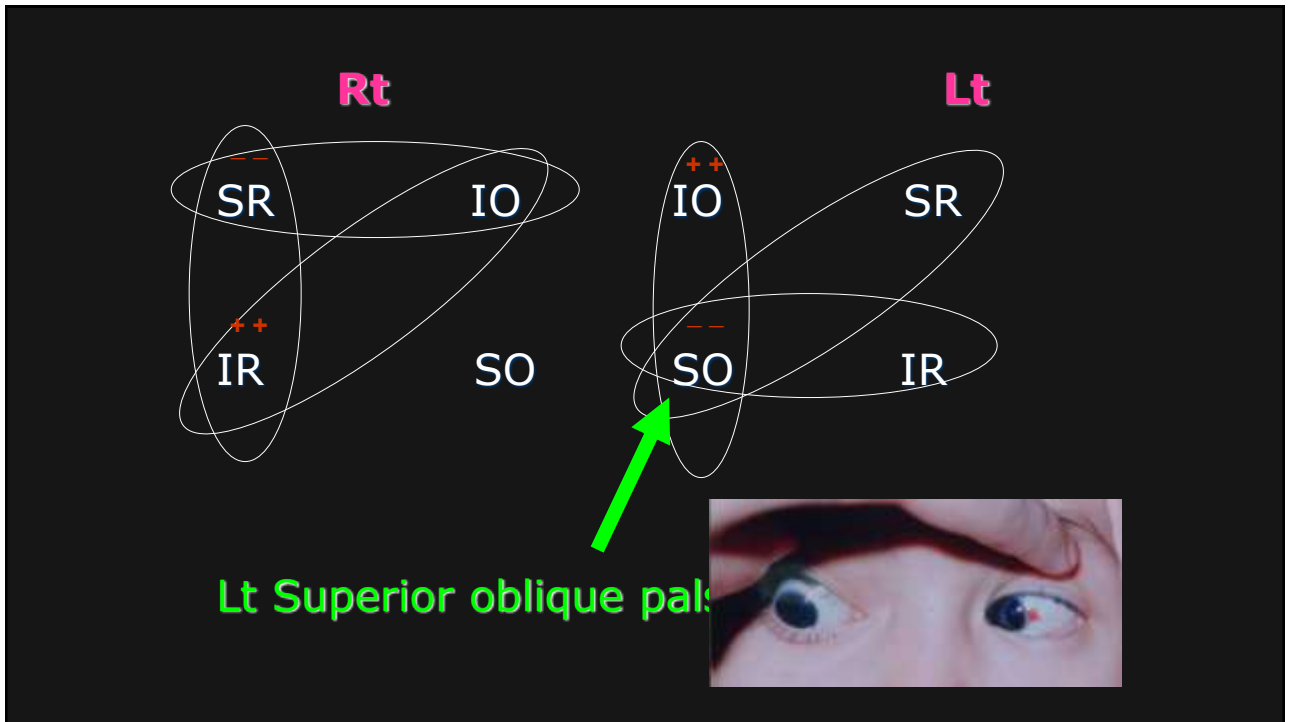
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Sometimes the
picture is not
the same

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21 years old lady

Rt hypotropia and
drooping of upper
eyelid dating since
childhood.



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Examination

External:
Rt. head tilt.

VA:
3/60 (no RE)
6/6



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**Eyelid:
Rt. pseudoptosis**



**Eye movement:
free with Rt.
Hypo and
exotropia**



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What is the possible diagnosis ?

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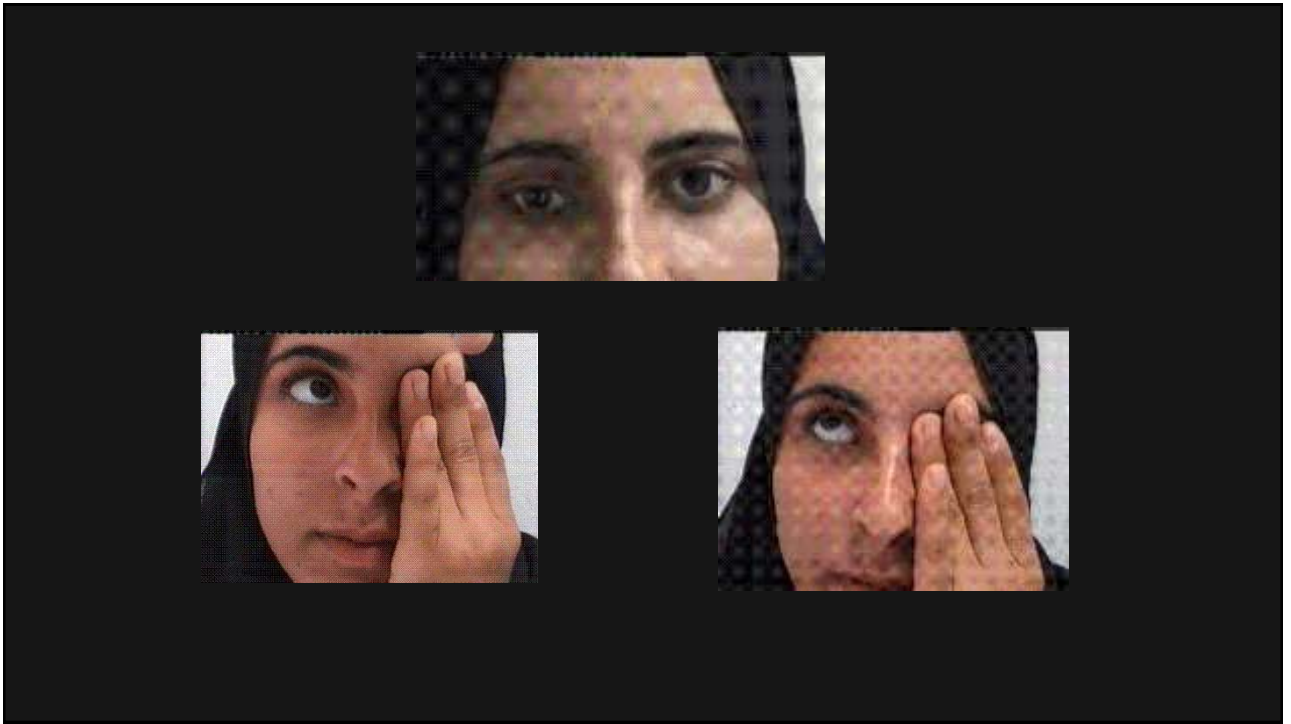


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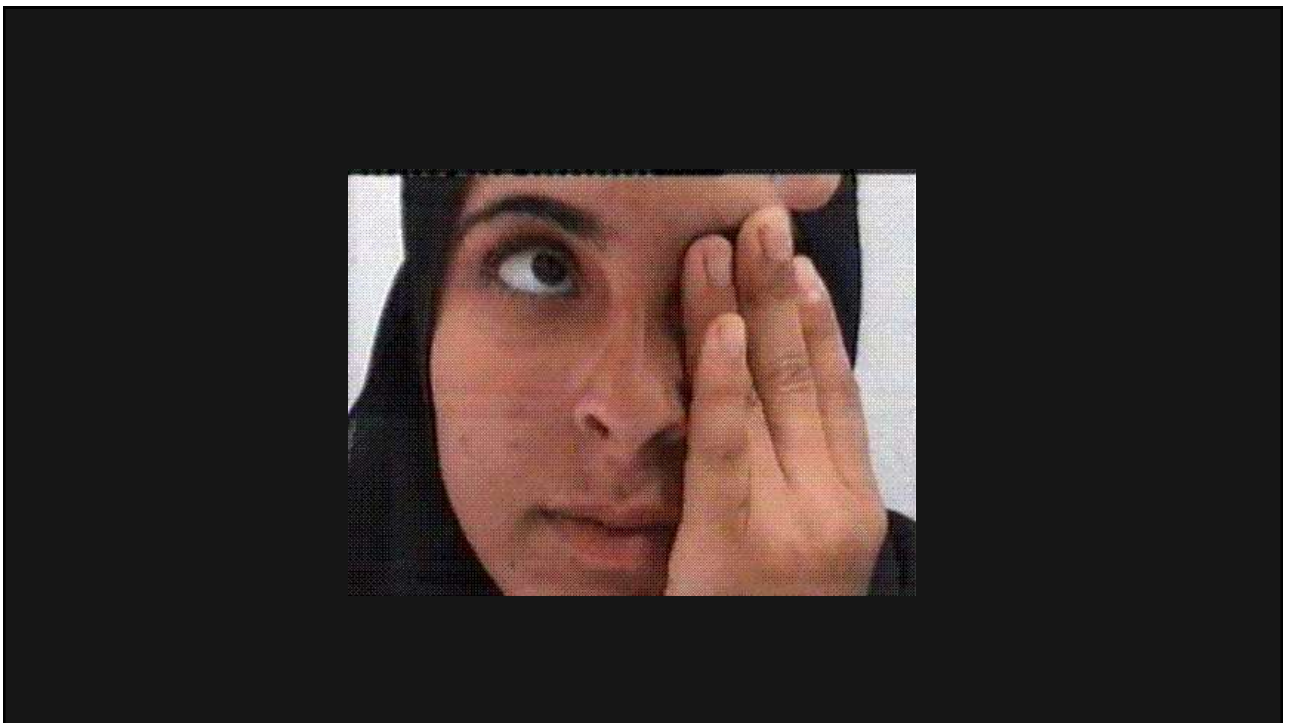
Causes of vertical strabismus:

- Paralysis of one of vertical acting muscles
(Isolated CN IV palsy).
- DVD.
- Brown syndrome.
- Blowout fracture.
- Double elevator palsy (DEP).
- Grave's ophthalmopathy.
- IOOA.

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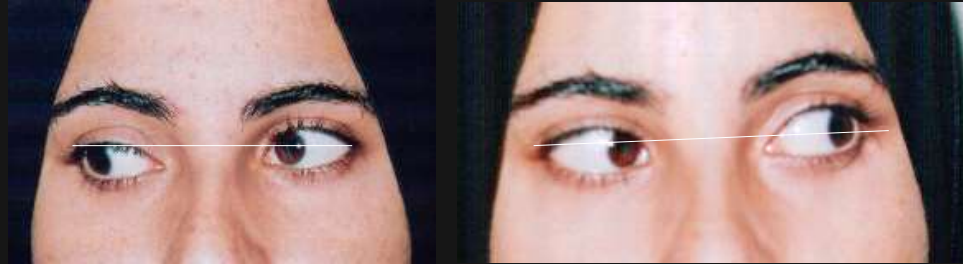


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Rt Hypotropia , increases on Rt gaze.



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RT Hypotropia, increase on Rt gaze & Lt head tilt.



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The diagram illustrates the innervation of the extraocular muscles. On the left, the normal innervation is shown: the Superior Rectus (SR) and Inferior Rectus (IR) are innervated by the Lateral Rectus (LR) and Medial Rectus (MR) respectively, while the Superior Oblique (SO) is innervated by the Trochlear Nerve (IV). On the right, a palsy of the left Superior Oblique (SO) is depicted, with a green arrow pointing to the affected muscle. The innervation is altered, showing the SO receiving input from the Lateral Rectus (LR) and Medial Rectus (MR) instead of the Trochlear Nerve. A clinical photograph shows the patient's eyes in a position of abduction, with the left eye being significantly higher than the right eye, a classic sign of a left superior oblique palsy.

Lt Superior oblique palsy

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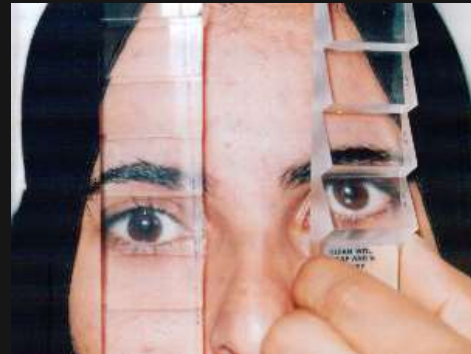
The top photograph shows the patient's eyes in a position of abduction, with the left eye being significantly higher than the right eye, labeled as "Lt 2ry IOOA." The middle photograph shows the patient's eyes in a position of abduction, with the left eye being significantly higher than the right eye, labeled as "Lt SO palsy." The bottom photograph shows the patient's eyes in a position of abduction, with the left eye being significantly higher than the right eye, labeled as "Inhibitional palsy of Rt. SR."

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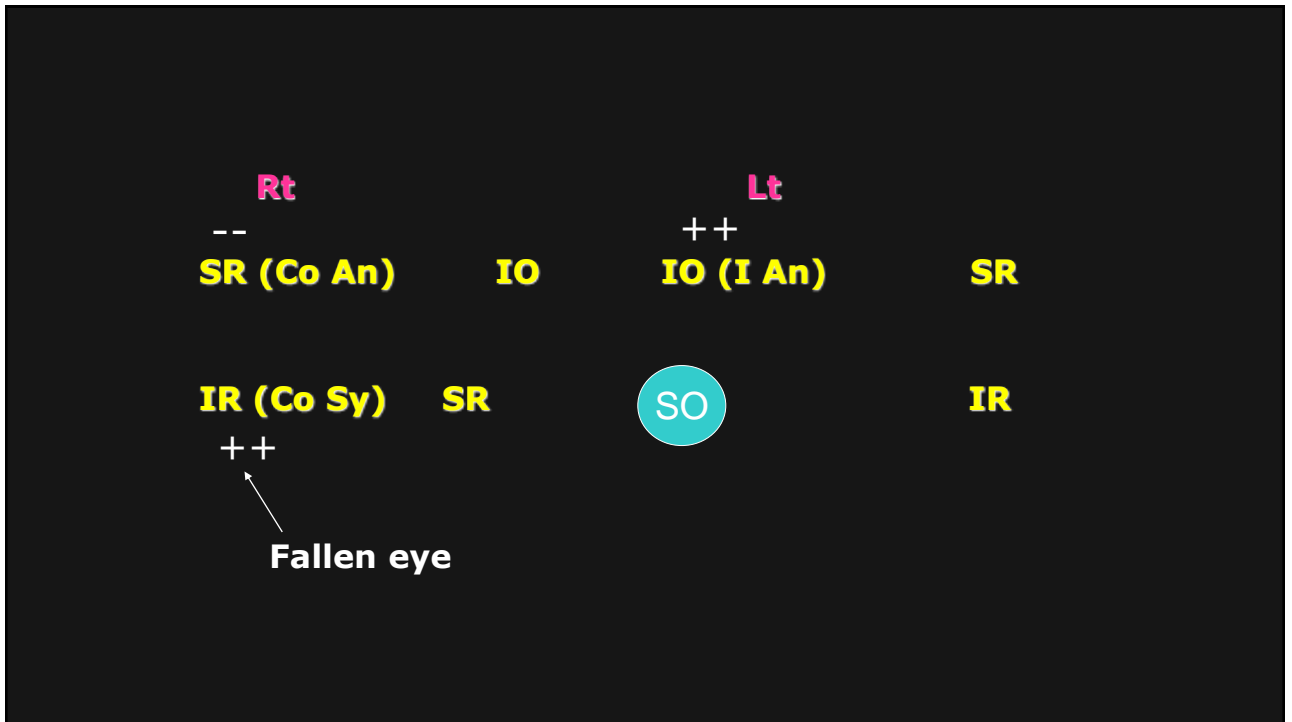


Down versus up gaze-----V- pattern

Measuring the angle of squint



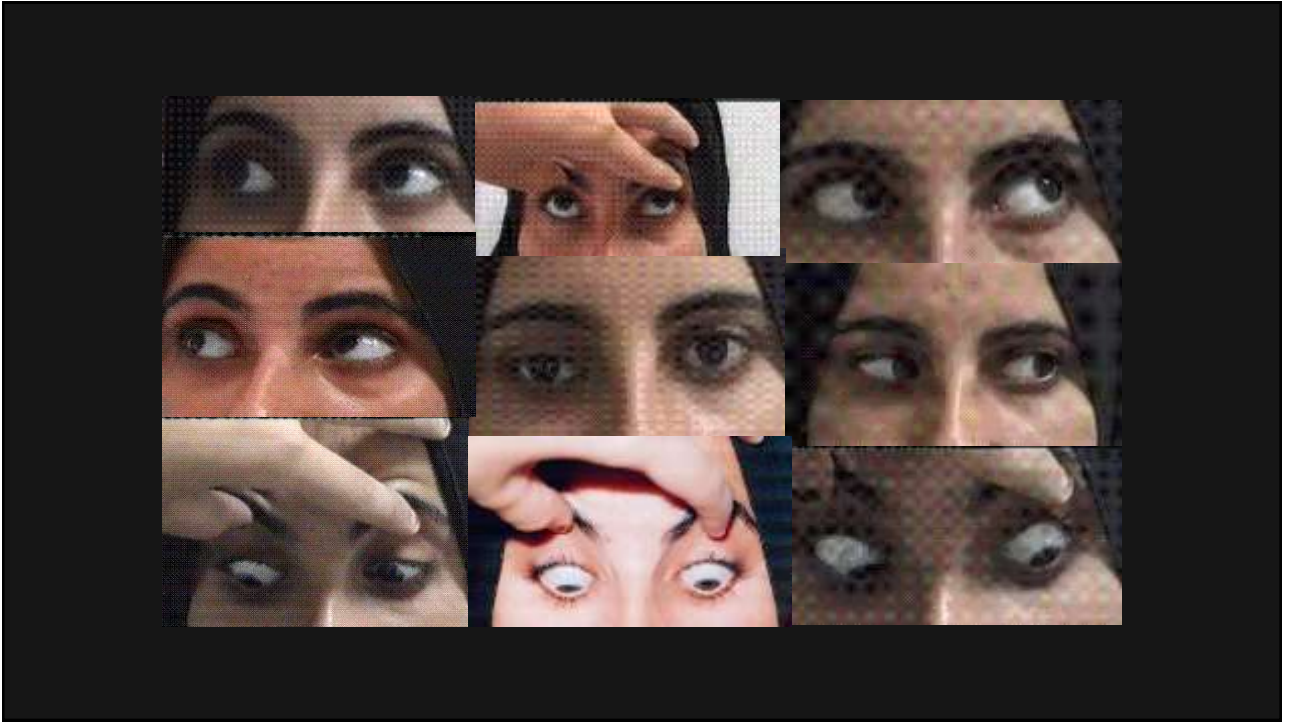
(Rt HT 35 pd & Rt XT 20 pd).



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Diagnosis:

Unusual presentation
of congenital SO palsy
in which
the paralytic eye is the dominant eye.

**Rt HT 35 pd , Rt XT 20 pd
& Rt pseudoptosis**

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How to manage ?

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Diagnosis

Lt SO palsy

2nd IO over
action

Hypertropia
in primary
position



Decision

Lt IO
weakening

Lt IO
Myotomy
Vs
Recession
Vs
Recession &
anteriorization

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Plane for surgery:

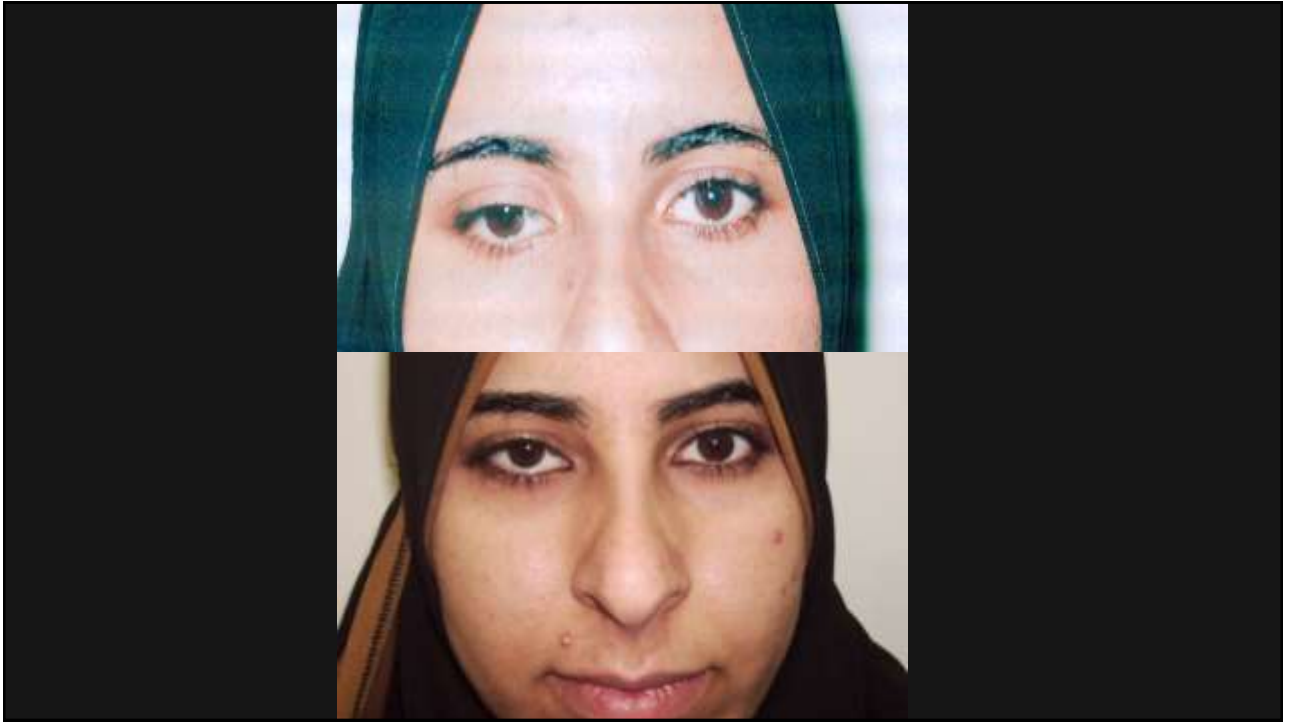


1. Operation on Rt amblyopic eye.
2. IR recession & SR resection.
3. Treat exotropia (LR recession) or reassess XT after surgery for vertical deviation
4. Follow up of pseudo ptosis

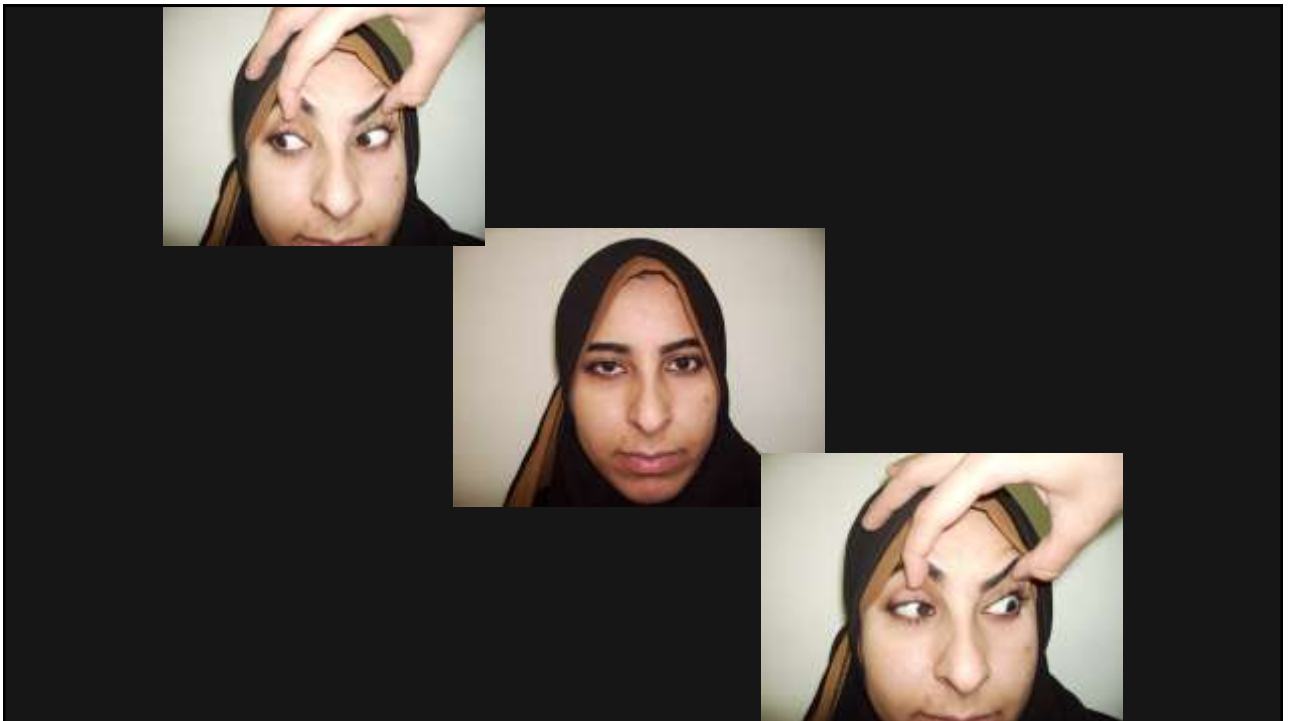
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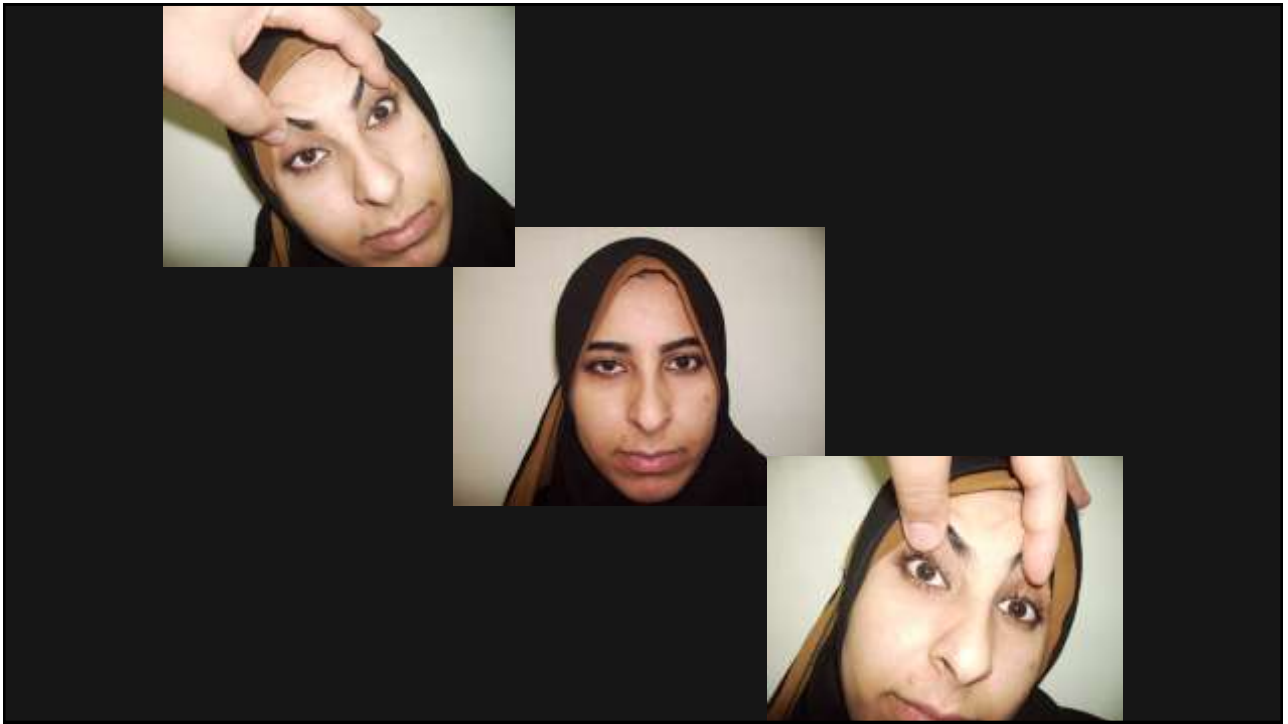
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Thank you

