Inferior oblique overaction is not always the same

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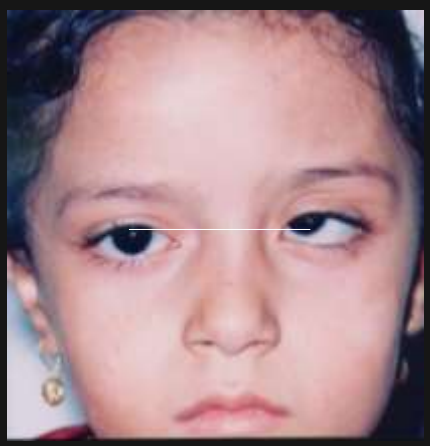

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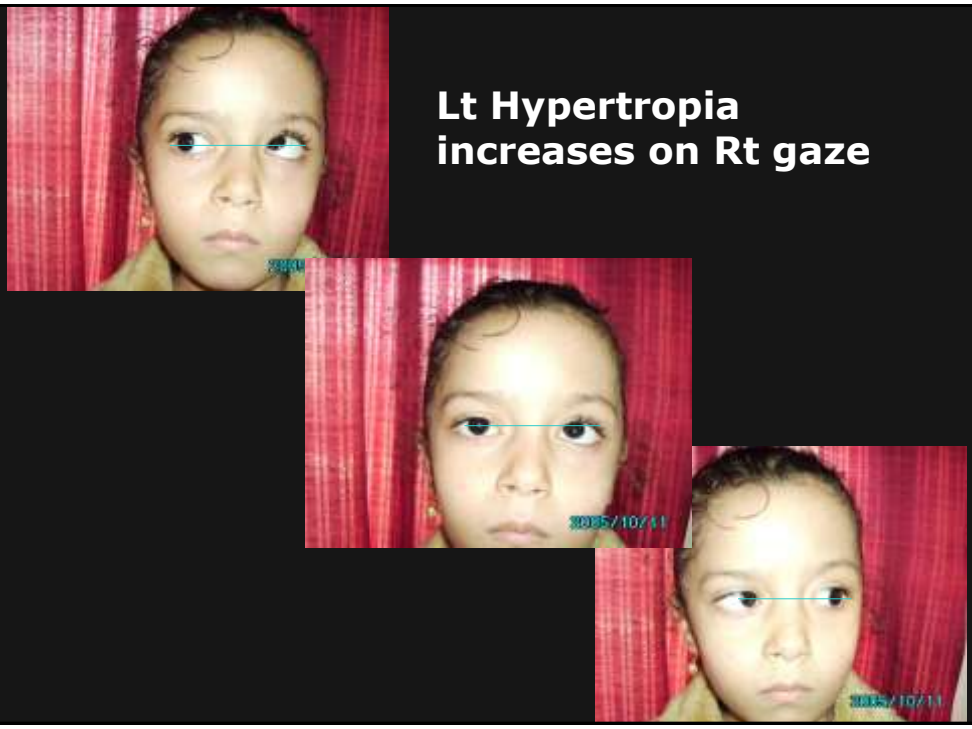

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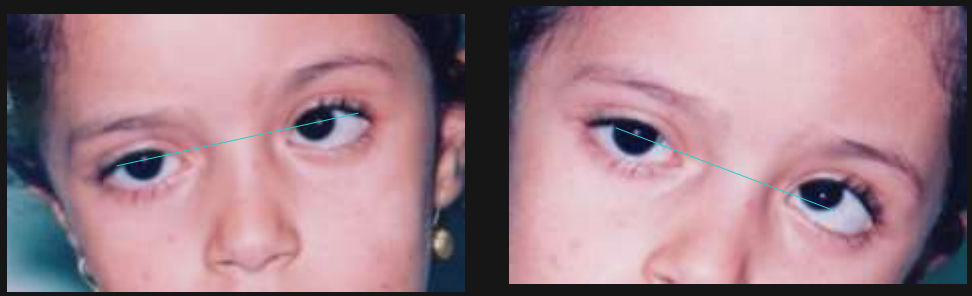
Lt Hypertropia increases on Lt head tilt



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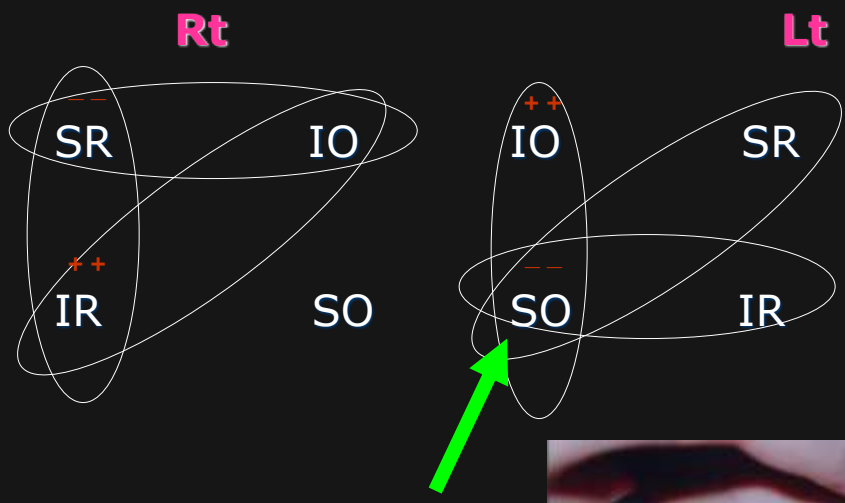

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Sometimes the picture is not the same

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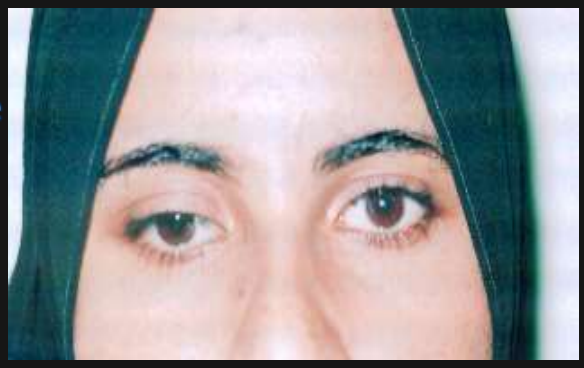
21 years old lady

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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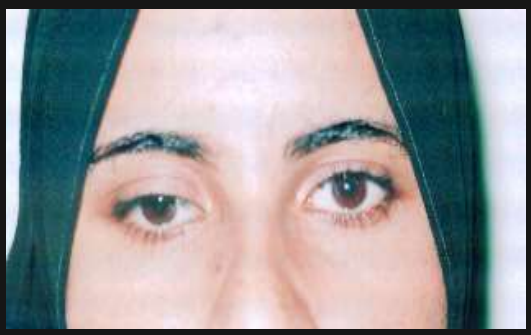
Eyelid:
Rt. pseudoptosis

Eye movement:
free with Rt.
Hypo and
exotropia



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What is the possible diagnosis ?

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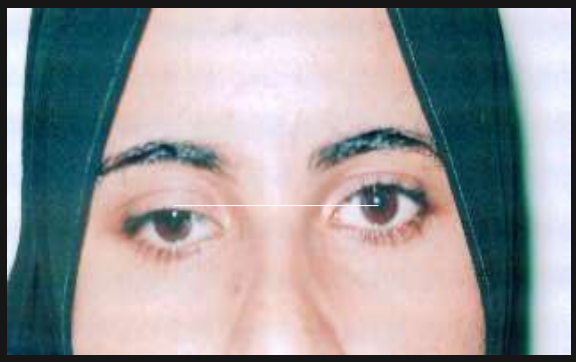

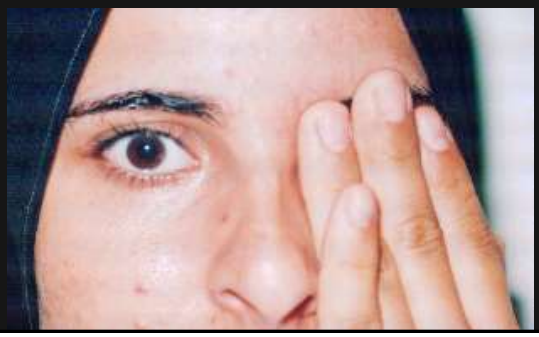

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Causes of vertical strabismus:

- 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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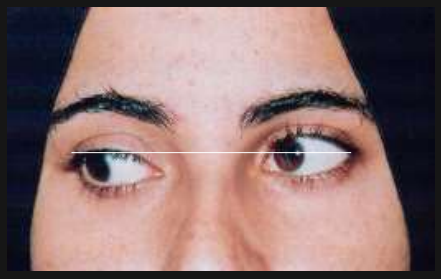
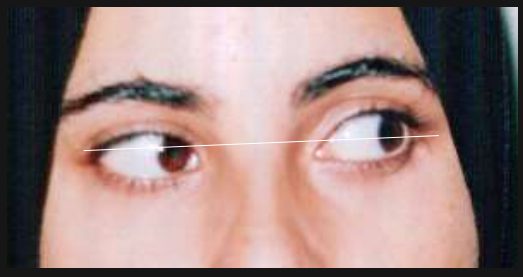
Rt Hypotropia , increases on Rt gaze.





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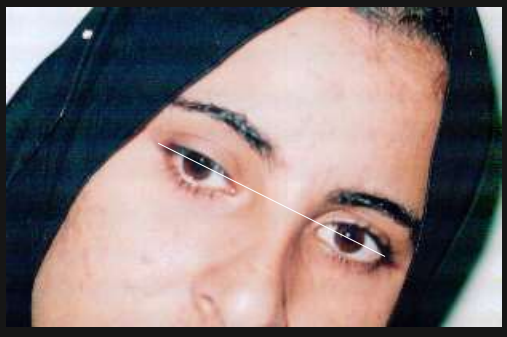
RT Hypotropia, increase on Rt gaze & Lt head tilt.



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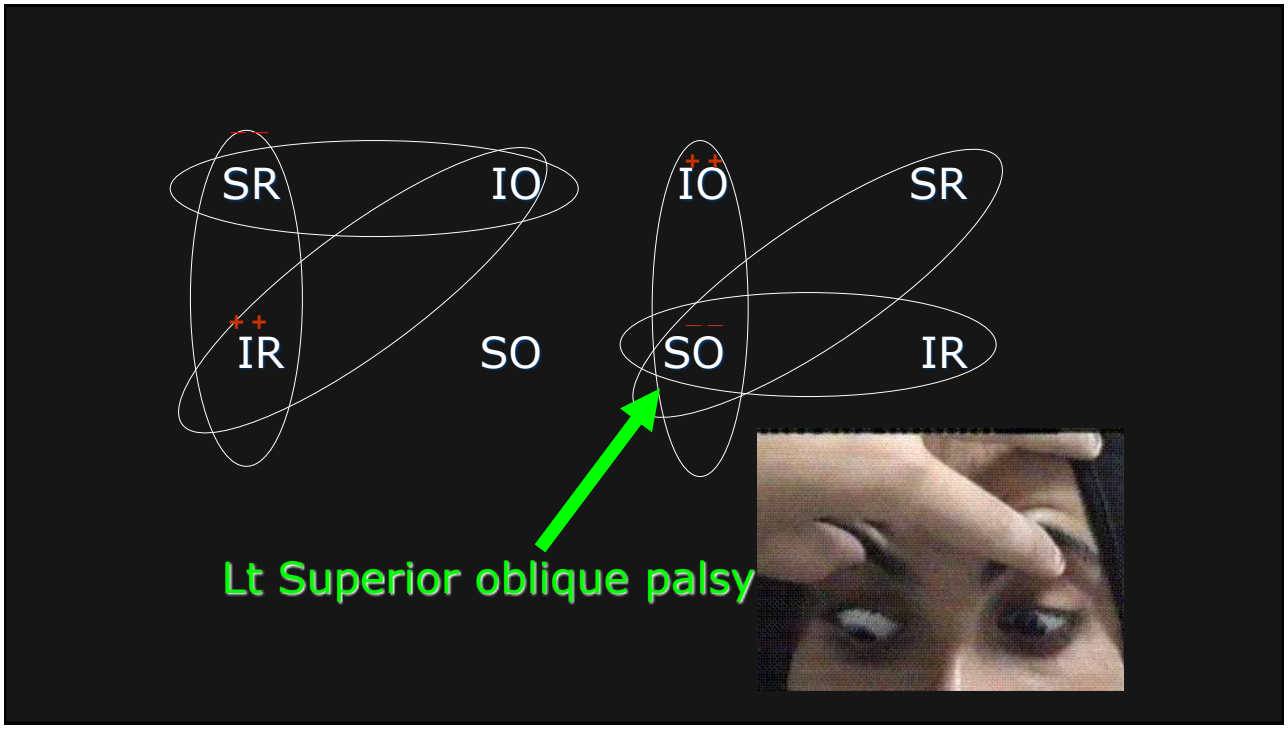

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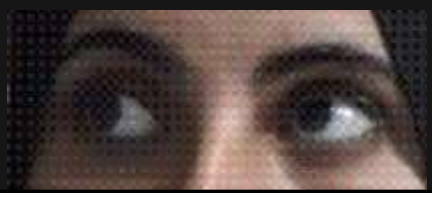
Lt 2ry IOOA.

Lt SO palsy



Inhibitional palsy of Rt. SR

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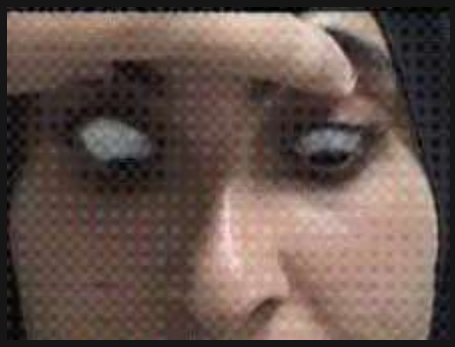

Down versus up gaze-----V- pattern

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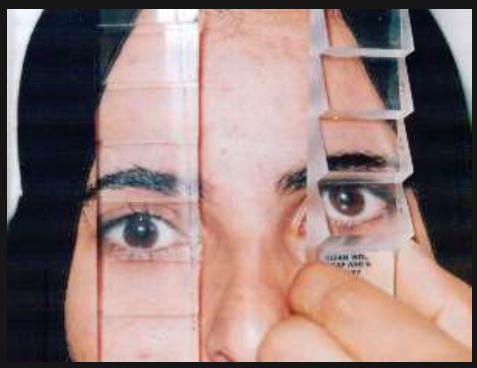
Measuring the angle of squint



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

20

Rt

--

SR (Co An)

IO

Lt

++

IO (I An)

SR

IR (Co Sy)

SR

SO

IR

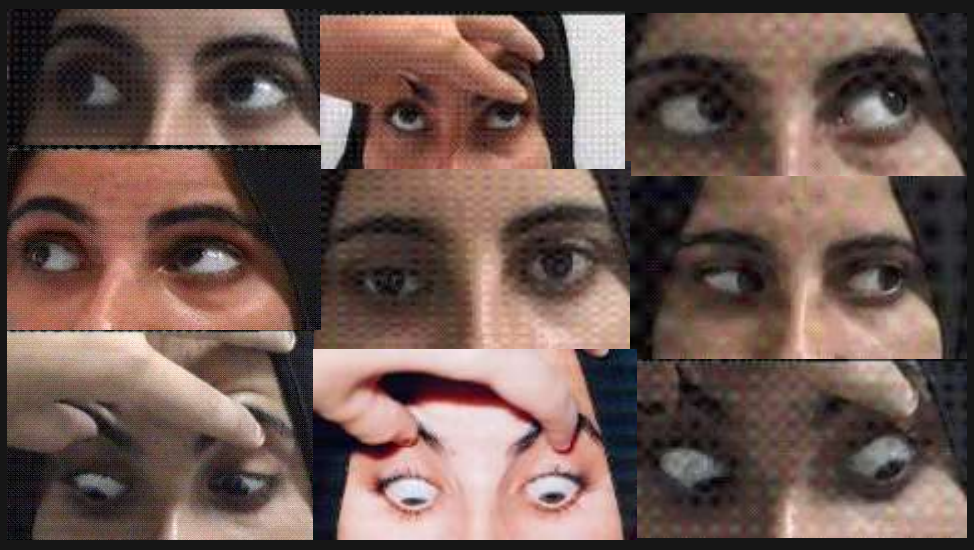
++

Fallen eye

21

Fallen eye

22



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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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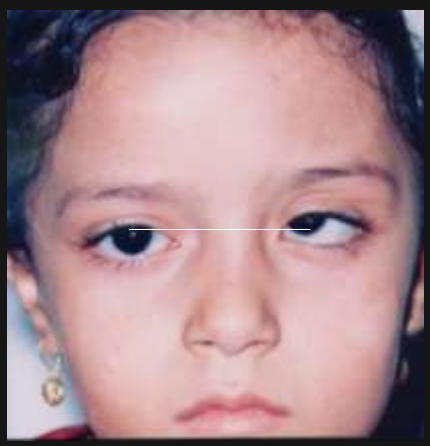
Diagnosis

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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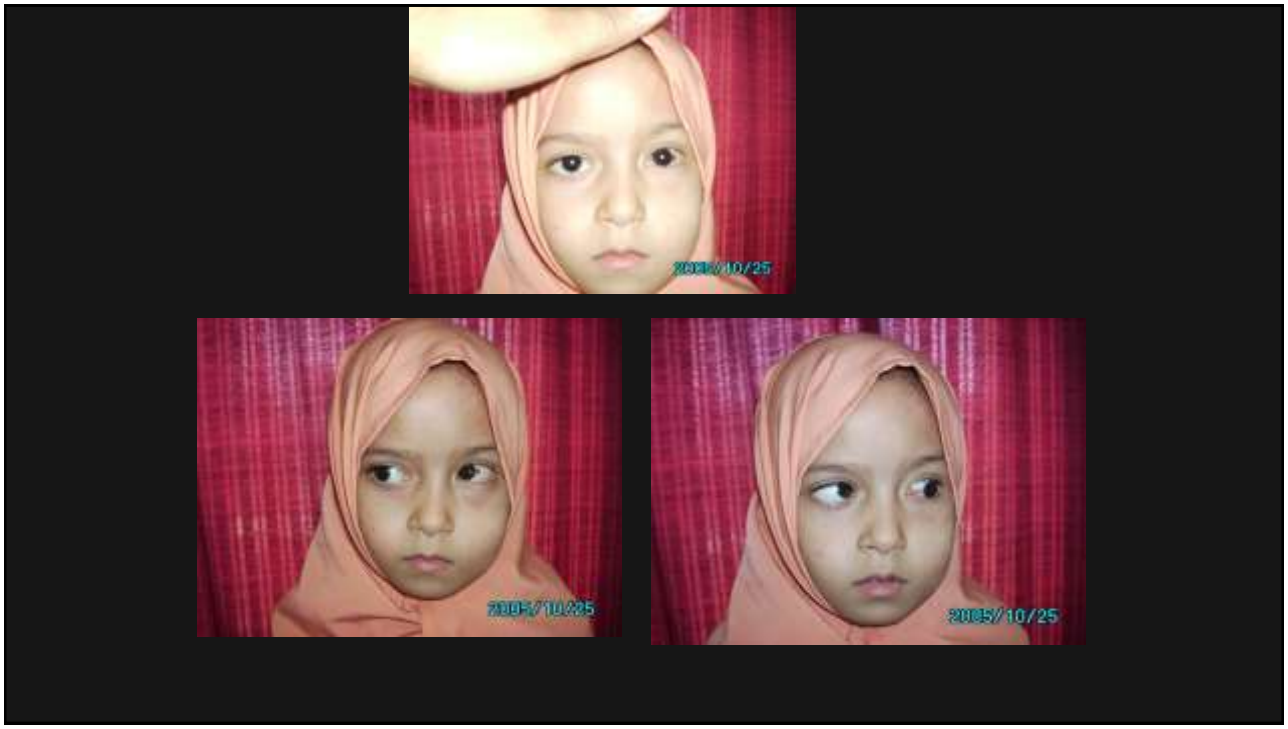

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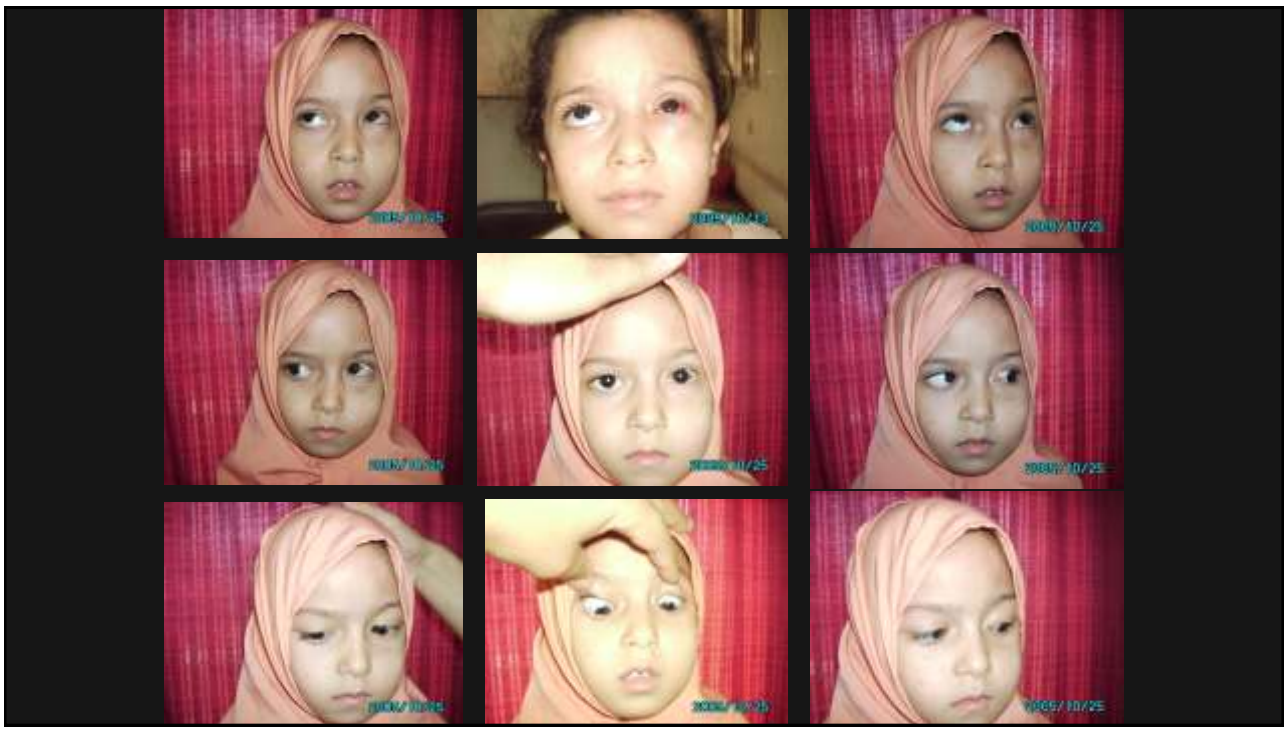

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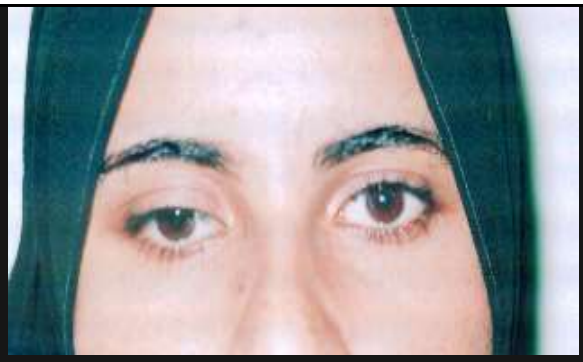
Plane for surgery:



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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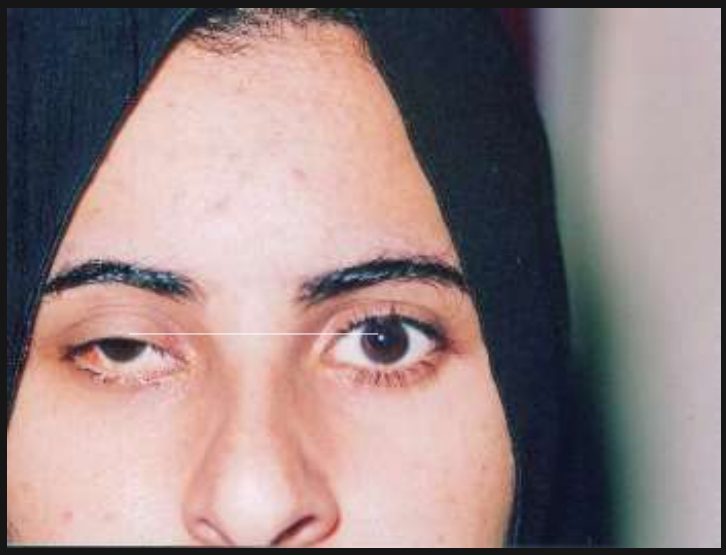

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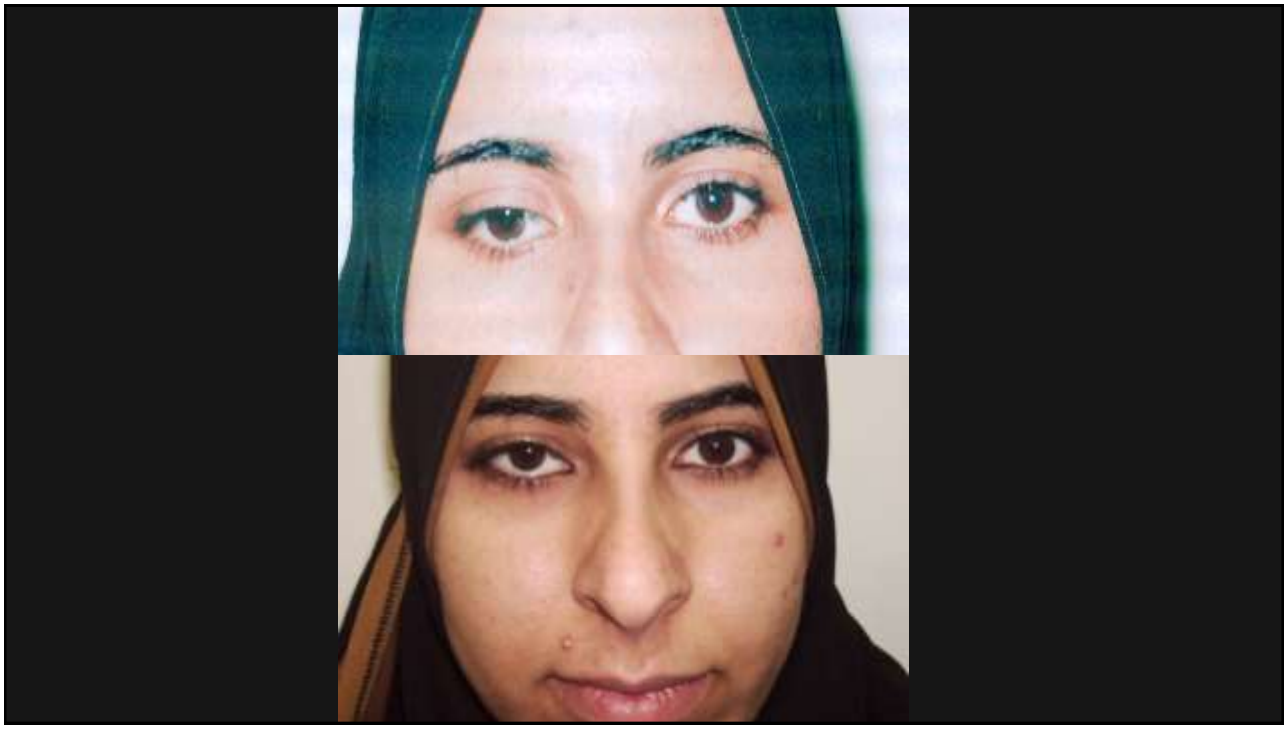

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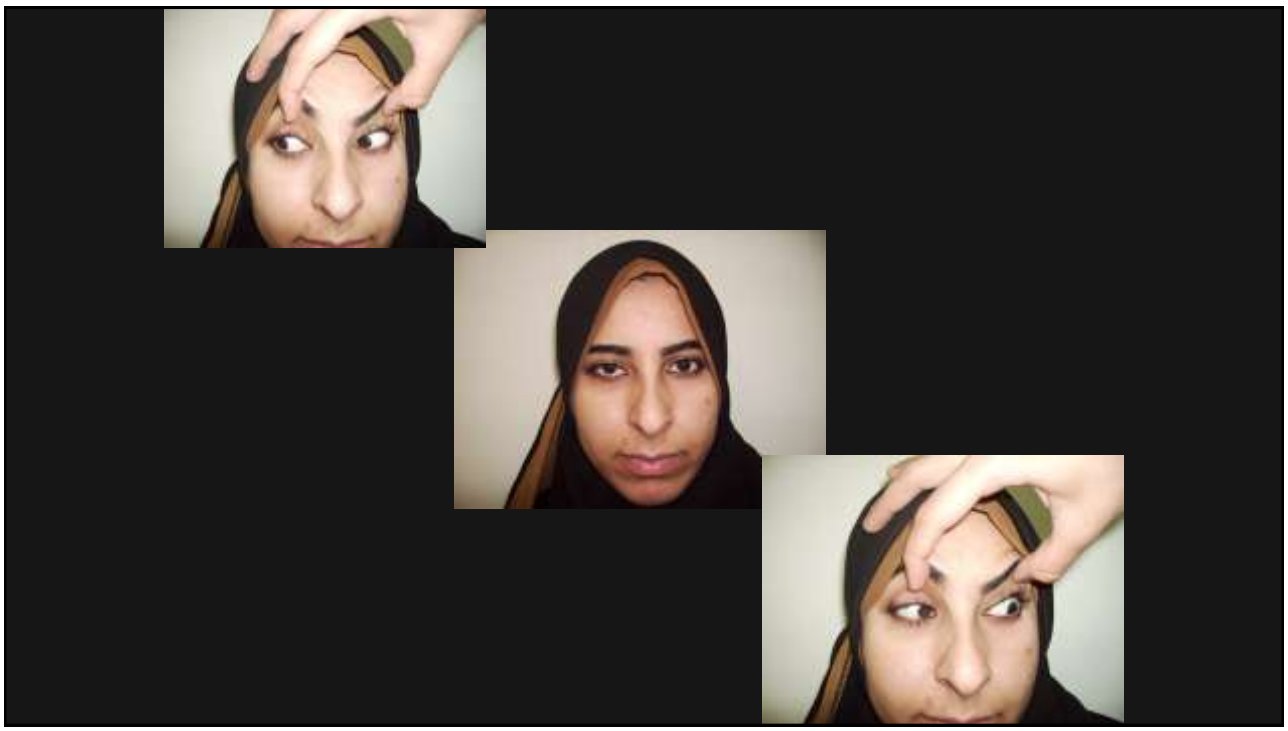

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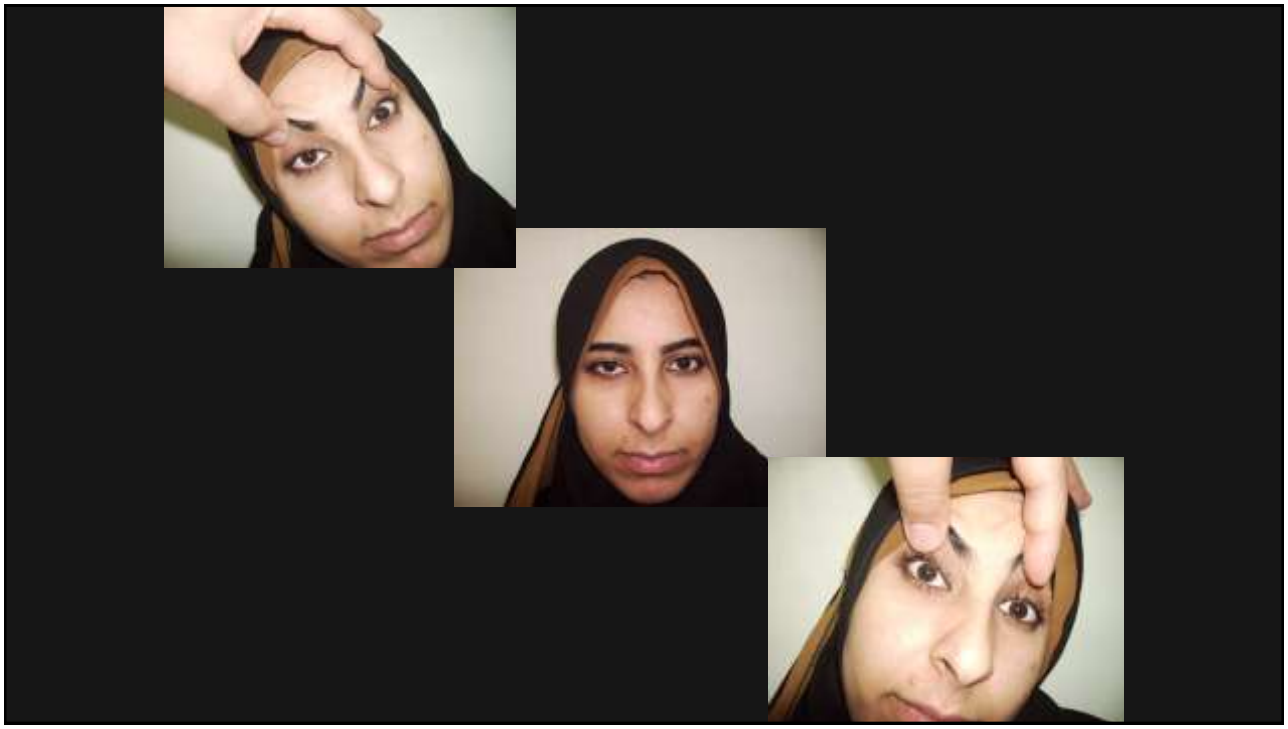

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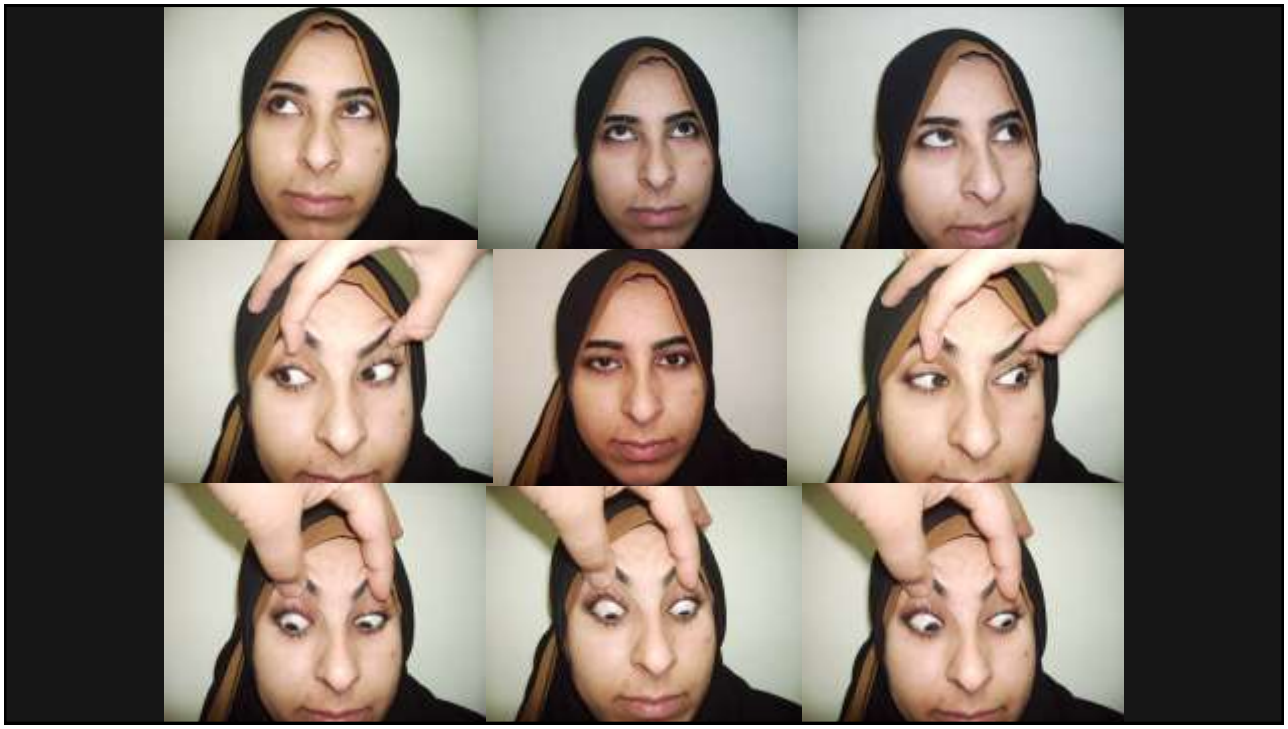

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Thank you

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