Dear Editor,

We read with interest the article by Kekunnaya et al. and would like to make certain observations.

The purpose, to study partially accommodative esotropia (ET) in esotropic Duane’s retraction syndrome (DRS), is skewed to say the least. Partially accommodative ET is that part which is left after full correction of the accommodative component, implying that partially accommodative component and eso DRS could be the same. Authors have not clarified as to how they have segregated the two, thereby concealing the entire study and attendant inferences.

Terms hypermetropia and accommodative ET are not synonymous, certain criteria have to be met for the latter. By preoperative data, only cases 1, 3 and 6 fall in accommodative category, only case 1 had vertical rectus transposition (VRT), other two did not. Both cases (2 and 4) that ended up with exotropia (XT) lacked a proven accommodative component, so also case 5 with VRT. Accordingly, it is misleading to use the term partially accommodative ET in such cases as the deviation was ostensibly due to eso DRS.

We don’t know how many were refractive/nonrefractive accommodative, high/low AC/A ratio, how many went in for deteriorated/decompensated accommodative ET, were decompensated monofixational esotropes, developed intermittent XT with accommodative component or simply passed from eso DRS to exo DRS due to long variable follow-up. Hypermetropia does not increase with the passage of time, it may only decrease due to the process of emmetropization. It is not clear why, at last follow-up, accommodative component worsened de novo after VRT surgery in cases 3 and 5. Refraction at last follow-up and change vis-a-vis preoperative values is not known to draw any logical conclusions regarding induced (non) refractive accommodative component.

Most patients are 1-year old, one being just 6 months; ocular deviation, motility cannot be assessed reliably, including the effect of glasses on the deviation. Most patients with DRS achieve alignment and fusion with abnormal head posture (AHP) and develop good binocularity. Moderate AHP in a 1-year old with fusion does not call for surgical intervention, larger AHP in an older child with symptoms like neck pain/cosmetic blemish may earn it. Operating on DRS without clear indications is not in order as a lot of negative planning is involved.

Full muscle VRT with Foster augmentation as an alternative to lateral rectus/medial rectus recessions for eso DRS in 1-year olds may raise ethical issues. VRT may only add to globe retraction (which was core criterion to diagnose DRS in this study), induce a vertical deviation (case 2), and limit adduction. The study does not address these issues, neither documents improvement in abduction if any.

There is absolutely no controversy that correction of refractive errors is a prerequisite before other surgical/nonsurgical measures are contemplated in treatment of strabismus, neither that ortho DRS may adopt AHP if deviation is induced by other concurrent factors. However, reasons for AHP in DRS are legion. XT after years could be due to diverse factors as stated above, words hypermetropia and accommodative ET have been used interchangeably, partially accommodative ET and ET due to DRS have not been pigeonholed, accordingly inferences drawn lack legitimacy.

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A 64-year-old male presented with a sudden vision palsy. His systemic investigations were within normal limits. During the follow-up of 20 months, he had multiple episodes of recurrent ME and was treated with intravitreal bevacizumab in both eyes. His best-corrected visual acuity was 20/160 in right and left eye respectively. On examination, there was ME in both eyes, with decrease in edema with CMT of 193 and 232 µ in right and left eye respectively. OCT showed a central macular thickness of 20/200 in both eyes. On examination, there was ME in both eyes, with recurrent edema in both eyes with CMT of 834 and 938 µ. At 1-month follow-up, his visual acuity improved to 20/100 in both eyes. He was diagnosed to have CRVO with recurrent ME and was treated with intravitreal bevacizumab in both eyes. His best-corrected visual acuity was 20/159 in his right and left eye respectively. OCT showed a central macular thickness of 558 µ in both eyes under aseptic conditions, with an interval of 0.05 ml in both eyes. The patient was subsequently followed at postinjection day 1, day 7 and day 30 of 5 weeks without any signs of inflammation/toxicity. The patient has been advised to undergo another injection and supports its use as the primary or second line of therapy.

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