

Acknowledgements

I should like to thank Dr. E. Finkelstein for permission to present this case, and for his help with relevant literature.

My thanks go also to the clinical photographers at the Royal Victorian Eye and Ear Hospital, and to the medical librarian for her help with references.

REFERENCE:

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CASE HISTORY: "ALTERNATE DAY SQUINT" IN AN ADULT

Jan Magin

Presented in Adelaide, April 1974

In the alternate day squint of children, hitherto described, manifest deviation of one eye occurs only on alternate days. The case here described is one of constant convergent squint in an adult, in which the angle of deviation increased regularly on alternate days to become grossly disfiguring.

Mrs. A.O. aged 55, had worn glasses since aged 6 years, her present corrections and vision being:

right eye $-16.0/+3.0$, 6/60
left eye $-2.25/+0.50$, 6/5

she knew that a right convergent squint, recognised at 6 years, had probably been present all her life. It was cosmetically acceptable, and she only became aware of it when the deviation increased and made her close work uncomfortable.

Seen in the orthoptic clinic on 17.8.72, Mrs. A.O. told us that 3 years ago, the eye began to "turn" (i.e. the deviation increased noticeably)

at night and when tired,

12 months ago, the eye "turned" every 24 hours, and was "non-squinting"

for every alternate 24 hours,

recently, the pattern had altered to cycles of 48 hours squinting

and 24 hours non-squinting,

she became very depressed when the eye "turned" and felt "off balance", she had to cover the convergent right eye for close work on the "squinting" day,

A neurological examination, E.E.G. thyroid and blood tests (including cholesterol) had all been negative.

Orthoptic findings : "squinting day".

Cover test at 6 metres & at 1/3 metre : right convergent squint, approx. 60A

Ocular movements : poor abduction of right eye

Visual acuity : right eye 1/36, left eye 6/6

Synoptophore angle, fixing left eye : 30° (by reflections)

Visuscope : right eye fixing about 5° nasal to, and slightly above fovea,
left eye fixing centrally

Orthoptic findings : "non-squint day" 20.2.72

Cover test at 6 metres & 1/3 metre : right convergent squint, approx. 16A

Synoptophore angle, fixing left eye : $+12^\circ$ (by reflections)

Visuscope : as on previous visit

"Squinting days" were now becoming more frequent, and more uncomfortable.

Surgery, a right medial rectus recession, was performed on 10.4.73

Postoperative examination 30.5.73

Cover test at 6 metres : right convergent squint approx. 4Δ

Cover test at 1/3 metre : right convergent squint approx. 8Δ

Ocular movements : abduction and adduction of right eye very slightly defective

Synoptophore angle, fixing left eye : +11° (by reflections).

Visuscope : unaltered.

Comment

The post-operative result was cosmetically excellent. The patient no longer found it necessary to occlude her convergent right eye for close work; she was symptom free, and extremely happy with her good appearance. It was interesting to find that the increased deviation of a fairly inefficient eye could bother her so much.

Acknowledgement

I would like to thank Dr. John Hart for allowing me to present this case history.

REFERENCES:

- Roper Hall, M.J. and Yapp, J.M.S., (1968) *The First International Congress of Orthoptics*, Henry Kimpton, London.
 Willoughby, Lucy (1969) *Australian Orthoptic Journal*, 9, 38.
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CASE HISTORY : UNILATERAL APHAKIA

Helen Hawkeswood

A.H. is 54 years old, a part time clerical worker. She and her husband are bird lovers, and have a feeding table in their back yard. One day seven years ago while they were feeding the birds, a peewee flew into her right eye; this resulted in a cataract, and for seven years the eye remained healthy but blind.

In July 1972 a capsulotomy was performed, and later A.H. was fitted with a contact lens. She was referred to us complaining of diplopia. Her vision was R.E. 6/12, L/E. 6/6. There was a variable divergent squint with unsteady fusion and simple stereopsis. Orthoptic treatment proved slow. It was not until the ninth visit that convergence started to improve, but by the eleventh visit it was so much better that we asked for the increased presbyopic correction, so that A.H. could read without having to close the right eye. She now comes periodically for review. Her convergence near point is almost full, and she appreciates full stereopsis. Questioned about the benefit obtained from treatment, she reacts very strongly in favour: she has no diplopia, she enjoys the accurate stereopsis, and she has taken up golf again.

Why did my other four cases of monocular aphakia fail to persevere with treatment?

The type of employment may be relevant. A contact lens is more comfortably worn if the patient is an indoor worker, as was A.H., and less comfortable if he works outdoors or in dusty surroundings. The orthoptist is wrong to assume that the contact lens is worn constantly just because the patient comes in wearing it. If the lens is worn on a part time basis, treatment must be slow. Diplopia becomes less of a problem too; it is much easier to shut one eye for a short time than for a long time. This may explain three of the four cases who failed to complete treatment. Careful questioning about their jobs might have saved unnecessary effort.

Depth appreciation must have some bearing on perseverance.

A.H. found it a great loss when she became monocular; others learn to adjust far more easily.

Then there is the personality of the patient. All orthoptists will agree that best results are achieved with tremendous co-operation from the patient. This we had from A.H.