

Binocular Vision Anomalies: Investigation and Treatment. By DAVID PICKWELL. Pp. 178. £17.50. Butterworths: Sevenoaks, Kent. 1984.

The author is a professor of optometry at Bradford University, and this book is intended for students and practitioners of optometry. Accordingly, there is greater emphasis on spectacles and exercises for the treatment of binocular anomalies than might be found in a medical or orthoptic text. There are a number of points that I disagree with in the text.

In chapter 1 the author states that cyclophoria can occur on dissociation. There is no evidence that this occurs, and in fact the author retracts the statement later in the text. In chapter 2 the fact that the eye behind the occluder may move in latent squint does not contravene Hering's law, which applies to conjugate gaze efforts only. Although the Hirschberg test is described, the much more accurate prism reflection test (Krimsky test) is not. In general, the section on measurement of angle of squint is sketchy.

In chapter 3 for some reason the prism and alternate cover test is not mentioned in the section on measurement of degree of heterophoria, despite its ease, accuracy, and universal use. In chapter 4, on prism relief of heterophoria, the use of Fresnel membrane prisms for temporary relief and for discovering the optimum correction is not described. In chapter 5 the striking claim is made that patients who work in stuffy atmospheres develop anaemia, which causes divergence weakness exophoria. The association of divergence weakness with raised intracranial pressure is not mentioned. I can find no reference to the use of miotics in convergence excess esodeviations. In chapter 6 it is implied that distinguishing between true and simulated divergence excess exodeviation is unimportant. Accordingly a distance cover test and measurement of AC/A ratio are not mentioned. In general the importance of the AC/A ratio in latent, and manifest horizontal deviations is surprisingly neglected. In chapter 7, on hyperphoria, nothing is said on compensatory head tilting (including examination of the family photograph album) or on the Bielschowsky head-tilt test. Dissociated vertical deviation is treatable surgically, with reasonable if not excellent results.

Chapter 11, on amblyopia, presents the now rather obsolete classification of 'amblyopia of arrest' and 'amblyopia of extinction,' based on a very misleading concept of infant visual acuity. 'Amblyopia ex anopsia' is preferred as a term to the much clearer 'simulus-deprivation amblyopia,' and bilateral ametropic amblyopia, as in high hypermetropia, is not mentioned, though meridional amblyopia is. It is recommended that children should be tested for visual acuity of the worse eye first to avoid memorising the letter chart. It should be remembered that some children regard the letter chart as a test, and are probably best encouraged by using the better eye first, with a fresh chart for the other eye.

In the treatment of amblyopia full-time occlusion is recommended, with part-time occlusion if this is impracticable. Current orthoptic practice, in Great Britain and elsewhere, regards part-time occlusion as at least as effective as full time treatment and much less likely to lead to problems. It is suggested that amblyopia can be treated by teaching awareness of physiological diplopia. I am sceptical about this.

In chapter 13 the traditional and never-explained 'tonus' allowance in cycloplegic refraction appears. There seems to be no sense in continuing this tradition if the object of convex lenses in esotropia is relaxation of accommodation. It is implied that consecutive exotropia is caused by giving glasses to hypermetropic patients who were operated on as children. Chapter 15 concerns examination of young children. Table 15.1 perpetuates the hoary old idea that a child can see no better than 6/36 at 1 year and 6/12 at 2 years. This has been conclusively disproved by preferential looking tests of acuity. In the description of nystagmus blockage syndrome (p. 146), the head turn is the wrong way. In chapter 16 investigation of incomitant deviations is considered. Obviously only guidelines are being given here, but a simple guide such as the Parks's three-step test would aid understanding of how to elicit the responsible vertical paretic muscle. The vital fact that *all* third nerve palsies with pupils affected are potentially aneurysmal is not mentioned, and should be. Traumatic fourth nerve palsies are not due to direct trochlear trauma as a rule. Again the role of Fresnel prisms is not covered in the section on management. In chapter 17 it is implied that 'miners' nystagmus' is still seen in mining areas. It is, but only because some individuals learn how to cause it voluntarily in order to gain compensation.

Overall, the role of surgery is underplayed and is consistently said to be inaccurate. With newer techniques such as adjustable sutures and botulinus toxin, this is no longer the case. In summary, although the book may well have a place in the optometry curriculum, it is not of value for ophthalmologists in training.

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Diagnostic Diagrams: Ophthalmology. By ANDREW P SCHACHAT AND ALAN F CRUICK. Pp. 124. £10.00. Williams and Wilkins: London. 1984.

The authors, in their foreword, realise the significant increase in material which the medical student has to assimilate, and their book is an attempt to make the assimilation of ophthalmology easier. They then provide a suggested reading list of 19 comprehensive books and articles and a slide collection of clinical photographs which rather negates the purpose of a simple book for medical students. The interested student very quickly finds further reading from his teachers; the rest require one simple readable book for their short time in ophthalmology.

The book is illustrated throughout in black-and-white and consists of text and diagnostic diagrams which lead to diagnosis of certain groups of symptoms and signs. In this manner, by describing the relevance of symptoms and signs and their elicitation, each chapter progresses to a diagnostic diagram. Visual loss, the red eye, anisocoria, visual field defects, strabismus, leucoconia, glaucoma, diplopia, proptosis, headache, and ocular emergencies are each treated in this way in turn. This type of diagnostic diagram is at present having a certain fashion in medical student teaching but is after all what all students have been doing informally for many years. It is a good way of revising and testing one's own knowledge, but whether it is beneficial as the formal basis of a textbook is open to question.

There is probably too much complicating detail for most medical students, and the lack of colour illustrations takes



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