Congenital fibrosis of superior rectus and superior oblique: a case report

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SUMMARY A rare case of possible postinflammatory fibrosis of the superior rectus and superior oblique muscles, resulting in marked hypotropia with pseudoptosis, is described, together with the surgical management.

Agenesis or hypoplasia of one or more extraocular muscles has been rather infrequently reported. Absence or hypoplasia of the superior rectus and inferior rectus in addition to the horizontal recti has been reported. However, combinations of various muscle anomalies have been less often reported—superior and inferior recti, lateral and inferior recti. Posey reported one case of absence of the inferior rectus treated by the Hummelsheim operation. Silverman and Fletcher reported a case of absence of the inferior oblique and an abnormal insertion of the superior rectus and another case of absent medial rectus and superior oblique with abnormal insertions of other muscles. Starkiewiez reported a case of absence of the trochlea. Prakash et al. have reported maldevelopment of the superior oblique and its fascial check mechanism.

Case report

A 7-year-old girl was admitted with a history of downward deviation, ptosis, and defective vision in the right eye since birth. Her birth had been at full term, was normal, and with no history of birth trauma. The mother did not have any illness during pregnancy. All the girl’s physical and mental milestones were normal, and she had never had diplopia. She was prescribed glasses a year ago and was referred to us for cosmetic surgery.

General physical examination did not reveal any significant abnormality. Local examination showed slight facial asymmetry, a visual acuity of 1/60 which improved to 3/60 with +6.0 D sph in RE, and 6/60 improving to 6/18 with +4.5 D sph; 0.5 D cyl+90° in LE.

No binocular functions could be elicited. Fundus examination revealed a hypermetropic appearance with dull foveal reflex in RE. X-ray of the orbit and skull did not show any significant abnormality.

The patient was admitted to hospital for cosmetic squint surgery after a forced duction test under general anaesthesia. The forced duction test showed a marked restriction of elevation in adduction and abduction and a moderate restriction of depression in both adduction and abduction.

On exploration it was seen that superior rectus and superior oblique could not be isolated. Instead a firm, thick fibrous band was adherent to the sclera, extend-
Fig. 1 Before operation. Right hypotropia in primary position with ptosis in RE. There is a marked restriction of right eye on dextro- and laevo-elevation.

Fig. 2 The area of adherence of the fibroed band and its possible course.

Discussion

With the restricted movements in laevo-elevation with the presence of a fibrous band palpable in the upper nasal quadrant of the orbit the case appeared clinically to be an atypical presentation of superior oblique sheath syndrome. However, the restriction of movement in dextro-elevation and dextro-depression did not support this diagnosis. The possibility of a musculofascial anomaly was entertained.

Reports are lacking of any instance of a combined anomaly of the superior oblique and superior rectus in the same eye or even a total absence of the two. As the two muscles develop from different segments of the mesoderm, it is difficult to explain the genesis of this defect. As discussed by Duke-Elder,9 there are two main views on the embryological development of the extraocular muscles. According to Lewis10 the muscles are developed from a single common pre-muscle mass, appearing at the 7 mm embryonic stage, which extends anteriorly and splits into rudiments supplied by 3 cranial nerves at the 10 mm stage. If this
is so, any interference with the superior aspects of the
globe might hinder the development of the 2 muscles
lying there.

But the more generally accepted view is that of
Gilbert, who considers that the extraocular muscles
arise from 3 independent but closely related meso-
dermal condensations supplied by the third nerve from
premandibular condensation, and by the fourth and
sixth nerves from two separate condensations lying in
close contact with the superior rectus anlage. The
boundaries of these two muscles become defined only
at the 10 mm stage and start separating from each
other. Any hindrance to mesodermal development in
this region during these stages may also interfere with
the development of the superior rectus and superior
oblique.

If we envisage a hindrance to the development at
such an early stage, it is inevitable that the levator
cpalebrae superioris would also be affected. Yet on
the contrary it was seen after the three operations and
the correction of the hypertropia that the levator was
perfectly normal, the ptosis having automatically
disappeared. So for the lesion to have involved the
superior rectus and superior oblique while sparing the
levator it must have occurred after the 55 mm
stage, when the levator had already separated from
the superior rectus. Owing to the close proximity of
the superior rectus and superior oblique at this
insertion it is possible for an intrauterine inflamma-
tion to have involved the two muscles. The clinical
finding of a fibrous band across the superonasal
quadrant of the orbit shows it to be in the region of
the superior oblique tendon, which seems to have become involved in postinflammatory fibrosis along
with the superior rectus. The anterior limits of the
fibrous tissue almost coincided with the insertion of
the superior rectus.

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