CORRESPONDENCE

CONVERGENCE DEFICIENCY

To the Editorial Committee of

THE BRITISH JOURNAL OF OPHTHALMOLOGY

DEAR SIRs—Dr. Mellick's article, "Convergence Deficiency", in the *British Journal of Ophthalmology* (1950), **34**, 41, raises some questions which may well need to be clarified. The author does not say how the convergence weakness was diagnosed; there is no mention of the near-point of convergence having been taken and found to have receded beyond the minimum normal.

In fact, from the context it seems that the only test taken was the prism convergence or adduction with a *distant* target. One infers this from the statement that for near one must converge 21 prism diopters.

"Individuals who are capable only of this degree of adduction [*i.e.*, 21 Δ] are employing their maximum convergence continuously . . . at near".

"Apparently there exists a group of people with even less than this minimum (21 Δ) who do not complain of symptoms referable to their defective convergence".

The most important test for the strength or weakness of convergence is the determination of the convergence near point. Next in importance is finding the convergence reserve, *i.e.*, the *near* adduction, the amount of prism base out the eyes can overcome at the reading distance. Distance adduction gives at best a very indirect and often a misleading clue to the state of convergence. One will often see patients whose distance adduction is only 10 to 15 prism diopters, and who yet have a normal near point of convergence and sufficient reserves at near.

It is important to note that with a *distant* target the innervation to converge, to overcome prism base out, is only fusional. With a *near* target there are the additional innervations from the associated accommodation, and, above all, from the sense of nearness.

Yours faithfully,

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