To the Editors of The British Journal of Ophthalmology.

Dear Sirs,—I have carefully studied with interest Mr. Law's article in last month's number of the British Journal of Ophthalmology.

It is refreshing to read at the outset that "it is high time that an impartial investigation was conducted in order to discover whether the immense amount of time and trouble now being devoted to orthoptics is bearing the fruits of success which one is entitled to expect from so highly organised and extensively practised branch of ophthalmology," but as one continues to read the article it becomes obvious that impartiality has not been strictly observed.

Figures quoting results of treatment can be converted into percentages so as to give a false impression, and one cannot help feeling that this is the case under consideration.

Mr. Law states in referring to Abnormal Retinal Correspondence (page 203), "it is in this group that the greatest disappointment is encountered for only three of fourteen cases were cured by orthoptic training." However, on investigation of these fourteen cases in the table on page 199, one finds that three more of the fourteen were discharged with partial stereopsis and an angle of squint less than 30° (which as Mr. Law points out on page 194 may be regarded as
a cure), four have just started treatment, two are unable to attend, one is too young for treatment and one only is a failure.

Taking into account therefore only those cases in which treatment has been completed, we find:

Three “cured” with full stereopsis.
Three “cured” with partial stereopsis.
One failure; i.e., six “cured” out of seven.

The fact that in three out of these six cases an operation was required in addition to orthoptic treatment, should not remove them from the “cures by means of orthoptics.” The four who have just started treatment obviously have a chance of being cured, and the two who are unable to attend, and the one too young must obviously not be included.

That far too much enthusiasm has been shown in certain quarters for orthoptic treatment I heartily agree, and an immense amount of time is sometimes spent in treating cases that are certainly incurable, but this fact should not be used as an argument against the value of orthoptic training. The fault sometimes lies with the ophthalmologist who insists upon referring cases to the orthoptist for treatment with a sort of half-hearted enthusiasm of “let’s try exercises,” when the case is clearly one that will not benefit thereby.

Ophthalmologists are familiar with the large group of accommodative squints that are “cured” with glasses alone, and it is this group of twenty-seven cases quoted by Mr. Law in which, for a cosmetic “cure,” no treatment other than glasses is necessary, but one would like to know—are all these cases “straight” or “binocular” when not wearing their glasses, and if so, do they possess useful binocular visual acuity without glasses?

To quote an instance:

A female office clerk, aged nineteen years, consulted me on account of headaches and blurring of vision when tired. She wore glasses which she had used since the age of four years for work only (+3.0 D. sph. each eye). I found her vision was 6/5 in each eye separately, but binocularly she could only read 6/36. She had three dioptres of hypermetropia and her vision with the correct glasses (which she was wearing) was 6/5 uniocularly or binocularly. She had a convergent angle of +12° with S.M.P. slides on the synoptophore without glasses, and +2° with glasses, and good fusion with stereoscopic vision.

Now it is obvious that the constant use of glasses was all that was required to effect a “cure,” but she objected to wearing glasses on account of appearance, so a course of orthoptic treatment was advised as a result of which she learned to dissociate “accommodation” from “convergence,” and she now reads 6/6 binocularly without glasses and finds her vision much improved. She continues with her glasses for near work.
I venture to suggest that in this class of case, orthoptic treatment is worth while, and the earlier it is administered the less likely are the symptoms to occur in later life.

I think in assessing a cure one is sometimes apt to think in terms only of performance on the synoptophore when what we really want to know is what is occurring in ordinary life.

Additional information as to the original angle of squint before wearing glasses, and the refractive error present would have been of interest in Table II.

The economic question of orthoptic treatment has been very rightly stressed by Mr. Law. In the case of children who have to travel long distances, it is often necessary to consider orthoptic treatment as unsuitable, unless the child is at the age when home-treatment supervised by an intelligent parent can be carried out.

Again in dealing with children from "uneducated homes" where their future position in life is such that the power of binocular vision is unlikely to matter very much, orthoptic treatment may be deemed superfluous.

Finally, I think it would have been more advisable to head the article "On the Value of Orthoptic Training in Cases of Concomitant Strabismus" rather than "On the Value of Orthoptic Training," since there is no doubt that in cases of heterophoria in adults, much can be done to alleviate symptoms by orthoptic measures, and a far higher percentage of successes obtained.

I would venture to suggest that the results of orthoptic treatment in the cases quoted by Mr. Law are on the whole most satisfactory.

Yours faithfully,

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NOTES

A new operating theatre has recently been opened at the Shrewsbury Eye, Ear and Throat Hospital, while the original theatre has been enlarged. The names of Swanzy and Russ Wood have been given to these new rooms. Mr. Russ Wood worked in Shrewsbury for 31 years and it is most appropriate that the enlarged theatre should in future be known by his name. We offer him, in the name of British ophthalmology, cordial congratulations.