CORRESPONDENCE

When is acute onset concomitant esotropia a sign of serious neurological disease?

Editor,—We read with interest the paper by Hoyt and Good in which they outlined the differences between patients with acute onset concomitant esotropia with coexisting central nervous system pathology and those who were otherwise neurologically intact.1

We fully agree with the authors that the vast majority of cases will have no obvious underlying neurological cause, making it of the utmost importance to have good clinical criteria for use in the selection of those patients who will need immediate neurological and neuroradiological investigation. As the authors state, the patient who presents with diplopia should prompt careful consideration of whether the strabismus is a sign of serious central nervous system pathology. The ophthalmic history (especially that of previous strabismus and occlusion therapy) and neurological findings (such as headache, papilloedema, clumsiness, etc.) are helpful in distinguishing ophthalmic from neurological causes of strabismus. Enquiry about previous head trauma is most important.2

The authors reach the quite correct conclusion that the presence of nystagmus in cases of acute concomitant esotropia should be considered an abnormality that warrants neurological investigation.

However, we do not agree that a history of monocular visual loss need cause little worry for the clinician. Unilateral reduced visual function is one of the various factors that may be a cause of concomitant esodeviations.3 Both tumours of the optic nerve and chiasmal region may be responsible for this unilateral reduced visual function. In such cases associated with visual loss, examination of pupillary reactions and visual fields is indispensable. Both should be normal in uncomplicated esotropia.

In summary, we believe that in cases of acute onset concomitant esotropia, the same risk factors for serious neurological disease should be considered as in cases of paralytic strabismus. Recently, these risk factors were summarised in the mnemonic: DON’T PANIC with ocular motor palsies.4 Using the mnemonic should help in the systematic analysis of the problem and in judging the seriousness of the situation.

Reply

Editor,—We thank Cruydsberg, Draaijer, and Sellar for their thoughtful and important comments on our paper. We do not disagree with the concern about the sensory esotropia associated with afferent visual pathway disease. However, we were only addressing acute esotropia presenting with diplopia. Our experience has been that the esotropia associated with monocular visual loss and tumours of the optic nerve and chiasm is more indeterminate in its onset and rarely associated with diplopia. This is not meant to minimise the importance of these tumours and the associated esotropia, but to say that this group of patients usually falls outside the clinical profile that we were addressing. We thank the authors again for their comments.

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