

Surgery, a right medial rectus recession, was performed on 10.4.73

Postoperative examination 30.5.73

Cover test at 6 metres : right convergent squint approx. 4Δ

Cover test at 1/3 metre : right convergent squint approx. 8Δ

Ocular movements : abduction and adduction of right eye very slightly defective

Synoptophore angle, fixing left eye : +11° (by reflections).

Visuscope : unaltered.

Comment

The post-operative result was cosmetically excellent. The patient no longer found it necessary to occlude her convergent right eye for close work; she was symptom free, and extremely happy with her good appearance. It was interesting to find that the increased deviation of a fairly inefficient eye could bother her so much.

Acknowledgement

I would like to thank Dr. John Hart for allowing me to present this case history.

REFERENCES:

- Roper Hall, M.J. and Yapp, J.M.S., (1968) *The First International Congress of Orthoptics*, Henry Kimpton, London.
 Willoughby, Lucy (1969) *Australian Orthoptic Journal*, 9, 38.
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CASE HISTORY : UNILATERAL APHAKIA

Helen Hawkeswood

A.H. is 54 years old, a part time clerical worker. She and her husband are bird lovers, and have a feeding table in their back yard. One day seven years ago while they were feeding the birds, a peewee flew into her right eye; this resulted in a cataract, and for seven years the eye remained healthy but blind.

In July 1972 a capsulotomy was performed, and later A.H. was fitted with a contact lens. She was referred to us complaining of diplopia. Her vision was R.E. 6/12, L/E. 6/6. There was a variable divergent squint with unsteady fusion and simple stereopsis. Orthoptic treatment proved slow. It was not until the ninth visit that convergence started to improve, but by the eleventh visit it was so much better that we asked for the increased presbyopic correction, so that A.H. could read without having to close the right eye. She now comes periodically for review. Her convergence near point is almost full, and she appreciates full stereopsis. Questioned about the benefit obtained from treatment, she reacts very strongly in favour: she has no diplopia, she enjoys the accurate stereopsis, and she has taken up golf again.

Why did my other four cases of monocular aphakia fail to persevere with treatment?

The type of employment may be relevant. A contact lens is more comfortably worn if the patient is an indoor worker, as was A.H., and less comfortable if he works outdoors or in dusty surroundings. The orthoptist is wrong to assume that the contact lens is worn constantly just because the patient comes in wearing it. If the lens is worn on a part time basis, treatment must be slow. Diplopia becomes less of a problem too; it is much easier to shut one eye for a short time than for a long time. This may explain three of the four cases who failed to complete treatment. Careful questioning about their jobs might have saved unnecessary effort.

Depth appreciation must have some bearing on perseverance.

A.H. found it a great loss when she became monocular; others learn to adjust far more easily.

Then there is the personality of the patient. All orthoptists will agree that best results are achieved with tremendous co-operation from the patient. This we had from A.H.