CASE HISTORY: RECURRENT SIXTH NERVE PARALYSIS IN A CHILD

Jenny Hunter, D.O.B.A.
R.V.E.E. Hospital, Melbourne

At age 2.11/12 K.L. presented with a large left esotropia obvious since a recent unspecified illness. The ophthalmologist noted a marked compensatory posture of a face turn to the left, and suspected a left lateral rectus underaction. Atropine refraction revealed minimal hypermetropia and no lenses were ordered.

At the first orthoptic assessment no head posture was noted. No manifest deviation was evident and there was full abduction of the left eye. It was suggested that a further assessment be made in the near future, however the patient did not present again until twelve months later.

At this visit the mother reported that since a bad case of mumps with a very high temperature, a large left esotropia with an abnormal head posture had again been noted.This posture of a face turn to the left with the chin down was very obvious. A left convergent squint of +15° in the primary position was well controlled with this head posture. There was no apparent abduction of the left eye beyond the midline.

Two months later there had been no change in squint or head posture. Visual acuity was assessed by the "E" chart at 6/9 right and left. An angle of +20° (F.R.) with N.R.C. was obtained at the synoptophore. The patient fused at this angle with a small range.

Four months later no squint or head posture had been noted for some time. Cover test revealed a well controlled esophoria with full abduction of the left eye. Six months later the eyes were still straight.

At the sixth orthoptic visit the squint and head posture were again evident, and, according to the mother, had been present since a severe bout of bronchitis associated with fever. A Hess chart showed a typical left lateral rectus paresis.

The opinion of a paediatric neurologist was that neurological examination was normal, and that further electrophysiological and tensilon tests were not indicated. A right medial rectus recession was considered.

At the next assessment no squint or head posture was evident. A well controlled esophoria with full abduction of the left eye was present. Surgery was therefore deferred.

Six months later the eyes remained straight, with full ocular movement and equal vision. An angle of +3° with N.R.C. was measured at the synoptophore. The Hess chart showed a slight esodeviation only.

Mother reported that K.L. was now receiving long term penicillin treatment for her bronchial problem and had been relatively well, and that no squint or head posture had been seen.

It seems apparent that there is a definite relationship between the onset of a sixth nerve paralysis and the presence of illness with a high fever in this patient.

My thanks to Dr L. Cebon for allowing me to present this case.