In a classic article, Dr. Malcolm Ing and his renowned co-authors first brought to our attention the possibility of achieving the limited binocularity characteristic of the monofixation syndrome in patients undergoing early surgery for infantile esotropia. In this issue, Dr. Ing reviews his results in 31 patients with infantile esotropia who were surgically aligned prior to 2 years of age and diagnosed as having monofixation syndrome.

The findings in the current study showed that the majority (28 of 31; 90%) of patients with monofixation syndrome examined during a 5-year period continued to have this form of binocularity. Only 2 of the 24 patients who required or responded to hyperopic correction decompensated. Both of these patients responded to secondary surgery. One-quarter of the patients with infantile esotropia later developed the need for hyperopic correction to stabilize the alignment achieved by surgery.

The retention of monofixation syndrome was relatively stable during the first two decades of life, with most remaining unchanged. A small percentage of patients were recorded as improving their sensory binocular status by developing their stereoacuity to a relatively higher grade over time. A second small percentage of patients showed decompensation, and this group of patients required secondary surgery to restore their limited binocularity. These findings indicate that surgically aligned patients with the monofixation syndrome need to be monitored for the possibility of decompensation. This is not easy to do in many cases as these patients age in a mobile society. Furthermore, his patients who developed misalignments greater than 8 prism diopters did not complain of diplopia, so would likely go unrecognized until the deviation became cosmetically unacceptable. In those postoperative patients in whom the decompensation of their alignment is recognized, the surgeon should consider hyperopic correction or secondary surgery to reestablish monofixation syndrome binocularity, a result that Dr. Ing has demonstrated in some of his patients. I question whether the loss of limited binocularity is easily recognized by these patients even in the acute phase. I suspect that it is not.

REFERENCE

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