Thursday, July 28, 2016

6:00 pm  Opening Reception
7:00 pm  David S. Friendly Award Presentation & Dinner

Friday, July 29, 2016

7:00-8:00 am  Scientific Program
  Welcome and Announcements, Coffee and Tea Service
  Jonathan Salvin

8:15-9:00 am  Breakfast & Business Meeting

9:00 am – 1 pm  Scientific Program (Continued)

Session I:  Infectious Disease and Oculoplastics
Moderator:  Jonathan Salvin

7:00-7:15 am  Update on Lymphocytic Choriomeningitis Virus (LCMV)
  Marilyn Mets

7:15 -7:25 am  Discussion of Previous Paper
  All Members

7:25-7:40 am  Gavaris Minimal Ptosis Repair: Long Term Results
  George Ellis

7:40-7:50 am  Discussion of Previous Paper
  All Members

7:50-8:05 am  The Pediatric Conjunctival Lesion
  Mohamad Jaafar

8:05-8:15 am  Discussion of Previous Paper
  All Members
8:15-9:00 am  Breakfast and Business Meeting

Session II  Children’s National Fellows Presentations
Moderator: Marlet Bazemore

9:10-9:25 am  High Resolution Orbital MRI Demonstrating Anatomic Correlates of Superior Rectus Palsy
Shatha Alfreihi

9:30-9:45 am  Stevens-Johnson Syndrome Case
Janhavi Shirali

9:50-10:05 am  Refractive Trends after Pediatric Intraocular Lens Implantation
Kim Le

Session III:  Workshop: Resident Education
Moderator: Elias Traboulsi

10:15-11:00 am  Resident Supervision and Training
Elias Traboulsi
Discussion

11:00-11:15 am  Break

Session IV  Strabismus and Amblyopia: Part I
Moderator: Cynthia Alley

11:20-11:35 am  The Treatment of Dissociated Vertical Deviation with Bilateral Graded Superior Rectus Recession
Sherwin Isenberg

11:35-11:45 am  Discussion of Previous Paper
All Members

11:50-12:05 pm  A New Procedure to Treat Bielchowski Phenomenon
Irene Ludwig

12:05-12:10 pm  Discussion of Previous Paper
All Members

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Session V: Legislative Affairs  
Moderator: Julie Conley

12:15-12:30 pm  OMIC Update: Lessons Learned from Malpractice Cases  
Denise Chamblee

12:30-12:40 pm  Discussion of Previous Paper  
All Members

Session VI: Remembrances: George Beauchamp  
Moderator: Mohamad Jaafar

12:40-1:00 pm  George Beauchamp Remembrance  
All Members

1:01 PM  End of Session

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Saturday, July 30, 2016

7:00-8:00 am  Scientific Program
             Coffee and Tea Service
8:15-9:00 am  Breakfast & Business Meeting
9:00 am – 1 pm  Scientific Program (Continued)

Session VII  Strabismus and Amblyopia: Part II
Moderator: Brooke Geddie

7:00-7:15 am  Recession by Central Tenotomy
               Everett Moody
7:15-7:25 am  Discussion of Previous Paper
               All Members
7:30-7:45 am  Congenital and Acquired Exotropia: Underlying Mechanisms
               Avery Weiss
7:45-7:55 am  Discussion of Previous Paper

8:00-9:00 am  Breakfast and Business Meeting
               All Members
9:05-9:20 am  Children’s National Medical Center Dominican Republic Mission Project
               Marlet Bazemore
9:20-9:30 am  Discussion of Previous Paper
               All Members
9:35-9:50 am  Curable Forms of Childhood Strabismus
               Brian Mohney
9:50-10:00 am Discussion of Previous Paper
               All Members
10:05-10:20 am Rectus Muscle Strengthening in Thyroid Eye Disease
               Monte Del Monte
10:20-10:30 am Discussion of Previous Paper

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All Members

10:35-10:50 am The Effect of Surgical Intervention for Dissociated Vertical Deviation Alone on Concurrent Horizontal Strabismus  
Elias Traboulsi

10:50-11:00 am Discussion of Previous Paper  
All Members

11:00-11:15 am Break

Session VII: Pediatric Ophthalmology History

11:00-11:15 am Drs. Costenbader and Parks: A Patient’s Experience  
Video Presentation  
Note: Shown During the Break

Session VI: 2016 David S. Friendly Lecture
Mary Lou Collins

11:15-11:20 am Introduction of David S. Friendly Lecturer  
Denise Chamblee

11:20-12:05 pm Parental Stress in the Pediatric Ophthalmology Population  
Mary Lou Collins

12:05-12:15 pm Discussion

Session VIII: Workshop: Pediatric Ophthalmology Mysteries
Moderator: Majida Gaffar

12:15-1:00 pm Case Presentations  
All Members

I Can’t See Out of My Eye Anymore!  
Julie Conley

Case #2
1:00 pm  Adjour
Update on Lymphocytic Choriomeningitis Virus (LCMV)

Marilyn Mets

Lymphocytic choriomeningitis virus (LCMV) is an arena virus that was discovered in 1933 but not classified until the late 1960s, when it was placed in the newly formed arena virus family of single-stranded RNA viruses with rodent reservoirs. (1, 2) *Mus musculus*, the common house mouse, is both the natural host and reservoir for the virus, which is transferred vertically within the mouse population by intrauterine infection. (3, 4) A nationwide outbreak in the 1970s provided evidence that pet (Syrian) hamsters may be competent alternative reservoirs. (5-9) Infections from house mice are associated with substandard housing, such as trailer parks and inner city dwellings. (4) Outbreaks have also been attributed to laboratory mice and hamsters; laboratory workers, especially those handling mice or hamsters, have a higher risk of infection. (7, 10-12). Transmission is thought to be airborne; from contamination of food by infected mouse urine, feces, and saliva; (10) or, possibly, from the bites of infected rodents. (4) The first case of congenital LCMV in the United States was reported in 1993. (13) Now there are 73 cases discussed in the World Literature, 45 of which were reported in the United States. The most common neonatal findings among these cases were ocular abnormalities, macrocephaly, or microcephaly. We will introduce two new congenital cases, one with an associate hearing loss, and the other presenting as Aicardi Syndrome.
Gavaris Minimal Ptosis Repair: Long Term Results

George Ellis

Paul T Gavaris, MD, one of our teachers in the Fellowship at Children's Hospital National Medical Center, taught us a measured variation of the Fasanella Servat ptosis repair operation which he called the Minimal Ptosis Procedure.

This presentation illustrates the procedure with video clips and gives long term results of one surgeon's experience.

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The Pediatric Conjunctival Lesion
Mohamad Jaafar

Most pediatric conjunctival masses are of benign origin, are observed for years and are rarely excised, except for cosmetic reasons or in response to parents apprehension.

We will present couple of pediatric conjunctival lesions that will exemplify the difficult thought process the Ophthalmologist goes through, at times.
High Resolution Orbital MRI Demonstrating Anatomic Correlates of Superior Rectus Palsy
Shatha Alfeihi

Introduction: To employ Magnetic Resonance Imaging (MRI) on patients with both isolated superior rectus (SR) palsy and secondary to disinserted SR.

Methods: At a single institution, surface coil coronal MRI was obtained at 312 µm resolution in quasi-coronal planes 2 mm thick throughout the orbit fixated monocularly on a target placed in central gaze. Maximum cross sections of the SR, medial rectus (MR), Inferior rectus (IR) and lateral rectus (LR) were computed and correlated with clinical findings.

Results: 13 affected patients (14 affected eyes, 12 clinically unaffected eyes) with SR palsy and 5 normal volunteers (10 eyes) were included. Four patients had undergone Scleral Buckle surgery, 2 had road traffic injuries, 4 had Schwanomas, 1 had maxillary sinus surgery and 1 had congenital isolated SR palsy. Maximum cross section area in affected SR was significantly smaller than the clinically normal unaffected eye (p=0.0009) and smaller than controls (p=0.002).

Conclusion: High-resolution MRI, coupled with quantitative morphometric analysis can directly demonstrate pathology of partial CN3 and affected EOM atrophy in strabismus caused by CN palsies. Direct imaging of CNs and EOMs by MRI is feasible and useful in differential diagnosis of complex strabismus.

References:

Stevens-Johnson Syndrome Case

Janhavi Shirali

Report

A 4-year-old male with no significant past medical history, a history of cutaneous allergy to penicillin presented to the emergency room with gingivostomatitis, fever and “eyes that would not open” according to his mother. He had received ocufloxacin eye drops and oral cefdinir one week prior to presentation at another emergency room for presumed conjunctivitis and acute otitis media. Prior to one week the patient did not have any ocular or oral symptoms. Per his mother, he started developing oral sores and worsening eyes redness two days after using the ocufloxacin eye drops.

Examination revealed a young boy with bilateral erythematous conjunctival adhesions in both eyes. Visual acuity was light averse OU. There was a limited view of cornea on day one of examination, however it appeared glistening and clear without discharge. The patient did not have any lesions on his hands, feet or genitalia. The following day, the patient underwent an exam under anesthesia. The patient underwent lysis of adhesions and amniotic membrane grafting in the fornices along with placement of symblepharon rings. Incisional biopsy of right lower buccal mucosa was also performed. The cornea had bilateral inferior superficial corneal abrasions, no herpetic or corneal ulcers were noted. Dilated fundus exam was normal in both eyes. The patient was placed on a regimen of cyclosporine, dexamethasone, moxifloxacin eye drops and tobradex ointment and artificial tears. The patient was treated with 3 days of intravenous immunoglobulin treatment for SJS.

Results

The patient’s serology was positive for mycoplasma IgG and IgM. Oral mucosal biopsy was positive for necrotic epidermis with underlying acute and chronic inflammation. HSV viral DFA and culture was negative from buccal lesions. Enterovirus culture was negative. Chest Xray was significant for left medial lung base opacity concerning for left lower lobe pneumonia. Patient did not have any respiratory symptoms. His laboratory workup was normal except for an elevated ESR and CRP. Blood culture and urine culture was negative. The patient did not develop new adhesions in eyelids and healed well after the surgery. Symblepharon rings were removed after ten days and the patient did not have any scarring.

Discussion

Our patient is a unique diagnostic dilemma, since it is unclear whether the patient’s oral and ocular lesions are a consequence of the ocular or oral antibiotics or related to mycoplasma infection. There have been several reports describing a mild version of SJS that accompanies mycoplasma infection. Our patient did not have any respiratory illness but presented with severe mucosal involvement of the ocular surface. Several case reports have described the use of amniotic membrane grafting for SJS. Our case uses amniotic membrane grafting along with punctal plug placement and symblepharon ring placement to treat the patient successfully with no decrease in vision and resolution of adhesions.

Conclusion

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Our case report supports the use of prompt surgery in a pediatric patient with signs of ocular SJS with a combination of amniotic membrane grafting, symblepharon ring placement and punctal plug placement. This case also highlights the potential of SJS to occur without skin involvement and to consider the involvement of M. Pneumonia in patients with mucous membrane involvement without the typical skin lesions of SJS. If M. Pneumoniae is recognized as a trigger it can be confirmed with Polymerase Chain Reaction (PCR) technology and can be treated with the appropriate antibiotics. As the skin may be completely non involved, it can be a missed diagnosis due to its atypical presentation. However, as this case demonstrates, prompt diagnosis and treatment is the key to avoiding long term ocular manifestations such as ocular inflammation, conjunctival scarring and ulceration that can occur during the acute phase of the disease.

References
Refractive Trends After Pediatric Intraocular Lens Implantation

Kim Le

Purpose: To evaluate refractive target and trend in pediatric cataract surgery.

Methods: Retrospective review of refractive outcome and trend over 4 years after surgery.

Results: 106 pediatric cataract surgeries were reviewed. Average age at surgery was 6.93 yrs old and 55.4% were male. Average K at surgery was 43.23 D and AL of 23.30 mm. At 4 years after the surgery, the average Avg refraction was +1.64D at 1 month, +0.93D at 6 month, +0.92D at 1 yr, +0.64D at 2 yr, +0.29D at 3 yr, and +0.09D at 4 yrs after the surgery. Avg visual acuity was 20/53 4 yrs after surgery. Factors associated with higher myopic shift include BCVA <20/40 at 2 yrs, age at surgery <6 yrs, traumatic cataracts, and AL <23mm. For unilateral non-traumatic cataracts, there is more than 2 diopters of myopic shift in the operated eye compared with the fellow eye (p=0.0027).

Conclusion: Pediatric cataract surgery perturbed the normal geometric development of the eye and induced a gradual myopic shift over 4 years. Poor vision, young age, and shorter eyes were associated with higher myopic shift.
Resident Education Workshop

Elias Trabousli
**The Treatment of Dissociated Vertical Deviation with Bilateral Graded Superior Rectus Recession**  
*Sherwin Isenberg*

**INTRODUCTION**
DVD is a motility disturbance of unknown cause. A popular surgical treatment is recession of one or both superior rectus muscles. We wished to analyze the success rate and the optimal amount of recession for the DVD angle using this technique.

**METHODS**
Twenty-three patients (46 eyes) with DVD underwent various amounts of superior rectus recession proportional to the extent of DVD. Mean follow up was 10.7 (+2.0) months.

**RESULTS**
Success, defined as residual DVD < 5 prism diopters (p.d.), was achieved in 35 eyes (76%) after one surgery. Linear regression models in the successful cases showed the reduction in DVD in p.d. = -4.30 +1.88 x mm recessed for distant targets and -2.39 +1.16 x mm recessed for near targets (p < 0.001 for both formulas). Six patients (26%) achieved a successful result after a second surgery; 4 with inferior rectus resection and 2 with inferior oblique anterior transposition. Surgery also improved stereopsis in 74% of subjects.

**CONCLUSION**
For DVD surgery, bilateral graded superior rectus recession is a reasonable and usually successful technique.
A New Procedure to Treat Bielchowski Phenomenon

Irene Ludwig

The Bielchowski phenomenon is a slow up and downward oscillation of a blind or poorly sighted eye, which can be a cosmetic nightmare. In this presenter’s practice, the inferior oblique anterior transposition has proved useful to treat the upward deviation, but the downward deviation has been difficult to improve, with inferior rectus Faden suture being largely ineffective.

The flap tear of the inferior rectus, which is a partial avulsion due to blunt force trauma, usually causes a restriction of downgaze of the eye. It was hypothesized that a surgically induced “pseudo flap tear” might help the downward oscillation in Bielchowski phenomenon.

Two patients underwent inferior rectus flapization along with anterior transposition of the inferior oblique to treat severe Bielchowski phenomenon of a unilateral blind eye. The temporal one third of the inferior rectus was disinserted and sutured to the inferior periorbita (adjacent to orbital floor periosteum) with non-absorbable suture. There was minimal postoperative pain or swelling, and results were dramatic, with no visible oscillation remaining in either patient.
OMIC Update: Lessons Learned from Malpractice Cases

Denise Chamblee

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Recession by Central Tenotomy

*Everett Moody*

Technique: Cut (disinsert) the central 6 mm at the insertion (leaving 2 mm on either side still attached to the globe) allowing a hang-back of about 4-5 mm.

Details of the technique:
- Cauterize the center point to allow easy insertion of the Wescot scissor tips.
- Extend the incision in both directions to leave 2 mm at either side for a 4-5 mm effect.
- Leave about 2.5 mm for about a 3 mm effect.
- Leave about 1.5 mm for a 6 mm effect.
- Grasp the center of the cut insertion with a curved locking forceps and release tension on the muscle hook to allow the tendon to move from vertical to the globe to flush with the globe. This allows for a better assessment of the amount of tendon remaining attached.
- Placing a central episcleral stitch with 7-0 suture at the apex of the hang-back can occasionally be done to gain an additional 1 prism diopter effect when needed. The stitch can best be done with the needle pointing posteriorly. “Episcleral” emphasizes that the stitch need not be deep, since it does not support the weight of the pull of the muscle. It only prevents the arch from drawing forward during healing. Additional effect can be gained by including some nearby Tenon’s capsule in the stitch, but beware that this can cause more uncertainty in the resulting effect. I no longer use this variable.

Advantages of the technique:
- IT IS SAFER, since it does not require sclera stitches. This is especially important if it is applied to the better seeing eye when visual acuity in the fellow eye is reduced.
- IT IS MORE PREDICTABLE, since very small recessions are notoriously unpredictable in their resulting effect. The middle range recessions (say lateral rectus recessions of 5, 6 and 7 mm) have dependable effects of 20, 25 and 30 prism diopters respectively when done bilaterally. Larger recessions (say, of 8 or 9 mm) have greater and less predictable effect, while smaller recessions (say of 2, 3 or 4 mm) have decreased and less predictable effect than those of the mid-range. This makes the Ken Wright recession by central tenotomy ideal for the smaller angles of deviation in terms of predictability.

Types of cases that can benefit from this technique:
1. Small vertical deviations (4-5 prism diopters)

```
        LHT=4
        LHT
e

        LHT=4
        LHT=4

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• “KW”—ONE vertical rectus

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• “KW” either RIR or LSR

2. Large vertical deviations (8-10 prism diopters)

   LHT 10
   LHT 10  LHT 10
   LHT 10

   • “KW” — Two vertical recti
   • “KW” both RIR & LSR.

3. Small horizontal deviation (8-12 prism diopters)
   in a patient who needs other surgery.
   (Small horizontal deviations by themselves rarely require surgery.)

   Overaction both superior obliques

   XT 4
   XT 8  XT 8  XT 8
   XT 16

   • “KW” — Horizontal recti
   • Posterior tenectomy LS
   “KW” both lateral recti.

4. Re-recession previously recessed recti
   (e.g.: medial recti)

   ET 10
   ET 10  ET 10
   ET 10

   • “KW” — Horizontal recti
   (Easier and safer in the more posterior position.)
   • (Medial recti were recessed in the past)

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5. Strabismus surgery in a patient with reduced vision in one eye.

<table>
<thead>
<tr>
<th>VA: R.E. = 20/60</th>
<th>L.E. = 20/20</th>
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- “KW”—on the better seeing eye
- R.E.: Recess LR 7 mm
  L.E.: “KW” with 5 mm hang-back.

6. Strabismus surgery for some mid-range deviations for asymmetrical bilateral surgery.

- Recess one horizontal rectus muscle 7 mm “KW” the other with a 5 mm hang-back.

ONE FINAL CAVEAT
Since this is not a widely used procedure, it is a good idea to include in the operative note language to reassure any “peer review” person who may not be familiar with the procedure as to its legitimacy and give the reason for this particular choice.
This is a sample of what I use…
“The recession was done by central tenotomy as described by Kenneth Wright of California. This procedure was chosen because it is a little safer (requires no sclera stitches) and also because it is the more predictable in its outcome than alternative procedures for smaller deviations.”
Congenital and Acquired Exotropia: Underlying Mechanisms

Avery Weiss

Introduction: Binocular eye alignment is maintained under static and dynamic viewing by the interactive relationship between interocular positional disparity and 2 vergence systems, one mediated by fine stereo-disparities (≤12D) and one mediated by gross disparities >12D. We postulated that the inability to establish or maintain binocular alignment during targeted eye movements could underlie congenital and acquired XT.

Methods: Twenty–six children (mean age 5.6y) with congenital or acquired exotropia had assessments of eye alignment, visual acuity, stereopsis (Titmus test), prism measurements of disparity-driven convergence (DDC). Targeted smooth pursuit and saccades were quantified by binocular video-oculography (VOG).

Results: Six children with congenital XT (35-75D) had no demonstrable DDC on VOG; 4 had developmental abnormalities of the brainstem or cerebellum. Eleven of 13 children with intermittent XT (10 to 45D) had stereo-acuities of 40-60 arcsec. During targeted EOM recordings children with X(T) displayed variable interocular disparities, both horizontal and vertical due to inferior oblique overaction (IOOA) or breakdown of DDC. The loss of eye alignment due to limited vergence reserve is further demonstrated by 3 subjects with acquired loss of DDC due to antecedent brainstem compression or trauma. Two children acquired convergence insufficiency type XT related to a tectal plate glioma or hydrocephalus. One child with distal arthrogryposis presented with an XT due to hypoplastic rectus EOMs.

Conclusions: We found that children with congenital XT uniformly failed to generate DDC in the context, presumably due to. Most children with intermittent XT had stereopsis of 40-60 arcsec indicating normal co-development of binocular vision and fine DDC. The delayed onset of XT ranging from 10-45D is consistent with loss of fine or gross DDC due to accumulation of vergence errors resulting from IOOA or loss of binocular alignment during conjugate eye movements. We postulate that the slow temporal dynamics of vergence eye movements relative to the faster dynamics of conjugate eye movements underlies the loss of alignment during targeted eye movements. Exotropia is the final outcome for numerous congenital and acquired abnormalities of the extended vergence pathway.
Children’s National Medical Center Dominican Republic Mission Project

Marlet Bazemore

Report from Santiago, DR, 2016

Casa de Luz and Children's National have been partnered for 11 years now. Many of our fellows, now Costenbader members, have participated in this surgical mission trip. This will be a report on our most recent expedition, highlighting obstacles and new opportunities.
Curable Forms of Childhood Strabismus

Brian Mohney

Introduction: The literature on the management of childhood strabismus emphasizes some subtypes while ignoring others, based upon the investigator’s experience or the popularity of the topic, and are often from single-institution, tertiary-care referral centers. The purpose of this presentation is to review which forms of childhood strabismus are potentially curable.

Methods: This overview considered all forms of childhood strabismus; however, it was limited to the more prevalent forms with the potential to be cured with glasses or strabismus surgery. A cure was defined as a life-long result of orthotropia to small angle strabismus with ≥ 50 seconds of stereoacuity and normal ocular motility.

Results: Children with sensory strabismus, strabismus in the setting of a developmental disorder, convergence insufficiency, dissociated strabismus and Browns syndrome were excluded. The literature concerning the postoperative motor and sensory outcomes for accommodative esotropia, acquired nonaccommodative esotropia, intermittent exotropia, paralytic strabismus, and congenital strabismus was reviewed for this presentation. Curable forms of childhood strabismus included some children with partial sixth nerve palsy, accommodative and acquired nonaccommodative esotropia and, in rare instances, a small percentage of children with intermittent exotropia.

Conclusions: Curable forms of childhood strabismus include, in declining order, some children with partial sixth nerve palsy, accommodative esotropia, acquired nonaccommodative esotropia, and only a handful with intermittent exotropia.
Rectus Muscle Strengthening in Thyroid Eye Disease

Monte Del Monte

Thyroid Eye Disease (TED) often presents with a severe restrictive strabismus. Recession of the restricted rectus and oblique muscles is the first line of treatment to realign the eyes and eliminate diplopia. But sometimes, especially following the much larger and more aggressive orbital decompression surgery often performed now (resulting greatly improved cosmesis) - significant horizontal and/or vertical deviations remain even after maximal rectus muscle recessions. In the past, we have been taught to avoid resections in restrictive strabismus to prevent further limitation of eye movements, increased incomitance and, since 2 rectus muscles have often already been recessed, to prevent anterior segment ischemia.

Recently we have been challenging that notion and have been performing resection/ plication of rectus muscles in TED with significant residual deviations too large for comfortable correction with prism glasses. This presentation will review my experience with this approach after completing our initial 13 cases, 11 with adequate data and follow-up. Plication was used in 5 patients and resection in 6/ with 6 involving horizontal rectus muscles and 5 vertical rectus muscles. 10 /11 patients obtained good to excellent final alignment (3 with small prisms). The results were stable or slightly improved in 9/11 patients between the initial healing at 6-8 weeks post op and the final exam.

Details of patient selection, surgical technique, and dose response obtained and post op course will be discussed.
The Effect of Surgical Intervention for Dissociated Vertical Deviation Alone on Concurrent Horizontal Strabismus

Elias Traboulsi

Introduction: The purpose of this study is to evaluate the effect of surgical intervention for dissociated vertical deviation alone in the setting of concurrent horizontal strabismus.

Methods: Retrospective chart review was conducted of patients who underwent surgical intervention by a single surgeon (EIT) for dissociated vertical deviation (DVD) and also carried a diagnosis of horizontal strabismus from 1998 through 2015.

Results: 55 total patients were included. Patients were divided into two groups: (1) those that underwent concurrent surgical correction for DVD and horizontal strabismus, and (2) those that underwent surgical correction for just DVD. 21 patients were included in Group 1. 34 patients were included in Group 2. Success of surgical intervention for both the DVD and horizontal deviation were evaluated. Successful outcome for the DVD was defined as resolution or improvement in the DVD not requiring subsequent surgery. Successful outcome for the horizontal deviation was defined as resolution of horizontal deviation, well-controlled intermittent exotropia, or constant horizontal deviation of less than 10 prism diopters. Failure was defined as any constant horizontal deviation greater than 10 prism diopters and/or subsequent surgical intervention for the horizontal deviation. 18 out of the 21 patients (85.7%) in Group 1 had a successful outcome for DVD. 29 out of the 34 patients (85.3%) in Group 2 had a successful outcome for DVD (p=1.00). 15 out of the 21 patients (71.4%) in Group 1 had a successful outcome for the horizontal deviation. 22 out of the 34 patients (64.7%) in Group 2 had a successful outcome for the horizontal deviation (p=0.77).

Discussion: There was no significant difference in rates of success for the outcome of horizontal strabismus between patients who underwent concurrent surgery for DVD and the horizontal deviation and those patients who underwent surgical intervention for DVD alone.

Conclusion: This preliminary study suggests that there are certain patients who have both DVD and horizontal strabismus who can have improvement in their horizontal deviation when undergoing surgical intervention for DVD alone.

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2016 David S. Friendly Lecture
Parental Stress in the Pediatric Ophthalmology Population
Mary Lou Collins
Pediatric Ophthalmology Mysteries Workshop
Majida Gaffar

Case #1:
“I Can’t See My Eye Anymore!”
Julie Conley

Purpose:
To discuss management of extremely large angle strabismus, specifically in the setting of sub-optimal supplies and conditions.

Methods:
This is a case report discussion of a very large angle esotropia in which the cornea was not visible. The patient was unable to abduct the eye at all and the cornea remained buried in adduction. The management of this patient will be discussed with an open discussion for the audience members to participate with previous experiences of similar cases and their preferred management.

Conclusions:
Extremely large angle strabismus can be difficult to manage, and this case discussion will hopefully lead to improved management in future cases for all audience members.

Case #2: