Diplopia and Torticollis in Adult Strabismus

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Introduction

We believe that, in some cases, in strabismus surgery there may be more than one option in the choice of surgical protocol, and each professional and his experience sets a more personalized pattern of action. Our objective is showing through this case, for ophthalmologists and other professionals who visit adult patients with strabismus, our experience in the surgical treatment of vertical and divergent deviation with torticollis and an associated diplopia [1-5].

History, Data and Method of Diagnostic Exploration

Patient 41 years old. The patient refers diplopia in increase for a year and torticollis for years. Tilt the head to the left shoulder to try to compensate the diplopia. Ocular antecedents: Lasik refractive surgery (myopia -5.00 both eyes).

Pre-surgery exploration

a. Visual acuity without correction right eye = 1
b. Visual acuity without correction left eye = 1

c. Refraction (cycloplegic) right eye = +1.50-0.50x170°

d. Refraction (cycloplegic) left eye = +0.50-0.75x145°

e. Corneal topography: Central ablation in both eyes.

Method Surgical

The day of the surgery is performed a tests of duction: right upper oblique muscle (- - -)

Primary position of gaze = 17Δ XTR / 28Δ HTR. Primary position of gaze = 17Δ XTR / 28Δ HTR. In infraversion = 9Δ XTR / 30Δ HTR.

Method Surgical

The day of the surgery is performed a tests of duction: right upper oblique muscle (- - -)

Surgical protocol

Backward movement of right upper rectus muscle 3mm.
Backward movement of right inferior oblique muscle 6mm.
**Post-surgery exploration**

The synoptophore after the intervention in the primary position was 3Δ HTR. There is no existence of stereopsis, but it can even fusion the images. The patient is subjectively satisfied. It is proposed, 4 months after the surgery, to begin orthoptic treatment to strengthen the ability of fusion images [5-10].

**Discussion**

The deviation of an adult’s strabismus is diagnosed and resolved the vertical and divergent strabismus in only one surgical intervention. It was discarded the differential diagnosis of non-ocular torticollis by the examination tests. It was considered, for the good maintenance of the obtained result and maintenance of the ability of fusion, to perform an orthoptic treatment after surgery. We consider that the patient will have more visual quality in their daily life when resolving their symptoms of diplopia, signs of torticollis and ocular asymmetry. We emphasize the exploration by the Lancaster test in patients with diplopia for its ease of use, graphical representation and its diagnostic ability and the following of the case over time.

**Conclusion**

The diagnostic and treatment protocol performed in this case show the optimal resolution of the diplopia and torticollis that the patient suffered.

**References**