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All about the Eye

Dr. Krati Gupta

Dr. Saurabh Deshmukh

www.eyelearn.in

Management of U/L &B/L SOP

Source- Handbook of pediatric strabismus and amblyopia- Kenneth Wright

TABLE 9-4. Treatment of Unilateral Superior Oblique Paresis.

Clinical manifestation	*Procedure*
Inferior oblique overaction: small hypertropia Hyperdeviation in primary position ≤15 PD; deviation is greater in upgaze	Inferior oblique weakening (author prefers graded anteriorization) (common)
Inferior oblique overaction: large hypertropia Hyperdeviation in primary position >15 PD	Ipsilateral inferior oblique weakening (author prefers graded anteriorization), with contralateral inferior rectus recession (common)
Lax superior oblique tendon with superior oblique underaction Hyperdeviation in primary position <15 PD; minimal inferior oblique overaction; deviation is greatest in downgaze	Small superior oblique tuck (rare)

TABLE 9-5. Treatment of Bilateral Superior Oblique Paresis.

Clinical manifestation	*Procedure*
Extorsional diplopia (partially recovered traumatic SOP) Extorsional diplopia (>5°), minimal hypertropia, <8 PD, small or no V-pattern (<10 PD), and minimal inferior oblique overaction and superior oblique underaction	Bilateral Harada–Ito Harada–Ito procedure, which consists of selectively tightening the
Bilateral superior oblique underaction or (often traumatic SOP, rarely congenital lax SO tendon) Hypertropia <8 PD and big arrow pattern (>15 PD increase in esotropia from primary to downgaze), >10° extorsion in primary position increasing in downgaze, and reversing hypertropias in sidegaze	Bilateral superior oblique tendon tuck with bilateral medial rectus recessions with inferior transposition one-half tendon width
Masked bilateral or asymmetrical bilateral superior oblique palsy (usually congenital SOP) Hyperdeviation in primary position >10 PD, asymmetrical inferior oblique overaction	Bilateral inferior oblique graded anteriorization (more anteriorized on the side of the obvious SOP) and recession of inferior rectus contralateral to the obvious SOP or If associated with a large head tilt, bilateral inferior oblique graded anteriorization (more anteriorized on the side of the obvious SOP) and Harada–Ito on the side of the obvious SOP