THIRD Quarter, 2009
VOLUME 24, NUMBER 3
Fall

*** ORIGINAL SCIENTIFIC ARTICLE ***

KHAN: Cycloplegic Refractions in Children Who Never Wore and Who Always Wore Prescribed Spectacles for Refractive Accommodative Esotropia: Exploring the Natural History of this Form of Strabismus and the Effect of Treatment on Their Hyperopia

*** CASE REPORTS ***

LARIA, TORRES, GAMIO, PRIETO-DIAZ and ALIO: Effect of Innervational Strabismus Surgery on a Patient with Hypotropic Strabismus and Pseudoblepharoptosis

KHAWAM, CHERFAN, MOLLAYESS and HAMAM: Partial Third Nerve Palsy Involving the Superior Rectus and Levator Palpebrae Muscles and Disruption of Central Binocular Vision Fusion from Brain Stem Infarction: A Case Report

Paul E. Romano, MD, MSO
Editor-in-Chief
SAVE THE DATE
Thirteenth Annual
Gunter K. von Noorden Visiting Professorship in Ophthalmology
October 1-2, 2009

Mohamad S. Jaafar, M.D., FACS, FAAP
Professor and Chief of Ophthalmology
Children's National Medical Center
The George Washington University
Washington, D.C.

October 1, 2009
Gunter K. von Noorden Lecture:
“Superior Oblique Palsy - Where Do We Stand”

5 - 6 p.m. Reception
Cullen Eye Institute, The Neurosensory Center
6501 Fannin, Room C 205

6 - 7 p.m. Thirteenth Annual Gunter K. von Noorden Lecture
Cullen Eye Institute Auditorium, The Neurosensory Center
6501 Fannin, Room C 202

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INDEX TO ADVERTISERS, VOLUME 24, NUMBER 2, 2009

Fresnel Prism and Lens Co. .................................................. Page 130
Gunter K. Von Noorden Visiting Professorship .................................. Page 131
Burton J. Kushner's Grand Rounds Collection .................................. Page 134
Gunter K. von Noorden's History of Strabismology .................................. Page 134
Eugene M. Helveston's Surgical Management of Strabismus ....................... Page 134
Wright's Color Atlas of Strabismus Surgery ........................................ Page 192
"... the belief that one's view of reality is the only reality is the most dangerous of all delusions ..."

-Watzlawick, 1976
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SURGICAL MANAGEMENT OF STRABISMUS
A Practical and Updated Approach, 5th edition
EUGENE M. HELVESTON, M.D.

Review by David K. Coats, M.D., Houston, Texas

Six pounds of pure muscle; no fat or byproducts here! That's what the 5th edition of Surgical Management of Strabismus packs. Quintessential strabismologist Eugene Helveston has done it again.

This classic textbook is once again jam-packed from cover-to-cover with all the information that the strabismologist needs to properly plan and execute the management of both simple and complex strabismus disorders.

The text is wonderfully illustrated with step-by-step instructions on how to perform all contemporary procedures that should be in the armamentarium of any serious strabismologist. One of my favorite "extras" in this textbook is a chapter that colorfully explores the history of strabismus surgery from its beginning. What most separates this edition of the textbook from previous editions is the inclusion of an extensive array of case examples complete with histories, clinical photographs, and details of surgical planning. While a few case examples were included in earlier versions, expansion of the case example section in this edition is so extensive that virtually any condition can now be reviewed in detail with a front row seat through the eyes of this world-renowned expert.

Space should be reserved for Surgical Management of Strabismus, 5th edition, in the bookcase of every ophthalmic surgeon. Undoubtedly this reserved space will be vacant most of the time, as this book is most likely to remain open and in constant use on the surgeon's desktop.
MULTIMEDIA REVIEWS

LEE M. JAMPOL AND ANGELO P. TANNA, EDITORS


To quote Dr. Kushner, "Many roads lead to orthophoria." The treatment of strabismus, that "art form" with scientific underpinnings, can be the bane or the joy, or more likely both, of the ophthalmologist's existence. For those of us in pediatric ophthalmology, it is our "bread and butter" and the source of endless discussions and debates. There is enough science to provide a logical approach, and enough art to make things really interesting.

This book is a compilation of 68 cases published over 17 years in the journal Binocular Vision and Strabismus in its "Grand Rounds" section, edited by Dr. Kushner. The cases are presented in a standardized format, including summary of the therapeutic problem, history, eye exam, and final diagnosis. Dr. Kushner states that he was not attempting to solve a clinical problem for a specific patient but rather presenting an intellectual exercise with input from respected colleagues. Indeed, he does not present his own opinion, nor the actual results following treatment on most of the cases. Several experts in the field present opinions on the diagnosis and treatment. Each case is followed by the editor's perspective which highlights the issues raised. The cases cover clinical topics from nonparalytic vertical strabismus to cataract. There were 249 different individuals who served as discussants for one or more cases. This provides a broad perspective covering many schools of thought.

The cases are numbered and have descriptive titles such as "A Case of 'V-pattern' Esotropia with Excyclotropia after Bilateral Superior Oblique Tucks." These allow for easy selection of cases for clinical purposes or teaching. The cases are interesting and informative analyses of complicated problems, primarily involving strabismus. However, although it is useful to have these case reports, previously published in a journal, collected together in one volume, it would have been more useful to have included outcomes and follow-up. Nonetheless, the compilation provides a thought-provoking read, an aid to clinical problem-solving, and a stimulating jumping-off point for teaching sessions.

Marilyn B. Mets, MD
Chicago, Illinois, USA


People and Places

from Sightline, Wilmer Eye Institute, spring 2009, p.4:

Thanks in part to funding from Research to Prevent Blindness, researcher David Guyton has developed an automated pediatric vision screener to catch amblyopia earlier in children, thereby increasing the opportunity for successful treatment.
One of BV&SQ’s authors was honored in the last issue of Consumers Reports; he was the author of “Stereo Sue” two years ago, an article he published in the New Yorker magazine, and which we republished as a unique case report of the late in life recovery of stereoscopic binocular vision.
EDITORIAL: Major Distractions; Innervational Strabismus Surgery, VideoOculography, Brain Stem Infarction Disruption of Binocular Vision; Spectacle Correction of Hyperopia in Esotropia; Non Ocular Dominance; Semantics Euphemisms! Economize = Compete= True “Reform”) Versus Healthcare Warfare? To Our End? By Our Self Anointed Royalty (a veritable tribe of kings!)

It is hard, isn’t it, these days, to concentrate upon our medical specialty of ophthalmology, and sub-specialty of binocular vision, and alignment, and strabismus when our whole profession, and our whole world of medicine, as we have known it, is under serious threat from our ever more invasive and all powerful government, with a leader who is so fixed and unreasonable in his ideas and objectives.

Taken to the worst extremes it is not hard to imagine that those lawyers and congressmen lawyers would eliminate M.D.s or otherwise take our freedom away by forcing us to become only government employees (see the Massachusetts plan on page 144) and perhaps even turning healthcare over to other subservient government employees... who used to be our physician assistants and nurse practitioners, or orthoptists and ophthalmic techs?. Medical care rendered under this system would have to be strictly “cookbook” and “take it or leave it” for the patients who would also have lost their freedom to chose anything about their health, including their doctors or even how and where to die.

It isn’t easy to either sleep or even think constructively with these multiple Damoclesian swords hanging over our heads. But we will try. (More about these major distractions later)

In THIS ISSUE

First, we bring you a followup on page 138 on our author Oliver Sacks, (of that story on “Stereo Sue” we “printed” two years ago). We found it in Consumers Reports, of all places, but for good reason. Sad to hear of his serious eye problems. We wish him well. See also the ad for the annual Von Noorden lecture and get-together in Houston in just a few days. You can still make it....

In the articles for this issue, note that we have two cases of third nerve paralysis with blepharoptosis for your consideration: A nosological note: One should always use, at least in titles or keywords of medical scientific articles this whole term, blepharoptosis, since any organ or structure can be ptotic (eyes, globes, kidneys, etc.) and the unspecified word is too broad and less useful in retrieval.

Cycloplegic Refractions in Children Who Never Wore and Who Always Wore Prescribed Spectacles for Refractive Accommodative Esotropia: Exploring the Natural History of this Form of Strabismus and the Effect of Treatment on Their Hyperopia. Khan AO. Binocul Vis Strabismus Q 2009; 24:151-156.

Dr. Khan adds to our knowledge and understanding of this relatively common form of
strabismus. Sorting his results, it is best to quote him directly:

“The current study suggests that full-time spectacle wear does not have a large effect on refractive shifts in refractive accommodative esotropia.”

But in his review of the literature he notes that what is generally true for these children with strabismus, is not for children without esotropia. So the esotropes do not outgrow their hyperopia like normal kids do and grow out of their accommodative deviation all by themselves, as much as we would wish this for them...

Maybe we should make accommodative esotropes do excessive reading or at least more. Or maybe their kind of hyperopia or a relative weakness of their binocular vision keeps them from reading ENOUGH ??? I wonder what kind of students they are and might there be a difference which contributes to this?


These authors provide, in addition to our standard metrics for binocular misalignments with videoOculographic evidence as well. They have previously contributed to this periodical on this subject. Prieto-Diaz J, Gamio MS. The Surgical Innervational Effect (BVSQ 2007; 22:169-178).

This case was a partial apparently congenital third nerve paralysis. The authors, through this case report illustrate well the difficulties in managing such cases

Their discussion is an excellent review of the various alternative management techniques


From the senior author (EK): “Isolated partial involvement of the SR/Lev was not, to my knowledge, reported before. In addition, I thought the absence of any fusional amplitude in that patient, following brainstem infarcts, was an interesting evidence of what Pratt-Johnson described as central disruption of fusional amplitude due to damage in the midbrain of a motor association area controlling fusional amplitude’ ”.

This is a most interesting neuroanatomy study, which does give us a better idea of exactly where binocular vision is going on... unfortunately not exactly but we are getting closer, however!

On the Composition and Resolution of those “Major Distractions”

Attached outside our kitchen window we have a bird feeder tray. There’s a daily show there of birds - fighting each other, regardless of specie, totally unnecessary for the amount of bird feed my wife puts out regularly. There is always more than enough seed for them but they attack each other with such constancy. It is quite a show. She shouts at them “be nice!” with no effect!, of course....

Dominance. That is what it is. And so typical of all living things, only slightly behind reproduction as job number 1! Mankind is just another example isn’t it. Like those birds, we too fight all the time and what for? Dominance! It is not the early bird that gets the worm- it’s the most dominant bird!!! I watch the news daily and there it is, constant fighting, for some or any presumed reason. Watch the politicians in D.C.! Watch the television commentators and interviewers! We humans don’t have to fight for food like the birds, or like we had to in the not too distant past just to survive, so we find other things to fight over, to determine and establish dominance over our fellow man, don’t we.
So there is not much likelihood that as living things we humans will ever abandon fighting and conflicting forever. That is the menu for achieving a dominant position. Men for sure. Women to a lesser extent. Their mothering instincts mandate some cooperation for survival of their too young to kill offspring, as reproduction exceeds dominance as job #1 for them, but when that is no longer job #1, they can dominate too! (And just as well as men- too -think Pelosi, Boxer, etc.) Men and women! Including even husbands or wives.

So I guess we are stuck with this “bipartisan” form of politics forever. Truly bipartisan actions are patently abnormal and extraordinary and may be expected only when some outside force (war) threatens both parties!!!

At the same time, there resides herein the ultimate proper, best solution for the governments Medicare money problem: Turn this dominance competitiveness into competition which is really the only way in this world to effectively minimize the cost of things in our society. Government cost control never works and that is proven over nd over and over again. But such competition is available only in the private sector. It is really the only solution, The reduction in costs can be actually accomplished in no other way in this world. So what the government needs to do is stick to making rules that maximize equitable level field competition instead of advantaging special interests. Level the playing field! That is your job as our government and your only job, Barack .

That is the only way to reduce the excesses and abuses allegedly heaped upon us by the health insurance industry. Running health care in and by the government just doesn’t work, or work well over the long haul for sure as we know from the experiences of Canada and Europe and elsewhere... And the burgeoning age, numbers and medical needs of the populace cannot be stopped.

Even Medicare should be turned over to the private sector as in Medicare Advantage which should be expanded, and NOT stopped as Barack proposes as an essential element in his plan.... Upside down! - that is the word that describes the mortgage customer these days. Don’t let it spread to the Medicare community!

That was all a preamble for further consideration of the current health care REFORM politics or if your are more wary (see below), health INSURANCE reform????

Ever since Hillary started being serious about attacking our profession, medicine, almost twenty years ago, I have been very, very angry with Hillary and all these politicians. First it was the “Hillary health care CRISIS” which it sure as heck wasn’t. Health care was just fine and doing well. The only “crisis” was that government (i.e., the tax and spend lawyers- the legal profession and their fellow professional politicians) wanted to control medicine from one end to the other and they weren’t yet doing so. Medical care was consuming a larger piece of our Gross National Product every year, and that was money, $$$$ that they were progressively losing influence and control over. That was the so called “crisis” and all it was then (and in fact all it really is today)

YET... Funny, but well before Hillary, almost fifty years ago, I chose academic medicine instead of following Marshall Parks and his many fellows into the private practice of pediatric ophthalmology. Among the several reasons for doing so, I thought way back then, that socialized medicine was just around the corner and since that meant to me, the private practice would be limited in both income and freedom, or maybe even abolished, academicians would probably be chosen to lead the reorganized socialized system, and would be a relatively good place to be. So that’s what I did. Here we are a half century later and we still don’t have socialized medicine, although we are losing more control of our profession with
every passing year.

The rest of the world’s doctors never resisted socialism with any vigor apparently. Their societies were socialistic basically. Another memory pops up: After a couple of years of general surgical training I became disenchanted and chose to serve my then unavoidable mandatory military service time. Luckily I was sent to Germany for my two year tour and enjoyed Europe immensely (I elected to stay for a third year). So much so that I considered remaining and living in Europe indefinitely (I couldn’t settle for that for a lifetime after the investment I had made in getting an M.D. (do European MDs get their degrees cheaper or easier? I wonder how they live with it? And we think our government abuses us?) So I shipped back to the USA.

Ultimately, and after 30 years of MD ing, by 1989, I felt we had lost enough more of our medical/personal freedom. The trend was down so much that it wasn’t fun anymore and so, given the old and proven Nazi treatment (“If you disagree with me, you are mentally ill”) by my chairman, for my medical myopia treatment advocacy and taking vacation time (he never took vacation because he was always in San Francisco “working” for the AAO, but he expected faculty to donate their time off to him while he destroyed the department by donating $15 million of the previously accumulated department funds to his favorite community charities and other favorites), so we’d had enough working for somebody else and the socialistic medical part of the state government and retired, to devote myself and ourselves to this publication and to making some serious money before I died.

But this time it was not a “crisis”. This time, they (who?) chose to use the word “reform” instead.

So we go from one euphemism (“crisis”) to another (“reform”). (I had to look euphemism up. It means substituting a mild or “good” word for another one less virtuous.) But reform has to be one of the worst words there is. And now I am really very very very very angry. Look at this::

So the very term “reform” is obviously a total judicial system in itself: it includes an accusation, a judgement, a conviction of “evilness” and a sentencing of punishment all in one simple six letter word.

Most efficient, right! Talk about weapons of mass destruction.

But did you ever think how damning and condemning that word is, especially when it is aimed at you? (It is!) And Hillary, and Barack, when they adopted that word to describe the government’s money problems, they damned and condemned the whole health care profession and business, didn’t they: “Healthcare is wrong and corrupt and needs to abolish and abandon its evil conduct and errors, abuses and disorders and beliefs”.. Thanks a lot Barack.

When Obama got some of the feedback for his uncivil accusations and sinful ways, then he shifted the aim of his “reform” weapon (of mass
destruction) to just one piece of the health care industry, the private insurance companies by renaming it his program for “Health INSURANCE Reform” releasing his grip on the throat of the medical profession per se.

They do have a serious problem in the government but it is ONLY a money problem, and not a health care problem. First second and third and all...

Why is the Government Involved in Healthcare At All? By Elizabeth Lee Vliet, MD “... I believe the hidden agenda for government takeover of healthcare is simple. The government needs the money that is currently in the private sector. Once everyone is swept into the public, Medicare-type, taxpayer-funded nationalized system, the federal government will gain control of all this additional revenue. How? The government can gain control of private sector money at least two ways: 1. Money now being paid for private health insurance premiums and medical services will go to government coffers, either as direct payments for premiums or as added taxes; and 2. The government can nationalize private insurance companies and confiscate their financial reserves. It would mean enormous new cash under government control.

We should sue the government for slander and libel for using the word “reform” on our profession and health care in general. What is truly EVIL and in need of reform is congress and government and their bedfellows and co-conspirators: tort lawyers.... try starting there Barack! (Shortly after we wrote this,Barack talked to congress again and begrudgingly said he MIGHT- “maybe he said” consider, after congress passed his HR 3200 giving an executive order to help reduce the cost of the practice of defensive medicine, making it sound that such was purely the fault of the doctors and not his buddy fellow lawyers!!!!)

This is really an all out fight for dominance between two professions, medicine and law. In fact it looks like a fight to the death of medicine at the hands of the lawyers. It has been a long time coming. The lawyers have always hated the doctors because their profession is so much more respected, applauded and approved. Yet the lawyers are all competitive people and very smart - except they have always been number two. They are the second profession, Most of them wanted to be in the first profession, medicine, but they weren’t quite good enough so they had to settle for the profession that is second best: law. They it is a very poor second, everyone knows that. And they never do get over it.

For the last half a century they have been trying to destroy the profession of medicine through their malpractice lawsuits. They have made our lives miserable and they have darn near succeeded, chasing us all out of the practice of medicine out of fear of their lawsuits and the potential for personal destruction or poverty. But we have held on, at least most of us....

But having failed to destroy us with all those law suits, most of which are misdirected or wrong or inappropriate or otherwise not worthy.... having failed thru that route to destroy in their jealous rage and envy the medical profession, now they have the ultimate weapon: (another weapon of mass destruction). They are going to absorb the medical profession into the government and make us all government employees!!!!!!! Only the government can control us 100%.

The government, controls all government employees!!! plus all the money that passes through our profession or insurance or whatever!!!!

In a word, it is WAR. Healthcare WAR

Total war, final war, war to the death... of the medical profession. We don’t have much of a chance of surviving because lawyers have all the serious weapons. All we can do is withhold
medical treatment- that is our only weapon, and they can outlaw that- and then we will have to quit, to keep from being thrown in jail. Then they will hire all the nurse practitioners and physicians assistants to take care of everybody and they can afford to pay them fairly well, or enough anyway.... And that is how they will cure the financial disaster which Medicare has to become because of increasing numbers and longer coverage which is upon us even now for the medicare population. To make a dent in the problem otherwise they would have to push out the age for medicare eligibility to 75 or 80 years!!!! No other way... and that would only be a temporary cure.

We discussed in our editorials in the last issue of this periodical our ideas as to how to help the situation. Since then, we have seen the exposed fears of the American Public, about death and dying and about losing the choice of doctors and medical care. After those reactions, like Barack, I will have to duck on my recommendation of the need to reduce the costs of terminal care somehow. I was projecting my own plans.

As someone recently said somewhere: “I am not afraid of death, but I am scared to death of dying!”

We would agree 100%.

We want to retain freedom, freedom of choice, freedom about how we will die. That is the singly most important freedom left to us to desire, but society will not allow it. So what if certain religions are opposed to any form of self determination in this realm (which is labeled regardless of what is done, to be forbidden suicide or assisted suicide. Yet that is the RIGHT that society as a whole denies us totally as individuals. That is senseless. And I don’t give a hoot about what YOUR religion says. You have no right to force me to observe or follow or obey YOUR religion. That is the very essence of religious freedom which we are supposed to have. Yet millions of religious people force the rest of the population to follow their religious principles by creating and maintaining laws which prohibit the rest of us from breaking their religious ideas or principles. That is NOT religious freedom! (Are you one of those people? Think about it...)

But that shines a light on our society and its culture and it has changed. We have slowly but surely and with accelerating rapidity it seems, lost the religious moral foundation of our culture. Two monster examples of this are the response of the public to Obama’s desire to save some money on health care (see, we will NOT repeat the R word!) Especially with their revulsion with any mention of anything resembling human euthanasia, regardless of how they may treat their pets. They really fear death regardless. The second monster example is runaway greed as in the mortgage financial mess which almost put us in a depression. Lots of people still go to church or otherwise practice their religion but morality seems to have been largely and seriously impaired in our present world.

Also In the News

The Darkest and scariest picture for the medical industry and profession seems to be what they want to do in Massachusetts!: read this!

from The Wall Street Journal July 17, 2009

by Philip Shishkin In Massachusetts, A New Idea for How to Pay. (Following bold is my editorial emphasis -per)BOSTON: A Massachusetts panel proposed that the state scrap traditional payment to doctors and hospitals for each office visit or procedure, and instead adopt a system where they receive a monthly or annual fee per patient.

The proposal is an effort to control the state’s health care costs, which are among the highest in the nation. (Which now are 33% higher than the US average and projected to grow faster than the rest of the country). Under the new system, doctors and hospitals would be
organized into groups responsible for all of a patient’s health care needs. ... 

The panel, created by state law, voted unanimously to adopt the recommendations. The commission included key state legislators, the state’s leading doctor and hospital associations and insurers. ... 

In 2006, Massachusetts adopted ... a model for national plans being debated in congress. But the plan has done little to control costs [see above]. 

In a statement, insurer Blue Cross Blue Shield of Massachusetts urged the state’s lawmakers ‘to take swift action to turn today’s recommendations into law.’ ...”

from BUSINESSWEEK July 27, 2009 by Catherine Arnst. Radical Surgery In Massachusetts. (Following bold is my editorial emphasis -per To cope with rising health care costs, the state is trying to eliminate the costly fee-for-service system. “...

Providers would instead get a yearly fee for each patient, thus eliminating financial incentives to over treat. (Yes, UNDER treatment is definitely cheaper than overtreatment and isn’t undertreatment what everybody needs?-per)The motivation for this switch is simple desperation - and it should be a warning to Washington. When Massachusetts enacted the most comprehensive insurance-for-all bill in the U.S. in 2006, it did nothing to address rapidly rising costs. Three years later the rate of uninsured residents has dropped from 8% to 2.6%, the lowest of all 50 states. But the cost of covering an additional 428,000 residents is wreaking havoc on the state’s finances. ... 

State officials need look no further than neighboring Maine to see what will happen if they don’t act. Maine’s uninsured rate is back at 10%, barely lower than the pre-“reform” level. ... 

A draft...calls for...”global payments” per person...by age, gender and health status [...] how to force doctors to do your rationing of care for you, no? They will have to turn patients down or away or starve, right?] Medical providers would cluster (now we really like that word! -per) into networks of doctors, clinics and hospitals capable of providing for all a patient’s needs.”(and I thought the constitution and our laws outlawed slavery... -per)

Legal

OK so from above, this is in fact a war with the lawyers for our survival as a profession, right? So let’s go: doctors of law (JDs) versus doctors of medicine. 

First, let us barrage Obama with contentious accusations about his outrageous overwhelming lawyer’s hypocrisy He is So terribly BAD. He is obviously a lawyer first second third and fourth. For over two years he has preached his healthcare warfare. During this period everyone has said you also need tort reform to reduce the costs of malpractice insurance and defensive medicine. Not once during this period has he even lip synced the words “tort reform” But earlier just this week, with his healthcare warfare in shambles and about to fail totally he finally said to congress Wednesday night, MAYBE, if the Republicans and his blue dog Democrats passed the current bill HR3200, then and ONLY after that was done, he would consider giving some executive orders to alleviate the medical malpractice costs. (I will yell LIAR again here, he will never keep this promise...-per)

In fact, just listening to Obama for the past two a half years, and perceiving his immense ego, hubris and total lack of humility, wouldn’t you say
that is just the typical lawyer? And they are all like that. They act like royalty all the time, don’t they...

[Apparently that comes with the J.D., after all we are a “nation of laws”, and if the J.D. enables one to make all the laws, isn’t that the SAME THING as being KING???? I.e. The Ruler makes the RULES!, that is why he is called the ruler!] How do you get rid of a whole tribe of kings???? (If you ever have a chance to watch congressional committees at work subpoenaing suspect witnesses and examining them, you will have no doubts. Major emesis material! You can’t treat your fellow humans so badly as they do unless you are king or think you are!

Do they work for us, or do we work for them?

OBVIOUSLY, since they’re the rulers we work for them. Live in D.C. You will know. I did.

Some Hope for tort lawyer reform can be imagined in this news:


‘With the recession crimping legal budgets, some big companies are fighting back against law firms’ longstanding practice of billing them by the hour. The companies are ditching the hourly structure - which critics complain offers law firms an incentive to rack up bigger bills - in favor of flat-fee contracts. One survey found an increase of more than 50% of this year in corporate spending on alternatives to the traditional hourly fee model. The shift could further squeeze earnings at top law firms. The past 18 months have been brutal for some big law firms as work that hinges on vibrant credit markets, such as deal making, has flat lined. ... Reported average cost savings of 15% from using alternative arrangements. It said 63% of the surveyed lawyers planned to increase their use of alternative billing arrangements. Companies have long complained that legal fees are inflated by a business model in which law firms have high priced junior lawyers who must be kept busy billing for work that could be handled more efficiently. With the recession, companies have the leverage to force changes, say some lawyers at both client companies and law firms. ‘Law firms are more receptive to change because they are in the business of needing legal work’ said Daniel Fitz, chairman of the Association of Corporate Counsel. ... hourly rates have risen to a range of $300 to $1000. ... Attorneys say it is doubtful flat fees could even supplant hourly billing for the most complicated and high stakes matters, such as an antitrust fight with the government or a particularly tricky corporate merger, where it’s too hard to estimate how much effort it will consume.

“In addition, ‘a client can’t expect to have the absolute best team of [trial] lawyers from a firm, and have the lawyers give up all the other work they could be doing on a regular fee basis, to work 18 hours a day for months of time on a flat fee engagement.’ ... graduates from elite law schools, who can command starting pay of $160,000, it is employing some college graduates who can perform routine tasks at a lower cost. ... ‘we were incentivized to get done in 10 hours what another lawyer at another firm have spent12 hours doing’ ...”

What a bunch of baloney. I heard one lawyer on TV saying we could solve the whole problem if doctors would only do more “pro bono” work like they the lawyers do !!!!! -per

from The Wall Street Journal July 15, 2009
by Philip K. Howard. **Health Reform Requires Lawsuit Reform.** "...Like a crash in slow motion, you can see Congress tumbling down toward the lowest common denominator - a reform package that will do little to contain costs, but will offend the least number of special interests. **But tort lawyers are the one special interest Democrats won’t offend.** Studies have repeatedly demonstrated that the current ad hoc system of justice, with verdicts that vary widely from one jury to the next, has spawned a culture of legal fear and self protection. Studies also show that the system fails injured patients - a claim takes an average of five years to resolve and nearly 60 cents out of every dollar spent in the malpractice system ends up going to lawyers or administrative costs. That’s why most of the important health care constituencies, from the American Medical Association to AARP, favor creating pilot projects for special health courts. Mr. Obama has recently talked about the need ‘to explore a range of ideas about how to ...scale back the excessive defensive medicine.’

"But one interest group hates the idea. You guessed which one. Sen. Mike Enzi (R, Wy) discovered just how powerful the trial lawyers are when he proposed creating health court pilot projects. His proposal was only to permit experiments, not broad scale tort reform, and it had been developed with Sen. Max Baucus (D, Mt), chairman of the Finance Committee. But when Mr. Enzi offered this modest proposal, other members of the Senate Committee on Health, Education, Labor and Pensions killed the idea, declaring that the Constitution requires juries to be the ultimate decision maker in civil lawsuits. THAT’S NOT TRUE. Special courts without juries are common in America and include courts for bankruptcy, tax disputes, workers compensation and more. America has a long history of using expert courts when there is a need for expertise and consistency. It’s hard to imagine any area that needs consistent justice more that health care. The senators weren’t willing to discuss the merits of an expert court. ...

“Actually, the enormous damage of unreliable justice is visible all around American society - in playgrounds stripped of athletic equipment (contributing to the epidemic of obesity), in schools where disorder is the norm because of loss of teacher authority, and in a health care system that squanders resources practicing unnecessary defensive medicine. Fear is the tool not of leadership but of the status quo. It could hardly be easier to scare people into keeping programs and institutions the way they are. But that only delays the days of reckoning. Congress is mortgaging our children’s future. Cost containment must be a goal. **PROTECTING TRIAL LAWYERS IS NOT THE SOLUTION.**” (Mr. Howard, a lawyer and author, is chairman of Common Good [www.commongood.org])

How far will Obama go to get what he wants?. He will distort and prevaricate far enough for sure to justify congressman Wilson’s uncivil accusation “liar” during Barack’s speech last Wednesday, September 9. Just how bad is he? See *Wall Street Journal* Monday 14 September p.A15: "**Fact-Checking the President on Health Insurance. His tales of abuse [by private health insurers] don’t stand scrutiny**" by Scott Harrington,... U. of Pa. Wharton School [of Business...].

One doctor prescribed (see next page) putting the shoe on the other foot: -as in what it would be like for the lawyers to take some of their own medicine which they are prescribing for the medical profession and business: (when you read this **you will comprehend much better** what is in Barack’s Reform Bill HR3200 ! Upside down!)
A Doctor's Plan for Legal Industry Reform

By Richard B. Rafal

Since we are moving toward socialism with ObamaCare, the time has come to do the same with other professions—even especially lawyers. Physician committees can decide whether lawyers are necessary in any given situation.

At a town-hall meeting in Portsmouth, N.H., last month, our uninformed lawyer in chief suggested that we physicians would rather chop off a foot than manage diabetes since we would make more money doing surgery. Then President Obama compounded his attack by claiming a doctor's reimbursement is between "$30,000" and "$50,000" for such amputations! (Actually, such surgery costs only about $1,500.) Physicians have never been so insulted. Because of these affronts, I will gladly volunteer for the important duty of controlling and regulating lawyers. Since most of what lawyers do is repetitive boilerplate or pushing paper, physicians would have no problem dictating what is appropriate for attorneys. We physicians know much more about legal practice than lawyers do about medicine.

Following are highlights of a proposed bill authorizing the dismantling of the current framework of law practice and instituting socialized legal care:

- Contingency fees will be discouraged, and eventually outlawed, over a five-year period. This will put legal rewards back into the pockets of the deserving—the public and the aggrieved parties. Slick lawyers taking their "cut" smacks of a bookie operation. Attorneys will be permitted to keep up to 3% in contingency cases, the remainder going into a pool for poor people.

- Legal "DRGs." Each potential legal situation will be assigned a relative value, and charges limited to this amount. Program participation and acceptance of this amount is mandatory, regardless of the number of hours spent on the matter. Government schedules of flat fees for each service, analogous to medicine's Diagnosis Related Groups (DRGs) will be issued. For example, any divorce will have a set fee of, say, $1,000, regardless of its simplicity or complexity. This will eliminate shady hourly billing. Niggling fees such as $2 per page photocopied or faxed would disappear. Who else nickels-and-dimes you while at the same time charging hundreds of dollars per hour? I'm surprised lawyers don't tack shipping and handling onto their bills.

- Legal "death panels." Over 75? You will not be entitled to legal care...
A Doctor’s Plan for Legal Industry Reform

for any matter.] Why waste money on those who are only going to die soon? We can decrease utilization, save money and unplug the courts simultaneously. Grandma, you’re on your own.

* Ration legal care. One may need to wait months to consult an attorney. Despite a perceived legal need, physician review panels or government bureaucrats may deem advice unnecessary. Possibly one may not get representation before court dates or deadlines. But that’s tough: What do you want for “free”?

My modest proposal to rearrange how lawyers do business.

* Physician controlled legal review. This is potentially the most exciting reform, with doctors leading committees for determining the necessity of all legal procedures and the fairness of attorney fees. What a wonderful way for doctors to get even with the sharks attempting to eviscerate the practice of medicine.

* Discourage/eliminate specialization. Legal specialists with extra training and experience charge more money, contributing to increased costs of legal care, making it unaffordable for many. This reform will guarantee a selection of mediocre, unmotivated attorneys but should help slow rising legal costs. Big shot under indictment? Classified National Archives documents down your pants? Sitting president defending against impeachment? Have FBI agents found $90,000 in your freezer? Too bad. Under reform you too may have to go to the government legal shop for advice.

* Electronic legal records. We should enter the digital age and computerize and centralize legal records nationwide. All files must be in a standard, preferably inconvenient, format and must be available to government agencies. A single database of judgments, court records, client files, etc. will decrease legal expenses. Anyone with Internet access will be able to search the database, eliminating unjustifiable fees charged by law firms for supposedly proprietary information, while fostering transparency. It will enable consumers to dump their clunker attorneys and transfer records easily.

* Ban legal advertisements. Catchy phone numbers such as 1-800-LAWYERS would be seized by the government and repurposed for reporting unscrupulous attorneys.

* New government oversight. Government overhead to manage the legal system will include a cabinet secretary, commissioners, ombudsmen, auditors, assistants, czars and departments.

* Collect data about the supply of and demand for attorneys. Create a commission to study the diversity and geographic distribution of attorneys, with power to stipulate and enforce corrective actions to right imbalances. The more bureaucracy the better. One can never have too many eyes watching these sleazy shysters.

* Lawyer Reduction Act (H.R. 3200). A self-explanatory bill that not only decreases the number of law students, but also arbitrarily removes 3,200 attorneys from practice each year. Textbook addition by subtraction.

Enthusiastically embracing the above legal changes can serve as a “teachable moment” and will go a long way toward giving the lawyers who run Congress a taste of their own medicine.

Dr. Rafal is a radiologist in New York City.
Letters to the Editor re Rafal’s Plan:

**On Treating Lawyers as Doctors**

Richard B. Rafal (“A Doctor’s Plan for Legal Industry Reform,” op-ed, Sept. 4) clearly fails to understand why his plan will never work: People will never tolerate anything that potentially violates the doctor–plaintiff relationship.

**JOSEPH HORTON, M.D.**
**Birmingham, Ala.**

Dr. Rafal left out an important component: a public option. A government-subsidized alternative will force all private law firms to be more fee-competitive. And of course, all of us who are happy with our present law firm will be able to keep it.

**C. E. ANAGNOSTOPOULOS, M.D.**
**Bloomfield Hills, Mich.**

The article written by Dr. Rafal was very clever and expressed the anger that so many of us feel. I am a registered nurse and resent that lawyers, politicians and union leaders are in control of my health care. It would be a good idea to send Dr. Rafal’s piece to all our legislators.

**RITA VANNAFTER**
**Valencia, Calif.**

Somehow, the legal profession has succeeded in being the regulator of every other profession/industry in the U.S. It has achieved this while retaining its complete autonomy and preserving its right to self-regulation. The legal profession remains the sole unregulated profession in this country and it has thoroughly abused this power. While I definitely disagree with the policies of the current administration and Congress, I dare say if they were just to enact meaningful regulatory authority over the entire legal profession, the resulting explosive growth in the economy may even be able to generate the revenue necessary to achieve all of their lofty goals.

**FRED GELDERMANN**
**Lake Geneva, Wis.**

**The Greatest Senators Came Before 1913 And Popular Election**

It is interesting that all of the great senators mentioned in Jay Winik’s “Kennedy for the Ages” (op-ed, Aug. 28) served prior to 1913 and the ratification of the 17th Amendment to the Constitution. That amendment changed the selection of senators from the state legislatures to popular election (superseding Article I, Section 3 of the Constitution.) Maybe our founders did know something about the need to temper the democratic tendencies of the House with a more republican Senate, Alexis de Tocqueville, that astute French observer of our nation, certainly thought they had the right idea.

**CHRIS DALY**
**Yucaipa, Calif.**

Letters intended for publication should be addressed to: The Editor, 1211 Avenue of the Americas, New York, NY 10036, or emailed to wsj.ltrs@wsj.com. Please include your city and state. All letters are subject to editing, and unpublished letters...
Cycloplegic Refractions in Children Who Never Wore and Who Always Wore Prescribed Spectacles for Refractive Accommodative Esotropia: Exploring the Natural History of this Form of Strabismus and the Effect of Treatment on their Hyperopia

ARIF O. KHAN, M.D.

from the Division of Pediatric Ophthalmology, King Khaled Eye Specialist Hospital, Riyadh, Kingdom of Saudi Arabia

ABSTRACT: **Purpose:** To compare cycloplegic refractions in accommodative esotropes who never and who always wore prescribed spectacles.

**Methods:** An institutional retrospective medical record review was performed for children with fully or partially refractive accommodative esotropia without neurological or other ocular disease. Only children with at least 3 years (y) follow-up, at least 2 separate cycloplegic refractions at least 3y apart, and clear documentation of full compliance or complete non-compliance with prescribed spectacles were studied.

**Results:** For the right eye, average youngest (<2y) and oldest (8-10y) spherical equivalents were significantly lower in noncompliant children (3.3D [n=15] and 2.49D [n=13]) than in compliant children (5.5D [n=8] and 4.69D [n=25]). The differences in mean hyperopia between <2y and 8-10y for the non-compliant (-0.81D) and compliant (-0.84D) children were similar as were levels of mean cylinder.

**Conclusions:** The differences in average spherical equivalent and average degree of astigmatism between <2y and 8-10y (slight decrease and slight increase, respectively) were similar for children who never and children who always wore prescribed glasses for refractive accommodative esotropia. Although full-time glasses wear did not appear to affect refractive shifts, limitations of this retrospective study include a lack of statistical power to detect differences less than 2 D.

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INTRODUCTION

Refractive accommodative esotropia is a convergent strabismus associated with the accommodative effort necessary to overcome the optical blur from an uncorrected hyperopia(1). Although full-time wear of the full hyperopic cycloplegic refraction is the recommended treatment for both fully and partially refractive accommodative esotropia, there is some concern that such treatment may impede emmetropization (1-6) as has been suggested by animal models (7-9). Accommodative esotropes show little change or a slight increase in their hyperopic spherical equivalent until approximately 7 years of age, after which a slight myopic shift may occur (1-6,10,11). Because the standard of care is to immediately prescribe children diagnosed with refractive accommodative esotropia full-time spectacles, the effect of full-time spectacle wear on the natural refractive history of accommodative esotropia is difficult to determine. An opportunity to better understand the natural history of the condition arises from the study of affected families who are completely non-compliant with wear of prescribed glasses. The purpose of the current study is to assess the effect of glasses wear on cycloplegic refractions in accommodative esotropia by comparing mean cycloplegic refractions of affected children who never wore their prescribed glasses to those of affected children who wore them full-time.

METHODS

Institutional review board approval was obtained for this project. A retrospective medical record review from was conducted for children with fully or partially refractive accommodative esotropia (decrease of esotropia at distance from >20 prism diopters to <10 prism diopters with spectacles) who initially presented from 1999-2002. Only children <= 10 years of age with at least 3 years' follow-up and at least 2 separate cycloplegic refractions at least 3 years apart were included. Examinations and refractions were performed by one of several staff pediatric ophthalmology attendings; retinoscopy was typically used with confirmation by autorefraction in older cooperative patients. Cyclopentolate 1% was used for cycloplegia. Children with developmental delay, neurologic disease, or other significant ocular disease (e.g., retinitis pigmentosa, cataract, glaucoma, eccentric fixation) were excluded. Potentially eligible medical records were reviewed for documentation of prescribed spectacle compliance. Only medical records with clear documentation of full spectacle compliance (always wearing prescribed glasses since the time of prescription) or complete non-compliance (never wearing prescribed glasses) were included in the study (children who wore their glasses part-time were excluded, as were children without documentation of the degree of compliance). Prescribed spectacles were the full cycloplegic refraction. The spherical equivalents of the cycloplegic refractions and the amount of minus cylinder in diopters (D) were grouped according to patient age in years at the time of the refraction (<2y, 2-4y, 5-7y, 8-10y). Descriptive statistics were calculated using Microsoft Excel 2003 for Windows. Inferential statistics were calculated using Graphpad on-line software (www.graphpad.com/quickcalcs/index.cfm, accessed January 10th 2009). Statistical comparisons were limited in order to minimize the change of Type I error - 4 comparisons were made with the 2-tailed unpaired t-test and an alpha level of 0.0125 (0.05 divided by 4) was used as the cutoff for significance testing (p value).

RESULTS

Eighty-two medical records that met the selection criteria were identified. Of the 82 children, 48 (59%) were males and 34 (41%) were females. Twenty-eight (34%) had fully accommodative esotropia and 54 (66%) had partially accommodative esotropia. Thirty-eight (46%) had amblyopia at presentation, which was treated with patching. The number of children (number of right eyes) who never and always wore their glasses for each age category are
TABLE: Patient-Subject Data and Results
in a Study of Refractive Error in 82 Children with Refractive Accommodative Esotropia Wearing or Not Wearing, Full Time, Hyperopic Correction

<table>
<thead>
<tr>
<th>ODsc vs. cc</th>
<th>Mean cylinder</th>
</tr>
</thead>
<tbody>
<tr>
<td>ODsc vs. cc</td>
<td>Mean cylinder</td>
</tr>
<tr>
<td>&lt;2y</td>
<td>0.67 D +/- 0.72 (15) 0.88 D +/- 0.58 (8) p=0.4861*</td>
</tr>
<tr>
<td>2-4y</td>
<td>0.65 D +/- 0.79 (32) 1.03 D +/- 0.58 (28)</td>
</tr>
<tr>
<td>5-7y</td>
<td>0.86 D +/- 1.01 (23) 1.27 D +/- 0.97 (45)</td>
</tr>
<tr>
<td>8-10y</td>
<td>1.10 D +/- 1.2 (13) 1.44 D +/- 0.98 (25) p=0.3538*</td>
</tr>
<tr>
<td>Astigmatic shift</td>
<td>Precision</td>
</tr>
<tr>
<td>ODsc</td>
<td>ODcc</td>
</tr>
<tr>
<td>ODsc vs. cc</td>
<td>Precision</td>
</tr>
<tr>
<td>0.81 D (83) 0.84 D (106)</td>
<td>0.43 D (83) 0.56 D (106)</td>
</tr>
<tr>
<td>1.3 D 1.3 D</td>
<td>0.32 D 0.32 D</td>
</tr>
</tbody>
</table>

OD: right eye, OS: left eye, sc: without correction, cc: with correction, y: years of age, D: diopters, (): indicates number of eyes, +/-: indicates standard deviation precision: one-half the width of the 95% confidence interval for the difference in means. * by the 2-tailed unpaired t-test

For the right eye, the <2y and 8-10y average hyperopia was significantly lower in children who never wore their glasses (3.30D vs. 5.53D [p=0.0033] and 2.49D vs. 4.69D [p=0.0019], respectively). The mild decrease in average hyperopia from <2y to 8-10y of age (a comparison of the <2y and 8-10y groups only) was similar for non-compliant and compliant children (0.81D vs. 0.84D, respectively). In both groups the precision for the decrease (i.e., the...
half-width of the 95% confidence interval) was 1.3D. Initial and final mean astigmatic refractive error (a comparison of the <2y and 8-10y groups only) was not significantly different between children who never and children who always wore their prescribed spectacles (<=2y: 0.67D vs. 0.88D [p=0.4861]; 8-10y: 1.10D vs. 1.44D [p=0.3538], respectively). In both groups the precision for the astigmatic increase was 0.32D. Data for the left eye (not shown in the Table) were similar. For the data collected, the current study is estimated to have roughly 80% power at the 2-tailed 5% significance level to detect a difference in mean spherical equivalent of approximately 2D and a difference in mean cylinder of approximately 1.3D (12).

DISCUSSION

For mean spherical equivalents and mean degrees of astigmatism, the absolute changes from <2y to 8-10y were similar for children who never and children who always wore prescribed glasses for refractive accommodative esotropia. This suggests that full-time glasses wear did not have a large (>2D) effect on absolute refractive shifts (the data was not well-empowered to detect a smaller difference or to address whether or not there was a difference in refractive shift relative to the total hyperopia). The mild decrease in hyperopic spherical equivalent and increase in astigmatism is in agreement with prior studies of accommodative esotropes followed after prescription of glasses. Noncompliant children had lower hyperopic spherical equivalents than children who were compliant with spectacle wear. This was likely because children with higher hyperopia had more constant accommodative demand from their uncorrected refractive error and therefore perceived more of a benefit from spectacle wear.

Most prior studies also suggest no effect of the wearing of hyperopic glasses on refractive shifts in refractive accommodative esotropia. Mulvihill (5) found stability in childhood annual cycloplegic refractions after prescription of the full cycloplegic refraction and felt spectacle wear impeded emmetropization. Ingram et al (6) suggested that abnormal emmetropization in accommodative esotropia is an intrinsic defect rather than an effect of glasses wear. Ingram et al (6) found that spectacle wear did not significantly affect serial refractions in hyperopic strabismic children (which were relatively stable with or without glasses). Unlike the current study Ingram et al (6) undercorrected their patients, i.e., the full cycloplegic refractions were not prescribed. In another study, Black (11) also concluded that there was no difference in refractive shifts in accommodate esotropes whether they wore their full hyperopic correction or were underplussed (by 1D in his study). Lambert et al (10) who did prescribe full cycloplegic refractions, found that the hyperopic refractive error peaked 3 years after full-time glasses wear and gradually decreased thereafter. Lambert et al (10) concluded that refractive shifts in accommodative esotropia are a function of when full-time glasses wear is initiated; the authors admitted that a cohort without any spectacle wear would have strengthened their conclusions. The current study supports the conclusion of Ingram et al (6) and Black (11) that there is no significant difference in refractive shift in accommodative esotropia whether or not glasses are worn.

Unlike what appears to be the case in refractive accommodative esotropia, the wear of hyperopic spectacles does seem to interfere with emmetropization in non-strabismic hyperopes. In infants with hyperopia >= 4D randomized to no treatment or partial correction with spectacles, Ingram et al (3) found that more of the children who consistently wore their spectacles retained hyperopia >= 3.5D after 3 years; Ingram also found that spectacle wear interfered with normal emmetropization (6). Atkinson et al (13) reported a small, transient effect on emmetropization for infants with at least one meridian of hyperopia > 3.5D who were randomized to a partial spectacle correction of their hyperopia. In children with high hyperopia and a family history of strabismus,
Aurell and Norsell (14) reported that the children with high hyperopia and a family history of strabismus who developed accommodative esotropia and were treated with spectacles maintained or increased their hyperopia while children who did not develop accommodative esotropia and who were not treated with spectacles lost most of their hyperopia by the time they were 4y of age.

Regarding astigmatism, one prior study (15) reported that full-time spectacle wear was not associated with the development of astigmatism in hyperopic non-strabismic children (consistent with the current study’s findings for refractive accommodative esotropes); however, spectacle wear has been reported to be associated with increasing astigmatism in both a non-human primate model (9) and in children with refractive accommodative esotropia (16). Ingram et al (15) found no effect of hyperopic spectacles on astigmatism in non-strabismic hyperopes. In 289 infants with hyperopia >= 5.25D in one meridian randomized to no treatment or partial correction with spectacles and followed from approximately 6 to 42 months of life, Ingram et al (15) found no effect of glasses wear on subsequent decrease in astigmatic error (although glasses-wear did decrease myopic shift [3]). The authors also found astigmatism to decrease in strabismic hyperopes but to less of an extent and unaffected by spectacle wear. Other studies have found that in strabismic patients astigmatism increases during childhood (17,18) and may not develop until after infancy. The effect of age when spectacles were initiated on astigmatism in refractive accommodative esotropia was the subject of a study by Lambert and Lynn, (16) who retrospectively analyzed medical records of 120 children with refractive accommodative esotropia. The authors concluded that there was an increase in the cylinder of children who were prescribed glasses when under 4y of age vs. a slight decrease in the cylinder of the children prescribed glasses when 4y of age or older.

The current study suggests that full-time spectacle wear does not have a large affect on refractive shifts in refractive accommodative esotropia. As is true for any retrospective study, data collection was limited by prior documentation. Longer longitudinal follow-up on each individual patient would have been ideal. Factors that may have played a role but were not analyzed because of incomplete documentation and/or small numbers include exact age, amblyopia, and accommodative convergence to accommodation ratio - such limitations may have limited the equivalency of the 2 groups. Cyclopentolate 1% may not have uncovered the full hyperopic correction for prescription in all cases (19). The relatively small sample sizes in some subgroups are another limitation of the study. The purpose of this study was to better understand the natural history of untreated accommodative esotropia, not to affect clinical practice. Only limited conclusions can be drawn from the current analysis, which was not well-empowered to detect a less than 2D difference in spherical equivalent and less than 1.3D difference in mean cylinder between the 2 groups.
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Case Report

Effect of Innervational Strabismus Surgery on a Patient with Hypotropic Strabismus and Pseudoblepharoptosis

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ABSTRACT : Purpose: We seek to analyze the results of the inervational surgery in a case of hypotropia with pseudoptosis with videooculography (3D-VOG)

Case Report: We present the clinical case of a 35 year old male suffering from acquired ptosis of the left eyelid, present since the age of 10 and who was interested in cosmetic surgery. The preoperative 3D-VOG shows hypotropia of the left eye (22.5°), minimum exotropia and intorsion together with limitation in the elevation of the left eye with positive passiveduction test and pseudoptosis.

Results: Surgery was carried out in three stages; 1. Recession of the superior rectus of the right eye (RE) resulting in an improvement in the elevation and the pseudoptosis; 2. Recession of the inferior rectus of the left eye (LE), with improvement in the elevation of the LE but deterioration of the pseudoptosis; 3. Resection of the inferior rectus of the RE which improves both the elevation as well as the pseudoptosis of the LE.

Conclusions: We consider the usefulness of the innervational techniques in the incomplete third nerve paralysis with important affectation in the elevation, making it necessary to check and in this case eliminate the restrictive effects although this may influence the effect on the pseudoptosis.

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The authors have no commercial or proprietary interest in the contents of this article.
INTRODUCTION

The paralysis of the third nerve is a problem difficult to solve due to the quantity of muscles that are affected, with only the lateral rectus and the superior oblique being not affected. Depending on the degree to which different muscles are affected, it can provoke a pronounced vertical deviation (hypotropia) with a limitation of elevation, horizontal deviation (exotropia) as well as mydriasis and blepharoptosis. It usually appears with variable affection in the number of muscles and their intensity (1).

CASE REPORT

A 35 year old male showing acquired blepharoptosis of the left eyelid, present since the age of 10, attends the consultation interested in cosmetic surgery.

The examination reveals a corrected bilateral visual acuity of 20/20 in both eyes and simple myopic astigmatism (-0.5x 140º RE and -2x 70º LE). The sensorial study not reveal stereopsis (TNO and vectography) or Dyplopia. The examination (Figure 1-A, next page->) shows LE hypotropia (45 dp) with a marked limitation of the elevation of the LE which not reach the half way line and pseudoptosis (Figure 1-B,C). A passive duction test (PDT) was carried out, demonstrating a limitation in the elevation of the LE.

The video-oculography (VOG)(2,3,4) confirms in primary position and by means of fixation of the RE (Figure 2A NEXT PAGE overleaf) hypotropia of the LE (22.5º), exotropia (2.4º) and minimum intorsion (2.1º). In the infra-abduction of the RE intorsion of the eye affection (6.6º) (Figure 2-B) is evident. When the LE is used, (Figure 2-C), hypertropia of the RE (27º), exotropia (5º) and minimum intorsor component (1.6º) appear.

RESULTS

Incomplete paralysis of the third nerve of the LE was diagnosed (1,5) and it was decided that a treatment of innervational surgery should be carried out in different stages in order to demonstrate the effect of the different surgical procedures used on pseudoptosis.

In the first stage, a recession of 14mm of the superior right rectus was carried out in spite of having confirmed the positivity of the passive ductions under general anesthesia. The postoperative results showed an improvement in the elevation of the LE (30 dp) and of the pseudoptosis (Figure 1-D). The VOG study (Figure 2-D, )confirms hypotropia of the LE (14.6º), exotropia (2.3º) and minimum intorsion (0.4º).

Afterwards, given the hypo-correction of the vertical deviation and keeping in mind the aforementioned restriction of the passive elevation of the LE, a recession of the inferior rectus of the LE (4.5 mm) was carried out until the duction was negative. An improvement of 20dp was obtained in the elevation, but there was a deterioration of the pseudoptosis (Figure 2-D). This led to a third intervention in order to reinforce the innervational effect by means of resection of the right inferior rectus of the RE.

The VOG study (Figure 2-E) revealed 8.7º of hypotropia with minimal horizontal and torsional components (< 1º) in primary position and an improvement in the elevation which passed the half way line (Figure 3, next page overleaf x2 BELOW). There was also an improvement in the pseudoblepharoptosis (Figure 2-F.).

DISCUSSION

It is very difficult to assess the action of the superior oblique in the paralysis of the third nerve as it is necessary to show the intorsion that is produced during the infra-abduction of the healthy eye. The analysis of the intorsion in the affected eye can be assessed by the displacement of the conjunctival vessels or with the aid of biomicroscopy (15). In our case we used the VOG study to observe (image 2-B) how the LE has an intorsion of 6.6 °, (cont’d next page overleaf x2)
Figure 1 (Laria et al): 1A: Preoperative study of the different cardinal gaze positions. 1B: Preoperative blepharoptosis; 1C: Evidence of pseudoblepharoptosis; 1D: Blepharoptosis after recession of superior rectus RE; 1E: Blepharoptosis after recession of superior rectus (RE) and inferior rectus (LE); 1F: Blepharoptosis after recession of superior rectus (RE), inferior rectus (LE) and resection of inferior rectus (RE).
Figure 2 (Laria et al): Video-oculography (3D-VOG) 2 A: Fixing RE (preoperative); 2 B: Fixing RE in infra-abduction (preoperative); 2 C: Fixing LE (preoperative); 2 D: VOG after recession of superior rectus (RE); 2 E: VOG after recession superior rectus (RE), inferior rectus (LE) and resection of inferior rectus (RE).
...indicating the integrity of the fourth nerve.

The diagnosis of incomplete paralysis of the third nerve is based on the lack of pupillary compromise, (our patient had isochoric pupils) as well as different degrees of affectation of the extrinsic muscles: slight exotropia that suggests smaller paresia of the medial rectus and great affectation of the levator muscles. Initially we should also consider whether the blepharoptosis is genuinely caused by the paralysis of the levator muscles or on the contrary, if it is due to pseudoptosis as a consequence of the hypotropia. This would be diagnosed by obliging the patient to stare with the hypotropic eye and to observe the effect on the eyelid: in the event of it being due to the levator muscle of the eyelid, it will remain fallen, whereas if caused by pseudoptosis the eyelid will open accompanying the elevation of the globe as seen in Figure 1-C (two pages prior).

The differential diagnosis should be established with the congenital fibrosis of the inferior rectus, based on the existence of a positive PDT for the elevation. However, in this case the patient's deviation appeared suddenly at the age of ten, without any traumatic antecedent (which therefore allows us to discard possible orbital fractures). An endocrinology control had been carried out on the patient, discard the possibility of Graves Bassedow’s disease by means of analysis and image studies that did not demonstrate muscular or vascular anomaly or orbital tumor.

The treatment proposed for the incomplete paralysis of the third nerve affecting the levator muscles consists of the Knapp technique (6,7,8). In order to carry out this intervention, a negative PDT is fundamental because the muscular transpositions do not correct the deviation by mechanical restriction. Therefore, in our case, following the recession of the superior rectus of the RE that improved the elevator effect of the affected eye, we decided to carry out the recession of the inferior rectus of the hypotropic eye until the passive duction was liberated. This was carried out in 2 stages in order to demonstrate the effect on the pseudoptosis (9). As expected, this initially showed an improvement that later on deteriorated after the recession of the inferior rectus with the same innervational effect. We
consider that the contracture of the inferior rectus was secondary to the amount of time that the eye had had hyptropia without treatment. It is possible that if the first intervention had been carried out years before, the inferior rectus contracture of the LE could have been avoided.

Given the significant hypotropia with pseudoptosis, as an alternative to improve both, we decided to reinforce the innervation effect, carrying out resection of the inferior rectus of the RE. In this way, we increased the innervation effect on the superior rectus of the RE (dominant) and therefore of the left superior rectus and of the levator muscle of the superior eyelid, being able to achieve an acceptable aesthetic position and with an improvement of the versions. This may have been more compromising with other transposition techniques.

CONCLUSION

We believe that innervational surgery is useful for incomplete third nerve paralysis mainly affecting the elevation. It is fundamental to carry out a study of passive ductions in order to eliminate any restrictions that can limit their effect and to keep in mind that the weakening of this restriction can influence pseudoptosis in an important way.

REFERENCES:

Partial Third Nerve Palsy Involving the Superior Rectus and Levator Palpebrae Muscles and Disruption of Central Binocular Vision Fusion from Brain Stem Infarction: A Case Report.

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ABSTRACT: Background and Purpose: To add to the literature a case of isolated third nerve paresis involving the nerve fascicles subserving the superior rectus and the levator palpebrae muscles from brain stem infarction and presenting the characteristics of central disruption of binocular vision fusional amplitudes.

Case Report: One patient with an old intracranial aneurysm and with old and recent brain stem infarcts and no other neurological manifestations, demonstrating characteristics of isolated paresis of the superior rectus and levator palpebrae muscles is reported.

Conclusion: This dual involvement of the superior rectus and levator palpebrae muscles supports the anatomical arrangement of the ocular motor nucleus fascicles in the midbrain, clarified by experimental studies on animals and clinical data in humans and emphasizes the juxtaposition of the superior rectus and levator palpebrae fascicles and placing the levator palpebrae muscle fascicle lateral to the medial rectus fascicle in the midbrain. The comitant vertical deviation and the negative Bielschowsky head tilt test support the vertical rectus muscle involvement. The constant diplopia with only 4 prism diopters of hypotropia and with the absence of fusional amplitudes evokes disruption of central binocular fusion.
INTRODUCTION

In general, fascicular oculomotor nerve (OMN) palsy are associated with other neurological signs such as cerebellar ataxia, tremor, hemiballism, or contralateral hemiparesis (1,2). However, there have been many reported cases of OMN fascicular injury with either transient or no neurological manifestations similar to our case. Several cases of isolated partial third nerve palsy are reported in the literature: Inferior oblique palsy (1,3). Ipsilateral paresis of the Inferior Oblique (IO), Superior Rectus (SR), Medial Rectus (MR) and Levator palpebrae (LP) muscles with sparing of the pupil and the Inferior Rectus (IR) muscle (4). Paresis of all ipsilateral muscles innervated by the OMN, but sparing the pupil (4). Complete ipsilateral OMN deficit, including pupillary dysfunction (5,6) Isolated IR palsy (7). Isolated pupillary involvement from medial infarction in the midbrain tegmentum (8).

Based on the above reported cases in humans and on animal experiments by Warwick (9), and by Buttner-Ennever & Albert (10) and the study by Kerr & Hollowell (11) on the location of the pupillary fibers, the organization of the OMN fascicles and the pupillary fibers was postulated in the ventral midbrain, from lateral to medial, as follows(1): IO fascicles, SR fascicles, MR fascicles, LP fascicles, IR fascicles, and medially the pupillary fibers

(See Figure 1. below)

Our patient presented with a 2.5 mm blepharoptosis of her left upper eyelid and a vertical diplopia due to paresis of her left SR muscle. She had an intracranial aneurysm of her left medial cerebral artery operated on nine years ago with a vascular clip. Recent computed tomography (CT) scan showed evidence of recent and old midbrain infarcts.

**Figure 1** (Khawam et al): (From Castro et al(1)): Schematic diagram showing the anatomic arrangement of the oculomotor fascicles in the midbrain, from lateral to medial. 
IO - inferior oblique; SR - superior rectus; MR - medial rectus; IR - inferior rectus
CASE REPORT

A 51 year old woman developed, nine years ago, sudden vertical diplopia following an intracranial aneurysm and cerebral infarction documented by CT scan and operated subsequently with a vascular clip. She had no other neurological symptoms.

On ocular examination she had a corrected visual acuity of 20/20 in both eyes. She showed a 2.5 mm blepharoptosis of her left upper eyelid. The pupils were round, regular, equal and reacted normally. Prism cover test with correction of the refractive errors showed a comitant left hypotropia of 4 prism diopters equal in all cardinal gazes. Ocular version disclosed weakness of elevation slightly more marked in abduction (-2 left SR muscle, approximately 50% of normal) and improving to -1 on duction (75% of normal). She had no abnormal head posture and the Bielschowsky head tilt test (BHTT) showed no forced tilt difference in the vertical deviation upon tilting the head to either should. Her left LP function was normal and equal to the right one. A 4 diopter prism applied base down to the right eye or base up to the left neutralized her vertical diplopia in all fields of gaze. The patient appreciated, with prisms, persistent superimposition of the images, but no fusional amplitude was obtainable by prisms in space.

Prism therapy was prescribed. No magnetic resonance imaging could be done because of the previously performed vascular clip. But recent brain CT scan showed evidence of recent and old cerebral infarcts. Figure 2, above, summarized the isolated involved fascicles.

DISCUSSION

Isolated fascicular involvement of the OMN without other neurological abnormalities is most likely to be caused by ischemic microvascular disease in the midbrain (4). It is estimated that an isolated non-traumatic pupil sparing oculomotor palsy has at least a 75%
probability of being ischemic in nature. Our case demonstrates an isolated involvement of the SR and LP fascicles due to loci of infarcts in the midbrain documented by CT scans. Indeed, it is at the level of the oculomotor nucleus or the nerve fascicles that the oculomotor neurons are still relatively separated (1). To our knowledge, isolated combined involvement of the SR and LP fascicles in the midbrain was not yet reported.

The dual involvement of the SR and LP fascicles, in our case, emphasizes the juxtaposition of the SR and LP fascicles and places the LP fascicle lateral to the MR fascicle (Figure 2).

The comitancy of the vertical deviation of our patient supports a vertical rectus muscle injury since palsy of a vertical rectus muscle is usually comitant as opposed to an injury of an oblique muscle where the vertical deviation is most incomitant and usually limited to its own field of gaze.

The absence of a forced tilt difference showing an increase of the vertical deviation upon tilting the head to the ipsilateral shoulder is common and not surprising since the inconsistence of the traditional teaching of the BHTT in patients with vertical rectus muscle palsy is the rule (12).

In IR palsy, the BHTT would require the IO to elevate the eye and increase the vertical deviation on contralateral head tilt. However, Jampolsky (13), was the first to demonstrate the inability of the IO muscle to elevate the eye above the midline. Therefore, because of this inability, the elevation may not occur and the BHTT would be inaccurate.

Similarly, in SR palsy, the BHTT may be inaccurate. Traditionally, the test assumes the if the SR is paretic, the ipsilaterial SO will depress the eye with head tilt towards the affected side, thus increasing the hypotropia. However, the SO muscle mirrors the function of the IO and is limited in depressing the eye (12). Therefore, the BHTT is usually inaccurate in SR palsy.

However, overaction/contracture of the SR muscle (13,14) is the most common cause of a positive BHTT showing a significant increase of the hypotropia upon tilting the head to the ipsilateral affected side.

The absence of fusional amplitude and the patient’s inability, during 8 to 9 years, to expand her vertical fusional amplitude in order to eliminate her retinal disparity of only 4 prism dipters of vertical deviation was pertinent. Patients with esophoria tend to have larger than normal fusional divergence amplitude and patients with exophoria tend to have larger than normal fusional convergence amplitude in order to obtain and maintain single vision. Similarly patients with hypertropia tend to build up, with time, their vertical fusional vergence amplitude. Our patient could not eliminate her diplopia despite a retinal image disparity of only 4 prism dipters. This finding concurs with Pratt-Johnson’s reported cases of central disruption of fusional amplitude (15,16). He postulated that a motor association area, controlling fusional amplitudes, exists possibly in the midbrain, and that if it is damaged, a loss of fusional amplitude occurs as the main sign with consequent constant diplopia as the main symptom. He believes head trauma and vascular lesion in the midbrain are the main causes.

CONCLUSION

Isolated paresis of ocular muscles subserved by the oculomotor fascicles without other neurological abnormalities is most commonly due to cerebral infarction.

Cerebral infarcts, documented in our patient by CT scan, involved the fascicles subserving the left SR and left LP muscles. This dual involvement places the LP fascicle lateral to the MR fascicle.

The comitancy of the hypotropia and the absence of any forced tilt difference in the vertical deviation upon tilting the head to either shoulder supports the SR involvement. The absence of fusional amplitudes and the constant diplopia due
to only 4 prism diopters of hypotropia, despite permanent superimposition of images with prisms, document a disruption of central binocular vision fusion of vascular origin.

REFERENCES


13. Jampolsky A. Superior rectus overaction/contracture syndrome. In:
Vision / Visual Acuity / Amblyopia


Manifest strabismus affected 1 in 30 white and 1 in 47 African American preschool-aged children. The prevalence of amblyopia was <2% in both whites and African Americans. National population projections suggest that there are approximately 677,000 cases of manifest strabismus among children 6 through 71 months of age and 271,000 cases of amblyopia among children 30 through 71 months of age in the United States. (Dr. David Friedman, Wilmer Eye Institute, Wilmer 120, 600 N Wolfe St, Baltimore MD 21210)


We found a more rapid visual acuity recovery with the Bangerter filters than with spectacles alone in eyes with anisometropic amblyopia. However, the 1 year visual acuity outcome was not statistically significantly different between the 2 treatments. (Dr. Agervi, Sept Pediatric Ophthalmology and Strabismus, St Erik’s Eye Hospital, Danderyd’s Hospital, S-182 88 Stockholm, Sweden


Our findings do not indicate that peripapillary retinal nerve fiber layer thickness is thinner in eyes with moderate amblyopia compared with their fellow eyes. (Dr. Repka, Jaeb Center for}

Binocular Vision


These findings are consistent with varying the magnitude of interocular suppression in computational models of both rivalry and masking, and imply the existence of a common suppressive process. Since dichoptic masking has been localized to the monocular neurons of V1, this is a plausible first stage of binocular rivalry. (Dr. Baker, School of Psychology, University of Southampton, Highfield, Southampton SO17 1BJ, UK)

Strabismus Diagnosis


Recent research on children with infantile onset esotropia has reinforced the need for early corrective surgery by reporting much improved binocularity and improved fine and gross motor skills in children operated on promptly after the onset of strabismus. Early intervention requires accurate measurement of the angle of strabismus, but is often limited in young infants who appear to be frequently distracted and upset by the hand movements directly in front of the face inherent in the prism cover test. ... A search of PubMed and Embase using the terms ‘Brückner reflex’ and ‘Krimsky test’ did not find any papers describing the combination of these tests. The technique that we are describing seems to distress infants much less than moving the hand from one eye to another during the performance of the prism cover test and offers the potential benefit of more accurate measurement. We recommend it as part of the strabismologists’ repertoire. (Dept Ophthalmology, Royal Children’s Hospital Discipline of Paediatrics and Child Health, University of Queensland,

We conclude that the strabismic eye contributes more to binocular vision than has been assumed on the basis of tests with targets presented solely to the strabismic eye (on a binocular background. (Dr. Kommerell, Universitäts-Augenklinik, Killianstr. 5, 79106 Freiburg, Germany)

**Strabismus Surgery**


Large unilateral medial rectus resection is a safe and effective procedure in the treatment of small to moderate angles of recurrent exotropia after bilateral lateral rectus muscle recession. The overcorrection rate was significantly lower after unilateral than it was after bilateral medial rectus resection. (Dr. Hwang, Dept Ophthalmology, Seoul National University College of Medicine Seoul National University Bundang Hospital, 166 Gumiro, Bundag-gu, Seongnam, Gyeonggi-do 463-707, Korea)


Researchers randomized 118 children, aged 3 to 8, to undergo surgery with one of the two techniques. Results with both techniques were equally predictable. There was no difference in the variation of the angle of strabismus after surgery, and there was no difference in the variation of the ratio between reduction in the angle of strabismus and the millimeters of muscle relocation.

**Strabismus, Non-Surgical Management**


Automated vision therapy delivered by the HTS system improved convergence and divergence amplitudes with a concomitant reduction in symptoms. The HTS system should be used on those patients with symptoms associated with an accommodative/vergence anomaly when in office vision therapy supplemented with home therapy is not practical. (Dr. Cooper, State University of New York College of Optometry, 33 W 42nd St, New York NY 10036)

**Strabismus Management, Outcome**


Significant differences exist in the clinical presentations of children who achieve functional orthotropia with single vision spectacles and those who require bifocals or surgery. An evidenced-based algorithm may help practitioners predict which intervention is most likely to benefit an individual child. (Dr. Coats, Cullen Eye Institute, Baylor College of Medicine, Texas Children’s Hospital, 6621 Fannin St, CCC 640.00, Houston TX 77030)

Edited by P.E. Romano, MD, MSO. Abstracts are selected on the basis of interest to our readers. To avoid duplication you will find none are from The American Orthoptic Journal, The British Orthoptic Journal, The Journal of the American Association for Pediatric Ophthalmology and Strabismus, The Journal of Pediatric Ophthalmology and Strabismus, or Strabismus, as most of our readers already subscribe to and/or read them. Publication herein does not constitute endorsement, recommendation or a validation of author’s conclusions.
HYDE PARK EDITORIAL: The Editor's Soapbox, Sandbox & B’LOG
(Prehistoric) Since 1985

More and More Stereoscopic 3D TV = ? More Stereo Sues??? 20/11!; Looking Younger vs. Older; Cheap Specs; Medical Error Management; Government Work; INSURANCE, ESPECIALLY MEDICAL HEALTH;

SCRUSHINESS.???

among the very most watched TV presentations in the world at anytime,

We waited for halftime at the Superbowl. They gave plenty of warning that the stereo ads were about to be shown. And they were sure stereo and in color!!!

The foregoing two paragraphs are from our last Hyde Park which was in fact 6 months ago. The first paragraph remains true, as we read everyday of some new application, The second paragraph was handicapped. Judy appreciated the stereo but my vision was so bad from my advancing cataracts, I was barely able to appreciate the stereopsis. But since then I have had both cataracts replaced with multifocal intraocular lenses and yesterday on my “final postop” exam for my second eye, got to 20/20 sc in that eye too. So now I am 20/15sc everywhere in my left eye and 20/20sc everywhere in my right eye (got a little posterior capsular opacity there, but I took a pass yesterday on the offered yag capsulotomy because that eye has a repaired RD and has had multiple vitreous hemorrhages from a wimpy bridge vessel. across the horseshoe flap.)

But here is more stereopsis and 3D stuff.

It’s everywhere now and spreading!

Shouldn’t all this be exposing more “Stereos Sue” BINOCULAR VISION AND STEREOPSIS type eye problems ? Let us know if you have seen any and what you did with and for them.....
On the thirteenth floor of the Weill Greenberg Center is a spot that seems to have been teleported straight from “Star Trek.” Using the latest imaging and computer graphics technologies, the Medical College’s 3-D Immersive Visualization room allows researchers and clinicians—wearing 3-D glasses and wielding a remote-control device called a “wand”—to view the human body with startling depth and detail. The images surround the viewer, who can change perspectives with a flick of the wrist—enlarging portions of an MRI or other study, changing views, exploring different layers.

The facility is what’s known as a CAVE, for computer-assisted virtual environment; there’s also one in the Center for Advanced Computing on the Ithaca campus. Weill Cornell’s is part of the Cofrin Center for Biomedical Information in the HRH Prince Alwaleed Bin Talal Bin Abdulaziz Alsaud Institute for Computational Biomedicine. “The use of this powerful new tool will increase quickly in all aspects of biomedical research in the College, and will allow us to attract the best and brightest minds in the world,” says institute director Harel Weinstein, DSc, the Upson Professor of Physiology and Biophysics. “It will provide unique support for Weill Cornell’s mission of medical education, clinical excellence, and scientific research.”

Inside look: Physiology and biophysics researcher Luis Gracia, PhD, stands within an image of a dopamine transporter. The red represents water, the yellow the molecule, and the green the membrane.
Magic Eye
Third dimension: Vanessa Borcherting (above), a systems administrator in the Department of Physiology and Biophysics, views the inside of a skull; the sinuses can be seen at left. Top right: Gracia explores an MRI image in which the parts of the brain are depicted in contrasting colors for a study on the neurological development of babies born addicted to crack cocaine. Bottom right: A visitor sporting the facility’s 3-D goggles views a bright pink image of the brain.
Get ready for laser-powered 3-D TV

IRVINE, Calif. - Last October, Mitsubishi Digital Electronics America Inc. announced that it was bringing to market laser-powered television. Called LaserVue, it lights up the screen with high-color-purity red, green and blue laser light instead of white lightbulbs and produces bright colors with a much wider color range. This approach is also said to be much more efficient than standard LCD and plasma screens because the lasers produce narrow-wavelength light of each primary color instead of filtering out the required wavelengths from full-spectrum white.

It uses Class 1 safety-rated lasers in a digital light projection display. Precisely focused laser beams yield $1920 \times 1080$-pixel resolution and 36-bit color depth. The 135-W operating power claims to be just one-third that of an LCD, and one-quarter that of a plasma TV.

The laser TV, in common with Mit-

The Mitsubishi L65-A90 Laser TV has a slim profile and produces bright colors while using only a fraction of the power of an LCD or plasma screen.

subishi's Home Theater HDTV product line, is 3-D-ready. For several years now, the company has been developing 3-D technology and working with program content providers in anticipation of high consumer demand. A 3-D display requires simultaneous input from cameras placed at different angles, and it is only recently that the necessary bandwidth has emerged for transmission and processing.

By displaying stereo-pair images at a multitude of viewing angles, Mitsubishi's autostereoscopic approach means that viewers see the 3-D effect with the naked eye, no matter where they sit relative to the screen. View-dependent pixels display different colors at different viewing angles. Mitsubishi's research laboratory is working on a data format that allows processing within the display to create the multiple view signals for controlling the pixels. The system even can produce a motion parallax effect, where the view changes appropriately as the observer moves around.

One way to produce view-dependent "pixels" is to place an opaque screen with vertical slits some way in front of a standard high-resolution display. Observers at different horizontal locations see different display pixels through the slits, and the two eyes of a single observer see different subsets of display pixels. Other methods involve lenticular sheets and holographic screens. Complex signal processing is needed to paint the correct image on each display area to present left and right eyes with the appropriate stereo effect.

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After Conquering the Movies, 3-D Viewing Makes Its Way Toward Home TVs

BY PAUL SONNE AND SAM SCHECNER

With 3-D movies popping up more frequently at the cinema, several companies are working through significant challenges to make 3-D viewing available in the home too.

Satellite-TV operator British Sky Broadcasting PLC is preparing to debut a 3-D television channel in the U.K. next year that will require specially-equipped TV sets. The venture may be the most ambitious yet toward a large-scale 3-D television rollout, which remains absent from most big markets outside of Japan.

In the U.S., satellite-TV provider DirecTV Group Inc. and cable network owner Discovery Communications Inc., among others, are working on or exploring 3-D offerings, spokesmen said. Though 3-D TV programs have appeared sporadically for several decades, the media companies are hoping new 3-D technology can transform the medium from its gimmicky past into a viable experience for the home.

David Naranjo, director of product development for Mitsubishi Digital Electronics America, predicted the U.S. could see its first high-definition 3-D channel as early as next year.

But bringing 3-D programming into the living room comes with several obstacles. Some programming, including Simpsons, Wendy Aylsworth, senior vice president of technology at Time Warner Inc.'s Warner Bros. Technical Operations, predicts 3-D will be the "next big thing in television" despite the seven or so formats vying for industry support.

"Everybody has an interest in getting it there," she said. "Studios see more content being sold, TV manufacturers see more television sets being sold, and distributors see more view-
Viewing in 3-D Heads to TV

Continued from page B1

normal HD cameras, one capturing video for the right eye and the other for the left. Producers will then package the two feeds together so that home set-top boxes think they’re playing normal HD video. With the glasses and a special TV, however, the images will appear in 3-D.

Sky’s transmission format, which requires bandwidth capable of handling the equivalent of two hefty HD feeds, is likely too large for competing cable providers to offer. Some British rivals fear that Sky will set a de facto standard for 3-D formatting that will be impossible for others to match, said Richard Lindsay-Davies, director general of Digital TV Group, an industry association for digital television in the U.K.

In the U.S., the Society for Motion Picture and Television Engineers is working on a standard for 3-D TV broadcasts, as individual companies explore their own options. Discovery, for instance, said it is working with manufacturers including Panasonic and Sony Corp. to refine technologies for shooting in 3-D. It is considering making a 3-D test episode of one of its series, such as slow-motion photography showcase “Time Warp,” executives said.

Discovery executives are also considering what it would take for viewers to adopt the technology. “It’s something that intuitively everyone would like,” said David Zaslav, Discovery’s chief executive. “But the question is will it be exciting enough that people will go through the trouble of wearing TV glasses at home?”

Like Real Life—Sort Of

U.S. TV networks have flirted with 3-D for years.

January 1989
NBC’s Super Bowl halftime show, dubbed ‘Bop Bambouzzled,’ included 3-D effects that required special glasses to see, including Frisbees that appeared to come out of the screen. “It was a little like watching a football halftime show in the distorted reflection of an old mirror,” the Associated Press said at the time.

May 1994
Fox aired a 3-D episode of ‘Married with Children.’

May 1997
For one week, ABC put nine of its shows in 3-D, including ‘Home Improvement,’ ‘Coach,’ ‘Spin City,’ ‘Family Matters’ and America’s Funniest Home Videos. A few weeks later, NBC aired a 3-D season finale of ‘Third Rock from the Sun.’

August 2000
Discovery Channel kicked off its annual Shark Week with ‘Sharks 3-D,’ which included scenes where sharks appeared to jump off the screen. ‘More like 2.5-D,’ wrote Washington Post TV critic Tom Shales.

November 2005
NBC aired a 3-D episode of psychic drama ‘Medium.’

February 2009
NBC showed a 3-D episode of dark-turned-spy series ‘Chuck,’ the day after the Super Bowl it aired included two 3-D advertisements.

—Sam Schechner

Monday, August 17, 2009
We would wonder how many of these players have had wavefront type of laser keratoplasties. For athletes a one line VA improvement can be the difference between a million dollar pro and a nobody.

Now we are not going to encourage your obesity to keep you from looking old inspite of this clipping in the next column. The eyes on all three left hand photos are more widely open for some reason and that, we think is the reason for the “? Younger look”. OOPs I disagree! 2 out of3!
simple strokes can age the face so easily? It is just a few almost imperceptible wrinkle lines on the forehead and new circles under the eyes and slightly deeper nasobial folds and less full lips, and thinner upper eye lashes and NO lower eyelashes... unblue irides and ungold hair, and an unround face and cheeks. No wonder cosmetics to cover the wrinkles and tone the skin are such a profitable industry...and now so are glaucoma eye drops!:  Latisse!
Finding Inexpensive Eyeglasses

from The Wall Street Journal July 2, 2009 by Charles Passy. On the Lookout for Inexpensive Eyeglasses. “... With that in mind, we decided to visit four cost-conscious retailers - online and in person - to see what their pricing (for frame and lenses combined), service and selection was like ... A Costco Wholesale ... A Sears Holding ... But best of all, the online retailers offer some exceptional buys. Frames Direct, Houston Texas, focuses on designer brands - several hundred in all from A (A&A Optical to Z (Zyloware). Naturally, designer specs cost more, but plenty of bargains can be had on the site. ... some selections indeed priced as little as $7.95 ... and EyeBuyDirect all but concedes the limitations of shopping for eyewear online: If you need to adjust your frames in any way after receiving them, the retailer suggests ‘walking into a nearby optical center,’ adding that in ‘most places they will be happy to assist you free of charge.’ Buy the glasses online, but try to have a bricks-and-mortar retailer handle the adjusting at no cost? That sounds a little short-sighted to us.” [We have used EyeBuy Direct and were initially satisfied; however with later orders we were disappointed in their service. We now use 39Dollarglasses.com where we have been most impressed. The order is filled and delivered in about a week. I have a rimless progressive bifocal in a highly myopic prescription - cost $112. I broke a pair and they quickly honored their one year free replacement for breakage. -JAR]

Hospital Errors / Complications

from The Wall Street Journal August 25, 2009 by Laura Landro. Hospitals Own Up to Errors. Some find that confronting mistakes reduces litigation - and future mishaps. “...under sedation in an MRI machine, her breathing tube was dislodged, cutting off her oxygen and causing a crippling brain injury. ... [your editor has a niece whose infant boy suffered just this sort of catastrophe following a medically ill advised pregnancy and premature delivery. But that was over a decade ago and the error was never determined.] Medical errors kill as many as 98,000 Americans each year, according to the Institute of Medicine, ... some hospitals ... are taking steps to admit grievous mistakes and to learn from them in order to overhaul flawed procedures. That represents a sharp departure from hospitals’ traditional response when something goes terribly wrong - retreating behind a wall of silence to guard against potential lawsuits. ... patients are less likely to sue if they receive full disclosure and an apology, along with an offer of compensation. ... since 2006, the center has had a policy of fully disclosing medical errors, apologizing when they occur, and swiftly offering a financial settlement. And patient-family members sit alongside staff on a board charged with overseeing plans to prevent errors. Dr. McDonald says that over the past four years, the number of lawsuits against the center is down 40% compared to the period between 1999 and 2004, even though the number of procedures increased 23%. While it can’t say for certain that the disclosure program was responsible for the decreases, ‘we can certainly say that it has not caused an increase in lawsuits or payouts’, he says. ...
The hospital began requiring an X-ray of patients at risk of retained objects, such as emergency abdominal or chest surgery, or morbidly obese patients. In the past three years, the X-rays have found eight objects left in patients after surgery, even though the manual count has shown that everything was accounted for ... the rate of adverse events - a key measure ... has risen by about 1% in each of the past six years, in part because of a rise in hospital infections. ... One in seven hospitalized Medicare patients experience one or more adverse events, and one in 15 hospitalized children are harmed by medication errors, other studies show. ... [The family] didn’t sue [the hospital]. But as part of the mediated settlement, the hospital agreed to provide free medical care for life for [the child], who is now 6 years old. Did it take malpractice suits to make this change happen? Maybe. It is, however, all for the better regardless.-per

Alternate Careers

For strabologists, orthoptists and pediatric ophthalmologists, doctors and any professional medical PEOPLE AS OUR PROFESSION(S), INDUSTRY, and BUSINESSES ARE DESTROYED BY Barack Obama and his fellow democratic tort lawyers and congressmen... in their insane compulsion to take over and nationalize all our health care.

Unions vs. Taxpayers. “…The results of such... are... the rich rewards that public sector employees now enjoy... the nonpartisan Employee Benefit Research Institute estimated that the average public sector worker earned 46% more in salary and benefits than comparable private sector workers [in 2005]. The gap has only continued to grow..., state and local worker pay and benefits rose 3.1% in the past year, compared to 1.9% in the private sector, according to the Bureau of Labor Statistics (BLS). But the real power of the public sector is showing through in this economic crisis.. five million private sector workers have lost their jobs in the last year alone, and their unemployment rate is above 9% ... By contrast, public sector employment has grown in virtually every month of the recession, and the jobless rate for government workers is a mere 2.8%....

“... voter revolts against new taxes are no longer effective because of the might that these public sector groups now wield. ... public unions have moved effectively to quash antitax movements. ... [public or private], more union members means more [union]voters. And [that] means more dollars for political campaigns to elect sympathetic politicians who will enact higher taxes to foot the bill for the upward arc of government spending on workers...for the indefinite future....” (Mr. Malanga is a senior fellow Manhattan Inst

See next page for more government help.

Figure 2: How NOT to wash your hands from Contact Lens Spectrum August 2009, supplement, page 6
This gov’t agency runs a heavy and very $$$ TV Ad campaign. I see it several times a day:

To encourage patients to be more inquiring & discriminating about their health and doctors.
Because caring for our now burgeoning elderly population is a growing need, here are some job titles that will survive and thrive and might even be employment opportunities for you too:

“Hiring one of these professionals isn’t cheap. ‘Initial assessments’ [by them] range from $200 to $850... Hourly rates can range from $80 to $200 [like a good car mechanic!] and may well NOT be covered by any of your insurance.

**SPEAKING OF INSURANCE:**

**INSURANCE IS THE WORK OF THE DEVIL, LIKE BANKING IS TOO**

Insurance and banking have much in common: they have NO product, but they make money for their owners by skimming your money. On one excuse or another. They take your money and invest it and maybe someday they will give some of it back to you or to somebody ELSE. It is all and always only YOUR money. They do not create wealth at all. They have little overhead and do not require raw materials or other input. Just YOUR money. We the people make the money, they do not. We the people pay for everything. They and the government pay for NOTHING, because without we the people they have nothing. So they take what we have and give a little back to justify their existence. Ditto taxes, right?

If you have any doubts, tell me who spends the MOST on **advertising** to get more money? The banks and the insurance companies right? And they spend enormous amounts to do so, since it costs them nothing! It is YOUR money they spend and they just want more of it, that’s all - the more they get, the more “profit” they will make.

We seem to forget that we have to pay for everything ourselves no matter how much, and that includes the rising costs of medical care for our country and its economy. We live longer and better and that costs money - OURS! No one wants the alternative living shorter and not getting cured of your cancers. Since these “products” don’t produce money to pay for them it will have to come from other places we normally spend it. You can’t cut Medicare any more, as it is already almost 100% “pro bono” for the MD providers!
But cutting Medicare is part of their plan! These health care “reformers” are all seriously nuts and do not understand this at all. They like the people don’t want to accept reality. But maybe the shock of the real estate bubble collapsing and the loss of wealth that has followed the financial catastrophe will get the public abused to the idea that a reduction in their standard and style of living is the price they will have to pay to retire at a reasonable age and to live longer and better. That is where their lives will be better than before, even if they would really rather have bigger houses, boats and cars instead. Can the wealth creators stand a tad more sharing and still be motivated as well to create it?? Yes but how?

Back to insurance:

Don’t forget that health insurers all call what they pay out to us for our medical bills: “Medical Losses” not “benefits” or “costs”. That says where their hearts and minds are: $$$. We seem to have some supporters in the weekly <<--news magazine business: For once we agree with our ultra liberal media. We still think health insurance should be a public utility and similarly regulated and profit limited. After all, wasn’t willingness to settle for doing good rather than WELL bottom line for the medical profession? Shouldn’t that apply to everyone in health care as well as us providers??

On the next page are two horrible examples of how bad health insurers can be. These two alone justify SEVERE regulation of all the private health insurers. There are lots of good ones (see Alabama Blue Cross, terribly and wrongfully indicted by Obama).

The second article (clipped below) is about the founder and CEO of a ?typical health insurance company. He is a crook! He is a thief! He is a third degree abuser of our society for his own personal benefit, at the expense of the entire medical profession and all Americans who must
UnitedHealth Net More Than Doubles

By Tess Styner and Avery Johnson

UnitedHealth Group Inc.’s second-quarter earnings more than doubled amid prior-year charges and an increase in revenue, though enrollment continued to decline as U.S. unemployment mounts and health-care overhaul looms.

Despite the better-than-expected performance, health insurers’ profits remain under pressure from rising medical costs and falling enrollment, as well as from the prospects of diminishing payments from government plans. The industry has been trying to discourage Washington from establishing competing public plans as the healthcare debate continues.

UnitedHealth executives have tried to position the company as proactive in the health overhaul effort, outlining cost-savings proposals it says could slash hundreds of billions of dollars from the system without threatening employer-sponsored health insurance.

UnitedHealth, the first insurer to report earnings, stands to gain from overhaul efforts that aim to cover 46 million uninsured Americans, but it could suffer if forced to compete with a government-run plan.

The insurer stands to gain from efforts targeting 46 million uninsured Americans.

“We see change as our ultimate opportunity,” said Stephen Hemsley, UnitedHealth’s president and chief executive officer. “Change provides us the opportunity to create an even more significant and diverse enterprise serving the needs of Americans across this immense and growing social marketplace.”

UnitedHealth posted profit of $859 million, or 73 cents a share, up from $337 million, or 27 cents a share, a year earlier. Prior-year items included legal settlements that the period’s profit by 40 cents. Analysts polled by Thomson Reuters were expecting earnings of 70 cents a share.

Revenue increased 7% to $21.66 billion, slightly below the average analyst estimate of $21.77 billion.

The health insurer also raised the lower end of its 2009 forecast by 10 cents and now expects a profit between $3 and $3.15 a share, straddling the average analyst estimate on Thomson Reuters of $3.07 a share.

—George Stahl contributed to this article.

Wall Street Journal 22July09 UNH stock=$22; $3 earnings = 13.6% profit = way too much! The profit for Blue Cross of Alabama is only 0.6 % six tenths of 1 percent for a decade-per
Big HealthSouth Verdict Sends

Continued from Page One

longed to her or the children. Mr. Scrushy, who is 57 years old, has appealed both his bribery conviction and the multibillion-dollar civil judgment. Mr. Scrushy could not be reached for comment.

Lawyers for the shareholders have located, in addition to the two mansions and exotic cars, a 92-foot yacht and hundreds of other items allegedly belonging to Mr. Scrushy from two porcelain roosters to an iron fruit stand. The lawyers’ search of accounts at 18 banks turned up $200,000. Plaintiffs say all that only adds up to about $10 million.

The lawyers have at least two clues about assets Mr. Scrushy might have: A 2003 federal-government inventory of his art, boats, planes, jewelry and other possessions, and a 2005 estimate by federal prosecutors of his net worth—nearly $300 million. Yet they haven’t been able to locate many of the items on the 2003 list, such as 68 pieces of jewelry studded with at least 450 carats of gems. The lawyers are especially interested in a 21.81-carat, emerald-cut diamond ring that they say Mr. Scrushy gave to his wife during the 2002 Christmas holiday. A lawyer for Ms. Scrushy says that the ring legally belongs to her.

Mr. Scrushy was acquitted in 2005 of criminal charges related to the HealthSouth accounting fraud, which he said was perpetrated by other company executives without his knowledge. But HealthSouth shareholders sued him in civil court for the damage done to the company by the fraud. An Alabama judge levied $2.88 billion in compensatory damages against Mr. Scrushy—the judge’s tally of improper compensation and the financial damage caused by the fraud. It is believed to be the largest civil judgment ever against a single executive.

Because the lawsuit was filed by shareholders on behalf of HealthSouth, the Birmingham-based company would receive the biggest slice of any proceeds. The company, says it expects the search for assets to drag on for more than a year and to involve a search for offshore accounts.

Mr. Scrushy’s lawyer, Mr. Sparks, had said his client, because of his incarceration, was unable to help much on the asset search. “Mr. Scrushy has a limited ability to acquire stamps and envelopes; he has no Internet access and only works with a limited number of people,” Mr. Sparks said.

Please turn to page A10
Lawyers on a Treasure Hunt

Lawyers attempting to collect on a verdict against Richard Scrushy are eyeing his estate in Alabama (above). On Friday, the county sheriff seized vehicles from his Birmingham home (left).

$s300 million in 2005, Mr. Sparks says he has "no idea" how much money his client now has. "I haven't investigated it," he says.

Plaintiffs' lawyers began inspections of Mr. Scrushy's residences in late July. At his 16,775-square-foot estate in the Vestavia Hills neighborhood of Birmingham, lawyers cataloged about two dozen vehicles, including a green late-1940s Nash Super 600, a cream 2000 Rolls-Royce Corniche, and a black 1995 AMC Hummer with a painted American flag.

At his mansion on Lake Martin, about 75 miles southeast of Birmingham, lawyers documented more than 350 other items, including a pre-World War I magnifying glass by Tiffany, a 1960s Fender Stratocaster guitar and a signed letter from the aviator Charles Lindbergh. A nearby hangar held a racing boat and a seaplane.

Lawyers for the plaintiffs have asked Judge Horn to authorize the seizure of "Chez Soiree," a 92-foot yacht that is in drydock in North Palm Beach, Fla. Mr. Scrushy's lawyers say the boat belongs to a third party, a corporate entity called Marin Ltd. Plaintiffs' lawyers said in a court filing that Mr. Scrushy, whose middle name is Marin, controls the company.

The 2003 government inventory of Mr. Scrushy's possessions listed seven boats, three airplanes, and 45 pieces of art, including one by Salvador Dalí, four by Pablo Picasso, four by Pierre-August Renoir, seven by Marc Chagall and 12 by Joan Miró. The listed jewelry included a 30-stone, 48.17-carat diamond bracelet and 6.08-carat diamond stud earrings.

Plaintiffs filed a complaint with the Birmingham court in July, alleging that Mr. Scrushy in recent years had spirited away money or assets through dummy corporations and more than half a dozen family trusts. They said that in addition to Marin Ltd., three similarly named companies—Marin Inc., Marin Properties LLC and Marin Air LLC—are controlled by Mr. Scrushy.

In a telephone interview last week, Ms. Scrushy, 40, said she moved to Texas in early August after plaintiffs' lawyers blocked payments from Mr. Scrushy's accounts of $9,590.61 of power and water bills at their Birmingham and Lake Martin homes. (The plaintiffs' lawyers say that after a brief mix-up, those bills are once again being paid.) She said she continues to sell over the Internet her line of pajamas, called Upseedaisees.

"I saw absolutely zero compassion" from the plaintiffs' lawyers, she said.

Her lawyer, Lee Benton, said his client only removed furniture, clothing and other items that belonged to her or the children from the Birmingham house. For instance, Ms. Scrushy took along just one of two matching love seats from the home, leaving her husband's seat behind, he said.

On Friday, Judge Horn scheduled a hearing for next Thursday to determine where the plaintiffs can question Mr. Scrushy about his holdings. Attorneys for Mr. Scrushy said they want the deposition to take place in the Texas prison so he won't have to be escorted to Birmingham in shackles.
suffer the title of “Patient” in any regard. All of us have been raped by him and his ilk in the name of “Medical -Health insurance”

My prior experience with founders of insurance companies was memorable. When we lived in Gainesville and I worked at the University of Florida for a while, the empty lot next door was purchased and a new home built there by a young couple. It was substantial. They were young. We were curious and found that he had founded some sort of a life insurance company and done quite well quite quickly. They weren’t the least bit friendly. We respected their privacy. Soon they adopted a couple of dogs, who they chose to let run free most of the time, in violation of local law OK. Then one morning, I looked out our back patio doors and saw the two of them obviously looking for a place to poop on our back yard lawn! I went out on the back deck with a broom stick and slammed it loudly on the rail yelling Get OUT! At the same time I looked left toward this neighbors’ property and saw Mr. Insurance CEO standing right at my property line overseeing his dogs doing their duty on my property in my back yard. He had his own back yard, bigger than ours! His dogs withdrew instantly, before I could attack them... Had I had a weapon, innocent as they might have been they would never have made it! I don’t think the law would excuse for killing their owner. But I have never had any experience since then to mitigate my new and permanent opinion of insurance people. Maybe I am prejudiced! But how about all the patients Scruhshy undoubtedly “denied”???!!!! to enrich himself! I think Scruhshy is worthy of a permanent eponymous bad name like Ponzi and Madoff!! SCRUSHINESS!

Since we (our American society) have abandoned our protestant work ethic totally now, and anything goes in business and in government, as demonstrated so well by the current outrageous stupid and greedy to the tenth power, illegal financial tsunami, (how much has it cost you so far?) have you any reason not to believe that scrushiness is not widespread and especially in the health care insurance industry where there is virtually no policeman at all...???

I will give you one more piece of nauseating evidence for my disdain.

As a beautiful mountain resort area where we live in Summit County Colorado, we have been overwhelmed in the past decade with the building of huge huge monster fancy mountain homes, lots of rock and timbers, truly cathedral living rooms, 10,000 square feet or more, worth multi millions of dollars (would you like to see a local real estate brochure?). Several years ago, in our plain view right across the valley in the foothills of Red Mountain is one of the very biggest. It was built by a health insurance honcho. It does spoil our view because we know that is what it is. John Elway is their neighbor. Now he deserves that sort of self-reward.

A final word:

“The intelligent learn from their mistakes; the really intelligent learn from others’.”

- Bill Ertle, president of Rockwell Laser Industries
RESULTS*; DISCUSSION OF RESULTS; CONCLUSIONS (& recommendations) REFERENCEs; TABLES; LEGENDS FOR FIGURES; FIGURES.

In the "Discussion of Results", do not introduce new reference material. Instead, we expect you to integrate YOUR NEW RESULTS into the current body of knowledge. Specifically: your results should be compared to results obtained by prior workers: Confirmations and agreements should be pointed out. But discordances also require enumeration, discussion, and explanation. Unique or unexpected results demand interpretation. The statistical significance* of results must be considered and their application should also be entertained.

REFERENCES: Order these numerically in sequence as they appear in the text. Indicate a reference number in the text with a full sized Arabic numeral enclosed in parentheses, i.e. (1).


For book references: author, title, volume (if more than one) edition number (if other than the first), publisher, city and year. If the reference is a chapter in a book, the order changes as follows: the author of the chapter, title of the chapter, "in" book title, volume edition, editors, publisher, city, year, inclusive pages of the chapter. Authors are responsible for accuracy.

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D. BRIAN STIDHAM MEMORIAL LECTURESHIP

LECTURE to be published annually in Binocular Vision and Strabismus Quarterly

Donations Solicited to Fund Lectureship

To the Editor:

The Pediatric Ophthalmology community lost a great doctor last October 6, 2005, with the death by murder of D. Brian Stidham. I am attempting to create an endowed lectureship to remember Brian in our community and within pediatric ophthalmology, and wonder if I could ask you to consider helping in this regard. I know that your journal concentrates on strabismus and binocular vision, but could I interest you in publishing the "Stidham Lecture in Pediatric Ophthalmology and Strabismus" that will hopefully be given on a yearly basis? I would work with the presenter to make certain that a manuscript would be produced that would be of acceptable quality. Having a target journal for the presentation would be a great carrot to draw top speakers to Tucson on a yearly basis to give such a talk.

We have raised $14,000 towards a target of $50,000 endowment that would ensure that the lecture would be perpetuated. I am committed to continue fundraising until the goal is met. If Binocular Vision and Strabismus Quarterly would serve as the publisher of the named lecture, I feel certain we will be able to both attract top speakers and donors to remember Brian in the years ahead, and to provide a great lectureship in pediatric ophthalmology and strabismus to our professional community which would enjoy greater readership and distribution.

Joseph M. Miller, M.D., MPH
Head, Ophthalmology and Vision Science
University of Arizona, Tucson, Arizona

In reply:

We are honored to be asked and will most definitely be pleased to publish this lecture each year. We would encourage our readership to donate to this fund: Checks should be made payable to The University of Arizona Foundation with memo of "Stidham Endowment" and sent to Dr. Miller at U AZ, Ophthalmology, 655 N. Alvernon Way, Ste 108, Tucson AZ 85711. - PER

ADVICE for authors submitting papers to Binocular Vision & Strabismus Quarterly©

1. READ & FOLLOW INSTRUCTIONS FOR AUTHORS! In addition:

   Reviewing the literature: A proper review of the literature starts with a review of current and appropriate textbooks, especially the latest edition (currently the Sixth von Noorden's Binocular Vision and Ocular Motility by Mosby, and Duané's loose-leaf text Clinical Ophthalmology. Anticipating a future requirement, it will only be to your credit now to specifically state what was included in your literature search, i.e., the topics or subjects and the sites searched. For any article submitted here that should include at a minimum, Index Medicus (Medline) from 1966 to the present, Index Bnocus Primus, 1985 to the present, and the Internet for the American Orthoptic Journal.

Acceptable TERMINOLOGY not acceptable

AHP Abnormal Head Postures:3

face turn head turn

chin up/down head up/down

Head tilt

retroequatorial myopexy Fadenoperation

retroequatorial myopexy posterior fixation suture

suspension-recession hang back, hang loose

Bielschowsky Head Tilt Test three step test

strabology, ist Strabology, ist

exact p values "Statistically significant"

Re: "lost to followup" - Avoid this at all costs; First it raises the possibility that the patient had a (=) bad result or was otherwise so unhappy with their care that they never came back - or went elsewhere or went nowhere out of fear or dissatisfaction. If they are "lost followup" you cannot refute the possibility that one those very unhappy thingsppened! Second it is inexcusable - medico-legally. Third: It reflects poorly on you as both a health care professional and as a scientist and Fourth: under the worse of circumstances suggests or indicates that you may discriminate against those of lower socio-economic status (research findings).

WRITING STYLE IS IMPORTANT TOO:
(from Investor's Business Daily Nov. 26, 1997 by M. Stettner)
'Make Dry Data Come Alive in Your Reports ... tips on making your technical writing come alive:

1. Remember that less is more. ... simplify your language and prune extra words. Eliminate jargon, and keep your sentences and paragraphs short. 'If you write in little bites, you break down lots of information for the readers so that it's easier to absorb,' said Carolyn Mulford, president of The Writing Coach.

2. White in the active voice. ... For example, write 'When you review the data, you will note these trends'. Avoid saying 'These trends were noted upon a review of the data.' Another example: Write 'We will examine', not, 'This has been examined'. ... simplify the language and prune extra words. Eliminate jargon, and keep your sentences and paragraphs short. 'If you write in little bites, you break down lots of information for the readers so that it's easier to absorb,' said Carolyn Mulford, president of The Writing Coach.

3. Insert 'talking subheads'. ... unbroken text can intimidate any reader, ... organize your writing in sections with each carrying an easy to understand subhead ... a talking subhead ... alerts the reader of what you're about to discuss ... for instance, instead of heading a section with 'Cost of Scanners' try 'Rising Cost of the Next Generation of Scanners'. subheads should average 7 words.

4. Run a test. ... ask someone in your audience group to read your manuscript.

TABLES: Don't forget the crowding phenomenon. It works in Tables too. We prefer spaces to lines to separate the items in a Table. You can also get more material within whatever size limits you may have, using spaces instead of lines, especially vertical lines. Horizontal lines are less of a sin. -PER 22(4)
Kenneth W. Wright, USC Keck School of Medicine, Los Angeles, CA, USA

Color Atlas of Strabismus Surgery

Strategies and Techniques

Color Atlas of Strabismus Surgery: Strategies and Techniques provides concise, comprehensive descriptions of surgical procedures by one of the world's leading experts. The accompanying DVD brings the book to life with real time, narrated video of the procedures. Dr. Wright's narration not only explains the procedures, but provides pearls and pitfalls to allow for the best possible patient outcomes. Pediatric ophthalmologists, ophthalmology residents and fellows, as well as general ophthalmologists, will find this atlas to be essential to their work.

Contents:
- Amblyopia Treatment.
- Principles of Strabismus Surgery.
- Infantile Esotropia.
- Acquired Esotropia.
- Exotropia.
- Cranial Nerve Palsies.
- Section Two – Surgical Techniques.
- Surgical Anatomy.
- Basic Surgical Techniques – Do's and Don'ts.
- Conjunctival incisions.
- Limbal Rectus Muscle Recession.
- Fomix Rectus Muscle Recession.
- Rectus Muscle Tightening Procedures.
- Adjustable Suture Techniques.
- Topical Anesthesia Strabismus surgery.
- Rectus Muscle Offsets and the Y-Split Procedure.
- Rectus Muscle Transposition for Sixth Nerve Palsy.
- Inferior Oblique Muscle Surgery.
- Superior Oblique Weakening Procedures.
- Superior Oblique Tightening Procedures.
- Faden Operation (Posterior Fixation Suture).
- Re-operation Techniques.
- Appendix.

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