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Scientists for the Abrogation of *Statistical Significance = p<0.05*

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IN OUR 25th YEAR OF PUBLICATION

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*ORIGINAL EVIDENCE BASED SCIENTIFIC ARTICLES*

GAMIO S, TÁRTARA A: Sensorial Strabismus Due to
Ocular Congenital Toxoplasmosis: Eso- or Exotropia?

KRAFT SP: [Conservative] Lateral Rectus Resection
Strabismus Surgery in Unilateral Duane
Syndrome with Esotropia and Limited Abduction.

*** CASE REPORT ***

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Case Report: Duane Retraction Syndrome
Associated with Hand Anomaly

*** OUR OTHER LIVES ***

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EDITORIAL: [& Welcome to] General Enzenauer;
Toxoplasmosis Strabismus Laterality;
Duane Retraction Syndrome: Limited Resections

HYDE PARK: [Historical] Explanation of a President

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in HOUSTON TX @ Baylor!
> CULLEN EYE Institute
Neurosensory Center
Room C205 Visiting Professor: Stephen P. Kraft
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The designation of individual issues is by the quarter, not the season, because seasons are never the same, but opposite, in the Northern and Southern hemispheres. The seasons are however designated on the cover with the Northern season, on the top and, inverted below, the current season in the Southern hemisphere.
“... the belief that one’s view of reality is the only reality is the most dangerous of all delusions ...”
-Watzlawick, 1976

EDITOR
Paul E. Romano, M.D., M.S.O

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Welcome *BV&Sq’s* Newest Ed Board Member:

**Robert W. Enzenauer, MD, MPH, MSS, MBA** is currently chief of ophthalmology at the University of Colorado’s new Children’s Hospital in Denver, Colorado. He is Professor of Ophthalmology and Pediatrics there (board certified in both specialties). He completed his pediatric ophthalmology and strabismus fellowship at the Hospital for Sick Children in Toronto, Canada, in 1990.

Dr. Enzenauer started his graduate education with a B.S.[in *nukes*] from West Point U.S. Military Academy in 1975. He then went to the University of Missouri School of Medicine receiving his M.D. in 1979.

Subsequently he has combined and followed two major life careers, that of a medical doctor and that of a soldier. On top of that he has an MBA in business administration, a Masters in *Strategic Studies* and a Masters in *Public Health* (epidemiology) He served his pediatric residency from 1980-1982 at Tripler Army Med Ctr in Hawaii. He served his residency in ophthalmology at the renowned Fitzsimons Army Medical Center from 1986-1989 in Aurora on the east side of Denver, Colorado. After his Toronto Fellowship, he returned to the “Fitz” to run the eye service there. That :striking “Fitz” hospital, skyscraper on the plains building is still there but is no longer U.S. Army or a hospital. The huge square miles campus that was that army base, thanks to the generosity of local Denver multibillionaire Phillip Anschutz, and the U.S. government, is now the campus of the all new University of Colorado hospital and medical sciences center (UCDHSC). The “Fitz” is now totally surrounded by even bigger buildings. The UCDHSC includes the brand new Rocky Mountain Lions Eye Institute (*where your editor had his bleeding retinal tear repaired and both cataracts removed and replaced with IOLs with which he now has 20/15- and 20/20+ scVA D&n! SC ! and sc!!! presbyopia GONE.*) and also a brand new monstrously huge Children’s Hospital, where Dr. Enzenauer has just taken over as Ophthalmology Head, completing a huge life long Denver centered career circle, which has also included army reserve tours of duty in both Iraq and Afghanistan (see his article published here in BV&SQ, 2007; 22(3):153-168.

Not only has he been an expert in two major medical areas, with many lectures and appearances, he has had over a hundred scientific articles published, and also chaired the University eye programs in Chattanooga and in Memphis, Tennessee.

Dr. Enzenauer has been and continues to be active in multiple community activities, societies and committees. He has numerous academic awards and honors and a very large peer-reviewed bibliography and C.V..

He was invited to join *BV&Sq* in June this year. Shortly THEREAFTER (and in no way connected) we heard he was to become a STAR both literally and figuratively in the SPACE business of our country- as a U.S. Army Brigadier General !... *(And ? In spite of joining our publication Ed Board), he was promoted!*

**BRIGADIER GENERAL ENZENAUER, U.S. ARMY**

“Enz” was promoted to Brigadier General in Watkins, Colorado July 10, 2010. From a story
“There’s a new star in Space over Colorado. “ The state is the home to the only National Guard Space Battalion, and is one of only three states, along with Alaska and California, which has a ground missile defense unit. Because of this, Colorado has the only Army National Guard’s assistant adjutant general for space [slot], a one star position. This position provides leadership to current operations, oversight and emerging mission capabilities, and ... ensures readiness, relevance and a fully modernized force. In simple terms, this position is the advocate and standard bearer for all things related to the National Guard space mission.

For the last three years, Brig. Gen. Stuart C. Pike held this position. He is retiring after 33 years of service. ... In 1998, ..., Pike persuaded then Lt. Col. Enzenauer to leave his position as the COARNG’s state flight surgeon and become the SF [Special Forces] battalion’s surgeon. Over breakfast one day, Pike to Enz, ‘The best job in the Army anywhere is to lead an SF Battalion. Perhaps the second best job is the battalion surgeon. Taking care of guys is leading.’ Pike was not only persuasive, but he must have been right, because Enz spent more than 10 years in that position. It was this position that earned Enz the privilege of wearing the Special Forces patch on his right sleeve.

Both he and [Chaplain] Meverden deployed together as one of the first COARNG units into Afghanistan in 2001. Early on in the war, the conditions were austere at best and soldiers were enduring the Afghan winter with personally procured kerosene and wood burning stoves. The day before New Year’s Eve 2002, Meverden’s wood burning stove was not assembled properly and was filling his quarters with smoke. Enz saw the smoke pouring out of Meverden’s quarters and rushed in to find Meverden unconscious in bed. He opened the windows and called the SF medics. ... After 24 hours of ventilation treatment, he was returned to duty. However, he wasn’t returned to his [prior] quarters. He had to spend the next three weeks bunking between Enz and the Dentist, Col. Daniel E. Savitske. ‘We only had one chaplain. We couldn’t afford to lose him’, Enz would often recount of the situation. Without Enz’s [timely] help, Meverden wouldn’t have had a new year.

As a civilian [now], Pike works as the emergency preparedness coordinator for the University of Colorado, Denver at the Anschutz Medical Campus [at the “FITZ”] in Aurora, Colo. It was this very campus, in 1986, where then Maj. Enzenauer first came to practice. The 1975 US Military Academy graduate chose Colorado believing that, for an ophthalmological surgeon, it beat out his other choices of Texas, Washington
State and Washington DC.

His desire to serve a 30 year active duty career [as soon, the ophthalmology chief at the “Fitz] was thwarted by the 1995 Base Realignment and Closure act. Fitzsimons was on that list [for closure]. With the thought of having to work for someone else doing the same job he was doing then [but no longer as his own boss], Enz opted to retire [from active military service].

While at Fitzsimons, Enz was both the head of ophthalmology and the flight surgeon. Since the COARNG did not have its own flight surgeon, numerous flight aviators and SF soldiers came to him to be cleared. Many of the Colorado Guard friendships he developed in that position influenced him to join the National Guard family. Since he had always wanted a long military career, shortly after his active duty retirement, he started the process of joining the National Guard.

.... Since joining the Army National Guard, Enz been a professor of Ophthalmology at the University of Illinois, the University of Tennessee at Chattanooga and Memphis, and finally now, where his journey all began, at the University of Colorado’s School of Medicine, located at the same campus where the previously closed hospital and military medical training center, now converted to a UC research facility, Fitzsimons still stands.

It may seem strange to have a doctor take on this vital space defense responsibility. Enz said in the ceremony, ‘I am sure there is at least some skepticism about my serving in this role. It goes something like this: “Enz is a good guy but he’s the doc”‘.

But Doctor Enz is no stranger to science and technology - or its advocacy. He has a bachelor’s in nuclear engineering, ..., and is certified in aviation medicine,... and the American College of Physician Executives recently awarded a fellowship to Enzenauer for demonstrating significant and enduring contributions to the advancement of medical management.

In this family that is the National Guard, our lives and careers both military and civilian are often intertwined, more so than we realize, until we look back upon that path and reflect. As we look at the path that lies before Brig. Gen. Enzenauer and wonder where it will cross again, we know that our space mission has a strong advocate.”

[What a life, and he is still young! Unmentioned specifically in this recounting are his obvious additional success as a father and family head and husband, And we haven’t even started to consider the contributions of Mrs. Enzenauer, which must be all but equally huge considering especially the number and range of their many career moves. We are exhausted just reading his story! And we know no one who has capitalized so well on fulfilling his service obligations-ed ]

**NEWS**

We regret to inform our readers of the recent death of one of our fellow strabologist-pediatric ophthalmologists, **Arthur Rosenbaum, M.D.**

We plan a proper recognition of his many contributions to life, to medicine, to our specialty and our subspecialty, and to BV&Sq, next issue. -per

**Leonard Apt, “Physician of the Year”**

Our And THE very first fellowship trained strabologist-pediatric ophthalmologist **Leonard Apt**, who is outliving some of his students like the aforementioned Art Rosenbaum and who has been previously biographed a number of times in these pages, has received yet another award, this time a United States “Physician of the Year” Award. More details in the next issue. -per
EDITORIAL:     GENERAL ENZENAUER;
TOXOPLASMOSIS STRABISMUS LATERALITY;
DUANE SYNDROME: LIMITED RESECTIONS;
AND A UNIQUE HAND DEFORMITY;
EGYPT: An Interview with Pharaoh Ay. HYDE Park:
THIRD PARTY HEALTH CARE (i.e.”INSURANCE”);
BO-P CARE=M.D.,CAREER TERMINATION 2019;
BO explained: He’s just a Lost Militant 2nd Generation
Anti-NeoColonialist DeConstructingU.S. & The World.

First:   I thought I knew Bob Enzenauer. No...

Think we first met at the 1990 AAPOS meet-
ing across the lake from Toronto where he was in
fellowship, at Bolton Landing, Lake George, upstate
New York. There he co-authored with Toronto men-
tors including S. Kraft, (idem this issue p.149) a
poster on one of my favorite subjects, the INstability
of postop’ binocular alignment after end-op’ (not
intraop’) adjustable suture strabismus surgery.

We were unaware that we were then both in
Colorado mid-1990 to 1994 while Bob ran the Army
eye service at Fitzsimons US Army Medical Center in
Denver while we bot a condo in Dillon in ski country
just an hour + away at the same time to which we
commuted half time to ski, from Florida, awaiting
justice after my clinical retirement in’89. After we got
that we moved here F.T.. in’95. Bob did the Professor
thing in Tennessee, then came back for the UCDMSC
to run their new Children’s Hospital eye department.

So now we are again both here in CO!. Reviewing
for the Ed Board his C.V., wow!, he has
packed so much into and accomplished so much in
these last two decades. Just call him “General”.Please
see this, his foregoing story,  pages 134-136.

ALSO IN THIS ISSUE

Sensorial Strabismus Due to Ocular Con-
genital Toxoplasmosis. Is It an Eso- or Exotropia?
Gamio S, Tartara A. Binocul Vis Strabismus Q
2010 25(3):138-148 The authors have collected a
number of cases, well illustrated. For a most current
view of this blinding acquired disease, we consulted,
for sheer efficiency, Wikipedia: “Toxoplasma gondii
is a... parasite ... cat as the definitive host... transmit-
ted to humans by... ingestion of the egg... in cat faecal
matter (pregnant women! don’t clean the cat box!!!
-Ed. ALSO: Always wash fresh fruit and vegetables
because the farm cat’s feces... “may contaminate
[them or], ingestion... in undercooked or raw meat,
(never red or too pink) and vertical transmission to
the fetus during maternal primary infection.”.

Lateral Rectus Resection Strabismus
Surgery in Unilateral Duane Syndrome with
Esotropia and Limited Abduction. Kraft SP.
Binocul Vis Strabismus Q 2010 25(3):149-157 The
author precisely describes the careful and very specifi-
cally limited application of this previously eschewed
technique for this condition, which produces better
outcomes. Read thoroughly before using it..

Case Report: Duane Retraction Syndrome
Associated with Hand Anomaly. Jafari AK, Ameri
A, Anvari F, Akbari MR. Binocul Vis Strabismus

This editorial section is continued as the last
section of this issue, and includes a political Hyde
Park so watch out. Our profession is under lethal at-
tack. We cannot ignore this.  (Cont’d on page 179)
Sensorial Strabismus Due to Congenital Toxoplasmosis. Is it an Eso- or Exotropia?

S. GAMIO, M,D. and A.TÁRTARA, M.D.

from the Ricardo Gutierrez Children’s Hospital, Buenos Aires, Argentina.

ABSTRACT: Objective: To examine sensorial strabismus due to congenital toxoplasmosis to elucidate differences and similarities between cases with esotropia (ET) and with exotropia (XT).

Methods: Retrospective analysis of 49 patients treated between 2002 and 2007. Visual acuity, cycloplegic refraction, strabismus patterns, presence of nystagmus, site of scar, surgery performed and strabismus surgical outcome obtained were evaluated.

Results: Mean age: 5 years old. 25 patients had bilateral involvement: 10 had ET, 10 XT and 4 were aligned. 15/24 unilateral cases presented with XT, 7 ET and other 2 orthotropia. 6/8 patients with the right eye affected, manifest ET and 14/16 patients with their OS affected had XT. (P=0.01).

Conclusion: In bilateral cases of ocular toxoplasmosis ET and XT are found in similar proportions; in unilateral cases, XT is more frequent and the left eye (OS) is affected in most cases by both the toxoplasmosis and the strabismus. Esotropia appears more frequently in cases where the right eye (OD) is so affected, whereas XT predominates in cases where the left eye (OS) is affected.
Figures (Gamio and Tártara): ALL: representative subject-patients and toxoplasmosis Retinal Lesions. See Appendix for specific individual subject-patient descriptions and data.
INTRODUCTION

Sensory strabismus is that produced by low vision in one or both eyes, excluding strabismic or anisometropic amblyopia as causes of poor vision.

There is a continuing controversy surrounding the question of why certain patients with sensorial strabismus have esotropia (ET) and others exotropia (XT).

Havertape et al. (1) relate it to age: they argue that children with early unilateral or bilateral visual loss (less than 6 months old) have a greater percentage of ET, while those suffering visual loss at a further age show XT more frequently.

Worth (2), related it to the refraction of the fixing eye and said: “When one eye only is blind its behavior will depend, to a great extent, on the refraction of the seeing eye. If this is normal or myopic the blind eye will as a rule diverge. If it is markedly hypermetropic it will usually converge”.

Mitsui (3), for its part, considers strabismus to be a functional disease in which optomotor reflexes play an important role, and argues that in ET the alteration is ipsilateral, while in XT it is strictly contralateral.

It was then decided to study a single disease causing sensorial strabismus, namely, congenital toxoplasmosis, which is primarily responsible for macular injury in children in our country, in an attempt to find similarities and differences among patients exhibiting esotropia and those with exotropia.

METHODS

Retrospective study of the medical records of 49 patients of the Ricardo Gutierrez Children's Hospital with a serologically confirmed congenital toxoplasmosis diagnosis, between January 2002 and January 2007.

We evaluated: Age at diagnosis, sex, visual acuity, refraction with cycloplegia, type of strabismus (ET, XT, VD), pattern of incomitance, presence of nystagmus, eye fundus, strabismus surgery performed and obtained outcome.

Those patients who were less than 6 months old and those who had no serological confirmation were excluded.

RESULTS

The average age at diagnosis was 5 years (range 6 months to 15 years). There was no difference regarding sex: 26 were male and 23 were female. Twenty-five out of forty-nine patients had bilateral eye fundus lesions. Twelve of them showed a bilateral macular scar; 10/49 presented ET, 10/49 presented XT and 4 were in orthotropia. Six patients had nystagmus, 4 of them with an eccentric null.

Among the 24 unilateral cases we found that the right eye (OD) was affected in 8 cases and the left eye (OS) in 16 cases. Seven patients had ET, 15 XT and 2 were in orthotropia.

What was particularly interesting was that 6/8 patients who had the OD affected had ET and 14/16 with injury in the OS had XT.

Surgery was performed in 18 patients: 12 with unilateral involvement and 6 with bilateral lesions.

Ten children were operated for having XT, seven for ET and one for hypertropia (HT). Monocular surgery was performed in
only 5 cases and the rest underwent surgery in both eyes. 5 patients also underwent inferior oblique muscles surgery.

The outcome of the surgery was successful in all cases, none of the patients required re-operation.

DISCUSSION:

Retinocoroiditis is the most common ocular manifestation of congenital toxoplasmosis.

Suhardio et al (4) mention a 71.2% chorioretinitis out of 173 cases of toxoplasmosis, 22.4% had macular injuries and 6.4% strabismus. On the other hand, Kodjikian et al. (5) found 130 patients with chorioretinal injury out of 430 cases of serologically confirmed toxoplasmosis. 16% had sensorial strabismus due to macular involvement in 86% of cases.

On the other hand the macular scar is a major cause of strabismus called sensorial; Oliveira et al (6), found that out of 191 cases, 49 were caused by a macular scar in the deviated eye.

Being congenital, this pathology provides a special model for the study of sensorial strabismus due to the precocity with which sight is affected in cases showing macular involvement.

Half of the cases in this series were bilateral and only 12 of them had bilateral macular scars. Six children had nystagmus, 4 of them with an eccentric null. The type of strabismus in this group showed equal incidence of ET and XT, 10 cases in each group and the remaining four were in orthotropia.

In the group of patients with unilateral involvement, the following was found: undisputed predominance of XT (15/24 patients), ET in 7 patients, the remaining patients were in orthotropia and the LE was more affected (16 / 24 cases).

Patients who had their OD affected had ET in 6/8 cases, one was orthotropic and the remaining one had X(T) with DHD and DVD suggesting that initially he may have been in ET and then evolved to X(T) as often occurs in DHDs.

Patients who had their OS affected had XT in 14/16 cases, one was in orthotropia and the remaining one had ET in Primary Position (PP) with nystagmus and an eccentric null.

This tendency to showing ET when the RE is affected, and showing XT when the LE is affected could be related to ocular dominance. One might consider as a hypothesis that early decrease in sight in the dominant eye would make it prone to esotropia and on the contrary, where the non dominant eye is affected XT would tend to occur.

Tables 1 and 2 and show the values of refraction and visual acuity of both groups. There is greater tendency toward myopia and myopic astigmatism in both unilateral and bilateral cases, both in cases of ET and XT, so that Worth’s hypothesis could not be corroborated in this series.

Eighteen patients were operated on: 10 for XT, 7 for ET and one for Dv (HT). Twelve of them had unilateral involvement and had 6 bilateral lesions.

Monocular surgery was performed on only 5 cases, on 2 with ET, on 3 with XT and
the child with Dv.

By observing the position of the eyes under General Anesthesia (GA), valuable information for deciding appropriate surgical intervention was obtained. Particularly in the case of XT. If the healthy eye is in clear divergence, it should not be excluded from the surgical plan, since it can determine undercorrection and/or recurrence of the deviation as Guyton (7) correctly points out. Long-standing sensorial strabismus often have a bilateral involvement demonstrated by symmetrical deviations under GA and positive bilateral passive ductions.

It can be interesting to perform Mitsui’s magic reflex test (8) in cases of sensorial XT. It consists of passive adduction with a forceps, and in response the esotropic eye adducts. Should this test be positive, it is advisable to perform bilateral surgery to avoid recurrences.

CONCLUSION

In our environment ocular toxoplasmosis is a common cause of sensorial strabismus.

Our findings in this study showed similar incidence of unilateral and bilateral injury, without incidence of sex, with a marked tendency to myopia and myopic astigmatism in the refraction.

In bilateral cases similar incidence of ET and XT was observed, while in unilateral cases XT was predominant, and the LE was especially affected.

In unilateral cases we found a marked tendency towards ET when the RE is affected, and towards XT when the LE is affected.

REFERENCES:


7. Guyton DL. Changes in strabismus over time: the roles of vergence tonus and muscle length adaptation. Strabismus 2006 Proceedings of the Joint Congress the Xth Meeting of the International Strabismological Association and the CLADE Feb 2006 , p 7-34

## APPENDIX: SUBJECT-PATIENT INFORMATION AND DATA

<table>
<thead>
<tr>
<th>Patient</th>
<th>Sex</th>
<th>Age (yrs)</th>
<th>ET</th>
<th>orthotropia</th>
<th>Nystagmus</th>
<th>refraction</th>
<th>Fundus</th>
<th>Visual Acuity</th>
<th>surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>M</td>
<td>7</td>
<td>30 pd XT</td>
<td></td>
<td></td>
<td>OD-1.75-250x150</td>
<td>macular scar</td>
<td>OD 0.05</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td>OS-150-150x110</td>
<td>macular scar</td>
<td>OS 0.3</td>
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<td>2.</td>
<td>F</td>
<td>14</td>
<td>ortho</td>
<td></td>
<td></td>
<td>OD-0.25-0.50x125</td>
<td>macular scar</td>
<td>OD 0.1</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OS -0.25 x 80</td>
<td>peripheric scars</td>
<td>OS 1.0</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>M</td>
<td>10</td>
<td>30 pd XT</td>
<td>whinpoint</td>
<td></td>
<td>OD-1.75325x199</td>
<td>macular scar</td>
<td>OD 0.2</td>
<td>OD MR recession</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OS-150-375x179</td>
<td>macular scar</td>
<td>OS HM</td>
<td>OS LR recession</td>
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<td>M</td>
<td>0.5</td>
<td>35 pd ET</td>
<td></td>
<td></td>
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<td></td>
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<td>peripheric scars</td>
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<td>M</td>
<td>0.8</td>
<td>50 pd ET</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>macular scar</td>
<td></td>
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</tr>
<tr>
<td>6.</td>
<td>F</td>
<td>14</td>
<td>40 pd ET</td>
<td></td>
<td></td>
<td>OD -</td>
<td>peripheric scar</td>
<td>OD 0.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OS+1.50+0.75x1 13</td>
<td>macular scar</td>
<td>OS 0.2</td>
<td></td>
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<tr>
<td>7.</td>
<td>F</td>
<td>6</td>
<td>30 pd XT</td>
<td>with null point</td>
<td></td>
<td>OD+1-3.25x25</td>
<td>macular scar</td>
<td>OD 0.1</td>
<td>OD LR recession + MR resection</td>
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<td>OS+025-275x170</td>
<td>macular scar</td>
<td>OS 0.2</td>
<td>OS MR recession</td>
</tr>
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<td>M</td>
<td>5</td>
<td>30 pd ET</td>
<td>whinpoint</td>
<td></td>
<td>OD-2.50-2x130</td>
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<td>OD 0.4</td>
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Lateral Rectus Resection Strabismus Surgery in Unilateral Duane Syndrome with Esotropia and Limited Abduction

STEPHEN P. KRAFT, MD, FRCSC

from the Department of Ophthalmology and Vision Sciences, The Hospital for Sick Children and the University of Toronto, Toronto, Ontario, Canada

ABSTRACT: Background: Resection of the lateral rectus (LR) in Duane retraction syndrome (DRS) with esotropia (ET) and limited abduction can be useful component of surgical planning in specific circumstances, when combined with medial rectus (MR) recession. This article reports the results of a prospective series of patients for whom this approach was used successfully.

Methods: Seven patients were treated, aged 3 to 52 years, with unilateral DRS with the following features: 1) ET at least 25 PD; 2) “mild” retraction on adduction; 3) clinically normal adduction; 4) significantly limited abduction; 5) no or mild upshoots/downshoots; and, 6) positive forcedduction to abduction at surgery. Surgery involved MR recession up to 5.0 mm and LR resection of maximum 3.5 mm. Postoperative followup was at least 6 months in all cases.

Results: ET angles ranged from 25 to 32 PD; abduction limitations ranged from -3.5 to -4. All patients had face turn postures preoperatively. Postoperatively, the binocular alignment in primary position was orthotropia and head postures were eliminated in all patients. Abduction postoperatively ranged from -1 to -2.5; adduction ranged from -0.5 to -1. Two patients had minimal worsening of upshoots and downshoots after surgery.

Conclusion: In treating DRS with ET and limited abduction, a small LR resection can be a safe and effective component of surgery. It has a low risk of worsening retraction or “crippling” adduction when done in appropriate cases.
INTRODUCTION

Duane Retraction Syndrome (DRS) is a spectrum of eye motility disorders whose common features are retraction of the globe, narrowing of the eyelid fissure that occur on attempted adduction of the involved nerve) eye. (1-4) Electromyographic (EMG) and neuroanatomic studies have shown that the pathophysiology in this group of conditions is an anomalous innervation of the lateral rectus (LR) muscle by a branch of the third cranial nerve (the oculomotor nerve) (5-12). This results in contraction of the LR along with the medial rectus (MR) on attempted adduction. Duane Syndrome is one entity among several congenital disorders of eye muscle innervation known collectively as the congenital cranial dysinnervation disorders (CCDDs) (13,14). Other entities under this umbrella include Moebius Syndrome, congenital fibrosis of the extraocular muscles (CFEOM), and congenital fourth and third cranial nerve palsy.

The most common form of DRS manifests as an esotropia (ET) in primary position, often with a compensatory face turn towards the affected eye to maintain binocular single vision.(1,8,9,15) There is a limitation of abduction, which can be partial or complete. The retraction phenomenon on attempted adduction can vary from mild to severe, and there can be an obvious upshoot and/or downshoot in the adducted position. The vast majority of cases are unilateral, although up to 15 percent can be bilateral.(1,2,9)

Various surgical approaches have been advocated in treating the unilateral cases of this common form of DRS. These options include ipsilateral medial rectus (MR) recession(1,2,15-18), ipsilateral MR recession with a retroequatorial myopexy of the contralateral MR (18,19), bilateral MR recessions with supramaximal recession on the non-involved eye (2-4,15,17,18), and various forms of partial or complete transposition of the vertical rectus muscles on the involved eye. (15,20-23)

Resection of the LR in an eye with this form of DRS has been avoided and recommended against because of the concern for severely limiting adduction and worsening the retraction phenomenon on adduction.(1) However, an article published in 2001 (24) co-authored by this author, showed, for the first time, that in carefully selected patients with DRS, a LR resection combined with MR recession can lead to good alignment results with minimal impact on adduction and retraction. (24) Furthermore, the recovery of abduction in some of these patients was impressive, rivaling the good results described for some cases of primary vertical rectus muscle transposition. (24)

The experience in that retrospective study suggested that LR resection could be advantageous and safe if a patient with unilateral DRS had the following constellation of findings: 1) ET measuring at least 25 PD in primary position; 2) “mild” retraction on adduction; 3) clinically normal adduction; 4) significantly limited abduction; 5) no or mild upshoots/downshoots; and, 6) positive forced duction to abduction at surgery. In addition, the least impact on adduction and retraction seemed to occur in cases in which the MR recession was limited to no more than 5.0 mm. while the LR resection did not exceed 3.5 mm.

Since publication of that study (24), the author has prospectively applied these findings by combining primary MR recession...
and LR resection for a select series of DRS cases that fulfilled all of these six criteria. This paper describes the clinical findings and results of surgery in this group of patients.

METHODS

All files from the strabismus research database were searched from 2001 through 2009 for cases of the author’s prospective combined LR resection and MR recession in unilateral DRS syndrome with esotropia. This case review was approved by the Research Ethics Board of the author’s institution.

All patients had complete ophthalmological assessments. Any hyperopic error over +2.00 diopters was corrected with spectacles. Measurements were performed in primary position and the secondary positions of gaze using the prism and cover test while the patient fixated with the unaffected eye on a target at 6 meters, and in primary position at 1/3 meter. Face turns were measured using an orthopaedic protractor. (22,24) Ductions were recorded for both eyes, and limitations were graded on a scale from 0 (full movement) to -4 (no movement past the midline).(17,24)

The severity of globe retraction was assessed on the basis of three findings: 1) adduction ability; 2) the narrowing of the maximum palpebral fissure height in mm. with fixation in primary position as compared with fixation in adduction; and 3) the presence or absence of an exodeviation in the field of gaze contralateral to the affected eye (that is, in the field of adduction of the ye with DRS). Retraction was considered “mild” if the adduction was full, there was narrowing of the aperture of no more than 33 per-cent on adduction compared to primary position, and there was no exodeviation measurable in that gaze field. The severity of an upshoot or downshoot in the adducted position was graded on a scale of +1 to +4, similar to the grading scheme used for oblique muscle overactions.(3) The upshoot or downshoot was considered “mild” if it was labeled no more than +1 on this subjective scale.

Surgery in the study group involved recession of the MR of a maximum 5.0 mm. and resection of the LR of a maximum 3.5 mm. These dosages were chosen to minimize the chance of significantly worsening the retraction phenomena. All patients were followed for at least 6 months after surgery.

After surgery the patients underwent full eye muscle balance evaluations, including best-corrected visual acuities, and measurements of any residual head postures. The binocular alignment in the primary position and secondary gaze positions were documented, along with the gradings of the ductions and any upshoots or downshoots (-1 to -4 for underactions, +1 to +4 for overactions). Finally, palpebral fissure heights were measured with fixation in primary position and in adduction, to compare to the preoperative findings.

RESULTS

The study group included 7 patients, all female, aged 3 to 52 years (mean 15.3 years) at the time of surgery. In 6 cases the DRS involved the left eye. The Table (see end of article) provides their ages at surgery, surgical dosages (in mm.) for the medial and lateral rectus muscles, and the clinical data at the last preoperative visit and at the latest visit after surgery. The average MR recession was 4.9 mm (range 4.5 to 5.0 mm), and the
average LR resection was 3.2 mm (range 3.0 to 3.5 mm).

Preoperatively, the face turns toward the affected eye were at least 10 degrees in all patients. After surgery the face turn was 5 degrees or less in all patients. The binocular alignment in primary position averaged 27.7 prism diopeters (PD) of ET before surgery (range 25 to 32 PD) and it improved to orthotropia in all cases. In 5 patients there was no postoperative heterophoria, while one patient showed a 4 prism dipter (PD) esophoria and another showed 2 PD of exophoria.

Abduction in the affected eye improved from a mean of -3.9 (range -3.5 to -4) before surgery to -1.6 (range -1 to -2.5) after the operation. Adduction was normal in all patients preoperatively, and after surgery it averaged -0.9 (range -0.5 to -1). No patient showed more than 40 per-cent reduction of palpebral fissure height on adducting the eye from primary position to adduction after their surgery. Finally, in 5 of the 7 patients the upshoot and downshoot phenomena were not changed after surgery, while in 2 patients their gradings of upshoot and downshoot increased from +1 before surgery to +2 after surgery, on a subjective scale ranging from +1 to +4.

**DISCUSSION**

For decades strabologists have categorized the form of DRS manifesting with esotropia and limited abduction as “type 1” among three or four subtypes. These subtypes have been assigned according to the relative deficits of abduction and adduction exhibited by the patient.(1,7,9,15) However, in practice it is helpful to avoid such schemes, as there is a spectrum of findings among patients, even among those within a specific type. Adhering to such classifications can limit one’s flexibility in designing optimal surgical plans for specific cases. Instead, it is best to analyze each case of DRS according to several clinical criteria (1,2,4,15,18):

1. Heterotropia in primary position, whether esotropia (ET), exotropia (XT), and/or hypertropia (HT);

2. Presence of compensatory head posture (CHP), which affords the patient binocular vision in the face of incomitance that is a characteristic of this disorder;

3. Severity of retraction, whereby over 50% reduction in palpebral fissure height on adducting the eye from primary position can be considered “severe”;

4. Severity of upshoot and/or downshoots on attempted adduction; and

5. Unilaterality versus bilaterality of the syndrome.

The patients in this study showed a specific and unique combination of these features that led the author to consider that their strabismus pattern was amenable to inclusion of LR resection in the surgical plan.(24) First, the surgeon must be sure that the retraction phenomenon is “mild”. This is suggested by three preoperative clinical signs:

1. The efficiency of adduction, which should be full;

2. The absence of an exodeviation in the gaze field contralateral to the eye with DRS, which attests to the efficiency of the adduction;
3. Minimal narrowing of the palpebral fissure height on adduction as compared to the primary position. The author’s arbitrary cutoff was less than 33% lessening of this height.

Second, the ET in primary position should be at least 25 PD. If the deviation is 20 PD or less, a two-muscle procedure would likely overcorrect the angle and lead to an XT postoperatively. Third, there must be a significant deficit of abduction. If there is abduction ability of -3 or better, preoperatively, then there is probably added risk of overcorrecting the primary position alignment.(3) Finally, there should be no or only a mild upshoot and/or downshoot on adduction (up to +1 on grading scale of +1 to +4).

The cited article by Morad et al (24) also defined the limits of surgery that are compatible with achieving the four-fold goals of good binocular alignment in primary position, preserving of good adduction, marked improvement of abduction, and low risk of worsening the retraction phenomena. The adduction efficiency and retraction severity were compromised when the LR resection was 4.0 mm or more. In all of the 9 patients reported in that study, the MR recession was held to 5.0 mm or less to try and preserve adduction ability. Therefore, for the current series of patients the author prospectively limited the LR resection to no more than 3.5 mm., while maintaining the practice of doing no more than 5.0 mm recession of the MR. Despite the fact that all of the patients showed positive forced ductions to abduction at the time of surgery, the modest MR recessions freed much of the restrictions, yet achieved the simultaneous goal of not severely compromising the adduction after surgery.

It cannot be overemphasized that the LR resection must be limited to very small number of mm. in treating DRS. The caveats from strabologists over recent decades to avoid LR resections in DRS (1) may have derived from the misplaced assumption that the dosages that would be utilized would match those typically used to treat comitant esotropia or sixth nerve paresis. The mm. of resections of the LR in such cases are typically much larger than those used in this study, ranging 5.0 mm. and higher. There is no doubt that such major dosages of LR surgery would lead to overcorrections, worsen retraction, and markedly compromise adduction if used in cases of DRS.

There are alternative approaches described in the peer-reviewed literature and in strabismus texts for dealing with similar cases of DRS with ET and limited abduction. The most common strategies reported have been unilateral or bilateral MR recessions (2-4,15-18), primary lateral transpositions of the vertical rectus muscles with or without retroequatorial myopexy sutures (15, 20-23), or combined MR recessions with partial transpositions of the vertical rectus muscles (15,18,20). Two series of unilateral DRS patients who underwent MR recessions showed only minimal improvements in abduction after surgery, with compromise of adduction of up to -2 induced by the surgery. (16,17) In these two reports, encompassing 35 patients, the mean abduction grading changed from -3.7 before surgery to -3.0 afterward, while adduction worsened on average from -0.1 prior to -1.1 after operation, with 4 patients limited to -2. In a series of 10 patients who had bilateral MR recessions, the
mean abduction improved from -3.7 preoperatively to -2.6 postoperatively, with the range of postoperative ratings being -4 to -1.5. The adduction gradings averaged -0.3 before surgery and -1.4 after surgery, with 4 patients showing -2 adduction on followup. (24) This reflects the experience of the author over many years of practice in which MR recessions have been his most commonly chosen procedure for this form of DRS: The abduction gains are small at best in the majority of cases, and inferior to the overall results seen when the LR resection is included. More worrisome is the tendency for MR recessions to limit adduction more severely than that seen in the recess-and-resect cases. This is related to the fact that when one does a MR recession alone on the eye with DRS, there is a tendency to recess more than 5.0 mm. in order to maximize the binocular alignment result.(15-17 ) The limiting of the MR recession in the 7 patients reported in this study preserved much of the adduction efficiency of the eyes.

There are several reports of primary vertical rectus muscle transpositions for Duane syndrome. The two options that have been most commonly used are simple transpositions of the superior and inferior rectus to the lateral rectus insertion (15,21,23) and the transpositions of these muscles with the addition of retroequatorial myopexy sutures several mm. posterior to the LR insertion (15,22,23). Two reports, including 31 patients who underwent simple transpositions (21,23), showed improvements of abduction from an average of -3.8 preoperatively to -2.5 postoperatively. The adduction was not compromised, as it changed from an average of 0 before surgery to -0.2 after surgery. Two reports (22,23), including a total of 26 patients, showed that vertical rectus transpositions with addition of myopexy sutures changed abduction from a mean of -4.0 before surgery to -3.0 after surgery. Adduction gradings showed no overall worsening induced by surgery, with average gradings of 0 before surgery and -0.1 afterward. The worst adduction reported was -1, which matches the worst seen in this series after the recess-and-resect procedure. (23) However, these two approaches have the inherent risk of creating a vertical tropia in the primary position in up to 10 to 15 per-cent of cases.(15,21-23) The improvements in abduction using the recess-and-resect procedure exceeded those reported for the vertical rectus transpositions, yet the approach poses almost no risk of inducing a new vertical tropia.

It is interesting to postulate how the recess-and-resect approach can yield marked improvements in abduction, with such modest amounts of LR resection. One reason, as was suggested in the earlier paper, is the fact that the length-tension curve of the LR in DRS is steeper than that of a LR of a non-DRS case. (1,24) Thus, once the LR is tightened, the tonus of the LR is increased. When the patient attempts to abduct the eye, it leads to a relaxing of the previously tight MR. The LR can then act as a “spring” to pull the eye over to the ipsilateral gaze field. Alternatively, there is some rudimentary sixth nerve innervation to the LR in some cases of DRS, as shown many years ago in electromyographic studies. (5-8) These findings are consistent with the imaging studies that showed that in some cases of DRS the sixth nerve nucleus and the nerve itself are hypoplastic, but not aplastic. (25) Thus, there are likely some signals from the sixth nerve getting to the LR in cases of DRS, even if the abduction clinically is very limited.(5,8,25)
The LR resection may add enough power to the muscle to respond to the (weak) signals coming from the sixth nerve. This is facilitated by the releasing of some of the positive forcedduction by recession of its antagonist, the MR.

In summary, when a strabologist is faced with surgical choices for patients with DRS with ET and markedly limited abduction, there are several choices for improving the primary position binocular alignment and efficiency of abduction. If the patient has the fortuitous combination of primary position ET of 25 PD or more, “mild” retraction signs, clinically normal adduction, and tightness of the MR at surgery, then an effective option is a modest MR recession (maximum 5.0 mm.) along with a small LR resection (maximum 3.5 mm.). By adhering to these guidelines the surgeon has a good chance to gain an excellent primary position binocular alignment and marked improvement in abduction efficiency, while minimally risking severe compromising of adduction or worsening the retraction phenomena.

REFERENCES


### Table: Subject-Patient Data: Seven Cases of Surgery for Duane Retraction Syndrome

Surgical Dosages and Preoperative and Postoperative Data

<table>
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<tr>
<th>Patient No.</th>
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<td>ABd</td>
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<tr>
<td>7</td>
<td>52</td>
<td>5.0 / 3.5</td>
<td>30</td>
<td>-4</td>
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</table>

Key: MRrec = medial rectus recession; LRres = lateral rectus resection; ET = esotropia; EP = esophoria; XP = exophoria; ABd = grading of abduction (scale -1 to -4; 0 = normal); ADd = grading of adduction (scale -1 to -4; 0 = normal); PACT = prism and alternating cover test; PD = prism diopters. Measurements listed were performed in primary position.
The Editor and Editorial staff of this periodical, *Binocular Vision and Strabismus quarterly* offer their heartiest congratulations to the *American Orthoptic Journal* and to Tom France and Jim Reynolds, recent and current Editors and all the members of the American Association of Certified Orthoptists and all those who have also worked so long and hard to achieve:

THEIR RECENT INDEXATION IN THE U.S. NATIONAL LIBRARY OF MEDICINE’s INDEX MEDICUS, MEDLINE, AND PUB MED.
Case Report: Duane Retraction Syndrome Associated with Hand Anomaly

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FARAMARZ ANVARI, M.D.,
and MOHAMMAD REZA AKBARI, M.D.

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Abstract: Duane Retraction Syndrome is a congenital eye movement disorder characterized by a failure of cranial nerve VI to develop normally, resulting in restriction or absence of abduction, restricted adduction, and narrowing of the palpebral fissure and retraction of the globe on attempted adduction. Patients with Duane Retraction Syndrome appear to have a significant increase in the number of associated congenital malformations. In the present paper, the authors report a case of Duane Retraction Syndrome with a unique hand abnormality not reported previously.

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INTRODUCTION

Duane Retraction Syndrome (DRS) is a congenital ocular motility disorder characterized by retraction of the globe with narrowing of the lid fissure in attempted adduction, frequent abduction deficiency with variable limitation to adduction, and upshoot and/or downshoot of the affected eye on adduction (1,2). Although most affected patients have DRS alone, many associated ocular and non-ocular congenital anomalies can be found and are reported (2,3).

The most frequent ocular anomalies are nystagmus, epibulbar dermoid, pupillary anomalies, blepharoptosis, cataract, and coloboma. (2,4). The associated systemic anomalies are Goldenhar Syndrome (oculo-acrilocovertebral dysplasia), facial hemiatrophy, Klippel-Feil anomaly, arthrogryposis, multiplex con-
genitalia, cervical spina bifida, cleft palate, Wildervank Syndrome (cervico-oculo-acoustic syndrome), Chiari type I malformation, paroxysmal gustatory-lacrimal reflex, deformities of the external ear, and anomalies of the limbs, feet and hands, (3,5, 6).

This article describes one patient with DRS and a particular hand anomaly that has not been reported previously.

CASE REPORT

A six-year-old Iranian girl came to our clinic with the complaint of an ocular deviation. She was born by normal vaginal delivery at 40 weeks gestation. Her growth and psychomotor development were normal. She had a small angle left esotropia in primary position and a left face turn (Figure 1, left frame, next page). An ophthalmic examination showed severe abduction limitation of the left eye and retraction of the globe on adduction, resulting in the diagnosis of left DRS type I (See again, Figure 1, middle frame, and right frame, next page). Visual acuity was 20/20 in both eyes and the eyes were otherwise normal.

Systemic clinical evaluation revealed that she had no usual metacarpal prominence of fourth and fifth fingers in her right hand (See Figure 2, left frame, next page, below or right) accompanied with abnormal posture of the fourth and fifth fingers compared to others (See again Figure 2 middle and right frames, next page, below or right). Plain film radiography of her hand showed defect and fusion of the distal end of fourth and fifth metacarpal bone (See Figure 3, next page, right or below). Audiologic examination revealed normal hearing. The parents were clinically normal, non-consanguineous and there was no family history of either DRS or similar hand abnormalities.

Figure 1. (Akbari et al): Case reported: 6-year-old girl with Duane Retraction Syndrome (DRS):
Left, small angle esotropia in primary position with a left face turn. Middle, note retraction of the left globe during adduction, manifested by vertical narrowing of the palpebral fissure. Right, severe abduction limitation of left eye can be seen in this frame.
Figure 2. (Akbari et al): Case reported: Left, showing absence of usual metacarpal prominence of fourth and fifth finger in right hand. Other fingers and left hand normal, for comparison. Middle, and right frames: Abnormal posture and length of the fourth and fifth finger. Compare to other long fingers.

Figure 3 Right >>>. (Akbari et al): Case reported: Plain film radiography of the right hand showed anatomical bone defect and fusion of the distal end of fourth and fifth metacarpal bones.

The patient and her family were analyzed for SALL4 mutations. Polymerase chain reaction (PCR) and sequencing methods were used to detect mutations in exons 2, 3 of SALL4 gene, but no mutations were detected.

DISCUSSION

Patients with DRS appear to have a significant number of associated congenital anomalies. The upper limb, the cranial nerves III, IV and VI, their nuclei and the corresponding innervation to the extraocular muscles all
develop between 4 and 8 weeks of embryogenic development (7). It has been hypothesized that DRS may result from an event at this critical period since it coincides with the hand abnormalities resulting from the disturbances developing between the fourth and the tenth weeks of gestation.

The triad of DRS, radial ray anomaly (consisting of the radius, scaphoid, trapezius, first metacarpal, and the two phalanges of the thumb), and sensorineural deafness was recognized and described separately by Temtamy et al. (8) in 1975 and Okihiro et al. (3) in 1977. Hayes (9) first attributed this entity to Okihiro, and it is now often referred to as Okihiro Syndrome. Chun et al. (10) reviewed the clinical findings of 41 individuals with Okihiro Syndrome from 9 affected families. Only 5 (21%) patients demonstrated the complete triad. Hearing loss was the characteristic least often reported (17%). However, 18 (44%) patients had both DRS and radial ray anomalies. He reported that if one characteristic was unilateral, the other two characteristics would always be either bilateral or on the same side. He showed that Okihiro Syndrome transmitted in autosomal dominant fashion. In contrast, our patient had left DRS and metacarpal anomaly in right hand in fourth and fifth metacarpals not in the first metacarpal. She had no hearing defect.

SALL4 gene, a human gene related to the developmental regulator spalt of Drosophila melanogaster, has been localized to chromosome 20q13.13-q13.2(11). It has been hypothesized that Okihiro Syndrome might be the result of mutations of SALL4 gene (11). Our patient and her family did not reveal mutations in SALL4 gene.

By reporting this case, we emphasize that DRS may be associated with various hand malformations, separately or in associated with systemic anomalies. Brief inspection of the hands of patients diagnosed with DRS can be accomplished with minimal additional time and effort. In addition, any child with newly diagnosed DRS should be considered for referral to a developmental pediatrician for comprehensive evaluation.

References, next page.
REFERENCES

Pharaohs (and Gods) names differently, for example:

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<td>Amen-Ra</td>
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<td>Ramesses II</td>
<td>Ramses II</td>
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“Our Other Lives”
Interview with a Pharaoh; the Exoneration of Ay

JAMES L. MIMS III, M.D., San Antonio, Texas
Professional Strabologist and Amateur Egyptologist

Editor’s Note: We are here all doctors of some sort or medical paraprofessionals. But for many, medicine is only a part of our lives. For most, having, raising and providing for a family is more than enough to handle in addition to a professional career. But some have other interests and even more needs to fulfill. Prior contributors whose extracurricular adventures have been featured here include Oliver Sacks, Robert Enzenauer, David K. Coats, and your editor, of course. Here’s another special story from another one of our editorial board members. Might you wish to do likewise?

INTRODUCTION

Thank you for inviting me to make a contribution to the "Our Other Lives" section of Binocular Vision & Strabismus Quarterly. I came to Egypt because I wanted to connect in a visceral way with my referring Pediatricians, almost all of whom had visited Egypt and who loved to talk about it at dinner meetings.

But there was more. I have been fascinated by New Kingdom Pharaonic Egypt since as a young child I read about the discovery of King Tutankhamen's tomb in the old National Geographic issues in my grandfather's study. Other boys built forts and bridges with their construction sets. I built Egyptian temples. I staged Pharaonic burial rituals and didn't feel the least bit weird about it since the Life magazines of my childhood were full of Egypt - from finding the giant boat at the foot of the Great Pyramid of Khufu (Cheops) at Giza (See above) to the amazing effort to preserve Abu Simbel from the encroaching waters of Lake Aswan. The earliest movie I remember was the 1954 “The Egyptian” (See Poster, Left). I saw it with my parents from our car at a drive-in movie theater.

Then my interest became dormant until 1977 when I was driving my usual route from
Philadelphia to the National Children's Medical Center to operate with Marshall Parks MD as part of my Pediatric Ophthalmology Fellowship at Wills Eye Hospital. My route took me past the Smithsonian Museum of Art and they were just unfurling a long banner that said "King Tut". I was among the first dozen to see the incredible artifacts, including the iconic golden funeral mask of Tut. After seeing the most amazing art I had ever seen in my life, I went back to the end of the line, and after an hour wait saw it all again. By the next day they were not letting anyone see it twice, and when the exhibit arrived at the final city of its tour, New Orleans, people were camped out 3 days in advance to secure a ticket. I still have this catalogue for the exhibit, and a replica of Selket, one of the four goddesses guarding his shrine of canopic jars, has graced the top of our television ever since (See Right above, also Selket on a canopic barge).

My previous travels had included only Canada, Mexico, and the US. I obtained my first passport. The local public radio station had partnered with Smithsonian Colette vacations, a company who had been taking US tourists to Egypt (and bringing them safely home) for 50 years. The trip included the Giza pyramids, (See prior page and Right, the author standing amongst the 1.5 ton stone blocks of, at the foot of, the Cheops Pyramid) the Cairo museum, Memphis (an ancient capitol with only a few large statues), The Valley of the Kings with the tombs of Tut and about 50 other pharaoh's, the ancient and huge temple complex at Karnak, Abu Simbel, and the 5000-year-old temple of Isis at Aswan. (Please see the Tourists' map of Egypt on the first page of this article.) (See also Next Pages for pictures of these most ancient and historic sights)
For a few extra American dollars I also got a rare privilege - examining Tut's mummy at extremely close range as it temporarily was laid out back in his tomb (like discoverer Carter himself, see Right) after the CT studies. Usually, the mummy is kept inside the outer coffin, out of sight.

BELOW: Luxor and Thebes; Valley of the Kings: Colossus of Memnon, Amenhotep III Mortuary Temple and the author, again...

RIGHT, Luxor and Thebes: Valley of the Kings: Queen Hatshepsut’s Temple, and the author yet again...
RIGHT: Further down the Nile River:

Top: ASWAN: Temple of ISIS and
Middle: Elephantine Island, hotel
Bottom: ABU SIMBEL

Tourists Sailing in a Felluca
Pharaohs Before and After Tutankhamen

1518-1504 Tuthmosis II, son of Tuthmosis I, a military man who married into royal blood line. Reigned 16 Years

1498-1483 Queen Hatshepsut, overshadowed her stepson, Tuthmosis III, for 15 years, built the grandest Mortuary temple in Valley of Kings, directly across the Nile from Karnak Reigned 14 Years

1504-1450 Tuthmosis III, son of Tuthmosis II by a minor wife, sidelined by his stepmother Queen Harshepsut for 14 years. She died, and he became the most legendary military man in Egypt's history, "the Napoleon of Egypt", extending her borders to the eastern Mediterranean, the Sinai peninsula (turquoise), and Nubia beyond the first Cataract (gold). Riches so gained fueled the later escapades of Akhenaten, etc. Reigned (without stepmom keeping him down) 33 Years

1453-1419 Amenhotep II, military campaigns Reigned 33 years

1419-1386 Tuthmosis IV, dream stelae at base of Sphinx Reigned 37 years

1386-1349 Amenhotep III, a prosperous and stable period Father of Akhenaten, Grandfather of Tutankhamen Colossi of Memnon are actually at the front of his mortuary temple destroyed by Nile floods. Reigned 40 years

1350-1334 Akhenaten, the heretic who tried to do away with the previous religion and substitute a pharaoh-centric monotheism with no chance for personal redemption save via the Pharaoh Reigned 16 Years

1334-1325 Tutankhamen, coronation at age 10 yrs, could not speak or walk normally; actual power in hands of Ay (Vizier) and General Horemheb. Reigned 9 years

1325-1321 Ay, vizier to 3 prior Pharaohs, Tut's mentor Reigned 3 years

1321-1293 Horemheb, the popular general Reigned 28 years
Exhausted at the end of this tour, I slept in my room at Aswan Dam site and dreamed of interviewing a Pharaoh, the much maligned Ay who was the true administrator of Egypt during a critical period for almost 50 years - and who did not murder Tutankhamen.

**THE INTERVIEW**

_BVQ (JLM III):_ So good of you to come. You don't look at all like that evil old man you have been portrayed as being.

Instead, You are young, handsome in your pharaoh's leopard skin robes, the same ones you are wearing on the wall of Tutankhamen's* tomb as you are performing the opening of the mouth ceremony:

_Ay: Amun-Re has been good to me. I am allowed to assume the image of me you have seen painted by the Amarna artists in Tutankhamun's* tomb._

_BVQ (JLM III):_ Then I was right all along. As much as I enjoyed Bob Brier's wildly popular book, *The Murder of Tutankhamen*, I thought the skull X-ray evidence against you that was the basis of his book was pretty flimsy. Now that Cat Scans have been done by a team led by Zahi Hawass, the head of Egypt's Supreme Council of Antiquities, everyone feels you have been exonerated. Their diagnosis of "Severe sepsis post compound fracture of the leg in the context of debilitating malaria" as the cause of Tutankhamen's death seems magnificently substantiated by rigorous science. Still, knowing the decades-long competition between the best-known American Egyptologist (Brier)
and the powerful Hawass, and being a bit skeptical about the fact that the CT study was funded by the Discover® channel for a television special, I still wasn't absolutely certain of your innocence until you showed up in your youthful visage and your pharaonic leopard skin robes. You didn't murder Tutankhamen. Amon-Re has blessed you with eternal life. Your heart must have been truly lighter than a feather when Anubis weighed it. (See very last page of this article).

Ay: I am humbled every time I think about that moment.

BVQ (JLM III): How and why did Tutankhamen die?

Ay: He died for the same reason that teenagers die in your culture; they fail to listen to the wisdom of their elders. As Vizier and his grandfather-in-law I told him repeatedly not to stay out in the marsh hunting until dark. The evil spirits come out then. Of course, you would say, more scientifically, that the anopheles mosquitoes carrying malaria come out at dusk. His ultimately fatal accident occurred when he was driving his chariot too fast, which is especially difficult if you are unsteady enough to require a cane to walk or to stand thanks to your club foot. The compound fracture he suffered and the subsequent sepsis, according to modern experts, did him in. Poor child, he so loved to hunt in the marshes and drive his chariot too fast. I know, he was 18 when he died, and he was the husband of my granddaughter, but I was so much older he was still a child to me.

BVQ (JLM III): Are you real or only a figment of my imagination?

Ay: I'm as real as Santa Claus, Virginia.

BVQ (JLM III): I have so many more questions for you! First, is the publication in
JAMA (Journal of the American Medical Association) correct about the family tree of Tutankhamen? [Hawass Z, Gad YZ, Ismail S. et al. Ancestry and pathology in King Tutankhamun's* family. JAMA 2010; 303:638-647.]

Ay: Given that maternity was always a matter of fact (which is why we used it to determine who could be Pharaoh), whereas paternity until recently was merely a matter of opinion, they probably nailed it.

BVQ (JLM III): To their pedigree (NEXT PAGE) I have added several other family members, including you. (Please see expanded Tut pedigree on following page.) Does my expanded pedigree look correct?

Ay: Yes, as far as it goes.

BVQ (JLM III): Let's talk about your close relatives. Were your parents prominent landowners and prominent politically? If your mother looks anything like her recently discovered golden mask, she must have been really beautiful. And your sister, the beloved Queen Tiy who captivated Amenhotep III as he was riding his chariot through the countryside, must have been a true beauty. I found myself enchanted by a large statue of her and Amenhotep III that occupies an entire wing of the Cairo museum.

Ay: My parents were wonderful people, but the truth is that business of being big landowners etc, was merely spin carved on the Marriage Scarab, in which Amenhotep III basically said this beautiful woman is going to be my number one wife and you had better accept it. My sister Queen Tiy and I succeeded for the same reasons that anyone else succeeds: talent, physical attractiveness, hard work, and (for me) family connections. My sister was one easy woman to love. I was Vizier (sort of like being prime minister and most of the US cabinet members all rolled into one office) under three pharaohs, Amenhotep III, Akhenaten, and Tutankhamun. I was their servant and servant of the people of Egypt.

BVQ (JLM III): Tell me about your two famous daughters.

Ay: Nefertiti, iconic Nefertiti who was the number one wife of Akhenaten, was the older of the two. She wasn't quite as beautiful as the artists portrayed her, but she was nice and suitable for the radical Akhenaten. Hawass and his team have recently confirmed that she was not the mother of Tutankhamun, which she never claimed to be. She bore Akhenaten six daughters, one of whom was a wonderful wife (and the only wife) of Tutankhamun, perfect in every way because she was his half-sister. Our other famous daughter, Mutnodjmet, was a bit difficult at times, but the great general Horemheb finally did conquer her.

BVQ (JLM III): Forgive me for mentioning a delicate subject, but in your time, your
people really didn't understand a thing about consanguinity, did you?

Ay: The merciful Amun-Re has allowed me to study all branches of human knowledge as it exists now, so I do understand the causes of the curses our pharaohs suffered, including palate abnormalities that made it impossible for Akhanaten and Tutankhamun to speak normally. I actually had to speak for both of them much of the time.
Yes, consanguinity gave Tutankhamun a club foot and may have impaired his intelligence, though it is always hard to judge when a person cannot speak normally. Consanguinity? Give me a break! Our gods were sisters and brothers and begat more gods from their unions. The Pharaohs (with Amenhotep III’s marriage to my sister a notable exception) were gods, so they behaved like gods!

**BVQ (JLM III):** Good point. One more delicate question. Did you really have to force your granddaughter, Tutankhamen’s widow, Ankhensnamun, to marry you?

**Ay:** Of course I did. The foolish girl famously wrote a letter to a Hittite ruler and asked him to send her one of his sons to be her husband, an incredibly ridiculous idea, but they did, and the young man was killed by a veteran of the Hittite wars as soon as he came to our northern border, just as you would expect. General Horemheb always resented my ceremonial marriage to my granddaughter, but it was the only way to save Egypt. It wasn’t that I thought I deserved to be Pharaoh, even though I had been, de facto, running Egypt for almost 50 years. I knew that General Horemheb, beloved by the people, would be a great Pharaoh, but according to the laws of matriarchal succession, there was no way he
could be a legitimate Pharaoh unless I became Pharaoh first by marrying my granddaughter who was also the daughter of a Pharaoh, specifically Akhenaten. Once I had been a Pharaoh, then my remaining daughter Mutnodjmet could, by marriage, make Horemheb the Pharaoh. Study of your expanded Tutankhamun pedigree should have made that obvious to you. Giving respect where respect is due, Horemheb did lust after her for many years before she became his ticket to Deity.

**Horemheb:**

**BVQ (JLM III):** Then that part of the movie *The Egyptian* was really correct!

**Ay:** Yes, the casting director was a genius in casting Victor Mature as Horemheb. He was perfect for the part, including his early overtures to my daughter Mutnodjmet.

**BVQ (JLM III):** It seems to me that they got almost everything else wrong in the movie. They skipped Tutankhamun entirely. They also missed the fact that the monotheism of Akhenaten was not a precursor to the Judeo-Christian monotheism. It was promptly squashed upon Akhenaten's death because it gave no possibility for personal redemption for the people. It was really a secular means to make the Pharaoh's power absolute.

**Ay:** It took me a while to figure that out. I and my wife really believed in Akhenaten at first. My unused tomb at Amarna preserves his "Great Hymn to Aten." In time, I knew I had to restore hope to the common man by restoring the old religion promptly after Akhenaten died. Bob Brier was right when he wrote that the people wept for joy when we gave them back their festivals and their merciful and personal gods.

**BVQ (JLM III):** On several of the temples I saw vertical grooves where the people would scratch out a few grains of sand to put into personal shrines in their homes.

**Ay:** Yes, that is what those grooves really were.

**BVQ (JLM III):** After Akhenaten's death, you were instrumental in restoring the old religions. Why is Akhenaten's mummy only a skeleton?

**Ay:** He wanted his body set out on an altar to his Sun God. It was all we could do to keep the vultures away. After a few weeks I mercifully retrieved it and had what remains were left mummified.
**BVQ (JLM III):** Why was Tutankhamen's mother brutally murdered with blows to the face and the calvarium?

**Ay:** Some of Horemheb's men thought that killing the remaining members of Akhenaten's household would speed the restoration of the old order. (Nefertiti had passed away some years earlier, before the death of Akhenaten.) I persuaded them to save the children, including Tutankhamun and my young granddaughter, Ankhensenamun, Tutankhamun's future wife. As you know, several years later, when Horemheb became Pharaoh after me, he began the eventual total physical destruction of Amarna, and used the building materials for his own monuments. Ramesses II later completed the leveling of Amarna.

**BVQ (JLM III):** Given that Akhenaten sired 6 daughters by Nefertiti and at least two sons by other women (Tutankhamen and Smenkaire), he must have been hormonally pretty normal. Why did he have himself depicted with female breasts and hips?

**Ay:** Early in his reign he had the idea that he could replace all the old Gods, both the males and the females, with himself, the Pharaoh. Of course, it came off as simply grotesque and repulsive. The priests quickly had the hermaphroditic statues at Karnak taken down shortly after died. The failure of that approach was one of the things that prompted Akhenaten to build a new capitol at Amarna, where he instructed his artists to depict everyone according to their natural and true appearance, regardless of age. Depictions of pot bellies were so common as to be characteristic of the era. That naturalism resulted in my portrayal in a bust as a not-so-attractive, indeed sinister, old man that Brier felt somehow validated his (false) accusations against me.

**BVQ (JLM III):** Why was Tutankhamen's tomb saved from the grave robbers?

**Ay:** Most of the plundering of the tombs of the Pharaohs in The Valley of the Kings occurred after the end of the reign of Ramesses III in 1150 B.C., when the guarding of the tombs was outsourced to mercenaries. (This is another thing the movie The Egyptian got wrong.) This was 175 years after Tutankhamun's death. Tutankhamun's tomb was comparatively inconsequential compared to the other tombs, and a scant 15 years after tomb robbing became rampant, the entrance to Tutankhamun's tomb was completely obscured by the rubble from the excavations for the adjacent tomb of Ramesses VI.

**BVQ (JLM III):** Until I actually went to Egypt, I found your religion hopelessly weird and complicated. Now I understand that the mighty Nile and your daily experience validated it for you. The wide, powerful Nile runs almost due north and the sun rises and sets at right angles to it. It is easy to visualize a dung beetle pushing it up in the morning just as it would a perfectly round ball of soil. The dung beetle becomes the sacred scarab, my favorite souvenir of Egypt. And when I placed my hand on the 5000-year-old altar of Isis in her temple at Philae and studied the carvings depicting her bringing Osiris back to life with the beating of her wings, I felt as loved and cared for as a devout Catholic must feel when she prays to the Virgin Mary.

**Ay:** Isis be with you. For now and for ever more.

**BVQ (JLM III):** Thank you.

(At that point, I awoke, just in time to brush a large anopheles mosquito off my bare chest. No More souvenirs!)
More to Explore


Skip the murder parts, now that they have been discredited. Start with Chapter 2 and learn why Brier has deservedly become the best known Egyptologist in the U.S. Don't be too impressed by his drama re the Newberry Ring on page 185; I have seen a nice photo of it in a catalogue for an exhibit at the Boston Museum of Art. It does exist, in the Ägyptisches Museum in Berlin, and proves that Ay did indeed marry the widow of Tutankhamen, his granddaughter Ankhensenamun, because it was the right thing to do! I certainly don't think Ay did her in, either. She was his grandchild, for Amun-Re's sake! She probably died of a broken heart. Death came so easily in ancient Egypt.


Egyptian
Judgement:
Comparing the weight
of your heart with
that of a feather:
(Editorial, “Also In this issue”, continued)


We didn’t realize it but by sharing with our readers as we have this past year or two, some of the extra curricular exploits of BV&Sq’s editorial board and contributors (and even before that the life long auto racing parallel side career and exploits of your editor), we now have a NEW regular feature which has been dubbed: “OUR OTHER LIVES”!

That is the wonderful part of owning your own publication, and worth every penny we don’t get paid. But if this subject has already been published in the scientific literature in no less a medical publication than the esteemed and ancient Journal of the American Medical Association, then we sure can do likewise. We’ll let the government decide (it’s not ever our final decision, we can only propose...) whether that is a sufficient reason to list it in Index Medicus and Medline. We will submit it. It really is very much about genetics and we all know how important they are in the medical history and future of mankind. Exoneration warrants publication.

More on Our General Enzenauer: In reply to our request for more on his remarkable accomplishments: “I knew I wanted to go to West Point ever since I was about 11 years old.... The service academies had become really “competitive” meaning what you know and NOT who you know” [any more, including now:] “SAT, or later ACT, academics, physical fitness, leadership, etc. I had no college role models (being the first in my family to go to college), so I had to do it all on my own” [and he did!]. “-per

More News and Meetings

2010 Houston Texas October 28-29. 14th Annual Gunter K. von Noorden Visiting Professorship in Ophthalmology. Cullen Eye Institute. The lecture will be given by Stephen P. Kraft, MD (see this issue BV&Sq page 147-..) and is titled “New modalities for imaging ocular rectus muscles’. Contact: 832-822-3237

2011 San Diego, California March 30-April 3. 37th Annual Mtg of the AAPOS. Contact: aapos@aaao.org
2011 Sydney, Australia, March 20-24. AAO Co-Sponsored Symposium at the Asian Pacific Academy of Ophthalmology. Contact: Michael X. Repka, MD <mrepka@jhmi.edu> or the AAPOS <aapos@aaao.org.

2011 Ouro Preto, Brazil June 8. AAPOS Co-Sponsored Symposium immediately prior to the Brazilian Society of Pediatric Ophthalmology. Contact: www.congressocbescbop.com.br

NEW FOUNDATION/ FACILITY
from the University of Michigan’s News. ANN ARBOR, MI. The new University of Michigan’s C.S. Mott Children’s and Von Voigtlander Women’s Hospitals - the largest construction project in the state and one that will create at least 500 new jobs - are opening a year ahead of schedule, in the Fall of 2010. The $754 million state of the art hospital complex will feature 1.1 million square feet and will include a nine story tower for clinic space and a 12 story tower with 855,000 square feet of space devoted to inpatient care, diagnostic, procedural and treatment services. It is located adjacent to the current University Hospital...funded by hospital reserves and philanthropy ... which includes a $25 million gift from the Flint-based C.S. Mott Foundation and $15 million gift from the Ted and Jane Von Voigtlander Foundation.

** ERRATUM **
Re:”Cycloplegic refractions in children who never wore and who always wore prescribed spectacles for refractive accommodative esotropia: ... natural history ... and the effect of treatment on their hyperopia.” Binocul Vis Strabismus Q 2009; 24(3):151-156.
The correct spelling of the author’s name is: KHAN ARIF O.

The journal regrets the mis-spelling of the name in the MedLine citation.

The publishing of this notice will result in correction of the Medline citation.
And it is going to be tough and political and Republican so If you are a real Liberal Democratic Party member, Or if America and our politics are not your “cup of tea” you can stop reading here.

I will now step up upon my soapbox:- per Health Care Insurance: We have told you many insurance horror stories in these pages before. I hate all Insurance and Insurers and may even agree with political democrats on health care insurers becoming mandatory public utilities: In fact I hate all THIRD PARTY deals, and transactions because they are ALWAYS grief for the first two parties and pure huge easy zero effort gold mines for the third party-ALWAYS. They should all be ILLEGAL.

At the Head of the line, professionally and otherwise, are all the lawyers, the ultimately greediest and constant third parties.

Second is the government with all their benefit and insurance programs. The biggest and worse example is our dear professional life line, Medicare and Medicaid, the gold dust twins! As a Medicare PATIENT I AM STILL IN TOTAL DISBELIEF AFTER READING THE BILLS AND THEIR PAYMENT FOR MYSELF FOR THE PAST DECADE. The charges are GI-normous and the payments are almost invisible. We came to this ridiculous situation through our ridiculous Congress. I understand that it was always a “deal”: doctors were expected to raise their fees like 10% every year and they expected to receive and were granted by the Congress yearly, only a small fraction of that requested increase, whether bonafide or not. So the docs and the pols could both feel they were doing their jobs: the docs were doing mostly “pro bono” medical care, and the Congressmen were saving the taxpayer’s money... getting something for nothing as usual.

My current care is limited to physical therapy for my pyriformis muscle injury and my 30 minute visits with him, mostly instruction in how to avoid reinjury and how
to do exercises to help it, plus a few minutes of massage and ten minutes with a heating pad or ice pack.... is billed for almost $1000 every week. Medicare pays about 5% of that and I have to co-pay 20% of that 5%. Well, so what? To prove to the government that those ridiculous fees are real and realistic, to receive any Medicare funds, doctors and hospitals have to charge everybody else, the same top fees for the same services’!!!! And collect!- We are self insured and get billed the full amount for non Medicare stuff. Judy is a pro anti-bill collector!

Now here’s two good and seconding opinions regarding third party payers:

**Physician Autonomy Comes With First-Party Payment**

Saul Greenfield’s “In Defense of Physician Autonomy” (op-ed, Sept. 7) has intuitive appeal, although one wishes that he had made a clear distinction between two facets of the issue: (1) the decisions of individual patients and their physicians on what they think is the proper response to a medical condition and (2) the decision of the administrators of collective insurance pools—be they tax-financed public pools or premium-financed private pools—on what treatment decisions to finance with the funds entrusted to them.

If physicians and patients wish that a third party pay for their treatment decisions, physicians should be prepared to justify these decisions to the third-party payer with appeal to robust, scientifically validated evidence. Can Dr. Greenfield or any dean of a medical school look their stu-

that the medical profession typically has operated in this way vis-à-vis the rest of society?

Neither Britain’s National Institute for Clinical Effective-ness (NICE) nor any insurer using clinical practice guide-
lines actually seeks to dictate to physicians what they may or may not do in their prac-
tices. In exercising their fiduciary duties to taxpayers or premium payers, they look to clinical practice guidelines in deciding whether or not to pay for a particular treatment.

**Prof. Uwe Reinhardt**
Princeton, University Princeton, N.J.

Dr. Greenfield has it exactly right. As a practicing physician with over 30 years of experience caring for indi-

Admittedly, such individual care can be very expensive. I advise we resist those who seek to control costs by re-
quarding mandatory adherence to “clinical guidelines” as the way to improve medical care. It will result in many disasters for individual patients.

**Peter C. Welch M.D. Ph.D.**
The fact that proposed rate increases for health insurance will mostly be borne by individuals and small-business employees simply adds insult to injury (“Health Insurers Plan Hikes,” page one, Sept. 8). These were the very groups that needed help the most, who could not benefit from access to a government health plan or the negotiating power of a large employer. Now, as predicted, it is even more difficult for these citizens to procure affordable health insurance.

It defies logic to think that the administration and Congress couldn’t foresee the effects of the disastrous health-care bill, so one must assume they did see and didn’t care because the ultimate goal was to force everyone onto a government-sponsored plan or single-payer system.

TANNAHILL GLEN, PSY.D.
Jacksonville, Fla.

Thanks to the new health-care law, my small-business group health-insurance premiums are expected to rise between 64% and 69% in response to preventative-care mandates and other so-called benefit enhancements that I neither asked for nor require.

Whoever named this law the Patient Protection and Affordable Care Act has a cruel sense of irony.

BETH ZIMMERMAN
Long Beach, N.Y.

More examples of government and private insurance company horrors:

**Democrats Plan to DEEP-SIX* Medicare to solve ALL related financial and longevity problems**

*deep/ six/, Slang. 1. burial or discarding at sea. 2. complete rejection or ruin. [1940-45]

deep-six (deep/siks’), v.t. Slang. 1. to throw overboard. 2. to get rid of; abandon; discard. 3. to reject, under manager’s at-use of DEEP

from The Wall Street Journal
Thursday September 9, 2010 by Peter Ferrara and Larry Hunter. How ObamaCare Guts Medicare.

“... Medicare payment rates for doctors and hospitals serving seniors will be cut by 30% over the next three years.” -[Ed emphasis] [10% per year x3.
This is to be coordinated with the Barick medicare bureaucracy designed to frankly deny seniors all life prolonging medical care since we can no longer afford to extend life, but must divert, redistribute funds to balance the budget and support the teachers and government worker SEIU and labor unions and UAW and all their outrageous pensions to keep them voting Democratic to keep the Democrats in power -ed]

“But effectively refusing to pay the doctors and hospitals that provide the medical care the program promises to seniors is no way to solve that problem.” (Mr. Ferrara is director of entitlement and budget policy at the Institute for Policy Innovations and author of ‘The Obama-Care Disaster’, forthcoming from the Heartland Institute. Mr. Hunter is president

Good news! People are living longer than ever!

Bad news- we don’t get to choose which people.
Should hospitals and other third party payers be able to make these sort of huge profits on humans who are medically sick? Now that I have been seriously ill a few times, there is no one in this world worse off than, say, someone with a cancer and pain. Only intentional physical torture might be worse. Society and our culture should NOT take advantage of them, in any way, including getting wealthy on or from their misery. It’s at the very least NOT FAIR. And that judgement is not at all an exclusively liberal or democratic party complaint or demand.
Yes I am a republican, because Life isn’t fair and never will be: we cannot (yet) control genetics ... or human fallibility (=accidents and fatal and/or disabling errors). No hope on the latter. So “making Life Fair”, which is job #1 for democrats, through redistribution and entitlements and benefits is crazy impossible. Rush Limbaugh said it well recently:
... the compulsion most democrats and liberals have to redistribute what little wealth is left in the world when the current recession-depression finishes, to try to make everybody equal but equally poor, is totally ANTI-FREEDOM, ANTI-HUMAN ANTI-PROGRESS, stupid, idiotic, and world and mankind suicidal (if you think it is not, then let’s just setoff all the remaining nuclear weapons and be done with this world - you for sure are not worthy of the gift of life).

In fact isn’t that just what our Constitution and Bill of Rights are all about: Fairness? Those documents are what has made our country so free and so desirable? That’s FREEDOM! But freedom to succeed is also freedom to fail. Or would you rather NOT be free? Romano’s Dictum #19: “Life isn’t Fair” is certainly true, but it is not really LIFE that is at fault... Life is actually pretty fair. IT IS PEOPLE THAT AREN’T FAIR !!!!!
SO, Now I find myself much in agreement with the Democratic position attacked in the following Wall Street Journal Editorial. (See next page). PER:
“Basically, since “Insurance” is based on NO truly productive work, if any at all, (Ed emphasis- see our previous editorial comments -per) but is rather based upon scaring the hell out of all human beings as much as possible, I AGREE THAT ALL HEALTH INSURERS SHOULD BE OR BECOME PUBLIC UTILITIES WITH VERY LIMITED MINIMAL UNTAXED PROFIT MARGINS (35% IS OUTRAGEOUS), say 7% plus the 8% mandatory social security expense, which would bring their total non taxable profit down to near 10% I think, and then take 90% in everything over that required to be rebated to the insured as excess profits. More than enough for such an immoral enterprise as all insurance is... Shouldn’t they be required to state the odds on your bet with them ? - Like “there is only a 1 in 1000 chance you the bread-winner will die without compensation for our survivors before your kids go off to marriage or college? “ (And WHO was the biggest most unconscionable loser in the mortgage mess? -it was an insurer of everything called AIG, right???? you will be paying for their losses for the rest of your lifetime, if you pay taxes. I don’t because I stuffed all of what we had saved into Roth accounts and paid all my taxes way back when...., 1998! Not paying any income taxes now remains my greatest $ pleasure in life now. Now if they would just elect a Value-added tax and eliminate ALL conventional SALES TAXES...they will and then we would really be happy... even if the prices of some things inevitably went up. That’s OK as we and BV have few major taxable acquisitions any more. Of course, they will never cancel any taxes - it is too much fun to spend someone else’s money, the essence of the ability to tax (&$PEND)!, In fact because it is and that is their job to spend our money, they-all congressmen and most government workers, should pay US, that’s us taxpayers, for all the fun they have!!!

Finally, at this point in my life I must say, I feel like I blew it. I have been taken by society for a real sucker as society treats everybody who is a humanitarian, and not just a psychopath or sociopath or just plain selfish or greedy. Especially Now, even though I quit the practice of medicine twenty years ago, I am outraged by the way our profession is mistreated currently, by the current democratic administration and by government in general. Only by quitting clinical medicine back then in 1989 was I able to accumulate a little wealth and get a taste of what many in our society, especially the financial fields, achieve relatively easily, compared to our professional training. I busted my buns for 20 years in school and then “payed my dues” for another ten in advanced training and the military service required of all M.D.s then, (and then only them), was lucky enough to miss combat and injury and death therefrom, and then I found the government ready to take any serious income I might accumulate in taxes ranging up to 70% to 90%. So I chose academic medicine instead of private practice, (I did not wish in fact I could not envision a life having to have our government as my major and dominant partner) and then I chose a pediatric sub-specialty (idiot!).

I feel today great sympathy for all my fellow pediatric ophthalmologist-strabologists and related professionals. You all deserve so much better than you are getting.... out of this life....
From Forbes (financial magazine). September 27, 2010: "Obama’s Problem with Business" [major title under-statement- we much prefer our title, see below] by Dinesh D’Souza, the president of the King’s College in New York City, is the author of the forthcoming book, “The Roots of Obama’s Rage” (Regnery Publishing)

In fact, we thought the subtitle for this article, imprinted at the top of each page of the article, “How He Thinks” might have been a better understatement if you’d insist.


Barack Obama is the most antibusiness president in a generation, perhaps in American history. Thanks to him the era of big government is back.

Obama runs up taxpayer debt not in the billions but in the trillions. He has expanded the federal government's control over home mortgages, investment banking, health care, autos and energy. The Weekly Standard summarizes Obama’s approach as omnipotence at home, impotence abroad.

The President’s actions are so bizarre that they mystify his critics and supporters alike. Consider this headline from the Aug. 18, 2009 issue of the Wall Street Journal: “Obama Underwrites Offshore Drilling.” Did you read that correctly? You did. The Administration supports offshore drilling—but drilling off the shores of Brazil. With Obama’s backing, the U.S. Export-Import Bank offered $2 billion in loans and guarantees to Brazil’s state-owned oil company Petrobras to finance exploration in the Santos Basin near Rio de Janeiro—not so the oil ends up in the U.S. He is funding Brazilian exploration so that the oil can stay in Brazil.

More strange behavior: Obama’s June 15, 2010 speech in response to the Gulf oil spill focused not on cleanup strategies but rather on the fact that Americans “consume more than 20% of the world’s oil but have less than 2% of the world’s resources.” Obama railed on about “America’s century-long addiction to fossil fuels.” What does any of this have to do with the oil spill? Would the calamity have been less of a problem if America consumed a mere 10% of the world’s resources?

The oddities go on and on. Obama’s Administration has declared that even banks that want to repay their bailout money may be refused permission to do so. Only after the Obama team cleared a bank through the Feds’ “stress test” was it eligible to give taxpayers their money back. Even then, declared Treasury Secretary Tim Geithner, the Administration might force banks to keep the money.

The President continues to push for stimulus even though hundreds of billions of dollars in such funds seem to have done little. The unemployment rate when Obama took office in January 2009 was 7.7%; now it is 9.5%. Yet he wants to spend even more and is determined to foist the entire bill on Americans making $250,000 a year or more. The rich, Obama insists, aren’t paying their “fair share.” This by itself seems odd given that the top 1% of Americans pay 40% of all federal income taxes; the next 9% of income earners pay another 30%. So the top 10% pays 70% of the taxes; the bottom 40% pays close to nothing. This does indeed seem unfair—to the rich.

Obama’s foreign policy is no less strange. He supports a $100 million mosque scheduled to be built near the site where terrorists in the name of Islam brought down the World Trade Center. Obama’s rationale, that “our commitment to religious freedom must be unshakable,” seems utterly irrelevant to the issue of why the proposed Cordoba House should be constructed at Ground Zero.

Recently the London Times reported that the Obama Administration supported the conditional release of Abdel Baset al-
It is certainly not the American dream as conceived by the founders. They believed the nation was a “new order for the ages,” a half-century later Alexis de Tocqueville wrote of America as creating “a distinct species of mankind.” This is known as American exceptionalism, but when asked at a 2009 press conference whether he believed in this ideal, Obama said no. America, he suggested, is no more unique or exceptional than Britain or Greece or any other country.

Perhaps, then, Obama shares Martin Luther King’s dream of a color-blind society. The President has benefited from that dream; he campaigned as a nonracial candidate, and many Americans voted for him because he represents the color-blind ideal. Even so, King’s dream is not Obama’s. The President never champions the idea of color-blindness or race-neutrality. This inaction is not merely tactical; the race issue simply isn’t what drives Obama.

What then is Obama’s dream? We don’t have to speculate because the President tells us himself in his autobiography, Dreams from My Father. According to Obama, his dream is his father’s dream. Notice that his title is not Dreams of My Father but rather Dreams from My Father. Obama isn’t writing about his father’s dreams; he is writing about the dreams he received from his father.

So who was Barack Obama Sr.? He was a Luo tribesman who grew up in Kenya and studied at Harvard. He was a polygamist who had, over the course of his lifetime, four wives and eight children. One of his sons, Mark Obama, has accused him of abuse and wife-beating. He was also a regular drunk driver who got into numerous accidents, killing a man in one and causing his own legs to be amputated due to injury in another. In 1982 he got drunk at a bar in Nairobi and drove into a tree, killing himself.

An odd choice, certainly, as an inspirational hero. But to his son, the elder Obama represented a great and noble cause, the cause of anticolonialism. Obama Sr. grew up during Africa’s struggle to be free of European rule, and he was one of the early generation of Africans chosen to study in America and then to shape his country’s future.

I know a great deal about anticolonialism, because I am a native of Mumbai, India. I am part of the first Indian generation to be born after my country’s independence from the British. Anticolonialism was the rallying cry of Third World politics for much of the second half of the 20th century. To most Americans, however, anticolonialism is an unfamiliar idea, so let me explain it.

Anticolonialism is the doctrine that rich countries of the West got rich by invading, occupying and looting poor countries of Asia, Africa and South America. As one of Obamas acknowledged intellectual influences, Frantz Fanon, wrote in *The
From a very young age Obama learned to see America as a force for global domination and destruction.

From the anticolonial perspective, American imperialism is on a rampage. For a while, U.S. power was checked by the Soviet Union, but since the end of the Cold War, America has been the sole superpower. Moreover, 9/11 provided the occasion for America to invade and occupy two countries, Iraq and Afghanistan, and also to seek political and economic domination in the same way the French and the British empires once did. So in the anticolonial view, America is now the rogue elephant that subjugates and tramples the people of the world.

It may seem incredible to suggest that the anticolonial ideology of Barack Obama Sr. is espoused by his son, the President of the United States. That is what I am saying. From a very young age and through his formative years, Obama learned to see America as a force for global domination and destruction. He came to view America’s military as an instrument of neocolonial occupation. He adopted his father’s position that capitalism and free markets are code words for economic plunder. Obama grew to perceive the rich as an oppressive class, a kind of neocolonial power within America. In his worldview, profits are a measure of how effectively you have ripped off the rest of society, and America’s power in the world is a measure of how selfishly it consumes the globe’s resources and how ruthlessly it bullies and dominates the rest of the planet.

For Obama, the solutions are simple. He must work to wring the neocolonialism out of America and the West. And here is where our anticolonial understanding of Obama really takes off, because it provides a vital key to explaining not only his major policy actions but also the little details that no other theory can adequately account for.

Why support oil drilling off the coast of Brazil but not in America? Obama believes that the West uses a disproportionate share of the world’s energy resources, so he wants neocolonial America to have less and the former colonized countries to have more. More broadly, his proposal for carbon taxes has little to do with whether the planet is getting warmer or colder; it is simply a way to penalize, and therefore reduce, America’s carbon consumption. Both as a U.S. Senator and in his speech, as President, to the United Nations, Obama has proposed that the West massively subsidize energy production in the developing world.

Rejecting the socialist formula, Obama has shown no intention to nationalize the investment banks or the health sector. Rather, he seeks to decolonize these institutions, and this means bringing them under the government’s leash. That’s why Obama retains the right to refuse bailout paybacks—so that he can maintain his control. For Obama, health insurance companies on their own are oppressive racketeers, but once they submitted to federal oversight he was happy to do business with them. He even

Wretched of the Earth, “The well-being and progress of Europe have been built up with the sweat and the dead bodies of Negroes, Arabs, Indians and the yellow races.” Anticolonialists hold that even when countries secure political independence they remain economically dependent on their former captors. This dependence is called neocolonialism, a term defined by the African statesman Kwame Nkrumah (1909–72) in his book Neocolonialism: The Last Stage of Imperialism. Nkrumah, Ghana’s first president, writes that poor countries may be nominally free, but they continue to be manipulated from abroad by powerful corporate and plutocratic elites. These forces of neocolonialism oppress not only Third World people but also citizens in their own countries. Obviously the solution is to resist and overthrow the oppressors. This was the anticolonial ideology of Barack Obama Sr. and many in his generation, including many of my own relatives in India.

Obama Sr. was an economist, and in 1965 he published an important article in the East Africa Journal called “Problems Facing Our Socialism.” Obama Sr. wasn’t a doctrinaire socialist; rather, he saw state appropriation of wealth as a necessary means to achieve the anticolonial objective of taking resources away from the foreign looters and restoring them to the people of Africa. For Obama Sr. this was an issue of national autonomy. “Is it the African who owns this country? If he does, then why should he not control the economic means of growth in this country?”

As he put it, “We need to eliminate power structures that have been built through excessive accumulation so that not only a few individuals shall control a vast amount of resources as is the case now.” The senior Obama proposed that the state confiscate private land and raise taxes with no upper limit. In fact, he insisted that “theoretically there is nothing that can stop the government from taxing 100% of income so long as the people get benefits from the government commensurate with their income which is taxed.”

Remarkably, President Obama, who knows his father’s history very well, has never mentioned his father’s article. Even more remarkably, there has been virtually no reporting on a document that seems directly relevant to what the junior Obama is doing in the White House.

While the senior Obama called for Africa to free itself from the neocolonial influence of Europe and specifically Britain, he knew when he came to America in 1959 that the global balance of power was shifting. Even then, he recognized what has become a new tenet of anticolonialist ideology: Today’s neocolonial leader is not Europe but America. As the late Palestinian scholar Edward Said—who was one of Obama’s teachers at Columbia University—wrote in Culture and Imperialism, “The United States has replaced the earlier great empires and is the dominant outside force.”
promised them expanded business as a result of his law forcing every American to buy health insurance.

If Obama shares his father’s anticolonial crusade, that would explain why he wants people who are already paying close to 50% of their income in overall taxes to pay even more. The anticolonialist believes that since the rich have prospered at the expense of others, their wealth doesn’t really belong to them; therefore whatever can be extracted from them is automatically justified. Recall what Obama Sr. said in his 1965 paper: “There is no tax rate too high, and even a 100% rate is justified under certain circumstances.”

Obama supports the Ground Zero mosque because to him 9/11 is the event that unleashed the American bogey and pushed us into Iraq and Afghanistan. He views some of the Muslims who are fighting against America abroad as resisters of U.S. imperialism. Certainly that is the way the Lockerbie bomber Abdel Basset al-Megrahi portrayed himself at his trial. Obama’s perception of him as an anticolonial resister would explain why he gave tacit approval for this murderer of hundreds of Americans to be released from captivity.

Finally, NASA. No explanation other than anticolonialism makes sense of Obama’s curious mandate to convert a space agency into a Muslim and international outreach. We can see how well our theory works by recalling the moon landing of Apollo 11 in 1969. “One small step for man,” Neil Armstrong said. “One giant leap for mankind.”

But that’s not how the rest of the world saw it. I was 8 years old at the time and living in my native India. I remember my grandfather telling me about the great race between America and Russia to put a man on the moon. Clearly America had won, and this was one giant leap not for mankind but for the U.S. If Obama shares this view, it’s no wonder he wants to cancel NASA’s space program, to divert it from a symbol of American greatness into a more modest public relations program.

Clearly the anticolonial ideology of Barack Obama Sr. goes a long way to explain the actions and policies of his son in the Oval Office. And we can be doubly sure about his father’s influence because those who know Obama well testify to it. His “granny” Sarah Obama (not his real grandmother but one of his grandfather’s other wives) told Newsweek, “I look at him and I see all the same things—he has taken everything from his father. The son is realizing everything the father wanted. The dreams of the father are still alive in the son.”

In his own writings Obama stresses the centrality of his father not only to his beliefs and values but to his very identity. He calls his memoir “the record of a personal, interior journey—a boy’s search for his father and through that search a workable meaning for his life as a black American.” And again, “It was into my father’s image, the black man, son of Africa, that I’d packed all the attributes I sought in myself.” Even though his father was absent for virtually all of his life, Obama writes, “My father’s voice had nevertheless remained untainted, inspiring, rebuking, granting or withholding approval. You do not work hard enough, Barry. You must help in your people’s struggle. Wake up, black man!”

The climax of Obama’s narrative is when he goes to Kenya and weeps at his father’s grave. It is riveting: “When my tears were finally spent,” he writes, “I felt a calmness wash over me. I felt the circle finally close. I realized that who I was, what I cared about, was no longer just a matter of intellect or obligation, no longer a construct of words. I saw that my life in America—the black life, the white life, the sense of abandonment I’d felt as a boy, the frustration and hope I’d witnessed in Chicago—all of it was connected with this small piece of earth an ocean away; connected by more than the accident of a name or the color of my skin. The pain that I felt was my father’s pain.”

In an eerie conclusion, Obama writes that “I sat at my father’s grave and spoke to him through Africa’s red soil.” In a sense, through the earth itself, he communes with his father and receives his father’s spirit. Obama takes on his father’s struggle, not by recovering his body but by embracing his cause. He decides that where Obama Sr. failed, he will succeed. Obama Sr’s hatred of the colonial system becomes Obama Jr’s hatred: his botched attempt to set the world right defines his son’s objective. Through a kind of sacramental rite at the family tomb, the father’s struggle becomes the son’s birthright.

Colonialism today is a dead issue. No one cares about it except the man in the White House. He is the last anticolonial, emerging market economies such as China, India, Chile and Indonesia have solved the problem of backwardness; they are exploiting their labor advantage and growing much faster than the US. If America is going to remain on top, we have to compete in an increasingly tough environment.

But instead of readying us for the challenge, our President is trapped in his father’s time machine. Incredibly, the U.S. is being ruled according to the dreams of a Loyo tribesman of the 1930s. This philandering, inept African socialist, who raged against the world for denying him the realization of his anticolonial ambitions, is now setting the nation’s agenda through the reincarnation of his dreams in his son. The son makes it happen, but he candidly admits he is only living out his father’s dream. The invisible father provides the inspiration, and the son dutifully gets the job done. America today is governed by a ghost.

Dinesh D’Souza, the president of the King’s College in New York City, is the author of the forthcoming book The Roots of Obamam’s Rage (Regnyer Publishing).
in case your computer/monitor made reading the last summary paragraphs hard, here it is again, enlarged x2 because it is so important to understanding the future and the recent

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past. Typically, all goverment sucks... always thinks its job is to continue fighting the last battle all over again. And Obama being a Classic lawyer politician is (?!)just being typical
but his last battle is inherited, not the last battle of OUR government because he is not an American, he is an African - an African tribesman. But for the time, he was not a Bush and he was the perfect color, and had no racial accent, (but was instead really silver tongued) and too many of us have already had enough Clinton for a lifetime. 
So that is how he got elected President so easily. If we took a survey after this revelation about what drives him, I will bet he would lose at least half of that majority he won with, if not more, then we would have Hillary for President now. Dinesh D’Souzas explanation is absolutely terrifying, isn’t it. We don’t have to worry about Osama Bin Laden destroying the United States. We have to worry about Barack Obama (that is so close to Osama isn’t it)destroying the United States. Don’t know which is the biggest threat but don’t care. We have not one but TWO huge guns pointed at all of our heads. What might happen if the two of them realized they have the same common Objective: DESTROY THE UNITED STATES!!!! One externally and other internally, from the inside! Here’s a really frightening thought: what if Osama and Obama discovered their mutual common goal to destroy the United States and Western culture????
BO has no loyalty to his supposed American citizenship, and not to any other country it seems, and his hatred of old colonials starts with England and includes most of the West. That is undeniable plain history. He comes from a culture strong in tribalism but he doesn’t seem to understand what a basic part of man’s genetics, tribalism, and all its aspects is. He seems ready to be the first “citizen” with no allegiance to anybody or anything but himself. Maybe he thinks he is the first citizen of the whole world, of earth? We would even agree with some of his complaints, like about the overcompensation of so many executives and financial people; like all the corruption and injustice that prevails, and poverty and illness....but for many of them (his complaints), he would have to be good and redesign radically homo sapiens, or his brain at least. BO doesn’t even seem to understand, however, the most basic things about human beings, what drives them, and motivates them. He remains truly lost in his own little world.

Now, We are about to turn the calendar page to October, the month of Halloween and especially ghosts so this, the Obama story is very timely!!!

And made even more so by the elections just beyond Halloween. Talk about ghosts!
We note that BO Senior, with 50 year old kids like your editor, must have been born about the same time. But for his anti neocolonialist son to accuse us of colonialism in Iraq and Afghanistan is insanity because they are all such losing not gaining endeavors.

I even found myself, although opposed to his anti colonial ideas, sympathetic to some... After all, my own career was greatly influenced by the 70-90% upper bracket tax rates I faced when I chose academic medicine over private practice. I was positively revolted by the idea that somebody else thought that they had a RIGHT TO OVER HALF of whatever wealth my labor might create. And today I identify myself when necessary on my computer as “gateshater” because twenty years ago, I had a mighty fine D.O.S. called appropriately Dr. DOS, which had back then about 90% of the DOSes we have available today, and watched Bill Gates kill the designer and creator and create in its stead the most unbelievable monopoly in history. Where have our anti-monopoly government regulators been for 20 years? And he still rips me for $ 500 to $ 1000 every year for virtually nothing except tribute to his continued monopoly. (Yes, I know I should have gone Apple a long time ago, but for many years PC was the better and cheaper choice if you couldn’t have Dr. DOS which I continued to use until the internet forced me to go Microsoft. I got crushed in the preceding Betamax war and didn’t want to do that again.

For example, I sure would like to see a REDISTRIBUTION of Bill’s billions. And I can’t believe the smartest investor in the world, Warren Buffet, can’t see through him. They play bridge together all the time. Mrs. Gates probably has (?must have) Warren wound ‘round her little finger. (And that’s just for starters, see next segment!)
To be very “tough love”ish: what about our population overrun. Bill Gates is spending his millions stopping malaria so that fewer children will die and the population overgrowth will be significantly facilitated with your help, Bill. By the way are Mrs Gates’ ovaries running you and your money???? Romano’s Dictum # 29: OK, “Men’s brains are in their testicles” as they say =>, we agree, but women’s brains are in their ovaries. Dictum #30 (=29 cont’d)... With little else to distract them from having more and more kids (while men have cars and sex and golf and money to distract them).

Bill and Warren: How about putting a little of that extra money you guys have so much of, into tackling the world’s number one problem: overpopulation!..... By rewarding parents for not having so many children or something like that, or rewarding single females for not getting pregnant with no husband or man or financial support- sort of an upside down welfare system where the ladies would get financial rewards for not having children???? Yes, you say, but! - they have such overwhelming hormonal demands - but maybe enough money would slow them down a bit, or stop that 50% “accidental” pregnancy rate. Or we could give males financial rewards for not getting their girlfriends pregnant- just give them all flat annual rates!

(My Letter to the Editor of the Summit Daily News, expressing just these same ideas was coincidentally published today as I do final editing here. Perhaps Scott Adams’ Dilbert ignited me last month:)

But back to the coming elections: again and again, Government sucks, and government sucks. It can be relied upon only.... to be in error, to be wrong, to be dishonest, to be stupid or gullible, to be grossly inefficient. Yet ours currently wants to enslave us all through impoverishment from taxes.... Is our own dictator in the making? Already he and his administration are disallowing all public criticisms of the administration, like Castro and Chavez and such others do so well too. In dictatorships, The Freedoms of Speech and Press are reserved for the ruling class only. (see you in Chi Town? -per)