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LETTER TO THE EDITOR

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Reply to "Acute acquired comitant esotropia in the era of the COVID-19 pandemic"

Piotr Loba

Department of Binocular Vision Pathophysiology and Strabismus, Medical University of Lodz, Poland

I would like to thank Dr Ali Nouraeinejad for his letter on increasing prevalence of acute acquired comitant esotropia (AACE), which I read with great interest. However, I feel obliged to comment on the relation of the reported phenomenon with the COVID-19 pandemic.

Acute acquired comitant esotropia that affects children and young adults is a disturbing disease due to its main symptom, which is diplopia. The diagnosis is made upon certain clinical findings which are nonaccommodative esotropia of a similar angle in all gaze directions and no ocular motility impairment. The causes of AACE are rarely associated with cerebral lesions or tumours and are mostly unknown. Burian and Miller [1] described three classic subtypes of the disease: type I (Swan) associated with fusion disruption with transient occlusion; type II (Franceschetti) associated with low hypermetropia but idiopathic in nature; and type III (Bielschowsky) associated with low to moderate myopia, sometimes mimicking divergence insufficiency, with larger esotropia for distance than near.

It is sometimes difficult to make a proper distinction between AACE and decompensated esophoria, which are similar but different entities [2]. The former is characterized by a large angle esotropia, which could not possibly be present in a latent form before the onset of the disease. In contrast, the latter arises from a latent deviation of moderate angle and is not associated with such sudden onset. Here symptoms arise along with increasing near work and fatigue. It also occurs more commonly in patients with low to moderate hyperopia and/or accommodation infacility.

Dr Nouraeinejad suggests that excessive near work and use of mobile phones/smartphones, and other digital screens, during the COVID-19 pandemic is a causative factor of higher prevalence of AACE. Nevertheless, although I concur with the observation that, in this special time, we are encountering more patients with esotropia and diplopia, I would rather classify them as decompensated phoria. My personal observation is that, in most such patients, symptoms arise from intense accommodative effort in the setting of latent strabismus.

DISCLOSURE

The author declares no conflict of interest.

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CORRESPONDING AUTHOR

Univ. Prof. Piotr Loba, PhD, MD, Norbert Barlicki University Teaching Hospital No. 1, 22 dr. Stefana Kopcińskiego St., 90-001 Lodz, Poland, e-mail: ploba@onet.pl