SOMETIMES, THE KEY IS IN THE NORMAL EYE

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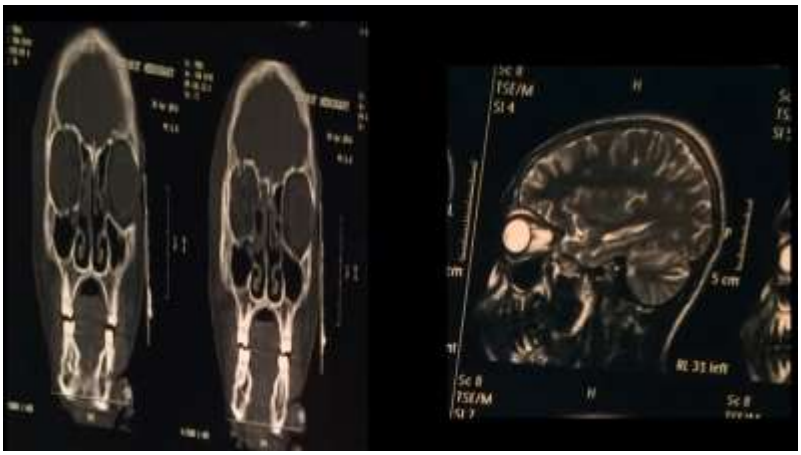
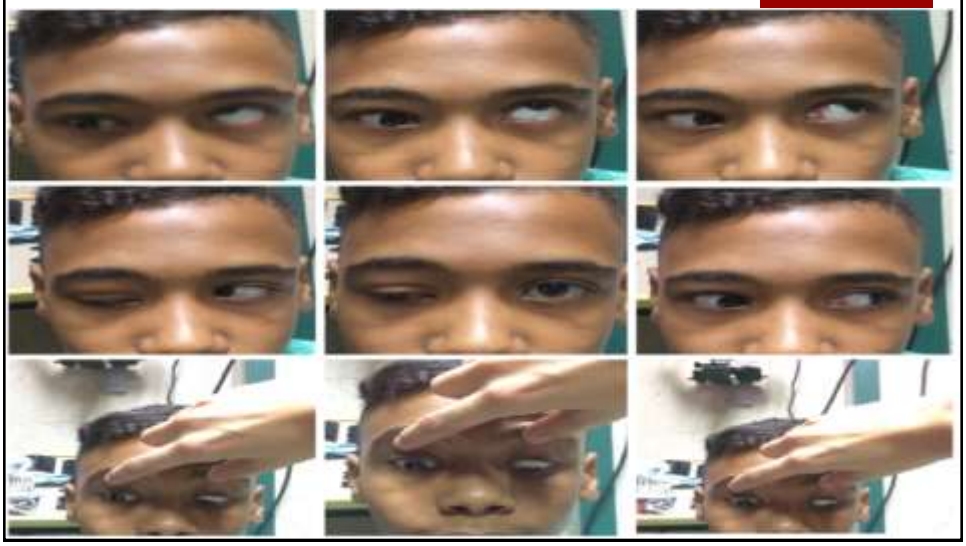
A 15 years old boy presented with:

- H/o of fall from height
- Free survey at the ER
- Rt ptosis
- mid-dilated fixed pupil OD
- RT XT 45 PD, Hypo 15 PD
- VA 2/60 OD
- RT optic atrophy

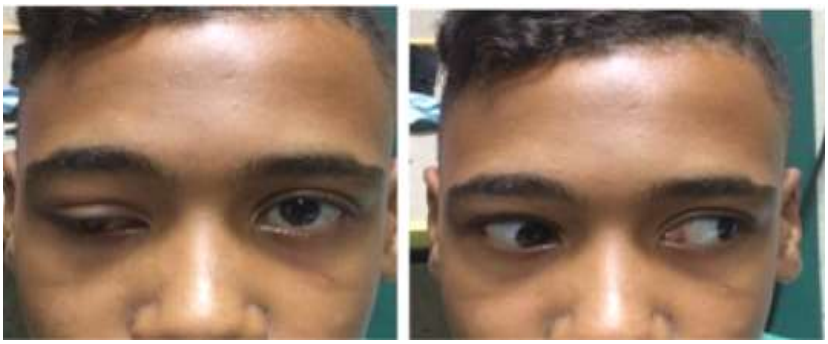
CT AND MRI



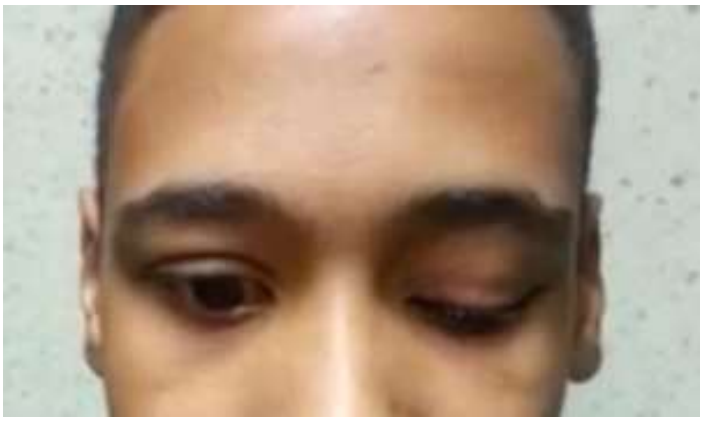
MOTOR EXAMINATION



INVERSE DUANE SIGN



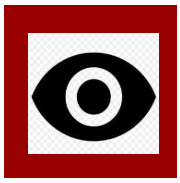
PSEUDO VON-GRAEFE'S SIGN



DIAGNOSIS

- A case of Rt traumatic 3rd nerve palsy with aberrant innervation

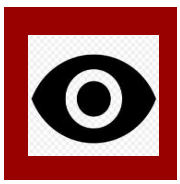
PLAN:



Correct squint first by Rt recess-resect and half tendon upwards transposition or by recess resect and IR recess

Followed by surgical correction of ptosis

BUT



IR– will worsen the cosmetic appearance of the Rt lid lag

The patient will need another surgery for the ptosis

OR!!

Make use of the aberrant innervation

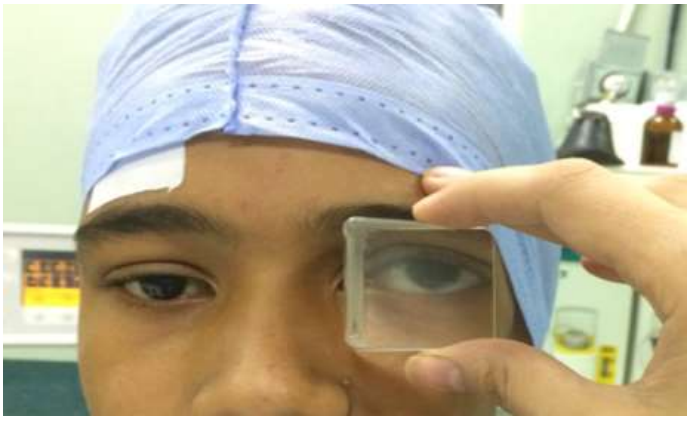
Do a recess- resect procedure primarily or exclusively on the contralateral fixing eye"make the fixing eye esotropic''

The fixing eye will be abducted by the patient to the primary position

Ptotic lid will elevate simultaneously

(Del Monte and Guyton, 1980)

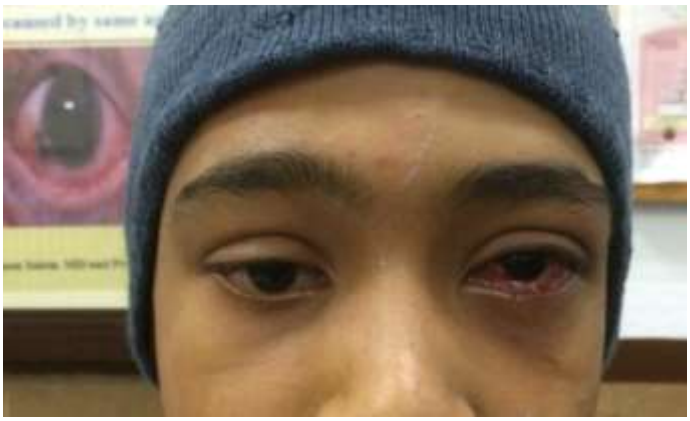
SIMULATION OF POST-OP RESULTS



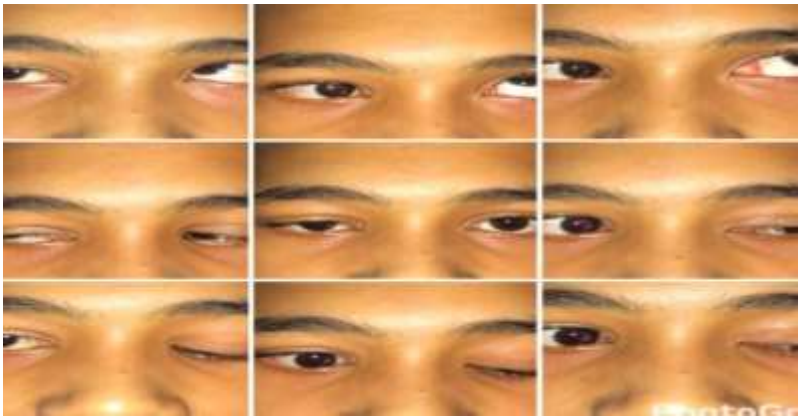
SURGERY

- FDT to IR OD was negative
- Recess-Resect OS with half tendon down transposition

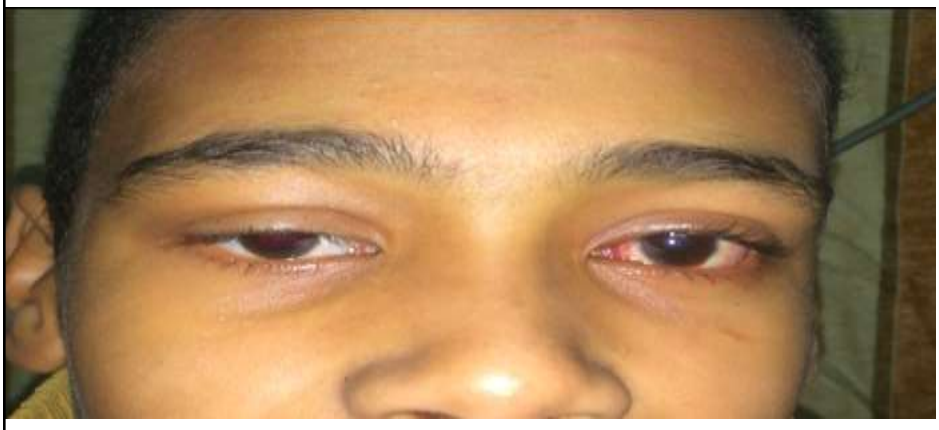
1 DAY POST-OP



1 MONTH POST-OP



3 MONTHS POST-OP



THANK YOU