MIMS III: Five Simple Rules for Treating Pediatric Intermittent Exotropia Strabismus (Correspondence)

*** ORIGINAL SCIENTIFIC ARTICLES ***

AMERI A, JAFARI AK, ANVARI F, AHADZADEGHAN I, and RAJABI MT: A New Modified Anchored Suspension-Recession (So-Called “Hang-Back”) Technique for High Risk Strabismus Surgery.

*** CASE REPORTS ***

KHAWAM E, FAHED D, and KHATIB L: Isolated Inferior Rectus Paresis With Falling Eye Phenomenon of the Contralateral Eye in a Patient with Pineal Tumor. A Case Report

BRAVERMAN RS and ENZENAUER RW: Incidental Detection of Bilateral Corectopia by Photo Screening Leads to the Diagnosis of Multiple Sclerosis. A Case Report

PLUS: News, Editorials, Abstracts, Hyde Park

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Dear Colleagues,

It is our privilege to invite you to the XIth Meeting of the International Strabismological Association to be held in Istanbul, Turkey on 22-25 September 2010.

ISA Meetings that were held every four years since 1986, have provided an opportunity to discuss the most current issues in binocular vision and ocular motility and have attracted general ophthalmologists, strabismologists, paediatric ophthalmologists and orthoptists worldwide.

We are honoured to invite colleagues from all over the world to our country, the land of miracles and boundaries where Hittites met Romans, Christianity met Islam, Europe met Asia and green met blue.

Istanbul, being the only city in the world built on two continents has formed its destiny as an imperial capital for 1600 years. As a consequence of its cultural history and cultural life, Istanbul has been chosen as the “European Capital of Culture” in 2010.

The city bears the characteristics of a link between the East and the West, the past and the present. From the empires of Roman, Byzantine and Ottoman, this metropolis with its rich history and natural beauty, offers a friendly welcome and genuine hospitality. Numerous museums, ancient churches, synagogues, basilicas, mosques, mausoleums, palaces and bazaars are standing today as the pride of all civilizations.

A fascinating social activities programme has been organized to accompany the scientific programme in order to make your stay a more pleasant one.

I am confident that ISA 2010 will provide a rich opportunity for sharing knowledge and experience as well as establishing enduring ties of friendship.

I look forward to welcoming you in Istanbul, at the crossroad of cultures for an unforgettable ISA Meeting.

Prof. Dr. Seyhan B. Özkan
Local Organizer
CALL FOR PAPERS

PRE-AAO PEDIATRIC OPHTHALMOLOGY DAY IN

CHICAGO!

Course Directors – Kenneth W. Wright MD, Los Angeles, CA

Marilyn Mets, MD, Chicago, IL

The Wright Foundation and Children’s Memorial Hospital are co-hosting a one-day pediatric ophthalmology and strabismus meeting on Friday, October 15, 2010, at Children's Memorial Hospital prior to the annual meeting of the American Academy of Ophthalmology (AAO). This is a call for papers, including interesting cases, research topics, short surgical videos and new innovations. We are looking for what’s new, interesting and challenging in pediatric ophthalmology and strabismus.

Approximately 6 hours of CME will be offered. Meeting registration fee is $150.00 ($75.00 for residents and fellows) Pay by check to Wright Foundation or email credit card info - Name, Card Number, Expiration Date, and card type. (The Wright Foundation is a 501 (c)(3) non-profit organization).

Please submit papers via email to Gabby Vilhauer, coordinator, at gwilliams34@gmail.com by APRIL 30, 2010.

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ABSTRACT (50 word maximum):

PRESENTATION TYPE: (e.g. case report, clinical research, surgical video)

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Thank you,

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“... the belief that one’s view of reality is the only reality is the most dangerous of all delusions ...”
-Watzlawick, 1976

EDITOR ISSN 1088-6281 FIRST Quarter of 2010
Paul E. Romano, M.D., M.S.O TABLE OF CONTENTS Volume 25, Number 1
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Information for Authors can be found on the web site (binocularvision.net) or by sending an email to perxbvg@colorado.net and a PDF copy will be sent to you.

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Noteworthies: (from the “Washington Report” of the AAO.)

The Bureau of Labor Statistics has created three specific classifications under a new dedicated “Ophthalmic Medical Technician” category that replaces the ambiguous “Other Healthcare Support Occupations” category. The new category, which includes certified ophthalmic assistant, certified ophthalmic technician, and certified ophthalmic medical technologists, heightens the career’s visibility and should help with recruitment of qualified, trained ophthalmic medical technicians. The Academy expressed support for the changes, noting the unique skills, knowledge and experience needed for ophthalmology office personnel.

Meeting Announcements

**Ann Arbor, Michigan.** April 23-24, 2010. Spring Conference at the new W.K. Kellogg Eye Center. Contact: Steven Archer, MD, Fax: 734-936-2340. sarcher@umich.edu


**Chicago, Illinois.** October 15, 2010. Pre-AAO Pediatric Ophthalmology Day. Children’s Memorial Hospital. Contact: Gabby Wilhauer, Coordinator: gwilliams34@gmail.com


**Tuscon, Arizona.** March 16, 2010. Brian Stidham Memorial Lecture. Speaker: Kristina Tarczy-Hornoch, MD, PhD from the University of Southern California and the LA Children’s Hospital. She will be discussing the perils of untreated hyperopia.

**Bangalore, India** January 14-16, 2011 ISGEDR [International Society for Genetic Eye Disease]. More information to come. Contact: Sandy Wong, Cleveland Clinic Foundation. Tel: 216-444-4363

**Geneva, Switzerland** June 4-7, 2011


Interested participants should contact Michael X. Repka, MD mrepka@jhmi.edu

Career Opportunities

**Tuscon, Arizona.** Academic Pediatric Ophthalmology. Join a top hospital serving to provide education, research and service throughout the Southwest. Contact: Yvonne Sheller, Physician Advisory Division and reference PO5482. Tel. 877-468-5577 (toll free). Email: ysheller@tlrec.com

Arnall Patz 1920-2010

It isn’t often that M.D.s are “remembered” in this journal (the WSJ), much less eye docs or major contributors to science, but (continued next page)
Five Simple Rules for Treating Pediatric Intermittent Exotropia Strabismus

To the Editor:

Attached (Next page, below or right) is a handout for a presentation I gave at the Texas Society for Pediatric Ophthalmology and Strabismus (TSPOS) in Dallas, Texas. This was a one page handout printed on the back page of a copy of a paper published by two of the members of the audience (David R. Stager, Sr. MD, and David R. Weakley, MD) with the original inspiration provided by another member of the audience, Monte Stavis, MD. At the 1988 meeting of the TSPOS, Stavis presented a series of 33 cases for whom he had recessed one LR 8 or 9 mm with a very high success rate. This inspired the Stager group to adopt this approach, and by 1992, they had enough data for a really good paper: Weakley DR, Stager DR. Unilateral lateral rectus recessions in exotropia. Ophthalmic Surg 1993; 24: 458-460. There did seem to be a consensus at the meeting that this was the approach that most of the members were using.

James L. Mims III, M.D.

(continued from prior page, Arnall Patz 1920-2010) Arnall is so honored in death as the man who “helped solve the riddle of how 10,000 babies went blind” (article by Stephen Miller).

[Correction: “helped”? What’s your problem, Stephen, do delete that unnecessary adjective!]

“A native of rural Georgia, Dr. Patz attended the Emory School of Medicine” in Atlanta.”

It is worth revisiting his breakthrough as described in this “remembrance”. In the 1950’s, Arnall was a resident physician ophthalmologist at Washington D.C.’s Gallinger Municipal Hospital (where this editor’s mother got her nurses training a quarter century prior to Arnall and where, as it became D.C. General Hospital, a decade after Arnall, in the 60’s, this editor, as another ophthalmology resident, received his initial training in strabismus surgery from Ed Raab, a fellow with Marshall Park’s pediatric ophthalmology fellowship program).

We are not informed as to what the inspiration for Arnall was that oxygen, or too much of it, was the problem causing retrolental fibroplasia, all sorts of iatrogenic causes were considered, but he tried to get a grant to study the possibility in laboratory animals. But he couldn’t get a grant to do it. So he borrowed the money from his family. He demonstrated his hypothesis was correct in opossums, rats and kittens (probably not even possible today?). Then he went on to human babies. Ditto.(and ditto.) “A wider study confirmed his results and was announced in 1954.”

“Just two years afterwards... Dr. Patz, and another researcher, Everett Kinsey, who performed the wider study, were given the Lasker award for clinical research.” At the award ceremony (pictured), Patz related later, his fellow icon and awardeer, Helen Keller, “seemed nervous”. “She kept feeling the inscribed nameplate on the statuette. After she handed it to Dr. Patz, he realized why: Someone had given her Dr. Jonas Salk’s statuette instead of Dr. Patz’s. (Email:remembrances@wsj.com)
Five Simple Rules for Treating Pediatric Intermittent Exotropia Strabismus

By James L. Mims III, M.D.

1. **Remember the basics, including Donders.** Eliminate unnecessary hyperopic correction; maximize myopic correction. Treat especially anisometric amblyopia vigorously.

2. **Recess one lateral rectus 9 mm for distance or near target angle of less than 22 XT.** Wait until age one year to recess one LR 9 mm for infantile exotropes.

3. **Encourage early referral by Pediatricians; perform surgery promptly.** Teach the Pediatricians to refer on the basis of parental observations and comments, frequently long before the Pediatrician can confirm the XT by his/her own observations. [*Teach pediatricians that parents, especially mom, are ALWAYS right when it comes to detecting ocular abnormalities and binocular misalignments. Refer on maternal complaint alone. Don’t even challenge her. -Ed]*

4. **Use Korean protocol for basic deviations.** The Koreans define a basic deviation as having more than 9 X at near and/or a near deviation (phoria or tropia) more than 50% of the size of the distance deviation. Dosage: 25XT 7.5mm, 30XT 8.5 mm, 35XT 9.5 mm, 40 XT 10.5 (all: bilateral recess LROU)

5. **Use alternate day patching for patchable 3 to 5 - year - olds to convert 50% to divergence excess pattern.** The divergence excess pattern has a better prognosis for cure with one surgery. (Mims III JL, Wood RC. The Effect of Preoperative Alternate Day Patching on Surgical Results in Intermittent Exotropia: A Retrospective Study of 66 Cases. Binocular Vision Quarterly 1990;5:189-195.)

**Really Useful References**


[The famous papers by Burton Kushner MD are not listed above; he has told me that in recent years he tended to favor the Korean approach rather than recess-resect. Also, I personally have not seen any patients with high AC/A overcorrections.]

James L. Mims III, M.D.
San Antonio, Texas
jameslmimiii@earthlink.net
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A History of this scientific periodical, Binocular Vision & Strabismus Quarterly. A Celebration of Our 24th Anniversary, Starting our 25th year

The year was 1984. Parks’ sub-specialty of pediatric ophthalmology, which had absorbed the previously free standing, but much less marketable subspecialty of ocular motility/strabology, in the United States, for sure, was growing rapidly. This was the era before managed care intruded. It was the very last of the good years to be a physician and/or an academician.

Our sole specialty periodical was the Journal of Pediatric Ophthalmology and Strabismus which had been founded as the Journal of Pediatric Ophthalmology (only) by Editor Samuel V. Abraham in 1964 (the very first year your Editor started his ophthalmology training!). With the advent of the American Association for Pediatric Ophthalmology (and [later] strabismus) in the early ‘70s, it was now fully owned by its New Jersey publisher, Slack. With the requirement of submission of all papers from the annual AAPOS meetings, the waiting time in 1984 for publication of an article in the JPOS was two and a half years! Even though the journal was subsidized by the AAPOS, Slack would not enlarge the journal enough or even at all to handle this demand, in spite of significant profits from the journal. No solution to this dilemma was apparent from Slack, or elsewhere.

At that time your founding editor (FE) was running the Pediatric Ophthalmology and Strabismus Service at the University of Florida in Gainesville. Another member of the faculty there, Frank Pollack, who ran the Cornea Service, had recently started a new journal entitled "Cornea" with the help of the American, New York, arm of the French publisher, Masson. At a departmental party at his home, he proudly showed us his new computer and office for running his journal. Realizing that our subspecialty could certainly use some help with regard to publishing that backlog of 2½ years for the JPOS, we mentioned our problem to Pollack. He said he was in charge of the eye journals. Pierre said they were very interested in another eye subspecialty periodical. We agreed on undertaking the job of assembling an Editorial Board and soliciting articles as the first Editor. It didn't take long to put together an outstanding, large, international Editorial Board. Alberto Ciancia and Joseph Lang were especially helpful. Everyone agreed it was a good idea. Only my old mentors refused an invitation to join the Ed Board! (I guess taking a job working for a former student is not a high priority!) They still thought it was a good idea. Excellent scientific articles were quickly volunteered by many Ed Board members. We started putting the first issue together with the help of Alvin Fayman who was to be our production manager at Masson.

Only one person in our professional community objected to BVQ, because he thought we were already publishing enough articles about strabismus and he didn't want to read any more. He wrote to our entire professional community in an effort to stop our efforts, but no one seconded his singular sentiments.

We titled the journal "Binocular Vision" because BV is what the study and treatment of strabismus is really all about. “BV” is also the first term of the title of our mentor von Noorden's esteemed textbook "Bible", so it had to be OK. "BV", we intended, would compliment and fit in with the "JPOS", both literally and figuratively. It would not sound like a direct competitive threat - which too many of our associates were all too ready to assume anyway.

To be sure, we further staked out our strabology area by adding as a subtitle "eye movements, strabismus, and amblyopia".

We called it a "quarterly", because that was our intended publication schedule for starting, and because we think the name of a periodical, when it takes a common term for a title, needs to have another word in the title so the periodical is not confused with, and does not have to be additionally separated from, the clinical item; (i.e., when you refer to periodicals like Ophthalmology or Retina or Cornea, don't you often find yourself adding, "the journal" so your listener knows that you are referring to a periodical and not to a piece of anatomy or a science? But "journal" is only French for "daily", so we called it "Quarterly" which it truly is).

In early 1985 as the first issue was about to go to press, in April, Masson suddenly decided to close its American branch and sell all of its scientific periodicals, "lock, stock and barrel", to Raven Press in New York. (We suddenly felt like a professional athlete getting "traded" without choice or input.) The President/owner of Raven Press, Dr. Alan Edelson, PhD, invited us to journey to their New York offices to discuss the future of BVQ with him.

On arrival, Edelson first told us that Tom France, then President of the AAPOS, had just visited him only the day before seeking a publisher to replace Slack, who would not permit the needed expansion of the JPOS.

Edelson suggested that France and the AAPOS and we could and should combine the two publications into one Raven publication.

Tom and I presented this idea to both of our Editorial Boards. But our board members were most enthusiastic about having a separate journal devoted specifically to strabismus and binocular vision and only by remaining separate could we do so. Nor did sharing their journal with us go over very well with Tom France, the JPOS Editorial staff, or the AAPOS.

That left Dr. Edelson and Raven with just us, BVQ.
Edelson said that BVQ did not justify his efforts financially. Since BVQ had not even printed its first issue yet, Edelson felt no obligation to me, BVQ, or its Editorial Board members. Therefore, he said, that he would not publish BVQ but rather would simply abandon/cancel BVQ and just let us die, evaporate or whatever.

Neither I nor our Editorial Board liked that at all. After further discussions Dr. Edelson agreed to "give" the ownership and rights to BVQ to your FE. He said we could try to publish it ourselves, on our own. We had to contractually agree to do it all by ourselves and not seek or use the assistance of, or sell BVQ to, any (other) publishing house for at least five years.

So we became owner, publisher and Editor.

The first major hurdle was to get the OK of our boss, the University of Florida Ophthalmology Professor and Chairman who was himself!, with his wife, a medical publisher (Triad Publishing, Gainesville). Fortunately, our non compete contract with Raven would not allow him to require that BVQ be published by his company, Triad.

We found a local printer in town, Ewing Press, who printed the football programs for the University of Florida football program, (Go Gators!) and with the help of a free lance local typesetter we set about publishing the journal. Your FE did the old cut and paste wax layout routine, [Can you remember that?!) The first issue was actually completed, printed and mailed out near the end of 1985. Volume 1 was initially called "1985" because we still had high hopes of printed and mailed out near the end of 1985. Volume 1 was actually completed, printed and mailed out near the end of 1985. Volume 1 was initially called "1985" because we still had high hopes of somehow making that year our first full year of publication. However, that was not to be and the first full year of the journal was actually 1986, denoted Vol. 1, "1985-1986".

Within that first year we were also to have the first of many recurring changes with printers. Ewing Press was bought out by another local printer, Marsh, and we had to break in another set of layout, typesetters and press operators.

Volume 2 was then calendar year 1987. In 1988 (Volume 3), half way through it our printer, Mr. Marsh, passed away and the firm closed down. We then went to our third local Gainesville printer in three years, Storter.

In early 1989, after leaving UF, and thanks to computers we took over in house production of BVQ. Fortunately, "desktop publishing" on computers had just reached the point where one did not have to be a computer engineer-whiz to do it.

So we plunged in full time, purchasing a 286-121 desktop (for about $1800!) and an HP Laser Printer (for another $1400!), which, believe it or not, has just been retired after 14 years of service although it has required repair from time to time. Unbelievably! that printer also had about 100,000 road miles on it as we trucked it back and forth between Florida and Colorado every 3 months for five years (until we moved here in 1995). We certainly have seen a number of computers (?12+) come and go, and almost as many copy and fax machines as well during this same 14 year period. But we still use our original word processing software WordPerfect 5.0 because that is all we needed then and now.

Your FE, because of his ancient artistic bent, (alternate careers at one point were architecture and industrial or automotive design) continued as the layout man and became also the typesetter while his "better half" became chief typist as well as both the managing editor and the business manager, which included doing just about everything else except the printing. She is in fact really "the publisher."

We learned a lot and fast. In those days, it took two months of our time, truly full time, both of us, to turn out each issue. That gave us a few weeks to breath and catch up on other things in between issues. (We have gotten a lot quicker at it, but it still takes the better part of a month.)

At the end of 1989, Storter decided they suddenly needed a lot more of our money just to print the journal since we were no longer paying them for layout and typesetting. So we searched for another printer which we finally found down in Kissimmee, (near Orlando), Cody Publications, who was at that time all periodicals. They were great, printing 50 or 60 commercial publications

Also that Spring, on recommendation, we traveled to Washington DC to personally talk to the people at the National Library of Medicine about getting into Index Medicus. It was already longer that we thought it should have been but we were soon to find our expectations not rapidly fulfilled. Nor did our visit to NIH seem to help at all, in spite of our attempt to play Washington politics.

Maybe, we thought, a more impressive title would help, so we became Binocular Vision & Eye Muscle Surgery thinking that "surgery" in the title might be a key to entry to the NLM as we could claim to be the only journal devoted to strabimusurgery.

Just a year later, in 1991, Mr. Cody retired and closed his printing business. One of his salesmen, a Mr. Willis, opened his own company and tried to service Cody's customers. However, as good as he was as a salesman, he was not a good printer's agent and after a couple of difficult issues, we again sought printing elsewhere.

This time we found it in the F.M.A., the Florida Medical Association. We turned to their printer in Jacksonville. Century Press. They did a nice job on the monthly Florida Medical Journal and they did a nice job for us. But once again, after just a few good years, the Florida Medical Association, which had created Century Press to print their journal, closed it and turned the printing over to a foreign printer. [early out-sourcing!] Some employees at Century, who had been most helpful to us, found themselves new printing jobs....
and us too a new, and our current, printer in Jacksonville, Economy Printing. We have been with them ever since even though we are now retired to Colorado. Fed Ex and UPS and faxes make it easy.

In 1995, following the introduction of a European journal entitled simply Strabismus two years earlier, our Board felt we should change our name replacing the "Surgery" in our title to become what we still are today, Binocular Vision and Strabismus Quarterly. We also finally officially retired from Florida and clinical practice, to the Rocky Mountains.

The last major chapter in our history to date, was our admission, finally, after 14 years, to Medline and Index Medicus in the middle of 1998. This was followed immediately by admission to Excerpta Medica and EM Base. This was at least largely the result of the good offices of BV&SQ Editorial Board members Larry Tychsen and David Guyton.

[For the most complete index, however, of what has appeared in BVQ over the past 17 years, including the dozen before we made the NLM grade we still compose and publish our own Index Binoculus. We shall continue to do so because the NLM is only interested in indexing scientific articles, and only according to the relatively general (for us) MESH keywords. A great deal of the material in BVQ such as meeting reports, book reviews, news, and editorial followup type material is therefore not NLM indexed. Index Binoculus also indexes scientific articles with more detailed and specific terms than MESH, facilitating your retrieval of information.]

Last year in the first issue of 2002, we updated and wrote here:

"Now in 2002, we enter yet another phase. A combination of events has contributed:
1. This "mom and pop" operation, successful for 17 years, is finding it harder and harder to keep up with the latest advances in the use of computers, (no thanks to Bill [the fraud] Gates) and the new on line services provided by large publishers.
2. There have been in the last two years, several exciting medical problems for your editor, which have left him unimpaired but which have made him realize that he's not going to be around forever, and it is time to look for a permanent home for BV&SQ, while I am still able to do so.
3. The journal has enjoyed cooperative efforts of co-promotion with Swets & Zeitlinger, the Dutch publisher of Strabismus. Now they are interested in merging the two journals in the near future.

Keep being a subscriber, but keep tuned for future events!

(Continued)

Update 2003: Well, it (2002) was an exciting year but it didn't turn out quite as we had intended or hoped. We have
described some of those happenings already in these pages [See BV&S 17(2):76 and 17(4):278]

1. Long time Charter Editorial Board member and [former] friend Carlos Souza-Dias, as outgoing Prexy of the ISA, cleverly blocked our well planned proposal for this journal to become the permanent ISA journal because he thought $49 a year for one merged journal which combined two journals currently costing $84 + $126 = $210 per year - that this was a not an affordable price for ISA members, who were already being taxed about $75 per person per year to pay for fellowships for non ISA members!

2. John Martin, the new head of Publisher Swets and Zeitlinger had so much trouble managing Huibert Simonsz, the Editor of his S&Z "Strabismus" Journal, that he changed his mind and upped (insisted upon) his requirement to total 100% Editorial control of the merged journal, in spite of the fact that nowhere in the scientific publishing world is this done by anyone. No M.D. was happy with that.

3. The S&Z Board, in spite of the fact that they would more than double or triple their profit by buying BV&SQ, reneged totally on previously discussed offers for BV&SQ. They limited their offer to initially only one sixth and then finally to only one third of what they had offered in preliminary discussions. I had been warned of Dutch businessmen but this was the biggest fraud that this publisher has ever been subjected to by anyone. [P.S. except Bill Gates, of course]

Some unintended consequences of these events were enumerated in last issue's lead editorial. Chief among these is Editor Burt Kushner, after 17 years and 68 cases of his superb strabismus "Grand Rounds", deciding to move on to other major projects since he too has not yet found the fountain of youth, and after almost two decades wishes to move on to other projects. We plan to publish in a book, all 68 of these articles.

Fortunately your Editor in Chief's repaired mitral valve is doing OK, and his ventricular tachycardia has not returned, and his retinas remain attached, so we can continue on for the present as we were. Thanks to a peculiar accommodation of one of our variable annuity investments, when I do finally kick the bucket, there will be enough bread available to set up a foundation to support an independent BV & SQ permanently.

In the meantime we are refreshing the Editorial Board with some new and younger faces, whom we hope will help to see that the foundation does its job, forever.

Revised and updated 2003; 18(1):4-6

Update BV&SQ 2005; 20(1): 4-6

Since the last printing of this history two years ago, with the help of Marcia Youngdahl, owner of our local print shop, we did get that book of Burt Kushner's 68 editions of his Grand Rounds published last year. We were all quite happy with the way it turned out. We did the best we could to copy the gorgeous cover style of Jean Paul Wayenborgh's History of Ophthalmology, but in a rich red rather than his royal blue.

Everything else continues unchanged in the lives of your FE and his publisher-orthoptist-wife. She put out Burt's book virtually single handed last year. [P.S. But who would have thought that Slack would continue publishing the JPOS, or that so many AAPOS members would be so willing to help them do so considering how poorly they treated the AAPOS and its membership for all those years? Who would have thought we could have not just one but FOUR scientific periodicals servicing our subspecialty — and surviving?]

Amazingly this is our twentieth volume and our twentieth year of publication. We plan to celebrate the completion of our twentieth year during the annual AAPOS meeting about this time next year, which will be held just five miles from our home and offices, up the road at the Keystone ski resort.

Update 2007 BV&S 22(1)

That 2006 AAPOS meeting next door was most successful but our 9500 foot altitude was not well tolerated by too many participants (see Dr. Mims III's report published in our pages in the Q2 summer issue page 102) so a repeat is not likely. There are, however, many good ski resorts available in the more comfortable 8000 or so foot range like our neighbor Vail.

At that meeting I found out that our recent myopia collaborator-contributor Michael Chiang was limiting his periodical subscriptions to those available on the internet. That did start us thinking about what you see culminating, thanks to a host of factors, including many advantages, in this first issue for 2007 conversion to an electronic internet version (see Editorial in 22(1), pages 15-16).

Update 2008 BV&S 23(1)
Conversion exceeded our expectations in many ways: very well received by virtually all subscribers but Bill Gates requires us to contribute two or three times as much time to editing, typesetting, proofing of BV&SQ than our old semi-cut and paste. That includes upgrading our know-how from 1987 WP 5.0 to MS Office, WP 10.0, Adobe PDFs, etc. Thank God we are retired so we could work FT for a year+ on it !!

Update 2009, 2010 BV&S 24(1), 25(1)
Onward, Unchanged! -PER, gateshater
The Hard Truth About the Future of America: Our Last Personal Freedoms are About to be Lost.

[Condensed - per]

Guest Editorial: The ObamaCare Crossroads

ROBERT THOMSON, Editor-in-Chief

“With the House’s climactic vote on ObamaCare tomorrow, Democrats are on the cusp of a profound and historic mistake ... Everyone is preoccupied now with the politics, but ultimately at stake on Sunday is the kind of country America will be. The consequences of this bill will not only be destructive for the health care system and the country’s fiscal condition, though those will be bad enough. Inextricably bound up in a plan as far reaching and ambitious as ObamaCare are also larger questions about the role of government, the dynamism of American enterprise and the nature of a free society. Above everything else, this explains why Democrats have had such trouble convincing the public, let alone their own Members.

Most acutely in the balance is the future of U.S. medicine ... we reprint a 1996 essay by the great Milton Friedman ... Drawing from Alexander Solzhenitsyn’s novel ‘The Cancer Ward’, [Friedman] the late Nobel laureate, traces the ways that national health care fundamentally alters ‘the consensual relation between the patient and the physician.’

In our world of infinite wants but finite resources, there are only two ways to allocate any good or service: either through prices and the choices of millions of individuals, or through central government planning and political discretion. This choice is inexorable. Stripped of its romantic illusions, ObamaCare is really about who commands the country’s medical resources. It vastly accelerates the march toward a totally state-driven system, in contrast to reforms that would fix today’s distorted status quo by putting consumers in control, ... the country arrived at our current pass, starting with the World War II era decision to offer tax subsidies for employer-sponsored coverage only. Like the company store, this inefficient and inequitable preference encourages workers to be paid in kind rather than cash ... this third party payer system it entrenched has inhibited competition and desensitized patients to the costs of their own care. ... [In] 1965, creation of Medicare for seniors and Medicaid for the poor, government has [forced the] shaping the way care is paid for and provided.

Naturally the result has been high and rising costs. Since 1962, the share of health care has risen to about 17% from 6%. ... A ‘universal’ system has been the core liberal aspiration since the age of Bismarck. But time and again this political ambition been thwarted by American individualism, distrust of government power, the check s and balances of the political system, and, every so often, good judgment in Washington.

[Now] Once the health care markets are put through Mr. Obama’s de facto nationalization, costs will further explode. ... Soon the public will reach its taxing limit, and then something will have to give on the care side. In short, medicine will be rationed by politics. ... As the Western European and Canadian welfare states, doctors, hospitals, and insurance companies will over time become public utilities. Government will set the cost minded priorities and determine what kinds of treatment options patients are allowed to receive. Medicare’s price controls will [continue to be] exported to [any] remnants of the private sector.

All bureaucratized systems also restrict access to specialists and surgeries, leading to shortages and delays of months or years. This will be especially the case for the elderly and grievously ill, and for innovation in procedures, technologies and pharmaceuticals. Eventually, quality and choice - the best attributes of American medicine in spite of its dysfunctions - will severely decline. ... [There will be death panels.] ...

Overall federal spending is already at 25% of GDP and heading north, and Medicare’s unfunded liabilities are roughly two and a half times larger than the entire U.S. economy in 2008. The ObamaCare bill already contains one of the largest tax increases outside the Great Depression or the world was, including a major new tax on investment income - and no one seriously believes it will be enough.

So a vote for ObamaCare is also a vote against the vitality of American capitalism. Business elites have mostly held their tongues, or calculated that they can later dump their health care liabilities on the government. Yet ObamaCare will lead to much higher levels of taxation across society [including a new VAT] The tax wedge - the share of labor costs that never reaches workers but instead goes straight to government - will start flying towards the 50% that prevails today in most of Europe. ... [from our current] 30%.

A self-governing democracy can of course decide that it wants to become this kind of super welfare state. But ... Americans want no such thing. There is no polling majority or any bipartisan support, much less a rough national consensus, for this expansion of government power. The election of Scott Brown in Massachusetts for Ted Kennedy’s seat, of all things, was as direct a referendum as you could have.

So if the health bill passes in the House, it will only do so [100%] with a narrow partisan majority, abetted by political bribery and intimidation, budget gimmicks and procedural deceptions. An entitleent the country can’t afford and doesn’t want may pass because of sheer ideological willfulness. The ugliness of the bill, and of its passage, means that some or all of it might be repealable, but far better not to make the tragic mistake in the first place.
EDITORIAL: Future of Medicine and the Profession; Universal Serotonin Addiction? Exotropia Five Rules; Safer Strabismus Surgery; Pinealoma; MS Corectopia

The Real Crisis

The real crisis in U.S. healthcare is the U.S. Congress and the new president, isn’t it. As I write this on the Ides of March, they are about to shove thru a 50% reconciliation vote, if they are lucky, of Obama-Pelosi Care, that abomination, that nuclear attack on the medical profession and the entire citizenry.

The status of our profession is clearest from the special extra workshops being offered at the soon to be APOS annual meeting for our subspecialty:

- **A Survival Guide for Managed Care Contracting and Reimbursement -- How to Swim With the Sharks Without Becoming Fish Food.** This workshop, given by Gil Weber, previous Director of Managed Care for the AAO, will include taking an aggressive approach to managed care contracting; dealing with delayed, denied, and downcoded reimbursements; making it harder for payors to manipulate your claims payments; take-backs; out of network services; and non-par status. It is scheduled Wednesday afternoon, April 14, prior to the opening reception. This is offered for a fee of $200.

- **Beyond the Basics - Coding Update for Pediatric Ophthalmologists.** Kevin Corcoran returns to present this symposium on Thursday afternoon, April 15. This is offered for $150.

- **Increasing Physician Income after Health Reform.** Kevin Corcoran will also present this workshop on Thursday afternoon, April 15, at a fee of $150.

In Spite of the fact that the U.S. population has increased by 30% since 1970, and even more since Medicare was passed in the decade prior to that year, it is not the government’s fault that there is a problem paying for medical care, its all our (the medical profession’s) fault. The medical profession has just been too good, too successful, at keeping people from dying sooner, or at all from previously killer diseases like cancer. And things are going to get even worse because it has been found that the profession wasn’t perfect but was still losing people from remediable situations like hospital acquired infections and medication errors! Once we get those problems fixed, which are said to be responsible for 44,000 to 98,000 plus 100,000 deaths per year respectively, then hardly anybody will die anymore, I guess.

Medicine is better but worse, this good medicine is even radically more expensive than it used to be. We are curing cancer much more of the time, but that cost for cancer treatment has doubled in the past two decades! Those radiation machines are so much more accurate and precise but they cost so much more too. Will a robot surgeon cost more or less than a live one?

We published in the last editorial my Medicare bill for an MRI = around $5000, for which the gov’t reimbursed the provider $300! Thank God for Medicare as coughing up the rest would have been brutal. This past week I got educated about more mundane medicine. That MRI showed spinal stenosis and nobody wants to cut on me, so I’ve been getting PT to help me deal with life. I’ve had one one hour initial session and three 45 minute sessions for respectively $868 and $500 each. Medicare paid the provider, the new University of Colorado Hospitals Anshutz outpatient department, spinal services, on the old Fitzsimons Army Hospital grounds east of downtown Denver (with a new Children’s Hospital by far the biggest such I have ever seen), $121 for...
my first visit and we co-paid $30. Thank God for Medicare.

We have only catastrophic insurance from the AAO, $ 25 K deductible, and my dear spouse is still 2 years short of Medicare so we are putting her in a glass box until then. After 40 years the two of us making a living with no kids, it still wouldn’t take much medical care at these list prices to put us in serious financial trouble. That AAO insurance has already been used twice.

But none of this is news to our readership.
The scariest part is that all those so socialistic European medical and financial schemes, based on taxation rates higher than ours, and much softer work than ours, all of which ration care to some extent, are all in severe financial trouble in spite of their attempts to avoid it.

But the biggest part of our current financial troubles- is not the cost of medical care but the huge losses suffered by the whole world with our mortgage bubble - which was the direct results of our government’s actions over a couple of decades to pursue a totally idiotic insane ideal, that everyone should own their own home. Now it is everyone should have medical insurance.

The chief instigator of the mortgage of mortgage disaster has never once recognized any cupidity on his part. He is still in office and powerfully so: Barney Frank. Nor has his party acknowledged their cupidity in any way whatsoever.... So we can only expect more idiotic legislation from the lawyers- our legislators, including the most terrifying lawyer of them all, B.O. not plenty...

Note that they will not accede to any effort to reduce the power of lawyers to intimidate the medical profession, not will they even concede at all to the contribution of tort lawyers to the ever increasing cost of medical care. Furthermore currently we are still going to suffer that 21% SGR cut in Medicare reimbursements it seems- as they refuse to take any action on that little item... and talk about dirty squeeze plays, they have suspended all Medicare payments for professional services “while they consider what to do about that cut in reimbursement” but today March 17, St. Patty’s Day, you have to commit to Medicare for the year or not!

The democrats feel that fee-for-service medicine is the real culprit and must be destroyed, so next, after they have put themselves in a position to control medicine, they will mandate that they wont pay anybody fee for service any more. All will have to work for a salary from a major employer like a hospital even if they won’t be able to pay off their student loans anymore. That is what they did to that computer engineer who crashed his airplane into the IRS Office in Austin Texas a few weeks back. They prosecuted and persecuted him because he kept trying to be an independent contractor which they had simply outlawed! They could just do the very same for M.D.s!

Alternately, follow Massachusetts and Maine: from BUSINESSWEEK July 27, 2009 by Catherine Arnst. Radical Surgery In Massachusetts. To cope with rising health care costs, the state is trying to eliminate the costly fee-for-service system. “... Providers would instead get a yearly fee for each patient, thus eliminating financial incentives to over treat...”[hey that must be the real cause of the crisis: doctors are OVER treating their patients -ed] “...the cost of covering ...residents is wreaking havoc on the state’s finances. ... look no further than neighboring Maine to see what will happen if they don’t act.... Premiums for the state-financed insurance play have risen 74%... Medical providers would cluster into networks of doctors, clinics and hospitals capable of providing for all a patient’s needs.”

So the legal profession will similarly destroy the medical profession financially, and then when they don’t have to worry about M.D.s anymore, they will just hire PAs (Physician Assistants) for a small fraction of the money. By then we should have robot surgeons to replace all the live ones who get such high fees.... And with the medical profession gone, guess who the number 1 profession will be? The legal profession of course, the rulers will rule totally....

We have been offering in our Hyde Park Editorials, tongue only partly in cheek for many years, a section titled “Alternate Careers” (for M.D. s). You may wish to peruse your old issues. If I had to give up retirement guess I would go to law school, like Ed Raab and Joe Alfano did.
But don’t wait too long:

“Poll shocker: Almost 1 in 3 physicians may leave medicine in response to gov’t health care
Wednesday, March 17, 2010
From a survey of physicians conducted by The Medicus Firm in December 2009, and appearing in the latest... New England Journal of Medicine:

"If health reform passes without the public option, 7.4% of physicians stated that they would quit practicing medicine, unless they were nearing retirement, in which case 21.8% said they would retire early, bringing the total loss of physician workforce to nearly one-third of [US]physicians...”

It is just too many people living too long unable to work or just not working anymore (including all those state employees in California who can retire at 50 on 90% or more of their best salary ever.... what a deal!!!) And except for them, not making any real money with which to pay for anything or any taxes. No society can afford them or it... You could confiscate all the wealth in the world and you still couldn’t pay for what is coming in the way of the total cost of health care for the world... China wins! Bill Gates!: maybe you could give back some of all that money you have taken from all of us over the past two decades! That would help...

Editorial Followup

Last year, in these columns (bV24, no.3) we talked about the cause of our political gridlock being due to the natural human drive for dominance, and how unavoidable it is and how impossible breaking that gridlock is.

It is even worse than I thought. Now we think that the drive for dominance is basically chemical and due to the addiction we all have to serotonin!!! read this from my favorite journal:

Of Monkeys and Medals

By Lionel Tiger

Humans are intensely and endlessly interested in status. The Olympics, particularly the medals, reflect a species-wide preoccupation with dominance, pecking order, excellence and failure. The entire pageant would be impossible without the dire contrast between the many, many losers and the few winners waving from the podium that raises them above the crowd.

It’s deep, this desire to be the best. With his colleagues at a primate lab at the UCLA Medical School, neuroscientist Michael McGuire was able to identify the manner in which the high status a monkey enjoyed was accompanied by neurophysiological changes associated with serotonin in the blood. Boss monkeys bubbled with twice as much serotonin in their systems as their subordinates.

This wasn’t a matter of a bio-elite of monkeys born with an extra-brim-ming cupful of this lovely juice. It had to be earned.

When a high-domination individual lost his spot, or was isolated, his blood level of serotonin crashed to be like our primate cousins, competition is in our blood.

My how the norm for the group. And after one or two months a new individual became leader and promptly boasted the gold medal of dominance. Serotonin is linked to drugs such as Prozac, and it seems clear that such medication provides an artificial if agreeable elevation in status. It’s equally clear the entire pageant of Olympic medal seeking rests on a human nature we share with primates and other animals—a white hot focus on hierarchy.

There is no earthly point to all the costly folderol other than delection of dominance. The Olympics are to the spirit of hierarchy what the legendary orgies of Pompeii were to sex. And the ever-full sports pages and 24 hours a day of TV sports are a recurrent demonstration of intense interest in the precise niceties of who’s playing for whom, who’s having a bad or miracle season, who can’t abide his catcher, who confuses water and beer—who will win the pennant next year.

All unbelievable, unless there are glandular energies in our species which turn European soccer games into near-wars and the bizarre spectacle of Olympic curling (grown men sliding stones on ice and frantically brushing the path before them) into something to get excited about.

Mr. Tiger, a professor of anthropology at Rutgers, is the author, with Michael McGuire, of “God’s Brain,” out next week by Prometheus Books.

The Wall Street Journal
Can’t you just see all that serotonin sloshing around inside the beltway in D.C.? When I lived and worked in Washington, D.C. for three years, back in the 60’s, there was an atmosphere in that city, that everything that happened outside of it was totally irrelevant - that only what happened inside the beltway was of any import and everything therein was... and only there. Like a miasma! I think that may have been due to the high levels of serotonin in the air there!

I have been on Prozac, that SSRI, (Selective Serotonin Re-Uptake Inhibitor) for a couple of decades and it does work for my depression. Several times when I needed more help, I doubled the dose, but got no further improvement. I guess you can only inhibit the reuptake of what you already have... You can’t give yourself some extra serotonin with an SSRI pill. Too bad! Wouldn’t that be fun!!!

And in the WSJ yesterday was an erudite opinion article on why we have religion - which says its serotonin again! Religion they say is a largely social function, and we get a lot of serotonin out of these social functions....!!!

IN THIS ISSUE

Five Simple Rules for Treating Pediatric Intermittent Exotropia. Mims III JL. Binocul Vis Strabismus Q 2010; 25:8-9. This is the very essence of the latest group think(ing) on this, otherwise known as THE consensus (very popular in Japan). And when everybody in Texas is doing it this way, you had better look and listen! (Before they secede again.)

This is to reduce the intraoperative risks of strabismus surgery and does just that so we are running out of excuses not to follow their recommendations. Ed Board member David Coats scared us when we heard he was visiting Iraq right after that last election and its attendant rebellion and put-down. But he made it safely, and even evaluated and recommended this paper for our publication - and our editorial board seconded his nomination. It is an excellent scientific study even though a real control group was not possible because of the nature of medical choice. One of those places you cannot follow all the desirable rules for randomized control studies. But they did the next best thing....

Following this good experience, we are going to ask David and Jim Mims to pre-approve (tentatively) for BV publication any good papers they see at AAPOS in Orlando in two weeks as we are not attending ourselves this year and David Hunter, JAPOS editor, has declared the lifting of the former requirement for this year that all AAPOS podium presentations have to be submitted to the JAPOS. We remain an easier route to listing in Pub Med than most other journals in our subspecialty.

Isolated Inferior Rectus Paresis with Falling Eye Phenomenon of the Contralateral Eye in a Patient with Pineal Tumor. A Case Report. Khawam E, Fahed D, Khatib L Binocul Vis Strabismus Q 2010; 25:31-36. Dr.Khawam and associates continue to find singular most interesting cases to report for which we are most appreciative.

Incidental Detection of Bilateral Corectopia by Photo Screening Leads to the Diagnosis of Multiple Sclerosis. A Case Report. Braverman RS, Enzenauer RW. Binocul Vision Strabismus Q 2010; 25:37-39. These authors are now our neighbors, so to speak, at the huge new Children’s Hospital in Aurora, Colorado, an eastern suburb of Denver, part of the relocation of the University of Colorado Health Sciences Center to the old U.S. Army Fitzsimons Hospital campus, famous for caring for our then president Dwight Eisenhower recover from his almost fatal heart attack while in office. When we last visited them we got a tour of where he stayed and ran the country remotely- per
A New Modified Anchored Suspension-Recession (So-Called “Hang-back”) Technique for High Risk Strabismus Surgery

AHMAD AMERI, M.D., ALIREZA K. JAFARI M.D., FARAMARZ ANvari, M.D., IRAJ AHADZADEGHAN M.D., and MOHAMMAD TAHER RAJABI, M.D.

from the Department of Ophthalmology, School of Medicine, Medical Sciences Tehran University, Iran

ABSTRACT: Purpose: To introduce a new method for rectus muscle recession in order to minimize the risk of a lost or slipped muscle and scleral perforation and compare it with the conventional method.

Patients and Methods: In a prospective study between May 2002 and December 2006, 69 patients underwent recession with the modified technique, and 50 patients underwent recession with the conventional method. We compared the results of strabismus surgery in these non-randomized series with esotropia or exotropia treated with conventional surgery with the modified technique surgery. Patients in the modified technique group were high-risk patients that had large angle recession, thin sclera or less exposure surgical field.

Results: Surgical outcomes were not significantly different in the two treatment groups that based on their findings had been classified into four subgroups. No complications such as globe penetration, muscle slippage or lost muscle were observed during the follow up period of 12 months.

Conclusions: It seems that the modified method introduced in this study can reduce the complications and risks involved in conventional and suspension-recession methods and it is safe and effective for muscle recession. It can decrease the risk of globe perforation since the sclera behind the insertion is penetrated only superficially because of anchor suturing to the muscle insertion stump, and the possibility of lost or slipped recessed muscles would be minimized.

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INTRODUCTION

The earliest reference to strabismus surgery was found in 18th century when Johann F. Dieffenbach, a general surgeon who performed myotomy of a medial rectus muscle in a child with esotropia (1). In the 1900s, Jameson (2) recessed a muscle with silk suture and fixed it to the sclera. Since Jameson’s time, different modifications have been adopted to decrease complications and increase the quality of strabismus surgery: Gobin (3) in the 1960s introduced loop recession or suspension method, Jampolsky (4) performed the adjustable technique in the 1970s, Repka & Guyton (5) described their “hang-back procedure” [suspension-recession] in 1987, and Potter III et al (6) modified the method to “hemihangback”. Coats & Paysse (7) used a technique to allow rectus muscle recession and resection without the placement of scleral sutures. They reported no evidence of slipped or lost muscle during 2 months follow up. Although modern instruments and surgical techniques have been advanced, there is still chance of lost or slipped muscle and scleral perforation, which can result in vitreous hemorrhage, retinal detachment, and endophthalmitis. In thin sclera or in situations where a large recession is required, the conventional procedure in which approximately one third of scleral thickness is penetrated for suturing may not be appropriate since globe perforation is possible. On the other hand, suturing to the sclera too superficially, a lost or slipped muscle may ensue.

Modified suspension-recession technique that was described by Macleod et al (8) is essentially the same as the conventional suspension-recession technique, but with an extra superficial partial scleral bite at the point of recession and finally the suture was tied with one double-armed from the insertion.

Here we present a newer version of modified suspension-recession technique. The modified method introduced here was for the first time presented in 14th Congress of the European Society of Ophthalmology, Madrid, Spain, June 7-12, 2003 (10). In the present study, we compared the results of this procedure with conventional recession procedure.

PATIENTS AND METHODS

In a prospective study between May 2002 and December 2006, 69 higher risk strabismus patients underwent recession with the new modified technique, and 50 normal risk patients underwent recession with the conventional method. This study was conducted in accordance with the declaration of Helsinki and was approved by the Ethics Committee of Tehran University of Medical Sciences.

Conventional surgery with direct attachment of the rectus muscle at the standard posterior scleral recession reattachment site was performed on 50 patients. The modified technique surgery was performed on 69 patients with attachment of the rectus muscle to the superficial sclera by tying of the sutures (as in the conventional technique) but then, without cutting...
the sutures, the same needle was passed forward through the muscle insertion stump (Figure 1) and the sutures were tied in a way that the length of the two ends of the sutures exactly corresponded to the required amount of recession in terms of millimeters (Figure 1). Finally, on each side of muscle we have two separate points of tying (one in the point of recession as we do in conventional technique and other on muscle stump that acts as an anchor (Figure 1). In order to ensure the accuracy of the amount of recession, the distance between muscle stump and the muscle fixed to the superficial sclera was measured once again at the end of the operation.

Patients with less surgical exposure, thin sclera, larger preoperative exotropia or esotropia requiring larger recession were included in modified recession group and patients without such factors included in conventional recession group. (Tables 1-2, next page).

All baseline and subsequent examinations were performed by an ophthalmologist. Horizontal deviations were measured at near and distant targets in all subjects, using alternate prism cover test, wearing spectacles if refractive error measured more than 2 D hyperopia, more than 1.25 D myopia, or more than 1.5 D astigmatism. The recorded deviation is the maximal deviation measured under dissociated conditions with prolonged alternate cover test.

The amount of recession or resection performed on all groups was based on the exo- or esotropic deviation at distance, using the same standard surgical dose table in all patients (11).

The primary outcome measure was surgical success, defined as no more than ±10 prism diopters (PD) of binocular misalignment deviation on distant or near measurement, with prolonged alternate cover test under dissociated conditions. Postoperative followup data were recorded 6 weeks after surgery, and at the time of most recent followup.

Baseline and surgical characteristics between the conventional and the modified technique surgical groups were compared using a two-sided t-test for comparison of means, and a $\chi^2$ test for comparison of proportions. Postoperative binocular alignment outcomes were compared using a two-sided Student’s t-test.

RESULTS

One hundred nineteen patients were enrolled in this study, of which 69 patients had the new modified technique surgery and 50 patients had conventional surgery. The
patients were classified into four subgroups based on the surgery that was required and chosen to correct their strabismic deviations based on whether the deviation was esotropic or exotropic and whether the surgery was bilateral or unilateral:

1) bilateral lateral rectus recession to correct exodeviation (Table 1);

2) recession and resection (R&R) in one eye (Table 1) to correct exodeviation;

3) bilateral medial rectus recession to correct esodeviation (Table 2); and

4) recession and resection (R&R) in one eye (Table 2) to correct esodeviation.

A comparison of baseline characteristics is shown in Tables 1 and 2.

The mean baseline deviation at distance and near, and total amount of surgical recession were statistically different between some of these subgroups. Patients undergoing the modified surgical technique had greater baseline deviation at distance and underwent more total recession surgery than those undergoing the conventional technique (Tables 1 and 2).

At 6 weeks followup, the success rate for patients with exotropia or esotropia in 4 subgroups was not statistically significant (Tables 3-4). The mean length of follow-up for the conventional group was 44 weeks, while the modified surgical group was followed for 48 weeks. At the most recent measurement, no statistical differences between the two groups were found for success rates (Tables 3-4).

No major complications were seen in either group. None of the subjects showed any evidence of globe perforation, lost or slipped muscle intra-operatively or in the followup period.

see Tables 1-4 on the following three pages.
Table 1. Comparison of baseline and surgical characteristics between the conventional and new technique in patients undergoing surgery for exotropia

<table>
<thead>
<tr>
<th>Baseline characteristics</th>
<th>Conventional Mean ± SE</th>
<th>new technique Mean ± SE</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1: patients undergoing bilateral rectus recession</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Age (yr)</td>
<td>15.90±15.39</td>
<td>17.84±13.05</td>
<td>0.746</td>
</tr>
<tr>
<td>Gender (Female)</td>
<td>7 (70%)</td>
<td>7 (53.8%)</td>
<td>0.454</td>
</tr>
<tr>
<td>Preoperative exotropia, near (PD)</td>
<td>30.90±6.91</td>
<td>37.46±5.50</td>
<td>0.019</td>
</tr>
<tr>
<td>Preoperative exotropia, distance (PD)</td>
<td>33.80±8.43</td>
<td>42.0±6.23</td>
<td>0.028</td>
</tr>
</tbody>
</table>

| Group 2: patients undergoing R&R for exotropia | | | |
| No | 10 | 8 | |
| Age (yr) | 25.60±19.91 | 15.87±13.13 | 0.253 |
| Gender (Female) | 6 (60%) | 4 (50%) | 0.69 |
| Preoperative exotropia, near (PD) | 29.70±6.92 | 36.37±9.05 | 0.095 |
| Preoperative exotropia, distance (PD) | 31.40±6.63 | 39.12±9.65 | 0.061 |

Table 2. Comparison of baseline and surgical characteristics between the conventional and new technique in patients undergoing surgery for esotropia

<table>
<thead>
<tr>
<th>Baseline characteristics</th>
<th>Conventional Mean ± SE</th>
<th>new technique Mean ± SE</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 3: patients undergoing bilateral medial rectus recession</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Age (yr)</td>
<td>7.92±5.7</td>
<td>8.23±9.03</td>
<td>0.917</td>
</tr>
<tr>
<td>Gender (Female)</td>
<td>5 (38%)</td>
<td>13 (50%)</td>
<td>0.508</td>
</tr>
<tr>
<td>Preoperative esotropia, near (PD)</td>
<td>33.3±8.46</td>
<td>38.88±6.79</td>
<td>0.035</td>
</tr>
<tr>
<td>Preoperative esotropia, distance (PD)</td>
<td>31.38±8.23</td>
<td>36.96±5.1</td>
<td>0.041</td>
</tr>
</tbody>
</table>

| Group 4: patients undergoing R&R for esotropia | | | |
| No | 17 | 22 | |
| Age (yr) | 12.64±7.67 | 15.40±11.66 | 0.404 |
| Gender (Female) | 8 (47%) | 9 (40%) | 0.710 |
| Preoperative esotropia, near (PD) | 35.00±7.33 | 36.00±10.07 | 0.732 |
| Preoperative esotropia, distance (PD) | 32.11±6.65 | 33.27±9.50 | 0.672 |
Table 3. Comparison of surgical outcomes between the conventional and new technique in patients undergoing surgery for exotropia

<table>
<thead>
<tr>
<th></th>
<th>Conventional</th>
<th>new technique</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ± SE</td>
<td>Mean ± SE</td>
<td></td>
</tr>
<tr>
<td><strong>Group 1: patients undergoing bilateral rectus recession</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 weeks postoperative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success N (% Ortho±10 PD)</td>
<td>7 (70%)</td>
<td>10 (76%)</td>
<td>0.56</td>
</tr>
<tr>
<td>Exotropia at near (PD)</td>
<td>8.40±3.09</td>
<td>7.69±3.98</td>
<td>0.648</td>
</tr>
<tr>
<td>Change in exotropia at near (PD)</td>
<td>-22.5±5.58</td>
<td>-30.5±3.86</td>
<td>0.001</td>
</tr>
<tr>
<td>Exotropia at distance (PD)</td>
<td>9.00±2.98</td>
<td>7.84±5.30</td>
<td>0.545</td>
</tr>
<tr>
<td>Change in exotropia at distance (PD)</td>
<td>-24.8±6.17</td>
<td>-33.15±4.52</td>
<td>0.001</td>
</tr>
<tr>
<td>Most recent follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success N (% Ortho±10 PD)</td>
<td>5 (50%)</td>
<td>8 (61%)</td>
<td>0.44</td>
</tr>
<tr>
<td>Exotropia at near (PD)</td>
<td>9.30±2.83</td>
<td>9.30±3.77</td>
<td>0.996</td>
</tr>
<tr>
<td>Change in exotropia at near (PD)</td>
<td>-21.4±4.88</td>
<td>-28.15±4.31</td>
<td>0.002</td>
</tr>
<tr>
<td>Exotropia at distance (PD)</td>
<td>10.1±2.84</td>
<td>9.61±3.45</td>
<td>0.723</td>
</tr>
<tr>
<td>Change in exotropia at distance (PD)</td>
<td>-23.7±6.78</td>
<td>-32.15±5.39</td>
<td>0.003</td>
</tr>
<tr>
<td><strong>Group 2: patients undergoing R&amp;R for exotropia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 weeks postoperative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success N (% Ortho±10 PD)</td>
<td>8 (80%)</td>
<td>6 (75%)</td>
<td>0.76</td>
</tr>
<tr>
<td>Exotropia at near (PD)</td>
<td>6.10±3.07</td>
<td>8.00±3.70</td>
<td>0.251</td>
</tr>
<tr>
<td>Change in exotropia at near (PD)</td>
<td>-23.6±7.74</td>
<td>-28.37±6.43</td>
<td>0.181</td>
</tr>
<tr>
<td>Exotropia at distance (PD)</td>
<td>6.60±5.31</td>
<td>8.50±3.16</td>
<td>0.387</td>
</tr>
<tr>
<td>Change in exotropia at distance (PD)</td>
<td>-24.8±7.36</td>
<td>-29.25±6.94</td>
<td>0.210</td>
</tr>
<tr>
<td>Most recent follow-up</td>
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<td></td>
</tr>
<tr>
<td>Success N (% Ortho±10 PD)</td>
<td>6 (60%)</td>
<td>6 (75%)</td>
<td>0.23</td>
</tr>
<tr>
<td>Exotropia at near (PD)</td>
<td>9.30±3.71</td>
<td>9.12±3.09</td>
<td>0.916</td>
</tr>
<tr>
<td>Change in exotropia at near (PD)</td>
<td>-20.8±6.66</td>
<td>-27.5±6.27</td>
<td>0.045</td>
</tr>
<tr>
<td>Exotropia at distance (PD)</td>
<td>8.90±3.24</td>
<td>9.62±2.92</td>
<td>0.630</td>
</tr>
<tr>
<td>Change in exotropia at distance (PD)</td>
<td>-23.5±6.88</td>
<td>-30.12±8.13</td>
<td>0.079</td>
</tr>
</tbody>
</table>
Table 4. Comparison of surgical outcomes between the conventional and new technique in patients undergoing surgery for esotropia

<table>
<thead>
<tr>
<th></th>
<th>Conventional</th>
<th>new technique</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ± SE</td>
<td>Mean ± SE</td>
<td></td>
</tr>
<tr>
<td>Group 3: patients undergoing bilateral medial rectus recession</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 weeks postoperative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success N (%) Ortho±10 PD</td>
<td>11 (84%)</td>
<td>18 (69%)</td>
<td>0.46</td>
</tr>
<tr>
<td>Esotropia at near (PD)</td>
<td>7.38±2.95</td>
<td>8.73±2.77</td>
<td>0.171</td>
</tr>
<tr>
<td>Change in esotropia at near (PD)</td>
<td>-26.0±6.90</td>
<td>-30.19±5.64</td>
<td>0.035</td>
</tr>
<tr>
<td>Esotropia at distance (PD)</td>
<td>6.15±3.07</td>
<td>7.61±2.72</td>
<td>0.139</td>
</tr>
<tr>
<td>Change in esotropia at distance (PD)</td>
<td>-25.38±6.57</td>
<td>-29.34±5.93</td>
<td>0.066</td>
</tr>
<tr>
<td>Most recent follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success N (%) Ortho±10 PD</td>
<td>10 (76%)</td>
<td>21 (80%)</td>
<td>0.79</td>
</tr>
<tr>
<td>Esotropia at near (PD)</td>
<td>8.53±2.06</td>
<td>8.50±2.21</td>
<td>0.959</td>
</tr>
<tr>
<td>Change in esotropia at near (PD)</td>
<td>-25.07±7.35</td>
<td>-30.38±6.51</td>
<td>0.027</td>
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<tr>
<td>Esotropia at distance (PD)</td>
<td>6.46±3.07</td>
<td>7.80±2.48</td>
<td>0.149</td>
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<tr>
<td>Change in esotropia at distance (PD)</td>
<td>-24.92±7.27</td>
<td>-29.19±6.74</td>
<td>0.078</td>
</tr>
<tr>
<td>Group 4: patients undergoing R&amp;R for esotropia</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6 weeks postoperative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success N (%) Ortho±10 PD</td>
<td>13 (76%)</td>
<td>17 (77%)</td>
<td>0.907</td>
</tr>
<tr>
<td>Esotropia at near (PD)</td>
<td>7.05±3.52</td>
<td>8.31±3.02</td>
<td>0.238</td>
</tr>
<tr>
<td>Change in esotropia at near (PD)</td>
<td>-28.0±5.77</td>
<td>-27.68±7.64</td>
<td>0.887</td>
</tr>
<tr>
<td>Esotropia at distance (PD)</td>
<td>6.88±2.86</td>
<td>8.00±2.20</td>
<td>0.177</td>
</tr>
<tr>
<td>Change in esotropia at distance (PD)</td>
<td>-25.23±5.80</td>
<td>-25.36±7.97</td>
<td>0.956</td>
</tr>
<tr>
<td>Most recent follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Success N (%) Ortho±10 PD</td>
<td>14 (82%)</td>
<td>17 (77%)</td>
<td>0.877</td>
</tr>
<tr>
<td>Esotropia at near (PD)</td>
<td>7.88±2.54</td>
<td>8.54±2.57</td>
<td>0.428</td>
</tr>
<tr>
<td>Change in esotropia at near (PD)</td>
<td>-27.35±5.61</td>
<td>-27.45±9.22</td>
<td>0.968</td>
</tr>
<tr>
<td>Esotropia at distance (PD)</td>
<td>7.82±2.06</td>
<td>8.40±1.59</td>
<td>0.324</td>
</tr>
<tr>
<td>Change in esotropia at distance (PD)</td>
<td>-24.29±5.35</td>
<td>-25.04±8.66</td>
<td>0.755</td>
</tr>
</tbody>
</table>
DISCUSSION

According to Helveston (12), it is better to have a suture bite of 1.5 mm and scleral depth of 0.2 mm, but it cannot be employed in all cases especially where limitations and complications may lead to scleral perforation and associated complications. The chance of perforation increases in high-risk individuals such as patients with thin sclera, multi-layered sclera (induced by repetitive reneedling of the globe intraoperatively), or when there is a restricted field of the operation, therefore some other modifications had to be made to reduce the above complications. Although the advances in the surgical techniques and modern surgical instrumentation have minimized the risk of the scleral perforation from 9-12% to 1-2%, however, perforations are two times more common in hands of residents or fellows and many globe perforations may never be counted or recognized (12-14). Taking less thickness of sclera increases the chance of a lost or slipped muscle and should be avoided. Scleral perforation can result in endophthalmitis, retinal detachment, vitreous hemorrhage, ectopia lentis, glaucoma and finally phthisis bulbi.

The thickness of sclera immediately behind the muscle insertion is the thinnest (0.3 mm) and its thickness increases as we move toward limbus (0.8 mm) or equator (0.4-0.6 mm). At the posterior pole, its thickness varies anywhere between 1.00 mm to 1.36 mm (15). Muscle recession usually takes a course between the equator and muscle insertion where the sclera is thinnest. To avoid above complications, Gobin (3) introduced loop recession as an alternative method. The loop recession differs from the adjustable and suspension-recession techniques in that scleral reattachment is posterior to the original insertion and the muscle is suspended from the posterior attachment site. Gobin’s technique, or recession with a loop increases the effect of a recession without further recession of the scleral reattachment; i.e. beyond 5 or 6 mm. His method, also called suspension-recession, “hang loose”, and loop recession, could be effective to reduce the above complications since sutures are placed through thicker sclera rather than through a thinner part. Suturing also placed anteriorly where the field of operation is more accessible and therefore it is performed with greater ease. The suspension-recession suture is a reliable method to prevent scleral perforation and has been used for high risk patients, however this method is less predictable in patients whom large recession (more than 7.5 mm) is required (16). Success of the suspension-recession method varies: Rajavi et al (17) reported the success rate of 100% for infantile esotropia, 46% for acquired esotropia and 76% for exotropia. Breckenridge et al (18) stated that in one group of patients, 33.3% and in another group 13.4%, needed re-operation after suspension-recession procedure. Repka et al (5) showed a success rate of 74% for the patients who undergo a suspension-recession.

The method introduced here is a blend of conventional recession and methods that came after suspension-recession. It utilizes both the advantages of the suspension-recession method and that of the conventional one, while it does not share their complications particularly when a large recession is necessary. In modified suspension-recession technique that was described by Meleod et al (8), they had an extra superficial partial scleral bite at the point of recession, but did not tie it at that point. Therefore, to our knowledge the risk of sagging or posterior riding is expected. On the other hand, direction of needling in their procedure was radial (parallel to the long axis of globe) (Figure 1) that not only the risk of posterior riding during tying is higher but also performance of such technique in high-risk patients and also the patients that require higher recession with limited field of operation is difficult. In our method, we tied the sutures at the point of recession and then after passing it from muscle stump again it was tied. In fact, the superficial scleral suture (Figure
1) decreases likelihood of globe perforation and holds the muscle in the intended site where the amount of recession is marked. The modified method secures the muscle in 4 points. Therefore, it is expected that the anterior displacement or sagging of the central part, moving to sides or lost/slipped muscle would be virtually absent. The absence of any evidence of slipped or lost muscle supports this argument. This method has advantages of conventional method because the fixation point is marked according to the amount of required recession in millimetre same as conventional method. The muscle would attach to the sclera during adhesion time. On other hand, the new method has the advantages of the suspension-recession since the main suture bite goes through muscle stump where the sclera is very thick and more accessible and therefore suturing is easily done. Our technique has 4 point of security in a square fashion whereas suspension-recession has two in triangular shape.

This method concluded in 1998 and since that time, it has been widely used in strabismus service in Farabi Eye Hospital, Tehran, Iran by ophthalmologists in the field, fellows, and residents. The satisfactory outcome of the method is justified by absence of any scleral perforation, lost/slipped muscle. Usually surgeons try to penetrate 0.2mm of the scleral depth but sometimes this may lead to repeat re-needling of the sclera that makes it multi-layered and consequently increases the chance of muscle lost or slippage. Therefore, it is recommended switching to the new method introduced in this study. The new method is also advised for patients with thin sclera including highly myopic patients, restricted field of the operation in children or difficulty accessing the desired site in large recession (more than 7.5mm).

Finally, the preferred method in any type of surgery is the one with high success rate and minimal complication as results of the present study show. We believe that the new method introduced can decrease the chance of undesirable complications in muscle recession in strabismus surgery. Even though, the conventional method has been widely accepted in most cases, in some situations, muscle recession may be associated with serious complications. We recommend the new technique in individuals with thin sclera, induced multi-layered sclera intra-operatively by re-needling, restricted field of operation in children, stress situated places or persons, and difficulty accessing the desired site where large recession is required. It is also recommended for residents and fellows who are beginners in the field of strabismus surgery. Our study results showed that this modified technique for rectus muscle recession is safe and viable option to the conventional recession technique in high-risk patients. This procedure has not any superiority to conventional technique as our study results showed. In any patient that the conventional method can be performed and risk of complication would be expected to be low, the conventional technique is desired one, but in high-risk patients with application of the technique introduced here, risk of complication would be low and outcome is expected to be similar to conventional technique.

Our study had some limitation: the surgeon "bias" of case selection, the inapplicability and lack of randomization, and the more difficult cases being done with the new modified suspension-recession method. Also limited sample size - because of the further subdivision into four subgroups. Therefore, this paper should be considered a pilot study of these techniques.

The modified technique serves as a promising alternative to the conventional technique for the various theoretical reasons stated in the manuscript, but that further investigation must be employed to demonstrate if there is any superiority of the modified technique.

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Case Report

ISOLATED INFERIOR RECTUS PARESIS WITH FALLING EYE PHENOMENON OF THE CONTRALATERAL EYE IN A PATIENT WITH PINEAL TUMOR: A CASE REPORT

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ABSTRACT: Purpose: To report a patient who developed an isolated inferior rectus paresis due to a pineal gland tumor, to our knowledge never reported before. Our purpose is also to demonstrate that, even in partial and mild inferior rectus muscle paresis, the findings of the inhibitional palsy described by Chavasse and the downshoot of the fellow eye in adduction help determine the diagnosis.

Case Report: A patient with pineal gland tumor demonstrated findings characteristic of unilateral isolated inferior rectus paresis.

Conclusion: Although bilateral sixth nerve paresis and Parinaud’s syndrome are commonly reported in pineal gland tumors; in the presence of an isolated inferior rectus palsy, one should also consider the pineal gland as the causative factor.

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INTRODUCTION

Isolated inferior rectus (IR) paresis has been reported in myasthenia gravis (1), after retrobulbar anesthesia in cataract surgery (2-4), after trauma (5) and after involvement of the nerve fascicles subserving the IR muscle due to brainstem infarcts (5,6). In a group of eight patients reported by Roper-Hall et al (7), the isolated IR paresis was due to presumed migraine in one case, to multiple sclerosis in another patient, and to vascular or undetermined causes in the others. But to the best of our knowledge, isolated IR paresis has not been reported in tumors of the pineal gland. Pineal gland tumors are germinomas, with the main ocular manifestation being signs of increased intracranial pressure, namely papilledema and bilateral sixth cranial nerve involvement. Bilateral palsy of the fourth nerves, defective pupillary reactions, retraction of the upper eyelids, and ptosis are other less common ocular signs encountered in pineal tumors (8). When the midbrain is involved in a pineal gland tumor, there may be palsy of upward conjugate gaze, and/or palsy of downward gaze, first described by Parinaud, and known as Parinaud’s Syndrome (8).

Downshoot, or falling-eye phenomenon

The downshoot or falling-eye phenomenon occurs mainly in oblique anomalies, such as in superior oblique (SO) palsy, in primary overaction of the inferior oblique (IO) muscle, in Duane Syndrome (DS), in overaction-contracture of the SO muscle, and in IR palsy:

SO paresis (SOP):

In SOP, the adducting affected eye sends excessive innervational input to the paretic SO muscle to balance the eye vertically in horizontal gaze, between the weak tonus of the weak SO muscle and its overacting antagonist, the IO muscle. Therefore; by Hering’s law, equal, excessive innervational input goes to the yoke IR muscle of the fellow eye, resulting in the so-called falling-eye phenomenon.

1- Primary overaction of the IO muscle:

On adduction of the eye with IO overaction, there will be an increased innervational input to the SO muscle to balance the eye in a vertically-neutral point. By Hering’s law, an equal, excessive innervational input goes to the yoke IR muscle, resulting in downward deviation or falling-eye of the contralateral eye.

Duane’s Syndrome:

Downshoot (as well as upshoot) of the adducting affected eye in Duane’s Syndrome is commonly encountered (9-11). It is mainly due to severe restrictions as well as anomalous innervation of the lateral rectus (LR) muscle by branches of the third nerve (9,12,13) acting as a leash. In gaze opposite the affected LR muscle, the leash effect results in retraction. But when the LR slips off the crest, the bridle effect of retraction is replaced by a “flip”-effect of upshoot on looking slightly upwards or a “flip”-effect of downshoot on looking slightly downwards[11]. Upshoots and downshoots are the retraction equivalent.

Moreover, in Duane’s Syndrome with upshoot of the affected eye in adduction, when the affected eye fixates in adduction, there is an innervational impulse sent to the depressors of that eye in order to balance the upshoot. Therefore, by Hering’s Law, an equal excessive innervation is sent to the inferior rectus of the fellow eye, resulting in falling of the abducted sound eye.
Overaction/Contracture of the SO muscle:
Overaction of the SO muscle, either primary, or secondary to an IO palsy, is manifested by downshoot of the affected eye in adduction. There is actual shortening of the SO muscle due to a true loss of sarcomeres. The sarcomeres are higher on their length-tension curve, and will pull harder than normal at normal innervation, resulting in depression of the eye in adduction[14].

IR palsy:
The falling-eye phenomenon of the contralateral eye in adduction in the presence of an IR palsy is less known and less described. The mechanism is as follows: in abduction of the affected eye, excessive innervational input is sent to the paretic IR muscle in order to balance that eye vertically. Therefore, a corresponding, equal, excessive innervation goes to the yoke SO muscle via Hering’s law. This increased innervational input to the SO of the contralateral eye in adduction causes downshoot or falling of that eye. Downshoot of our patient in levoversion is well illustrated in Figure 1, right.

Inhibitional palsy of Chavasse:
Inhibitional palsy of the yoke of the antagonist muscle was first described by Chavasse in 1939 as “inhibitional palsy of the contralateral antagonist” (15). The antagonist of a palsied muscle requires less innervation to move the eye in its field of action, since the normal tonus of the palsied muscle is decreased. Consequently, by Hering’s law of equal innervation, the yoke muscle of the antagonist will receive less innervation and will appear underacting. Indeed, the underaction of the right IO muscle of our patient was seen only when the affected left eye fixates in abduction and elevation, but disappeared on duction (Figures 2 and 3, below).
A 14 year-old boy with a 2-year-history of growth arrest, associated with a recent onset of polyuria and polydipsia. The patient then developed headache and diplopia, for which he presented to medical attention. Brain magnetic resonance imaging (MRI) done before the patient presented to us revealed a pineal gland density. The diagnosis was confirmed as pineal germinoma in our institution by a biopsy done in October 2009. The plan of action was to start chemotherapy, followed by radiation therapy. While in the hospital, the patient was advised to occlude his affected eye to relieve his diplopia and was then referred to us. On exam, best corrected visual acuity was 20/20 in both eyes (with +1.00+1.00x90 in both eyes). Both pupils were regular, round and equal. Slit lamp examination of the anterior segment was within normal limits. His motility exam was as follows: he had a -2 limitation of depression of the left eye in abduction (50% of normal). Movements of the horizontal muscles were normal, but on levoversion, there was downshoot of the right eye in adduction (Figure 1). All other ocular movements were within normal limits. His motility exam was as follows: he had a -2 limitation of depression of the left eye in abduction (50% of normal). Movements of the horizontal muscles were normal, but on levoversion, there was downshoot of the right eye in adduction (Figure 1). All other ocular movements were within normal limits. Alternate cover test showed a left hypertropia (LHT) of 10 prism diopters (PD) in primary gaze and in horizontal gazes. The LHT decreased to 3PD in upgaze, and increased to 14 PD in downgaze. When the left eye in abduction looked upward, there was a significant limitation of elevation of the right eye in adduction: -2 right IO muscle (50% of normal) (Figure 2) which disappeared onduction (Figure 3). Bielschowsky head tilt test (BHTT) revealed 7PD LHT on right head tilt and 5PD LHT on left head tilt—a negligible head tilt vertical difference. Double Maddox rod (DMR) test consistently showed 6 degrees of incyclotropia. The diplopia was neutralized with 10PD base down to the left eye. Prism therapy,

![Image of patient's eye](image1)

![Image of patient's eye](image2)

![Image of patient's eye](image3)

**DISCUSSION**

Tumors of the pineal gland, known as pinealomas, are reported to cause bilateral sixth cranial nerve palsy, Parinaud’s syndrome and
papilledema secondary to increased intracranial pressure (8). Our patient shows left IR muscle paresis secondary to a pineal germinoma. Indeed, it is at the level of the oculomotor nucleus, or the nerve fascicles in the midbrain that the oculomotor neurons are still relatively separated (16) (Figure 4).

Involvement of a single muscle subserved by the oculomotor nerve, has, to our knowledge, never been reported before in tumors of the pineal gland. The clinical features of our patient are typical of IR paresis: the comitancy of the vertical deviation on lateral gazes is typical of a vertical rectus injury; and the absence of a significant forced-head-tilt vertical difference upon tilting the head to either shoulder is common and not surprising –since the inconsistency of the traditional teaching of the BHTT in patients with vertical rectus muscle paralysis is the rule (16,17). In IR palsy, the BHTT would require the IO muscle to elevate the eye and increase the vertical deviation on contralateral head tilt. However; Jampolsky was the first to demonstrate the inability of the IO muscle to elevate the eye above the midline (18). Therefore, because of this inability, the elevation may not occur and the BHTT would be inaccurate.

The falling right eye on adduction, the incyclotropia, and the inhibitional palsy of Chavasse of the right IO muscle illustrate the classical clinical picture of a left IR palsy.

A mnemonic rule to identify the muscle involved in an inhibitional pseudo-palsy in each cyclovertical muscle palsy would be to change Oblique to Rectus, or Rectus to Oblique; Right eye to Left eye, or vice versa; and keep Superior, or Inferior unchanged. Our patient with left IR paresis had, indeed, an innervational inhibitional palsy of the RIO muscle.

We considered occlusion of the affected left eye –previously prescribed to this patient-contraindicated, since occlusion of an eye with a paretic extraocular muscle will favor further lengthening of the paretic muscle by true gain of sarcomeres and will favor contracture of the direct antagonist, therefore increasing the deviation, by true loss of sarcomeres (14).

Occlusion of the sound eye in extraocular muscle palsy is almost always preferable, since this will tend to stimulate the paretic muscle, and therefore prevent its further lengthening. By Sherrington’s law of reciprocal innervation, an equivalent, inhibitory impulse is sent to the antagonist muscle, hence relaxing it and preventing its contracture.

The plan is to only resect the paretic left IR muscle for the hypertropia, since the palsy is partial and mild, and the deviation is small. Correcting the HT will simultaneously correct the incyclotropia: the IR muscle being an extorter, its
strengthening will create extorsion and correct the incyclotropia. In case of any postoperative residual HT, the left SR muscle, subsequently, will be recessed. The SR muscle being an intorter, its weakening will also correct any residual incyclotropia.

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Incidental Detection of Bilateral Corectopia by Photo Screening Leads to the Diagnosis of Multiple Sclerosis. A Case Report

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ABSTRACT: Purpose: To describe a case of an incidental finding of bilateral corectopia detected by photo screening which ultimately led to the diagnosis of multiple sclerosis

Methods: Case presentation and literature review.

Results: Corectopia may be congenital or acquired. Midbrain corectopia is commonly caused by infarction and demyelinating diseases can cause autonomic pupil abnormalities resulting in corectopia.

Conclusion: A careful history and ocular examination can aid in determining the etiology of corectopia. Additional genetics or neurology consultation may be necessary to diagnosis systemic disease.

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CASE PRESENTATION

A 43 year old female was referred for evaluation of bilateral irregular pupils. The patient had photo screening performed by a colleague who developed a new iScreen prototype. The photographs revealed bilateral misshapen pupils (See Figure 1, right). She reported a recent onset of a droopy left upper eyelid and that she had

Figure 1 (Braverman, Enzenauer): Bilateral corectopia in photograph taken with iScreen photo screening device.
difficulty reading on the computer due to the words moving around. Her past ocular history was remarkable for myopia and soft contact lens use. Her past medical history was remarkable for migraine headaches. Her social and family history was non-contributory. Review of systems revealed fatigue but no other complaints.

Ocular evaluation revealed that her best corrected vision was 20/25 in both eyes. Her prescription was -2.00 D. sphere in the right eye and -1.75 D. sphere in the left. She had normal stereopsis with the TITMUS stereo test and normal color vision with PIP color plates each eye. Motility evaluation revealed full extraocular movements, orthophoria at distance and a flick esophoria at near via alternate cover testing.

Slit lamp examination revealed a normal anterior segment except for bilateral corectopia with oval shaped pupils displaced inferior-nasally. She also had 2 mm of left upper eyelid ptosis. Her dilated fundus examination was normal in both eyes.

A MRI of the brain with and without contrast revealed multiple hyperintensities of the periventricular and deep white matter of both cerebral hemispheres. The radiologist felt the abnormalities may be due to small vessel disease and ischemic gliosis. However, the orientation of some of the linear hyperintensities raised concern for a possibly demyelinating process such as multiple sclerosis. A consultation with neurology confirmed the diagnosis of multiple sclerosis.

**DISCUSSION**

This is a case of an incidental finding of bilateral corectopia with photo screening. Photo screening is a tool used extensively in the preverbal pediatric population to identify amblyogenic factors such as significant refractive errors, strabismus and eyelid ptosis (1). Pupil defects such as a coloboma or an absent red reflex due to a cataract or intraocular tumor can also be detected with photo screening. Socioeconomic studies of photo screening for children does not reveal a clear economic benefit (2). Photo screening adults is not likely to be cost effective and the authors do not support its wide spread use for adults. See **Figure 2** below for a normal photograph of a normal adult taken with a photo screening camera.

![Figure 2](image-url)

**Figure 2 (Braverman, Enzenauer): Normal adult photograph taken with iScreen photo screening device.**

Corectopia may be congenital or acquired. Congenital corectopia can be associated with ectopia lentis et pupillae, anterior segment dysgenesis but less frequently genetic or neurologic disorders (3). Acquired corectopia may be due to trauma, inflammation, neoplasm, post surgical changes, and infection. Midbrain corectopia has been reported most commonly secondary to midbrain infarction (4-6). Autonomic pupil abnormalities associated with multiple sclerosis have been reported (7,8).

The mechanism of corectopia in neurologic diseases such as multiple sclerosis is not clear. It may be due to segmental loss of parasympathetic or sympathetic innervation to the pupil. Surakka et al (7) performed pupillometry on mild to moderate disabled MS patients and found that both parasympathetic and sympathetic pupillary functions were affected and were age related. Age related changes were hypothesized to be due to the decreased ability of the central nervous system to re-myelinate with increased age. Selhorst et al (6) postulated that with midbrain infarction segmental innervation of the pupil by the Edinger-Westphal nucleus results in an oval or eccentric pupil.
REFERENCES


Vision / Visual Acuity / Amblyopia

Prevalence of Amblyopia and Strabismus in Young Singaporean Chinese Children. Ching A, et al. [Authors Results (condensed) and Conclusion]

Results: The amblyopia prevalence in children aged 30 to 72 months was 1.19% with no age or gender differences. ... the prevalence of strabismus in children aged 6 to 72 months was 0.80% with no gender or age effects. The exotropia:esotropia ratio was 7:1 with most exotropia being intermittent.

Conclusion: The prevalence of amblyopia was similar while the prevalence of strabismus was lower than in other populations. (Audrey Chia. wla_chia@yahoo.com)


Purpose: investigate oculomotor strategies in strabismic amblyopia and evaluate abnormalities during monocular and binocular reading.

Conclusions: In strabismic amblyopia, reading is impaired not only under monocular viewing with amblyopia eye, but also with non-amblyopia eye and binocularly, even though normal visual acuity pertains to the latter two conditions. The impaired reading performance is associated with differences in both saccadic and fixational patterns most likely as adaptation strategies to abnormal sensory experiences such as crowding and suppression. (Dr. Gottlob. ig15@le.ac.uk)


The use of liquid crystal glasses in patients with amblyopia yielded an improvement in visual acuity for near and distance and in stereopsis. Treatment was well accepted...

(Dr. Abraham Spierer spierera@post.tau.ac.il)

Low- and High-Level Motion Perception Deficits in Anisometropic and Strabismic Amblyopia: Evidence from fMRI. Ho CS, Giaschi DE. Vision Research 2009; 49:2891-2901 [Authors Conclusions]

Participants with anisometropic amblyopia showed the same pattern of cortical activation although extent of activation differences was less than in controls. For those with strabismic amblyopia, there was almost no difference in the cortical activity for low-level and high-level RDKs, and activation was reduced relative to the other groups. Differences in the extent of cortical activation may be related to amblyopia subtype. (Dr. Cindy S. Ho. Fax:604-875-2683, Canada)

Stereopsis


There is a long history of research into depth percepts from very large disparities, beyond the fusion limit. Such diplopic stimuli have repeatedly been shown to provide reliable depth percepts. A number of researchers have pointed to differences between the processing of small and large disparities, arguing that they are subserved by distinct neural mechanisms. Other studies have pointed to a dichotomy between the processing of 1st and 2nd order stimuli. Here we review the literature on the full range of disparity processing to determine how well different proposed dichotomies map onto one another, and to identify unresolved issues. (Laurie M. Wilcox. Fax: 416-736-5857, Toronto, Canada)
**Strabismus**


The muscle hypoplasia could be defined as such when the paretic side/contralateral side ratios of cross-sectional areas of the superior oblique muscle on magnetic resonance images fell outside the 95% confidence interval of the ratios in normal controls.

(Dr. Matsuo, matsuot@okayama-u.ac.jp)

**Strabismus Surgery - Outcome**


We believe that 10 mm SO posterior tenectomy combined with frenulum dissection effectively collapses A-Pattern deviation of less than 25 PD with mild to moderate SO overaction and reduces associated vertical deviation of 10 PD. (Sang Wee Park, MD, Dept Ophthalmology, Chonnam University Medical School & Hospital, 8 Hakdong, Dongnnngu, Gwngju, South Korea 501-757)

**MYOPIA**

**Bifocals Appear to Slow Myopia Progression in Children.** Arch Ophthalmol January 2010. [as abstracted by the AAOs Academy Express]

This study randomized 135 Chinese Canadian children with high rates of myopic progression (at least 0.5 D in the preceding year) into one of three treatment groups: single vision lenses, bifocals or prismatic bifocals. The treatment effect of bifocals was significant (P<.001), with the myopic progression averaging 0.59 D and 0.85 D less in the bifocal and prismatic bifocal groups, respectively, than in the single vision lens group. Also, both bifocal groups averaged 0.21 mm less axial elongation than the single vision lens group.


In this population-based study of children with intermittent exotropia, myopia was calculated to occur in more than 90% of patients by 20 years of age. Observation versus surgical correction did not alter the refractive outcome.

(Dr. Brian Mohney, mohney@mayo.edu)

Atropine for the Treatment of Childhood Myopia: Effect on Myopia Progression after Cessation of Atropine. Tong L, Huang XL, Koh ALT, Zhang X, Tan DTH, Chua H. [Authors Conclusions]

After stopping treatment, eyes treated with atropine demonstrated higher rates of myopia progression compared with eyes treated with placebo. HOWEVER, THE ABSOLUTE MYOPIA PROGRESSION AFTER 3 YEARS WAS SIGNIFICANTLY LOWER IN THE ATROPINE GROUPS COMPARED WITH PLACEBO. (Editors note: This was incomplete treatment). (Louis Tong, FRCS, DM, Singapore National Eye Center, 11 Third Hospital Avenue, Singapore 168751)
HYDE PARK EDITORIAL: The Editor's Soapbox, Sandbox & B’LOG

(Prehistoric) Since 1985

The first 3D TVs NOW Available from Samsung and Panasonic $2500+.
Alice and Avatar Succeed, 3D is Everywhere now: Laptops, Ophthalmology, Advertising; also: Taxes! More “Augmented Reality”

You can’t watch Avatar on your TV yet because the commercial film is circular polarized for 3D (no switching shutter 3D). Now that kind of 3D can be viewed simultaneously in 2D when not wearing the 3D glasses because the screen image is doubled by circular polarization in opposite directions and that is not diplopic or otherwise appreciated when viewed without your 3D specs. Makes you wonder if we will have to choose between the two 3D methods for home viewing in the future. Right now if you want to have a family viewing with a spouse and couple of kids, you will have to cough up another $450 for three extra sets of 3D shutter specs…. not good.

In fact there is NO 3D material at all being broadcast on cable or satellite or fiberoptic TV today!

If you want to watch a 3D production on your TV today, you will have to cough up another $350 for a Blue-Ray CD player and buy (and they are not as cheap or as available as conventional DVDs) a Blue Ray DVD and play it on your player and 3D TV…. they didn’t say anything about the current library. On my next trip to Target (my Walmart doesn’t carry Blue Ray) I could find NO Blue Ray DVDs with a 3D recording. No Avatar!

BINOCULAR VISION

Stereoscopic 3Dimensional depth perception is the epitome of vision and binocular vision.

Wow It is 7am ET Wednesday 10 March 2010

CNBC TV is broadcasting live from a local Best BUY store which has just opened featuring the brand new:

Panasonic-Samsung 1080p 50 inch plasma 3D HD TV for $2400 (cf $1500 for a non 3D 50 inch plasma version)

includes ONE pair (set, one unit) of 3D shutter glasses for ONE viewer...
extra shutter specs are $150 a pair per person,

and theater surround sound too.

P.S. Panasonic sold out in four days

the image is diplopic without the specs but you can select to view your TV in 2D or 3D but not at the same time so no mixed audience of shutter spectacle wearers and non wearers is acceptable to all viewers!
The above picture from Avatar is 2D. It is not 3D.

Don’t panic. You have not lost your stereopsis!

Professionally we were expecting to see and hear, for the last several months that 3D movies have been in the theaters, the anguished complaints of what should be from one to maybe four or five per hundred in the general population who are residual amblyopes or strabismus cases who don’t have normal or good or any stereopsis.

In the press there have only been vague reports of some people getting only nauseated by these 3D movies! Boooooooo! No diplopia even...

I did go to see Avatar. At Avatar, I myself found sitting too far forward in the most forward one third of the theater to be not for my liking for the sheer wall to wall picture environment and image movement and moved myself toward the rear of the theater. Half way back was OK. And I got to keep and take home the circular polarized glasses I paid 3 bucks for. (The ticket 3D premium).

I did a month ago receive a telephone call from a young female correspondent at the Toronto daily newspaper who wanted me to describe to her what this 3D movie craze was all about. I was a bit baffled on just how to describe stereopsis to her. Further inquiry revealed that she is an old amblyope who refused to wear a patch when she was a child! She didn’t want to hear that that was her problem. Before she hung up on me, I told her to go see Steve Kraft before giving up hope. I haven’t heard anything more from either of them. But honestly, how do you tell a person who has never experienced stereopsis what it is like and or what they are missing? EPIPHANY! SUDDENLY I REALIZE WHY THERE HAVE BEEN NO COMPLAINTS! THEY DON’T KNOW WHAT THEY’RE MISSING!!! and they suppress so they don’t get diplopia !!! and they should distribute our “Stereo Sue” article in all 3D theaters!!!!...

On the next two pages, courtesy of Popular Mechanics is how Cameron made Avatar:
Directing a Virtual World

1. The Volume

Most of James Cameron’s space epic, Avatar, was shot on a performance-capture stage, known as the volume, in Playa Vista, Calif. The volume was rimmed by 120 stationary video cameras, which could record the movements of all actors at once in 3D, with submillimeter precision. Data from the cameras was streamed into Autodesk software, which translates actors’ movements into digital characters in real time within a low-resolution computer-generated environment. So riding a fake banshee mockup onstage instantly translated to CG footage. Multiple cameramen were used on set for reference video, but because the volume essentially captures performances from every angle at once, Cameron could digitally render whatever angles and shots he wanted after the performance, adjusting the camera movements while viewing playback.

2. Digital Closeup

Like many actors in Avatar, Zoe Saldana plays a fully computer-generated character, Na’vi princess Neytiri. To map her movements to her digital doppelgänger, Saldana wore a motion capture bodysuit with reference markers and stripes. She also wore a head rig designed by Cameron that aimed a small video camera at her face. That camera tracked green ink dots, painted on Saldana’s face, throughout the scene, giving Cameron close-up-level detail of changes in expression to map to Neytiri’s CG face.

3. On-Set Playback

To shoot a scene within a totally CG world, Cameron had virtual production supervisor Glen Gray rig up augmented reality cameras. Cameron could watch from the sidelines as his actors’ performances were instantly mapped to their CG characters and displayed via an on-set screen. Or he could use a portable, motion-tracking video camera to walk through the volume and view the CG environment of the movie on its LCD screen.
4 Final Render

To transition from the CG produced on set to the photorealistic world of the finished movie, Cameron sent his rough footage to Weta Digital in New Zealand. There, special-effects programmers used a facial solve program and facial action coding to translate the actors’ every minute muscle movement—blinks, twitches, frowns—to believable expressions on the faces of Pandora’s aliens.

EVER THE HANDS-ON DIRECTOR, JAMES CAMERON HELPED DESIGN THE FUSION 3D CAMERA THAT HE USED TO SHOOT LIVE-ACTION SEQUENCES IN THE MOVIE AVATAR.

3D Comes Home

Stereoscopic movies make more money per theater than their 2D counterparts, but according to the 3D@Home Consortium, Hollywood studios generate as much as 50 percent of revenue from DVD sales. So the next big push for stereoscopic content is the home theater. But is it worth the upgrade? Here’s what you need to know. BY ERIN MCCARTHY

What equipment will I need to play 3D?

Some TVs, such as DLP rear-projection sets, can already play 3D content, but current LCDs and plasmas can’t, so most people will have to spring for a new set—Panasonic has announced stereoscopic plasmas for 2010. New 3D Blu-ray players are also coming this year, but some current machines, such as the PlayStation 3, will need only a simple firmware upgrade. Also required: shutter glasses, such as the Nvidia 3D Vision Kit ($199, above).

What about content?

Right now, PC games are the only widely available stereoscopic content, but 3D@Home’s Chris Chinnock expects approximately 35 movies to be released on the upcoming Blu-ray 3D format within the next year, and approximately 130 titles in the next two years—pricing for the new discs is still unknown. Stereoscopic video games for PS3 (left), Xbox and Wii are also coming this year, and 3D movies will eventually be downloadable to PCs and TVs via services such as Roxio CinemaNow.
It occurs to me that maybe we are gonna be stuck with these two different methods of making 3D pictures and movies, polarized for movie theaters and diplopia shutters for home use, because you can make and project two different circular polarized digital files in a theater, but you cant transmit over cable TV two such different files for each channel or program. Maybe someday we can expand bandwidth and give every channel two channels to transmit 3D. (But how come a year ago, when they showed all those half time 3D advertisements at the Superbowl, you only needed a free pair of blue and amber specs? How come they didn’t do it again this year???)

And how come at the recent Oscars, The Masters of ceremonies are wearing those amber and blue anaglyphic glasses to watch movie clips of Avatar????? Is there more than one version of

And what 3D information is German Chancellor Angela Merkel watching at the Hannover “Commuter Fair”? Are those shutter specs? (See next page)

Everybody’s Doing IT, Doing IT !!!!!

The CNBC correspondent said he had watched sports in 3D and they are really something to see.

Knowing our society’s obsession with sports (see my Editorial in this issue, “followup” page 14). They also announced today that March Madness, the annual collegiate basketball championships will be closed circuit 3D televised to movie theaters in just a few weeks here. That’s the sport the CNBC guy was so impressed with in 3D....

Almost all my life I have worn spectacles. My cataract surgeon put IOLs in that give me 20/15 sc D & N. But now I have to wear glasses again for 3D movies and TV! So does everyone else
anyway. I don’t know how long people will tolerate that. [P.S. but see next column]. Could we use the technology from the Lang no specs stereotests? The TV makers say it will be five to ten years before they figure that out. That is about when they will again run out of hot reasons to buy a new TV AGAIN every couple of years. They have achieved the old automotive frequency- buy a new car or TV every two years to keep up with the latest advances or the Joneses…. whatever.

In the meantime everybody is going 3D:

Now that flat panel TV’s are the price that the old tube type TVs were, the manufacturers are looking for new high margin profits, so we will get a big push in these. I noticed that Sony is also introducing FOUR color HD TV which is supposed to be much better than the now “old” red green and blue pixeled HD. Yellow is the newly added fourth pixel color. But there are no 3D four color sets yet! But Sony is in partnership with RealID a maker of 3D TV type technology so its only a matter of time… In fact every TV manufacturer has some thing in the works.

March 24, 2010; caught Avatar Cameron live on CNBC predicting the future: The anaglyphic or polaroid or shutter specs will NOT (repeat NOT) be necessary for 3D on your I phone - when 3D does become available on it in a year or two [and I surmise this is the secret of the no specs 3D Fuji camera we featured in Hyde Park in the last issue of last year!]. Small screens will be thick and have multiple screens and multiple real depth imagery! The 3D will be real, just miniature !!! And NO specs laptop 3D screens will follow!

On the following page is a critique of 3D TV from the current issue March issue of Consumer Reports (to which we presume all our very intelligent subscribers already subscribe), but the rest of that article is all about how to buy a new TV set now, if you must, before all the current advances in TV have arrived, been sorted, settled and come down in price!
3D TV: Has its time finally come?

Even before James Cameron’s movie “Avatar” became a three-dimensional juggernaut, it was clear that 3D would be a major buzzword for 2010. The concept of 3D-ready TVs isn’t new; about a year ago we looked at 3D-capable rear-projection DLP TVs from Samsung and Mitsubishi, with less-than-satisfying results. Now several major brands, including LG Electronics, Panasonic, Samsung, and Sony, are expected to ship 3D-ready flat-panel TVs this year, perhaps by summer. We believe the new 3D TVs on the horizon will provide a much better experience for several reasons.

Very good quality, more content
The demos we’ve seen have been impressive, with very good three-dimensional depth and resolution, especially on animated content.

And 3D content is finally coming. The success of theatrical 3D releases such as “Avatar” (20th Century Fox) and “Up” (Pixar) has led more studios to produce and release 3D films, so there will be a steady stream of 3D titles that can jump from theater to home.

In addition, the industry recently finalized the specifications for the 3D Blu-ray players needed to play such videos. We’ve also heard that DirecTV and ESPN will begin offering 3D fare this year.

But one big drawback to 3D isn’t going away: You still need to wear glasses to enjoy the 3D effect with most of the new 3D sets. They’re not the inexpensive paper shades given out at movie theaters. They’re shutter-style models that blink on and off rapidly so that each eye sees its own, slightly different image in full 1080p. Many 3D-capable LCD and plasma sets will come with one or two pairs, but you’ll have to buy extras, which could be pricey.

Bottom line. We still don’t know how 3D TVs will be priced, but we wouldn’t be surprised if they were very expensive at first. Unless you’re an early adopter willing to pay to be among the first to experience 3D at home, we’d suggest holding off. Prices for 3D-capable TVs and Blu-ray players are sure to come down over time, and there will be a bigger library of 3D titles available the longer you wait. It’s likely that 3D broadcasts will begin once enough consumers have purchased 3D sets for their homes.
Appetite for 3-D Imagery Propels 'Alice' to Top in Box-Office Sales

BY ETHAN SMITH

Walt Disney Co. benefited from audiences’ continuing appetite for 3-D imagery, which propelled its “Alice in Wonderland” to the top spot at the box office, taking in an estimated $116.3 million at U.S. and Canadian theaters over the weekend, the sixth-biggest movie opening ever.

According to Hollywood.com, ‘Alice’ had the biggest opening ever for a movie that wasn’t a sequel.

3-D: The next leap in video games

It’s no longer just movies that are popping out of your screen.

BY JOHN GAUDIOSI USA WEEKEND - Dec. 18-20, 2009

If you didn’t know, 3-D is the future of entertainment. This year alone, at least a dozen 3-D movies opened in theaters, everything from an X Games documentary to Disney’s A Christmas Carol with Jim Carrey. Electronics manufacturers also have embraced the format with 3-D-capable TVs. And now there’s a sprinkle of video games that has us dodging action with our heads as well as our thumbs.

“There’s definitely an explosion of 3-D going on,” says Titanic director James Cameron. For three years, Cameron has been working with Ubi-soft on a game version of Avatar, his new 3-D sci-fi film. James Cameron’s Avatar: The Game ($29.99 to $59.99) incorporates technology similar to what’s used on the film. (You need a 3-D monitor or HDTV.) The Game is set two years before the movie on the alien moon Pandora. Players control a signals specialist brought in to help track down a sacred site that holds the key to resources desperately needed back on Earth.
THE MOSSBERG SOLUTION | Edited by Walter S. Mossberg

Two Laptops Take Images to

By Katherine Boehret

Wednesday, March 3, 2010

If switching from standard to high-definition television wasn't confusing enough, there's another wave of TV technology on the horizon: 3-D. But 3-D TVs and much of the 3-D content won't be available until later this year, and even then most of these sets will be pricey and will require people to wear special glasses for viewing. If you can't wait for a 3-D TV to hit your living room, you can get a preview of what's to come with the latest in 3-D laptops.

I feasted my eyes on 3-D laptops this week, testing the $770 Acer Aspire 5738DG (http://3.ly/KxiZ) and checking out the $1,700 Asus G51J 3-D (http://3.ly/vzyW). These two computers are aimed at different crowds and each uses different technology to display enhanced images. The Acer is designed as a laptop first and a 3-D game player second, and it's priced for mainstream consumers—only about $70 more than the model without 3-D. The Asus laptop is meant for serious gamers who care about a high-quality 3-D experience. Unfortunately, you still need to wear the 3-D glasses with both.

The Acer Aspire laptop applies a slightly older 3-D method known as micro-polarized display, often referred to as "micropol." It combines software, a film layer on the computer screen and 3-D glasses to make videos and photos pop out. This laptop can take 2-D videos and photos and display them in 3-D; it also plays about 150 3-D games as well as 3-D movies, of which there aren't many.

Acer converts 2-D content to 3-D by using a third-party software program called TriDef 3-D, which people must use to see their photos and videos in 3-D. Using this program is a bit clumsy and I tested it by loading my own photos and videos onto the Acer. A faster way to see photos or videos in 3-D is by right clicking on the file from anywhere else on the PC and selecting an option to see it in TriDef's 3-D player. It was fun to see old images and videos in this 3-D simulation.

I looked through a friend's photos from a trip to Petra, Jor-
Another Dimension

The pricier Asus G51J 3-D laptop comes loaded with Nvidia's 3-D Vision, considered to be a much higher quality 3-D experience. This technology was originally only available on a desktop PC with several different necessary components. Now on a laptop, it displays 3-D images to people as long as they're wearing special battery-powered glasses and are standing no more than 40 feet away. These Nvidia glasses deliver the highest resolution possible per eye and enable wide viewing angles. The screen also has a high refresh rate of 120 hertz compared to the Acer's 60 hertz.

Unlike the Acer Aspire, 2-D photos and videos can't be viewed in 3-D on the Asus. Instead, this laptop depends on originally produced 3-D content, including photos or videos that are captured using special technology like that found on 3-D cameras such as Fujifilm's FinePix REAL 3-D WL, which are rare. As is also true on the Acer Aspire, movies only play on the Asus if they were created in 3-D.

Games are another story. Nvidia 3-D Vision will convert 2-D games to 3-D in real time using the computer's graphics processor. Nvidia has tested some 430 games that work with this technology today.

Asus couldn't send a G51J 3-D laptop to me in time for this column, but I got a look at it in January while wearing the battery-operated Nvidia glasses, which work for 40 hours before a recharge and can fit over prescription glasses. This laptop has an Intel Core i7 processor and can have a hard drive of up to 500 gigabytes. It comes with 4 gigabytes of memory.

Later this year, Acer also plans to make a laptop with Nvidia's technology. (Acer currently uses Nvidia's technology in its monitors.)

It's obvious that, right now, 3-D technology isn't necessarily something most mainstream consumers want or need. Gamers will see Asus's G51J 3-D as an exciting mobile alternative to what was once only available in a desktop. And the Acer Aspire will appeal to casual gamers and people who want a trusty laptop and/or the ability to view some photos and videos in 3-D. One thing's for sure: Wearing the special glasses—no matter how stylish—is still a wearisome part of seeing things in 3-D.

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Madison Avenue Flirts With 3-D

‘Augmented Reality’ Plays Role in Pushes for Papa John’s, GE, Postal Service

BY SUZANNE VRANICA

Remember Princess Leia’s holographic message to Obi-Wan Kenobi? Madison Avenue does, and it’s starting to make 3-D digital images part of its marketing arsenal.

Papa John’s International, the U.S. Postal Service and General Electric have begun to incorporate “augmented reality,” or AR—a technology that lets consumers interact with hologram-like images—into their marketing. One well-known example of AR: the yellow first-down lines in TV broadcasts of football games.

Starting in June, pizza chain Papa John’s is affixing an AR image to the back of 30 million pizza boxes, for a rollout in coming weeks. Customers can visit a special Web site, hold the image up to a Webcam and use their keyboard to drive an animated, 3-D 1972 Camaro on the computer screen.

It was a Camaro that the chain’s founder, chairman and chief executive, John Schnatter, sold in 1984 to buy the restaurant equipment needed to open his first pizza place. The move also ties in to the chain’s broader marketing program, which includes a cross-country road trip by Mr. Schnatter.

This week, the Postal Service will start running an ad campaign that touts a flat-rate shipping fee for its Priority Mail service. The online portion of the ad effort includes a “virtual box simulator” on the prioritymail.com site. The simulator allows consumers to hold an object, such as a cup or a book, in front of a Webcam and use the resulting 3-D image to determine the right size box for shipping the object.

The push into AR comes as companies have grown dissatisfied with relying solely on static advertising or passive media like TV commercials, which have washed over couch potatoes for years. In pursuit of alternatives, they have pumped money into approaches that encourage consumers to “engage” with their message or product, something ad executives believe helps increase sales.

AR is “a great way to get customers involved in a promotion in a more interactive way than just reading or seeing an ad,” says Jim Ensign, Papa John’s vice president of marketing.

Madison Avenue has high hopes for the gimmick. “It’s the new bright and shiny object that marketers want,” says Tom Redecarre, chief executive of AKQA, a San Francisco digital marketing firm that created the Postal Service campaign. AKQA is currently pitching several of its clients’ campaigns that include the technology.

Still, diving head first into a relatively new marketing technique carries some risk, marketing executives say. The technology “can be glitchy,” says Christian Haas, a group creative director at Goodby, Silverstein & Partners, an Omnicom Group firm that created an AR campaign for General Electric earlier this year to illustrate ways to find new forms of energy.

When Web surfers held up an image in front of their cans, a 3-D wind farm appeared that showed three wind turbines with which they could interact. Goodby had to work overtime on the technology to make sure it functioned smoothly.

Moreover, though the number of Americans who own a Webcam is increasing rapidly because most new laptops come with the device, only about 18% of the nation’s 68.5 million broadband households had one as of April, according to Parks Associates, a research firm.

Still, Goodby says, the GE push got plenty of attention. There have been more than one million visits to the company’s Eco Smart Grid site since it was launched in February, and more than a quarter-million visitors to the site have spent more than five minutes on it. In addition, a demonstration of the GE promotion on Google’s YouTube has been viewed more than one million times, according to Goodby.

Marketing executives are trying to make sure AR isn’t just a flash in the pan. “Just because you can make a logo spin doesn’t mean you should make a logo spin,” says Mike Sabatino, senior vice president and partner at Fleishman-Hillard, the Omnicom Group public-relations firm that created the Papa John’s pitch.

The Papa John campaign hopes to use the technology to sell pizzas by incorporating special discount offers available only through the billboards shown in the AR images. That way, the thinking goes, the chain can drive sales and also track how many people use the technology.
Pediatric Ophthalmology

and a final word re TV: 3D PLUS !!!!

I will bet you not infrequently have parents who complain to you that their kids sit too close to the TV all the time and they worry about it and don’t like it. So you reassured them and that went over like a lead balloon right?

Now we have something hard and serious you can offer those caring parents: a TV set that can monitor their kids’ proximity and shut the TV off when they get too close! And it is so good, it has a height sensor linked to a computer which makes sure it is monitoring kids and not your half blind grandfather who is getting too close to the TV!

Now Dad, we think you can really get behind this good idea too. We won’t tell Mom that this is one of those new 3D TVs that you were trying to figure how to justify blowing the budget again for! From the Wall Street Journal Wednesday March 10, 2010. We bring you the latest hot stuff, right! Without any boring stock tips....

3D stuff in Ophthalmology:
QUASI 3D AUGMENTED REALITY

While standing on the sidewalk in downtown Washington, I hold up my iPhone and slowly turn around, watching the camera image on the screen. As I rotate, a Washington Metro icon appears superimposed on the picture. Avoiding some curious stares, I follow the direction indicated by the icon until I reach a subway entrance.

The application I have just described is an example of augmented reality. This long-awaited technology combines a smartphone’s ability to take pictures, pinpoint your location, and search online to put information about what the camera sees right on the screen. There are just two problems: As it exists today—mainly in the form of iPhone apps—the technology doesn’t work all that well. And the cool stuff it can do today is often a step down from just using conventional mapping and search applications. Someday I may be able to walk down a street, point my phone at a building, and get guidebook information on what I am seeing, but that day seems to be a ways off.

Consider Pressel Development Studio’s 90c Washington Metro app, one of the better augmented reality programs I have tried. For most people, I predict, the novelty of having the subway entrance location superimposed on a picture will wear off pretty fast. However, if you want to see what it could do, visit the studio’s website.
How Your Phone Could Augment Your World

The camera in your smartphone snaps a photo of a building or other landmark.

A GPS receiver in the phone determines your position—latitude and longitude.

The phone’s built-in compass reports the direction in which the device is pointing.

A server associated with the app you’re running analyzes these three inputs.

The server superimposes relevant info over the image on your screen.

How your phone could augment your world.

Quickly, if you are far enough away from the station to need instructions, you’re probably better off using an old-fashioned map that can show you the best way to the station—e.g., turn right at the next corner and walk two blocks—rather than trying to follow an icon on the screen. Fortunately, an un-augmented map option is built into this app. On the other hand, if you are close enough for an augmented reality app to point to a picture of the entrance, well…you could just look up and see it.

Pocket Universe from Craic Design ($2.99) is a different sort of augmented reality program. Point your iPhone camera at the night sky and the app gives you a star map of what you are seeing. I found it a bit hard to assess in Washington’s extreme light pollution, which can make it hard to see the Big Dipper. While it wasn’t accurate enough to find a specific star, the maps did give a good general idea of what you were looking at.

Augmented reality uses three technologies that are, or soon will be, ubiquitous on smartphones: a camera to generate the image, a GPS receiver to determine your location, and the newest addition, a compass to sense the direction in which the phone is pointed. In theory, a service should be able to take your latitude, longitude, and orientation and tell you exactly what you are looking at.

Alas, the data aren’t nearly accurate enough for that. The receivers in phones don’t get close to the theoretical GPS accuracy limit of one meter or so. A GPS fix that puts you somewhere within a 20-meter circle is adequate for car navigation and most other location-based services. But it’s not good enough to tell exactly what building you are in front of as you walk down the street.

There’s an even bigger conceptual problem with augmented reality as it is used today by a variety of search apps such as the Layar Reality Browser, Wikitude World Browser, or Pressel’s Bionic Eye. They do a great job of guiding you to the nearest McDonald’s, but only if it is somewhere in your line of sight. If the target is on the next block behind the building you’re looking at, the information gets superimposed on the building in front of you, not the one to which you are being guided. Again, a conventional map is far more useful.

The technology will get better as the apps improve. Right now, you mainly see the warts. For example, Wikitude, a program that gives on-screen links to Wikipedia entries on objects around you, by default tries to show every point of interest within 100 miles. You can turn the range down to a mile, but even then produces a jumble of links in an attraction-filled place like D.C.

Augmented reality still feels like something that exists only because, technologically, it can. But behind the gimmicky, you see the possibility of mobile devices giving you real-time information on your immediate surroundings. With better location accuracy and some deeper thought given to the applications, it could live up to its meaning: something that adds to what we have.

BUSINESSWEEK.COM
For past columns and online-only reviews, go to businessweek.com/go/techmaven.

Business Exchange

Read, save, and add content on BW’s new Web 2.0 topic network.

Don’t Get Real, Get Realer

Interested in taking a deeper dive into the fast-evolving world of augmented reality? An article on the Web site HowStuffWorks.com not only details how augmented reality combines data and images but also gives some tantalizing suggestions on where the technology may be heading.

To read this article and others on the topic, go to http://bx.businessweek.com/augmented-reality/reference/
Wouldn’t it be nice to preview a house before it’s been built?

EtHip Enterprises, LLC has taken this concept and makes it reality with cutting edge digital technology. Creating three dimensional exterior and interior renderings takes the "guesswork" out of building and eliminates the need to interpret architectural drawings. 3D technology promotes your project and allows your customers to experience the impact of the design before it’s built.

EtHip Enterprises, LLC provides the following services:
- Color 3D Floor Plans
- Color 3D Elevations
- Color 3D Site Plans
- Interior Renderings
- Exterior Renderings
- Photorealistic Renderings
- Design Review Boards
- Animation

A PICTURE IS WORTH MORE THAN A THOUSAND WORDS

We can create unlimited 3D views of your floor plan

The benefits of 3D illustration
- Increase profitability
- Reduce risk
- Minimize inefficiencies in building design
- Highly customizable, scalable 3D modeling and rendering solutions
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- Gives a clear understanding of "real space"
- Reduces the need for change orders
- Reduces overall costs
- Eliminates uncertainty in the buyer
- Facilitates communication between the client, design professional, and contractor

See it Before you build it

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MONEY $$$ last word on 3D:

The avoidance of taxes is the only intellectual pursuit that carries any reward.
—John Maynard Keynes

income TAXES are due in a couple of weeks!  

The best new advice I have seen is DON’T OBSERVE and submit your 1040 before the first and imminent April 15 deadline: especially if you have not received all the tax notices you know you need, 1099s, 1099Rs, 5498s, K-1 (very frequently LATE). Extension to the second deadline date, October 15 is virtually automatic without a reason. Yes you do have to submit a request to extend (form xxxx) and you do have to pay now whatever your best estimate of tax owed is. But otherwise, if you file on April 15, and then get more info that should be part of your return, you have to REFILE your whole return!!!! and that is much more work and much more dangerous (it attracts audits). And this year you have still another excuse- all the tax changes STILL in the works right now and some of which could or might be EVEN retroactive to last year.

TAXATION AVOIDANCE:

MOTIVATIONAL:

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Summit Daily News  Thursday, March 18, 2010

Enough with taxes

Re. “Breaking Amazon’s tax-avoidance model” by David Sirota, opinion, March 14:

We just don’t need his extreme liberal tax and spend propaganda. It just ruins the day to hear that garbage over and over again.

Tell David, “life isn’t fair.” For example: Of every buck that goes to government, over half of it is always wasted.

We cannot stop that because humans can’t control themselves when they are spending somebody else’s money, and that is exactly what everyone who works for government does.

The government never created one red cent. It only spends the money it takes from taxpayers. It will never take “enough” because it never hurts them and therefore has no limits. So much for “fair.”

Therefore it is the duty of every citizen to fight as hard as possible against every cent of government taxation. That is the only way we can in any way slow or limit the otherwise limitless suicidal deficit spending.

Tax evasion is illegal, but tax avoidance is 100 percent legal and a right we all still have. Amazon is just exercising that right.

If everybody avoided taxes as much as possible, maybe we could slow or brake the insane “Not unintended acceleration” of public debt. There is no other way.

Paul Romano, Dillon
More motivation to avoid income tax:

from The Wall Street Journal, January 12, 2010 “Overheard”. “The goddam Senate says come over and answer questions - what I’m doing, what I’m not doing. Why? A senator ... is the only man on God’s green earth who is allowed to talk forever without knowing what he’s talking about and nobody can stop him! Nobody! Greatest time waster in the world, the United States Senate and there’s nothing anybody can do about it.”

“That first paragraph is A line from the production of Howard Teichmann and George S. Kaufman’s 1953 comedy: ‘Solid Gold Cadillac.’ Complete with a bitter argument over the excesses of CEO compensation, the play, at Washington’s Studio Theatre, is a timely reminder: In business and politics, the actors change but the script often stays the same.” (overheard @wsj.com)[see carton next page !]

note: “the actors change but the script often stays the same.” That’s a good idea, an that is exactly what we need.

frankly I think the solution to our horrible Congress, is to vote them all out every time we have a chance. Only then can we re-establish that they are supposed to represent us, the citizenry, not their own personal interests, not their incumbency, and not all the special interests and corporations

Right- no matter how “good” a job they may have done, they have to forget about making a career out of incumbency. “Get an honest job”!

Notable & Quotable

The Cato Institute’s Chris Edwards commenting on the institute’s Web site about a new report on federal employee pay levels from the U.S. Bureau of Economic Analysis:

The George W. Bush years were very lucrative for federal workers. In 2000, the average compensation (wages and benefits) of federal workers was 66% higher than the average compensation in the U.S. private sector. The new data show that average federal compensation is now more than double the average in the private sector. ... It’s time to put a stop to this. Federal wages should be frozen for a period of years, at least until the private-sector economy has recovered and average workers start seeing some wage gains of their own. At the same time, gold-plated federal benefit packages should be scaled back as unaffordable given today’s massive budget deficits. There are many qualitative benefits of government work—such as extremely high job security—so taxpayers should not have to pay for such lavish government pay packages.
Final word on our government. They are become the enemy of the people, the common man- of course we mean THOSE WHO ARE NOT UNION EMPLOYEES OR GOVERNMENT EMPLOYEES. All those people are co-conspirators of the government takeover and expansion. They make it possible in a number off ways... from voting to paying.

It is them against the rest of us, now the minority. The “Tyranny of democracy” is here!

Especially now in the cloak of Democratic Party supremacy. Obviously, they do want to run our whole world themselves. They no longer are interested in freedom- our freedom. They are only interested in totally dominating and running our lives, to their profit of course, +serotonin instead of ours.

There is that word “domination” again.

No, the enemy is no longer external like the old days: Russia, or China, or even Iran today. Our enemy is our very own government. It wants everything that we have, including our freedoms.

It is called “Socialism”, FYI. Fulltime. Is that what you want?

-per
More physicians choosing hospitals over private practice.

On the front of its Business Day section, the New York Times (3/26, B1, Hamis) reports that "an increasing share of young physicians, burdened by medical school debts and seeking regular hours, are deciding against opening private practices. Instead, they are accepting salaries at hospitals and health systems." At the same time, "a growing number of older doctors — facing rising costs and fearing they will not be able to recruit junior partners — are selling their practices and moving into salaried jobs, too." The Times calls this "a mixed blessing" for patients, as "bigger healthcare organizations can provide better, more coordinated care. But the intimacy of longstanding doctor-patient relationships may be going the way of the house call."

Medical students still choose more lucrative specialties.

The Green Bay Press-Gazette (3/26) reports, "Even with the increased spotlight on wellness during the national healthcare debate, medical students are pursing more financially lucrative areas of specialization, including orthopedic and cardiac care." That is because a specialist’s salary can be "double the average $150,000 annual salary of a primary-care doctor, according to Modern Healthcare magazine." Consequently, "by 2020, the country will face a shortage of 85,000 doctors, the Council on Graduate Medical Education projected in 2005." And "In November 2008, the Association of American Medical Colleges estimated a shortage of at least 124,000 physicians by 2025 across all specialties."

Idaho Senate approves $25 million in tax assessments on private hospitals.

The Idaho Report (3/25, Herndon) reported that in Idaho, "private hospitals are agreeing to pay $25 million in assessments to the state...in order to ensure federal funding through Medicaid." On March 24, the state Senate "approved the proposal...which now heads to the governor." During a Senate hearing on the bill, Idaho Hospital Association President Steve Millard said that this group of private hospitals supports the assessment "as a way of dealing with the Medicaid shortfall during the next two years." The proposed assessment is projected to garner $18 million from hospitals, with an additional $7 million derived from the settlement of cost overpayments to the state’s Department of Health and Welfare.

Idaho Health Department says it cannot afford to pay hospitals, nursing homes caring for Medicaid patients. On its website, KTVB TV (3/25, Gupta) reported in a related story that the Idaho state health department says it cannot afford to pay millions of dollars in state and federal payments to hospitals and nursing homes that take care of patients on Medicaid. Currently, "the department is not getting enough money from the state, which means no matching funds from the federal government, leaving no money to pay," the state intends to pay providers, but payments will be delayed. By early July, however, with the start of the new fiscal year and by-deduct replenishment, "the state health department says it will be able to make all Medicaid payments."

Florida woman sentenced to eight years for defrauding Medicare.

The AP (3/26) reports, "A Florida woman who stole millions of dollars from Medicare while running Deblo-island clinics expanded her scheme by setting up her daughter and son-in-law with their own fraud mill." During the course of "one year, Daisy Martinez ripped off Medicare for $10.7 million at three clinics," and her daughter got $649,000 in just four months as they billed the government for sham drug treatments while using desperate people off the street with cash, food and painkillers." On Thursday, Martinez "was sentenced...to eight years in federal prison." The AP notes, "Settlements, fines and restitution in fraud cases added up to $1 billion nationally in the 2008 fiscal year, just the tip of the iceberg," Daniel Levinson, inspector general of the U.S. Department of Health and Human Services, told Congress this month.

Report finds Florida Medicaid fines do little to deter fraud. The AP (3/26) reported that Health News Florida has found that state "Medicaid’s fines for fraud and abuse have been so low — and so often waived — that they might not be a deterrent to wrongdoing." According to their report, "providers have often been able to avoid fines if they quickly reaped amounts that had been overbilled." Thus, "Health News warned, ”officials need to set a limit on how much of state-paid premiums HMOs can keep for themselves."

This next story is amazing! Does HeLa ring any bells?
Public Safety: Autos and Driving

21st Century PROHIBITION, Please PRINT this page and then cut and stick tape or glue these important reminders everywhere as indicated!

- household liquor cabinet or bar
- door to GARAGE OR CARS
- family car KEYS or steering wheel
- and DON’T FORGET, DRIVING DRUNK WITH YOUR KIDS IS A FELONY!!! Print another page for four more. Add to above $ your time losses!

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### Achieving Immortality

By Rebecca Skloot

The cancer researcher opened a floor-to-ceiling freezer as Deborah Lacks clutched the dictionary she used to look up words like “DNA” and “cells.” She inched forward, staring at thousands of plastic vials. “Oh, God,” she gasped. “I can’t believe all that’s my mother.” Fifty years earlier, her mother, Henrietta Lacks, checked into the segregat-
TRANSMISSIONS !!!

from the last issue of HydePark v24no.4:

TIP on CAR care: DON’T BELIEVE YOUR CAR MANUFACTURER’S MANUAL WHERE IT SAYS THAT YOU EITHER DON’T NEED TO EVER CHANGE THE OIL, OR ONLY A LOT MORE RARELY THAN YOU USED TO.

Oil is still relatively dirt cheap, while car parts continue to get more complicated and much more expensive:

Your editor managed to totally destroy the transaxle on his Audi Allroad at 40,000 miles. Chipped so the car was out of warranty. The repair quote: $11,000 (yes that is eleven thousand dollars)- the whole car cost less than 50K new. (After a year of searching we found one grey mkt replacement for just half that 11k price.)

The family van, a Toyota Sienna recently started missing automatic shifts at a similar mileage, just out of the five year warranty. This was cured by an UN-required tranny oil change. The old oil was GROSS! Now it shifts fine again.

And all those TV ads where horrible black sludge suddenly dumps on cars or people. You don’t need magic oil to avoid that- you just need to change your engine oil every 3-5000 miles. Cheap ordinary oil will do the job. Skip the expensive synthetics because they may last forever, but the world is still a dirty place and your oil filters are not perfect. (We cant even find a coffee pot filter that doesn’t let some grounds thru even when we use triple name brand filters).

The above was hardly dry when the column below was published in the WSJ:

?Neither Bogardus nor Welsh say anything about changing the transmission oil, but that is the FIRST thing both of them should have thought about. Our vehicles have become so technological we have forgotten all the most basic physics and mechanics !!! Don’t change the oil every now and then - just change the whole transmission every year or two!

- per

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ME & MY CAR

**Wednesday, November 25, 2009**

Columnist Jonathan Welsh answers readers’ questions about automobiles

Q: I own a 2001 Honda Odyssey with 190,000 miles. It has gone through four transmissions and has 23,000 miles on its fifth one. Other than that, it has had no problems. I drive about 20,000 long-distance miles a year and wonder if I am gambling on waiting another year for a new car.

—H. Bogardus, Austin, Texas

A: Second-generation Odysseys—model years 1999 through 2004—have a history of second-gear overheating. Still, I am surprised the van has gone through so many transmissions. If you traveled an average of almost 42,000 miles before each of the previous ones failed, the current one should have about 19,000 miles of life left.

You should make sure your current transmission’s lubrication system has been modified by Honda, in which case it’s probably safe to drive the van for another year.
Hyde Park Editorial

CATCH UP CARTOONS

(These appeared after earlier articles were in final format)

HEART OF THE CITY/ by Mark Tatulli

This one obviously goes with our editorial ...

..Comments on Obama-Pelosi Medical Care
CALL FOR PAPERS
PRE-AAO PEDIATRIC OPHTHALMOLOGY DAY IN
CHICAGO!

Course Directors – Kenneth W. Wright MD, Los Angeles, CA
Marilyn Mets, MD, Chicago, IL

The Wright Foundation and Children’s Memorial Hospital are co-hosting a one-day pediatric ophthalmology and strabismus meeting on Friday, October 15, 2010, at Children's Memorial Hospital prior to the annual meeting of the American Academy of Ophthalmology (AAO). This is a call for papers, including interesting cases, research topics, short surgical videos and new innovations. We are looking for what's new, interesting and challenging in pediatric ophthalmology and strabismus.

Approximately 6 hours of CME will be offered. Meeting registration fee is $150.00 ($75.00 for residents and fellows) Pay by check to Wright Foundation or email credit card info - Name, Card Number, Expiration Date, and card type. (The Wright Foundation is a 501 (c)(3) non-profit organization).

Please submit papers via email to Gabby Vilhauer, coordinator, at gwilliams34@gmail.com by APRIL 30, 2010.

EMAIL SUBMISSION FORM
NAME:
EMAIL:
CELL PHONE:
PRESENTATION TITLE:
ABSTRACT (50 word maximum):
PRESENTATION TYPE: (e.g. case report, clinical research, surgical video)

Presentations will be in ARVO format, 7 minute presentation, 3 minute discussion.

Thank you,

Kenneth W. Wright, MD