

Authors' Reply

Dear Sir,

We would like to thank Agrawal *et al.*^[1] for their comments on our article. We agree that cycloplegic refraction is a primary step in the management of all patients presenting with an ocular deviation. We emphasized this point in our article. However, our goal in publishing this case series was to emphasize that there may be an accommodative component to the esotropia present in some patients with Duane's syndrome. In addition, we believe that the cause of the compensatory head posture (CHP) in most Duane's syndrome patients is esotropia in primary position. Hence, if one can correct the esotropia by optical or non-optical methods, CHP will be corrected. Contrary to patients with Duane's syndrome, patients with pure accommodative esotropia do not have an incomitant esotropia (unless they have an "A" or "V" pattern), and therefore, their esotropia does not improve with a head turn. Therefore, CHP does not correct esotropia in these patients. The status of binocular vision is not available for all patients as we have children from all age groups, including some who were unable to participate in stereoacuity testing. As a routine practice in comprehensive pediatric ophthalmology, the spectacles were prescribed at the first visit and then children also underwent vertical rectus transposition (VRT) for the residual esotropia with their hyperopic correction. Over the course of 12 years follow up, the child developed exotropia, but we believe

that this was because her hyperopia was initially undercorrected. Finally, we agree that ocular motility measurements are difficult in children and occasionally, the angle of esotropia can be incorrectly measured. However, we do not agree that a medial rectus recession with or without posterior fixation would be more accurate. In addition, medial rectus recession does not improve the binocular field of single vision, as vertical rectus transposition has been shown to accomplish.^[2] Medial rectus recession may be required after vertical rectus transposition in patients with larger primary position esotropia and greater restriction to abduction on forced duction testing.^[3] Exotropic overcorrection is also possible in patients undergoing medial rectus recession, especially in the long term, should their accommodative component not be fully corrected in rare cases of coexistent accommodative esotropia with Duane's syndrome.

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