Spontaneous late-onset comitant acute nonaccommodative esotropia in children

Dear Editor,

We read the article by Kothari,[1] with great interest. The author has described the clinical characteristics of spontaneous, late-onset comitant acute nonaccommodative esotropia in children. We appreciate that the author has drawn attention to this relatively uncommon clinical entity. We would like to put forward a different view regarding neuroimaging in such cases.

Many intracranial lesions present with comitant nonaccommodative esotropia without neurological deficit in early stage.[2] Sometimes acute-onset nonaccommodative esotropia is the only presenting sign of intracranial neoplasm. There are many studies in the literature which state that intracranial lesions may present with acute-onset comitant esotropia without any neurological deficit or other signs.[2-4]

In patients with acute esotropia with corpus callosum gliomas, clinical signs are absent in the early part of the disease. Also, tumors involving the corpus callosum give rise to no distinctive signs.[3] Posterior fossa lesions are typically known to present with only acute-onset comitant esotropia with no other systemic signs such as papilledema.[2]

Acute comitant esotropia has also been described in patients with Arnold Chiari malformation even prior to onset of typical down beating nystagmus.[4] It is important in these cases of acquired esotropia to rule out the possibility of intracranial tumor, Arnold Chiari malformation or other neurological abnormalities.

Although most children with this form of esotropia are otherwise healthy, central nervous system lesions must be considred.[5]

Missing a brain tumor, however rare, in a child presenting with acquired comitant nonaccommodative esotropia will be an act of negligence. So we feel that neuroimaging should be done in any patient presenting with acquired comitant nonaccommodative esotropia.

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