

of primary inferior oblique overaction [PIOOA] as part of this new syndrome.

The authors do not offer evidence whether overelevation in adduction in this case is due to inferior oblique overaction and that too primary and not secondary. Secondary inferior oblique overaction can arise due to superior rectus/oblique underaction and overelevation in adduction has diverse etiologies and presentations. As levator palpebre superioris [LPS], superior rectus [SR]/superior oblique [SO] and upper halves of horizontal recti all develop from the same superior mesodermal complex,<sup>2</sup> they may get implicated together in disorders like this and plausibly to a variable extent. It seems more appropriate to ascribe overelevation in adduction in this case to the underaction of SR or to both of superior muscles [SR, SO], along with LPS, as both can produce overaction of inferior muscles [IO and IR] leading to overelevation in adduction, a V pattern and extorsion. A positive head tilt test on tilt to either side will offer insight regarding primary or secondary inferior oblique overaction provided both superior muscles are not knocked out. Presence or absence of objective extorsion may offer a clue regarding inferior oblique overaction. Results of such tests are not known in the present case.

To attribute overelevation in adduction in this case to PIOOA is like clubbing all meningitides as meningococcal.

**Pramod Kumar Pandey, MD; Pankaj Vats, MS;  
Navjot Kaur, MS; Ajit G Kulkarni, MS**

Guru Nanak Eye Centre, Maulana Azad Medical College,  
University of Delhi, New Delhi-110 002, India

Correspondence to Dr. P.K. Pandey, A-170, Pocket IV, Mayur Vihar,  
Phase I, Delhi - 110 091, India.  
E-mail: pkpandey\_001@yahoo.co.in

## References

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## Retinitis pigmentosa associated with blepharophimosis, blue dot cataract and primary inferior oblique overaction

Dear Editor,

We read with interest the report by Vedantham *et al.*<sup>1</sup> We would like to make certain observations regarding inclusion