

on with the related study on this treatment mode. Thank you very much for your comments and discussion of the article.

Conflict of interest

The authors declare no conflict of interest.

Acknowledgements

This work was supported by the Fundamental Research Funds of State Key Laboratory of Ophthalmology, National Nature Science Foundation in China (Grants No. 81300785; 81170865; 30901642).

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Eye (2015) **29**, 1625–1626; doi:10.1038/eye.2015.137; published online 31 July 2015

Sir, Results of conservative management for consecutive esotropia after intermittent exotropia surgery

I read with interest the article by D W Kim *et al*¹ on conservative management for consecutive esotropia (ET) after intermittent exotropia (IXT) surgery.

The authors managed patients with full-time alternate occlusion and/or with a Fresnel prism. Immediate postoperative esodeviation from 8PD to 40PD, the authors used regular spectacles incorporated with a prism or prisms divided to each eye. In our hospital, we also use Fresnel prism to treat postoperative ET. According to our experience, consecutive ET that is ≥ 20 PD after surgery, especially with factor of accommodation, is hard to achieve ocular alignment at 1-year follow-up. In addition, in this study, 19 patients had amblyopia preoperatively and 16 were in younger age stratum. ET may cause suppression, decreased visual acuity and amblyopia. As we all know, visual acuity will decrease with increasing prism power. However, in this paper, some patients wear prisms for several months without newly developed amblyopia. Why patients' visual acuity was not affected by prisms? Was a training program needed for amblyopia child?

Conflict of interest

The authors declare no conflict of interest.

Reference

- 1 Kim DW, Han S, Kim US, Baek SH. Results of conservative management for consecutive esotropia after intermittent exotropia surgery. *Eye* 2015; **29**(6): 776–782.

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Eye (2015) **29**, 1626; doi:10.1038/eye.2015.148; published online 28 August 2015

Sir, Reply to 'Results of conservative management for consecutive esotropia after intermittent exotropia surgery'

We thank JJ Jiang and Q Wu for their interest in our study. They focus on the possible association of large overcorrection with poor prognosis and the prism's influence on visual acuity and amblyopia development.

For patients with persistent esodeviation months after occlusion therapy (average: 4.6 months, range: 0.5–12.0 months), we prescribed Fresnel prism, sometimes later changing to regular spectacles with prism(s). The average prism usage was 9.5 months (range: 1.5–24.0 months); at final follow-up, no patient still required it. We do not believe that large-angle overcorrection is associated with poor long-term ocular alignment: our four patients with immediate postoperative esodeviation ≥ 20 PD achieved ocular alignment within 6 PD of orthotropia by 1-year follow-up. As for accommodation, most of our subjects had myopia, not hyperopia. Fourteen eyes of 10 patients (6.7%) out of 149 of this patient group had preoperative spherical equivalent of $\geq +1.0$ D. Among them, only one had immediate postoperative esodeviation over 20 PD, who became exotropic 3 weeks postoperatively with alternative occlusion therapy. There was one patient with small esophoria at distance and a larger esotropia at near; he was prescribed bifocal spectacles at 2 months follow-up, later showing orthotropia at 7 months follow-up without amblyopia development. Hwang *et al*¹ reported long-term conservative management outcomes for 68 patients with 20 PD or more initial overcorrection following exotropia surgery. They determined that in most patients, overcorrection had been reduced to 10 PD or less (distance and near) within 4 weeks.

Visual acuity reduction can be induced by Wafer prisms, Fresnel trial set prisms, and conventional prisms; however, the effect is negligible with prism powers < 12 PD.² All of the prisms we used had powers of ≤ 12 PD, and we believe that there was no substantial visual acuity deterioration or, therefore, any significant potential for prism-related amblyopia development. At the final follow-up, among the 19 patients who had preoperative amblyopia, none demonstrated a BCVA below 20/30. Neither was there