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LETTER

Fenestration of Medial Rectus Muscle versus Combined Resection Recession for Management of Near-Distance Disparity Esotropia [Letter]

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Dear editor

We read with the great interest the recent article by Ghali et al describing the suture less fenestration of the medial rectus for the management of near-distance disparity esotropia.[1] We would like to congratulate the authors on this thoughtful and innovative, scleral-suture–sparing approach, which has the potential to reduce the risk of scleral perforation and expands the surgical options available for this challenging condition. The reported outcomes are encouraging and represent an important contribution to the literature. We would be grateful, however, for further clarification on a few points that may assist clinicians in incorporating this technique into routine practice.

1. Previous studies have suggested that early surgical success in near-distance disparity esotropia may decline over time, potentially due to changes in the gradient AC/A ratio.[2] In the current study also there was significant difference in outcome of both groups, (71.4% for bilateral medial rectus fenestration vs 96% for combined resection and recession group). While the isolated overcorrection in the resection–recession group was effectively managed by muscle advancement, we were interested in how the authors would approach similar situation in cases treated with fenestration. Because a substantial central portion of the muscle (up to 7.5 mm) is removed, the scope for subsequent adjustment might differ from that after conventional surgery. It would also be very helpful if the authors could share their views or experience regarding the feasibility and safety of re-operating on a previously fenestrated muscle—whether by additional fenestration, recession, advancement, or transposition—should under correction or recurrence of near-distance disparity arise over longer follow-up.
2. Earlier reports of muscle fenestration have mentioned potential issues such as progressive subconjunctival hemorrhage, limitation of ocular motility and post-operative pain.[3] As in the fenestration group neither suture nor cautery was used over free edge of fenestrated muscle. Additional information on the severity and course of subconjunctival hemorrhage, as well as on patient-reported pain, would be valuable for preoperative counseling, particularly in pediatric cases where parental concern is high. Given that technique removes the central bulk of the muscle while preserving only superior and inferior strips, there is a theoretical risk of adduction limitation, especially in larger angles requiring longer fenestration lengths. Systematic assessment of ductions, versions, and any symptomatic limitation of adduction, along with their correlation to the extent of fenestration, would provide critical information on the functional safety profile of this procedure beyond simple alignment outcomes.

We once again commend the authors for their important and innovative work and would welcome any additional insights they can provide on these aspects, which we believe will be of great interest to surgeons considering medial rectus fenestration for near-distance disparity esotropia.

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Disclosure

The authors report no conflicts of interest in this communication.

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