The treatment of small angle hypertropia in the primary position with inferior oblique overaction is often a dilemma for pediatric ophthalmologists. Some patients have a face turn and diplopia in the primary position as well as in side gaze. Prisms are often unsatisfactory because of incomitance. Alternatively, vertical strabismus surgery or standard inferior oblique weakening procedures may cause an overcorrection.

In this issue, Yang et al. reported an alternative procedure for the treatment of inferior oblique overaction with small angle hypertropia. I was impressed with their pilot study results of performing a transposition of the inferior oblique muscle belly. They encountered no overcorrections or anti-elevation occurrences postoperatively.

Similar to most pilot studies that document a positive result for a particular procedure, further studies are necessary to establish its validity without negative ramifications. It might be worthwhile to compare the inferior oblique muscle belly transposition procedure to the Z-myotomy procedure for small angle hypertropia and inferior oblique overaction in a larger patient population.

Leonard B. Nelson, MD, MBA
Editor

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