Surgery for Bilateral Superior Oblique Palsy

Class	HT	V	IOOA	SOUA	Torsion	DMR	AHP	Treatment
1	No	22	>+2	-1 to 0	No	10°	No	BIOc
2	No	16	0 to +1	> -2	Yes	13°	Chin down	BSOt or Harada-Ito
3	No	40	> +2	> -2	Yes	14°	Chin down	BIOc & BSOt or Harada-Ito∗
4a	Yes	21	> +2 asym	> -2	Yes	14°	Tilt	Bilat. Harota-Ito or SOt and unicaat IOc
4b	Yes	20	+1 to +2	> -2 asym	Yes	12°	Tilt	BSOt or Harada-Ito & IRc or SRc ± BIOc
4c	Yes	22	> +2 asym	> -2 asym	Yes	15°	Tilt	BIOc & BSOt or Harada-Ito & IRc or SRc
5 ★	Yes	10	> +2 unilat	-1 to -3 unilat	No	6°-11°	Tilt	Unilat IOc ± IRc brings out contralateral SOP

HT: Hypertropia in primary gaze
V: mean amount of V pattern present in upgaze/downgaze
IOOA: Inferior oblique over action
SOUA: Superior oblique under action
Torsion: Subjective torsion
DMR: Average torsion on Double Maddox Rod test
AHP: Abnormal head position
Treatment: Suggested treatment
BIOc: Bilateral Inferior Oblique recessions or other weakening procedure
BSO Tuck: Bilateral Superior Oblique Tuck
IRc: Inferior rectus recession
SRc: Superior rectus recession
Asym: Asymmetrical under or over action
Bilat: Bilateral
Unlat: Unilateral
SOP: Superior Oblique Palsy

∗ For class 3 patients: consider Bilateral Medial Rectus Recessions for Esodeviation >8 diopters
★ Masked Bilateral Superior Oblique Palsy (9-16% of all Bilateral Superior Oblique palsies)

Based on Scott WE, Kraft SP. *Classification and Treatment of Superior Oblique Palsies:II. Bilateral Superior Oblique Palsies*. Transactions of the New Orleans Academy of Ophthalmology. 1986: 265-91.

Strabismus Surgery

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