body weight methylprednisolone is given intravenously on 3 consecutive days. This treatment has been effective in several types of immunologic diseases, including juvenile rheumatoid arthritis and nephrotic syndrome. Onset of action may be rapid and rigorous, and short-term side effects mostly are absent. The therapeutic profile of SPT is far superior to that of oral steroids or cytotoxic drugs, all of which display a considerable delay until the desired effects become apparent. The side effects of SPT compared with continuous oral steroid medication usually are negligible. In accordance with reports from the literature, our patient did not show elevation of blood pressure or serum lipids or depression during the SPT, although we observed these severe side effects with oral steroids. We recommend performing SPT under close supervision; however—incorporating monitoring heart rate and serum electrolytes—as dysrhythmias during SPT have been reported.

The short-term effect of SPT was encouraging that VA increased from 0.1 to 0.7 within 2 weeks, and to 1.0 after a second SPT. We believe that this fast suppression of inflammation helped improve the prognosis in our patient. The fast and persuasive action of SPT allowed us to discontinue the oral steroid medication, which had severe side effects and would have diminished longitudinal growth.

In the long run, however, the inflammation could not be suppressed entirely by repetitive SPT alone. Cyclosporin A was included in the therapy, and, later, methotrexate. Chlorambucil was not used despite its reported good effects in severe SO due to the risk of secondary malignancy and sterility—especially important considerations in children.

In conclusion, SPT proved highly effective and safe in rapidly suppressing inflammation in devastating SO in the short term, and may be tried in severe cases when immediate action is required. In the long term, other drugs may be necessary to stabilize these effects.

REFERENCES

Perioperative Care of the Strabismus Patient

Scott E. Olitsky, MD; Steven Awner, MD; and James D. Reynolds, MD

INTRODUCTION

The primary goals of strabismus surgical management include achieving the desired result and avoiding complications. When complications occur, the additional goals of recognition and appropriate treatment are important. Reliable preoperative strabismus measurement; avoidance

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sions, or a simple lack of data, it is not surprising that strabismus surgeons vary dramatically in perioperative surgical management. We documented this variability and trends in managing surgical strabismus patients by a physician survey.

MATERIALS AND METHODS
A survey was sent to 430 members of the American Association for Pediatric Ophthalmology and Strabismus (AAPOS) in North America in 1994. Members were asked about their routine care of strabismus patients undergoing surgery. Responses were received from 353 members (82%).

RESULTS
In the absence of amblyopia, 56% said they would schedule surgery after the initial visit. The remainder required at least two measurements beforehand. A total of 125 surgeons (35.4%) routinely instilled a pharmacological agent at the time of surgery, usually 2.5% neosynephrine, presumably for hemostasis/mydriasis.

Antibiotic/steroid use was highly variable. Preoperatively, 5.3% use antibiotics before the day of surgery; 6.7% instill an antibiotic at the time of surgery; 54.7% use topical 5% povidone-iodine solution at that time. Postoperatively, 74.2% of respondents instill an antibiotic; 64.7% have the patient use them at home as well. Of those that use antibiotics postoperatively, polymyxin B/neomycin was the most commonly used (29.2%), followed by tobramycin (23.5%) and erythromycin (7.2%). Among those who use antibiotics, 93.5% add a topical steroid, usually in a combination preparation. Oral antibiotics are used routinely by 5.6%.

When asked about management of a known or suspected suprachoroidal needle pass, 47.4% of respondents stated that they would not deviate from their standard routine. Of those who would change their management, 48.3% would perform a fundus exam in the OR, 29.5% would place the patient on oral antibiotics, 16.1% would inject a subconjunctival antibiotic, and 5.4% would add a topical antibiotic. We did not receive data on prophylactic retinal cryopexy.

The first postoperative exam is performed as follows: Day 1 (39.1%), day 2 to 4 (36.4%), 1 week (20.4%), 3 to 4 weeks (3.2%), and more than 1 month (0.9%).

DISCUSSION
This survey sought to document the routine care given to strabismus patients by a group of experienced strabismus surgeons. The variability in practice patterns is dramatic, but several trends are noteworthy. Our respondents tend to schedule surgery on an appropriate surgical candidate after one or two visits when no mitigating factors such as amblyopia are present. A majority were satisfied with one measurement under such circumstances; the remainder required at least two visits to document angle size stability or establish better social rapport.

Very few surgeons use outpatient preoperative antibiotics. Only 5.3% of respondents use these despite evidence of effectiveness in decreasing conjunctival flora. On the contrary, most use a chemical prophylaxis of the conjunctiva just prior to or after surgery. Topical 5% povidone-iodine solution instilled as part of the surgical preparation is common, as is one-time installation of antibiotic at the end of the case. The literature supports this practice in decreasing conjunctival flora considerably. The use of povidone-iodine solution has increased from 34% in 1992 to 55% in our study of 1994 habits. This may be due to heightened awareness of this supportive body of literature. The lack of universality of this simple and cost-effective regimen may be due to the lack of conclusive evidence linking a reduction in conjunctival flora to a reduction in postoperative strabismus infections.

Outpatient use of topical postoperative antibiotics are used by nearly three quarters of respondents. This almost always is in conjunction with a topical steroid. This is a high number considering that little evidence in the literature suggests that outpatient topical antibiotics postoperatively have any impact on the infection rate. Wortham and coworkers performed a prospective randomized masked trial of antibiotic-steroid drops following strabismus surgery and concluded that routine outpatient use of such medication serves no benefit. A small fraction of respondents use outpatient oral antibiotics postoperatively. Again, the scientific rationale for this is lacking and anecdotal at best.

Suprachoroidal passes during strabismus surgery are common and management remains controversial. Most respondents in our survey stated that they would not change their routine for a known or suspected suprachoroidal pass. However, a large percentage of those who indicated this use topical antibiotics routinely after surgery anyway. A large minority (29.5%) would add oral antibiotics. This may be done to prevent endophthalmitis but initiation of antibiotics after wound closure is of questionable value.

The timing of the first postoperative examination varied considerably among surgeons. Most respondents did not indicate the rationale for their routine. The two important developments being evaluated during this time are the surgical results and postoperative complications including slipped muscle, cellulitis, abscess, and endophthalmitis. Although endophthalmitis typically is not noted until the second to fourth postoperative day, the range of onset of serious infections is impressively wide. An examination on day 1 or day 7 may not be useful in detecting this during its acute phase. Furthermore, as most surgeons do not make decisions regarding further treatment options
for over- and undercorrections this soon after surgery, an examination on day 1 or day 7 does not seem to provide much useful information in postoperative care. No perfect postoperative timing in early recognition of serious complications exists.16

Our intention in this survey was to seek consensus on various issues and evaluate the rationale for various approaches. The responses, however, indicate that a consensus of opinion does not exist on most of these points. No overwhelming majority on any single management issue exists. Near universal agreement occurs only regarding the futility of routine postoperative oral antibiotics and the desire to evaluate postoperative patients sometime within the first week.

REFERENCES

Malignant Peripheral Nerve Sheath Tumor of the Orbit in a Newborn: a Case Report and Review

John P. Fezza, MD; Darrell E. Wolfley, MD; and Stuart D. Flynn, MD

INTRODUCTION
Malignant peripheral nerve sheath tumors (MPNSTs) are extremely rare and aggressive neoplasms of the orbit characterized by local recurrence and intracranial extension. We are reporting a case of the youngest known patient to have this entity in the orbit. The patient was 4 days old when this tumor was first detected. He underwent an exenteration at 6 weeks and remains tumor-free 27 months after surgery.

CASE REPORT
This infant was born with Kartagener's syndrome (triad of situs inversus totalis, dextrocardia, and ciliary dyskinesia). He had been the product of an uneventful pregnancy between two first cousins. There was no family history of genetic disease.

He underwent a magnetic resonance imaging (MRI) study of the head in an attempt to explain fluctuating arterial oxygen levels. This study failed to demonstrate any intracranial abnormalities, but revealed a 2×2×3-cm triangular-shaped mass located within the superior lat-

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