SUMMARY

Strabismus may represent as a complication following many of ophthalmic surgeries. It is considered a rare complication in most of the cases. The anesthetic effect on extraocular muscles and orbital tissue, mechanisms that can cause diplopia include direct needle injury to the muscle, especially the inferior rectus muscle, haemorrhage within the muscles or a myotoxic effect of injected local anesthetics.

Strabismus may occur after cataract surgery due to any of three factors. First, Pre-existing unnoticed disorder such as dysfunction of cranial nerves, myasthenia gravis, dysthyroid, childhood strabismus and previous surgical trauma. Second, disorders due to prolonged occlusion caused by cataract which induce loss of control of latent strabismus previously controlled by fusion, in addition, patients with long-standing unilateral cataracts may be uniquely at risk for postoperative intractable diplopia caused by permanent disruption of central fusion. third, optical causes associated with aphakia and pseudophakia, especially anisophoria and anisokonia.

The incidence of strabismus following glaucoma implant devices is variable; it appears to be more common following placement of large-plate implants. This condition can be avoided by choosing less problematic quadrant (superotemporal quadrant), avoidance of direct injury to the extraocular muscle(s) as well as to the sheaths of those muscles, careful surgical technique, and prudent choice of the best glaucoma implant type. Motility disturbances following retinal detachment surgery may be transient and resolves spontaneously within

a few weeks or permanent. So Follow up for several weeks is required before any interference which includes prism management, occlusion, and Botox injection, while resistant cases require strabismus surgery.

Strabismus may occur as a recurrent condition that represent after surgical treatment for strabismus, and mainly caused by under- or over-correction of the primary condition. It also may occur due to slipped or lost extraocular muscle. Strabismus may occur after orbital decompression, its incidence depends on many factors include preoperative muscle affection, orbital procedure used in decompression, and asymmetrical herniation of orbital contents. Muscle affection may be in restrictive form, oblique muscle injury, torsional diplopia, or nerve injury. Strabismus also may occur as a complication of orbital fracture repair. Its occurance depends on age of the patient, type of fracture, time of orbital reconstruction, type of approach, and the material of implant. Most postoperative diplopia resolves spontaneously within 3-6 months postoperative.

Refractive surgery does not cause ocular misalignment; rather, it only allows the manifestation of the ocular misalignment that was previously present. This can be avoided by careful preoperative history taking and examination aiming to discover any binocular or muscle abnormalities. The most common mechanisms in occurrence of strabismus after pterygium are scar formation at the graft site, and trauma to the medial rectus muscle. The aim of surgical management of these cases is to release restriction following pterygium excision, which require surgery on the conjunctival-perimuscular connective tissue complex and the medial rectus muscle.

Strabismus may be caused after blepharoplasty due to injury of extraocular muscle, entrapment of the superior oblique tendon, or cranial nerve affection. While strabismus after ptosis surgery occur rarely due to due to paresis of superior oblique or in some cases superior rectus muscle. Strabismus was reported as a rare complication after Conjunctivodacryocystorhinostomy (CDCR), with insertion of the Lester-Jones pyrex glass tube, which can result from conjunctival scarring at the Jones tube site causing restriction in lateral gaze.