

All About Strabismus

by [Dr. Jeffrey Cooper](#) & [Rachel Cooper](#) (no relation). © 2001-2005

Development, Causes, Diagnosis, Types, and Treatments.

Table of Contents

Evolution of Two-eyed Vision:

- [Two Eyes to the Side](#)
- [Two Eyes in Front](#)
- [Benefits of Two Eyes in Front](#)
- [What is Stereopsis \(3D Vision\)?](#)
- [Benefits of Stereopsis](#)

Evolution of Two-eyed Vision

Two Eyes to the Side

Nature has given animals the physical attributes necessary for survival. Lateral placement of the eyes is essential to the survival of hunted animals or herbivorous animals (e.g., horse, rabbit, cow) as it allows them to increase side or peripheral vision.

Side vision (increased by lateral placement) is a sensitive detector for motion or movement. Peripheral vision allows creatures to effectively scan for danger. The rabbit must be constantly aware of its natural enemies while it eats your garden greens. At the first sign of danger, peripheral vision, the motion detector system, alerts the rabbit that there is danger. The immediate reflexive response is for the rabbit to run.



Dr. Jeffrey Cooper
FAAO. FCOVD



Two Eyes in Front



Faster moving carnivorous hunters do not need as much peripheral vision as the hunted. It is more important for hunters to locate their prey and accurately determine the distance from themselves to that prey. Therefore, animals that hunt (carnivorous or meat eating animals, e.g. lion, cat) as well as humans have frontal placement of the two eyes in order to determine the exact location of their prey. The hunters sacrifice the large peripheral motion detection system afforded by side placement of the eyes in favor of the incredibly accurate depth perception system created by frontal placement of the eyes. To make up for the loss of peripheral vision, most carnivorous animals have also developed a sophisticated, pivoting system which extends the range of side vision...that is, the neck.

The Benefits of Two Eyes in Front

Frontal placement of the eyes allows for a remarkable visual phenomenon called stereopsis. Stereopsis is the 3D perception that occurs as a result of both eyes working together to create relative depth perception.

Many of you have experienced exaggerated demonstrations of stereoscopic depth by viewing I-Max 3D movies or old stereoscopes. Or, perhaps, you have seen photos of theatergoers in the 1950's wearing special Polaroid glasses in order to view 3D movies.



What is Stereopsis?

Stereopsis results from the combination of the two images received by the brain from each eye. Each eye views the world from a slightly different vantage point (See Fig 1).

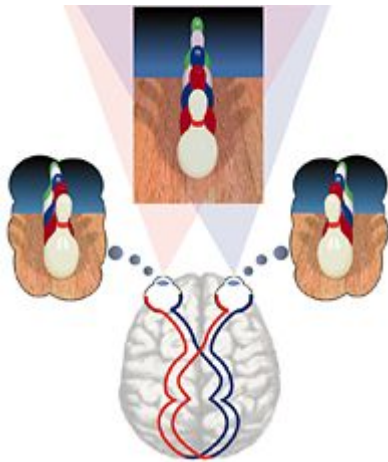


Figure 1

activity that requires accurate depth perception at close distances.

The fusion of these two slightly different pictures from our two "cameras" (the eyes) gives us the sensation of strong three-dimensionality or relative depth.

At near, there is a greater difference in what the two eyes view as compared to far. Thus, stereopsis is strongest and most important at near distances. **At near is where man uses accurate hand-eye coordination to make tools and other items!**

The Benefits of Stereopsis

Stereopsis has been very important in human development. Keen and accurate two-eyed depth perception has allowed man to develop tools and the manufacture of goods, a central aspect of modern civilization. Stereopsis plays a role in many other human activities, such as, catching a ball, parking a car, threading a needle, performing surgery, or any other

Animals that have lateral position of the eyes and individuals who have **constant** strabismus (eye turn) lack stereopsis. This does not mean that they have absolutely no depth perception. There are many one-eyed (monocular) depth perception cues that allow us to make reasonably accurate depth judgements. These monocular depth perception cues may be familiar to you and include: perspective, overlay, shadowing, aerial perspective (color of the sky), relative motion, relative size, etc.

Binocular vision cues (from two eyes), such as stereopsis and parallax, are dependent on accurate alignment of the eyes and appropriate unification of the



two images by the brain. People with only monocular or one-eye depth perception skills can do fine in many situations. However, they are not allowed to fly a rocket ship, drive the trains in New York city subways, and they definitely should not be surgeons. They may have trouble catching a fly ball or becoming a NBA point guard. However, many jobs do not require stereopsis and thus the lack of stereopsis does not preclude a successful life.

Stereopsis does enhance quality of life and life choices, however! Some eye doctors might tell you that it is a luxury, but it is part and parcel of our evolution and human potential. 3D vision is a human skill we all want and deserve. Every attempt should be made to develop this visual-motor skill in a child [and it's not too late for many adults!]

What is the "critical period?"

In the early 1960's, two Nobel Prize winners from Harvard , Hubel and Weisel, did research on the development of vision. They studied monkeys and cats who have stereoscopic vision similar to humans. This led to conclusions regarding a "critical period" of development for stereopsis.

What is the "critical period" and what does it mean in regards to you or your child and your treatment options. Explore this controversial topic by reading the following two articles by Dr. Jeffrey Cooper and Dr. Paul Harris, two different experts on strabismus. Dr. Harris refers to the famous 1960s Hubel and Weisel study as well as later studies by Hubel and Weisel and others. Many of the more recent studies call into question the idea of a finite "critical period." Dr. Cooper explains the Hubel and Weisel study and its implications in detail.

[The Myth of the Critical Period](http://www.strabismus.org/critical_period_myth.html)

by Dr. Paul Harris at http://www.strabismus.org/critical_period_myth.html

[Development of Vision](http://www.strabismus.org/critical_period_Hubel.html) (Critical Periods)

by Dr. Jeffrey Cooper at http://www.strabismus.org/critical_period_Hubel.html

Why does my eye doctor say it is "too late?"

Whenever an eye doctor tells you that it is "too late" to treat your child's loss of binocular vision (or eye turn or "lazy eye"), he or she is probably referring to his or her earlier education regarding the "critical period." He or she might even be directly or indirectly referring to the aforementioned research dating from the 1960s.

Remember, a great deal has been learned about the human brain since the 1960s! For example, a new ground-breaking study on the brain's plasticity (its ability to change and grow) was released to broad media fanfare in the year 2000.

We recommend that you [find a doctor](http://www.optometrists.org/eye_doctors.html) (at http://www.optometrists.org/eye_doctors.html) who is more up-to-date on the latest in developmental vision and the brain (neuronal plasticity).

When is it too late to treat strabismus or lazy eye?

It is often asked at what age should treatment no longer be attempted. The answer is, everyone deserves a chance! Age should not be a deterrent, though treatment under age 6 (especially before 2) is ideal and allows better results than later treatment. After age 6, age is not important.

"... every attempt should be made to improve strabismus and lazy eye."

The best chance of success in eliminating the effects of the **most difficult conditions**, amblyopia or constant strabismus, occurs before the age of two. However, this does not preclude excellent success in many older patients and at least partial success in **most** patients older than 6 years of age. There are numerous studies that demonstrate that treatment after the age of 6 is very successful. One study compared treatment before age 6 to treatment after age 6. They found no statistical difference between the two groups. As a matter of fact, loss of an eye in patients over the age of 65 who were never treated for their amblyopia experienced a spontaneous improvement in vision in over one-third of

the cases.

Thus, every attempt should be made to improve strabismus and lazy eye, though treatment might not be as effective after the age of six, and definitely requires more work. Also, remember that if an eye turn occurs only some of the time (intermittent), the cells of the brains do not develop the changes associated with the more challenging cases of constant eye turns.

An analogy to understanding the relationship of age in regards to the treatment of eye muscle anomalies would be to consider the relationship of one's age in learning to speak a second language. During the period of neurological development, around the first year of life, language development is natural and spontaneous. Children raised in families that speak two languages from birth automatically learn both languages. However, if the second language is introduced in later school years, language development takes a longer time and is more arduous. Yet, remember, people learn languages well into their sixties and seventies. The very same is true of visual development. It is easier to develop normal vision during the critical period, but with work, many people can develop normal binocular vision in later years.

"It is never too late to try!!"

References

Birnbaum MH, Koslowe K, Sanet R. Success in amblyopia therapy as a function of age: a literature review. *Am J Optom Phys Opt.* 1977; 54:269-275.

Cooper J, Ciuffreda K, Kruger P. Stimulus and Response AC/A Ratios in Intermittent Exotropia of the Divergence Excess Type. *British Journal of Ophthalmology*, 66(6): 398-904, 1982.

Cooper J, Feldman JM, Selenow A, Fair R, Bucciero F, MacDonald D, Levy M. Reduction of Asthenopia Following Accommodative Facility Training. *Am J Optom Physiol Opt.* 64, 30-436, 1987.

Cooper J, Burns C, Cotter S, Daum KM, Griffin JR, Scheiman M. Optometric Clinical Guideline: Care of the patient with accommodative or vergence dysfunction. *Am. Optom. Ass.* 1998.

Cooper J, Ciuffreda KJ, Carniglia PE, Zinn KM, Tannen B. Orthoptic Treatment and Eye Movement Recordings in Guillain-Barre Syndrome. A case report. *Neuro-ophthalmology* 15(5):249-256, 1995.

Cooper J, Duckman R. Convergence Insufficiency: Diagnosis and Treatment. *Journal of the American Optometric Association*, 49(6):, 1978.

Cooper J, Feldman J. Operant Conditioning of Fusional Convergence Ranges Using Random Dot Stereograms. *American Journal of Optometry & Physiological Optics*, 57(4): 205-213, 1980.

Cooper J, Feldman J. Panoramic Viewing, Visual Acuity of the Deviating Eye and Anomalous Retinal Correspondence in the Intermittent Exotropia of the Divergence Excess Type. *American Journal of Optometry & Psychological Optics*, 56(7): 422-429, 1979.

Cooper J, Medow N, Dibble C. Mortality Rates in Strabismic Surgery. *Journal of the American Optometric Association*, 53(5): 391-395, 1982.

Cooper J, Medow N. Intermittent Exotropia of the Divergence Excess Type: Basic and Divergence Excess Type (Major Review). *Bin Vis Eye Mus Surg Qtly* 8:187-222, 1993.

Cooper J, Selenow A, Ciuffreda J, Feldman J, Faverty J, Hokoda S. Reduction of Asthenopia in Patients with Convergence Insufficiency Following Fusional Vergence Training. *Am J Opt Physl Opt*, 60: 982-989, 1983.

Cooper J. "Diagnosis and Remediation of Accommodative Anomalies", Chapter in *Clinical Diagnosis of Optometric Problem* Ed: John Amos Butterworth Publications, 1987.

Cooper J. A Case Report: Treatment of a Decompensating Esotropia Who Had Diplopia and Vertex Headaches. *Journal of American Optometric Association*, 48(12): 1557-1558, 1977.

Cooper J. Intermittent Exotropia of the Divergence Excess Type. *Journal of the American Optometric Association*, 48(10): 1251-1273, 1977.

Cooper J. Orthoptic Treatment of Vertical Deviations. *J Amer Optom Ass*. 59 (6): 463-468, 1988.

Cooper J. Review of Computerized Orthoptics with Specific Regard to Convergence Insufficiency. *Am. J. of Optom. and Phys. Optics*. 65(6): 455-463, 1988.

Cooper, J. Clinical Implications of Vergence Adaptation. *Opt Vis Sci*, 69 (4): 300-307, 1992.

Cotter S. Conventional therapy for amblyopia. *Probl Optom*. 1991; 3:312-330.

Feldman J, Cooper J, Reinstein F, Swiatoca J. Asthenopia Induced by Computer-Generated Fusional Vergence Targets. *Opt Vis Sci*, 69: 710-716, 1992.

Flax N, Duckman RH. Orthoptic treatment of strabismus. *J Am Optom Ass* 1978; 49:1353-1361.

Flom NC. The prognosis in strabismus. *Am J Optom Arch Am Acad Optom*. 1958; 35:509-514.

Garcia RP. Efficacy of vision therapy in amblyopia: a literature review. *Am J Optom Phys Opt* 1987; 64:393-404.

Ludlam WM. Orthoptic treatment of strabismus. *Am J Optome Arch Am Acad of Optom*.

1961; 38:369-388

Ludlam W, Kleinman B. The long range results of orthoptic treatment in strabismus. *Am J Optom Phy Opt*. 1965; 42(11); 647-684.

North RV, Henson BD. Effects of orthoptics upon the ability of patients to adapt to prism induced heterophoria. *Am J Optom Phys Opt*. 1982; 59: 983-986.

Scheiman M, Ciner e. Surgical success rates in acquired, comitant, partially accommodative and non-accommodative esotropia. *J Am Optom Ass* 1987; 58:556-561.

Wick B. Vision therapy of small angle esotropia. *Am J Optom Physiolk Opt*. 1974; 51(7); 490-496.

Wick B, Cook D. management of anomalous correspondence: efficacy of therapy. *Am J Optom Physiol Opt*. 1987; 64:405-410.

Ziegler D, Huff D. Rouse MW. Success in strabismus therapy: a literature review. J Am Opt Ass. 1982; 53:979-983.

All About Strabismus by Dr. Jeffrey Cooper & Rachel Cooper (no relation) is located at http://www.strabismus.org/all_about_strabismus.html and is used courtesy of The Optometrists Network. © 2001-2005.