

A CASE OF INTERMITTENT DIVERGENT SQUINT – BASIC TYPE WITH LATERAL INCOMITANCE

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ABSTRACT

Intermittent divergent squint (IDS) is a common form of childhood exotropia characterized by episodic outward deviation of one or both eyes. It can impact binocular vision and psychosocial development. We present a case of a 14-year-old female with a 10-year history of IDS, classified as basic type with lateral incomitance. Orthoptic assessment and scoring using Newcastle and PEDIG scales guided the management plan.

INTRODUCTION

Intermittent exotropia, a subtype of divergent squint, typically presents in childhood with variable control over fusion. Classification based on deviation pattern, control, and fusional amplitudes informs management.

CASE PRESENTATION

A 14-year-old female presented with complaints of outward deviation of both eyes for 10 years. The onset

was gradual, intermittent, alternating, and non-progressive, exacerbated by fatigue and evening hours. There was no history of vision loss, diplopia, trauma, or systemic illness. Birth history was uneventful except for neonatal jaundice. No relevant family or treatment history was noted.

Ophthalmic examination showed alternate suppression on Worth Four Dot Test (WFDT)

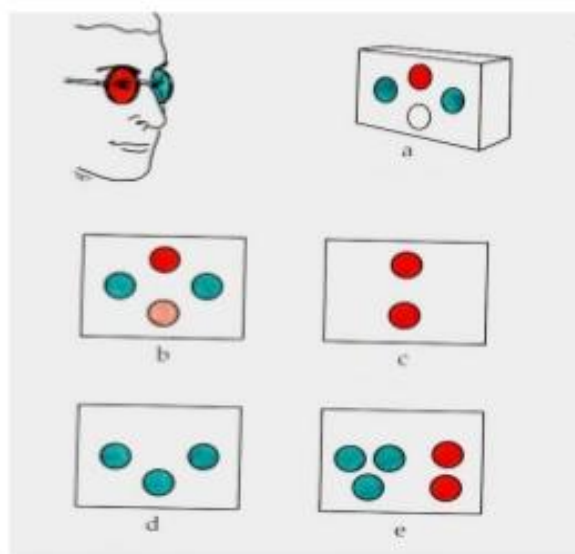


Figure 1: WFDT showing alternate suppression both for near and distance.

Fusion was present on TNO. Stereopsis was measured at 80 seconds of arc. The Hirschberg test revealed central reflexes.



Figure 2: HT- central.

Cover-uncover and alternate cover tests confirmed intermittent exotropia with near and distance measurements consistent with a basic type deviation.

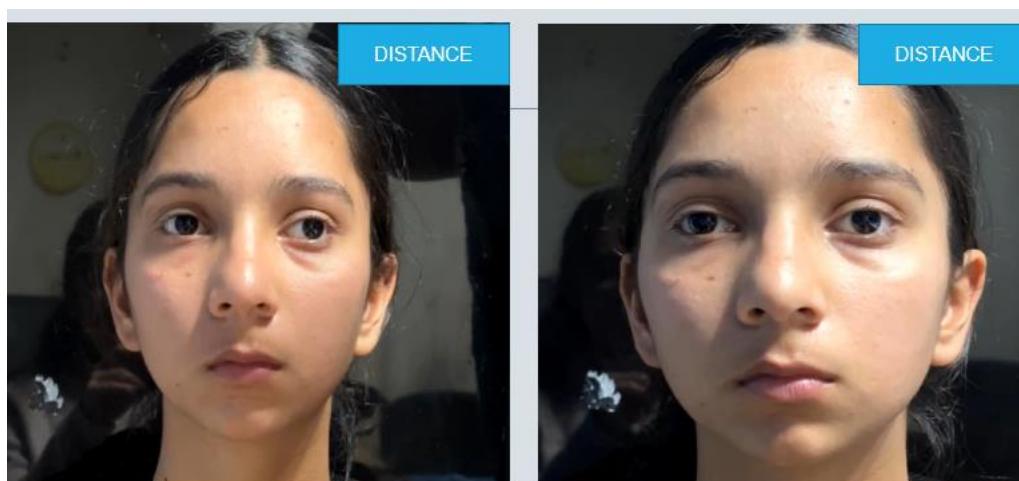


Figure 3: Alternate Xt On Cover Uncover Test – With B/E Good Vision And No Fixation Preference.

Prism bar cover test showed 40 prism diopters base-in for near.

	35-40 PD BI	
25PDBI	40 PDBI	30PDBI
	30 PDBI	

NEAR 40 PDBI

Figure 4: Prism bar cover test showed 40 prism diopters base-in for near.

Orthoptic workup showed convergence amplitude break point at 10–12 PD and recovery at 6–8 PD. Divergence amplitude break was 6 PD and recovery 4 PD. Near point of convergence was 8 cm and near point of accommodation was 10 cm.

SCORING AND CLASSIFICATION

Newcastle Score: 4 (2+1+1)

PEDIG Control Scale: 4

Classification: Basic type with lateral incomitance (Calhounz Phase 3)

Diagnosis: Intermittent exotropia – Basic type with lateral incomitance

MANAGEMENT PLAN

Given the worsening control and a Newcastle score >3, surgical correction was considered appropriate. The plan included Recession-Resection (R&R) procedure based on the deviation pattern and presence of lateral incomitance.

DISCUSSION

Intermittent exotropia affects 1% of the population and has a higher prevalence in females. Progression from phoria to tropia often results in loss of binocular fusion. Standardized control scoring (e.g., Newcastle, PEDIG) and classification (e.g., Burian, Kushner, Calhounz) are vital for objective management. The choice of surgery depends on type and extent of deviation. In basic type, R&R or bilateral lateral rectus recession are commonly used.

CONCLUSION

This case highlights the importance of detailed orthoptic evaluation and standardized scoring in the diagnosis and management of intermittent exotropia. Timely surgical

intervention guided by clinical and orthoptic data ensures better functional and cosmetic outcomes.

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