College of Optometrists in Vision Development
215 W. Garfield Road, Suite 210, Aurora, OH 44202
Voice: (330) 995-0718 or (888) 268-3770 | Fax: (330) 995-0719
Website: www.covd.org

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MONOCULAR COMITANT ESOTROPIA
ICD-9-CM: 378.01

DEFINITION:
A sensorimotor anomaly of the binocular visual system in which the foveal line of sight of one eye deviates inward and fails to intersect the object of fixation. The angle of deviation remains constant for all positions of gaze. [NOTE: Cases of monocular comitant esotropia may be accompanied by functional amblyopia and anisometropia.]

SIGNS AND SYMPTOMS:
The signs and symptoms associated with monocular comitant esotropia may include, but are not limited to, the following:
1. avoids eye contact
2. inaccurate/inconsistent depth judgment and/or eye-hand coordination
3. reduced monocular acuity, tendency to cover/close one eye
4. diplopia (ICD: 368.2) or awareness of suppression
5. eye turn, deviation (ICD:378.9)
6. avoidance of visually demanding tasks
7. reduced efficiency and productivity/diminished accuracy/inconsistent work product
8. abnormal postural adaptation/abnormal working distance (ICD: 781.9)
9. spatial disorientation
10. incoordination/clumsiness (ICD: 781.3)

DIAGNOSTIC FACTORS:
Monocular comitant esotropia is characterized by one or more of the following diagnostic findings:
1. strabismus, esotropia (ICD:378.00)
2. unilateral deviation, often associated with amblyopia
3. asymmetrical performance between the two eyes
4. deviation influenced minimally by accommodation

THERAPEUTIC MANAGEMENT CONSIDERATIONS:
The doctor of optometry determines appropriate diagnostic and therapeutic modalities, and frequency of evaluation and follow-up, based on the urgency and nature of the patient's conditions and unique needs. Vision disorders that are not totally cured through vision therapy may still be ameliorated with significant improvement in visual function and quality of life. The management of the case and duration of treatment would be affected by:
1. the severity of symptoms and diagnostic factors, including onset and duration of the problem
2. the complications of associated visual conditions
3. implications of patient's general health, cognitive development, physical development, and effects of medications taken
4. etiological factors
5. extent of visual demands placed upon the individual
6. patient compliance and involvement in the prescribed therapy regimen
7. type, scope, and results of prior interventions

8. occupational/avocational goals

PRESCRIBED TREATMENT REGIMEN:
The goal of the prescribed treatment regimen is to address the diagnostic factors and alleviate the presenting signs and symptoms associated with the diagnosed condition. The treatment of monocular comitant esotropia requires the use of optometric vision therapy/orthoptics, which may include the use of lenses and/or prisms. In some cases, surgery may be required in conjunction with pre-and post-surgical optometric vision therapy/orthoptics, which incorporates the prescription of specific treatments in order to:

1. equate monocular skills
2. address fusion (sensory) development
3. address associated visual conditions
4. establish bifoveal fixation
5. normalize fusional vergence ranges, facility, flexibility, and stability
6. normalize accommodative/convergence relationships/normalize depth judgments and/or stereopsis
7. integrate binocular function with information processing
8. reduce esophoria
9. normalize abductive ranges
10. integrate binocular skills with accurate motor responses
11. integrate binocular skills with other sensory skills (vestibular, kinesthetic, tactile, and auditory)
12. increase visual stamina/integrate newly established skills with information processing

DURATION OF TREATMENT:
The following treatment ranges are provided as a guide. Treatment duration will depend upon the particular patient's condition and associated factors. When duration of treatment beyond these ranges is required, documentation of the medical necessity for additional treatment services may be warranted for third-party claims processing and review purposes.

1. The most commonly encountered monocular comitant esotropia usually requires 60 hours of office therapy.
2. Monocular comitant esotropia may require substantially more office therapy, if complicated by associated factors such as amblyopia, anomalous correspondence, prior eye muscle surgery, cerebral vascular accident, head trauma, and/or systemic conditions.

FOLLOW-UP CARE:
At the conclusion of the active treatment regimen, periodic follow-up evaluation is required. Should signs, symptoms, or other diagnostic factors recur, further therapy may be medically necessary. Therapeutic lenses may be prescribed during or at the conclusion of active vision therapy to assist in the maintenance of long-term stability.

NOTE: MONOCULAR NONCOMITANT ESOTROPIA (ICD-9-CM: 378.04) HAS THE SAME DEFINING AND DIAGNOSTIC FEATURES EXCEPT THAT THE DEVIATION IS NOT THE SAME IN ALL POSITIONS OF GAZE. THE PROTOCOL IS THE SAME AS FOR MONOCULAR COMITANT ESOTROPIA. IT IS ADVISABLE TO TREAT THE PATIENT IN THE POSITION OF GAZE THAT IS MOST COMMONLY USED FOR THEM OCCUPATIONALLY/AVOCATIONALLY. NONCOMITANCY MAY ADD 20 HOURS OF OFFICE TREATMENT TO THE PROGRAM.