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College of Syntonic Optometry

Two Case Reports of Bilateral Amblyopia

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Case Report No. 1

Patient: M.L. Date June 16, 2941.

Age 11 years. Grade in school 6B.
Physical condition past and present: Good. Handedness: Right.
Complaint: She can see only light and objects, with extreme photophobia. She is wearing extra dark, smoked, sunglasses, with the sides covered, keeping out all light. Indoors she wears smoke No. 3 in plane. Her brother is the same (See case No. 2). Lessons are read to them in school by other students. Mother has taken them to may specialists, including university medical clinics, with no results. Both are completely color blind.
Ophthalmoscope: Negative. Naked vision: RE and LE, 5/400. by squinting to the point that the eye lids are almost completely closed. Versions: Fair. Rotations: Fair. Absolute convergence: 5 inches. Movements: Slow. Pupils: 8mm. Pupillary reflexes: Sluggish. The following are normal: irises, lids, conjunctivas, cornea, lenses and lachrymal apparati.

Ophthalmometer: RE 44.75 at 80 LE 44.75 at 90
44.00 at 170 44.00 at 180

Static: OU 43.00
Dynamic at 20" OU +5.50
Dynamic at 40" OU +4.50

Subjective: OU +2.50. Acuity: on chrome charts: Red: ET, Blue: ETA.
After 13 visits, NV OD, OS, OU, 20/200. Subjective +2.50, Acuity now 20/70. Visual training consisted of work on the squint korrector and teleyetrainer, also one of the Peckham devices, without flashing, and follow by Syntonic Rx No. 1 (NL 4 m.; α 6 m. FF: α + θ 5 m. FF; α +S 5 m. FF.) alternated with Rx No. 2. (NL 5 m.: μ 5 mi. ; θ +S 5 m. FF; μ + υ 5 m.)

Unfortunately, after her thirteenth visit, she left to go home, which was in another city, and did not return. However, they were so pleased with her results that they sent her brother to me for help. His case report follows. However, her acuity had improved to the point where the patient was now able to read her own lessons, and her work in school improved.

CASE REPORT No. 2

Patient: R. L. Date July 31, 1941
Age 12, 7th grade in school.
Physical condition, past and present: Good.
Complaint: Extreme photophobia, with vision limited to light ad objects. He is totally color blind. Since the age of 1 years, he has been examined by at least six medically grained eye men, including a University Medical Clinic. He has never been able to see well enough to read print or lessons b y himself. He has always had someone else read his lessons to him.

Versions: Slow. Rotations: Slow. Absolute convergence: 3 ½ inches.
Movement: slow. Pupils: 6 mm. Pupillary reflexes: Sluggish. The following were normal or negative: irisaes, lids, conjunctivas, corneas, lachrymal apparati, lenses.

PD. 64/61. Ophthalmoscope: Negative.
Old Rx none. Naked vision, RE and LE 5/400, and that by squinting.

Ophthalmoscope: RE 43.50 at 175 LE 43.25 at 135
44.00 at 90 44.00 at 65Static: OU +2.75
Dynamic at 20": OU +4.25
Dynamic at 40": OU +3.00
Subjective: OU +1.50 VA 20/200 by squinting.

After 7 visual training visits, naked vision was 20/200 by squinting, and his subjective was still the same, but his acuity was now 20/80-2 with each eye. The training consisted of work on the squint korrector, and tele-eye-trainer, followed by syntonic Rx No. 1 alternated with No. 2. After that time the patient had to leave the city, and then the war followed. I did not see the patient again until August 21, 1946. An examination at that time disclosed no great change in my findings compared with what he had been able to achieve before coming under my care, the results were outstanding. He had done better in school, read his own lessons, has finished high school and plans to attend some college.

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