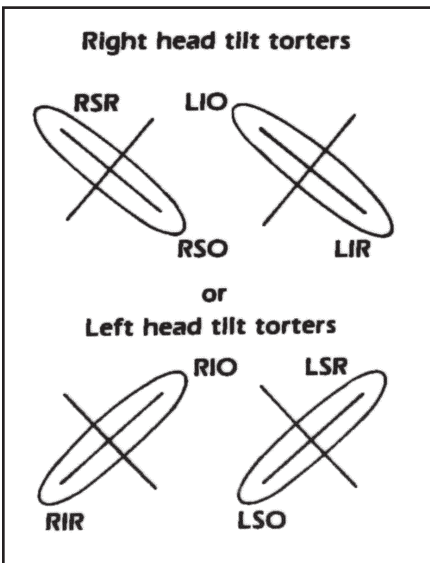


**Figure 2-8.** The 3ST. Maddox rod measurements of a patient with LHT. Head is tilted to the left and the base of the prism is held parallel to the floor of the orbit. The Maddox rod is held so that the red line (visible to the patient) is also parallel to the floor of the orbit.



**Figure 2-9.** The 3ST. Step 3: An HT worse on right head tilt could be due to a palsy of the right eye intorters—RSR or RSO, or the left eye extorters—LIO or LIR (top). An HT worse on left head tilt could be due to a palsy of one of the right eye extorters—RIR or RIO, or the left eye intorters—LSO or LSR (bottom).

eye against a weak RSR would result in the eye dropping hypo. Thus, the original LHT would be largest during head tilt to the right in an RSR palsy.

If the LSO was palsied instead, it would try to intort the eye only during head tilt to the left. Its synergist for intorsion, the LSR, would also be elevating the left eye against a weak LSO (which should normally be depressing the eye). Therefore, a weak LSO would result in an increased LHT during head tilt to the left.