



PRIMARY OPEN ANGLE GLAUCOMA CLINICAL IMPORTANCE OF CAREFUL FOLLOW-UP EXAMINATION

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ABSTRACT

Patients with high intra-ocular pressure deserve careful follow-up examinations so that glaucomatous changes can be identified and treated quickly. In a case study evaluated during a vision screening shows how changes can develop, even over relatively short periods of time.

INTRODUCTION

Open-angle glaucoma is the most common form of glaucoma. The "open" drainage angle of the eye can become blocked leading to gradual increased eye pressure. If this increased pressure results in optic nerve damage, it is known as chronic open-angle glaucoma. The optic nerve damage and vision loss usually occurs so gradually and painlessly that you are not aware of trouble until the optic nerve is already badly damaged.

CHIEF COMPLAINT

Anigbogu Mary is a 41-year-old female Accountant whom we saw in February of 2000 at a "Save your vision week" glaucoma screening in Abakaliki. During the screening, her intraocular pressure as measured by schiotz tonometer were 24mm Hg in both eyes, and her cup/disc ratios were 2/4 in both eyes. She saw us in April for a full eye examination and complained that her left eye was blurry.

A.M. had a history of hypertension, she was taking one tablet of Aldomet per day. Her mother had a history of cataracts.

DIAGNOSTIC DATA

Visual acuity: - Uncorrected visual acuity was 6/6 OD, 6/9 OS and 6/6 OU. At near her visual acuity were 0.62m in both eyes and with a pin hole, visual acuity was 6/6 with OS.

REFRACTION

A manifest refraction of +0.50 D gave 6/5 vision in the right eye; a +0.75/-50x90 correction gave 6/5 in the left eye and +2.00 add was given for near.

EYE HEALTH

All external tests were normal. The disc had good rims with visible lamina. There were no spontaneous venous pulsations at the nerve head. The rest of the disc had a good pink colour, and the vessels, maculae and back grounds were normal. Slit lamp examination and visual field as measured by perimetry were normal.

Other Tests

The patients blood pressure was 130/70, and her colour vision as measured on the ishihara test chart was good.

DISCUSSION OF DATA

She is hyperopic and Astigmatic. She is also presbyopic, we also suspected glaucoma. She had fairly large cup to disc ratio. We prescribed glasses for her and advised her to return in six months for a glaucoma work-up.

FOLLOW-UP CARE

On a follow-up visit six months later, her disc, blood pressure visual fields, intraocular pressure were unchanged, so we asked her to return again in another three months.

At the time of second follow-up visit, there were elevations in her blood pressure and her intraocular pressure, and changes in her visual fields.

Her blood pressure stood at 150/100. Intraocular pressure were 25mm Hg. in both eyes. Both of her eyes showed slightly enlarged blind spots as shown on a target screen with a 2/1000 white target.

Our consulting ophthalmologist recommended that we watch the patient closely for signs of field changes.

Over the next year, A.M's finding remained stable, with mildly elevated intraocular pressure, mild hypertension and relatively stable visual acuity. The blind spot remained somewhat enlarged.

At A.M's follow-up exam four months later, we noticed definite changes in her visual fields. Her I.O.P. remained at 25mm Hg O.U. we referred A.M to an ophthalmologist with a diagnosis of open angle glaucoma.

DISCUSSION

The I.O.P. we measured should not be considered low for open angle glaucoma. In a random sample for women in Abakaliki and Afikpo, intraocular pressure for women over 40 averaged 20.00mm Hg, with standard deviation of 4.00. In A.M. case, I.O.P. was in the abnormal two percent of the population.

TREATMENT PLAN

Our consulting ophthalmologist reviewed our data from the past two years, and decided to treat A.M with pilocarpine 1% twice a day.

Treatment lowered A.M's I.O.P to 17mm Hg OD and 18mm Hg OS, the patient adapted well to the visual side effects of pilocarpine therapy, and to date no problems have occurred.

CONCLUSION

Routine follow-up on patients with elevated intraocular pressure may lead to early and successful diagnosis of glaucomatous changes. Early diagnosis and prompt treatment can often prevent serious and sight-threatening consequence from developing.

REFERENCES

1. D. Vaughan & Asbury. General Ophthalmology 8th Edition, Chapter 17 and pages 20 and 39.
2. Irvin M. Borish, Clinical Refraction. Third Edition Volume one. Pages 488-497 and 519-522.