PO-09

Clinical case report of a patient with primary angle closure glaucoma and the condition after central retinal artery occlusion in the left eye, and with primary angle narrowing in the right eye

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PURPOSE A clinical case report of a 43-year-old patient with suddenly occurring blurry vision in his left eye. At the first examination, combined retinal artery and vein occlussion with normal intraocular pressure was suspected. During subsequent treatment the intraocular pressure in his left eye was elevated. In the process of identifying the cause of the elevated intraocular pressure primary angle narrowing was found bilaterally, which could, together with intraocular pressure spikes, be the primary cause of changes visible in the eye fundus.
METHODS A review of patient's medical records.
RESULTS At the first examination of the patient at the emergency department, visual acuity in the left eye was corrected by 0.2 using a Snellen chart, and the intraocular pressure was within normal limits. In the eye fundus, disc haemorrhages above the optic nerve head, white swollen retina and tortuous veins were visible. Combined retinal artery and vein occlussion was suspected. Later, fluorescein angiography was performed, which suggested prolonged filling of venules in the later stages, veins were minimally tortuous, fluorescence blocks were visible on "bear tracks", there were no ischemic areas. Thorough imaging and laboratory diagnostics of cardio-vascular risk factors were performed, and they were within normal limits. Five months after the primary event, the elevated intraocular pressure in patient's left eye was found. The OCT of the left optic disc showed retinal nerve fibre layer thinning, and defects paracentral nasal inferior in visual field Octopus G2 top. During this time, secondary glaucoma in the left eye was suspected. Nine months after the primary event, the patient was examined in a glaucoma outpatient clinic to exclude angle neovascularization. In the examination, markedly shallow anterior chambers, without NVI, were clinically reported, and the optic nerve head in the left eye was fully excavated. Laser iridotomy was performed bilaterally and a diagnosis of primary angle closure glaucoma was made.
CONCLUSION At the first examination in an outpatient clinic, the most visible clinical changes in the eye status are not necessarily always the primary cause of problems. A thorough medical history of a patient and a precise clinical examination are important.

Predstavitev kliničnega primera pacienta s primarnim glavkomom zaprtega zakotja in stanja po zapori centralne mrežnične arterije na levem očesu ter s primarnim ožjim zakotjem na desnem očesu

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NAMEN Predstavitev kliničnega primera 43-letnega pacienta z nenadno nastalim meglenim vidom na levem očesu. Ob prvem pregledu je bil postavljen sum na kombinirano zaporo arterijskega in venskega sistema na levem očesu ob normalnem očesnem pritisku. Tekom nadaljnjih obravnav je bil prisoten povišan očesni pritisk na levem očesu. Ob iskanju vzroka za povišan očesni pritisk je bilo ugotovljeno primarno ožje zakotje obojestransko, kar bi lahko ob skokih očesnega pritiska bil primarni vzrok za nastale spremembe, ki so bile vidne na očesnem ozadju.
METODE Pregled dokumentacije bolnika.
REZULTATI Ob prvem pregledu pacienta v urgentni ambulanti je bila korigirana vidna ostrina na levem očesu 0,2 po Snellenu, očesni pritisk je bil v mejah normale. Na očesnem ozadju je bila videti plamenasta krvavitev nad papilo, makula z ishemijo ter zvijugano žilje. Postavljen je bil sum na kombinirano zaporo arterijskega in venskega sistema. Pacient je kasneje opravil fluoresceinsko angiografijo, kjer se je nakazovalo podaljšano polnjenje venul v poznih fazah, žilje je bilo minimalno zvijugano, vidni so bili bloki fluorescence na mestih »bear tracks«, ishemičnih področij ni bilo. Opravljena je bila obsežna slikovna in laboratorijska diagnostika srčno žilnih dejavnikov tveganja, ki je bila v mejah normale. Pet mesecev za primarnim dogodkom je bil pri pacientu ugotovljen povišan očesni pritisk na levem očesu. Na OCT papil levo so bile stanjšane plasti RNFL, na vidnem polju Octopus G2 top je bil prisoten izpad paracentralno nazalno spodaj. V tem času je bil pacient voden kot suspektni sekundarni glavkom na levem očesu. Devet mesecev po primarnem dogodku je bil na pregledu v glavkomski ambulanti zaradi izključitve neovaskularizacije v zakotju. Ob pregledu sta bila klinično opisana izrazito plitka sprednja prekata, brez NVI, papila vidnega živca levo je bila v celoti ekskavirana. Opravljena je bila laserska iridotomija obojestransko in postavljena diagnoza primarni glavkom zaprtega zakotja.

ZAKLJUČEK Ob prvem pregledu v ambulanti ni vedno nujno, da so najbolj opazne klinične spremembe v očesnem statusu tudi primarni vzrok težav. Pomembna je temeljita anamneza bolnika in natančen klinični pregled.