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# PRIMARY eyecare

## Visual Fields Analysis Alerts GP to Cancer Progression

A 52 year old business owner recently presented to her optometrist for an eye examination. Symptoms centered around dull headaches around her right temple, often present on waking (but not severe enough to actually waken her). She also felt that her vision had changed, and specifically mentioned a difficulty in reading fine detail.

This latter symptom is one almost expected of an individual enmeshed in the age-normal presbyopic progression, and the examining optometrist fully expected to find the usual hypermetropic shift with the subsequent need to represcribe her 2 year old "progressive" spectacles.

Her most recent eye examination had been 2 years prior; on that occasion she demonstrated only minor refractive error, correcting to 6/5 with each eye. Progressives were prescribed, mainly due to the variable nature of her visually-oriented tasks rather than for any specific need to correct her distance vision. Questioning revealed a history of glaucoma in the family, albeit distant. She had experienced breast cancer in 1999 and had briefly been treated with chemotherapy. Contemporary history revealed that she was currently being treated for a Thyroid disorder, Thyroxine having been prescribed. It was noted that she had a very slight slur to her speech, apparently intermittent.

The examining optometrist's first concern was that he was unable to improve her acuity to any better than a difficult 6/6 with her right eye and 6/9 with her left; she had experienced minimal refractive change in the intervening period. There appeared to be no obvious physiological rationale for this reduction in acuity; specifically, her ocular media were clear and her maculae normal and healthy. Her optic discs to stereoscopic analysis looked normal, with minimal cupping. Certainly, they were not oedematous although there was a slight question of possible sectorial pallor temporally. Intraocular pressures measured normally, in the mid teens (consistent with previous measurements).

A visual field screening revealed an apparent depression of sensitivity in the inferio-temporal quadrants of each eye, this being more apparent in the para foveal area rather than peripherally. This somewhat nebulous result was repeatable, and her GP, responding to the optometrist's report of the apparent field defect, was able to arrange on urgent CT scan.

The patient was found to have metastatic tumours, secondary to the primary in her breast, occupying areas in the region of the pituitary fossa and also the right occipital lobe.

## Visual Fields and Glaucoma

Two patients seen at NZAO optometry practices could have avoided loss of vision had their glaucoma been detected earlier.

The first lady was an ACC client who had suffered a nasty fall and believed that her vision had been affected by the accident. She had never been for an eye examination and had used ready made spectacles for several years.

A comprehensive eye examination indicated her eyes had been unaffected by the fall. However, she does have glaucoma and has already lost some of her vision due to this. In fact, the visual field contraction may well have caused her fall.

The second case was a woman who failed the driver licensing screening assessment at the AA. Unaided vision was R 6/6—L 6/12 and fields were marginal. There had to be something else going on. An examination of the back of the back of the eyes revealed suspicious looking optic nerves and the pressure was very high in the left eye. Another case of glaucoma stealing sight until detected

*"Optometrists will assist your diagnosis by providing a comprehensive eye examination for your patient."*

## BLURRY VISION — ALWAYS A CAUSE FOR CONCERN

A very fit 42 year old male triathlete consulted his optometrist with an awareness of "blurry vision" with his left eye. He was a long-standing soft contact lens wearer, so relatively contemporary recordings were on hand with respect to his previous visual status and associated physiology.

Vision with his contact lenses was recorded as R 6/9 and L 6/36. The left eye improved to 6/6- after a considerable reduction in his myopia was adjusted for. He was given a temporary disposable lens of appropriate power, and during a follow up consultation a week later, expressed satisfaction that his vision now seemed normal and clear.

The examining optometrist however was unsettled by the very unusual unilateral reduction in myopia, especially since good visual acuity had been maintained which mitigated against any possible swelling of the macula region (which in any case appeared healthy and normal).

His optic discs appeared normal and arguably as had been recorded a year prior; the view gained of the discs was perhaps not as clear as it should be, suggesting possible inflammatory turbidity in the vitreous.

On questioning, he admitted having had headaches associated with nausea some months prior; these had been diagnosed as a form of migraine and in any case ceased after physiotherapy attention to an old neck injury.

At his follow-up consultation, despite his complete lack of any current symptoms, his optic discs were noted to be showing the early signs of papilloedema.

Acute after-hours referral was arranged to the local Eye Department, with subsequent on-referral to neurology. A CT scan revealed a significant mass in the left temporal and parietal lobes, compressing the left lateral ventricle and shifting midline structures to the right. An emergency operation was scheduled, and, in time, the patient was able to return to a comparatively normal life.

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