



Acute Visual Loss

OBJECTIVES:

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DONE BY: Samar AlQhtani, Yara Aldigi, Ghada Alhadlaq.

REVISED BY: Deena AlNouwaiser, Shrooq Alsomali

REFERENCES: lecture, 436 teamwork, Lecture note book.

[Editing file](#)

Color index: [Important](#) | [Notes](#) | [Book](#) | Extra

Special thanks to 436 (A) teamwork.

Acute visual loss

- **What is acute visual loss (AVL)?**

- ◆ Sudden onset of blindness or significant visual impairment. Loss of vision is usually considered acute if it develops within a few minutes to a couple of days.
- ◆ A disaster for most people and you should be able to evaluate such a patient and be able to recognize situations requiring urgent action.
- ◆ It may affect one or both eyes, all or part of visual field, or it may arise from a pathology in any part of the visual pathway.

- **Etiology:**

- ◆ Acute visual loss (AVL) can be classified by:
 - Presence of pain.
 - Structure affected.

| AVL classified by PAIN | |
|---|---|
| Painful | Painless |
| <ul style="list-style-type: none"> ◆ Acute Angle Closure Glaucoma: can be acute or chronic (and becomes open angle). <ul style="list-style-type: none"> - in the past, they misdiagnosed it with MI due to pain severity, they presented with severe headache, drop of vision, severe eye pain, nausea and vomiting. ◆ Uveitis: <ul style="list-style-type: none"> - It may be slow or sudden and acute. - Patient is always in pain. ◆ Keratitis: <ul style="list-style-type: none"> - Infection (microbial keratitis) or inflammation of cornea. - Very severe pain, more than uveitis". ◆ Hyphema (Traumatic): can be asymptomatic unless if it's associated with other things. ◆ Endophthalmitis: infection of the eye as a whole (infection of the globe). | <ul style="list-style-type: none"> ◆ Vitreous Hemorrhage: <ul style="list-style-type: none"> - It can be painful if it is traumatic. ◆ Retinal Detachment: <ul style="list-style-type: none"> - It could be caused by trauma or w/o trauma. - The patient may have it and not discover it until covering one eye. ◆ Retinal vascular occlusions: <ul style="list-style-type: none"> - arteries/veins. ◆ Optic neuritis: <ul style="list-style-type: none"> - It happens in cases with MS could present with pain or without. - Sometimes eye movement may cause mild pain, but usually it is painless. ◆ Ischemic optic neuropathy. ◆ Cerebrovascular accident (CVA) (or stroke). ◆ Functional "no underlying cause". |

AVL classified by **STRUCTURE**

- ◆ **Media opacities:**
 - Something interferes with the passage of light from cornea to vitreous; Usually the pathology is not within the lens as it only causes visual loss in cases of very severe trauma.
- ◆ **Retinal disease:**
 - Improper absorption of light.
- ◆ **Optic nerve disease.**
- ◆ **Visual pathway or neurological disorders:**
 - Stroke/neuritis.
- ◆ **Functional disorders.**
- ◆ **Acute discovery of chronic visual loss:**
 - Usually unilateral, the patient will close one eye (the good eye) and notice he can't see from the other eye and rushes to the emergency.

All of the above may cause mild, moderate, severe visual loss or total blindness.

- Trauma causing 1) rupture of globe 2) Retinal detachment 3) Traumatic cataract 4) the lens falls backward into the vitreous if the zonules are ruptured (traumatic lens subluxation) 5) bleeding.

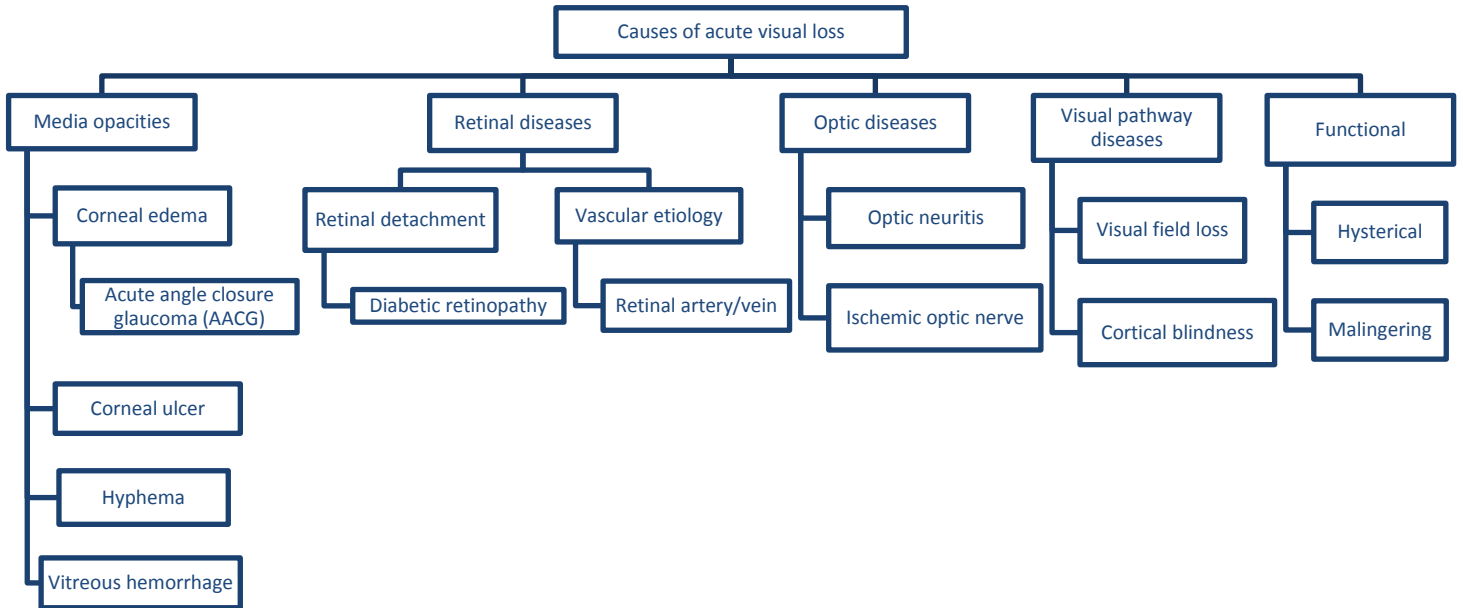
Clinical approach

History (Hx)

- ◆ **What is the patient's age and general medical condition?**
 - If pt is diabetic for example; You would expect certain causes of visual loss.
 - Young with no systemic disease → think about neurological causes: optic neuritis, retinal detachment or trauma.
 - Old with chronic medical condition → vascular cause.
- ◆ **Is the visual loss transient, persistent, or progressive?**
 - **Transient:** Vascular, migraine (ex: amaurosis fugax).
 - **Persistent** (continuous) such as retinal detachment, hemorrhage, or optic neuritis.
 - **Progressive:** non-vascular, could be the progression of optic neuritis.
- ◆ **Is the visual loss monocular or binocular?**
 - **Mononuclear:** (before optic chiasm-decussation) such as optic neuritis.
 - **Binocular** (after optic chiasm-decussation) such as cortical blindness.
 - Think about central causes and confirm it by pupillary reflex => it is 100% normal.
- ◆ **Did the visual loss occur suddenly, or it developed over hours, days or weeks?**
 - **Sudden** → vascular (ischemic, central retinal artery occlusion).
 - **Hours** → acute angle closure glaucoma.
 - **Days-Weeks** → optic neuritis and retinal detachment.
- **Did the patient have normal vision in the past and when was vision last tested?**
 - Some people will only realize loss of vision from one eye; when they cover the good eye.
- **Was pain associated with visual loss?**
- **Contact lens use?** corneal ulcer.
- **History of trauma?**

Physical Examination (P/E)

- ◆ **Visual acuity testing: after vital signs**
 - To see if the visual loss is mild, moderate, or severe.
- ◆ **Confrontation visual fields test:**
 - It is useful if there is a pathology in the distal part of visual pathway.
 - if it is suspected in the history, so it is useful in neurological deficit.
- ◆ **Pupillary reactions (very important).**
- ◆ **External examination of the eye with a pen light:**
 - we look at the eye in general to see if there's any trauma.
- ◆ **Ophthalmoscopy exam: (Direct)**
 - It can exclude media opacity; we observe the red reflex: In normal people it is present and equal in both eyes.
- ◆ **Tonometry to measure the intraocular pressure.**
- ◆ **Biomicroscopic examination (Slit lamp examination).**



• Media Opacities

- Corneal opacity is either due to edema or infection (like uveitis) or trauma corneal ulcer

◆ Corneal edema

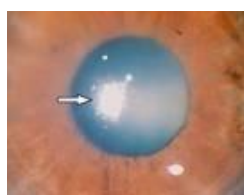
- The cornea usually translucent and made of collagen fibers in a way that makes it clear but here it appears like a ground glass (مطحون او مثلج) rather than its normal clear appearance (steamy cornea).



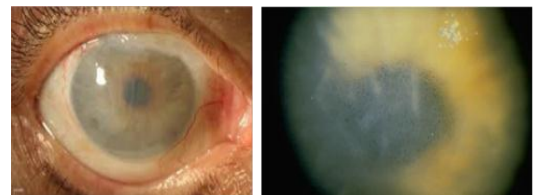
- The most common cause of corneal edema is **increased intraocular pressure** & occurs typically in acute **angle closure glaucoma**.
 - This is almost always the presentation of corneal edema. Why does it cause edema? because the high intraocular pressure interferes with the function of the endothelium which is bundling the aqueous humor from the stromal cells to detergent the cornea. This is true for abnormal ocular pressure of any cause!
 - Other causes of corneal edema include severe ocular hypotony¹.
- The other cause of corneal edema is infection
 - Any acute infection of the cornea by a corneal ulcer may **mimic** corneal edema.



Corneal opacity & hypopyon
Complication: corneal ulcer
(scarring) & glaucoma.



Abscess



Extra

¹ Hypotony is usually defined as an intraocular pressure (IOP) of 5 mmHg or less.

◆ **Corneal ulcer.**

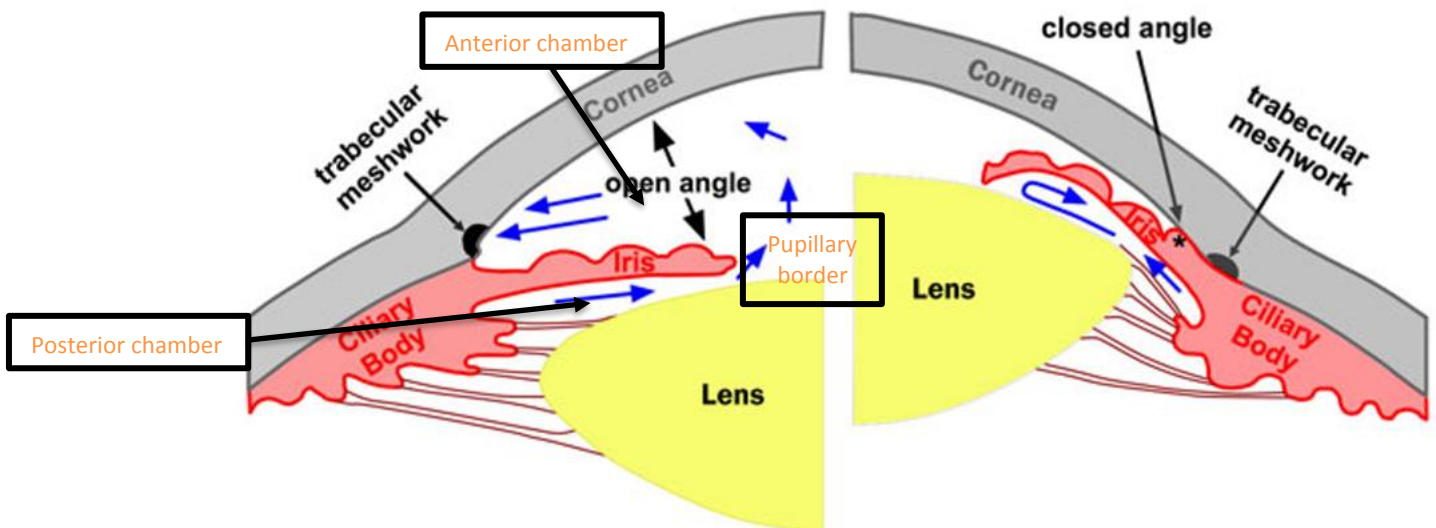
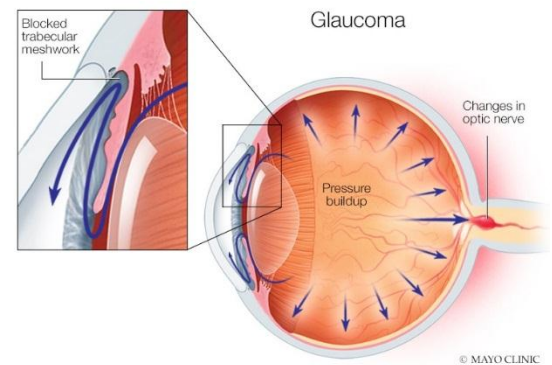
- When there is a corneal opacity due to destruction of tissue by infiltration of microorganisms and WBCs.
- It could be viral, bacterial, fungal, neurotrophic protozoal or in etiology.



◆ **Acute Angle Closure Glaucoma:**

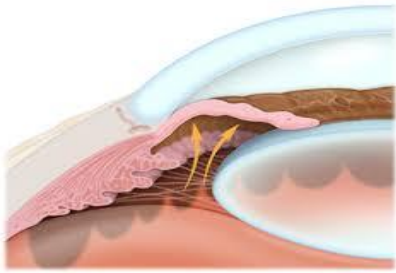
• **Signs & symptoms**

- Increased intraocular pressure.
- Media opacity (**corneal edema**).
- Congested injected eye w/ mid-dilated non-reactive pupil.
 - Why mid-dilated non-reactive pupil?
 - Normally the pupil either constricts or dilates.
 - In glaucoma, the IOP is so high that the blood supply stops to iris muscles (sphincter papillae & dilator papillae) resulting in ischemia.
- Acute decreased vision.
- Severe pain (sometimes people go the ER complaining of headache; they do CT/MRI & they find nothing while pt is screaming) around 27 mins.
- Redness.

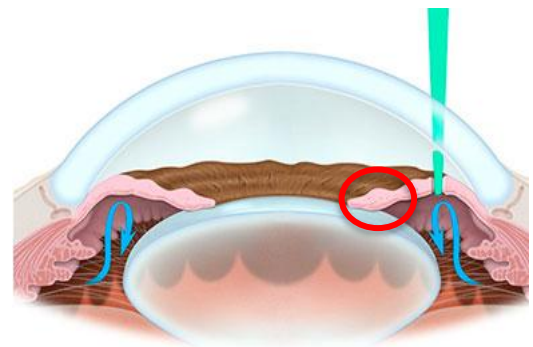
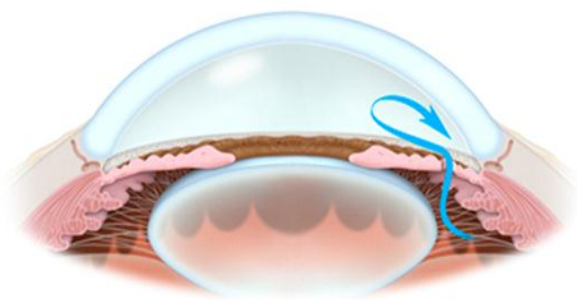


- Normally, the aqueous humor which is produced by the ciliary body travels from the posterior chamber through the pupillary border into the anterior chamber then it gets drained in the trabecular meshwork.
- What happens in acute angle closure glaucoma is that patients have a narrow angle to start with; At a certain point, may be with aging which involves the lens getting bigger the angle will become more narrow until it totally occluded & no fluid can be drained through the trabecular meshwork;

adding over this, the iris may bow anteriorly because of the pressure effect & touch the lens which will make the angle more occluded.



- The angle is narrow & the trabecular meshwork is occluded by the iris **touching** (if pt presents early) the periphery of the cornea & the pupillary edge of the iris bows against the lens closing the posterior chamber & pressure is building up.



- Management: by laser (Yag peripheral iridotomy)

- Aims of acute ACG management:

- Decrease IOP.
- Prevent future attacks in OU (oculus uterque, which means "both eyes") prophylaxis.

if pt presents **late** the iris will stick to the lens causing (**posterior synechia**) *red circle*

◆ Hyphema

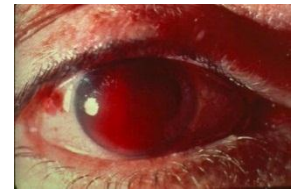
- Hyphema is blood in the anterior chamber.
- The hyphema is a direct consequence of blunt trauma to a normal eye (some people are more prone to bleed).
- However, it can occur with tumors in front of the eyes, advanced stages of diabetes, intraocular surgery (post-op), chronic inflammation and uveitis which all cause neovascularization.
- Sick cell pts are more prone to develop the bleed especially after trauma It may need evacuation in sickle cell patient, to avoid vascular accidents "there is high IOP and the deformed RBCs can't pass through the trabecular meshwork".



Hyphema

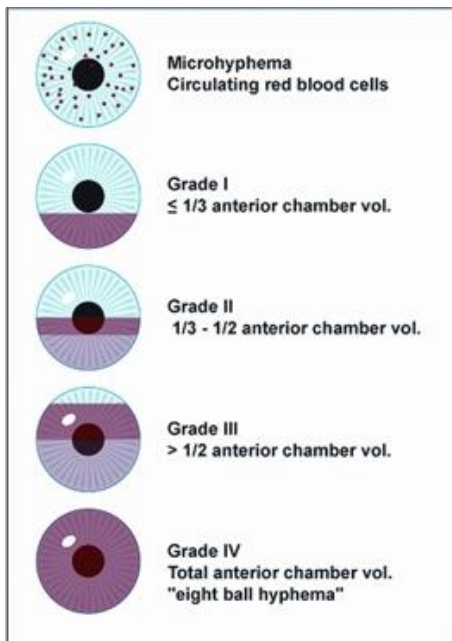
Complications: posterior synechiae & glaucoma.

- Blood in the AC makes levels as it fills up and those levels are described by percentages when it's filling the whole anterior chamber it's called "Eight ball Hyphema".



Eight ball hyphema

- The most common cause of hyphema is trauma. In case of trauma, it usually resolves spontaneously within 3 days (bed rest and minimize the activity to avoid re-bleeding).
- This usually settles with rest, but a rebleed may occur in the first 5–6 days after injury
- Steroid eye drops are given for a short time, together with dilation of the pupil. Steroids reduce the risk of rebleeds.
- The commonest complication is a raised ocular pressure, particularly if there is a secondary bleed,
- If it's not resolved and the pressure is high it may cause corneal blood staining, which would take years to clear. This will affect the vision dramatically.



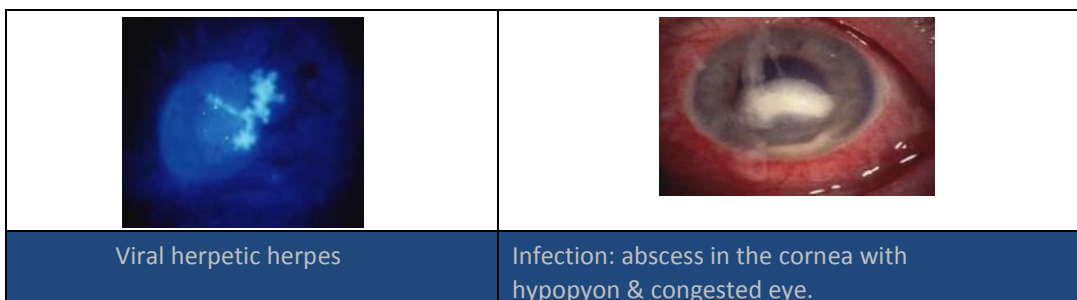
Extra



Extra

◆ Uveitis:

- Uveitis doesn't only cause visual impairment on the corneal side but also on the turbidity of the anterior chamber. In uveitis, the inflammation leads to changes in aqueous humor contacts, usually there is a protein present in the anterior chamber and its concentration is 1% of that in the serum. In severe uveitis, the concentration is similar to the serum.



◆ Vitreous hemorrhage

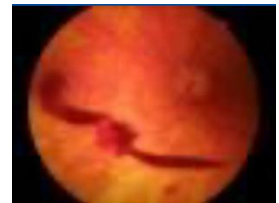
- Not a diagnosis rather is a sign of many diseases.
- Extravasation or leakage of blood into the areas in & around the vitreous humor of the eye.
- Any bleeding into the vitreous (**visual axes**) will also reduce the visual acuity.

- Because it's a media opacity:
 - Opacity in the cornea? edema.
 - Opacity in the vitreous? blood.
 - Opacity of lens? cataract.



- It can result from: trauma, diabetes, retinal vein occlusion, acute posterior vitreous detachment and intraocular surgery; it may also accompany sub-arachnoid hemorrhage (Terson's syndrome).

- Many diseases can cause VH, even TB can cause VH.
 - **The most common cause of vitreous hemorrhage is diabetes (MCQ).**
 - **2nd most common cause of vitreous hemorrhage is branched retinal vein occlusion.**

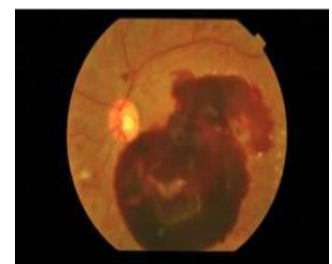


- On examination

- If you cannot appreciate a red reflex with a **direct ophthalmoscope** and the lens appears clear, **you should suspect a vitreous hemorrhage.**
- The diagnosis is confirmed with a **slit lamp examination through a dilated pupil.**
- **B scan (bi-model ultrasound) is important** to know the etiology.
 - US tells you how dense the vitreous hemorrhage & if the retina is in place or detached.
- Absence of red reflex means **MEDIA OPACITY** (where? It can be anywhere, in the cornea, AC, lens, vitreous, retina not in place) and then you assess it with a direct ophthalmoscope.
- Leukocoria (leuko = white, coria= pupil), white pupils, is used to describe a reflex of pupils in pediatric patients.

- Management:

- Bed rest & treat underlying cause.

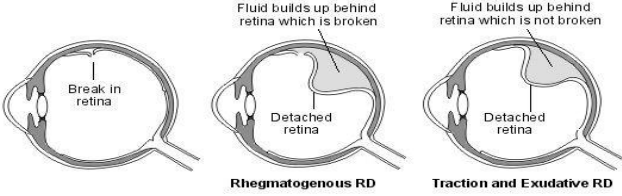


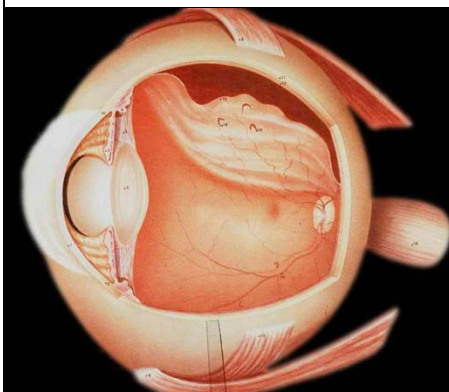
Extra

• Retinal diseases

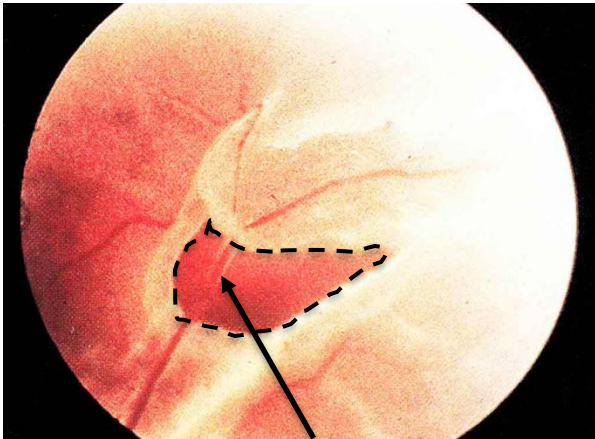
◆ Retinal detachment

- An abnormal separation between the sensory retina and the underlying retinal pigmented epithelium (RPE) and choroid plexus. the outer third (the part furthest from the inner vitreous) of the retina gets its nourishment primarily from the underlying choroidal vascular bed. With a detachment, the photoreceptor layer separates from the choroid, and without this blood supply becomes ischemic.
- In a normal retina, there is no actual connection or junction between them. It is a potential space, firm, and adherent.
- When the retina breaks, fluid leaks between the 2 layers and separates them.
- Retinal detachment is one of the painless causes of acute visual loss.
- It will cause sudden or acute visual loss if it was in the macula, but macular involvement takes time, so the pathophysiology is chronic, but the visual loss will be acute.

| Types of retinal detachment | | |
|---|--|---|
| 1. Rhegmatogenous RD (rhegma = break) | 2. Traction RD | 3. Exudative RD |
| <ul style="list-style-type: none"> ◆ Most common. ◆ An acute cause of visual loss that has prodrome (flashes &/or floaters). ◆ Tear in the retina can allow liquefied vitreous to gain entry to the subretinal space causing a progressive detachment. ◆ Caused by intrinsic cause in the retina. ◆ Most likely need intervention. | <ul style="list-style-type: none"> ◆ Slow and gradual loss of vision due to diabetes or TB. ◆ Treatment is surgery (requires intervention). <ul style="list-style-type: none"> ▪ Here the retina is detached but continuous with no tear. If it is pulled off by contracting fibrous tissue on the retinal surface. ◆ Retinal changes sec. to another cause. | <ul style="list-style-type: none"> ◆ If we treat the underlying pathology, the problem will be solved. Here it's usually a systematic disease. ◆ DON'T touch the eye. ◆ Chronic & slow. ◆ Pt complains of gradual loss of vision. |
| <p>Extra</p>  | | <ul style="list-style-type: none"> ◆ Picture: when a break happens, subretinal space allowed vitreous fluid to travel into the break and detach the retina. |



Breaks without detachment



Break (dash line) - Retinal vessel bridging the break

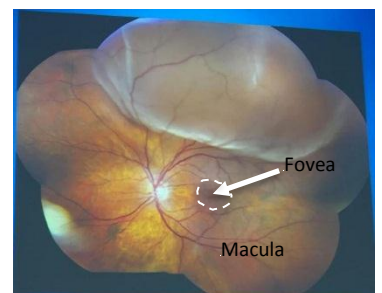
Horseshoe break:

if the break gets pulled more (by the vitreous) → can rupture a vessel → RD & hemorrhage.

- If this break was big enough, this retinal vessel will break & cause vitreous hemorrhage; thus, we will not see what is behind the vitreous hemorrhage, so we do **B-scan** to find if there is a break & retinal detachment.
- What causes this? vitreous changes.
In newborns, the vitreous is a gel-like structure & with time the vitreous gel liquefies to water & solid. The solid component is the floaters that pt sees.
- Diabetics & myopic pts are more prone to develop liquefaction of the vitreous.
- When the gel liquifies it contracts & pulls on the retina causing this retinal detachment.
- If the vitreous is still gel-like, pt can have breaks **without** retinal detachment.

- Signs & symptoms: (This is applied in rhegmatogenous RD).
 - Prodromal symptoms: **flashes** bolts of thunder + **floaters** like cobwebs, lines or dots.
 - If a pt comes early, we may save the eye by surgery which means there is something we can do; But, if the pt is late, pt will present w/ **visual field loss-curtain-like (painless vision field loss)**
 - Sudden, painless loss of vision; The course may be so short that no matter what you do you're late.
 - **Afferent pupillary defect.**
 - The diagnosis is confirmed by ophthalmoscopy through a dilated pupil, and retina appears elevated with folds and the choroid background behind the retina is indistinct.

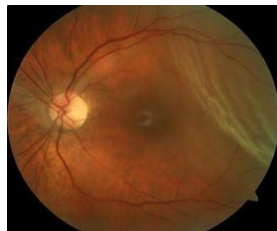
- Risk factors:
 - **High myopia.**
 - H/O retinal detachment (in the other eye or family hx).
 - Hx of surgery because you play w/ vitreous.
 - Mechanical
 - Trauma.
 - Aphakia (No lens).
 - In the past, they used to deal with cataract aggressively, traumatic surgeries).
 - because it's a sort of trauma, its abnormal, there should be a lens inside: pseudophakia (artificial lens) → less risk of RD.
 - Peripheral retinal degenerations. e.g. lattice degeneration, retinal tufts, etc.
 - Usually peripheral retina is weaker than the central retina. If a pt has weaker retina w/ degenerations, pt will have a higher chance of developing break in the peripheral retina.
 - Keratoconus.
 - Posterior Vitreous Detachment (PVD)



- The vitreous is attached to the eye at the optic head and ora serrata. Due to trauma, surgery, or spontaneous liquefaction secondary to aging, the vitreous detaches and pulls the retina and break it.

- Management:

- RD is an urgent condition.
- Needs emergency surgery.
 - If a pt comes early enough w/ only breaks & NO fluid pass by (**didn't** develop detachment) →you can surround it by laser.
 - But if w/ detachment → do surgery.
- Scleral buckle, cryotherapy, SRF drainage.
- Vitrectomy **most common**, AFX (**air fluid exchange**), endolaser, long acting tamponade (gas, silicone oil).
- In the management, there are two types based on the status of the macula, macula on and off.
 - Macula on: the macula is still attached, and the intervention is required within 24 hours (Because central visual acuity is still preserved).
 - Macula off: The macula is detached, and intervention is less critical (within 10 days).



Traction

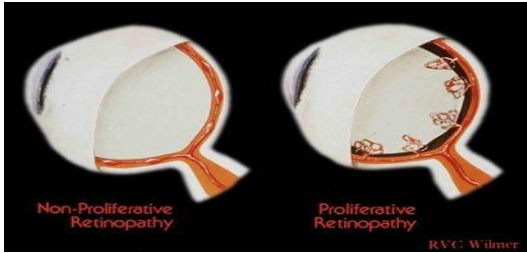
There is a flat retina and the bulging part is detached (if the macula is not involved you can treat this surgically).

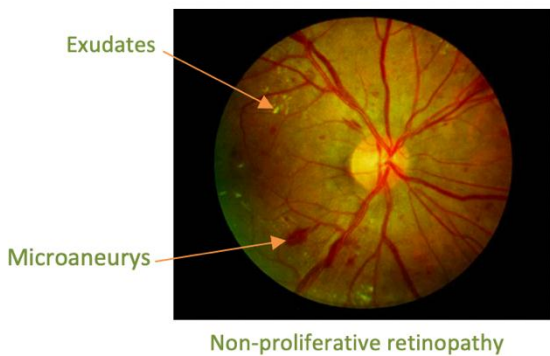
The potential space between the neuroretina and its pigment epithelium corresponds to the cavity of the embryonic optic vesicle. The two tissues are loosely attached in the mature eye and may become separated:

- If a tear occurs in the retina, allowing liquefied vitreous to gain entry to the sub-retinal space. This causes a progressive, rhegmatogenous, retinal detachment which may be partial or total.
- If it is pulled off by contracting fibrous tissue on the retinal surface, e.g. in the proliferative retinopathy of diabetes mellitus (traction retinal detachment).
- When, rarely, fluid accumulates in the sub-retinal space as a result of an exudative process, which may occur with retinal tumours or during toxæmia of pregnancy (exudative retinal detachment).

• **Diabetic Retinopathy**

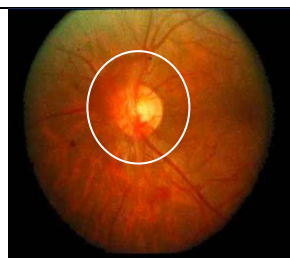
- ◆ Diabetic retinopathy is the term used to describe the retinal damage causing visual loss. Diabetics have a high prevalence of retinopathy.
- ◆ Diabetic retinopathy causes neovascularizations when ruptured causing vitreous hemorrhages resulting in acute visual loss.

| | | |
|--|---|---|
|  | | <p>They start off as non-proliferative and if the DM isn't taken care of then it progresses to proliferative.</p> |
| <p>Non-proliferative</p> | <p>Proliferative</p> | |
| <ul style="list-style-type: none"> ▪ Vascular changes on the retina. ▪ Exudates & microaneurysms (dot & blot hemorrhages). | <ul style="list-style-type: none"> ▪ Neovascularization happens in the choroid but here they pop up from the retina into the vitreous cavity. ▪ The vessels undergo fibrosis and contract causing tractional or tractional + rhegma RD (thus pt may present w/ floaters). | |

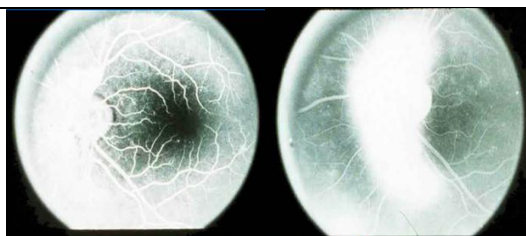


If it's on the disc > NVD (neovascularization on disc).

If it's outside the disc > NVE (neovascularization elsewhere).

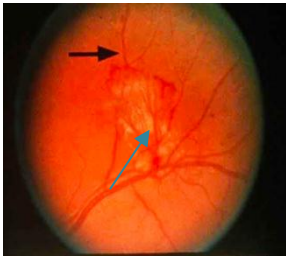


White circle showing neovascularizations.

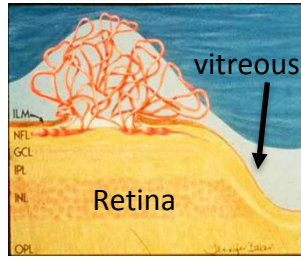


The neovascularizations are leaking on fluorescein angiography.

An ischemic retina releases vasogenic factors (e.g. VEGF) which result in the growth of abnormal blood vessels and fibrous tissue onto the retinal surface and forwards into the vitreous. These intravitreal vessels are much more permeable than normal retinal vessels, so that they leak dye during retinal fluorescein.

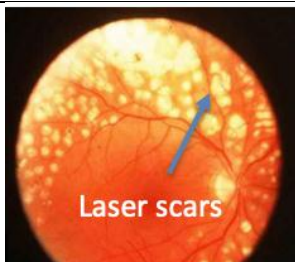


This white (blue arrow) is the fibrous tissue that forms causing the traction (tractional RD).

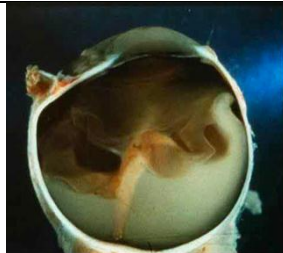


The neovascularization bulging into the vitreous; they should stay below the ILM. But, in ischemic pts like diabetics the vessels grow into the vitreous cavity > become fibrosed > contract > detach.
- Before undergoing fibrosis, the vessels can bleed causing vitreous hemorrhage which is the cause of acute visual loss.

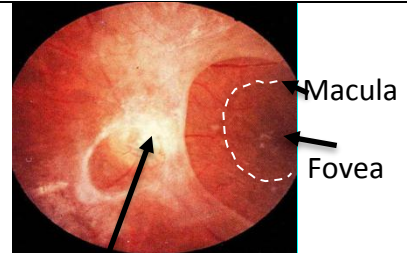
- ◆ Fibrosis and contraction of vessels occurs in tractional retinal detachment, the retina is not in its place so it can't function properly.
- ◆ Treatment: laser
 - The retina goes back in place after laser, but it doesn't mean they'll have good vision. Because the traction is chronic & pts already have photoreceptor loss & other retinal structural abnormality.
 - The goal of the surgery is that pts don't worsen NOT to regain 20/20. It's a measure we take along with tight control of blood sugar so pts don't go blind.
- ◆ The retina is a part of the brain with neurons, so it is not just an ischemic problem.
- ◆ Neovascularization + vitreous hemorrhage > go away with immediately with laser.



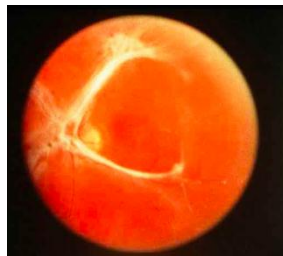
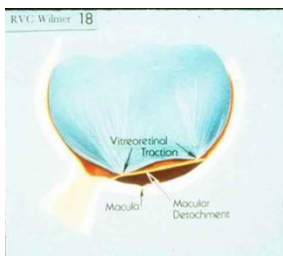
Retina after laser



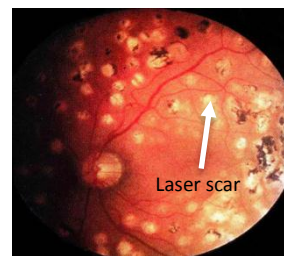
Retinal detachment in histology



Fibrous tissue



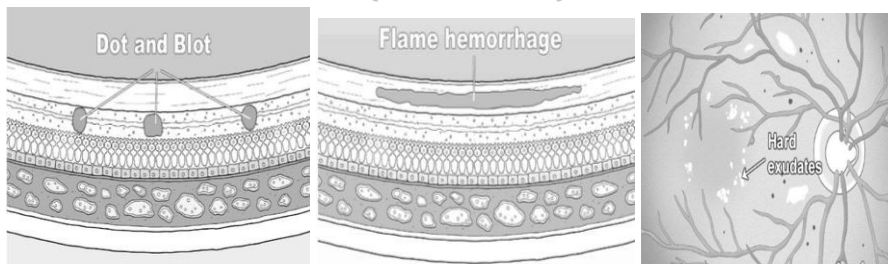
Tractional RD



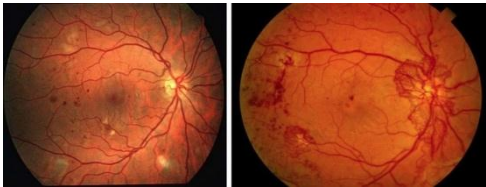
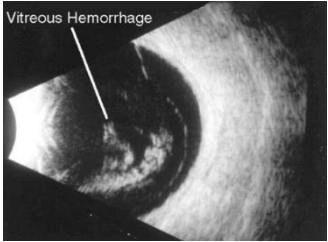


Laser scar




NPDR features:

- ◆ Injured capillaries can leak fluid into the retina and the aneurysms themselves can burst, forming **“dot-and-blot hemorrhages.”**
- ◆ Dot-blot hemorrhages look small and round because they occur in the deep, longitudinally-oriented cell layers of the retina. This contrasts with the **“flame hemorrhages”** of hypertension that occur within the superficial ganglion nerve layer, and thus spread horizontally.
- ◆ . As vessel damage progresses, you can also see beading of the larger retinal veins and other vascular anomalies.
- ◆ **Complications:** visual field loss (tunnel vision).



| Non-proliferative Diabetic Retinopathy | Proliferative Diabetic | B scan |
|--|---|--|
|  <p data-bbox="277 1395 352 1424">Extra</p> |  <p data-bbox="571 1361 1018 1429">Neovascularization at the disc & is treated by photocoagulation.</p>  <p data-bbox="751 1626 826 1655">Extra</p> |  <p data-bbox="1219 1373 1294 1402">Extra</p> |

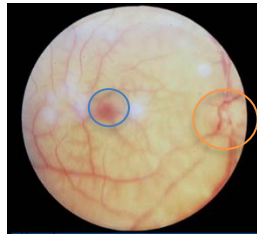
◆ **Retinal vascular occlusions:**

| ● Central retinal artery occlusion | ● Branched retinal artery occlusion |
|---|--|
| <ul style="list-style-type: none"> ◆ A sudden, painless and often complete visual loss (no light perception) may indicate central retinal artery occlusion (CARO). ◆ Several hours after a central retinal artery occlusion, the inner layer of the retina becomes opalescent (opaque, why? because of ischemia). ◆ A cherry red spot is seen due to the pallor of the perifoveal retina in contrast to the normal color of the fovea & underlying choroid (fovea is the thinnest part of the retina; thus, the opacity in the fovea is less compared with its surroundings).  <ul style="list-style-type: none"> - (in picture 1, there is an opaque retina with an edematous disc (small arrow) and the big arrow is pointing at the macula, the dark area is a cherry red spot of the fovea in the center of the macula. Which means: central retinal artery occlusion).  <ul style="list-style-type: none"> ◆ A chronic cherry red spot is also a feature of the storage diseases such as Tay-Sachs disease and Niemann-Pick disease. - Causes of cherry red spot on retina: *mnemonic: Cherry Tree Never Grow Tall* <ul style="list-style-type: none"> ▪ Central retinal artery occlusion Tay-Sachs disease Niemann-Pick disease Gaucher's disease Trauma (Berlin edema). ▪ There is no generally accepted acute management. | <ul style="list-style-type: none"> ◆ When only a branch of the central retinal artery is occluded, vision is only partially lost (refer for VF). ◆ This is more likely to be the result of an embolus and the source of the embolus should be sought (if the embolus is a cholesterol embolus it's called hollenhorst plaque). ◆ Loss of vision may be severe because it causes macular edema. ◆ If the visual acuity is affected, attempts should be made to dislodge the embolus by ocular massage. <ul style="list-style-type: none"> - Another way to dislodge the embolus is by asking the pt to rebreath into a bag so CO2 causes vasodilation. - Basically, for both branch and central occlusion you try to cause vasodilation.  <p>Picture:</p> <ul style="list-style-type: none"> - If it was a central occlusion, you'd see a cherry red spot. The dark fovea is a normal finding due to the retinal pigment epithelium to help with 20/20 vision. Only at the fovea you can see 20/20. <p>Branched retinal artery occlusion.</p> <ul style="list-style-type: none"> - Notice how white the affected retina (above) is compared to the normal retina. The ischemia stopped just short of the macula, so this patient most likely didn't have his vision completely affected (but his lower visual field is gone). - Upper retina: lower. Lower retina: Upper Temporal: nasal. Nasal: temporal ◆ Treatment should be directed at reducing associated macular edema by injecting anti-vascular endothelial growth factor agents "Anti-VEGF", CRVO is not true ophthalmic emergency. |

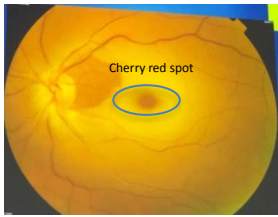


Cherry red spot (blue circle).
Disc (orange circle).
Opaque retina.

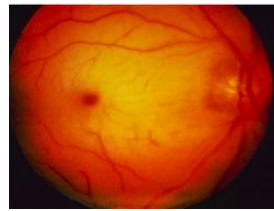
Opaque retina & attenuated artery > central retinal artery occlusion.



Normal perfused retina; why? 20% of people have a branched artery (cilioretinal artery) that pierces through the retina before the central retinal artery is formed & supplies the macula causing good vision even in the case of CRAO.



♦ Visual prognosis depends on degree of associated retinal ischemia.



Pale retina with cherry red spot. Indicating central retinal artery occlusion.

• **Retinal vein occlusion: [Extra table here](#)**

- Ophthalmoscope pictures of disc swelling, venous engorgement, cotton wool spots & diffuse retinal hemorrhages like blood & thunder.
- Loss of vision may be severe.
- There is no generally accepted acute management.
- Central retinal vein occlusion is not a true ophthalmic emergency, but it may cause acute visual loss.

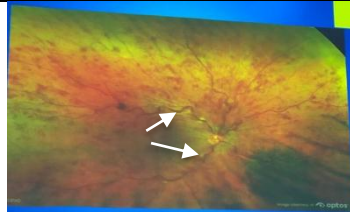


Flame-shaped hemorrhages all over.
Cotton wall spots (blue circles).

- Cotton wool spots are patchy & large unlike exudates which are smaller & well-defined.
 - Cotton wool spots are fluffy white focal lesions with indistinct margins.
- Cotton wool spots are infarctions in the nerve fiber layer (2nd layer of retina thus the cotton wool spots are on the surface).



- Hemi-retinal vein occlusion.
 - Half of the retina is occluded completely, while the other half is slightly occluded; Still there are tortuous vessels, viscous not well-defined swollen optic disc (non-)flame shaped hemorrhages.



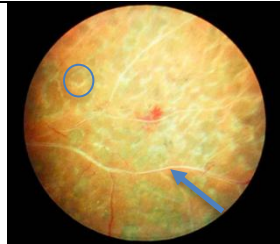
- Tortious vessels (arrows) & flame shaped hemorrhage.



- Hemi-retinal (branched) retinal vein occlusion.



- Macular branch retinal vein occlusion causing a small flame shaped hemorrhage.



Laser scar (blue circle)
 Clear vessel (no blood anymore) arrow



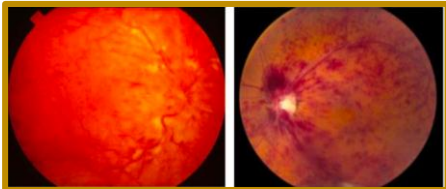
Retinal vein occlusion (with central or branched).

How can vein occlusion cause acute visual loss?

1. Blood covering the fovea.
2. Macular edema & exudation.

Treatment?

- Intravitreal injection of anti-vascular epithelial growth factor (anti-VEGF).
- Laser is another option.

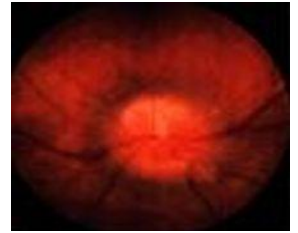


Central vein occlusion characterized by painless visual loss.
 On funduscopy: stormy sunset.

• Optic Diseases

◆ Optic neuritis:

- Optic neuritis is an inflammation of the optic nerve and is usually idiopathic, but it may be associated with **multiple sclerosis** (as first clinical manifestation) in a significant number of cases.
- The visual acuity is markedly reduced, and an afferent pupillary defect is present (**IMP IN OSCE**).
- Associated with pain on extraocular muscle movement in 90% of patients.
- The optic disc initially appears hyperemic and swollen.
- The visual acuity usually recovers. However, repeated episodes of optic neuritis may lead to permanent loss of vision. (so, the goal of management is to prevent recurrence, you have to treat with steroids and interferon).



Papilledema



- Swelling of the optic nerve head.
- If bilateral swelling of optic nerve head, it is called papilledema.

- It has three types: Optic papillitis (Optic nerve head is involved), retrobulbar neuritis (the posterior part of the nerve is involved), or neuroretinitis (Optic nerve head with contagious retinal inflammation).
- Most common type is retrobulbar neuritis. Here, the fundus looks normal, but the vision is severely affected with central visual fields defect (most common presentation).
- Most of the time It is reversible with return of normal vision within 4-6 weeks (self-limiting).
- But if one eye only is affected you may use steroids to enhance the recovery (speed it up).

| | Extra information: difference between | | |
|------------------------|---|---|---|
| | Papilledema | Papillitis | Retrobulbar neuritis |
| Definition | Swelling of optic nerve head due to increased ICP | Inflammation or infarction of optic nerve head | Inflammation of orbital portion of optic nerve |
| Uni/bilateral | Bilateral | Unilateral | Unilateral |
| Vision impairment | Enlarged blind spot | Central/paracentral scotoma to complete blindness | Central/paracentral scotoma to complete blindness |
| Fundus appearance | Hyperemic disk | Hyperemic disk | Normal |
| Vessel appearance | Engorged, tortuous veins | Engorged vessels | Normal |
| Hemorrhages? | Around disk, not periphery | Hemorrhages near or on optic head | Normal |
| Pupillary light reflex | Not affected | Depressed | Depressed |
| Treatment | Normalize ICP | Corticosteroids if cause known | Corticosteroids with caution |

• Visual Pathway Disorders

◆ Homonymous hemianopia

- Loss of vision on one side of both visual fields.
- May result from occlusion of one of the **posterior cerebral arteries** with infarction of the **occipital lobe**.
- Other vascular abnormalities occurring in the middle cerebral artery distribution may produce a hemianopia, but usually other neurological signs are prominent (like in stroke).
- **Any patient with hemianopia needs a CT or MRI to localize & identify the cause.**
- Refer to neurology.
- Behind the optic chiasm.



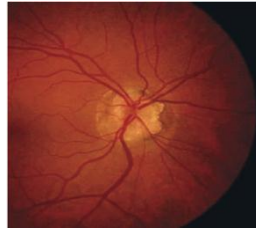
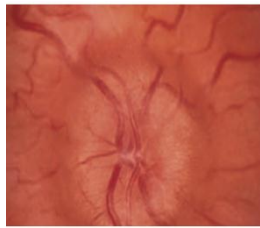
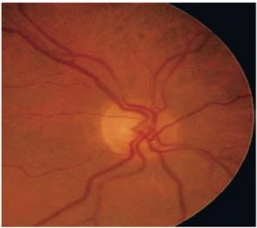
◆ Cortical Blindness

- A rare extensive bilateral damage to the cerebral visual pathways resulting in a **complete loss of vision**.
- This condition is referred to as cortical, central or cerebral blindness.
- **As the pathways serving the pupillary light reflex separate from those carrying visual information at the level of the optic tracts, a patient who is cortically blind has normal pupillary reactions.** Remember that the Lateral Geniculate Body is in the brainstem at the midbrain and the optic nerve won't be atrophied because the problem is BEHIND the optic chiasm
- Thus, a patient with a normal fundus examination along with normal pupillary reactions, most likely has cortical blindness (if pt has complete loss of vision).

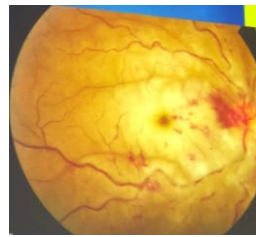
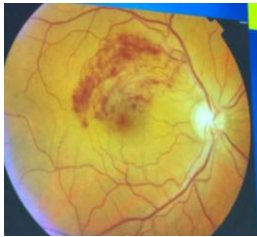
- Poor vision, loss depends on which part of the cortex was affected.

- **Functional visual loss**

- ◆ A functional disorder is used in preference to hysterical or malingering to describes visual loss without organic basis (there is no actual visual loss).
- ◆ A patient may report complete blindness in one eye and normal vision in the other eye, and **no relative afferent pupillary defect (RAPD)**.



Optic disc swelling



Branched retinal vein occlusion.

Combined retinal artery & vein occlusion.
Central retinal artery occlusion (cherry red spot).
Retinal vein occlusion (hemorrhage).

Questions:

1. Aims of ACG management:

- A. Decrease IOP
- B. Prevent recurrent attacks
- C. Increase IOP
- D. Prevent future attacks in OU

2. Absence of red reflex means:

- A. Leukocoria
- B. Media opacity
- C. Retinoblastoma
- D. Cataract

3. we see cherry red spot in:

- A. Central retinal artery occlusion
- B. Central retinal vein occlusion
- C. Branch retinal vein occlusion
- D. Branch retinal artery occlusion

4. Atherosclerosis can be a cause of:

- A. AION
- B. Optic neuritis
- C. NAION
- D. Functional visual loss

5. Hyperopia is a risk factor for retinal detachment

- A. True
- B. False

Answers: 1:A 2:B 3:A 4:C 5:B

Good luck!