SECONDARY GLAUCOMA FOLLOWING OCCLUSION OF THE CENTRAL RETINAL ARTERY*

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SECONDARY glaucoma following occlusion of the central artery of the retina is rare; Wolter and Liddicoat (1958) were able to cite only six cases from the literature. The following case, which closely resembles these, may be of interest.

Case Report

A 52-year-old man came to the clinic on May 6, 1958, with a history of sudden painless loss of vision in the left eye on April 26, 1958.

Examination.—The visual acuity was 6/5 in the right eye and hand movements in the left eye. The right fundus was normal except for moderate arteriosclerotic changes. The left fundus showed the typical picture of occlusion of the central retinal artery. The blood pressure was 186/110, and had risen 3 days later to 220/140. Other investigations revealed nothing abnormal and the patient was referred to the medical department for treatment of the hypertension.

Progress.—3 months later the patient complained of severe pain in the left eye, which was found to be red, congested, and stony hard. The cornea was hazy and exhibited marked oedema. No flare or keratic precipitates were detected. A diagnosis of secondary glaucoma was made.

On September 9, enucleation was advised but refused.

On November 29, the patient had a sudden right hemiplegia which is now recovering.

On January 5, 1959, the left eye again showed corneal oedema and many blood vessels on the iris surface and in the angle of anterior chamber. The fundus could be seen only with difficulty. The disc was cupped. No retinal haemorrhage could be seen. The ocular tension with a 10-g. weight was 70.6 mm. Hg (Schiötz).

Comment.—It seems likely that the glaucoma and the arterial occlusion were associated. The patient was hypertensive and showed arteriosclerotic changes in the other eye. The occurrence of glaucoma 3 months after the initial loss of vision suggests a thrombosis of the central retinal vein. There was no evidence of primary glaucoma in either eye, and the facility of aqueous outflow remained normal in the affected eye on all occasions.

REFERENCE

WOLTER, J. R., and LIDDICOAT, D. A. (1958). *Amer. J. Ophthalm.*, **46**, 182.

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