Acquired colour vision defects in glaucoma—their detection and clinical significance

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Colour vision defects associated with ocular disease have been reported since the 17th century. Köllner1 in 1912 wrote an abstract description of the progressive nature of colour vision loss secondary to ocular disease, dividing defects into “blue-yellow” and “progressive red-green blindness”.2 This classification has become known as Köllner’s rule, although it is often imprecisely stated as “patients with retinal disease develop blue-yellow discrimination loss, whereas optic nerve disease causes red-green discrimination loss”. Exceptions to Köllner’s rule3–5 include some optic nerve diseases, notably glaucoma, which are primarily associated with blue-yellow defects, and also some retinal disorders such as central cone degeneration which may result in red-green defects. Indeed, in some cases, there might be a non-specific chromatic loss.

Colour vision defects in glaucoma have been described since 18836 and although many early investigations indicated that red-green defects accompanied glaucomatous optic neuropathy,7 later studies suggested that tritan defects predominate.8 This change of view largely reflected improved experimental design over time—in early studies no distinction was made between the various types of glaucoma, nor was any allowance usually made for the age distribution of subjects in the sample. A summary of the early research can be found in Drance et al.9

Although modern studies control for confounding factors such as increasing lens density and decreasing pupil size with age, some controversy still surrounds the nature of colour vision defects in primary open angle glaucoma (POAG). Comparing previous research evaluating chromatic discrimination in POAG is complicated by wide variations in methodology and experimental conditions.

In recent years, computer generated colour tests have provided the means for isolating the processing of chromatic signals from the accompanying achromatic cues.10–13 In these tests, typically, the subject is asked to report the presence of a coloured target such as a spot, bar, or grating on a background of a different colour. To avoid detection based on luminance cues, either the equiluminance is determined empirically or any luminance cue is masked using spatial masking techniques. One advantage of using computer generated colour tests comes from their ability to test neuronal processing at specific retinal locations, giving them the potential to be used to detect and monitor ocular disease in a way similar to standard white on white perimetry. Although white on white threshold perimetry remains the gold standard for detecting and monitoring loss of visual function in POAG, one third or more of the optic nerve axons may be lost before a field defect can be detected.14 Therefore, much recent research into colour vision in POAG has focused on the usefulness of colour discrimination tests in the early detection and monitoring of progression of the disease.

The aims of this paper are:

- to provide a review of the modern literature on acquired colour vision in POAG
- to differentiate the characteristics of congenital and acquired defects, in order to understand the type of colour vision defect associated with glaucomatous damage
- to compare classic clinical and modern methodologies (including modern computerised techniques) for assessing visual function mediated through chromatic mechanisms
- to assess the effects of acquired colour vision defects on quality of life in patients with POAG.

Comparing congenital and acquired colour vision defects

Congenital colour vision deficiencies result from inherited cone photopigment abnormalities. The most common form of deficiency is due to abnormal responses to red-green stimuli, originating from an abnormal/ functionally absent long wavelength sensitive photopigment (protan-type anomalies) or intermediate wavelength sensitive (deutan-type) photopigment. A less frequent form of chromatic anomaly is the tritan-type, caused by an absent or abnormal short wavelength photopigment. Inherited red-green colour vision deficiencies have a two gene X linked recessive inheritance.15

The prevalence of red-green deficiency is reported to be approximately 8% in males, made up of approximately 6% deutan-type and 2% protan-type defects, and 0.4% in females.16 Tritanomaly, in which the short wavelength sensitive photopigment is absent, shows autosomal dominant inheritance and Wright17 estimated its prevalence to lie between 1 in 13,000 and 1 in 65,000. Tritanomaly, in which short wavelength sensitive photopigment is abnormal, has a prevalence of approximately 1 in 1000.18

Unlike congenital defects, acquired colour vision anomalies are evenly distributed between males and females. A summary of characteristic differences between congenital and acquired defects is given in Table 1.19

Of the many attempts to classify acquired colour vision deficiencies, Verriest’s classification published in 1963 was the most widely used, and a simplified version is given in Table 2 describing the three main types of anomaly. More precise classifications20 based on Table 2 and other classifications of acquired colour vision deficiencies21 are available.

This classification suggests the key element defining the type of acquired chromatic discrimination defect—the relation between the retinal distribution of chromatic mechanisms and the localisation of the disease process. For example, a patient suffering from a disease resulting in early destruction of foveal function will normally present initially with a central scotoma, poor visual acuity, and a
The Farnsworth-Munsell 100 hue test is widely used for the assessment of colour vision defects. It is a psychophysical monochromatic test that can be used to distinguish between congenital and acquired colour vision defects. Arrangement tests are particularly sensitive for screening for use in POAG. There are several versions of this test in circulation and the “desaturated” version, using the same colours, but with low saturation, is very sensitive for screening for use in POAG. The F-M 100 hue test is particularly useful for evaluating patients with eye disease because their demands on acuity are low, and no specific colour confusions are predicted.

Deterioration of chromatic discrimination with age
Because the prevalence of POAG increases with advancing age, it is important to distinguish between age-related deterioration in chromatic discrimination ability and deterioration caused by the disease itself. In normal eyes, for example, miosis and yellowing of the aging lens result in a loss of hue discrimination of a type similar to that found in tritan-like defects.

Assessment of acquired colour vision defects
Colour vision testing is always performed monocularly when acquired colour deficiency is suspected or when monitoring for possible progression of ocular disease.

| Table 1 Comparison between the characteristics of congenital and acquired colour vision defects |
|-------------------------------------------------|-------------------------------------------------|
| Present at birth | Onset after birth |
| Type and severity of defect is stable throughout life | Type and severity of defect may fluctuate |
| Type of defect can be classified precisely | Type of defect may not be easy to classify. Combined or non-specific deficiencies frequently occur |
| Both eyes are equally affected | Monocular differences in the type and severity of the defect often occur |
| Visual acuity is unaffected (except in monochromatism) and visual fields are normal | Visual acuity is often reduced and visual field defects often occur |
| Predominantly protan or deutan | Predominantly “tritan-like” |
| Higher prevalence in males | Approximately equal prevalence in males and females |

| Table 2 Von Bez' classification of acquired colour vision anomalies |
|-------------------------------------------------|-------------------------------------------------|
| Name | Alternative names | Colour discrimination defect | Visual acuity |
|-------------------------------------------------|-------------------------------------------------|
| Type I | Acquired R-G, protan-like | Mild to severe confusion of R-G hues, little or no loss of B-Y CD | Moderate to severe reduction |
| Type II | Acquired R-G, deutan-like | Mild to severe confusion of R-G hues with a concomitant mild loss of B-Y CD | Moderate to severe reduction |
| Type III | Acquired B-Y, tritan-like | Mild to moderate confusion of B-Y hues with a lesser impairment of R-G CD | May be normal or moderately reduced |

R-G = red-green, B-Y = blue-yellow, CD = colour discrimination.

CLASSIC TESTS

Arrangement tests
In general, these use a variety of Munsell hues of the same saturation and luminance. The hues are chosen to be distributed around a complete circle surrounding the equal energy white point in the CIE (Commission Internationale de l’Eclairage) diagram. Arrangement tests are particularly useful for evaluating patients with eye disease because their demands on acuity are low, and no specific colour confusions are predicted.

Farnsworth-Munsell 100 hue test (F-M 100 hue)
This consists of 85 coloured caps, numbered on the back, and arranged in four trays. The patient arranges each tray of randomly ordered caps in a natural colour order between two fixed colours in each tray, and the result is plotted on a polar chart. Completely correct ordering produces a perfect circle of points, and the numbers on the backs of the caps will be consecutive. However, transpositional errors cause points to be further away from the centre of the chart, with some or all non-consecutive numbers. Subjects with significant congenital colour vision defects produce characteristic patterns, which have clusters of errors confined to restricted areas, localised at nearly diametrically opposite regions of the circle. The “error score” for each cap is the sum of the absolute numerical differences of the two adjacent caps, minus 2, and each error score is either plotted on the line representing that colour or plotted serially. The severity of the discrimination defect is quantified by the “total error score” (TES), obtained by summing the error scores for each cap. Although the F-M 100 hue test is particularly useful for monitoring progression in acquired deficiency, it is unable to distinguish subtle differences, such as between severe trichromatic anomalies and pure dichromacy.

Farnsworth-Munsell D-15
The D-15 is designed to identify moderate to severe colour vision defects. The 15 caps are arranged in a natural colour order from one fixed colour, in a similar way to the F-M 100 hue test. The plotted error pattern, which in subjects with moderate to severe colour deficiency consists of cross crossing lines which demonstrate isochromatic confusion axes, will indicate the type of defect. Although a quicker test than the F-M 100 hue, the D-15 was not designed to be a screening test and is not considered to be very sensitive for screening for use in POAG. There are several versions of this test in circulation and the “desaturated” version, using the same colours, but with low saturation is often used.
The City University test
There have been three editions of this test,1 a derivative of the D-15 test, with the most recent in 1998. Most published clinical data are for the second edition, which has 10 charts. Each chart has a central colour and four surrounding colours, three of which are typical isochromatic confusions for protan, deutan, and tritan congenital deficiency, while the fourth is an adjacent colour in the D-15 sequence and is the usual preference of those with normal colour vision. Although classification of congenital protan and deutan deficiency is imprecise, the City University test is useful for acquired defects.2

Pseudo-isochromatic plates
These are the most widely used clinical tests to assess colour vision because they are portable and easy to use. In general, these tests are most useful for detection of congenital anomalies.

Ishihara plates are the most efficient pseudo-isochromatic test. The major disadvantages of the Ishihara plates are that they do not contain designs for the detection of tritan defects, and that patients require 6/18 visual acuity to resolve the test. Consequently, the Ishihara test is not appropriate for the assessment of the majority of acquired anomalies, which are associated with tritan-type defects.

The H-R-R test was designed for the detection of congenital, including tritan, deficiencies and has a series of plates having different colour difference steps allowing grading of protan, deutan, and tritan defects. The minimum visual acuity required for interpretation of the test is 6/60. Moderate and severe acquired type III deficiencies are detected by the H-R-R plates. A third edition became available in 1991 (Richmond International Inc). Other pseudo-isochromatic tests with tritan plates include the Lanthony Tritan Album, and the F2 plate, introduced by Farnsworth to detect congenital tritanopia.

The ability of quick, simple to apply clinical tests to detect type III (tritan-like) deficiencies in POAG and patients with ocular hypertension has been assessed,3 and the battery of tests consisted of the H-R-R, Lanthony, and F2 plates, plus the D-15 and desaturated D-15, and the City University test. In general, individual tests showed poor sensitivity for the detection of glaucoma. Indeed, the Farnsworth F2 test did not detect any type III defects. Best validity was shown by the City University and the H-R-R tests, and the results from a combination of these tests may be a useful addition to other data collected in glaucoma screening programmes.

Anomaloscopes
These colour matching instruments are more efficient than arrangement and pseudo-isochromatic tests for the discrimination between normal trichromats and the various types of colour deficiency. The patient matches one half of a field, using a variable mixture of two colours of fixed luminance, with the test colour of variable luminance. Of particular importance in acquired colour deficiency is the "matching range"—the range of colour ratios over which the mixture of the two fixed luminance colours appears to match the test colour. In types I and II acquired deficiency, when red and green are mixed to match yellow, the matching range widens as the disease progresses. Patients with type III (tritan-like) deficiencies, due to retinal disease, frequently exhibit pseudoprotanomaly, where the colour match is slightly displaced towards red.

In the Nagel anomaloscope, the spectral colours red and green are mixed to match monochromatic yellow. In addition to matching yellow with a red and green mixture, the Pickford-Nicolson anomaloscope, which uses broad band glass filters, also matches blue-green with blue plus green.

The Pickford-Nicolson anomaloscope has been used extensively by Lakowski and his co-workers in the study of acquired colour deficiency in glaucoma patients.7 17 However, the blue and green filters are not optimal, leading to high variance in the normal match because of variations in macular pigment.14 This problem can be overcome by choosing blue and green wavelengths for which macular pigment absorbance is equal. A further slight modification of the wavelengths used allows them to lie on a tritanopic confusion line,15 while retaining approximate equality of macular pigment absorbance. Patients suffering from glaucoma usually accept wide ranges of matching compared with normal subjects, but in general do not show complete tritanopia.

Both red-green and blue-green matches are available on the Spectrum "colour vision meter", from Interzeug. Although anomaloscopes have been widely used in research into colour deficiency in POAG they have little place in screening procedures because the test procedure for the blue-green match is complicated.

Some of the most common clinical colour vision tests described above are simplified versions of psychophysical methods and are usually based on pigment colours. The more sophisticated psychophysical methods used in research involve computerised and calibrated equipment, and allow a more detailed evaluation of the deficient chromatic mechanisms. A review of the earlier psychophysical techniques has been described in King-Smith 1991.37

COLOUR MONITOR METHODS
The introduction, in the late 1980s, of high resolution colour monitors under computer control, paved the way for a new generation of techniques to assess colour vision. Often, the observer's task is to detect a stimulus whose chromaticity is modulated in different directions of chromatic space on a background of different chromaticity. Computer emulations of clinical colour vision tests (for example, HRR, Ishihara, City) have also been introduced.38 39 40

The most extensively used research methods to assess acquired colour vision defects are based on one of the following techniques:

(1) Measurement of colour contrast sensitivity by means of flicker heterochromatic photometry40–49 The chromatic threshold for detection of a striped pattern at constant luminance is determined, allowing the measurement of pure chromatic discrimination.

(2) Measurement of computer controlled colour mixture thresholds, in order to estimate equiluminous, chromatic thresholds and compare them with achromatic thresholds measured under the same conditions.42

(3) Measurements of the luminance threshold for detection of a coloured target presented on a coloured background. The technique is similar in principle to the two colour increment threshold developed by Stiles46 to probe the basic colour vision mechanisms. Coloured backgrounds are used to adapt two types of cone, so that the resulting spectral sensitivity curve is dominated by the third type. Blue on yellow perimetry uses this principle to study the loss of sensitivity of chromatic mechanisms (SW cones) as a function of position in the visual field.

(4) Determination of pure chromatic discrimination thresholds in the absence of possible additional luminance cues formed at the stimulus boundaries. Luminance masking techniques are used to eliminate the luminance cues. The stimuli are often formed by small elements, each one with its own profile and randomly set luminance.47 48 The mean luminance of the stimulus is always the same as that of the background, therefore the observer is forced to use...
Acquired colour vision defects in glaucoma

Prevalence estimates for the different types of colour vision defect in POAG have been obtained using a variety of non-computerised tests. Based on these reports, typical prevalences are 20–40% for normal colour discrimination, 30–50% blue-yellow defects, 5% for red-green defects, and 20–30% for a general loss of chromatic discrimination.

Several possible explanations have been suggested for this predominance of blue-yellow (tritan-like) defects in POAG, including:

- short wavelength cones or their neuronal connections are less able to resist the effects of raised IOP;
- there is selective damage to blue-yellow sensitive ganglion cells or their axons. Blue-yellow ganglion cells have larger receptive fields, are larger than red-green cells, and have a unique morphology and connectivity to second order neurons, which may make blue-yellow ganglion cells more susceptible to IOP related damage;
- the relative scarcity of ganglion cells which code blue-yellow signals, and the relatively little overlap between adjacent receptive fields of these ganglion cells. As a consequence, although only a few ganglion cells may cease to function, there is preferential impairment of the blue-yellow discrimination threshold compared with red-green, even if the proportion of damaged fibres is the same for both types.

Differences between age related and glaucomatous changes in colour vision was established when a group of patients with POAG was compared with a control group, matched for age and lens density. There were significantly more F-M 100 hue error scores in the glaucoma group, demonstrating that their colour vision loss is partly caused by the disease process, and cannot be explained solely on the basis of changes in age and lens density.

Specific losses of the red-green chromatic mechanism are usually associated with advanced POAG. When chronically raised IOPs were induced in monkeys, the greatest losses in the red-green opponent channel were found in those animals with the most advanced glaucoma. In patients with POAG, colour vision defects precede the development of standard white on white visual field loss. However, some patients with POAG never develop chromatic defects or only develop them in advanced disease. Several studies have found greater colour vision losses in high tension POAG compared with normal tension glaucoma, suggesting that there may be two separate mechanisms for damage to visual function in glaucoma. One mechanism operates as a result of elevated IOP and is responsible for central and parafoveal visual function loss, including chromatic discrimination loss, and the second mechanism is independent of the level of IOP.

There have been many attempts to correlate the severity of visual field defects in POAG with colour vision changes measured using clinical tests. Lakowski and Drance reported that 34% of those with early visual field defects, 54% with moderate visual field defects, and 74% with severe defects produced scores beyond the 95th percentile for normals on the F-M 100 hue test. In a 5 year study, the percentage of patients with ocular hypertension with F-M 100 hue error scores of >100 and/or a score of more than 80 on the Pickford–Nicolson anomaloscope who subsequently developed field defects were 77% and 55% respectively. Surprisingly though, around one third of those who developed visual field defects failed to show a colour vision defect initially, and were therefore negative. Although age, visual acuity, and pupil size were not controlled in this study, it offers some pointers to the predictive ability of these clinical colour vision tests. In cases of POAG with suspicious visual fields, elevations of the differential threshold at the centre of the field were associated with high F-M 100 hue error scores. This demonstrates the existence of chromatic disturbance at the foveal level, even when field defects are not extensive. Breton and Krupin, on the other hand, taking care to minimise the effects of age by applying a correction for age related changes in F-M 100 hue scores, in a sample of suspicious and glaucomatous patients, found a significant correlation between colour anomalies and visual field defects only in the 60–69 years age group. In addition, there was no evidence that the overall loss of field was closely related to the severity of the colour vision deficit.

A comparison of the fovea luminance and chromatic sensitivities in a group of glaucoma patients and glaucoma suspects was carried out using a flicker detection technique by Adams et al. They demonstrated a loss of foveal sensitivity in both mechanisms in glaucoma patients and in some glaucoma suspects indicating that the foveal sensitivities are also affected relatively early in the disease process. Greenstein et al. also studied the foveal effects of POAG on the colour opponent and luminance systems by measuring the chromatic modulation threshold necessary to discriminate a 3 degree disc from a white background. The equiluminance was determined by flicker photometry. Both those with the disease and suspects demonstrated similar sensitivity losses for both the red-green and blue-yellow opponent systems, accompanied by decreased sensitivity to achromatic contrast—that is, sensitivity losses were not restricted to the S cone system.

All these studies used tests which evaluate colour discrimination at the fovea only. Although foveal processing of colour is often affected in POAG, modern computerised techniques allow the determination of colour discrimination both at foveal and eccentric retinal locations, which can be analysed in conjunction with visual field data from the same locations. The following studies describe the use of such techniques.

Falcao-Reis et al. measured colour contrast sensitivity using an extramacular stimulus, at 6 month intervals for a period of 2 years in POAG patients and those with ocular hypertension. Colour contrast sensitivity thresholds were more than 2 SDs greater than the control group in 69% of POAG subjects and 32% of ocular hypertensive subjects.

All 84 patients with POAG examined by Yu et al. using a contrast heterochromatic flicker technique, showed thresholds of more than 2 SDs above the normal mean. Their extramacular stimulus was a 25 degree diameter annulus of thickness 1 degree, concentric with a central white fixation spot. The subjects’ task was to identify the quadrant in which a 45 degree gap was introduced into the annulus, while the colour of the annulus was modulated. Furthermore, their 77 high risk hypertensive patients fell into two differentiated groups—one with thresholds similar to normals and one with elevated thresholds, which in 50% of cases were more than 3 SDs above the normal mean. Using a similar method, Felius et al. measured cone contrast thresholds along long (L), medium (M), short (S), L-M, and L+M cone contrast directions at 12 degrees eccentricity in groups of POAG patients, at-risk patients, and normals. Colour contrast defects in POAG and in at-risk subjects occurred in all five modulation directions, although abnormalities in the short wavelength (blue) direction were more pronounced. Fristrom used the colour contrast threshold technique to compare groups of glaucomatous, normal, and ocular hypertensive subjects.
The colours tested were varied along the protan, deutan, and tritan colour confusion axes. At all axes there were significant differences in mean colour contrast threshold between the glaucomatous and normal groups. However, because values for colour contrast thresholds overlapped for all groups, it was difficult to determine a cut off point which achieved an adequate separation between normals and those with POAG.

Using a novel computerised technique we have compared chromatic discrimination (CD) thresholds in a group of 19 POAG patients, 10 ocular hypertensives, and 28 normal age matched controls. Chromatic discrimination thresholds were measured both for foveal and peripheral viewing conditions, along 12 equispaced orientations in x, y CIE colour space. The foveal data showed a significant decline in discrimination performance for chromatic displacements towards the red region of colour space as well as the tritan axes in POAG patients compared with normal controls. These results were in agreement with other reports described above using F-M 100 hue tests. It is noteworthy that the CD thresholds were elevated significantly, along all orientations tested, for the 6 degree peripheral viewing condition in all POAG patients. Results for the small ocular hypertensive group in both foveal and peripheral viewing conditions were not significantly different from those in the normal controls. Although these studies show that the progress of the disease can be monitored by measuring peripheral chromatic discrimination, whether it can be used as a predictor of those patients who will convert from ocular hypertension to glaucoma remains to be established in follow up investigations with a larger group of patients.

The neurobiology of the functional deficits outlined above are not yet fully understood. From the literature reviewed so far, it appears that the chromatic sensitivity loss and the reduction in luminance sensitivity as measured by conventional perimetry may appear either in isolation or together in POAG. This had led Airaksinen et al to suggest that multiple mechanisms may be responsible for the measured functional deficits. Both diffuse and localised nerve fibre damage occurs in POAG. Flammer has suggested that a diffuse loss may be as a result of a direct mechanical damage related to an increased IOP, whereas a localised nerve fibre loss may be primarily caused by a vascular disorder. Both diffuse and localised losses may result in functional deficits. It has been suggested that the foveal colour vision loss observed in POAG patients is as a result of a diffuse nerve fibre loss. On the other hand, localised glaucomatous field defects may be detected earlier using the short wavelength automated perimetry technique described below.

### Short wavelength automated perimetry (SWAP), or blue on yellow perimetry

Short wavelength sensitive cones and ganglion cells are relatively sparsely distributed throughout the retina. Therefore, short wavelength visual losses resulting from early POAG may be detected earlier than those from other pathways in which there is less redundancy. SWAP is a technique that employs a high luminance yellow background which adapts the medium wavelength and long wavelength cones, and simultaneously saturates rod activity. The stimulus is a size V blue stimulus, and standard Humphrey visual field analyser full threshold techniques are often used. In eyes with early to moderate glaucomatous loss, scotomas detected using SWAP are more extensive and deeper than conventional perimetry, and blue on yellow defects may precede the development of white on white defects by several years.

However, short wavelength transmission losses resulting from absorption and forward light scatter by the ocular media may be indistinguishable from early glaucomatous loss. There are several methods for correcting SWAP results for individual differences in lentilc absorption and scattering of short wavelength light, but the methods are either time consuming, or expensive, or both. Also, data from SWAP exhibit increased test variability compared with conventional perimetry which may result in less sensitive detection of visual field progression.

The examination of the visual fields using SWAP is a technique that in itself takes longer than conventional perimetry using the equivalent Humphrey program. An increase of 15% (full threshold) to 17% (FASTPAC) in SWAP examination duration was found in one study compared with white on white perimetry. There was also an increase in short term fluctuation with SWAP. Increased interindividual variability is another clinical limitation of current methods of SWAP and this persists even when allowance is made for media absorption. Faster threshold strategies, such as SITA for SWAP, offer improvements in the speed of the procedure, but await validation.

There is a reduction in SW cone sensitivity with increasing age, although the methods used in this study did not permit any differentiation between the effects on sensitivity resulting from yellowing of the crystalline lens, and the effects resulting from an increase in neural losses in the SW cone pathway. A similar rate of decline was found in an age matched group with POAG, who suffer both the normal age related decline in SW cone sensitivity, plus a concurrent disease related sensitivity reduction. When allowance is made for media absorption in healthy older subjects, a small, statistically significant loss of sensitivity with aging remains.

### Quality of life measures in POAG

Although the assessment of symptomatology and quality of life measures among patients with glaucoma have received little attention until recently, there is growing recognition of the importance of these measures across a wide range of ophthalmic conditions. Parrish et al investigated the relation between visual field impairment, visual functioning, and global quality of life in POAG, finding a modest correlation between a visual acuity impairment score and colour vision ($r = -0.47$), and between visual field loss, assessed by Estermann binocular visual field impairment score, and colour vision ($r = -0.42$). Colour vision is one subscale in the National Eye Institute visual functioning questionnaire (NEI-VFQ), and this was completed by 147 POAG subjects in a recent survey. There was no significant correlation between the extent of their visual field loss, as assessed by the AGIS scale, and the colour vision subscale. However, other NEI-VFQ subscales which were significantly correlated with the extent of visual field loss may be affected by defective colour vision—for example, the general vision scale, the dependency scale, and the driving scale. To date, there is insufficient evidence to be certain of the significance of acquired colour deficiency in POAG symptomatology and quality of life measures. Symptom scales specific to POAG are now in use, and their successors may tease out further quantitative data on the impact of acquired colour deficiency on patients’ lives. Clinical reports confirm that patients with acquired tritan-type defects observe that colours in general appear desaturated or “washed out”. Perception of specific colours can be especially impaired, with yellow appearing white and blues appearing black.
Summary

By the time the earliest visual field defects in POAG can be detected using typical increment threshold perimetry, extensive, irreversible neuronal damage has occurred. Investigation of colour mechanisms may allow detection of POAG at an earlier stage than conventional perimetry, resulting in improved prognosis. Standard clinical colour vision tests involving anomaloscopes, pseudo-isochromatic plates, and arrangement tests, although distinguishing patients with well developed glaucoma from normals, do not appear to have enough sensitivity and specificity to act as screening techniques at earlier stages of the disease. Compared with these clinical tests, the new computerised techniques are potentially more valuable in detecting POAG because they can assess colour vision at specific retinal locations. However, data published to date suggest that investigation of chromatic signals on its own may not be sufficient to detect or predict the progress of the disease. This is partially due to the fact that the precise neurobiology of the disease is not yet fully understood and POAG may differentially affect various neuronal layers of the retina. It is, therefore, possible that a battery of tests which include investigation of chromatic signals together with transient motion signals, flicker/luminance sensitivity, and SWAP may yield more accurate indices for predicting/monitoring the various stages of the disease.

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