Ocular Pneumoplethysmography and Ophthalmodynamometry in the Diagnosis of Central Retinal Artery Occlusion

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SUMMARY Ocular pneumoplethysmography and ophthalmodynamometry measure ophthalmic arterial system pressures to assess noninvasively the hemodynamics of the carotid system. A previously unreported circumstance in which these tests complement one another is central retinal artery occlusion. Typically, the ipsilateral retinal artery pressure, measured by ophthalmodynamometry, is greatly decreased or is zero, whereas the ophthalmic systolic pressure, measured by ocular pneumoplethysmography, is normal.

CENTRAL RETINAL ARTERY OCCLUSION usually presents as an acute, painless, unilateral loss of vision. Ophthalmoscopically, the optic disk and the retina become pale, the retinal vessels narrow, and a macular cherry red spot is often visualized. Central retinal artery occlusion may be confused with venous occlusions, branch artery occlusions, and ischemic optic neuropathy, despite the usual differences in temporal profile, clinical course, and ophthalmoscopic manifestations. Furthermore, any of these phenomena may occur in various combinations. Ocular pneumoplethysmography and ophthalmodynamometry, in combination, provide a safe and rapid means of confirming the diagnosis of central retinal artery occlusion and may provide clues as to the cause of the condition.

Report of Cases

Case 1

A 59-year-old man with a long history of hypertension experienced an episode of left amaurosis fugax 1 month before admission. The episode lasted 4½ minutes and resolved completely. Two more such episodes occurred on the same day, prompting hospitalization and treatment with intravenously administered heparin. Results of four-vessel cerebral angiography were normal. The patient was dismissed on warfarin therapy. Two weeks before admission, he had another episode of sudden onset of complete visual loss of the left eye, without improvement. An ophthalmologist in his home community diagnosed ischemic optic neuropathy. Treatment with inhalation of 95% oxygen and prednisone was given, but no improvement occurred. A left temporal artery biopsy specimen was normal, as was the sedimentation rate. He was referred to the Mayo Clinic for further evaluation.

Ophthalmologic examination showed a visual acuity of 14/21 on the right and light perception only on the left. Intraocular tensions were 16 mm Hg bilaterally. There was a left-sided afferent pupillary reflex defect. Ophthalmoscopic examination of the left eye showed a pale retina with thready vessels and edema of the macular area with an associated cherry red spot. Ophthalmodynamometry revealed retinal artery pressures of 130/54 mm Hg on the right and 12/0 mm Hg on the left. Ocular pneumoplethysmography revealed ophthalmic systolic pressures of 110 mm Hg bilaterally, with brachial systolic pressures of 154 mm Hg on the right and 148 mm Hg on the left. Results of a periorbital Doppler study were normal. General examination revealed a blood pressure of 190/110 mm Hg but was otherwise normal, as was a cardiac sector scan.

Case 2

A 71-year-old man reported the sudden onset of decreased vision in his right eye 2 weeks before admission. He could only see gross hand movements. By the following day, he was blind in the right eye. An ophthalmologist in his home community made a diagnosis of central retinal artery occlusion and referred the patient to the Mayo Clinic for further evaluation. The patient’s medical history had been unremarkable, with the exception of long-standing mild hypertension treated with a diuretic (Dyazide).

On admission, visual acuity was nonexistent on the right and 14/21 on the left. Ocular tensions were 11 mm Hg on the right and 15 mm Hg on the left. There was a right afferent pupillary reflex defect. Ophthalm-
moscopic examination of the right eye showed a mark-
edly pale retina, no discernible blood flow in the ves-
sels, and a prominent cherry red spot. The left
ophthalmoscopic examination showed grade 1 retinal
arteriolar narrowing and sclerosis. Ophthalmodynam-
ometry revealed retinal arterial pressures of 0/0 mm
Hg on the right and 94/32 mm Hg on the left. Ocular
pneumoplethysmography showed ophthalmic systolic
pressures of 123 mm Hg on the right and 120 mm Hg
on the left. Brachial systolic pressures were 136 mm
Hg on the right and 142 mm Hg on the left.

Case 3

While driving a car 2 days before her admission, a
70-year-old woman suddenly lost vision in her right
eye. Two hours later, she was seen by an ophthalmol-
ologist in her home community, and a tentative diagnosis
of central retinal artery occlusion was made. Treat-
ment was attempted with inhalation of carbon dioxide
and ocular massage for 3 hours. The patient regained
some right temporal vision after this treatment, but
central vision did not return.

Her examination 2 days later at the Mayo Clinic
revealed only vague light perception in the right tem-
poral field of the right eye. The left visual acuity was
14/21. Ocular tensions were 18 mm Hg on the right
and 23 mm Hg on the left. Ophthalmoscopic examina-
tion of the right eye revealed a pale gray retina with
extremely narrowed arterioles and a macular cherry
red spot. The left eye was normal ophthalmoscopically.

Ophthalmodynamometry revealed retinal artery
pressures of 40/20 mm Hg on the right and 106/50 mm
Hg on the left, and ocular pneumoplethysmography
showed ophthalmic systolic pressures of 126 mm Hg
on the right and 123 mm Hg on the left, with brachial
systolic pressures of 150 mm Hg on the right and 142
mm Hg on the left. Auscultation over the neck re-
vealed bilateral carotid artery bruits localized to the bi-
furcations. An ultrasound B-scan and pulsed Doppler
study showed bilateral irregular stenoses of the internal
carotid and common carotid arteries, greater on the
right than on the left. A transfemoral cerebral angi-
ogram showed an irregular segmental stenosis of 70% in
the proximal portion of the right internal carotid artery
and the distal portion of the right common carotid
artery, with a deep ulcer located posteriorly along the
right internal carotid artery. An irregular stenotic le-
sion of 60% involved the proximal portion of the left
internal carotid artery, with diffuse atheromatous
changes and eccentric plaques in both the distal left
common carotid artery and the proximal left internal
carotid artery. A right carotid endarterectomy was per-
formed and an atherosclerotic ulcerated plaque along
the distal right common carotid artery and proximal
right internal carotid artery was excised.

Case 4

A 78-year-old woman experienced the sudden onset
of loss of vision in her right eye 3 weeks before admis-
sion. An ophthalmologist in her home community sus-
pected a "blockage of a blood vessel." Past medical
history included long-standing diabetes mellitus and
hypertension but was otherwise unremarkable.

Examination at the Mayo Clinic revealed a right eye
visual acuity of finger counting at 4 feet and a left eye
acuity of 14/28. Ocular tensions were 20 mm Hg bi-
laterally, and an afferent pupillary reflex defect was
noted on the right. Ophthalmoscopic examination of
the right eye revealed a pale retina with a decreased
caliber of the arterioles and no apparent blood flow.
The left eye was normal ophthalmoscopically, without
evidence of background diabetic or hypertensive retin-
opathy. Ophthalmodynamometry revealed retinal ar-
tery pressures of 0/0 mm Hg on the right and 101/30
mm Hg on the left. Ocular pneumoplethysmography
showed ophthalmic systolic pressures of 125 mm Hg
bilaterally, with brachial systolic pressures of 188 mm
Hg on the right and 186 mm Hg on the left. Cardiac
examination revealed a grade 3–4/6 rough systolic
ejection murmur at the base, which extended to the
apex and the carotid arteries bilaterally. There was a
grade 2/6 diastolic murmur over the left lateral sternal
border. A cardiac sector scan revealed evidence of
mild to moderate aortic stenosis and aortic insufficien-
cy, a calcified mitral valve anulus, and mild left ven-
tricular hypertrophy. The patient was treated with aspi-
rin and dipyridamole. No further symptoms have
occurred during the past 9 months.

Discussion

All four patients demonstrated typical clinical
symptoms and classic ophthalmologic signs of central
retinal artery occlusion. In each patient, the ipsilateral
retinal artery pressure, as measured by ophthalmom-
dynamometry, was greatly reduced whereas the oph-
thalmic systolic pressure, as measured by ocular pneu-
oplethysmography, was normal.

The pathogenesis of central retinal artery occlusion
varies widely and includes vaso-obliteration due to
local central retinal artery inflammatory, hypertensive,
or atherosclerotic changes (or combinations of these),
as well as occlusion of the vessel from emboli from
cervical artery or cardiac sources.1 Patients 1 and 2 had
long-standing hypertension historically, without iden-
tifiable embolic sources or inflammatory disease, and
hence the mechanism of the central retinal artery oc-
cclusion likely involved local hypertensive or athero-
sclerotic (or both) changes. In patient 3, the presumed
mechanism for central retinal artery occlusion was em-
bolization from the ulcerated atherosclerotic lesion of
the ipsilateral internal carotid-common carotid system.
The stenosis of this lesion was not sufficient to reach
pressure significance (greater than or equal to luminal
area stenosis of 75%), and therefore the results of
ocular pneumoplethysmography were normal. Patient
4 had a potential cardiac embolic source (aortic and
mitral valvular abnormalities) as well as long-standing
hypertension, and either could be implicated as the
underlying mechanism.

The two most frequent sites of central retinal artery
occlusion are where the artery enters the dura of the
optic nerve sheath and at the lamina cribrosa. In both instances, the pressure in the distal retinal vessels becomes greatly reduced or unmeasurable, producing abnormality on ophthalmodynamometry. However, the medial and lateral posterior ciliary arteries, which supply approximately 90% of the total ocular blood, have origins in the ophthalmic artery that are separate from the central retinal artery. Consequently, these vessels remain intact in central retinal artery occlusion, allowing normal eye pulsation and normal ocular pneumoplethysmographic results. Thus, abnormal ophthalmodynamometric results (particularly when the values are 0) in the presence of ipsilateral normal ocular pneumoplethysmographic results are strongly suggestive of central retinal artery occlusive disease. Conversely, when both ophthalmodynamometric and ocular pneumoplethysmographic results are normal, the diagnosis of complete central retinal artery occlusion should be seriously questioned. If the clinical setting is typical for central retinal artery occlusion and both ocular pneumoplethysmographic and ophthalmodynamometric results are abnormal, a separate pressure-significant lesion of the internal carotid system probably exists proximal to the central retinal artery and may have served as an embolic source.

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References


Pattern Difference of Reversed Ophthalmic Blood Flow Between Occlusion and Stenosis of the Internal Carotid Artery

An Ultrasonic Doppler Study

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SUMMARY Reversed ophthalmic blood flow in the occlusions (33 patients) and stenoses (11 patients) of the internal carotid artery (ICA) was examined using the ultrasonic Doppler technique. The Doppler shift frequencies of the blood flow signal were analyzed to obtain their sound spectrogram. In stenosis of the ICA, "presystolic notch" was more frequently observed and "d/S" value (S, d; maximum blood flow velocity at systolic and diastolic) was smaller than in occlusion.

These two characteristics of stenosis distinguish it from occlusion with 89% accuracy although this method is applicable only for the patients with reversed ophthalmic blood flow.

REVERSED BLOOD FLOW in the ophthalmic artery is frequently detected by the ultrasonic Doppler flowmeter in patients with occlusion or stenosis of the internal carotid artery (ICA).

Reports suggest that obstructive lesions of the ICA may be diagnosed noninvasively by detection of the reversed ophthalmic collateral flow.

A few authors have reported the possibility of the differential diagnosis between occlusion and stenosis of the ICA with the use of the Doppler techniques. No author has discussed the differences in patterns blood flow in the ophthalmic artery itself as a distinguishing feature. The purpose of this report is to clarify the rheological differences of reversed blood flow in the ophthalmic artery per se between the occlusion and the stenosis using an ultrasonic Doppler method and then to describe the possibility of the differential diagnosis.

Subjects and Methods

Consecutive patients with 54 occlusions and 62 stenoses of the ICA admitted from June 1976 to October 1979 were all examined both by cerebral angiography and ultrasonic Doppler studies. The ultrasonic Doppler examination was performed after angiography except for 15 patients. Among them, 33 patients with carotid occlusion (21 were men, and 12 were women, the average age was 63.6 years old) and 11 patients with stenoses of the ICA (9 were men, and 2 were women, with an average age of 69.3 years old.) were
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