Case 2

Name : Aliyar

Age : 68 yrs | Male

Address : Chelakkullam

Occupation : Works in oil refinery

Presenting complaints

Blurring of vision of right eye × 8 yrs.

Blurring of vision of left eye × 2 yrs.

History of presenting complaints

The patient came to the OPD with complaints of ~~three~~ blurring of vision on both eyes. On the right eye duration was of 8 years and left eye 2 yrs. Blurring of vision on both eye were of gradual onset and slow progression.

There were no history of associated pain.

He gave a history of blackspots on looking against bright backgrounds.

No history of glare

No history of coloured halos, photophobia, redness of eye or itching of the eye.

No history of recent trauma.

Past history

- No similar history in the past
- No history hypertension
- No history of hypertension
- No history of thyroid disorders
- No history of steroid / and other drug intake.
- history of conjunctivitis 2 weeks ago
- No history of past trauma.

Family history

- No relevant family history.

Personal history

Mixed diet
Sleep and apetite normal
unaltered Bowel and Bladder movements
No h/o alcoholism or smoking
No history of drug allergies.

Examination

General examination

- The patient was conscious and co-operative.
- Moderately built and nourished.
- No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema.
- Vital are ~~norm~~ stable.
- All systems are within normal limits.

Ocular examinations

	Left eye	Right eye
1. Visual acuity distance vision	6/60 improved on pinhole test to 6/9	6/60 improved on pinhole test to 6/36
2. Near vision	N_8	N_{36}

3. External ocular examination
- head posture - normal, no head tilt / chin elevation
- Both eyes are orthophoric
- No facial assymetry
- Extraocular movements full in all directions of gaze.
- Forehead wrinkling present on both halves and skin normal
- orbital margin intact.
- Eyebrows -
  Both at same levels
  No madarosis.

• Eyelids
→ Normal in position
→ No abnormal drooping
→ No swelling or redness.
→ No trichiasis.
→ Lid margins normal; no entropion / ectropion.
→ palpebral aperture - normal.

	Right eye	Left eye
Lacrimal apparatus	No swelling / discharge regurgitation test - negative	No swelling / discharge. regurgitation test - negative.
conjunctiva	No congestion No discolouration No haemorrhage	No congestion No discolouration, No haemorrhage.
Sclera	No thinning No bulging	No thinning No bulging
Cornea	normal in size and shape. Arcus senilis present corneal sensation intact	normal in size and shape. Arcus senilis present corneal sensation intact
Anterior chamber	normal depth clear No hypopyon / hyphema	normal depth. clear No hypopyon / hyphema
Iris (a) colour (b) pattern	 Normal Normal • No iridodonesis	 Normal. normal. No iridodonesis
pupil size shape. position pupillary light reflex } direct / indirect	 Normal Circular normal brisk reaction	 normal circular normal. brisk reaction

Lens	Greyish white opacities Iris shadow present	Greyish white opacities Iris shadow present

Fundus examination : Not done.

Summary

63 year old Aiyar from Chitakullam presented to the OPD with complaints of blurring of vision on both eye with duration of 3 yrs on right eye and 2 yrs of left eye. Onset was gradual and slow progression for both eyes. The patient give history of seeing floaters. No other associated symptoms. On ocular examination visual acuity was found to be 6/60 on both eyes but it increased to 6/9 on left eye and 6/36 on right eye on pinhole test. Lens of both eye shows greyish white opacities and iris shadow.

Provisional diagnosis

Immature senile cataract on both eyes.