

An Approach to Medical Ophthalmoplegia

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Disclosures

None

Learning Objectives

- “ Formation of a Systematic approach to Anatomical Localization based on clinical and radiological clues
- “ Acquisition of the Skill of recognition of etiology, diagnosis and management of patients of Ophthalmoplegia

Key Message

- “ Is there a lesion ?
- “ Where is the lesion ?
- “ What's the lesion?

Gordon Holmes (1905)

OPHTHALMOPLEGIA

Define symptoms- 'Diplopia' 'Pain' 'Ptosis' 'Proptosis'

Mono-ocular

Binocular

Horizontal separation

Vertical separation

False Image

True Image

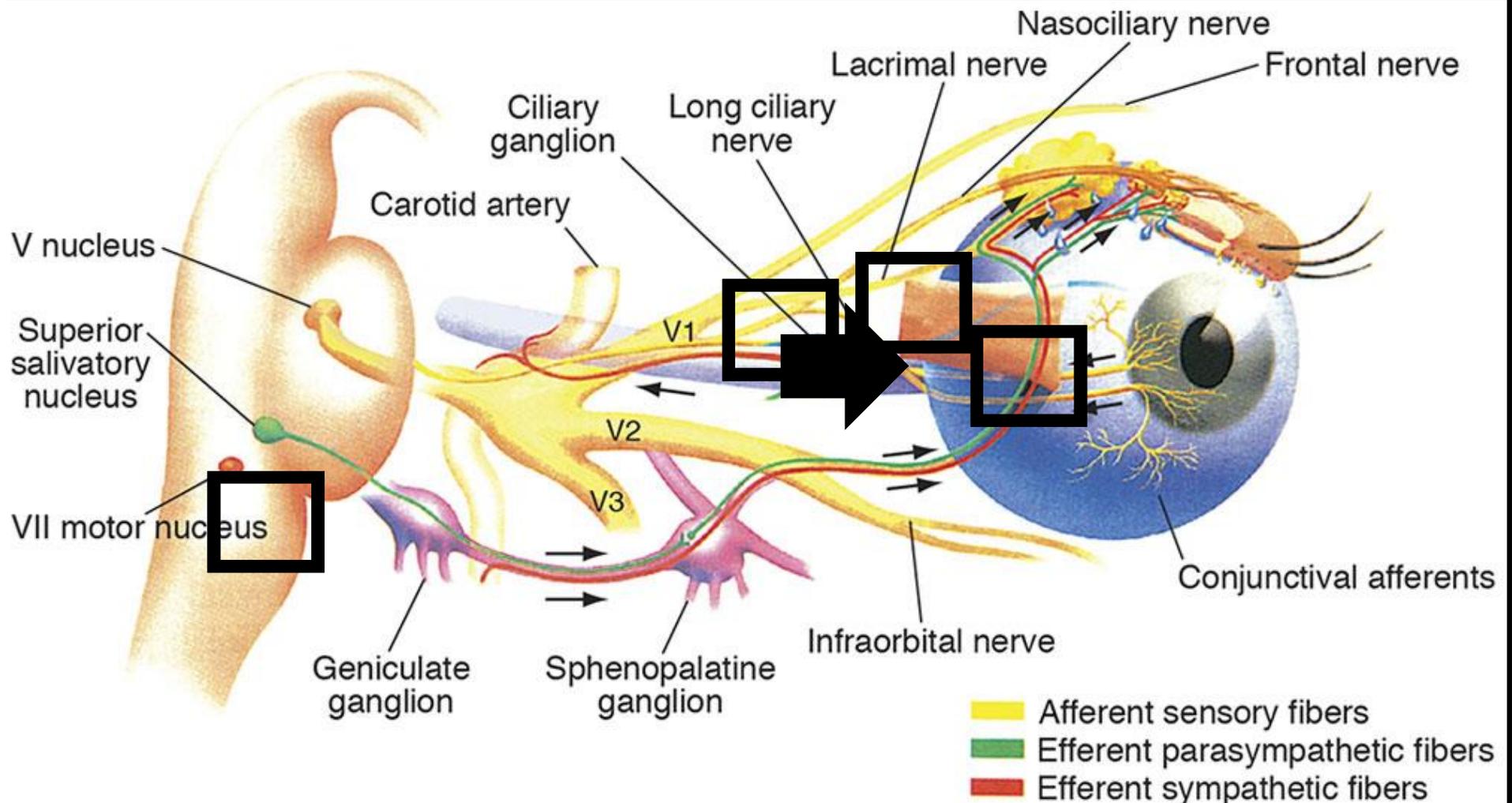
Effect of Head Tilt

Effect of distance to target

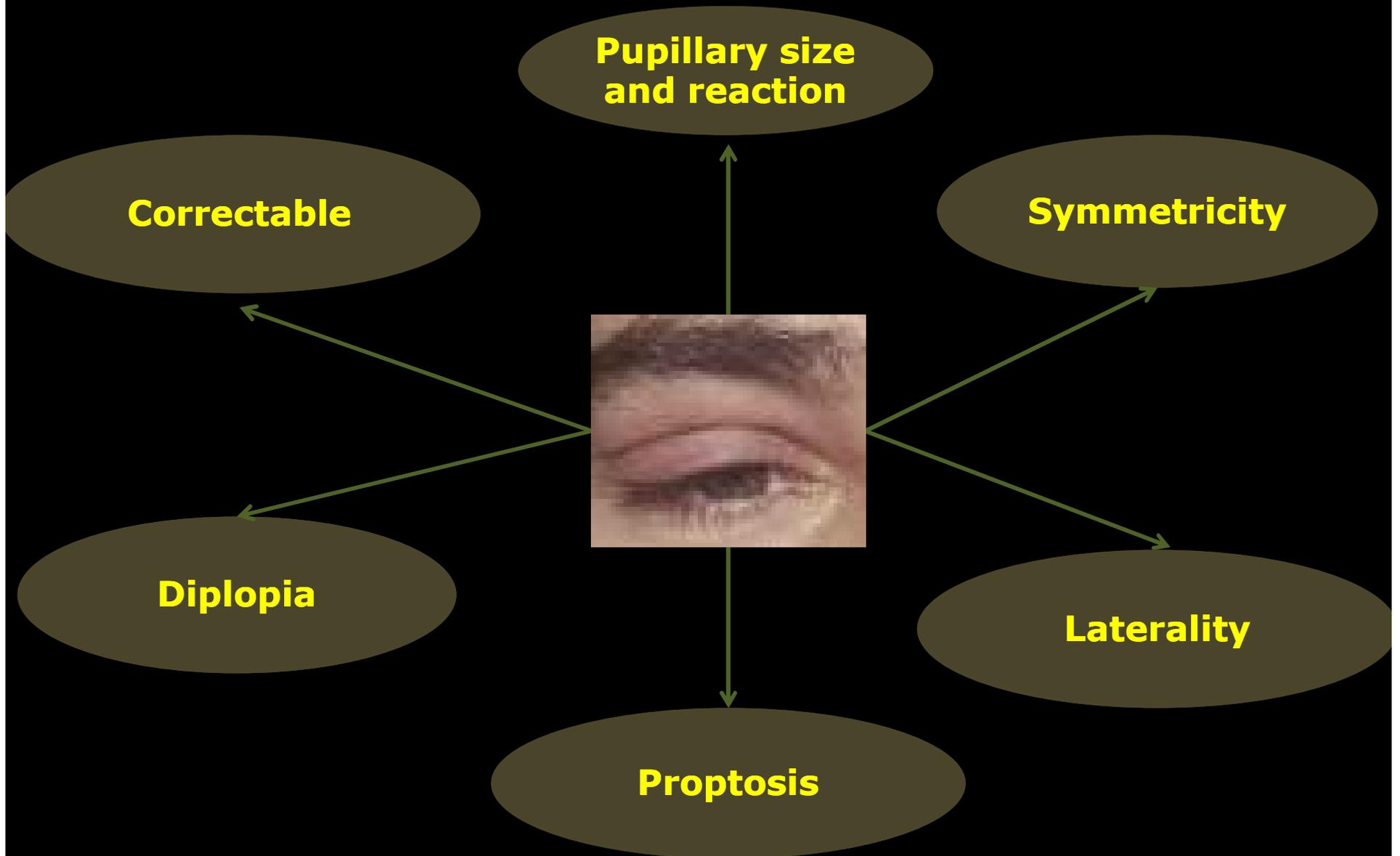
Effect of gaze direction

Fluctuations

WHY WE SEE THIS?



PTOSIS



12 M

Low grade fever	10 d
Headache and Vomiting	10 d
Diplopia	10 d



Bilateral, Asymmetrical, Non fluctuating ptosis with Diplopia

The Eye Opener: Finding and Targeting the
Midbrain Lesion

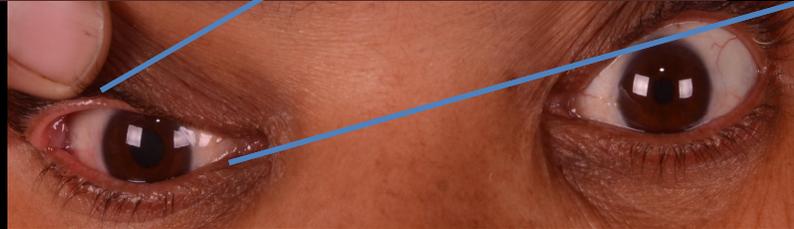
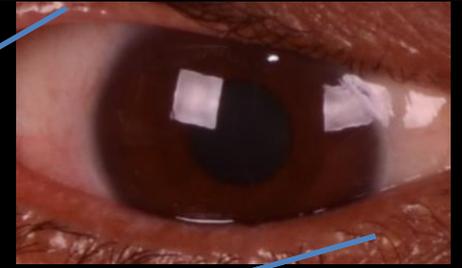
65 F

Sudden onset Severe Headache

Altered Sensorium

Noted Right eye ptosis and diplopia when conscious

4 months back

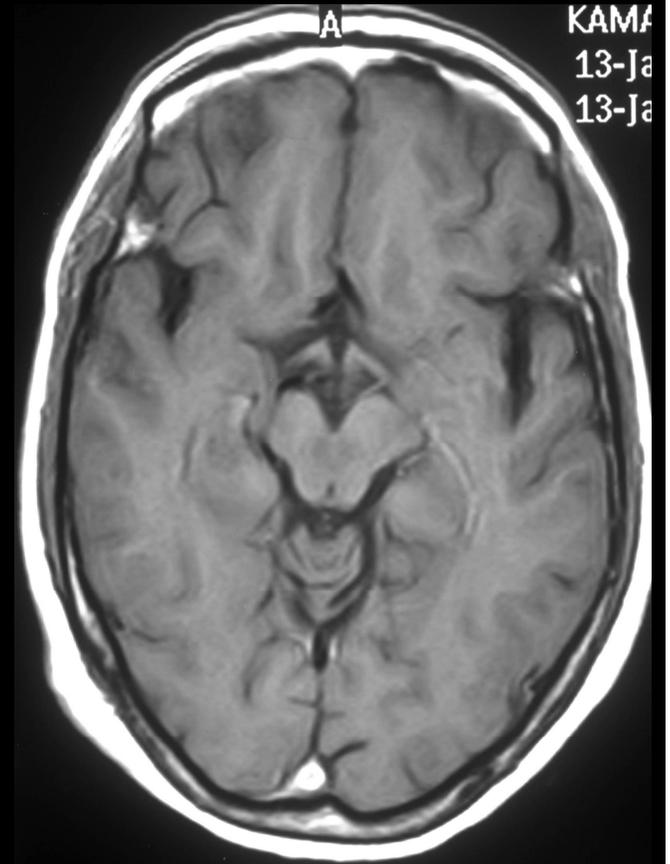


Unilateral, Complete, Non correctable, Pupil Involving



55 M

Ptosis and Diplopia 2 weeks duration



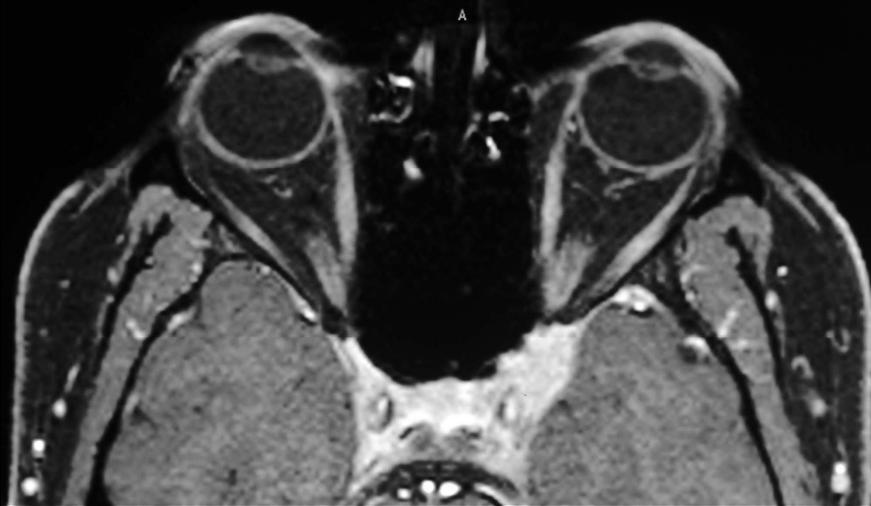
Unilateral, Non correctable ptosis, Pupil Sparing

40 M

Ptosis and Diplopia 2 weeks duration



Unilateral, Complete, Non correctable, Mild Proptosis



55 M

DM x 5 yrs

Left hemi-cranial headache and Double vision

8 weeks

Drooping of left eyelid

7 weeks

Improved partially with oral steroids

6 weeks back

O/E :

Left eye- complete ptosis and ophthalmoplegia; Pupil spared

Left V1, V2 decreased sensation

Unilateral, Complete, Non correctable, Mild Proptosis, Trigeminal



29 M

Left peri orbital and retro-orbital pain 2 d

Ptosis LE 1 m

Visual loss LE 1 m

Double vision 2 d



Unilateral , Complete, Non correctable, Mild Proptosis

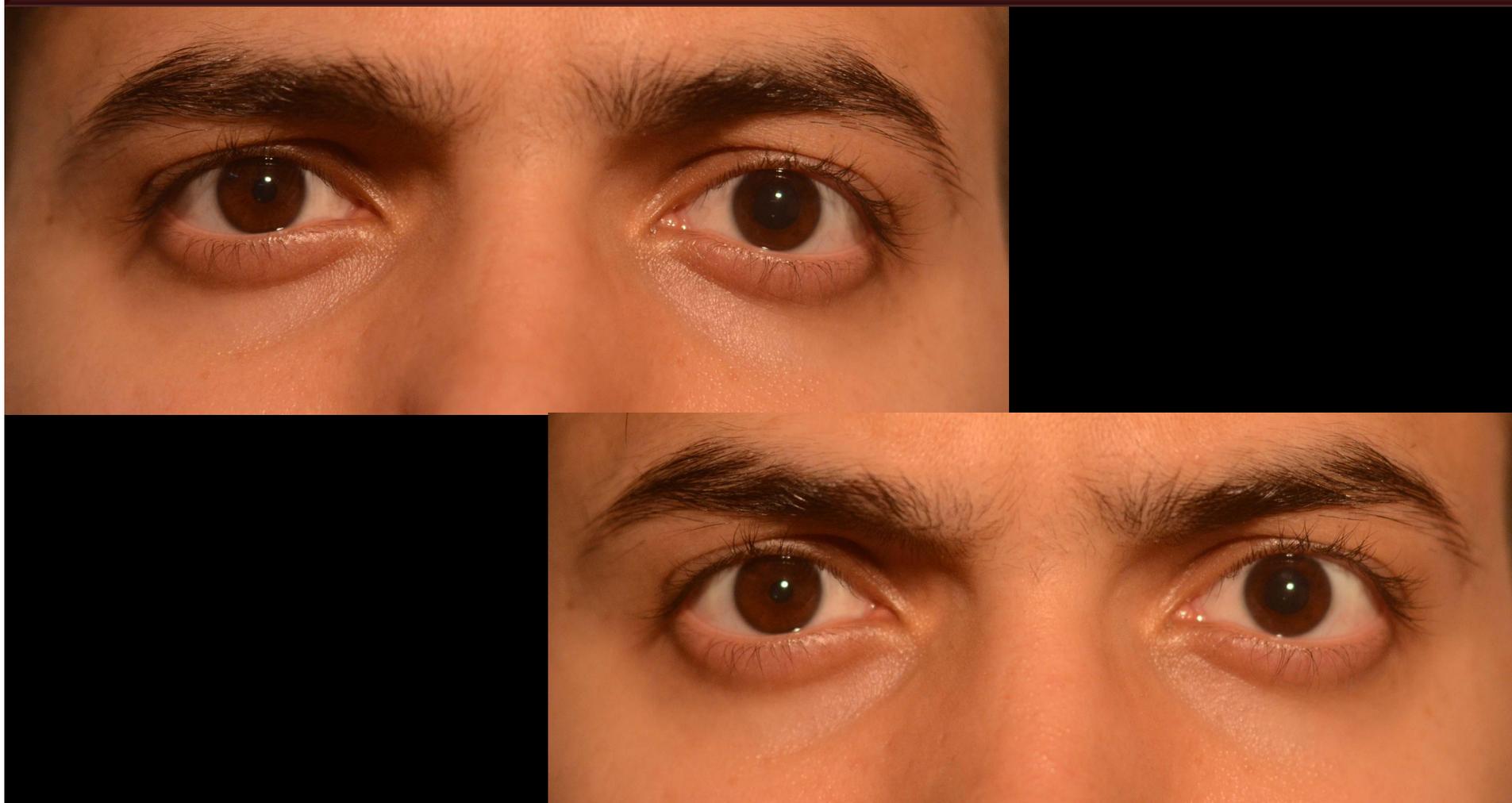
25 M

Photophobia

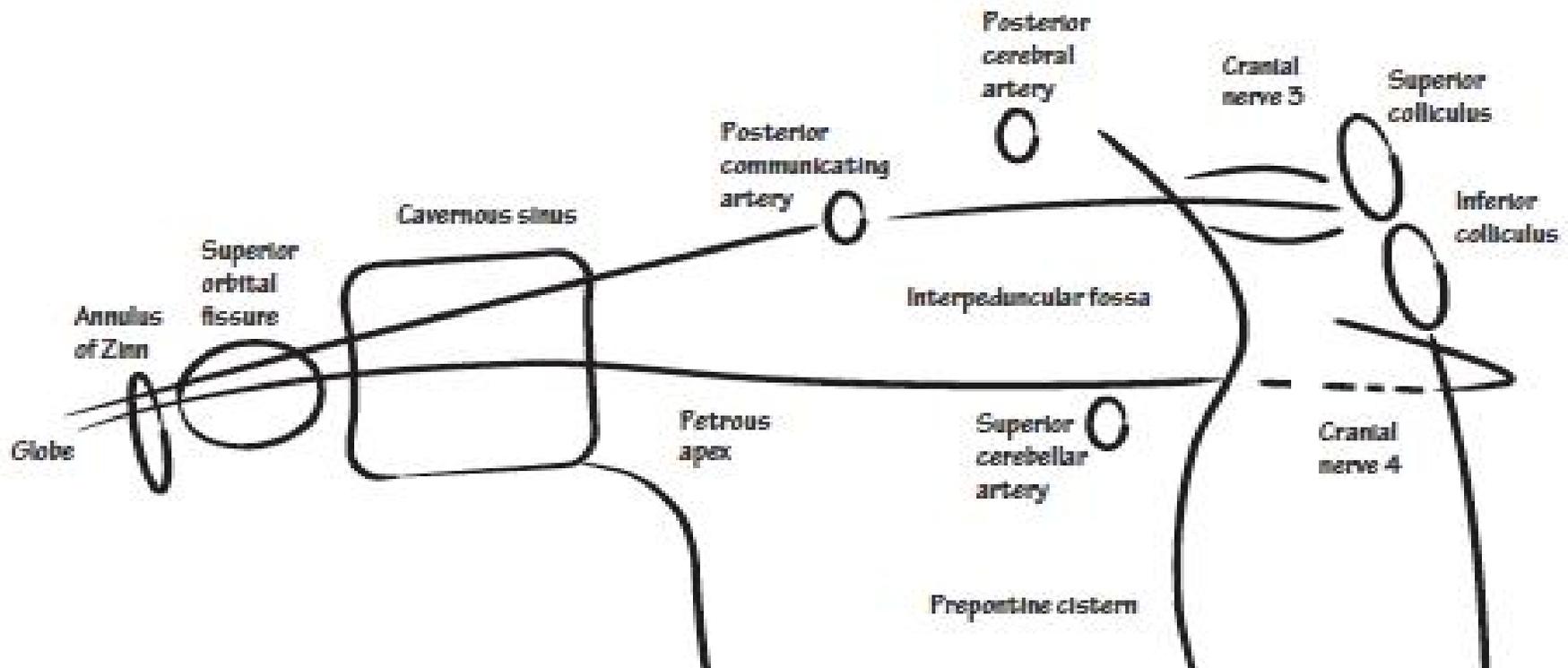
Blurred Vision

Dilated Left Pupil

15 d



TROCHLEAR NERVE



DIPLOPIA- Vertical; Downgaze(Walking down the stairs)

Superior oblique

Intorsion

Abduction

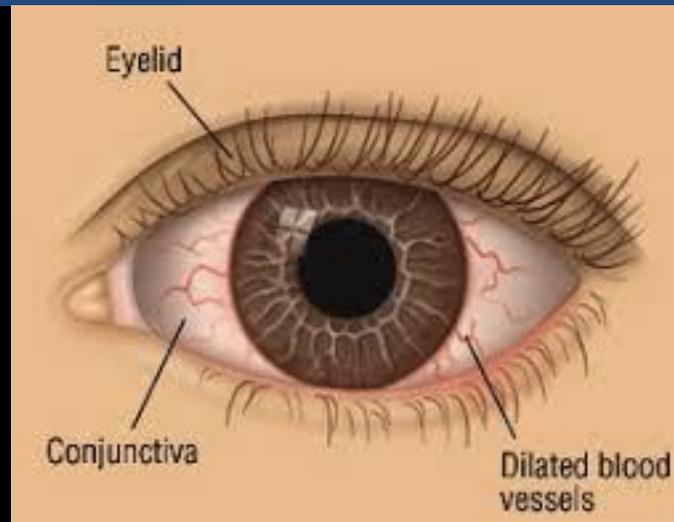
HYPERTROPIA

Limited depression on adduction

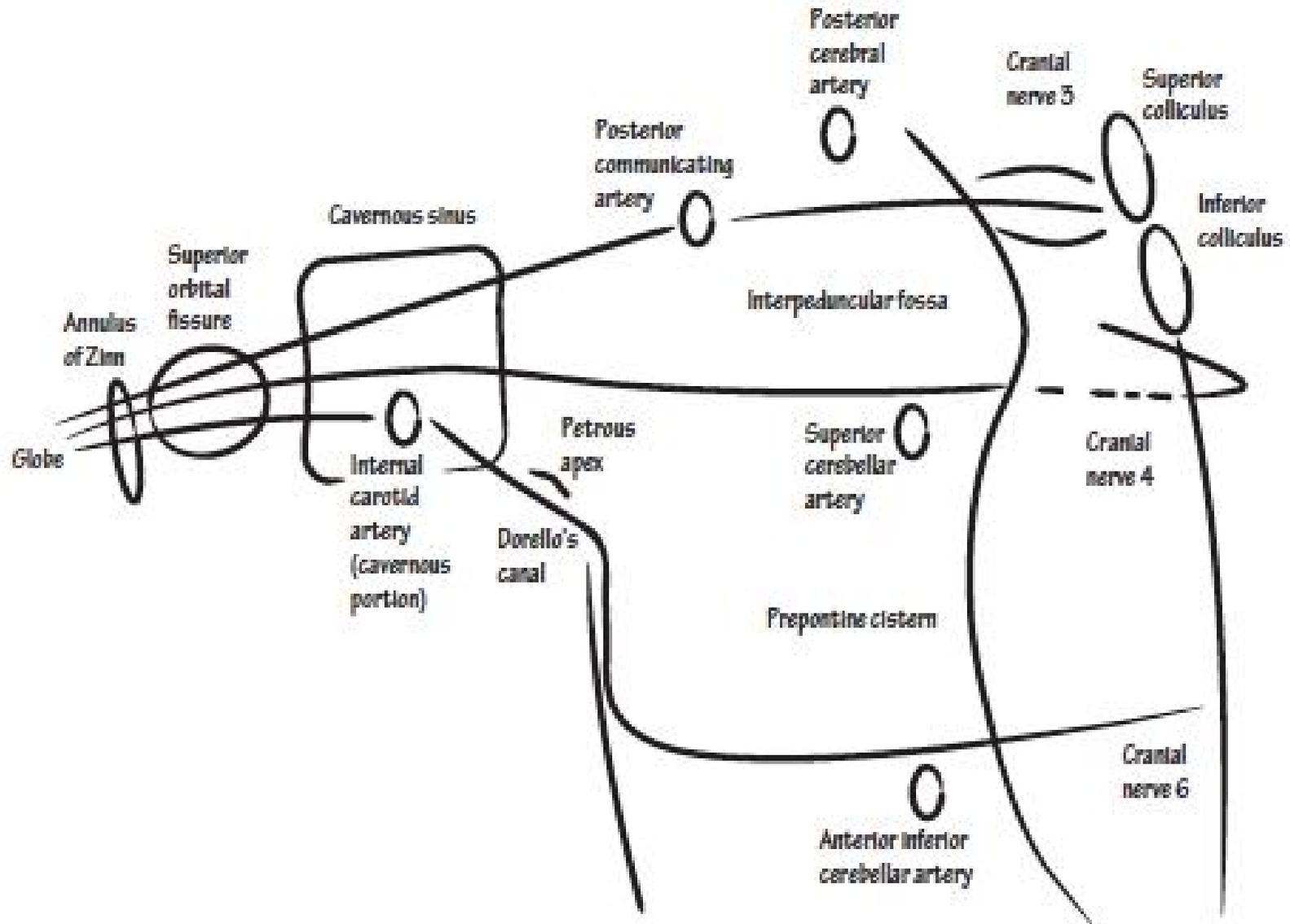
Head – Takes a posture in direction of SO

Turns to Opposite side

IN THE SETTING OF THIRD NERVE PALSY

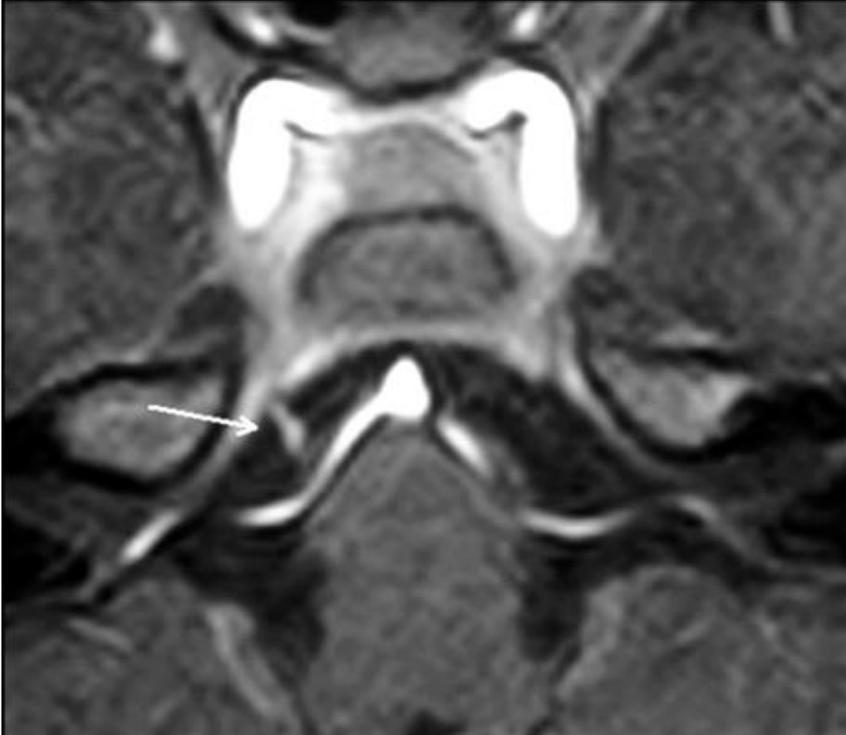


ABDUCENS NERVE



12 F

Recurrent episodes of Headache with double vision



COMMENTARY

Are some ophthalmoplegias migrainous in origin?

Vivek Lal, DM, and Louis Caplan, MD

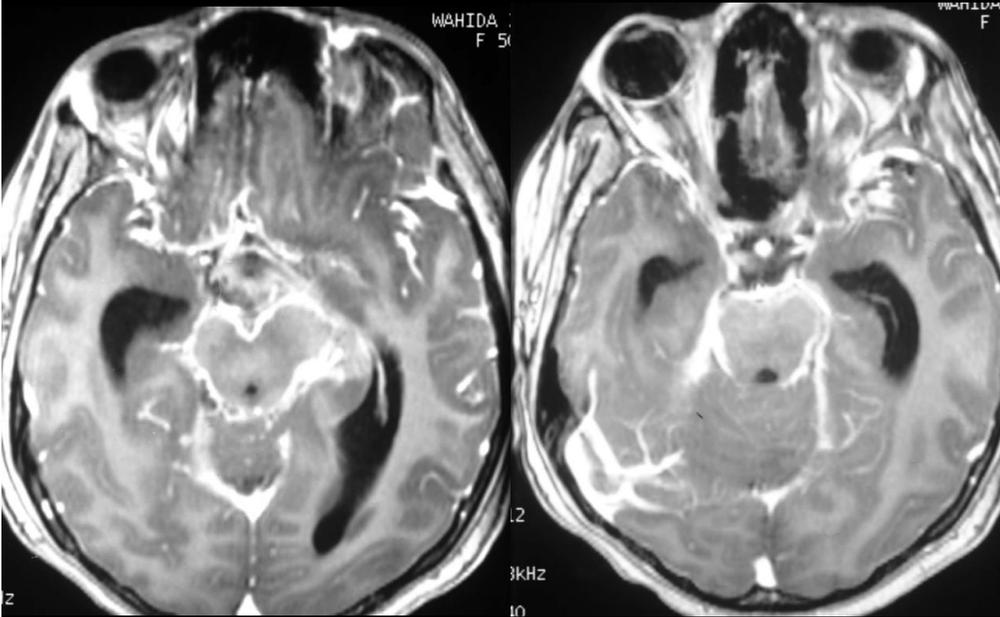
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20 F

Fever, Headache, Vomiting, Diplopa 1 m

Normal Visual acuity and fundus examination



Conclusion

- “ Ophthalmoplegia : Clues and Diagnostic Pearls
- “ Anatomical localization is the 'Key'
- “ Recognition of etiology : Detailed History and Clinical examination

Thank you

