How useful is visual field testing in an African glaucoma clinic?

Purpose: To investigate the usefulness of visual field testing in the diagnosis and subsequent management of glaucoma in a specialist glaucoma clinic at Groote Schuur Hospital, Cape Town, South Africa.

Methods: A retrospective case note review of 344 patients who attended the glaucoma clinic between January and June 2010.

Results: The study population consisted of 201 (58%) females and 143 (42%) males. The diagnoses included 207 (60%) cases with primary open-angle glaucoma, 58 (17%) cases with chronic angle closure glaucoma, 46 (13%) cases with secondary glaucoma, 17 (5%) cases with normal pressure glaucoma, ten (3%) cases with ocular hypertension, and six (2%) glaucoma suspects. Visual field testing contributed to the diagnosis of glaucoma in only 34 (10%) cases. A total number of 2,604 fields were performed. Of these fields, 1,931 (74%) were reliable. A baseline was reached in only 141 (53%) patients. There was evidence of field progression in only 24 (9%) cases. Changes to glaucoma treatment were based on inadequate control of intraocular pressure alone in 309 (90%) patients. Visual field progression contributed to changes in treatment in only 15 (4%) cases.

Conclusion: Visual fields are not used in the diagnosis and management of glaucoma in the majority of patients in our clinic. Patients present with advanced disease, which is easily diagnosed without the use of visual fields. Progression of fields seldom contributes to monitoring and intraocular pressure is mainly used to monitor the adequacy of treatment.

Keywords: Humphrey visual fields, reliability, diagnosis, progression

Introduction

In Africa, 15% of blindness is due to glaucoma and it is also the region with the highest prevalence of blindness relative to other regions worldwide. Socioeconomic deprivation, poor access to health care, and suboptimal diagnosis and management are contributing factors and this often leads to late presentation. Due to difficulties previously encountered in case detection and uncertainties about how to manage the disease in a blindness prevention program, it was not included as a priority disease in the first phase of Vision 2020 planning for Africa. Vision 2020 is the global initiative for the elimination of avoidable blindness, a joint program of the World Health Organization (WHO) and the International Agency for the Prevention of Blindness (IAPB). Automated perimetry has been established as the standard method of testing by which patients at risk for glaucoma and those with documented field loss are followed in research studies and in clinical practice. There are a number of visual field analyzers available on the market, but many landmark clinical studies utilized the Humphrey Field Analyzer (Carl Zeiss Meditec AG, Jena, Germany) to assist with glaucoma diagnosis and progression.
Many eye units in Africa are not equipped with visual field analyzers and there have been no reports of the contribution of visual fields to glaucoma management in those centers that do have the equipment. The use of visual field analyzers has been recommended for glaucoma management in African clinics, specifically to assist in screening, diagnosis, and monitoring of progression as part of the Vision 2020 program.

The eye clinic at Groote Schuur Hospital is a tertiary-level referral center that treats patients with primary, secondary, and tertiary eye diseases. The clinic is equipped with two Humphrey visual field II-i-series analyzers, which have been in use for approximately 15 years. Other tools available in this unit to assist with the management of glaucoma are disc photography and Goldmann applanation tonometry.

Therefore, the aim of this study was to determine the contribution of Humphrey visual field testing to the management of glaucoma cases in our specialist glaucoma clinic.

Materials and methods

We conducted a retrospective, consecutive case note review of 446 patients attending the glaucoma clinic for the 6 months between January and June 2010. Ethical approval was obtained from the Research Ethics Committee of the Faculty of Health Sciences, University of Cape Town (Cape Town, South Africa). The diagnosis of glaucoma was based on the findings noted by the clinician in the clinical notes, namely disc findings in keeping with glaucoma – a vertical cup-to-disc ratio of 0.7 or more ± raised intraocular pressure ± a visual field defect suggestive of glaucoma. Visual field reliability was defined as per the manufacturer’s guidelines for standard threshold testing: less than 20% fixation losses or less than 33% false-negative responses or less than 33% false-positive responses. A visual field was indicative of glaucoma if the hemifield test was outside normal limits and there was a cluster of three contiguous points at the 5% level on the pattern deviation plot. Baseline was defined as two early, similar, reliable fields. Visual field progression was defined as deterioration of three or more points at the same location at the $P<0.05$ level on three consecutive visual fields. Data was captured on an Excel spreadsheet and then analyzed using STATA (v10.0).

Results

Of the 446 case notes reviewed, 344 patients had performed Humphrey visual fields at some stage during their attendance at the clinic. Table 1 provides a summary of the sex and diagnosis groups of the subjects. The median age (± interquartile range) at diagnosis was 58 (±18) years (range 17–93 years). The visual field testing strategies that were used are presented in Table 2. The median number of field tests performed per patient was six (IQR ±8; range 1–32). Of the total 2,604 field tests performed, 1,931 (74.2%) were found to be reliable and 725 (28%) tests were unreliable based on analysis of a single parameter, ie, fixation losses alone, false-negatives alone, or false-positives alone. The most common reason for unreliability was fixation losses (60%), followed by false-negative responses (34%), and false-positive responses (6%). Table 3 provides the criteria used by clinicians to diagnose glaucoma. Ninety-four subjects were not included in this subanalysis – 57 subjects were diagnosed elsewhere, 21 subjects were diagnosed before Humphrey visual fields were in use in the clinic, and 16 had ocular hypertension or were glaucoma suspects. Optic disc cupping with raised intraocular pressure was used more than any other criteria to diagnose glaucoma. This was statistically significant ($P<0.005$). The median time between diagnosis of glaucoma and the first visual field test was 5.6 weeks. Eighty patients were excluded in the assessments of the baseline and evidence of progression because they had only performed one field test. The number of subjects reaching baseline was 141 (53.4%). The number of subjects showing evidence of visual field progression was 24 (9%). Treatment changes were based on a number of factors as presented in Table 4. In 90% of subjects, the decision to change treatment was based on inadequate intraocular pressure control alone. This was statistically significant ($P<0.005$).

### Table 1 Sex and diagnosis distributions of patients reviewed

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Male</th>
<th>Female</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>POAG</td>
<td>94</td>
<td>113</td>
<td>207 (60)</td>
</tr>
<tr>
<td>CACG</td>
<td>18</td>
<td>40</td>
<td>58 (17)</td>
</tr>
<tr>
<td>NTG</td>
<td>7</td>
<td>10</td>
<td>17 (5)</td>
</tr>
<tr>
<td>OHT</td>
<td>4</td>
<td>6</td>
<td>10 (3)</td>
</tr>
<tr>
<td>Glaucoma suspect</td>
<td>0</td>
<td>6</td>
<td>6 (1.7)</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>26</td>
<td>45 (13)</td>
</tr>
<tr>
<td>NVG</td>
<td>1</td>
<td>0</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Total</td>
<td>143</td>
<td>201</td>
<td>344 (100)</td>
</tr>
</tbody>
</table>

**Abbreviations:** CACG, chronic angle closure glaucoma; POAG, primary open angle glaucoma; NTG, normal tension glaucoma; NVG, neovascular glaucoma; OHT, ocular hypertension.

### Table 2 Visual field testing strategy used

<table>
<thead>
<tr>
<th>Testing strategy</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SITA-fast 24-2</td>
<td>2,581 (99.1)</td>
</tr>
<tr>
<td>SITA-fast 10-2</td>
<td>4 (0.2)</td>
</tr>
<tr>
<td>Fastpac</td>
<td>16 (0.6)</td>
</tr>
<tr>
<td>Full threshold</td>
<td>3 (0.1)</td>
</tr>
<tr>
<td>Total</td>
<td>2,604 (100)</td>
</tr>
</tbody>
</table>

---

Lenake et al

Clinical Ophthalmology 2014;8
Table 3 Criteria used by clinicians to diagnose glaucoma

<table>
<thead>
<tr>
<th>Criteria</th>
<th>POAG</th>
<th>CACG</th>
<th>NTG</th>
<th>Secondary glaucoma</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disc only</td>
<td>9</td>
<td>1</td>
<td>11</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>Disc + IOP</td>
<td>125</td>
<td>36</td>
<td>2</td>
<td>27</td>
<td>190</td>
</tr>
<tr>
<td>Disc + IOP + HVF loss</td>
<td>21</td>
<td>6</td>
<td>0</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Disc + HVF loss</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>IOP + HVF loss</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>IOP only</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>156</td>
<td>43</td>
<td>15</td>
<td>36</td>
<td>250</td>
</tr>
</tbody>
</table>

**Abbreviations:** CACG, chronic angle closure glaucoma; HVF, Humphrey visual field; IOP, intraocular pressure; NTG, normal tension glaucoma; POAG, primary open angle glaucoma.

**Discussion**

This is the first clinic-based study describing the contribution of Humphrey visual field testing to the management of glaucoma in Africa.

Our results may be summarized as follows: 1) the majority of visual fields performed in this patient population were reliable; 2) most patients with glaucoma are diagnosed without the use of visual field tests; 3) only half the patients reach a baseline; and 4) there was evidence of visual field progression in a minority of patients and this contributed to changes in management in only a small number of patients.

Various population-based surveys assessing the prevalence of glaucoma in Africa included automated perimetry as part of the assessment. However, only two of these used the Humphrey Field Analyzer. In all these studies, the majority of subjects were diagnosed based on advanced structural changes with unproven field loss.

We found that the SITA-fast testing strategy was the most commonly used testing strategy in our clinic. It has been reported to have excellent sensitivity and specificity for glaucomatous visual field loss and is much faster than the full threshold testing strategy. However, it has also been reported to have variable repeatability. For this reason, some authors do not recommend the use of SITA-fast for glaucoma follow-up, while others suggest that it can be used, provided that all subsequent fields are performed using the same strategy to allow for comparison.

Current literature suggests that no consensus exists regarding the reliability criteria that should be used for the SITA testing strategy. The manufacturer recommends the following criteria for reliability when using the SITA testing strategy: less than 20% fixation losses and less than 15% false-positive errors. There is no limit displayed on the machine for false-negative errors with SITA testing, but the machine prints these errors out as a percentage. Bengtsson published a report on the reliability of SITA-standard testing, stating that the reliability of a visual field can be predicted by the amount of field loss alone and that reliability indices contributed very little in this regard. A study by Budenz et al comparing full threshold testing to SITA used the reliability criteria similar to those recommended by the manufacturer (<33% fixation losses, false-negative errors, and false-positive errors) and found that glaucomatous defects are measured shallower using the SITA algorithms but are approximately the same size and severity compared with full threshold measurements. We used the original guidelines recommended by the manufacturer: less than 20% fixation losses, less than 33% false-negative errors, and less than 33% false-negative responses.

Although the majority of Humphrey visual field tests performed were reliable, they assisted in the diagnosis of glaucoma in only 34 (10%) subjects in this study group. Furthermore, the first visual field was performed after the diagnosis of glaucoma had already been made in over half of the subjects in this study. There was no difficulty in making the diagnosis of glaucoma in the majority of subjects as it was clinically evident in 190 (55%) subjects—the intraocular pressure was high and disc changes in keeping with glaucoma were present.

In our study, fixation loss errors were the most common cause of unreliability. A similar finding was reported in
earlier studies. Katz and Sommer\textsuperscript{15} initially reported unreli-
bility rates of 45% in glaucomatous subjects and 30% in
normal controls. Most test results were unreliable because
they failed to meet the criterion for fixation losses. Katz
et al\textsuperscript{19} found that 19% of normal subjects, 28% of those with
ocular hypertension, and 37% of patients with glaucoma
were unreliable on initial automated testing. Fixation losses
were the prime reason for almost all the repeatedly unreliable
tests. An analysis of reliability indices of an urban glaucoma
population by Birt et al\textsuperscript{20} showed 59.9% overall reliability.
The most common cause of unreliability was fixation loss
(39%), followed by false-negative errors (9%), and false-
positive errors (5%).

Several landmark glaucoma trials have discussed the
importance of having baseline fields to be able to compare
future fields for progression.\textsuperscript{5,6,21,22} In our study, baseline was
reached in half the subjects and visual field progression was
evident in only 10% of subjects who had performed two or
more visual field tests. The lack of usefulness of visual field
testing was further demonstrated by the fact that visual field
progression contributed to changes in management in only
15 (4.4%) subjects.

There were no reports found in the literature of similar
studies performed in eye clinics elsewhere in the world.

The main limitation of this study is its retrospective
nature. Retrospective case record reviews are restricted to
the information available in the records. Furthermore, a num-
ber of subjects were excluded from the subgroup analyses
for various reasons; however, we believe that the numbers
remained large enough to provide reliable statistical analysis.
Some may also argue that this was a biased sample as most
glaucoma is managed in non-subspecialty clinics – patients
referred to the subspecialty clinic already have the disease
and are often those who have complex management issues.
This patient population is most likely skewed to the severe
end of the spectrum and probably represents the “worst
of the worst” patients in our clinic, but all these patients,
including those with advanced disease, presented initially
to ophthalmologists working in general clinics and not to
glaucoma specialists.

\section*{Conclusion}

In our glaucoma clinic, Humphrey visual field testing makes
little contribution to the management of the majority of glau-
coma cases seen. Although our clinic is better equipped than
many other clinics on the continent, a significant proportion
of our patients still present with advanced disease, which is
easily diagnosed without the use of visual fields. Progression
of fields seldom contributes to monitoring, and intraocular
pressure is mainly used to monitor the adequacy of treatment.
Ocular hypertensives, glaucoma suspects, and those with
early glaucoma are also seen in our clinic and they continue
to benefit from visual field testing. We do not know if the
findings from this study necessarily represent the status quo
of visual field testing in other African centers, but population-
based surveys have also shown that the majority of glaucoma
cases in Africa present with advanced structural disease,
which can be diagnosed without a visual field. Further
research should be carried out to determine the usefulness of
visual field testing in other centers in Africa – this will assist
in planning for future blindness prevention programs.

\section*{Acknowledgments}

The authors would like to thank the division of Ophthalmol-
ogy at Groote Schuur Hospital (Cape Town, South Africa)
for permitting the study to take place. It was presented at
Ophthalmic Society of South Africa (OSSA) annual meeting
in Cape Town in March 2013.

\section*{Disclosure}

The authors report no conflicts of interest in this work.

\section*{References}

1. Resnikoff S, Pascolini D, Etya’ale D, et al. Global data on visual impair-
Global Initiative for the elimination of avoidable blindness. Geneva,
sion Treatment Study: a randomized trial determines that topical ocular
hypotensive medication delays or prevents the onset of primary open-
4. Musch DC, Lichter PR, Guire KE, Standardi CL. The Collaborative Initial
5. Leske MC, Heijl A, Hyman L, Bengtsson B. Early Manifest Glau-
coma Trial: design and baseline data. Ophthalmology. 1999;106(11):
2144–2153.
6. Comparison of glaucomatous progression between untreated patients
with normal-tension glaucoma and patients with therapeutically reduced
intraocular pressures. Collaborative Normal-Tension Glaucoma Study
7. Advanced Glaucoma Intervention Study. 2. Visual field test scoring
prevalence of primary angle closure glaucoma and open angle glaucoma
in Manure, Western Cape, South Africa. Arch Ophthalmol. 1993;111(9):
1263–1269.
9. Buhrmann RR, Quigley HA, Barron Y, West SK, Oliva MS, Mmbaga BB. Prevalence of glaucoma in a rural East African popula-
10. Rotchford AP, Johnson GJ. Glaucoma in Zulus, a population-based
cross-sectional survey in a rural district in South Africa. Arch Oph-
Visual field testing in African glaucoma