

## **THE REAL OPHTHALMOLOGIC EMERGENCY: ORBITAL COMPARTMENT SYNDROME AND ITS MANAGEMENT**

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A 45-year-old man exposed to blunt orbital trauma presented to the emergency department with complaints of pain and loss of vision in the left eye. He declared that one hour prior, his left eye was exposed to an impact by a blunt glass bottle. Initial visual acuity was light perception in the left eye. Proptosis, severe periorbital edema and ecchymosis were noted. There was a skin laceration on the left lower eyelid. Extraocular muscle movements eye were limited. In the biomicroscopic examination, there was subconjunctival hemorrhage and chemosis. The pupil was fixed at 3 mm and there was no pupil light reflex. The optic nerve and retina were normal. Orbital decompression was performed in the emergency department via lateral canthotomy and inferior cantholysis. Upon assessment by orbital CT, fracture of the medial and inferior orbital wall, hyperdense retrobulbar haemorrhage that displaced the optic nerve superiorly was detected. The patient's visual acuity improved to 0,05 next day. Conjunctival hemorrhage and chemosis started to recover. Pupil diameter and light reflex returned to normal. Temporal section of optic disc was pale. A visual acuity was 0,8 after one week. Ocular movements were normal to all direction and periorbital edema and proptosis completely healed. OCS is essentially a clinical diagnosis. Evidence of increased orbital pressure include "tense lids" and "a tight orbit". Correct management depends on a speedy and accurate diagnosis. Emergent surgical intervention should not be delayed by imaging and other diagnostic testing or invitation of the ophthalmologist.