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18th Asia Pacific
OPHTHALMOLOGISTS ANNUAL MEETING
July 29-30, 2019 | Melbourne, Australia

A case of isolated sixth nerve palsy

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Case Report: A 38 years old female came with complaints of headache for the past two years over the frontal area aggravated on working and relieved by medication patient also had history of guidiness and has history of PG usage. Patient was having history OG surgery done for poliomyelitis in her childhood. Patient is not a known case of HTN, DM and TB. On examination her anterior segment was normal with visual acuity of 6/9 with PG in both eyes. Color vision and confrontation was normal in both eyes. On examining extra ocular movements abduction of left eye was not possible by the patient. Right eye the extra ocular movements were full all the other cranial nerves were intact and patient had no diplopia, fundus examination was also normal. Patient was diagnosed to have isolated sixth nerve palsy left eye.

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