NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Acute Angle-Closure Management and Peripheral Iridotomy in adults

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

GGH Guidelines for the management of acute angle-closure in adults

Check for sulfa allergy
Acetazolamide 500 mg IV stat and T Diamox 250mg PO QID
G Timolol 0.5% and G Apraclonidine (Iopidine) 1%† stat and then BD (unless contra-indicated)
G Pilocarpine 2% stat then QID to both eyes (a*void intensive Pilocarpine regimen)*
G Maxidex stat and QID
Analgesics and anti-emetics as necessary
Patient to lie supine

Stage 2
Recheck IOP after one hour
If IOP not ≤ 40 mm Hg give iv Mannitol 20% at a dose of 1g/kg body weight to be administered over 45 minutes via infusion pump (caution in cardiac and renal patients)‡
50% Glycerol 1g/kg bodyweight in a 50:50 mixture of lemon juice (caution in diabetics) may be given as an alternative. Avoid glycerol if nausea or vomiting present.
Patient lies supine for a further one hour

Stage 3
Recheck IOP after one hour
If IOP not ≤ 40mm Hg
If mannitol already used in stage 3 discuss with senior colleague

If not already used in stage 3, commence Mannitol 20% at a dose of 1 g/kg body weight intravenously over 45 minutes via infusion pump (caution in cardiac and renal patients)‡
Stage 4
Recheck IOP after one hour
If IOP not reduced discuss with senior colleague
Options include anterior chamber paracentesis, laser iridoplasty/iridotomy
If IOP still not controlled contact glaucoma team

Laser iridotomy
Is the definitive treatment for acute angle-closure
Always discuss with senior colleague prior to laser treatment.
Do not attempt laser if significant inflammation or corneal oedema present or if IOP is too high.
Remember to repeat gonioscopy as initial lowering of IOP in itself is not indicative of success unless it can be demonstrated that the angle has been opened

Footnotes
†Brimonidine may be used as an alternative if Iopidine 1% unavailable
‡Mannitol 10% may be used at the same dose per kg if 20% unavailable

Provided by Dr A Rotchford (1/9/2017) reviewed (08/09/2020) reviewed (27/10/2022) reviewed (07/01/2026)