

Acute Angle-Closure Glaucoma: An Eye Emergency at Any Age

EMERGENCY WARNING

Painful red eye with blurred or smeared vision, colored halos, headache, nausea, or vomiting? Seek emergency eye care now—regardless of age or birth history. Go immediately to an eye emergency service or emergency department. Do not drive yourself.

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Do not wait for a routine appointment, a complete set of symptoms, or an online answer. Sudden severe eye pain or a sudden change in vision also requires emergency assessment now, even if the eye is not obviously red. If you are very unwell or cannot get to emergency care safely, call your local emergency number. These symptoms can have several causes, but acute angle closure is one time-sensitive possibility. This guide is education—not a diagnosis or a home-treatment plan. [1] [2] [3]

Key Takeaways

- Acute angle closure can sharply raise pressure inside the eye and cause irreversible vision loss. Do not assume that there is a safe period to wait.
- Pain, redness, blurred vision, colored halos, headache, nausea, and vomiting can occur together. You do not need every symptom to have an emergency.
- Primary angle-closure disease is more common with advancing age, but younger adults and children can have angle closure. “Too young for glaucoma” is not a safe reason to dismiss concerning symptoms.
- Premature birth and especially a history of retinopathy of prematurity (ROP) are important to disclose. They are clues to possible abnormal eye anatomy—not a diagnosis and not prerequisites for angle closure.
- A small 1991 series of late-onset ROP-associated angle-closure glaucoma reported a mean age of 32, range 12–45, in 10 patients. It did not establish that all 10 had acute attacks and does not define a usual age.
- Treatment must match the mechanism. The right treatment for pupillary block may not be right for every ROP-associated or medication-induced case.

These points are explained and sourced below. The emergency instruction comes first because reading the full evidence review should never delay care. [4] [5]

1. Recognize the warning pattern—and act

A person may describe the problem as a painful or bloodshot eye, pressure in or around the eye, smeared vision, or rainbow-colored rings around lights. Others emphasize a severe headache, nausea, or vomiting and may not immediately connect those symptoms to the eye. A rapidly developing combination of eye pain and altered vision is particularly concerning. [1] [2] [4]

What you might notice	Why it matters	What not to conclude
Red or bloodshot eye with pain	Acute angle closure is one possible cause; infection or inflammation can also be urgent.	Not every red eye is glaucoma, and redness alone cannot establish the diagnosis.
Blurred, foggy, or smeared vision	High pressure may cause corneal swelling, affecting vision.	Do not assume a sudden change is just a dirty contact lens or a needed glasses update.
Colored or rainbow halos around lights	Halos can accompany corneal swelling during an attack.	Halos are not specific to glaucoma, but halos with pain or vision loss need urgent attention.
Eye or brow pain, headache, or a sensation of pressure	Pain may be felt around the eye rather than described as eye pain.	Feeling pressure does not measure intraocular pressure; the eye must be examined.
Nausea or vomiting with eye symptoms	The eye problem can produce prominent symptoms elsewhere in the body.	Do not assume a stomach illness or migraine explains a painful red eye with changed vision.

The table is a recognition aid, not a home diagnostic test. A clinician must assess vision, the eye, pressure, and drainage anatomy. Emergency eye conditions overlap; finding a different cause does not mean seeking urgent care was unnecessary. [4] [6]

Do not drive yourself, wait overnight to see what happens, or delay while trying someone else’s drops or old prescriptions. Bring your medicines and eye-history information if readily available, but do not postpone departure to find records. If you have already been assessed and your pain or vision worsens—or the problem remains unexplained—seek urgent reassessment. [1] [7]

2. What closes, and why pressure can rise so quickly

The eye continuously makes a clear fluid called aqueous humor. This is different from tears on the outside of the eye. It normally flows through the front of the eye and drains through tissue near the junction of the iris—the colored part—and the cornea—the clear front window. That junction is called the drainage angle. [3]

If the iris obstructs access to the drainage pathway, fluid can accumulate and pressure inside the eye can rise. In an acute attack, the rise can be rapid and marked. The pressure is called intraocular pressure, or IOP. A blood-pressure reading does not measure it, and touching or pressing the eye is not a safe substitute for an eye examination. [4] [8]

One common mechanism is pupillary block: fluid has difficulty moving through the pupil, the pressure difference bows the iris forward, and the peripheral iris blocks the angle. But an angle can also close because structures behind the iris push it forward, because scarring pulls tissues across the drainage area, or because several mechanisms coexist. This distinction matters greatly in eyes affected by ROP, prior surgery, inflammation, or medication reactions. [4] [9] [10]

Acute angle closure versus established glaucoma

People commonly use “acute angle-closure glaucoma” or AACG for the emergency. Current ophthalmic terminology also uses acute angle-closure crisis for an occluded angle with symptomatic high pressure. Strictly, glaucoma means characteristic optic-nerve damage; an acute attack can be detected before that damage is established. [4]

That terminology is a reason to treat promptly—not a reason to wait for damage before taking symptoms seriously. The immediate goal is to stop a dangerous pressure event and protect vision. [4]

3. Why delay can cause permanent and severe vision loss

The optic nerve carries visual information from the eye to the brain. Damage from glaucoma is irreversible with current treatment. Severe pressure elevation can also affect other eye structures. An acute attack is therefore an emergency even if the person still has useful vision when symptoms begin. [2] [8]

Clinical emergency guidance warns that irreversible loss can occur within hours. This is not a countdown or a guaranteed safe window. The pressure, duration, underlying mechanism, circulation, existing damage, and treatment response vary. Do not use a statement such as “within 24 hours” to justify waiting until tomorrow. [8]

Some early blur may improve when pressure falls and the cornea clears. That does not mean all lost vision will return: temporary optical blur and permanent nerve damage can coexist. Nor does feeling better by itself prove that the drainage problem is resolved. Examination and follow-up are needed to determine what happened and what risk remains. [4] [2]

4. Glaucoma is not exclusively a condition of older people

The familiar picture of glaucoma is a slowly progressing disease in an older adult, often without early symptoms. That picture is incomplete. In the United States, open-angle glaucoma is the most common form; that familiar diagnosis should not obscure an acute angle-closure emergency. Open-angle glaucoma, primary angle-closure disease, an acute angle-closure attack, and secondary glaucoma are not interchangeable diagnoses. [2] [4]

Older age is a recognized risk factor for primary angle-closure disease. Other associated factors include family history, certain ancestry groups, farsightedness, and a crowded front portion of the eye. But these are risk patterns, not a checklist that safely excludes someone who does not fit them. [4]

In younger people, clinicians need to consider developmental or structural differences, plateau iris, inflammation, lens-related problems, previous eye procedures, medications, and ROP-associated changes. A younger-patient series found several distinct causes rather than one uniform disease. “You are too young” should not substitute for examining a painful eye with changed vision. [11]

Similarly, nearsightedness does not guarantee an open drainage angle. ROP-associated eyes can be highly myopic yet have a small or crowded anterior segment. An individual eye’s anatomy matters more than the stereotype that angle closure occurs only in farsighted older adults. [10] [12]

5. Premature birth and ROP: why childhood history still matters

Retinopathy of prematurity (ROP) is a disorder of retinal blood-vessel development in premature infants. It is not simply another name for premature birth: some people born prematurely never had ROP, and ROP varies greatly in severity and treatment. Older records may use the term retrolental fibroplasia. [13] [14]

The retina is at the back of the eye, while the drainage angle is at the front. Nevertheless, altered growth, scarring, tissue traction, and changes associated with severe disease or its treatment can affect the eye’s overall structure. Small corneas, thicker lenses, shallow anterior chambers, or forward displacement of the lens–iris diaphragm can contribute to angle crowding in some ROP-associated eyes. [11] [10] [15]

A 2020 report described a combination of microcornea (a small cornea), pachyphakia (a thick lens), and angle closure in selected patients with treated ROP. The authors could not determine whether prematurity, ROP itself, retinal ablation, or their combination explained the pattern. It would therefore be misleading to say that a particular childhood treatment caused every later attack—or that appropriate ROP treatment should have been avoided. [10]

A separate adult study measured eye anatomy in people born at different gestational ages. Treated ROP was associated with a shallower anterior chamber and thicker lens, but this was an anatomy study, not a study measuring acute-attack incidence. It supports biological plausibility, not a precise personal risk or predicted age. [15]

ROP-associated glaucoma can also involve abnormal new blood vessels and other secondary mechanisms, particularly in advanced disease. A recent review emphasizes that these problems can present late and require long-term attention. Adult late angle closure should not be equated with every form of glaucoma seen in an infant with severe ROP. [16]

Tell the emergency team: “I was born prematurely and had ROP,” if that is known. Mention childhood laser, cryotherapy, retinal surgery, lens surgery, and any previous narrow-angle diagnosis. If your birth or eye history is uncertain, say so; do not delay care to verify it. [11] [10]

6. Age evidence in ROP-associated angle closure

Angle closure can occur in younger adults, but the age evidence requires qualification. Michael and colleagues reported in 1991 on 10 eyes of 10 patients with late-onset angle-closure glaucoma associated with ROP, mean age 32 years, range 12–45. [5]

The reported age is a mean, not a median or a population “usual age,” and it comes from a small selected clinical series. The abstract describes eight nonneovascular and two neovascular eyes; it does not establish that every patient had the same mechanism or an identical acute attack. [5]

Report	Who was studied	Reported age	What the result does not establish
Michael and colleagues, 1991	10 patients / 10 eyes with late-onset ROP-associated angle-closure glaucoma.	Mean 32; range 12–45 years.	A usual age for all AACG, an age cutoff, or a population risk curve. Original abstract verified. [5]

Chang, Liebmann, and Ritch, 2002	Seven patients with ROP within a 67-patient series of angle closure diagnosed at age 40 or younger; five ROP patients presented with acute closure.	ROP subgroup: mean 24.3; range 3–37 years at diagnosis.	The onset pattern of all adults born prematurely. The ROP subgroup differs from the whole young-patient cohort. [11]
Baciu and colleagues, 2012	12 previously treated ROP patients evaluated for narrow angles or acute angle-closure glaucoma; total eyes not reported.	Average 18.7; range 8–30 years.	A rate of acute attacks among all ROP survivors; this is a meeting abstract and combines narrow angles with acute disease. [17]
Chang and colleagues, 2020	11 treated-ROP patients / 19 eyes in a small tertiary-center retrospective series with angle closure.	Mean 11.9; range 4.2–25.6 years at presentation.	A typical adult-onset age; not every eye was reported as having an acute symptomatic attack. [10]

Do not combine these age ranges into a supposedly definitive “AACG age range.” These studies differ in referral patterns, childhood treatment era, mechanisms, inclusion criteria, and whether they count narrow angles, acute attacks, or established glaucoma. A separate 2025 clinical case discussion described a 22-year-old with prior ROP, headache, vomiting, and very high eye pressure—an illustration that young adults can be affected, not an estimate of frequency. [12]

Practical summary: Angle closure can occur in younger people, including some with a history of prematurity and ROP. One small ROP-associated series reported a mean age of 32 and a range of 12–45, but age does not rule this emergency in or out. [5] [4]

7. Why the diagnosis can be missed

The most prominent complaint may be headache, nausea, or vomiting rather than “my eye pressure is high.” Redness may be mistaken for a surface-eye problem, and the person may never have been told that childhood ROP could remain relevant in adult care. A young age or atypical anatomy can also make a simple stereotype misleading. [7] [12] [11]

A published BMJ report documents three examples of delayed or mistaken recognition, including cases labeled conjunctivitis and resulting permanent visual harm. Those patients were older adults. The report shows that mistakes can happen and matter; it does not measure how frequently AACG is missed or prove that young ROP patients are commonly misdiagnosed. [7]

Likewise, a study of delayed presentation cannot automatically be described as a study of clinician misdiagnosis. People may delay seeking help, encounter referral delays, or have the condition initially overlooked. A 2024 Moorfields study examined long-term outcomes after acute primary angle closure; its population should not be relabeled as young adults with ROP. [18]

The practical lesson is not to diagnose yourself or assume that every headache is glaucoma. It is to clearly report the combination: “My eye hurts, my vision has changed, and I am seeing halos / feeling nauseated.” If you have a history of prematurity or ROP, add that. State that you need urgent eye assessment, including pressure measurement; do not let this conversation delay emergency care. [1] [4]

8. Not every painful red eye is angle closure

Corneal infection, inflammation inside the eye, scleritis, injury, and other conditions can also threaten vision. Contact-lens wear, discharge, light sensitivity, trauma, and recent surgery help clinicians work through the possibilities, but none provides a reliable home rule-out for serious disease. [6]

Conjunctivitis can cause a red eye, and migraine can cause headache and visual symptoms. Nevertheless, a new painful red eye with reduced vision should not simply be assumed to be either. The purpose of emergency assessment is to establish the cause and begin the right treatment—not to confirm one favored diagnosis. [6] [7]

Other urgent visual problems may be relatively painless. Retinal complications are separately important in people with an ROP history. Retinal detachment can be painless: new flashes, a sudden increase in floaters, or a curtain/shadow over vision requires eye-doctor or emergency-room assessment right away. Do not wait for pain or redness. [14] [19]

9. What an urgent eye assessment may include

The clinician will ask about the onset, affected eye or eyes, vision change, headache or vomiting, previous episodes, prior eye disease or surgery, family history, and recent medicines. Birth history and old ROP treatment are useful when known. [4] [10]

Assessment	What it helps determine
Visual acuity and pupil examination	How vision is affected and whether there are important neurologic or ocular signs.
Slit-lamp examination	Corneal swelling, anterior-chamber depth, inflammation, and other front-of-eye findings.
Tonometry	The actual intraocular pressure; a symptom or blood-pressure reading cannot substitute.
Gonioscopy	Whether the drainage angle is open, narrow, or closed, and whether adhesions or another mechanism are present.
Examination of both eyes	Risk or disease in the fellow eye, even if symptoms are currently one-sided.
Ultrasound biomicroscopy or anterior-segment imaging when appropriate	Additional anatomical detail, especially in unusual or secondary mechanisms.
Optic-nerve assessment, OCT, and visual-field testing when feasible	Existing damage and a baseline for follow-up; these do not justify delaying acute pressure treatment.

Some tests are performed after the immediate crisis is controlled or when the cornea is clear enough. Current AAO guidance places gonioscopy at the center of angle assessment; imaging is complementary rather than a universal replacement. [4]

10. Emergency treatment: lower pressure, then address the cause

Treatment is clinician-directed. Depending on the circumstances, the team may use pressure-lowering eye drops, systemic medicines, treatment for inflammation and symptoms, and an appropriate laser or surgical procedure. Drug choices, doses, and sequences depend on eye anatomy, medical conditions, allergies, and the suspected mechanism and should not be attempted without the treating team. [4] [8]

For a pupillary-block mechanism, a laser peripheral iridotomy creates an opening in the iris so fluid can bypass the block. The fellow eye may also need preventive treatment when it has susceptible anatomy. That decision must be made from the examination—not assumed for every kind of secondary angle closure. [4]

Lens extraction may be appropriate in some patients because removing a crowded lens can deepen the front of the eye. The EAGLE randomized trial supports lens-based treatment in a defined group of adults with primary angle closure or primary angle-closure glaucoma. Participants were at least 50 years old; the findings do not establish one preferred emergency operation for a 33-year-old with ROP or for every acute attack. [20]

In ROP-associated disease, persistent crowding, lens changes, scarring, or multiple mechanisms can make management more complicated. A 2024 case report describes lens extraction after recurrent or progressive closure despite earlier laser procedures. It illustrates an individualized option, not a universal protocol or proof that all patients should have clear-lens surgery. [21] [10]

11. Medicines can sometimes trigger angle closure—but mechanisms differ

Some medicines can dilate the pupil and precipitate closure in an anatomically susceptible eye. Other drug reactions push the lens–iris diaphragm forward through swelling or fluid changes, including in eyes not previously known to have narrow angles. Bring a complete list of prescriptions, over-the-counter cold/allergy products, supplements, and recent eye drops. Do not assume that every medicine in a broad drug class is dangerous for every person with glaucoma. [9]

Topiramate, used for conditions including epilepsy and migraine prevention, has a specific warning for acute myopia and secondary angle-closure glaucoma. Symptoms may involve both eyes and include sudden reduced vision or eye pain. A medication-related cause does not make the situation less urgent. [22] [9]

Seek emergency eye care now and tell the team you take topiramate; do not wait for a routine prescriber appointment. Obtain urgent clinician-directed advice about further doses and withdrawal. The prescribing information calls for stopping topiramate as rapidly as the treating physician judges appropriate; withdrawal ordinarily occurs gradually to reduce seizure risk, but medically necessary rapid withdrawal requires appropriate monitoring. The emergency team and prescriber should coordinate this urgently, with seizure precautions. Do not improvise an unsupervised taper or abrupt stop. [22]

Mechanism matters here: an iridotomy does not correct every drug-related pushing mechanism, and medicines such as pilocarpine are not appropriate for every type of angle closure. This is another reason not to borrow eye drops or follow an internet drug protocol. [9]

12. After the attack: pressure relief is not the end of care

Follow-up should clarify the cause, whether the angle remains open, whether pressure is controlled, whether permanent damage occurred, and whether further treatment is needed. A person may still need glaucoma medicines, additional procedures, visual-field monitoring, or rehabilitation despite improvement in pain. The fellow eye also needs an appropriate plan. [4] [2]

If you had treated ROP, plan for lifelong ophthalmic follow-up: the 2025 RANZCO guideline explicitly recommends lifelong annual review for this group. That recommendation should not be expanded into a universal lifelong schedule for every person born prematurely. The broader ROP literature describes retinal, lens, refractive, and glaucoma-related problems extending beyond childhood. The visit interval should reflect your current findings; an annual schedule is not a substitute for the closer follow-up needed after an acute event. [23] [16] [14]

If you were born prematurely but do not know whether you had ROP, discuss that history during non-emergency eye care and ask whether old records would help. Prematurity alone does not establish that you have narrow angles or need preventive laser treatment. Conversely, no recorded ROP history does not make acute symptoms safe to ignore. [13] [4]

13. Questions to take to the eye-care team

During an emergency, the priority is treatment; these questions should not delay it. After stabilization, they can help clarify the plan. [4]

- Was this acute angle closure, another form of glaucoma, or a different eye emergency?
- What was the pressure in each eye, and what evidence is there of temporary corneal blur versus permanent damage?
- Is the mechanism pupillary block, lens-related crowding, plateau iris, ROP-related scarring, medication-related swelling, or a combination?
- Do my prematurity, ROP, or past eye procedures change the diagnosis or treatment?
- Is the other eye at risk, and does it need treatment or closer monitoring?
- What did laser or surgery correct, and what risk remains?
- Which medicines should I use now, and who will coordinate any necessary changes with my other prescribers?
- What symptoms require immediate return, where should I go, and when is my next follow-up?
- Do I need ongoing retinal care as well as glaucoma care?

Frequently Asked Questions

Is a red or bloodshot eye always acute angle-closure glaucoma?

No. Redness has many possible causes. But redness with pain, sudden blurred vision, halos, headache, nausea, or vomiting requires prompt emergency assessment. You do not need to identify the diagnosis before seeking help. [1] [6]

Can I have it at 33—or younger?

Yes, acute angle closure can occur in younger people, including ROP-associated cases, but no typical age of 33 is established. The reported mean of 32 and range of 12–45 came from a small mixed late-onset glaucoma series, not an acute-attack age distribution. Other selected reports include younger patients. None of those ranges is a safe rule-out boundary. [5] [11] [10]

Does being born prematurely mean I will develop angle closure?

No. Prematurity and ROP are not interchangeable, and the available evidence does not predict an attack for every premature-born person. Documented ROP, treatment history, and actual eye anatomy are relevant to assessment, but symptoms still require urgent care whether or not that history is present. [13] [15]

Can it affect both eyes?

The fellow eye may have susceptible anatomy even when one eye is symptomatic. Some secondary drug-related mechanisms can affect both eyes. One-sided versus two-sided symptoms do not establish the cause by themselves. [4] [9]

If the pain eases, can I wait?

If these symptoms are happening now, seek emergency eye care immediately. If they have stopped, do not wait for a routine appointment: obtain urgent same-day eye-care advice and assessment, because intermittent angle closure can recur and symptom relief does not prove that the angle or pressure is safe. [3] [21]

Will treatment restore all lost vision?

Not necessarily. Some blur may improve as the acute problem is controlled, but established glaucoma damage is irreversible. Early assessment and treatment aim to prevent additional loss; they cannot guarantee full visual recovery. [2] [4]

Evidence and limitations

This guide uses government and professional patient guidance, the AAO 2025 Primary Angle-Closure Disease Preferred Practice Pattern summary posted February 2026, primary clinical reports, observational studies, regulatory labeling, and an appropriately scoped treatment trial. Older ROP reports are identified by publication date because they remain directly relevant to the age question, not because their treatment approaches should automatically govern current care. [4] [5]

The ROP age evidence is mostly small, clinically selected case series; one source is a meeting abstract. Available population evidence does not establish age 33 as typical, a universal ROP-associated onset range, or a reliable percentage of cases missed specifically because patients are young. Case reports demonstrate possibilities, not frequencies. Original abstracts are identified where full articles were unavailable. Treatment decisions require an ophthalmologist's examination. [5] [17] [10] [7]

If the symptoms described at the start are happening now, stop reading and seek emergency eye care.

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