With sluggish constriction to light, the near reaction is tested. If there is a brisk response to near stimuli, then the pupilloconstrictors are intact and the spectre of a third nerve palsy is removed. The differential diagnosis of light-near dissociation is then entertained (see list below). Alternatively, if the near reaction is also sluggish, then there is clear dysfunction of the pupilloconstrictors. A common innocent cause is Adie’s tonic pupil which can be confirmed by pilocarpine 1/8%. If the response to dilute pilocarpine is negative, the intraocular pressure can be measured with Schiotz tonometry to exclude narrow angle glaucoma. Finally, in the setting of a normal or near normal IOP, pilocarpine 1% can be used to distinguish third nerve palsy from iris dysfunction or pharmacologic blockade. If both pupils respond briskly to light, then dilatation lag (or cocaine 4% drops) can be used to distinguish Horner’s syndrome from physiologic anisocoria. Further, anisocoria in Horner’s syndrome will be greater in a lighted room versus a darkened room. Advanced pharmacologic techniques have been excluded from the flow chart as "front line" decisions usually do not rely on highly specific diagnostic categorization. The only "extra" tool that is recommended is pilocarpine ophthalmic solution 1%, which is routinely used as an anti-glaucoma medication, and is available in all hospital formularies.

Differential Diagnosis of Light-Near Dissociation:
Blind Eye
Argyll Robertson
Type I Diabetes
Aberrant Regeneration of the Third Nerve

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