Raynaud's phenomena and subclavian steal syndrome: Differential diagnosis for retinal artery occlusion

Dear Sir,

We read with interest the article titled, "Cilioretinal artery occlusion following intranasal cocaine insufflation" by Kannan *et al*.[1] We appreciate the authors' research work. We would like to highlight few points regarding Raynaud's phenomena which are a differential diagnosis for vaso-occlusive disorder. Raynaud's phenomena[2] are characterized by exaggerated vasoconstrictive color changes (pallor and cyanosis) in the fingers, usually due to exposure to cold. Primary Raynaud's phenomena (PRP) are not associated with underlying systemic disease. Secondary Raynaud's is associated with systemic lupus erythematosus, scleroderma, and peripheral vascular disease.[2] Stress is a risk factor for Raynaud's phenomena.[3] PRP may be a manifestation of diffuse vasospastic disorder affecting cerebral, coronary, mesenteric vessels. PRP patients have higher incidence of chest pain, migraine, and stroke. Evidence suggest that abnormalities in smooth muscle and endothelium of blood vessels, central sympathetic control of vascular tone, and circulating mediators may all be involved in its pathogenesis. Calcium channel blockers, topical nitroglycerine (fingers), and sildenafil may play a part in management of Raynaud's phenomena.[3] Ophthalmic artery vasospasm due to subclavian steal syndrome may clinically present as incomplete central retinal artery and short posterior ciliary artery occlusion.[4]

To conclude, Raynaud's phenomena and subclavian steal syndrome should be considered in differential diagnosis of ocular arterial occlusion disease.

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Conflicts of interest

There are no conflicts of interest.

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