



City Research Online

City St George's, University of London

Citation: Monter, V. M., Crabb, D. P. & Artes, P. H. (2017). Reclaiming the Periphery: Automated Kinetic Perimetry for Measuring Peripheral Visual Fields in Patients With Glaucoma. *Investigative Ophthalmology & Visual Science*, 58(2), pp. 868-875. doi: 10.1167/iovs.16-19868

This is the published version of the paper.

This version of the publication may differ from the final published version. To cite this item please consult the publisher's version.

Permanent repository link: <https://city-ref-test.eprints-hosting.org/id/eprint/19703/>

Link to published version: <https://doi.org/10.1167/iovs.16-19868>

Copyright and Reuse: Copyright and Moral Rights remain with the author(s) and/or copyright holders. Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge, unless otherwise indicated, provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way. For full details of reuse please refer to [City Research Online policy](#).

Reclaiming the Periphery: Automated Kinetic Perimetry for Measuring Peripheral Visual Fields in Patients With Glaucoma

Vera M. Mönter,^{1,2} David P. Crabb,¹ and Paul H. Artes²

¹Division of Optometry and Visual Science, School of Health Sciences, City, University of London, London, United Kingdom

²Eye and Vision Research Group, Institute of Health and Community, Plymouth University, Plymouth, United Kingdom

Correspondence: Paul H. Artes, FF19 Peninsula Allied Health Centre, Derriford Road, Plymouth, PL6 8BH, United Kingdom; paul.artes@plymouth.ac.uk.

Submitted: May 9, 2016

Accepted: January 4, 2017

Citation: Mönter VM, Crabb DP, Artes PH. Reclaiming the periphery: automated kinetic perimetry for measuring peripheral visual fields in patients with glaucoma. *Invest Ophthalmol Vis Sci*. 2017;58:868–875. DOI: 10.1167/iovs.16-19868

PURPOSE. Peripheral vision is important for mobility, balance, and guidance of attention, but standard perimetry examines only <20% of the entire visual field. We report on the relation between central and peripheral visual field damage, and on retest variability, with a simple approach for automated kinetic perimetry (AKP) of the peripheral field.

METHODS. Thirty patients with glaucoma (median age 68, range 59–83 years; median Mean Deviation −8.0, range −16.3–0.1 dB) performed AKP and static automated perimetry (SAP) (German Adaptive Threshold Estimation strategy, 24-2 test). Automated kinetic perimetry consisted of a fully automated measurement of a single isopter (III.1.e). Central and peripheral visual fields were measured twice on the same day.

RESULTS. Peripheral and central visual fields were only moderately related (Spearman's ρ , 0.51). Approximately 90% of test-retest differences in mean isopter radius were $< \pm 4$ deg. Relative to the range of measurements in this sample, the retest variability of AKP was similar to that of SAP.

CONCLUSIONS. Patients with similar central visual field loss can have strikingly different peripheral visual fields, and therefore measuring the peripheral visual field may add clinically valuable information.

Keywords: glaucoma, visual field, peripheral vision, automated kinetic perimetry

Since the advent of computerized visual field testing in the 1970s, almost all innovations in perimetry have focused either on improving the sensitivity to early visual field damage in glaucoma,^{1–6} or on increasing either efficiency^{7–9} or speed¹⁰ of the tests. This drive toward high diagnostic performance has led to a situation where almost all visual field tests performed in glaucoma patients are confined to the central 25–30 degrees of the visual field, an area that constitutes less than 20% of the entire field of vision.

Peripheral vision contributes to postural stability^{11–14} and the guidance of attention,¹⁵ and it is important for estimating motion from optical flow.^{16–18} In people with normal vision, eliminating clues from the peripheral visual field decreases postural stability,¹¹ and patients with glaucoma rely more heavily on vestibular and proprioceptive cues to maintain balance than do healthy controls.^{12–14} Thus, the central visual field alone does not provide a complete picture of the patients' real-world field of vision, and examinations of the peripheral visual field may help us to more fully understand the impact of the disease on individuals.

The peripheral visual field may also add information relevant to clinical decision making, for example, for diagnosis,^{19–21} disease phenotyping, and monitoring progression. For example, peripheral visual field damage has been demonstrated in 15% of glaucoma patients with normal central visual fields.²² At the other end of the spectrum, in patients with advanced damage in whom much of the central visual field may be damaged beyond the useful dynamic range of static perimetry,²³

tracking peripheral vision may be useful to demonstrate stability or to uncover further deterioration.^{24–27}

A key reason for why peripheral visual fields are not measured more often is the lack of fast and efficient automated tests. Static programs that include the periphery are available on the Humphrey Field Analyzer (HFA), Carl Zeiss Meditec, Jena, Germany) and the Octopus instruments (Haag-Streit, Köniz, Switzerland).^{28–32} However, threshold examinations, for example with the 60-4 test of the HFA,^{33,34} usually take more than 10 minutes, in part because they still rely on the classic full-threshold procedures³⁵ rather than the more efficient techniques for threshold estimation and stimulus pacing introduced by the Swedish interactive thresholding algorithms.⁷ Likewise, the suprathreshold tests of these instruments have scarcely changed since the 1980s. Last, statistical tools for interpretation of peripheral perimetry (such as total- and pattern-deviation probability maps) have not been made available commercially.

Manual kinetic Goldmann perimetry,³⁶ as introduced in 1945, is probably still the most extensively used technique for measuring peripheral visual fields. In the hands of a highly trained examiner, it is a very flexible technique, but it is difficult to standardize, difficult to quantify, and difficult to compare between different examiners. Progressively fewer centers possess the resources to perform this technique, and manufacture of the original Goldmann instrument (Haag-Streit, Köniz, Switzerland) has recently been discontinued. Semi-automated kinetic perimetry (available on the Octopus 900 perimeter, the



TABLE 1. Descriptive Statistics of the Patients' Age, Visual Acuity, and Contrast Sensitivity in the Study Eye

	Mean (SD)	Median (IQR)	Range
Age (y)	69 (6)	68 (67, 73)	59, 83
VA (logMAR)	+0.10 (+0.19)	+0.07 (0.00, +0.14)	−0.20, +0.30
CS (log)	1.60 (0.30)	1.65 (1.35, 1.95)	0.60, 2.05

VA, visual acuity; CS, contrast sensitivity.

official successor of the Goldmann instrument) retains much of the flexibility of the manual technique but permits more precise control of stimulus motion. But, since it still requires an interactive examination conducted by an expert examiner with substantial training and experience, the technique is not widely used outside specialist centers.

A key problem in automating kinetic perimetry is that single responses, close to threshold, are highly variable and error-prone. This has previously been pointed out by Lynn et al.³⁷ who referred to “spurious spikes” in the isopters with an early attempt to automate the technique. In manual Goldmann perimetry, the examiner will seek to confirm responses that are not in keeping with expected values and will disregard implausibly early or late responses. A different solution will need to be established for fully automated kinetic perimetry (AKP).

In this paper, we demonstrate the large dissociation between central and peripheral visual fields in a group of patients with moderately advanced glaucoma. We report on a simple approach of repeated kinetic presentations to estimate isopter positions without interactive input from the examiner. We show that the precision of this technique is comparable to that of static perimetry of the central field and suggest further avenues for more efficient perimetry of the peripheral visual field.

METHODS

Participants

Thirty patients with open-angle glaucoma were recruited from participants of previous studies at City University, London.^{38–40} Patients had been recruited from the glaucoma clinics at Moorfields Eye Hospital, and inclusion criteria were a visual acuity of at least +0.30 logMAR (6/12), ametropia within ± 5.00 diopter (D) equivalent sphere and ± 2.50 D cylinder, and no concomitant ocular or systemic disease. Table 1 provides descriptive statistics on the patients' age, visual acuity and contrast sensitivity. All patients were experienced in static perimetry, but none had previously performed kinetic perimetry. The study adhered to the Declaration of Helsinki; the protocol was approved by the School of Health Sciences Research Ethics Committee at City, University of London, and all patients provided written informed consent.

Examinations

Of each participant, one study eye was randomly selected and two static examinations were performed of the central visual field, along with two kinetic tests of the peripheral visual field. All tests were carried out during a single session that lasted approximately 2.5 hours including breaks. Visual acuity (Early Treatment Diabetic Retinopathy Study chart, distance 4 m) and contrast sensitivity (Pelli-Robson chart, at 1 m) were measured at the outset of the session.

Visual Field Tests. All visual field tests were performed on a projection perimeter (Octopus 900 with EyeSuite software version 3.0.1; Haag-Streit), with a hemispherical bowl (radius,

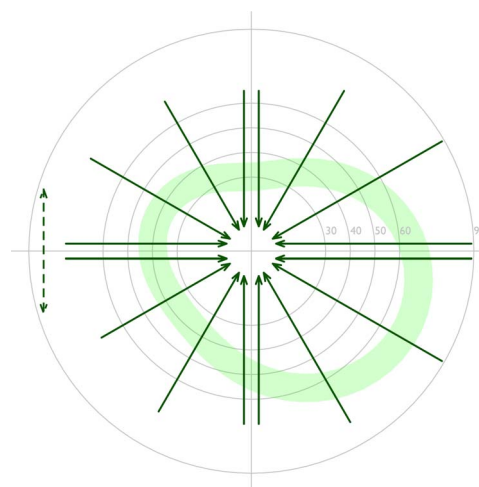


FIGURE 1. Kinetic automated perimetry: Goldmann IIIe stimuli were moved along 16 meridians (green arrows) at a speed of 5 deg/s. Three stimuli were shown on each meridian. Starting points of the arrows represent the start location of the stimuli. If not detected, they moved to within 3 degrees of the fixation point. The dashed arrow represents the location of the six false-positive catch trials. The lightly shaded region indicates the normative response range according to Vonthein et al.⁴²

300 mm) and a background luminance of 10 cd/m². Stimuli were circular luminance increments (Goldmann size III, subtending 0.43 degrees). For kinetic perimetry, the nominal maximum stimulus luminance corresponded to that of the Goldmann perimeter (318 cd/m² [1000 apostilb (asb)]); for static perimetry it was 1273 cd/m² (4000 asb). Full-aperture (38-mm diameter) trial lenses were used to correct refractive errors for static perimetry of the central field. To avoid lens rim artefacts, kinetic perimetry of the peripheral visual field was performed without refractive correction.

Kinetic Perimetry of the Peripheral Visual Field.

Kinetic perimetry was performed with Goldmann III.1.e stimuli at a speed of 5 deg/s. According to Goldmann nomenclature, these stimuli are circular spots subtending a visual angle of 0.43 degrees with a luminance of 10 cd/m² (i.e., a 1.5 log unit attenuation of the 318 cd/m² maximum-intensity stimulus of Goldmann perimetry. In terms of contrast, this luminance increment corresponds to a 25-dB stimulus with the HFA [nominal $\Delta L_{\max} = 3183 \text{ cd/m}^2 = 10,000 \text{ asb}$] and to a 21 dB stimulus with the static programs of the Octopus 900 [$\Delta L_{\max} = 1273 \text{ cd/m}^2 = 4000 \text{ asb}$]).

Kinetic stimuli started well outside the normal range of visibility⁴¹ and moved at a speed of 5 deg/s from the periphery toward the center. The entire visual field was sampled along 16 meridians (Fig. 1). Three repetitions were performed for each vector, and the final isopter was defined by the median (middle) of the three responses. Stimuli were presented in random order. The mean radius of the isopter (MIR) was used as a global summary measure, and the reproducibility of an individual patient's answers was summarized as the median absolute deviation (MAD) of individual responses from the final isopter.

Unlike in manual kinetic Goldmann perimetry where perimetrists add additional stimuli to define the shape of isopters in areas of visual field damage, estimates that fell within the central 10 degrees of fixation were treated as missing data and would appear as a gap in the isopter (see patient *u* for example).

False-positive catch trials ($n = 6$) were stimuli presented in the far nasal periphery where they were invisible while the sound associated with the movement of the perimeter's

TABLE 2. Summary Statistics of the Central and Peripheral Visual Field Tests

	Mean (SD)	Median (IQR)	Range
Central visual field (GATE)			
Mean deviation (dB)	−8.4 (4.4)	−8.1 (−11.9, −5.1)	−16.3, +0.1
False-negative response error rate	0.09 (0.12)	0.08 (0, 0.19)	0, 0.63
False-positive response error rate	0.06 (0.11)	0 (0, 0.12)	0, 0.54
Test duration (min:s)	6:13 (0:58)	6:03 (5:30, 6:45)	4:44, 9:30
Peripheral visual field (AKP)			
Mean isopter radius (deg)	33.2 (7.9)	31.7 (29.8, 38.1)	11.5, 48.1
Isopter confidence band (deg)	2.7 (1.4)	2.2 (1.6, 3.3)	1.1, 7.4
False-positive response error rate	0.08 (0.13)	0 (0, 0.16)	0, 0.5
Test duration (min:s)	11:30 (1:45)	11:30 (10:15, 12:30)	8:00, 16:30

IQR indicates interquartile range.

projection system was audible. To acquaint patients with the procedure, three training stimuli were presented at the outset of the tests. The entire examination was programmed as a custom test in the XML language of the EyeSuite software. Altogether, each test consisted of a total of ~60 presentations (3 training stimuli, 48 kinetic stimuli, and 6 false-positive catch trials) and took approximately 11 minutes.

Static Automated Perimetry of the Central Visual Field. Static perimetry of the central visual field was performed with the German Adaptive Threshold Estimation (GATE) strategy with a 24-2 test pattern and a stimulus duration of 200 ms. The GATE strategy has been described previously.^{42,43} At the outset of the first test, thresholds are determined at four seed locations, and initial intensities at other locations are then adjusted accordingly. In subsequent tests the GATE strategy starts with stimuli slightly brighter than the thresholds estimated during the previous test and varies stimulus intensities according to a 4-2 dB staircase that normally terminates after two response reversals. In contrast to the classic full-threshold strategy,³⁵ a maximum-intensity stimulus (0 dB) is shown if the initial stimulus has not been seen. If this stimulus is not seen, then the procedure terminates; otherwise, a stimulus 4 dB brighter than the initial intensity is presented next. Finally, the threshold is estimated as the intensity midway between the brightest stimulus not seen and the dimmest stimulus seen.

As a summary measure we used the mean deviation (MD), the average difference of all 54 threshold estimates from their age-corrected expected values. During the test ~10 false-positive and ~10 false-negative catch trials were presented to estimate the observer's reliability. GATE tests involved ~200 stimulus presentations and took ~6 minutes.

Analyses

The relation between central and peripheral visual field damage was examined via Spearman rank order correlation between MD (central field) and MIR (peripheral field).

Retest variability was estimated with a modified version of Bland-Altman analysis,⁴⁴ which relates the differences between repeated tests to the best available estimate of the underlying "true" value (the mean of the repeated tests). The median of the retest differences indicates systematic changes between the first and second test that can arise from learning effects, and the retest variability is estimated from the dispersion of the differences. Because the standard deviation of the differences is highly affected by outliers, we used the MAD of the retest differences to estimate the limits of agreement. We defined these as the median difference $\pm 2.2 \times \text{MAD}$, which estimates the range in which 9 out of 10 observations would be expected to fall if the data were normally distributed.

Graphical representations of the visual fields and statistical analyses were performed in R statistical software (version 2.15.1; <https://cran.r-project.org/bin/windows/base/old/2.15.1/>, provided in the public domain by the R Development Core Team).

RESULTS

Most patients in this sample had moderate to moderately advanced damage in the central visual field, and only one patient had an MD better than −3.0 dB (Table 2).

Relationship Between Peripheral and Central Visual Fields

Our results demonstrated the large dispersion between peripheral and central visual fields (Fig. 2). For example, some patients with deep central losses showed a nearly normal peripheral isopter (see patient *e* in case examples, Fig. 6),

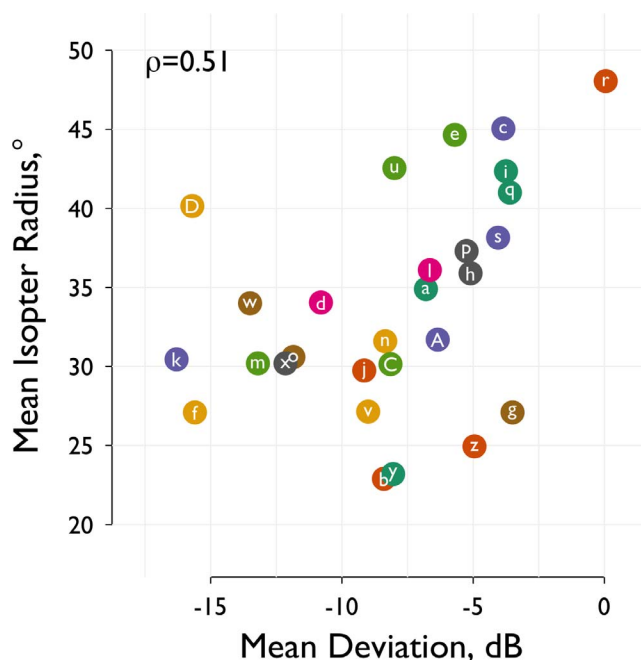


FIGURE 2. Relationship between global summary measures of peripheral visual field (MIR) and central visual field damage (MD). Each data point shows the mean of the two repeated tests. The Spearman rank order correlation coefficient was 0.51 (95% CI: 0.18, 0.74).



FIGURE 3. Relationship between test-retest differences in MIR and the range of peripheral visual field damage (mean of MIRs of two repeated tests). The height and width of the gray rectangle indicate the 90% retest interval of the MIR (± 4 degrees, height of the rectangle) and the range of estimates in this sample (12–48 degrees, width of rectangle). The red line indicates the median of the test-retest differences.

while others with similar or less-marked central damage showed a much more constricted peripheral isopter (see patient *z*; Fig. 7). In particular, in patients with severe central damage, the position of the peripheral isopters varied substantially (see patients *B* and *f* in the Supplementary Material).

The Spearman rank order correlation coefficient of MIR and MD was $\rho = 0.51$ (95% confidence interval [CI]: 0.18, 0.74; Fig. 2). This correlation is considerably lower than the correlations between the test and retest values of MD ($\rho = 0.89$, 95% CI: 0.78, 0.95) and MIR ($\rho = 0.92$, 95% CI: 0.84, 0.96). This means that the lack of a close relationship between central and peripheral visual field estimates in our data is a true finding and not caused by poor precision of individual examinations.

Test-Retest Variability of Static and Kinetic Perimetry

There were no meaningful systematic differences between the results of the two tests, in either the central or the peripheral

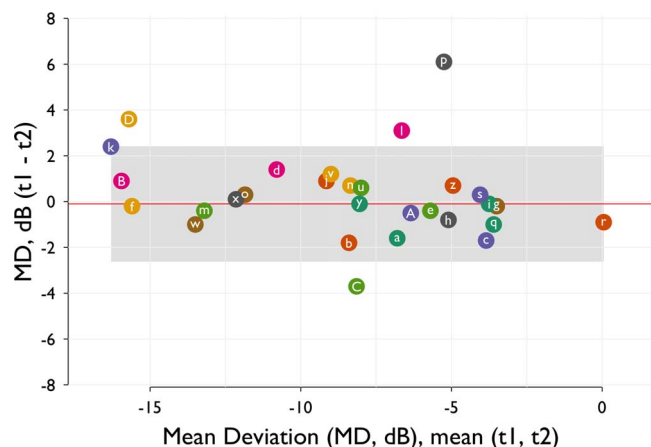


FIGURE 4. Relationship between test-retest differences in MD and the range of central visual field damage (mean of MDs of two repeated tests). The gray rectangle indicates the 90% retest interval (± 2.5 dB, height of the rectangle) and the range of mean MDs in this sample (-16.1 to $+0.1$ dB, width of rectangle).

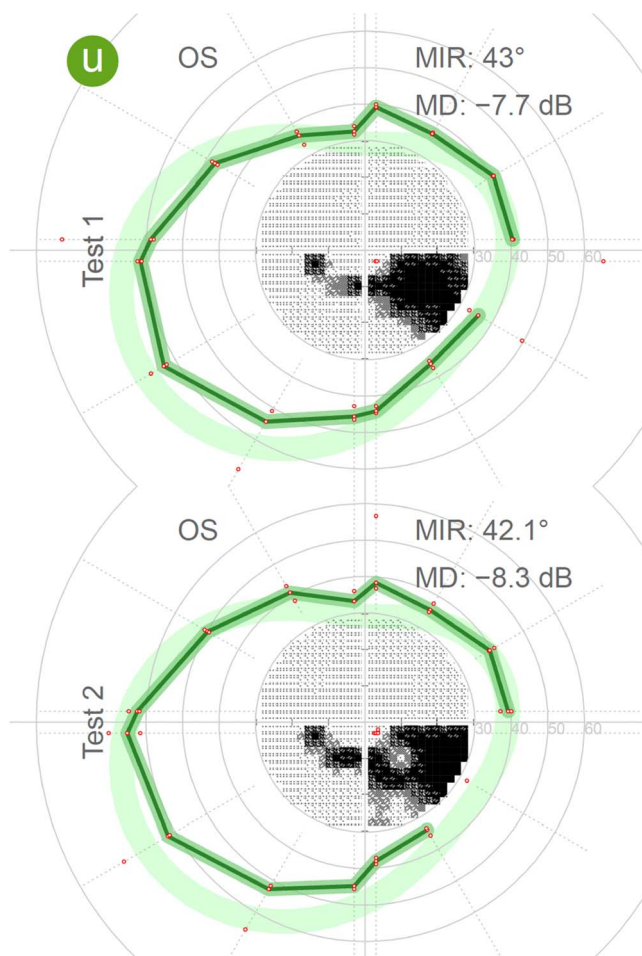


FIGURE 5. Patient *u*'s central field showed a dense inferior arcuate scotoma with a nasal step. The III.1.e isopter (dark green) showed that the nasal step extended far into the periphery. Elsewhere, the isopter was close to the expected values of Vonthein⁴¹ (light green band). Most responses (red dots) were tightly clustered, and the confidence interval around the isopter was narrow (MAD test 1: 1.3 degrees; test 2: 1.2 degrees; medium dark-green band). Both peripheral and central visual field test results appeared rather similar in the first and second examinations.

visual field (median test-retest difference, 0.25 degrees and -0.1 dB, $p = 0.28$ and 0.78 , respectively). The median absolute differences between test and retest were 1.3 degrees with MIR and 0.9 dB with MD, and approximately 90% of test-retest differences were within ± 4 degrees (MIR) with kinetic perimetry and within ± 2.5 dB (MD) with static perimetry.

A formal comparison of retest variability between static automated perimetry (SAP) and AKP is problematic—after all, different regions of the visual field are measured with different estimation techniques and with different units of measurement. We therefore related the spread of the retest differences to the range of measures obtained in this sample (Fig. 2 for peripheral kinetic visual field tests, Fig. 3 for central static visual field tests). The ratio between the ranges of the data (width of the gray rectangle) to the spread of test-retest differences (height of the rectangle) was similar for central and peripheral examinations. Thus, the precision of AKP of the peripheral field is similar compared to that of SAP of the central visual field.

Most patients completed the session without any problems, but in two patients the initial kinetic tests had to be interrupted to instruct the patients to avoid false-positive

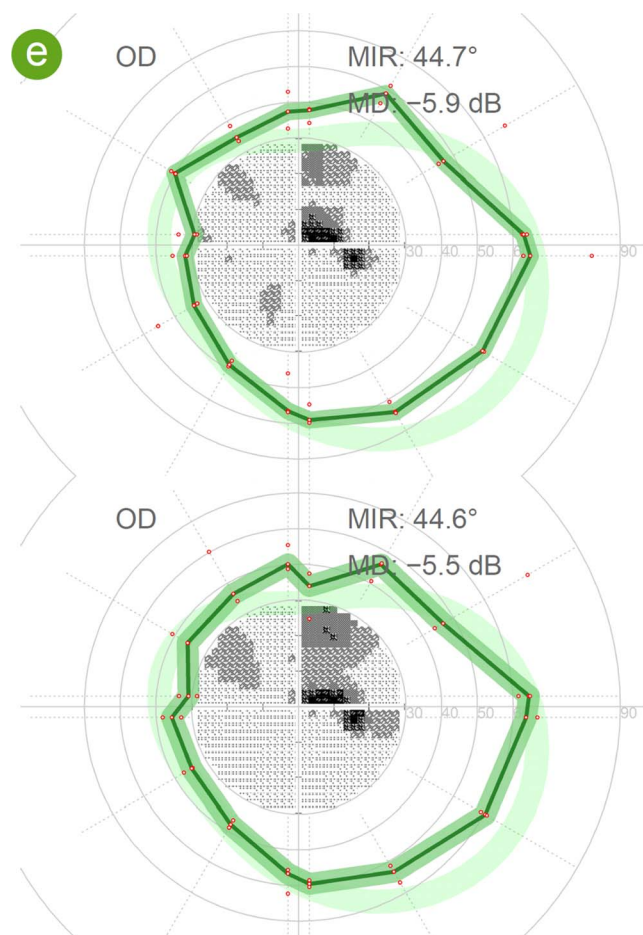


FIGURE 6. Patient *e* had deep focal damage in the central superior visual field but a substantially preserved peripheral III.1.e isopter. Retest variability was low with both central static and peripheral kinetic techniques.

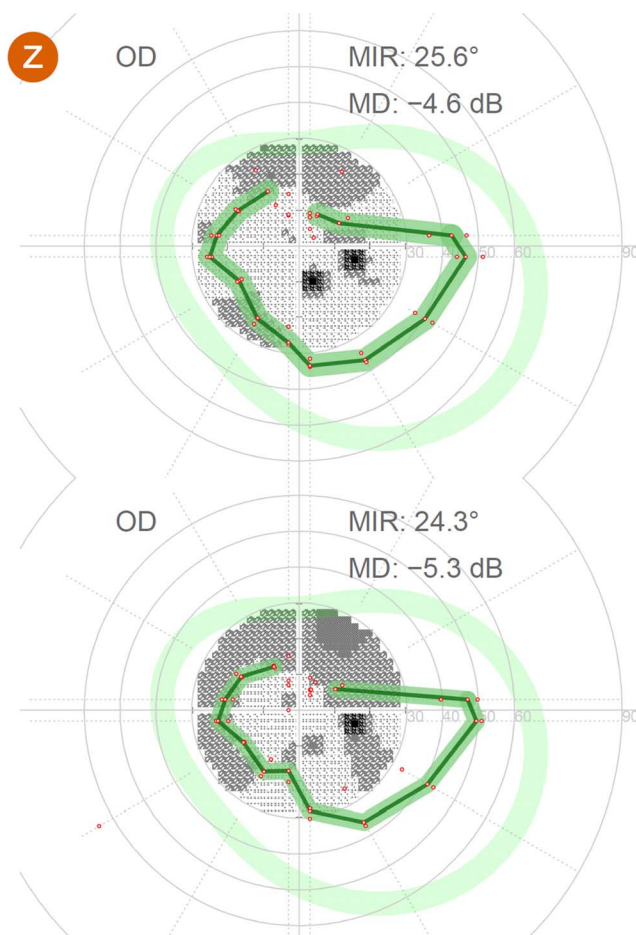


FIGURE 7. Patient *z* had moderate diffuse central visual field damage with static perimetry and a substantially constricted III.1.e isopter (mean MIR 25 degrees. In comparison, an MIR ~47 degrees would be expected in a healthy person of the same age).

responses. Obviously erratic “outlier” responses occurred in about two thirds of tests (see single responses in case examples, Figs. 5–7, and Supplementary Material). This confirmed the need to obtain several responses to achieve a precise estimate of isopter position. The width of the confidence interval around the isopters, derived from the MAD of repeated responses, varied between patients by a factor of >5 (Table 2).

In 19 patients (65%) our technique resulted in gaps in the isopter (see patients *u* and *z* in Figs. 5, 7), because some stimuli could not be detected until they were close to fixation. In one patient with deep and widespread visual field damage, no useful isopter could be estimated with the III.1.e stimulus because more than 75% of responses were located within the central 10 degrees (patient *B* in Supplementary Material).

Case Examples

Examples of three individual patients illustrate the relationship between peripheral and central visual fields and the repeatability of the tests (Figs. 5–7). Both central and peripheral visual field examinations are shown by overlaying the grayscale representation of the central visual field with a plot of the kinetic isopter. Single kinetic responses are shown as red dots, and the final isopter is plotted in dark green. Median responses <10 degrees were treated as “missing data” and appear as gaps in the isopter. The MAD measuring the scatter

of single responses is shown as a green band surrounding the isopter, and normative values⁴¹ are represented as the light green band.

DISCUSSION

The objective of this study was to explore differences between central and peripheral visual field damage in glaucoma and to investigate the precision of isopters that are estimated from repeated kinetic stimulus presentations. Our results show that patients with similar central visual field loss may have strikingly different peripheral visual fields, and this suggests that peripheral perimetry may provide an important component of a more complete assessment of patients’ visual field–related functional impairment. Furthermore, our results demonstrate that kinetic perimetry of a single isopter can provide a global estimate of peripheral visual field with precision similar to that of the MD of static perimetry in the central visual field. In contrast to other approaches to automate kinetic perimetry,⁴⁵ the simple approach reported here does not aim to reproduce the often complex isopter shapes of manual Goldmann perimetry in damaged visual fields. Rather, it aims to provide a clinically useful summary measure of peripheral visual field extent that can be used to complement information available from static perimetry of the central visual field.

Lynn et al.³⁷ have previously described “spurious spikes” in isopters from automated kinetic perimetry. As in Lynn’s data, our results revealed obvious “outlier” responses in most of the automated kinetic exams. One approach to reducing the impact of such outliers is to increase the number of obtained responses. Nowomiejska et al.,⁴⁶ for example, measured along 24 instead of the traditionally recommended 12 meridians. In contrast, we increased the sampling by *repeating* presentations at the same meridians. By pooling this information on the reproducibility of responses at each position of the visual field, this approach allowed us to estimate a confidence interval for the isopter for each individual patient. The ± 4 -degree retest interval of the III.1.e isopter compares favorably to data reported previously.^{24,46–55}

With manual Goldmann perimetry, the peripheral borders of the visual field are traditionally determined with the I.4.e stimulus in healthy visual fields or with the III.4.e or V.4.e stimuli when visual fields have already sustained some damage. In this study, we used the III.1.e stimulus (approximately equivalent to the I.3.e isopter, which is the largest Goldmann isopter not constrained by facial features, in healthy eyes), to keep stimulus size similar to that most often used in static perimetry (0.43 degrees). Given that our technique will almost always be applied to patients with moderate and advanced visual field damage, more intense (larger and/or brighter) stimuli must be considered for future work. However, this does not change our principal conclusion that, with a fully automated kinetic technique, isopters are best derived from repeated rather than single stimulus presentations.

The kinetic approach used in this study was designed for currently available commercial equipment (Octopus 900, with tests fully prespecified in an EyeSuite XML file). The long test times (~11 minutes, on average) would make its clinical application challenging. With the Open Perimetry Interface (OPI),⁵⁶ it will now be possible to reduce test time through more efficient sampling strategies. For example, stimulus presentations should start closer to the expected isopter locations, and when two closely spaced responses have already been obtained on a particular vector, a third presentation may not be needed. It may also be useful to confine kinetic perimetry to those parts of the peripheral visual field that are likely of greatest importance to real-world performance (e.g., inferior and temporal visual field) rather than over the entire 360-degree circumference of the visual field. Finally, application of the OPI will make it possible to adapt stimulus speed more interactively to the response latencies of the patient and to the location of the stimulus (faster in the periphery and slower in the center of the visual field).

Our study demonstrated that precise estimates of peripheral isopters can be obtained from a fully automated kinetic approach when repeated presentations are offered. Further work is now being performed in our laboratory and others to improve the efficiency of this approach, to investigate how it can best be used to complement information obtained with static perimetry, and to answer the question of how perimetry of the entire visual field can help to improve clinical decision making in patients with glaucoma.^{29,57–60}

Acknowledgments

The inspiration for this work was a keynote lecture by Lars Frisén (Göteborg, Sweden) at the Imaging and Perimetry Society meeting at Portland, Oregon 2006.

Supported by an unrestricted project grant from the Merck Investigator Studies Programme (DPC, VMM), by research support

from Haag-Streit International (Köniz, Switzerland; loan of the Octopus perimeter), and by a grant from Fight for Sight UK (PHA).

Disclosure: **V.M. Mönster**, None; **D.P. Crabb**, None; **P.H. Artes**, Haag-Streit (R)

References

1. Baez KA, McNaught AI, Dowler JG, Poinoosawmy D, Fitzke FW, Hitchings RA. Motion detection threshold and field progression in normal tension glaucoma. *Br J Ophthalmol*. 1995;79:125–128.
2. Sample PA, Bosworth CE, Blumenthal EZ, Girkin C, Weinreb RN. Visual function-specific perimetry for indirect comparison of different ganglion cell populations in glaucoma. *Invest Ophthalmol Vis Sci*. 2000;41:1783–1790.
3. Medeiros FA, Sample PA, Weinreb RN. Frequency doubling technology perimetry abnormalities as predictors of glaucomatous visual field loss. *Am J Ophthalmol*. 2004;137:863–871.
4. Artes PH, Hutchison DM, Nicolela MT, LeBlanc RP, Chauhan BC. Threshold and variability properties of matrix frequency-doubling technology and standard automated perimetry in glaucoma. *Invest Ophthalmol Vis Sci*. 2005;46:2451–2457.
5. Racette L, Medeiros FA, Zangwill LM, Ng D, Weinreb RN, Sample PA. Diagnostic accuracy of the Matrix 24-2 and original N-30 frequency-doubling technology tests compared with standard automated perimetry. *Invest Ophthalmol Vis Sci*. 2008;49:954–960.
6. Mulak M, Szumny D, Sieja-Bujewska A, Kubrak M, Heidelberg edge perimeter employment in glaucoma diagnosis—preliminary report. *Adv Clin Exp Med*. 2012;21:665–670.
7. Bengtsson B, Heijl A. SITA Fast, a new rapid perimetric threshold test. Description of methods and evaluation in patients with manifest and suspect glaucoma. *Acta Ophthalmol Scand*. 1998;76:431–437.
8. Bengtsson B, Heijl A. Inter-subject variability and normal limits of the SITA Standard, SITA Fast, and the Humphrey Full Threshold computerized perimetry strategies, SITA STATPAC. *Acta Ophthalmol Scand*. 1999;77:125–129.
9. Artes PH, Iwase A, Ohno Y, Kitazawa Y, Chauhan BC. Properties of perimetric threshold estimates from Full Threshold, SITA Standard, and SITA Fast strategies. *Invest Ophthalmol Vis Sci*. 2002;43:2654–2659.
10. Morales J, Weitzman ML, Gonzalez de la Rosa M. Comparison between tendency-oriented perimetry (TOP) and octopus threshold perimetry. *Ophthalmology*. 2000;107:134–142.
11. Berencsi A, Ishihara M, Imanaka K. The functional role of central and peripheral vision in the control of posture. *Hum Mov Sci*. 2005;24:689–709.
12. Elliott DB, Patla AE, Flanagan JG, et al. The Waterloo Vision and Mobility Study: postural control strategies in subjects with ARM. *Ophthalmic Physiol Opt*. 1995;15:553–559.
13. Kotecha A, Richardson G, Chopra R, Fahy RT, Garway-Heath DE, Rubin GS. Balance control in glaucoma. *Invest Ophthalmol Vis Sci*. 2012;53:7795–7801.
14. Kotecha A, Chopra R, Fahy RT, Rubin GS. Dual tasking and balance in those with central and peripheral vision losses. *Invest Ophthalmol Vis Sci*. 2013;54:5408–5415.
15. Muller HJ, Rabbitt PM. Reflexive and voluntary orienting of visual attention: time course of activation and resistance to interruption. *J Exp Psychol Hum Percept Perform*. 1989;15:315–330.
16. Stoffregen TA. Flow structure versus retinal location in the optical control of stance. *J Exp Psychol Hum Percept Perform*. 1985;11:554–565.

17. Stoffregen TA, Schmuckler MA, Gibson EJ. Use of central and peripheral optical flow in stance and locomotion in young walkers. *Perception*. 1987;16:113-119.
18. Brandt T, Dichgans J, Koenig E. Differential effects of central versus peripheral vision on egocentric and exocentric motion perception. *Exp Brain Res*. 1973;16:476-491.
19. Stewart WC. Static versus kinetic testing in the nasal peripheral field in patients with glaucoma. *Acta Ophthalmol (Copenh)*. 1992;70:79-84.
20. Stewart WC, Shields MB. The peripheral visual field in glaucoma: reevaluation in the age of automated perimetry. *Surv Ophthalmol*. 1991;36:59-69.
21. Williams TD. Goldmann field testing in glaucoma. *Optom Vis Sci*. 1995;72:532-534.
22. LeBlanc EP, Becker B. Peripheral nasal field defects. *Am J Ophthalmol*. 1971;72:415-419.
23. Wall M, Woodward KR, Doyle CK, Zamba G. The effective dynamic ranges of standard automated perimetry sizes III and V and motion and matrix perimetry. *Arch Ophthalmol*. 2010;128:570-576.
24. Nevalainen J, Paetzold J, Krapp E, Vonthein R, Johnson CA, Schiefer U. The use of semi-automated kinetic perimetry (SKP) to monitor advanced glaucomatous visual field loss. *Graefes Arch Clin Exp Ophthalmol*. 2008;246:1331-1339.
25. Nowomiejska K, Wrobel-Dudzinska D, Ksiazek K, et al. Semi-automated kinetic perimetry provides additional information to static automated perimetry in the assessment of the remaining visual field in end-stage glaucoma. *Ophthalmic Physiol Opt*. 2015;35:147-154.
26. Scheuerle AF, Schiefer U, Rohrschneider K. Functional diagnostic options for advanced and end stage glaucoma [in German]. *Ophthalmologie*. 2012;109:337-344.
27. Tonagel F, Voykov B, Schiefer U. Conventional perimetry. Antiquated or indispensable for functional glaucoma diagnostics? [in German]. *Ophthalmologie*. 2012;109:325-336.
28. Brenton RS, Phelps CD. The normal visual field on the Humphrey field analyzer. *Ophthalmologica*. 1986;193:56-74.
29. Black AA, Wood JM, Lovie-Kitchin JE. Inferior field loss increases rate of falls in older adults with glaucoma. *Optom Vis Sci*. 2011;88:1275-1282.
30. Rowe FJ, Noonan C, Manuel M. Comparison of Octopus semi-automated kinetic perimetry and Humphrey peripheral static perimetry in neuro-ophthalmic cases. *ISRN Ophthalmol*. 2013;2013:753202.
31. Caprioli J, Spaeth GL. Static threshold examination of the peripheral nasal visual field in glaucoma. *Arch Ophthalmol*. 1985;103:1150-1154.
32. Young WO, Stewart WC, Hunt H, Crosswell H. Static threshold variability in the peripheral visual field in normal subjects. *Graefes Arch Clin Exp Ophthalmol*. 1990;228:454-457.
33. Berezina TL, Khouri AS, Kolomeyer AM, Clancy PS, Fechtner RD. Peripheral visual field thresholds using Humphrey Field Analyzer program 60-4 in normal eyes. *Eur J Ophthalmol*. 2011;21:415-421.
34. Berezina TL, Khouri AS, Winship MD, Fechtner RD. Visual field and ocular safety during short-term vigabatrin treatment in cocaine abusers. *Am J Ophthalmol*. 2012;154:326-332.e2.
35. Bebie H, Fankhauser F, Spahr J. Static perimetry: strategies. *Acta Ophthalmol (Copenh)*. 1976;54:325-338.
36. Goldmann H. Fundamentals of exact perimetry. 1945. *Optom Vis Sci*. 1999;76:599-604.
37. Lynn J, Swanson W, Fellman R. Evaluation of automated kinetic perimetry (AKP) with the Humphrey Field Analyzer. *Perimetry Update*. 1990;1991:433-452.
38. Smith ND, Glen FC, Monter VM, Crabb DP. Using eye tracking to assess reading performance in patients with glaucoma: a within-person study. *J Ophthalmol*. 2014;2014:120528.
39. Glen FC, Smith ND, Crabb DP. Saccadic eye movements and face recognition performance in patients with central glaucomatous visual field defects. *Vision Res*. 2013;82:42-51.
40. Smith ND, Glen FC, Crabb DP. Eye movements during visual search in patients with glaucoma. *BMC Ophthalmol*. 2012;12:45.
41. Vonthein R, Rauscher S, Paetzold J, et al. The normal age-corrected and reaction time-corrected isopter derived by semi-automated kinetic perimetry. *Ophthalmology*. 2007;114:1065-1072.
42. Schiefer U, Pascual JP, Edmunds B, et al. Comparison of the new perimetric GATE strategy with conventional full-threshold and SITA standard strategies. *Invest Ophthalmol Vis Sci*. 2009;50:488-494.
43. Luithardt AF, Meisner C, Monhart M, Krapp E, Mast A, Schiefer U. Validation of a new static perimetric thresholding strategy (GATE). *Br J Ophthalmol*. 2015;99:11-15.
44. Bland JM, Altman DG. Statistical methods for assessing agreement between two methods of clinical measurement. *Lancet*. 1986;1:307-310.
45. Hashimoto S, Matsumoto C, Okuyama S, Takada S, Arimura-Koike E, Shimomura Y. Development of a new fully automated kinetic algorithm (program K) for detection of glaucomatous visual field loss. *Invest Ophthalmol Vis Sci*. 2015;56:2092-2099.
46. Nowomiejska K, Vonthein R, Paetzold J, Zagorski Z, Kardon R, Schiefer U. Comparison between semiautomated kinetic perimetry and conventional Goldmann manual kinetic perimetry in advanced visual field loss. *Ophthalmology*. 2005;112:1343-1354.
47. Quinn GE, Fea AM, Minguini N. Visual fields in 4- to 10-year-old children using Goldmann and double-arc perimeters. *J Pediatr Ophthalmol Strabismus*. 1991;28:314-319.
48. Gramer E, Proll M, Krieglstein GK. Reproducibility of central visual field testing using kinetic or computerized static perimetry [in German; author's transl]. *Klin Monbl Augenheilkd*. 1980;176:374-384.
49. Bittner AK, Iftikhar MH, Dagnelie G. Test-retest, within-visit variability of Goldmann visual fields in retinitis pigmentosa. *Invest Ophthalmol Vis Sci*. 2011;52:8042-8046.
50. Ross DE, Fishman GA, Gilbert LD, Anderson RJ. Variability of visual field measurements in normal subjects and patients with retinitis pigmentosa. *Arch Ophthalmol*. 1984;102:1004-1010.
51. Pineles SL, Volpe NJ, Miller-Ellis E, et al. Automated combined kinetic and static perimetry: an alternative to standard perimetry in patients with neuro-ophthalmic disease and glaucoma. *Arch Ophthalmol*. 2006;124:363-369.
52. Ramirez AM, Chaya CJ, Gordon LK, Giacony JA. A comparison of semiautomated versus manual Goldmann kinetic perimetry in patients with visually significant glaucoma. *J Glaucoma*. 2008;17:111-117.
53. Rowe FJ, Rowlands A. Comparison of diagnostic accuracy between Octopus 900 and Goldmann kinetic visual fields. *Biomed Res Int*. 2014;2014:214829.
54. Hirasawa K, Shoji N. Learning effect and repeatability of automated kinetic perimetry in healthy participants. *Curr Eye Res*. 2014;39:928-937.
55. Bjerre A, Codina C, Griffiths H. Peripheral visual fields in children and young adults using semi-automated kinetic perimetry: feasibility of testing, normative data, and repeatability. *Neuroophthalmology*. 2014;38:189-198.
56. Turpin A, Artes PH, McKendrick AM. The Open Perimetry Interface: an enabling tool for clinical visual psychophysics. *J Vis*. 2012;12(11):22.

57. Haymes SA, Leblanc RP, Nicolela MT, Chiasson LA, Chauhan BC. Risk of falls and motor vehicle collisions in glaucoma. *Invest Ophthalmol Vis Sci.* 2007;48:1149-1155.
58. Glen FC, Smith ND, Crabb DP. Impact of superior and inferior visual field loss on hazard detection in a computer-based driving test. *Br J Ophthalmol.* 2015;99:613-617.
59. Glen FC, Crabb DP, Garway-Heath DE. The direction of research into visual disability and quality of life in glaucoma. *BMC Ophthalmol.* 2011;11:19.
60. Szlyk JP, Mahler CL, Seiple W, Edward DP, Wilensky JT. Driving performance of glaucoma patients correlates with peripheral visual field loss. *J Glaucoma.* 2005;14:145-150.