RESEARCH PAPER

Advances in Central Visual Field Testing: A Narrative Review of the 24-2C SITA Faster Strategy

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ABSTRACT

Background: Standard automated perimetry remains a cornerstone in the diagnosis and monitoring of glaucoma. The conventional 24-2 test grid has been widely adopted in clinical practice due to its balance between spatial coverage and test duration, but it provides limited sampling of the central visual field. As the need to examine changes in the central visual field increases, the 24-2C grid has been developed to bridge this gap by incorporating additional central test locations into the existing 24-2 framework. This modification aims to improve the detection of central defects without substantially increasing testing time.

Purpose: To synthesize current evidence on the clinical utility of the 24-2C SITA Faster strategy for central visual field (VF) assessment and to compare its performance with conventional 24-2 and 10-2 perimetric grids.

Methods: A narrative review of peer-reviewed studies was conducted using PubMed, Scopus, and Google Scholar up to 2025. Studies reporting outcomes on central defect detection, global indices, diagnostic accuracy, structure–function relationships, reliability, and test duration were included.

Results: The 24-2C grid improves detection of central defects compared to 24-2, identifying additional defective points and clusters within the central 10°. Differences in global indices (MD, PSD) are small and often not significant with SITA Faster. Compared with 10-2, 24-2C demonstrates lower sensitivity for fine paracentral defects but shows moderate-to-strong agreement in global indices. Diagnostic accuracy is improved with 24-2C central sampling, and test duration remains shorter than 24-2 and10-2 grids.

Conclusion: The 24-2C SITA Faster strategy enhances central VF assessment and offers a practical balance between diagnostic yield and efficiency. It should be used as part of a tailored testing approach rather than replacing 10-2.

Clinical Significance: This narrative review provides a consolidated appraisal of current evidence on the 24-2C SITA Faster strategy, offering clinicians a structured understanding of its role in central visual field assessment. By integrating findings across comparative, diagnostic, and structure–function studies, it clarifies the relative strengths and limitations of 24-2C in relation to conventional 24-2 and 10-2 strategies.

Keywords: *24-2C; SITA Faster; visual field; perimetry; HFA*

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INTRODUCTION

Among all ocular diseases, glaucoma is not a single disease but a group of multiple factors that result in optic neuropathy and is one of the leading causes of irreversible blindness worldwide. On a global scale, the number of affected individuals exceeds 76 million, a figure projected to reach approximately 111.8 million by 2040 [1]. It is known as "the silent thief of vision" because people gradually lose their sight as cells continue to degenerate, typically without noticeable symptoms in the early stages. The death of retinal ganglion cells leads to visual impairment, which often appears primarily in the peripheral visual field [2]. However, central field defects appear more frequently than expected [3]. This is particularly important because central visual field defects (CVFDs) cause a greater decrease in vision-related quality of life than peripheral VF defects [4], likely because central vision is more important than peripheral vision for conducting everyday tasks [5]. Due to the nature of the disease, early detection is an essential requirement to prevent damage to the optic nerve.

The Standard Automated Perimetry (SAP) is an essential tool for functional assessment in glaucoma diagnosis and progression monitoring [6]. Among the available testing paradigms on the Humphrey Visual Field Analyzer 3.0 (Carl Zeiss, Meditec, Inc., Dublin, CA), the 24-2 SITA

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Standard has long been considered the reference standard for its accuracy and reproducibility. However, the increasing recognition that glaucomatous defects may occur early in the central visual field [7] has created a need to enhance the testing strategy, as the traditionally used 24-2 Swedish Interactive Threshold Algorithm (SITA) Standard grid has a 6-degree space between test points in the central 10-degree area from the point of fixation, which may miss the early central field changes in glaucoma patients.

To address this, the 24-2C SITA Faster grid was introduced in early 2019. This test combines the speed of SITA Faster, which is approximately 50% faster than the conventional SITA Standard [1], with an additional 10 points incorporated into the 24-2 grid to increase sensitivity to central field loss. The points are not symmetrically arranged across the vertical and horizontal meridians like other test grids. The points are located in areas commonly affected by glaucoma [8]. The 24-2C test grid detects CVFDs while reducing chair time and improving structure-function (S-F) concordance compared to the traditionally used 24-2 grid.

Multiple studies have compared the HFA 24-2 and 10-2 test grids with the newer strategy 24-2C. This narrative review compares the diagnostic performance of the 24-2C test grid (detection of CVFDs, global indices, test duration, and S-F concordance) with the traditionally used 24-2 and 10-2 tests, as established in the existing literature.

Search Strategy

A narrative literature review was conducted to identify relevant studies evaluating the 24-2C SITA Faster visual field strategy and its comparison with conventional perimetric approaches. Electronic databases, including PubMed, Google Scholar, and Scopus, were searched for articles published up to 31 December 2025.

Search terms included combinations of: *"24-2C", "SITA Faster", "visual field testing"," standard automated perimetry", "24-2", "10-2", "Humphrey visual field analyzer,"* and their synonyms. Reference lists of selected articles were also manually screened to identify additional relevant studies. Non-English articles, conference abstracts without full text, and studies not directly related to perimetric comparison were excluded.

Ethical Guideline

This review is based on previously published studies and does not involve any new data collection from human participants or animals. Therefore, institutional ethical approval and informed consent were not required.

All included studies were assumed to have been conducted in accordance with the Declaration of Helsinki and relevant ethical guidelines. Proper acknowledgment of original sources has been ensured throughout the manuscript.

Central Visual Field Assessment Using 24-2C SITA Faster

The evolution of SAP has increasingly focused on improving the detection of central visual field defects, particularly in glaucoma, where early damage often involves the macular region. The introduction of the 24-2C grid was intended to bridge the gap between the sparse central sampling of the 24-2 strategy and the dense central evaluation of the 10-2 test grid.

Multiple studies have assessed the ability of the 24-2C SITA Faster test grid to detect central visual field defects. Early comparative work by Phu & Kalloniatis in glaucoma suspects and patients highlighted subtle yet clinically relevant differences between the 24-2 and 24-2C strategies [8]. When evaluated using SITA Standard, the 24-2C grid demonstrated a significantly lower mean deviation compared to 24-2 (median difference −0.73 dB; 96.2% CI: −1.01 to −0.06 dB; $p = 0.0038$), alongside a reduction in central mean sensitivity (median difference −0.35 dB; 96.2% CI: −0.70 to 0.03 dB; $p = 0.0226$). Despite these differences, parameters such as pattern standard deviation and glaucoma hemifield test outcomes remained comparable, suggesting that the additional central points primarily influence localized sensitivity rather than global defect classification.

Interestingly, these differences were not observed in SITA Faster testing, where both mean deviation (median difference of −0.02 dB;96.7% CI, -0.33 to 0.30 dB; $p = 0.9745$) and central sensitivity (median difference of −0.13 dB; 96.7% CI, -0.27 to 0.04 dB; $p = 0.769$) were statistically similar between the two grids. This finding suggests that algorithmic differences may modulate sensitivity to central defects.

Beyond global indices, cluster-based analyses further emphasized the clinical relevance of 24-2C. In approximately 31% of cases, additional statistically significant defect clusters were identified on 24-2C but not on 24-2, indicating improved sensitivity for localized visual field loss.

These findings were further supported by Behera et al., who demonstrated that 24-2C detected an average of 5.5 additional defective points in total deviation plots and 2 additional points in pattern deviation plots within the central 10° when compared to 24-2 [9]. Despite this increased detection, agreement between the two strategies remained high, with intraclass correlation coefficients of approximately 0.95 for mean deviation and 0.93 for pattern standard deviation ($p < 0.001$). Bland–Altman analysis showed a mean difference of 0.89 dB for mean deviation, indicating no systematic bias between the two strategies.

To further examine diagnostic performance across different groups of central points of the 24-2C, Nishijima et al. conducted a study in patients with mild glaucoma, with and without central visual field defects. 24-2 SITA Standard, 10-2 SITA Standard, and 24-2C SITA Faster test grids were performed [1]. Central detection was evaluated

using ROC analysis by comparing four central 24-2 points that coincide with 10-2 (Center4), 12 points within 10° (24-2–12), and 22 central points from the 24-2C grid (24-2C–22), based on total deviation and pattern deviation probability plots. The findings suggested that the area under the curve (AUC) values for upper central defects increased progressively from Centre4 (TD 0.50; PD 0.53) to 24-2–12 (TD 0.75; PD 0.81), and were highest for 24-2C–22 (TD 0.85; PD 0.84). A similar trend was observed for lower central defects, where 24-2C demonstrated superior performance in pattern deviation analysis (PD 0.81).

These findings indicate that expanding central sampling significantly enhances diagnostic accuracy, particularly when analyzed using pattern deviation metrics.

Additionally, 24-2C demonstrated improved detection of visual field defects beyond the central 10°, identifying upper-field defects in 88.2% and lower-field defects in 75.7% of patients. Upper defects were detected more frequently, suggesting potential asymmetry in sensitivity across hemifields.

Structure–Function Relationship in Early Glaucoma

Early detection of central defects plays a crucial role in monitoring disease progression. Pre-perimetric glaucoma (PPG) is characterized by structural changes without significant visual field defects. To analyze the importance of the additional 24-2C SITA Faster points, Çelik et al. conducted a study evaluating the role of additional central points in identifying early glaucomatous changes [10]. Significant structural differences were observed between pre-perimetric glaucoma patients and healthy controls, with mean retinal nerve fiber layer (RNFL) thickness reduced to 93.01 ± 3.78 µm in the glaucoma group compared to 108.53 ± 5.33 µm in controls. Comparable findings were observed in the mean macular ganglion cell complex (mGCC) with 83.80 ± 2.46 µm in the PPG group compared to healthy cohorts (96.47 ± 1.68 µm). This indicates notable deterioration in the RNFL and mGCC structures among patients with PPG.

However, functional indices showed only mild deviations, with a mean MD of −1.13 ± 0.47 dB in the PPG group versus −0.74 ± 0.99 dB in controls, and a mean PSD of 1.25 ± 0.41 dB versus 1.12 ± 0.48 dB, respectively. A statistically significant positive correlation was found between the average of additional points (AAP-2C) and mGCC thickness ($r = 0.385$, $p = 0.003$); however, no significant correlation was found between the structural changes and the global indices.

Test Duration and Clinical Efficiency

Test duration remains a key determinant in the clinical applicability of visual field strategies, particularly in routine glaucoma monitoring. Work by Phu & Kalloniatis highlighted the substantial reduction in testing time achieved with SITA Faster compared to SITA Standard, with a median difference of 153.5 seconds ($p < 0.001$) [8]. Within the SITA Faster paradigm, the inclusion of additional central points in the 24-2C grid resulted in only a modest increase in duration compared to the conventional 24-2, with a median difference of 26 seconds ($p < 0.001$), suggesting that improved central sampling can be achieved with minimal impact on efficiency.

Subsequent studies have further contextualized this balance between diagnostic yield and test duration. Behera et al. reported mean test durations of 408 seconds for 24-2, 244.5 seconds for 10-2, and 210 seconds for 24-2C, indicating that 24-2C offers enhanced central assessment while remaining considerably faster than 10-2 [9]. Comparable findings were reported by Nishijima et al., who observed average durations of 308 seconds for 24-2, 343 seconds for 10-2, and 165 seconds for 24-2C, reinforcing the relative efficiency of the 24-2C grid [1].

Further evaluation by Nishijima et al., demonstrated that 24-2C SITA Faster (166.5 seconds; SD 37.4) was approximately 55% shorter than 24-2C SITA Standard (371.8 seconds), while maintaining comparable global indices [11]. Notably, no significant differences were observed in mean deviation or pattern standard deviation between the two algorithms, suggesting that the reduction in test duration does not compromise diagnostic performance.

Table 1: Overview of studies assessing the clinical utility of the 24-2C visual field strategy

Author (Year)	Title of Study	Study Design / Method	Study Population	Key Outcome
Phu, J., & Kalloniatis, M. (2020)	Ability of 24-2C and 24-2 Grids to Identify Central Visual Field Defects and Structure-Function Concordance in Glaucoma and Suspects	Patients underwent both 24-2C & 24-2 V.F. test. Ganglion Cell Analysis was extracted, and the structure-function relation was compared.	100 Glaucoma and high-risk glaucoma suspects	Better structure-function concordance was achieved with the 24-2C grid; however, half of the test locations did not align with the macular scans.
Phu, J., & Kalloniatis, M. (2021)	Comparison of 10-2 and 24-2C Test Grids for Identifying Central	Comparative analysis using global indices, cluster points, central	131 Glaucoma and 57 glaucoma suspects	Although the 24-2C identified a clustered central visual field

	Visual Field Defects in Glaucoma and Suspect Patients	mean sensitivity and structure-function correlations.		defect, the 10-2 remains a superior approach for central defect characterization
Chakravarti et al. (2021)	Agreement between 10-2 and 24-2C visual field protocols	Identification of central visual field defects (CVFDs) using Cohen's Kappa (k) of TD and PD plots	165 healthy, 62 glaucoma patients and 12 suspects	Moderate to substantial agreement between 24-2C and 10-2 in detecting central defects
Yamane et al. (2021)	Introducing the 24-2C Visual Field Test in Neuro-Ophthalmology	Comparative analysis of TD and PD flagged points	25 Neuro-ophthalmology patients	No significant difference in the number of flagged points between 24-2C and 10-2
Behera et al. (2023)	Comparing Static Perimetry Protocols of Central Field Testing among Patients with Glaucoma	Comparative study using the intraclass correlation coefficient and Bland–Altman analysis using MD and PSD values	60 Glaucoma patients	24-2C detected more central defective points than 24-2 with excellent agreement in MD and PSD, and significantly shorter test duration
Nishijima et al. (2024)	Comparative Analysis of 24-2C, 24-2, and 10-2 Visual Field Tests for Detecting Mild-Stage Glaucoma with Central Visual Field Defects	Comparative study using ROC analysis of TD and PD plots	Mild-stage glaucoma patients	24-2C showed high diagnostic accuracy for central defects and was 53% faster than 24-2 SITA Standard and 48% faster than 10-2
Çelik et al. (2024)	Evaluation of additional points in 24-2C visual field test in pre-perimetric glaucoma	Evaluation of functional changes (MD, PSD, VFI, Average of additional 10 points) with structural changes (RNFL and mGCC thickness)	59 pre-perimetric glaucoma patients	Significant reduction observed in RNFL and mGCC thickness, with no significant changes observed in functional values

DISCUSSION

The present review evaluates the clinical performance of the 24-2C SITA Faster strategy in comparison with conventional 24-2 and 10-2 perimetric grids. The available evidence suggests that the primary contribution of the 24-2C grid lies in improved sampling of the macular region; however, the extent of its clinical impact varies depending on the outcome measure assessed.

Across studies, differences in global indices between 24-2 and 24-2C are generally small and, in several instances, not statistically significant, particularly when evaluated using SITA Faster algorithms. Phu & Kalloniatis reported that while mean deviation and central sensitivity differed under SITA Standard testing, these differences were not observed with SITA Faster, indicating comparable global indices between the two strategies [8]. This finding reflects the limited sensitivity of global summary measures, such as mean deviation and pattern standard deviation, to detect localized changes within the central field.

In contrast, analyses focusing on spatial characteristics demonstrate a more consistent effect. The 24-2C grid has been shown to identify additional defective points and localized clusters within the central visual field compared to the conventional 24-2 pattern. Behera et al. further quantified this difference, demonstrating that 24-2C detected more defective central points while maintaining strong agreement with 24-2 on global indices (ICC ≈ 0.93–0.95) [9].

Comparisons with the 10-2 grid provide additional insight into the performance of 24-2C. The 10-2 strategy consistently demonstrates greater sensitivity in detecting central and paracentral defects, with studies reporting significantly more defective points within the central 10°. Phu & Kalloniatis and Yamane & Odel both reported comparable global indices between 24-2C and 10-2, despite the higher sensitivity of 10-2 in detecting central defects [12][13]. Similarly, (Chakravarti et al. demonstrated moderate to substantial agreement between the two strategies (κ = 0.48–0.70), indicating that while differences exist in defect detection, overall classification remains comparable [14].

These findings suggest that the difference between 24-2C and 10-2 is primarily related to sampling density rather than inconsistency in performance. The 10-2 grid, with its higher spatial resolution, is more sensitive for detecting small paracentral scotomas, whereas the 24-2C grid retains

the ability to detect broader arcuate and hemifield defects due to its wider field coverage. Accordingly, the two strategies should be considered complementary rather than interchangeable.

The role of 24-2C in early glaucoma is of particular interest. Structural studies have demonstrated that macular damage may precede detectable functional loss. Çelik et al. reported significant structural thinning in pre-perimetric glaucoma despite minimal differences in functional indices, highlighting the limitation of perimetry in early disease [10]. The addition of central test points in the 24-2C grid improved detection of functional abnormalities corresponding to these structural changes; however, the persistence of structure–function discordance indicates that enhanced sampling alone is insufficient to overcome the limitations of functional testing.

Diagnostic accuracy analyses provide further support for the utility of enhanced central sampling. Nishijima et al. demonstrated improved discrimination of central visual field defects with increasing numbers of central test points, with higher area under the curve values observed for 24-2C compared to conventional 24-2 central sampling [1]. However, variability in performance across different regions and analytical methods suggests that these findings are influenced by the definition of central defects and the statistical approach used.

Test duration remains an important practical consideration. The SITA Faster algorithm significantly reduces testing time compared to SITA Standard, with Phu & Kalloniatis reporting a median reduction of 153.5 seconds [8]. Within this framework, the 24-2C grid introduces only a modest increase in duration compared to the conventional 24-2, while remaining substantially shorter than 10-2 testing [1]. This further demonstrates that 24-2C SITA Faster reduces test duration by approximately 55% compared to SITA Standard without compromising global indices. These findings support the clinical applicability of 24-2C SITA Faster in routine practice.

Several limitations should be acknowledged. Most studies are cross-sectional, and there is limited evidence regarding the role of 24-2C in longitudinal monitoring or progression detection. Differences in study design, patient populations, and analytical methods limit direct comparability across studies. Additionally, while increased detection of central defects is consistently reported, its impact on clinical decision-making and long-term outcomes remains unclear.

CONCLUSIONS

The 24-2C grid represents a hybrid perimetric strategy, designed to bridge the gap between the wide-field assessment of 24-2 and the high-resolution central mapping of 10-2, thereby enabling simultaneous evaluation of central and peripheral functional loss. While differences in global indices compared to the conventional 24-2 grid are generally limited, the additional central test points enable detection of localized defects that may otherwise be underrepresented.

Despite this advantage, the 24-2C grid does not achieve the spatial resolution of the 10-2 strategy and demonstrates lower sensitivity for identifying fine paracentral abnormalities. Its role is therefore best considered complementary rather than substitutive, particularly in patients with established or suspected central involvement.

From a clinical perspective, 24-2C SITA Faster provides a practical balance between efficiency and diagnostic capability, supporting its integration into routine glaucoma assessment. However, its contribution should be interpreted alongside structural findings and, where indicated, supplemented with 10-2 testing.

Further longitudinal studies are required to determine whether the enhanced central detection offered by 24-2C translates into improved monitoring of disease progression and meaningful changes in clinical management.

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