To Be or Not To Be...Glaucoma

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This is the case of a 70 year old male patient, MG.
The patient was referred to our clinic as a glaucoma suspect.
He was examined in March 2008, and the findings were:
VOU=20/20
OD IOP=16mmHg, OS IOP=15 mmHg
Pachimetry: OD 526 μm, OS 535 μm
Gonioscopy: OU open angle, grading III
Examination of the fundus: OU C/D ratio=0.8, nasaly deviated vessels, visible holes of lamina cribrosa. ISNT rule is not respected.

The visual field was assessed with an Optopol perimeter PTS 910.
(Normal: MD= -1 - +1 dB, PD ≥0, near 0; higher positive values are pathological.)
There were 5 visual field exams over a period of 10 months, during which the patient showed a slight deterioration of the following indexes:
OD: PD increased from 1.04 to 1.66, with a slight come back to 0.89 during the last examination.
OS: PD increased from 0.63 to 1.48, with a slight come back to 0.56 at the last examination.

In the meantime, the patient was referred to an HRT examination, to assess the optic disc.
The HRT on MRA showed (May 2008):
OD: outside normal limits on the whole and in all quadrants
OS: outside normal limits on the whole and in all quadrants with the exception of the nasal quadrant which was classified as borderline.
The stereometric examination of the optic nerve head shows a megadisc, with a C/D ratio of 0.8 and a mean thickness RNFL at the lower end of the normal range.

The fundus photos show just a very discreet change of the right optic nerve head between examinations.
IOP values were always normal.
The HRT reexamination (February 2009) didn't show modifications.

The further examinations (VF, HRT, fundus photos) were identical.
In conclusion, there still is the question: is it or isn't it glaucoma? Is it or not a slow progression? This patient should be treated or only observed?