

Available online at www.sciencedirect.com

SciVerse ScienceDirect

journal homepage: www.elsevier.com/locate/survophthal

Clinical challenges

Muscle cramping over the diagnosis

David R. Lally, MD^a, Mark L. Moster, MD^{a,*}, Rod Foroozan, MD^b

^a Neuro-Ophthalmology Service, Wills Eye Institute, Jefferson Medical College, Philadelphia, Pennsylvania, USA ^b Department of Ophthalmology, Baylor College of Medicine, Houston, Texas

ARTICLE INFO

(In keeping with the format of a clinical pathologic conference, the abstract and key words appear at the end of the article.)

Article history: Received 12 December 2012 Accepted 18 December 2012 Peter Savino and Helen Danesh-Meyer, Editors

1. Case report

A 44-year-old white man was referred for neuroophthalmologic consultation for optic disk edema. Six months before, he had one episode of transient blurry vision in the right eye lasting 20 minutes. Over the past month, he noted halos around lights. He also had pulsatile tinnitus, but denied headache, diplopia, or transient visual obscurations.

Past medical history was significant for hypogonadism and adrenal insufficiency diagnosed 2 years previously. He also had a history of pernicious anemia and gastroesophageal reflux. Medications included hydrocortisone 40 mg/day, testosterone enathate 100 mg intramuscular injections every 2 weeks, cyanocobalamin 1000 mcg/mL injections monthly, aspirin, and pantoprazole. His medication regimen had been stable for 1 year.

Visual acuity was 20/20 OU with no relative afferent pupillary defect. Humphrey visual fields were normal. Extraocular motility was intact and slit lamp anterior examination showed 1+ nuclear sclerosis OU. Intraocular pressure was 14 mm Hg in each eye. Dilated fundus examination revealed mild bilateral disk swelling (Fig. 1), and spectral domain optical coherence tomography showed thickening of the peripapillary retinal nerve fiber layer OU (Fig. 2). His body mass index was 27, and blood pressure was 121/69.

Survey of Ophthalmology

What is your diagnosis? What tests would you perform?

2. Comments

2.1. Comments by Rod Foroozan, MD

This patient has optic disk edema on each side. The more common optic neuropathies that cause bilateral optic disk edema include:

- Papilledema-optic disk edema secondary to elevated intracranial pressure
- Hypertensive optic neuropathy
- Ischemic optic neuropathy
- Inflammatory or infiltrative optic neuropathy

His visual function is relatively well preserved, a characteristic of early papilledema where the optic disk appearance parallels visual function; the transient visual

^{*} Corresponding author: Mark L. Moster, MD, Neuro-Ophthalmology Service, Wills Eye Institute, Jefferson Medical College, 840 Walnut Street, Suite 930, Philadelphia, PA, 19107.

E-mail address: markmoster@gmail.com (M.L. Moster). 0039-6257/\$ — see front matter © 2014 Elsevier Inc. All rights reserved. http://dx.doi.org/10.1016/j.survophthal.2012.12.005



Fig. 1 - Photographs at presentation showing bilateral disk edema.

obscurations of papilledema, however, typically last seconds and not 20 minutes. He also has another symptom suggestive of elevated intracranial pressure, pulsatile tinnitus. Although he is not obese by body mass index (BMI 30 or greater), he is an estimated 20% overweight. It may be helpful to know if there has been a recent weight gain associated with the visual symptoms and pulsatile tinnitus.

The evaluation of and common entities causing bilateral optic disk edema were reviewed in another Clinical

Challenge.¹⁰ I would order a magnetic resonance imaging (MRI) of brain and orbits with contrast and fat suppression and magnetic resonance venography (MRV) of the head. The orbital MRI will help exclude the optic nerve enhancement expected with inflammatory and infiltrative optic neuropathy, and may show signs of elevated intracranial pressure such as posterior bowing of the globes, increased T2-weighted signal around the optic nerves, and an empty sella. The MRV would help exclude venous sinus thrombosis.

He does have multiple endocrine deficiencies. Some hormonal medications may cause elevated intracranial pressure, including corticosteroids (typically during a tapering of the medication) and growth hormone. So I would ask if he is using any other prescription or over-the-counter hormones.

3. Case report (continued)

Brain MRI and MRV showed no evidence of a mass lesion or dural sinus thrombosis. Lumbar puncture showed an opening pressure of 28.5 cm H20, no cells, a protein of 139 mg/dL, and normal glucose.

Two weeks later, his vision was stable, but the disks appeared more swollen. He also reported progressive



Fig. 2 – Spectral domain optical coherence tomography of the optic nerves at presentation showing bilateral increased thickness of the retinal nerve fiber layer (RNFL).

Download English Version:

https://daneshyari.com/en/article/4032594

Download Persian Version:

https://daneshyari.com/article/4032594

Daneshyari.com