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CLINICAL CHALLENGES

PETER SAVINO AND HELEN DANESH-MEYER, EDITORS

That's a Wrap

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

Case Report. A 52-year-old white man presented in November 2003 with acute severe headache and photophobia. A computed tomographic (CT) scan of the head revealed a subarachnoid hemorrhage and a cerebral angiogram showed a ruptured anterior communicating artery aneurysm. The patient underwent successful clipping of the aneurysm via a right frontoparietal craniotomy. The postoperative course was complicated by Streptococcal meningitis and infarction of the right corpus callosum presumed secondary to vasospasm.

The patient did well following surgery and was seen in follow-up on May 4, 2004. A follow-up magnetic resonance (MR) scan of the head showed old ischemia of the right corpus callosum and in the anterior cerebral and middle cerebral artery distributions bilaterally and clip artifact in the suprasellar space.

On July 13, 2004, the patient presented to his local ophthalmologist with a 1-week history of painless, progressive blurred vision in his left eye. Ophthalmologic exam revealed a visual acuity of 20/40 OD and 20/40 OS, with subtle right optic disk pallor. Automated (Humphrey 24-2) perimetry showed superior and nasal defects OS (Fig. 1) and non-specific changes OD. The vision worsened and a non-contrast head CT showed no evidence of a new hemorrhage.

On August 3, 2004, the patient presented to the Neuro-ophthalmology Service at The University of Iowa Hospitals and Clinics with decreased peripheral vision. Ophthalmologic examination revealed a best corrected visual acuity of 20/30- in the right eye and 20/30- in the left eye. There was no relative afferent pupillary defect (RAPD). Kinetic perimetry revealed a bitemporal hemianopia (Fig. 2). Ophthalmoscopy showed mild temporal pallor of both optic nerves, but the remainder of the examination was normal.

Is there any additional history that might be helpful? What further evaluation should be performed?

Comments

Comments by M. Tariq Bhatti, MD, and Stephen B. Lewis, MD

In this era of easily accessible, sophisticated medical technology and an ever-increasing demand on revenue-generating clinical productivity (in both the academic and non-academic settings), an occasionally overlooked and under-appreciated aspect of

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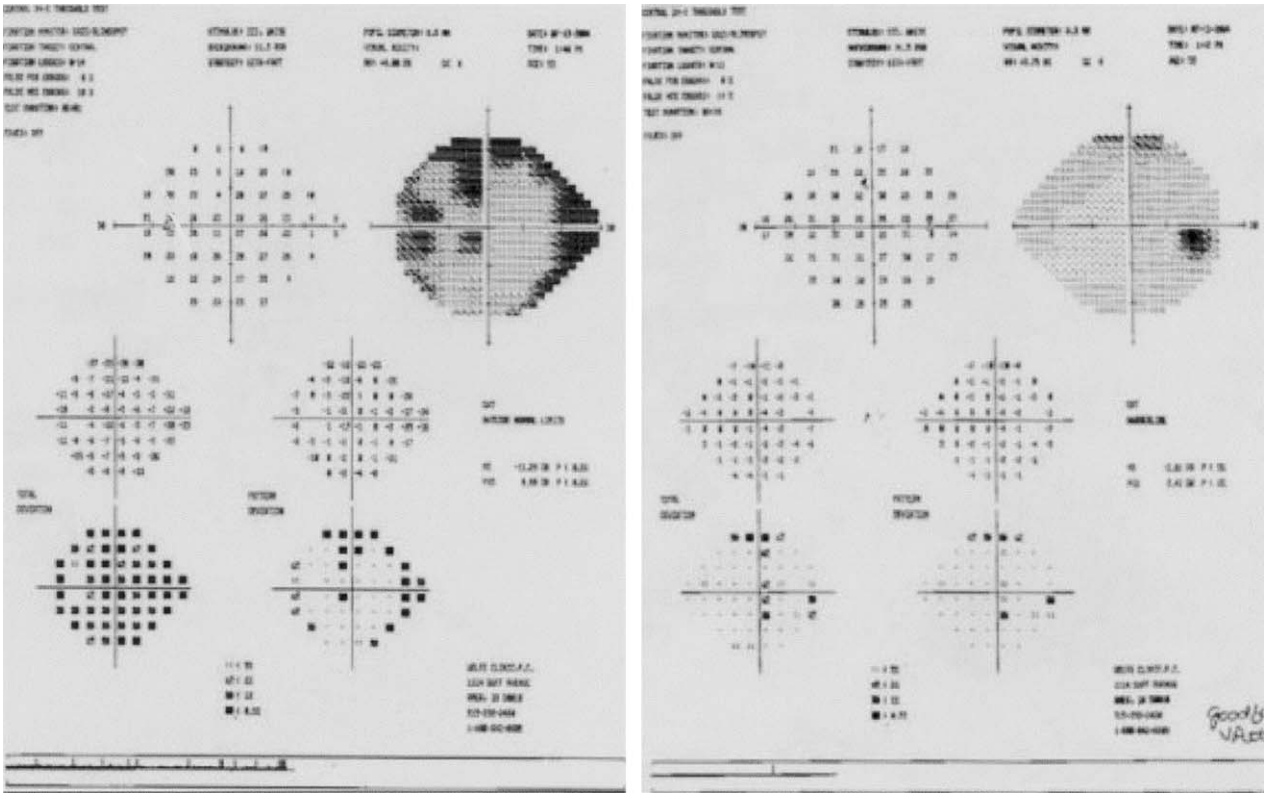

Fig. 1. Automated (Humphrey 30-2) visual field testing on July 13, 2004, showing visual field loss in the left eye (*left*) superiorly and nasally. The right eye (*right*) shows non-specific changes.

evaluating a patient is the performance of a thorough and detailed medical history with review of medical records. Taking a medical history is not just an exercise in asking a set of haphazard or random questions, but rather an art form of asking a series of relevant questions to obtain the needed information to arrive at a correct diagnosis and treatment plan. The diagnostic impression, and at a minimum the differential diagnosis, is founded upon the medical history with the physical examination and para-

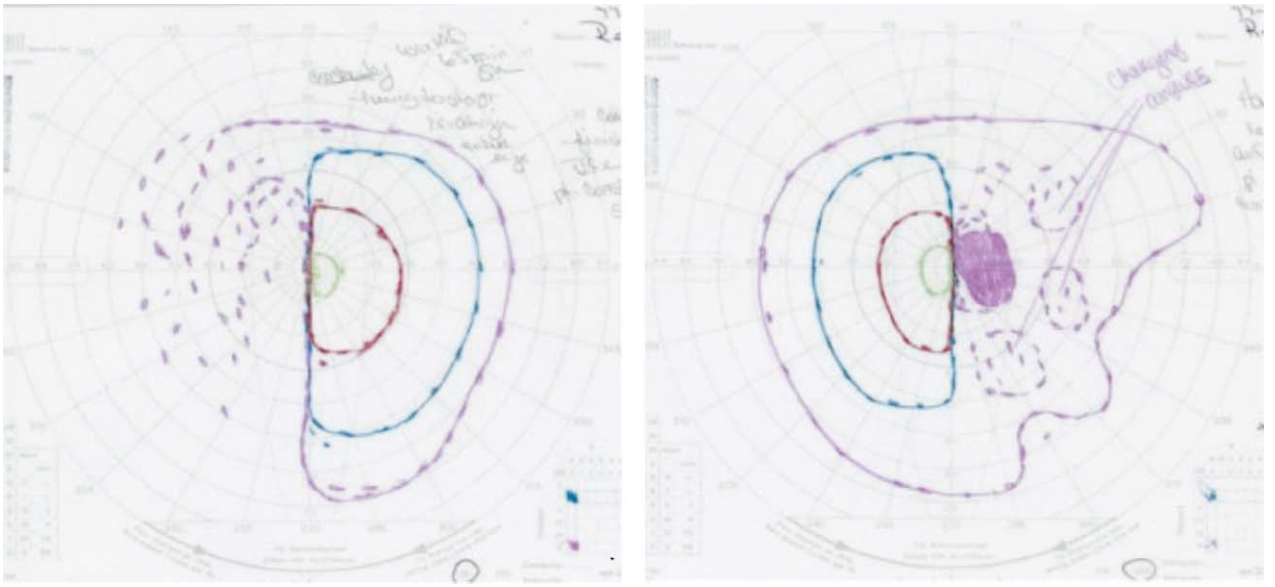

Fig. 2. Kinetic visual field testing on August 3, 2004, reveals a bitemporal hemianopia.