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Case Report

Progressive severe bilateral loss of vision in a relatively young patient: Think beyond malingering

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ARTICLE INFO

Article history:
Received 28 August 2015
Accepted 12 May 2016
Available online xxx

Keywords:
Severe progressive vision loss
Bilateral
Malingering
Meningioma

Introduction

Progressive painless bilateral loss of vision in a relatively young patient with no other ocular or systemic complaints is usually a diagnostic dilemma specially when there are no other obvious positive signs evident. More often than not, such patients are erroneously labelled as malingerers, especially when they are initially examined by young relatively inexperienced medical officers in the periphery. Here, we present one such case that was transferred as a malingerer suspect, to our centre and who on evaluation was in fact detected to have a life threatening pathology.

Case report

A 46-year-old patient was transferred to this centre with complaints of painless, gradually progressive blurring of vision in both eyes for the past 6 weeks. He had reported to a peripheral hospital where his best corrected visual acuity was recorded as 6/60 (right eye) and 6/36 (left eye). There was no history of ocular redness, discharge, diplopia, injury or any major systemic illness like hypertension or diabetes. Ocular and systemic examinations were all within normal limits (WNL). The patient had been counselled and treated with some placebo eye drops. However, when the patient claimed that his vision had further deteriorated, he was transferred to this centre as a case of suspected malingering. On presentation, the patient gave a history of repeated falls leading to multiple superficial minor injuries as he was unable to see while negotiating his way through the real world. Ocular examination on presentation revealed his VA as 4/60 (right) and 1/60 (left), with no refractive error. His near vision was N-36 in both eyes, improving to N-18 with +2 dioptre spherical lenses in both eyes. Ocular movements were painless, full and free. Pupils were 3 mm in size bilaterally; however, on carrying out the swinging flashlight test in a dark room, there was definite evidence of relative afferent papillary defect (RAPD) in the right eye. A detailed slit lamp anterior segment examination did not reveal any pathology. Ishihara colour vision test was carried out in good daylight and with the near correction in place, and found to be normal. Intra-ocular pressure was a normal 14 mm

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http://dx.doi.org/10.1016/j.mjafi.2016.05.006

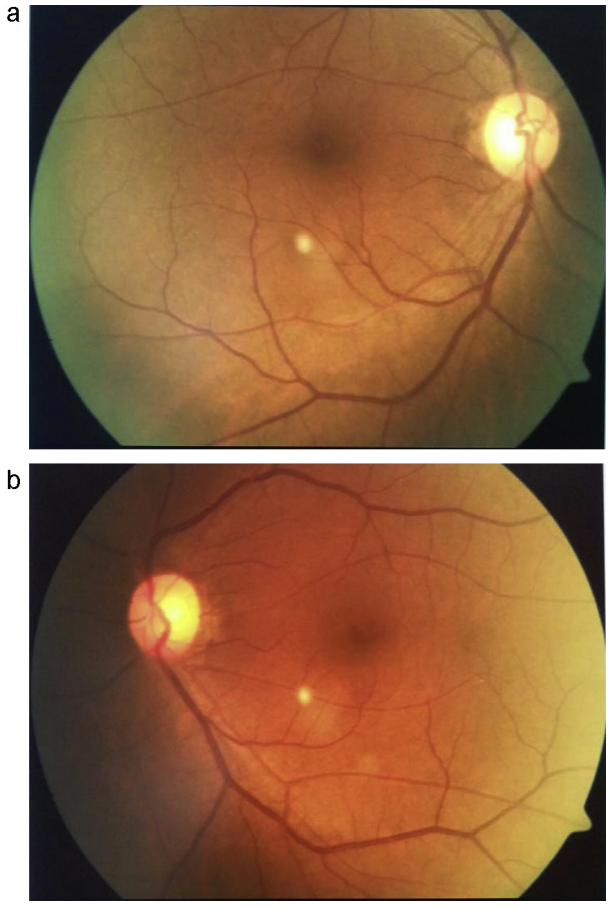

Fig. 1 – (a and b) Fundus photographs of the eyes revealing a mild pallor in both the optic discs.

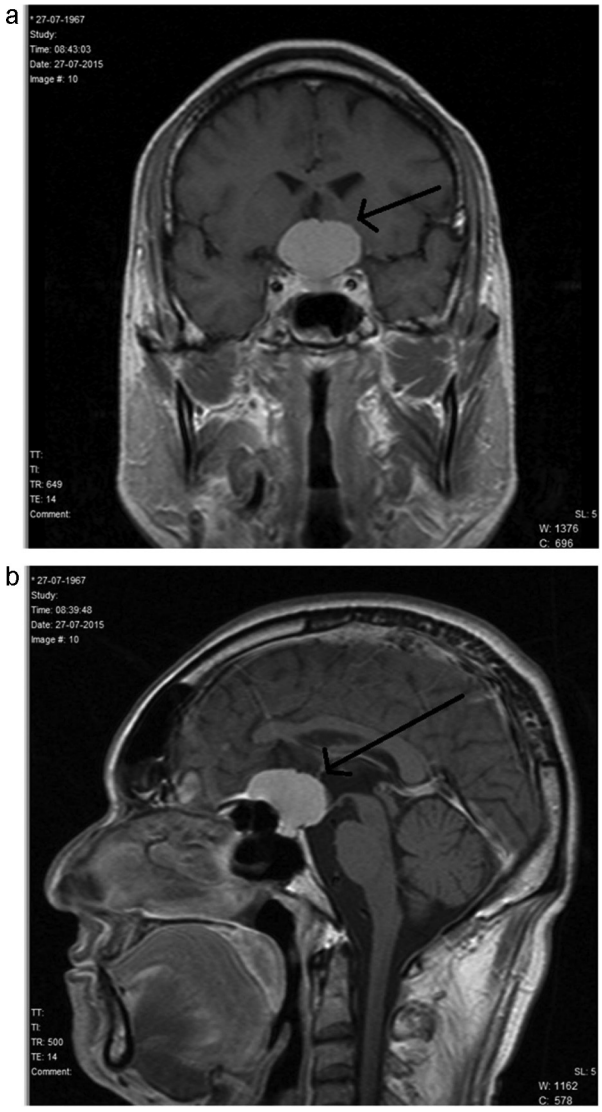

Fig. 2 – (a and b) Contrast enhanced MRI brain orbits coronal and sagittal sections revealing a well defined smoothly marginated extra axial mass in the supraselar region measuring 2.3 mm × 3.2 mm × 3.3 mm.

of Hg both eyes as measured with a non-contact tonometer. A detailed visual field testing using a Humphrey Field Analyzer was not possible due to the patient's poor vision; however, testing by the confrontation method revealed field defects in the temporal hemifield and supero-nasal quadrant in the right and temporal hemifield defect in the left. Dilated fundus examination too was normal in all respects expect for a mild pallor in both the optic discs and the veins being obviously congested (Fig. 1a and b). A detailed systemic including a neurological evaluation was all WNL. The patient was further investigated with a magnetic resonance imaging (MRI) of the brain and orbits followed by a visual evoked potential (VEP). The MRI revealed a well-defined smoothly marginated extra axial mass in the suprasellar region measuring 2.3 mm × 3.2 mm × 3.3 mm (CC × TR × TP). This mass was extending inferiorly into the sella and abutting the pituitary gland and superiorly it was indenting upon the floor of the anterior third ventricle. The optic chiasma too appeared to be compressed by this mass (Fig. 2a and b). While the VEP showed mild demyelinating type of bilateral (left > right) optic pathway dysfunction (Fig. 3). A diagnosis of a suprasellar mass, most likely meningioma, was made and an urgent neurosurgical consultation sought. The patient underwent a frontal craniotomy with tumour excision within the next 48 h. The histopathological report of the excised mass too confirmed the diagnosis and was reported as classical meningioma (transitional/syncytial). WHO classification was Grade 1. Postoperative period was uneventful. Visual evaluation 1 week post-surgery revealed a remarkable improvement in the patient's vision (right 6/6 and left 6/36). The patient was sent on 4 weeks sick leave. Visual evaluation after 4 weeks post-surgery was a normal 6/6 in the right eye and 6/12(P) in the left. The visual fields too were evaluated and revealed a superior hemi field defect in the left eye and a superiotemporal quadrant field defect in the right eye (Fig. 4a and b). The patient is now on a regular follow-up on an OPD basis.

Discussion

The intentional fabrication of mental or physical symptoms by anyone who has an ulterior motive (e.g. avoiding military duty,

Please cite this article in press as: Mishra A, et al. Progressive severe bilateral loss of vision in a relatively young patient – Think beyond malingering, *Med J Armed Forces India*. (2016), http://dx.doi.org/10.1016/j.mjafi.2016.05.006