ARCH SOC ESP OFTALMOL. 2017;xxx(xx):xxx–xxx

ARCHIVOS DE LA SOCIEDAD ESPAÑOLA DE OFTALMOLOGÍA

www.elsevier.es/oftalmologia

Short communication

Bilateral exudative retinal detachment associated with central serous chorioretinopathy in a patient treated with corticosteroids☆

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ARTICLE INFO

Article history:
Received 25 July 2016
Accepted 10 January 2017
Available online xxx

Keywords:
Central serous chorioretinopathy
Vogt–Koyanagi–Harada disease
Exudative retinal detachment
Corticosteroids
Pars plana vitrectomy
Subretinal liquid drainage
Photodynamic therapy

ABSTRACT

Case report: The case is presented on a 54-year-old woman with a central serous chorioretinopathy, misdiagnosed as Vogt–Koyanagi–Harada disease, and treated with systemic corticosteroids. The patient presented with a bilateral bullous exudative retinal detachment. *Discussion:* Discontinuation of corticosteroid therapy, surgical drainage of subretinal fluid, and photodynamic therapy, led to anatomical and functional improvement. The recognition of an atypical presentation of central serous chorioretinopathy may avoid complications of the inappropriate treatment with corticosteroids.

Desprendimiento de retina exudativo bilateral asociado con coriorretinopatía serosa central en una paciente tratada con corticoesteroides

Palabras clave:
Coriorretinopatía serosa central
Enfermedad de
Vogt-Koyanagi-Harada

RESUMEN

Caso clínico: Presentamos el caso de una mujer de 54 años con una coriorretinopatía serosa central diagnosticada erróneamente de enfermedad de Vogt-Koyanagi-Harada y tratada con corticoides sistémicos. La paciente desarrolló un desprendimiento de retina exudativo bulloso en ambos ojos.

☆ Please cite this article as: Rueda-Rueda T, Sánchez-Vicente JL, Llerena-Manzorro L, Medina-Tapia A, González-García L, Alfaro-Juárez A, et al. Desprendimiento de retina exudativo bilateral asociado con coriorretinopatía serosa central en una paciente tratada con corticoesteroides. Arch Soc Esp Oftalmol. 2017. http://dx.doi.org/10.1016/j.oftal.2017.01.002

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Desprendimiento exudativo de retina
Corticoides
Vitrectomía pars plana
Drenaje de líquido subretiniano
Terapia fotodinámica

Discusión: La interrupción del tratamiento con corticoides junto con el drenaje quirúrgico del líquido subretiniano y la aplicación de terapia fotodinámica consiguió la mejoría anatómica y funcional. El correcto diagnóstico de las formas atípicas de la enfermedad podría evitar las complicaciones del uso inadecuado de los corticoides.

Introduction

Central serous chorioretinopathy (CSC) is characterized by the presence of serous retinal detachment (SRD) or retina pigment epithelium detachment (RPED) generally limited to the macula and associated to the dissemination of liquid into the subretinal space.[1]

In typical CSC, SRD resolves spontaneously with visual recovery. However, atypical forms with bullous SRD associated to multiple large RPED can be confused with the Vogt–Koyanagi–Harada (VKH) disease.[2]

The case of a patient with chronic CSC erroneously diagnosed as VKH is presented. Systemic corticosteroid treatment worsened the condition with increased detachments and chronification of the disease. Discontinuation of corticosteroids was insufficient and it became necessary to surgically drain the subretinal fluid (SRF) through pars plana vitrectomy and the application of photodynamic therapy (PDT).

Clinical case

Female, 54, without relevant history, referred due to diminished vision with over 6 months evolution. Maximum uncorrected visual acuity was 0.25 in the right eye (RE) and 0.4 in the left eye (LE). Intraocular pressure and anterior chamber biomicroscopy were normal.

In RE ocular fundus, the papilla exhibited normal color and was well defined. Diffuse macular edema with perimacular hemorrhages and retina pigment epithelium alterations could be observed. The LE exhibited a diffuse macular edema, notably the presence of 2 cystic formations adjacent to the superior temporal arch. Papilla was normal (Fig. 1).

Spectral domain optical coherence tomography (SD-OCT) (Topcon® 3 D OCT-1000, Topcon Corporation, Tokyo, Japan) showed edema with large cysts in the RE central macula with SRF in the rest of the posterior pole. LE exhibited foveal neuroepithelium detachment with SRF in the entire posterior pole. Two larger cystic formations with RPED and SRF were observed adjacent to the superior arch (Fig. 2).

Fluorescein angiography evidenced diffuse retina pigment epithelium alterations in the RE, limited to posterior pole, with uneven hyperfluorescence. RPE hypertrophic areas could be observed together with stain accumulation areas. In the LE, the diffuse hyperfluorescence area was smaller, exhibiting 2 large areas of fluorescein accumulation corresponding to the cystic lesions in the superior temporal arch, as well as lesions compatible with RPED (Fig. 3).

The patient was diagnosed with VKH, beginning treatment with systemic corticosteroids and cyclosporine and referred to the Collagenosis and ENT Unit, discarding other associated systemic alterations.

Hematimetry, biochemistry, serology and Mantoux were negative.

The condition of the patient worsened and it was decided to adminster 3 intravenous bolus of corticosteroids (1 g methylprednisolone). After this treatment, the patient exhibited significant worsening with diminished VA (0.16 in RE and 0.032 in LE), the appearance of bullous SRD that compromised the inferior retina of both eyes (BE) (Fig. 4), which led to considering a diagnostic of chronic CSE. Corticosteroids and cyclosporine dosages were diminished prior to discontinuation.

Due to SRD persistence in BE 8 weeks after discontinuing corticosteroid treatment that prevented laser treatment or PDT due to the height of the detachment, surgical drain was decided followed by bilateral PDT in different surgical interventions. Pars plana vitrectomy with 23 G was performed with liquid perfluorocarbon injection, external SRF drainage through 2 radial sclerostomies having a length of 3 mm, at 10 mm of the limbus on both sides of the medial rectus, intraocular laser in suspected diffusion areas and liquid-air-SF6 20% exchange.

After reapplication of the retina, diminished fluency PDT was performed (25 J/cm^2) with normal dose of verteporfin (6 mg/m^2), during 83 s over an area of approximately 3000 μm corresponding to the diffusion areas, upon which the condition stabilized.

At present, after 20 months follow-up, the corrected visual acuity of the patient is of 0.1 in the RE and 0.2 in the LE. The retina remains applied, with intense subretinal fibrosis with atrophy and hypertrophy of the retina pigment epithelium and macular epiretinal membranes in BE, possibly as a post-surgery complication (Fig. 5).

Discussion

The association between corticosteroids and CSC is well-known. Patients with extended corticosteroid treatments could develop a chronic and recurring form of CSC.[3] In addition, the use of steroids could worsen existing CSC and give rise to atypical forms such as diffuse epitheliopathy, bullous SRD and SRD with exudation and subretinal fibrosis.[4] These forms could be confused with other entities, particularly VKH, which require the use of corticosteroids. The differential diagnostic of these atypical forms should include regmatogenous retina detachment, VKH, hypertensive choroidopathy,