MULTIPLE RETINAL PIGMENT EPITHELIAL DETACHMENT IN CENTRAL SEROUS CHORIORETINOPATHY

LARISSA CAROLINE MANSANO SOARES[2], CAROLINA RODRIGUES BARRETO MENDES [2], CRISTINA NERY CARBAJO[2], LUCIANO RABELLO NETTO CIRILLO[2] , PRISCILA ALVES NASCIMENTO [1] , LETICIA FERNANDES MONTEIRO [2], JULIO ZAKI ABUCHAM NETO[3]. VAGNER LODUCCA LIMA[4]

Retina and Vitreous fellow of Faculdade de Medicina do ABC (FMABC).[1]

Resident in Ophthalmology of Faculdade de Medicine do ABC (FMABC).[2]

Chief of Retina and Vitreous sector of Faculdade de Medicina do ABC (FMABC).[3]

Chief of Ophthalmology residence program of Faculdade de Medicine do ABC (FMABC).[4]

INTRODUCTION

Central serous chorioretinopathy (CSC) is a disease that is characterized by detachment of the neurosensorial retina as a result of the accumulation of serous fluid between the neurosensorial retina and the retinal pigment epithelium (RPE)[1]. Although the exact pathophysiology of CSC is not yet fully understood, the primary pathology is thought to begin with disruption of the choroidal circulation. The RPE is then decompensated and allows exudate from the choroidal vasculature to pass into the subretinal space. [2]

CSC preferentially affects male individuals (in 85% of cases), aged 20 to 45 years, [2] typically present in patients with a personality described as “type A profile”, characterized by high levels of emotional tension and anxiety.

The exact pathomechanism of CSC is not yet completely understood, but evidence suggests hyperpermeability and increased hydrostatic pressure within the choroidal circulation, leading to the formation of pigment epithelial detachments (PEDs), a condition in which the retinal pigment epithelium is detached from its basement Bruch’s membrane due to pathological accumulation of fluid.[6]

In this case report we present an atypical variant, which is usually found in healthy middle-aged men and presents with multiple a PEDs and multiple bullous serous neurosensory detachments that demonstrate shifting fluid.[5]

CASE REPORT

Male, 46-year-old, presented with progressive low visual acuity (VA) in the left eye (OS) four month before visiting the Ophthalmology Department of FMABC. Only eye patient for 18 years due to trauma. Pathological history showed anxiety and gout, making continuous use of allopurinol. He denies using corticosteroids or other medications. At initial ophthalmological examination, VA was no light perception (NLP) in the right eye (OD) and 20/50 cc in OS.

A fundus examination revealed in OS circumscribed elevation in the macula and in the superior temporal arch (Figura 1 and 2).

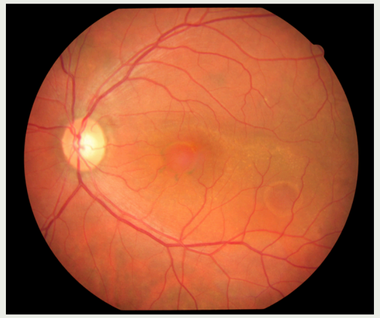

Figure 1

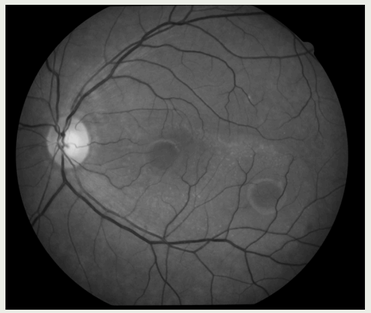

Figure 2

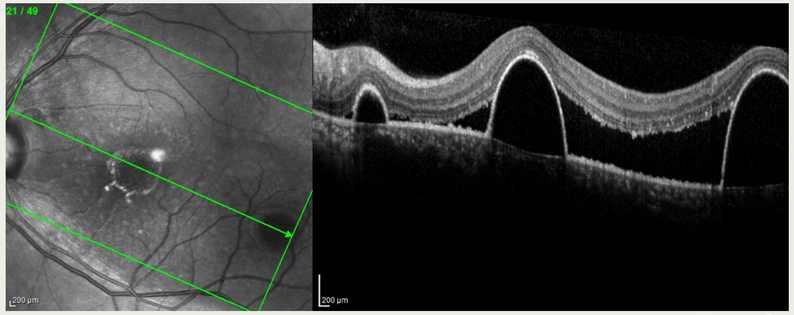

Figure 3

Optical coherence tomography (OCT) revealed multiple PEDs retinal detachment of the RPE, associated with a mechanical reason due the size of the PEDs and not because of subretinal fluid (Figure 3). The fluorescein angiography shows an early-phase hyperfluorescence by pooling that increase in intensity a long of the exam without expanding the size (Figura 4 - A,B). It was opted to adopt oral treatment with spironolactone 50 mg and follow-up of the patient with monthly VA and OCT. During patient returns, the patient reports improvement in visual acuity, evolving with 20/25 vision in the left eye with best corrected visual acuity.

DISCUSSION

CSC typically occurs in younger patients and is characterized by decreased and distorted vision, often associated with metamorphopsia, micropsia, mild dyschromatopsia and reduced contrast sensitivity.[4]

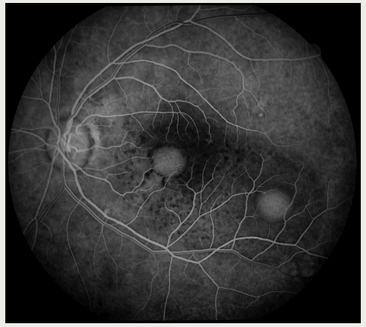

Figure 4 - A

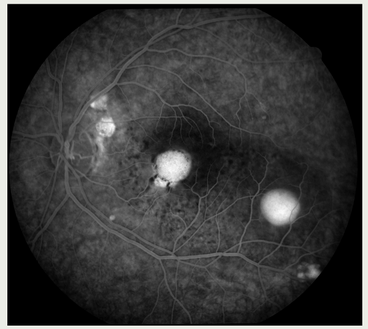

Figure 4 - B

Acute CSC is in most cases self-limiting with spontaneous resolution of the subretinal fluid (SRF) and therefore initially observation is recommended. If SRF is persisting over 3 months, initiation of therapy is recommended to avoid irreversible loss of visual acuity and RPE and/or photoreceptor atrophy. Although there are no evidence-based guidelines, treatment options based on case series consist of systemic carbonic anhydrase, mild laser photocoagulation, selective retina therapy, diode micropulse laser photocoagulation, half dose/half fluence photodynamic therapy , intravitreal injection of VEGF inhibitors and inhibitors of the mineralocorticoid receptor.[4]

We report a rare of CSC, characterized by large, multiple PEDs without SRF as presented in the AGF images, that shows the retinal detachment of the RPE, associated with a mechanical reason due the size of the PEDs and not because of subretinal fluid like in a typical case of CSC.

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