

had improved to 6/6. The visual field done at 6 weeks post incident showed a reduction in the central and paracentral scotoma.

Conclusion: Sildenafil can be associated with a transient deterioration of vision.

Keywords: *Central retinal vein occlusion, Cyanopsia, Sildenafil, Transient loss of vision*

References

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A Case of Atypical Central Serous Chorioretinopathy in Occult Pulmonary Tuberculosis at MDR-Lighthouse Medical Eye Centre Lokoja

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Background: Central serous chorioretinopathy (CSCR) is a common cause of acute or subacute unilateral central vision loss, characterized by serous neurosensory macula detachment due to increased permeability of the choroidal capillaries alongside retinal pigment epithelial dysfunction.^{1,2,3} Atypical CSCR cases are usually characterised by multiple or large serous macula detachments which do not resolve spontaneously unlike in typical CSCR, in addition to unusual Fundus Fluorescein Angiography (FFA) patterns.^{4,5,6,7}

Case Report: A 45-year-old African male, former cattle herder and currently security officer presented with a four-day history of sudden, painless and progressive loss of vision in the right eye, involving distant and near vision. He had a positive history of image distortion but there was

no glare, seeing of haloes around light, floaters, flashes of light, or curtain field defect. There was also no history of chronic use of steroids or sex enhancing drugs. He lost vision in the left eye three years prior to presentation following blunt ocular trauma and had been reliant on vision from the index eye for his daily activities. He did not use prescription spectacles and had not undergone any ocular surgery.

He had no long standing systemic disease except for systemic hypertension which was diagnosed two months prior to presentation and he was regular on his prescription anti-hypertensive medications. He had no history of chronic cough, fever, or night sweats.

Ocular examination revealed an unaided visual acuity in the right eye of 6/60 with no improvement with pinhole. The anterior segment was quiet and dilated funduscopy revealed multiple peripapillary and macular retinal detachments with subretinal serous exudation. Intraocular pressure (IOP) was 13mmHg. Amsler grid test revealed metamorphopsia. Fundus photograph, fluorescein angiography, and optical coherence tomography of the right eye at presentation are shown in Figures 1(a), 2(a & b), and 3(a) respectively.

Visual acuity in the left eye was light perception with poor projection. There was 360-degree posterior synechiae, intumescent opaque lens with no fundal view. IOP was 02 mmHg.

General and systemic examination were essentially normal. Investigations performed included Complete Blood Count which showed leukocytosis with lymphocytosis and retroviral screening which was non-reactive. In addition, VDRL test was negative and ocular ultrasound scan was normal in the right eye, with the left eye showing a cataract with total retinal detachment. Chest radiograph showed a wedge shaped right upper lobe lung consolidation with air bronchogram and Mantoux test was positive.

A diagnosis of right atypical central serous chorioretinopathy secondary to occult pulmonary tuberculosis was made. He was co-managed with pulmonologists and placed on anti-tuberculous medications: Rifampicin, Isoniazid, Pyrazinamide, Ethambutol, Streptomycin.^{6,8} Subthreshold micropulse macula laser was initially administered to the right eye at presentation with no improvement in symptoms and was repeated one week after commencing anti-tuberculous medications.

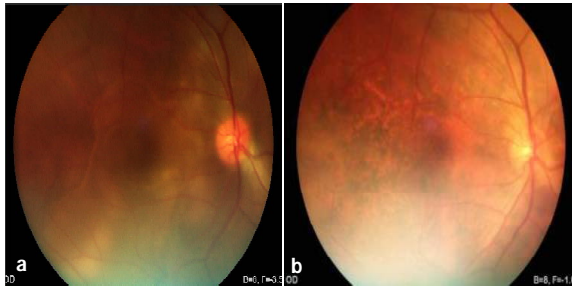


Figure 1: Fundus photography of right eye; (a) at presentation showing neurosensory detachment and subretinal fluid at the macula, superior and inferior peri-optic spaces (b) after three months of anti-TB medication showing a flat and attached retina at the posterior pole

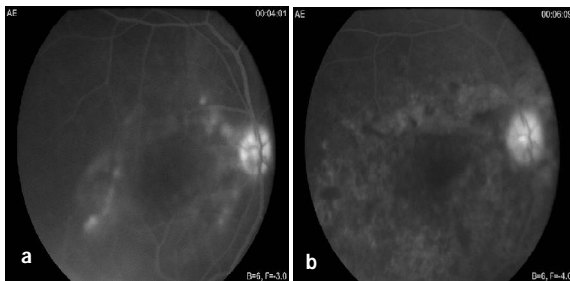


Figure 2 (a & b): Fundus fluorescein angiography of the right eye at presentation showing multiple hyperfluorescent leakage spots in the peripapillary area and at the macula

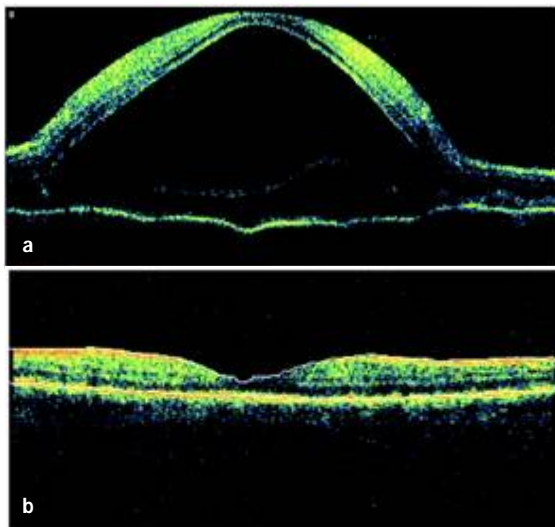


Figure 3: OCT of right eye (a) at presentation showing a large optically empty neurosensory detachment at the macula (b) after three months on anti-TB medication showing resolution of subretinal fluid and flat macula.

After three weeks on anti-TB medication, unaided visual acuity in the right eye improved to 6/36. Further improvement was noted over the next six weeks with unaided visual acuity in the right eye improving to 6/9, with pinhole vision maintained at 6/9 at three months. The fundus photograph and OCT pictures before and after treatment are as shown in Figures 1 and 3.

Conclusion: Atypical CSCR may not be as uncommon as previously thought.¹ It should be considered in any case of CSCR with an unusually bullous appearance and multifocal FFA leakage pattern. Detailed history, examination and appropriate investigations should be explored in patients presenting with these features and tuberculosis screening should be considered in such cases. A trial of Rifampicin in bizarre CSCR presentations may be beneficial.

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