

THE IMPORTANCE OF OPHTHALMIC SIGNS IN THE DIAGNOSIS OF SUPRASellar MENINGIOMA – A CASE REPORT

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ABSTRACT

A forty-two year old lady presented with gradual, painless, progressive blurring of vision of her left eye for four months. There were no other associated ocular or systemic complaints. Examination showed decreased visual acuity in both eyes and a pale optic disc on the left side. Visual field examination revealed a temporal field defect of the right eye which aroused the suspicion of an intracranial mass lesion. MRI of her brain revealed a suprasellar meningioma. We would like to emphasize the importance of visual field examination of both eyes in patients presenting with unilateral loss of vision.

Keywords: Unilateral visual loss, visual field defects, suprasellar meningioma, chiasmal lesion.

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INTRODUCTION

Loss of vision is a common ophthalmic complain. In cases of unilateral visual loss, binocular involvement is often not appreciated until the patient is examined.¹ Clinical clues such as relative afferent papillary defect (RAPD), asymmetrical cup-disc ratio (CDR), the colour of neuroretinal rim and the pattern of visual field defects are very helpful in localizing an intracranial lesion. This case report illustrates the importance of such clinical clues which guided the clinicians to the diagnosis of a suprasellar meningioma.

CASE REPORT

A 42 year old lady presented with four months' history of gradual loss of vision of her left eye. The loss of vision was slowly progressive and she described it as a generalized dimming of vision. Otherwise, there was no precipitating, aggravating or relieving factor. There was also no history of trauma, headache, ocular pain, eye redness or lacrimation. She reported vision of her right eye as normal. There were no neurological or endocrine symptoms. There were no significant past ophthalmic, medical, surgical and drug history.

On examination, her higher mental functions were normal. There were no neurological deficits. The visual acuity (VA) of her left eye was counting finger (CF) at 1 meter which was not

improved with pinhole. The refraction of her left eye was +1.0 DS / -0.5 DC x 075 with the best corrected visual acuity (BCVA) of CF. Her right eye's BCVA was 6/18. Confrontation visual field was not possible for her left eye due to poor VA, but she reported that the penlight at the temporal visual field appear dimmer than the nasal field. Confrontation visual field test of her right eye showed unsuspected visual field defects in the temporal hemifield and infero-nasal quadrant. The intraocular pressures (IOP) were 16 mm Hg (left eye) and 18 mm Hg (right eye). Pupils were 3 mm bilaterally and equally reactive to light. Relative afferent pupillary defect (RAPD) was positive for her left eye. Ocular motility was normal and there was no pain during eye movement.

Anterior segment of both eyes were normal. Fundus examination showed a pale optic disc on the left side compared to the right (Figure 1). There was asymmetry of the cup-disc ratio (CDR) in the vertical axis; the vertical CDR of her left eye was 0.4 while the vertical CDR of her right eye was 0.1. Otherwise, the disc margins were distinct bilaterally. Spontaneous venous pulsations were present bilaterally. The retinal fields and macula were normal bilaterally.

A computed perimetry was performed for her right eye with the Humphrey Field Analyzer (Figure 2). The differential light sensitivity (DLS) of her right fovea was 24 dB. The expected foveal sensitivity for her age was 33 dB. Thus the foveal sensitivity was markedly reduced. Total deviation print out