



A CASE REPORT OF SERPIGINOUS CHOROIDITIS TREATED WITH ORAL STEROIDS

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ABSTRACT A 28y/o male, came with complain of sudden painless blurring of vision in Right eye(RE) since 2 months. Anterior segment evaluation in BES was WNL. Posterior segment evaluation by indirect ophthalmoscopy, fundus photo and OCT revealed multiple well-defined lesions starting from disc and spreading towards periphery suggestive of Serpiginous Choroiditis. Patient was prescribed Oral Steroids with gradual tapering after ruling out TB exposure.

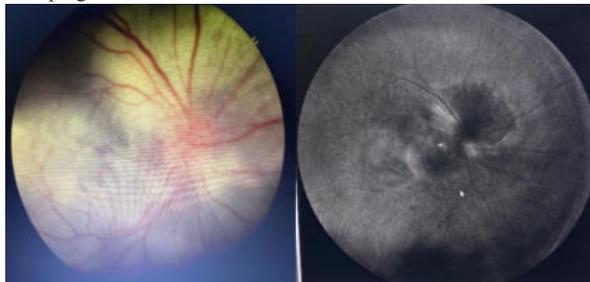
KEYWORDS : Serpiginous Choroiditis, Oral Steroids

INTRODUCTION

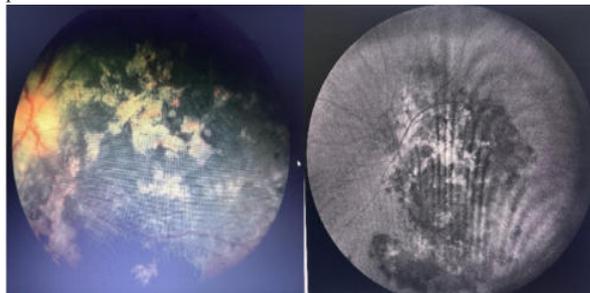
This is a case report of a young male patient who presented with gradual painless Diminution of vision in Right eye since 2 months and was diagnosed as Serpiginous Choroiditis after Ophthalmological investigations like Indirect Ophthalmoscopic examination, OCT, Fundus Autofluorescence and other Laboratory investigations like Routine blood work up and TB workup. Such cases can be managed well conservatively with Oral corticosteroids alone.

Case Study

A 28y/o male, came with complain of gradual painless blurring of vision in Right eye (RE) since 2 months. On examination, vision in RE was PL+ PR in all quadrants and LE was Counting fingers at 2m. Autorefractometer reading was as follows: RE -0.25DS and LE 0.00. Anterior segment evaluation in Both eyes was WNL. Posterior segment evaluation of Right eye by indirect ophthalmoscopy, fundus photo and OCT revealed Multiple, well defined yellowish grey Chorioretinal lesions with fuzzy borders arranged in Snake like (Serpiginous) fashion, starting from Optic disc and extending towards macula, along with Optic disc edema. Left eye fundus showed Multiple greyish-white, diffuse, depigmented patches with sharp margins seen radiating from optic disc to periphery with pigment clumping at the borders.



Following is the Fundus Photo and FAF picture of Right eye at presentation:



Left Eye Fundus Photo and FAF picture at presentation:

Patient underwent all routine blood investigations which showed Raised ESR and WBCs. Montaux test and Quantiferon Gold test was negative, thus ruling out past or present Tuberculosis infection. Chest Xray and HRCT chest was WNL. Patient was started on Tablet Prednisolone 1mg/kg/day with weekly tapering.

DISCUSSION

Serpiginous choroidopathy (SC) is a rare, bilateral, chronic, progressive, recurrent inflammatory disease of the retinal pigment epithelium (RPE), choriocapillaris, and choroid of unknown etiology. Its origin is probably immunogenic since it responds to treatment with corticosteroids and other immunosuppressants. There is a likely association between SC and infectious etiologies such as *Mycobacterium tuberculosis* and herpes viruses.

SC presents with gray-yellowish subretinal infiltrates that usually spread centrifugally from the peripapillary region in a serpiginous (snake-like) manner. Active lesions show a leading edge and resolve with subsequent RPE and choriocapillary atrophy. Consecutive recurrences cause further atrophy leaving hypo- and hyper-pigmented lesions that spread irregularly over the posterior fundus. Systemic or periocular corticosteroids are frequently used, but recurrence prevention usually requires long term anti-inflammatory treatment with a steroid-sparing agent, such as antimetabolites (methotrexate, mycophenolate mofetil, or azathioprine), Cyclosporine A, or anti-TNF agents, such as adalimumab or infliximab, once tuberculosis has been ruled out.

CONCLUSION

Serpiginous Choroiditis is primarily an inflammatory disease of the Retina and Choroid which is diagnosed primarily by clinical examination and fundus imaging, supported by blood investigations. Mainstay of treatment remains Corticosteroids, after ruling out TB, which aims to stop chorioretinal inflammation especially when the advancing lesions threaten the fovea.

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