Case report of simultaneous bilateral optic neuritis

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ABSTRACT

A 28-year-old woman with underlying Hb E beta-thalassemia, presented with sudden onset both eyes (BE) blurring of vision. She also had BE pain on movement for the past 3 days. She has no history of prior optic neuritis. Systemic review was negative. Upon examination, BE vision was counting finger at 1 foot, relative afferent pupillary defect (RAPD) negative, with reduced light and red saturation, and failed colour vision test for BE. The anterior segment was unremarkable. BE fundus shows hyperaemic optic disc with blurred disc margin, no macula star, no vitritis, retinitis or choroiditis. The neurological examination was unremarkable. Magnetic resonance imaging of brain and orbit shows retrobulbar intra-orbital segment of bilateral optic nerve thickened (right>left) and enlarged. There is also streakiness, thickening and irregularities of the optic sheath. The impression is bilateral optic neuritis and optic nerve perineuritis, no evidence of demyelinating brain lesion. She was treated with a course of intravenous methylprednisolone 250 mg QID for 3 days. Post treatment, right eye (RE) vision improved to 6/36 (PH 6/24) while left eye (LE) 6/24 (PH 6/12). There was no more eye pain. RAPD negative, with improvement in red and light saturation BE. BE fundus noted reduction in optic disc swelling. She was discharged with a course of oral prednisolone for 10 days. Her vision further improved the following week, RE vision 6/24 (PH 6/9), LE vision 6/12 PH 6/9, with reduction in optic disc swelling. Cerebrospinal fluid (CSF) electrophoresis showed oligoclonal band. CSF aquaporin-4 antibody was negative. Simultaneous bilateral optic neuritis is considered rare in adult and with a course of corticosteroid therapy, vision may improved. RAPD may be negative in bilateral optic neuritis, therefore a proper optic disc evaluation is important.