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EDUCATION

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Ciliary body metastasis masquerading as scleritis

Clinical presentation

A 54-year-old Caucasian male presented to the Cole Eye Institute for a second opinion regarding a diagnosis of iritis. He described 4 months of ongoing redness, pain and photophobia in the right eye. Initially, he was treated with topical prednisolone acetate 1% without improvement. Subsequently, homatropine 5% and combined neomycin, polymyxin B and dexamethasone drops were prescribed without any relief. For a month prior to presentation, he had been off all medications and his symptoms had gradually worsened.

He denied any past ocular history of trauma, surgery or inflammatory disease. His past medical history was significant for a left testicular teratocarcinoma in 1987. At that time, he underwent orchiectomy and chemotherapy for suspicion of pulmonary metastases. However, subsequent wedge resection of the lung confirmed the lesions to be hamartomas. His social history was significant for smoking (1.5 pack per day for the past 30 years) and the review of systems was negative.

On examination, visual acuity was 20/20 in the right eye and 20/25 in the left eye. Intraocular pressures were 32 mm Hg in the right eye and 16 mm Hg in the left eye. Deep episcleral injection was observed inferotemporally in the right eye and a few cells were present in the anterior chamber. The iris and lens were normal. Dilated fundus examination of both eyes was normal. In addition, an ultrasound B scan was normal. Previously performed investigations were negative and included chest x ray, PPD, ACE level, RPR, FTA-ABS, Lyme antibody, ANA and HLA-B27.

A diagnosis of idiopathic anterior scleritis of the right eye was made. Fluorometholone 0.25% topical drops hourly in the right eye and oral indomethacin 25 mg three times a day were prescribed. Additional workup including antineutrophilic cytoplasmic antibodies, complete blood count, complete metabolic panel and chest CT with contrast were ordered.

Two weeks later, the patient returned for follow-up stating that his symptoms had improved. However, on examination, the deep episcleral injection was still present. In addition, the iris was displaced anteriorly at the 7–8 o'clock position. Yellow gelatinous deposits were observed in the corresponding quadrant in the anterior chamber angle (fig 1A). Ultrasound biomicroscopy was performed to evaluate the angle and ciliary body region (fig 1B). Transcorneal fine needle aspiration biopsy was confirmatory (fig 2).

Questions

- (1) Describe the ultrasound biomicroscopic findings (fig 1B)
- (2) What is the diagnosis based on fine needle aspiration biopsy (fig 2)?
- (3) How would you manage this patient?

Figure 1 (A) Anterior segment photograph showing scleral injection in the inferotemporal quadrant. Note yellow gelatinous deposits in the corresponding anterior chamber angle region. (B) Ultrasound biomicroscopy was performed to evaluate the angle and ciliary body region.

Figure 2 (A) Fine needle aspiration biopsy. (B) Histopathology of the enucleated globe.

See page 1649 for answer

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