CORRESPONDENCE

The Diagnosis and Treatment of Optic Neuritis

by Prof. Dr. med. Wilhelm and Prof. Dr. med. Schabet in issue 37/2015

Important: Asking Patients About Lead Symptoms

Optic neuritis is a textbook case for coordination between a vigilant primary care doctor and a critical ophthalmologist. The more time has passed since a practicing physician completed his/her original medical training, the more it will be the case that the only thing that remains in their minds about the symptoms of optic neuritis in non-eye-related disciplines is the mnemonic: "The patient can't see anything, and neither can the ophthalmologist." This mnemonic exaggerates and distorts the distinctive complex of symptoms consisting of pain on visual movements, the need for unfamiliar lighting for precision work/reading, and reduced perception of color. During the medical training of students, the swinging flashlight test to elicit a patient's pupillary reaction is embedded in association with optic neuritis.

In more than 20 000 consecutive cases in my medical practice I have not observed a single case of acute optic neuritis in primary care. By contrast, on taking over the continuation of previously initiated treatment in 30 000 (20 000 patients with a mandate for diagnostic evaluation, and, over time, 10 000 patients added in with a mandate for treatment), I have treated optic neuritis by continuing parenteral steroid treatment. This provided opportunities to ask for the lead symptoms.

I find these clinical questions reflected in the CME article (1). The question on how to assess the success of training has an easy answer. Reading the complete article requires more time than a cross-section of the CME article: the eye and its appendages (2) provide access to the person and to their likely pathology. Screening examinations of cohorts provide welcome training for doctors in many disciplines (3) and lay the foundations for clinical practice. DOI: 10.3238/arztebl.2016.0136a

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Conflict of interest statement

The author declares that no conflict of interest exists.

Additional New Therapeutic Options

This review article also mentions one of the potential, but rare, differential diagnoses of optic neuritis—Leber's hereditary optic neuropathy (LHON) (1). LHON results in most cases—with very few exceptions—in pronounced and mostly irreversible loss of vision. This rare pathology has a prevalence of 1–9/100 000. To date, no essential therapeutic intervention for this rare mitochondrial disorder is available.

On 9 September 2015, two days before this article was published, the substance idebenone was licensed by the EMA for use within the EU in the context of an orphan drug designation for the treatment of visual impairment in adolescents and adults with LHON. Approval was granted on the basis of data from the RHODOS phase III study (2). The treatment was administered orally for 24 weeks. Even though the primary endpoint was not met in this study, the secondary endpoints showed an improvement in the vision defect compared with untreated patients with LHON. For this reason, it seems to make even more sense to bear in mind LHON as a rare differential diagnosis of optic neuritis. A reliable diagnosis can be made on the basis of confirming the typical mitochondrial DNA mutations, and treatment with idebenone may be considered accordingly. DOI: 10.3238/arztebl.2016.0136b

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Conflict of interest statement

Dr Müller-York is employed by Santhera, the manufacturer of the preparation idebenone.

In Reply:

We thank Dr Wedig for his positive comments (1). The swinging flashlight test is extremely important and helps avoid drastic misdiagnoses. Leber's hereditary optic neuropathy (LHON) is fortunately rare, but it is indeed an important differential diagnosis. LHON is almost always confused with optic neuritis, as long as only one eye is affected and no other cases have been diagnosed in the same family. It requires a certain amount of experience to identify the typical peripapillary changes. The fact that some cases of LHON are accompanied by similar foci of demyelination as is multiple sclerosis makes things even more difficult. We also recommend treatment with idebenone. A problem of the study cited by Dr Müller-York is the fact that recruitment was possible even 5 years after disease onset. Under these circumstances it is amazing that a positive result was achieved at all. A practical problem might lie in the fact that time passes until a genetic diagnosis is made, because it seems sensible to start treatment as early on as possible. The high costs of the treatment should be borne in mind. DOI: 10.3238/arztebl.2016.0136c

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