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Case Report

Progressive severe bilateral loss of vision in a relatively young patient: Think beyond malingering

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A 46-year-old patient was transferred to this centre with complaints of painless, gradually progressive blurring of vision in both eyes for the past 6 weeks. He had reported to a peripheral hospital where his best corrected visual acuity was recorded as 6/60 (right eye) and 6/36 (left eye). There was no history of ocular redness, discharge, diplopia, injury or any major systemic illness like hypertension or diabetes. Ocular and systemic examinations were all within normal limits (WNL). The patient had been counselled and treated with some placebo eye drops. However, when the patient claimed that his vision had further deteriorated, he was transferred to this centre as a case of suspected malingering. On presentation, the patient gave a history of repeated falls leading to multiple superficial minor injuries as he was unable to see while negotiating his way through the real world. Ocular examination on presentation revealed his VA as 4/60 (right) and 1/60 (left), with no refractive error. His near vision was N-36 in both eyes, improving to N-18 with +2 dioptre spherical lenses in both eyes. Ocular movements were painless, full and free. Pupils were 3 mm in size bilaterally; however, on carrying out the swinging flashlight test in a dark room, there was definite evidence of relative afferent papillary defect (RAPD) in the right eye. A detailed slit lamp anterior segment examination did not reveal any pathology. Ishihara colour vision test was carried out in good daylight and with the near correction in place, and found to be normal. Intra-ocular pressure was a normal 14 mm

Introduction

Progressive painless bilateral loss of vision in a relatively young patient with no other ocular or systemic complaints is usually a diagnostic dilemma specially when there are no other obvious positive signs evident. More often than not, such patients are erroneously labelled as malingerers, especially when they are initially examined by young relatively inexperienced medical officers in the periphery. Here, we present one such case that was transferred as a malingerer suspect, to our centre and who on evaluation was in fact detected to have a life threatening pathology.

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Fig. 1 – (a and b) Fundus photographs of the eyes revealing a mild pallor in both the optic discs.

of Hg both eyes as measured with a non-contact tonometer. A detailed visual field testing using a Humphrey Field Analyzer was not possible due to the patient's poor vision; however, testing by the confrontation method revealed field defects in the temporal hemifield and supero-nasal quadrant in the right and temporal hemifield defect in the left. Dilated fundus examination too was normal in all respects except for a mild pallor in both the optic discs and the veins being obviously congested (Fig. 1a and b). A detailed systemic including a neurological evaluation was all WNL. The patient was further investigated with a magnetic resonance imaging (MRI) of the brain and orbits followed by a visual evoked potential (VEP). The MRI revealed a well-defined smoothly margined extra axial mass in the suprasellar region measuring 2.3 mm × 3.2 mm × 3.3 mm (CC × TR × TP). This mass was extending inferiorly into the sella and abutting the pituitary gland and superiorly it was indenting upon the floor of the anterior third ventricle. The optic chiasma too appeared to be compressed by this mass (Fig. 2a and b). While the VEP showed mild demyelinating type of bilateral (left > right) optic pathway dysfunction (Fig. 3). A diagnosis of a suprasellar mass, most likely meningioma, was made and an urgent neurosurgical consultation sought. The patient underwent a frontal craniotomy with tumour excision within the next 48 h. The histopathological report of the excised mass too confirmed

Fig. 2 – (a and b) Contrast enhanced MRI brain orbits coronal and sagittal sections revealing a well defined smoothly margined extra axial mass in the suprasellar region measuring 2.3 mm × 3.2 mm × 3.3 mm.

the diagnosis and was reported as classical meningioma (transitional/syncytial). WHO classification was Grade 1. Postoperative period was uneventful. Visual evaluation 1 week post-surgery revealed a remarkable improvement in the patient's vision (right 6/6 and left 6/36). The patient was sent on 4 weeks sick leave. Visual evaluation after 4 weeks post-surgery was a normal 6/6 in the right eye and 6/12(P) in the left. The visual fields too were evaluated and revealed a superior hemi field defect in the left eye and a superiotemporal quadrant field defect in the right eye (Fig. 4a and b). The patient is now on a regular follow-up on an OPD basis.

Discussion

The intentional fabrication of mental or physical symptoms by anyone who has an ulterior motive (e.g. avoiding military duty,

Fig. 3 – Visual evoked potential showing a mild demyelinating type of bilateral optic pathway dysfunction (left > right).

Fig. 4 – (a) 1-Month postoperative visual field analysis of the patient (left eye) showing superior hemi field defects. (b) 1-Month postoperative visual field analysis of the patient (right eye) showing superior temporal field defects.

Fig. 4. (Continued).

or even his daily routine work, or for obtaining some financial compensation) is regarded as malingering.¹ The actual incidence of malingering is extremely difficult to determine as most of the cases are not reported.² It has been reported that around 10–30% of outpatient population in neurology clinics have no organic pathology, while 5–12% of patients presenting with visual loss to a neuro-ophthalmologist are finally diagnosed as functional.³ Other studies too have shown that up to 1–7% of all patients attending the eye outpatient

departments are malingerers.^{4,5} An interesting study on the incidence of malingering among military personnel in Israel estimated that nearly 25% of the soldiers reporting sick were indeed malingerers.⁶

All these figures notwithstanding, it is most essential to rule out all possible organic causes by a thorough clinical examination and using all the necessary investigative procedures. In our case, the patient presented with visual loss, which also happens to be the most common ophthalmic

symptom in malingerers.² Evaluation revealed a visual field defect grossly as well as bilateral optic disc pallor, which prompted us to investigate him further with a MRI and a VEP which confirmed the diagnosis of an underlying pathology.

Suprasellar tumours can present with ophthalmic manifestations, visual loss (commonest), eye pain, diplopia and ptosis.⁷ Meningiomas constitute around 30% of all primary intracranial tumours and are the commonest benign intracranial tumours in adults.⁸

Suprasellar meningioma commonly arises from the tuberculum sellae or the sulcus chiasmatis and usually present with visual disturbances as it involves the visual apparatus early due to its close location with it. Compression of the chiasm results in bitemporal field defects, while prechiasmal involvement affects the vision, usually one eye being affected more seriously than the other.^{8,9}

The definitive treatment of meningioma is surgery. Incompletely resected, recurrent or malignant meningiomas require radiotherapy.^{8,10}

Conclusion

Decreased visual acuity and/or visual field defects are usually due to either an ocular pathology or the ocular manifestation of a systemic pathology. Rarely, it might be due to a nonpathologic cause or a structural abnormality and termed as functional or malingering. Functional vision loss is a diagnosis of exclusion and all possible organic causes of visual loss must be ruled out before reaching its diagnosis. This includes a complete systemic examination including recording the patient's medical history and lifestyle, a detailed ophthalmological evaluation, the necessary neuroimaging tests and also requires a psychiatric consultation.¹¹

This case also serves to highlight the fact that even in the absence of sophisticated equipment, simple clinical tests, like the confrontation test and the detection of RAPD by a simple torch light examination can give a reasonable indication about a serious underlying pathology.

Suprasellar meningiomas usually cause visual disturbances early and hence it becomes that much more important to recognise these symptoms and diagnose it in time. Once correctly diagnosed, aggressive management in the form of

surgery and/or radiotherapy goes a long way in preserving the remaining vision and it may sometimes even show a significant improvement⁸ as was seen in our case. However, relapse is a known complication and so all such cases require a long-term follow-up.

Conflicts of interest

The authors have none to declare.

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