ACUTE RETINAL PIGMENT EPITHELIITIS: A CASE REPORT

EPITELITIS RETINIANA AGUDA. A PROPÓSITO DE UN CASO

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ABSTRACT

Clinical case: We report the case of a 45-year-old male who attended our emergency service with loss of vision in his left eye after an attack of influenza. The vision in his left eye was slightly inferior to that in the right eye. Ophthalmoscopy showed small orange lesions in the macular and foveolar area. Fluorescein angiography was carried out producing features like an acute retinal epitheliitis.

Discussion: Acute retinal epitheliitis is a clinical picture seen in younger patients often following a viral illness. Spontaneous resolution usually occurs (Arch Soc Esp Oftalmol 2007; 82: 451-454).

Key words: Acute retinal pigment epitheliitis, fluorescein angiography, visual acuity, epithelial pigment.

INTRODUCTION

Acute retinal epitheliitis (ARE), also known as Krill disease, is a disease of unknown etiology, described by Krill and Deutman in 1972 (1). It affects the pigment epithelium of the foveolar retina and predominantly presents in young, healthy adults (2). It usually resolves itself spontaneously in a few months, affects both males and females similarly, and may be either unilateral or bilateral (3-5). In certain cases it is associated with viral conditions prior to the onset of the first
symptoms (1). Ophthalmoscopy showed yellow lesions located at the pigment epithelium level of the retina, surrounded by a yellow 300 to 500 micron diameter halo. They are usually found in the posterior pole, in the foveolar area. Fluorescein angiography (FAG) shows lesions with a hypofluorescent center surrounded by a hyperfluorescent halo similar to a honeycomb (1). The symptoms usually resolve between six and twelve weeks, although recurrences sometimes occur (1,3). The electrophysiological tests usually indicate an altered electroculogram (EOG) in the acute phase that normalizes itself once the symptoms are resolved (3-5). It normally resolves itself spontaneously without treatment, but one of the treatments described, among others, is the use of non-steroidal anti-inflammatory drugs (NSAIDs), although the usefulness of this therapy is still unknown (2).

**CASE STUDY**

A 45-year-old male arrived at the emergency room because of an abrupt decrease in vision in his left eye. An important factor was that the patient had recently had the flu a few days earlier. A complete eye exam was done that determined visual acuity = 1.0 in the right eye, which fell within normal exam parameters, including the funduscopic exam (figure 1). Examination of the left eye, however, showed a visual acuity of 0.800 and lesions were seen in the macular and central foveolar areas that were orange and round (figure 2). Given the patient’s history and that fact that he had recently had the flu, treatment with NSAIDs (ibuprofen 600 mg every 12 hours) was started and FAG and EOG tests were ordered.

The EOG showed a slight alteration in the left eye, compatible with the normal limits of the right eye. The FAG in the right eye was within normal limits, but in the left eye hyperfluorescent areas with pinpoint hypofluorescence can be seen, and with no diffusion in the late phase (figures 3a and 3b).

Additional tests confirmed the suspicion of ARE and since it resolves itself spontaneously, treatment with NSAIDs was suspended.

The patient progressed favorably, recovering his sight to 1.0 in his left eye between the third and fourth week from the onset of the symptoms.

**DISCUSSION**

ARE is an infrequent disorder of unknown etiology, but usually associated with a viral process, which may mean that it is a sub-acute secondary response of the sensorineural retina to that very same viral process (2). Prognosis is good, which is why treatment is usually not given (2-5). In this case, while awaiting confirmation of the diagnosis, we ordered an empirical treatment because we considered it would be dangerous for our patient and this therapy
would decrease the feeling of powerlessness that the patient felt. Our patient had unilateral symptoms; bilateral cases are not seen frequently.

Differential diagnosis should be done, above all, in cases of isolated drusen in the posterior pole; acute multifocal placid epitheliopathy; and, albeit less likely to be confused with the macular hole, diabetic microaneurisms from diabetic retinopathy; fundus flavimaculatus and internal pinpoint choroidopathy (4).

We may conclude that, even though ARE is not frequent, it may not be so infrequent since, as it presents a benign clinical course and spontaneously resolves in a short period of time, ophthalmologists may not be diagnosing it correctly.

The role of NSAIDs is not clear and, even though they had been suspended, the improvement in symptoms continued just as in other cases where NSAIDs were used until symptoms were no longer observed (2). They may speed up the healing of the eye condition, perhaps by tackling the underlying process.

REFERENCES