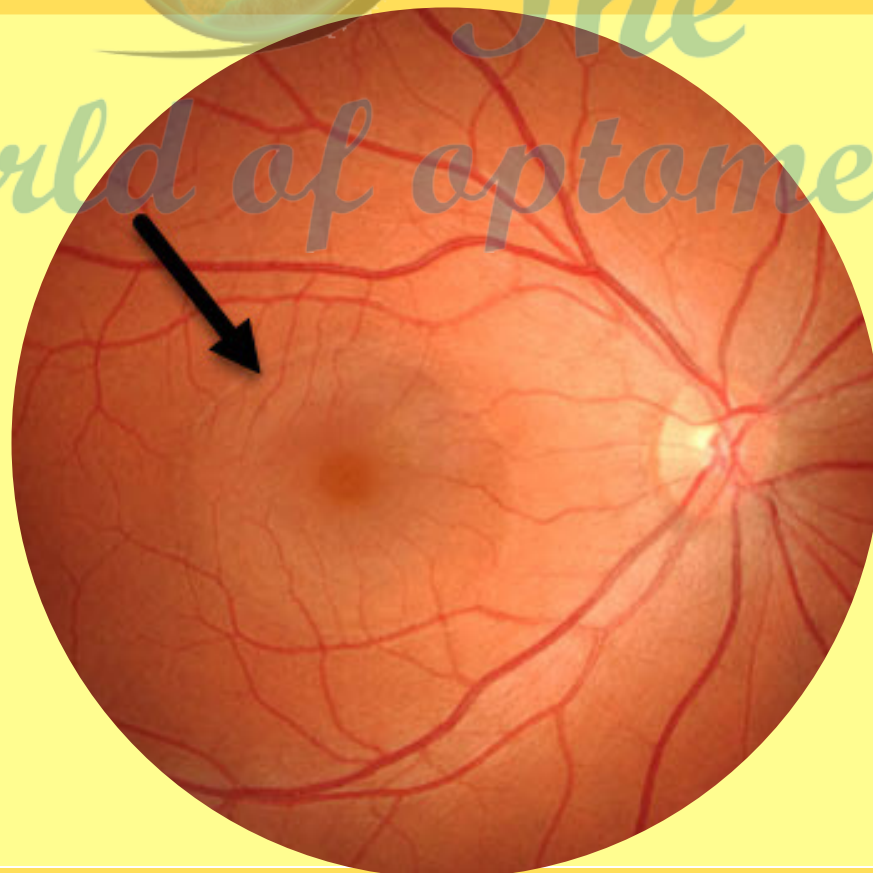




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Twop Case Study

Central Serous Chorioretinopathy (CSCR)



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Patient History

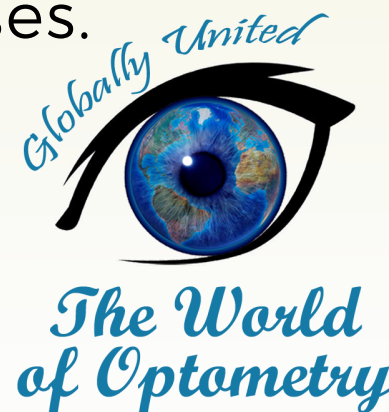


CHIEF COMPLAINTS: 32 years old, Male, LE progressive DOV for both distance & near since 1 month

OCULAR HISTORY: None

PAST MEDICAL HISTORY: smoking cigerrate, drinking alcohol since many years

FAMILY HISTORY: Not known hx of ocular diseases.



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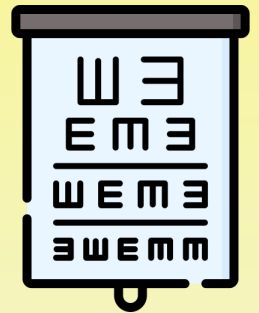
Ocular Examination

Visual Acuity (UNAIDED)

- OD 20/20
- OS 20/200

IOP (GOLDMANN)

- 16mmHg
- 14mmHg



Pupils: ----RRR----

EOM: ----FULL----

PCT (UNAIDED)

6M: ORTHO

1/3M: ORTHO



Fundus Evaluation

OD: CDR 0.3, flat macula with normal foveal light reflexes, normal vessels.

OS: Clear view, CDR 0.3, serous retinal detachment, at the macula.

Slit Lamp Findings

- Lids/Lashes: Clear OU
- Conjunctiva: NAD OU
- Cornea: Clear OU
- Anterior Chamber: D&Q OU
- Iris: Brown, NAD
- Lens: Clear OU

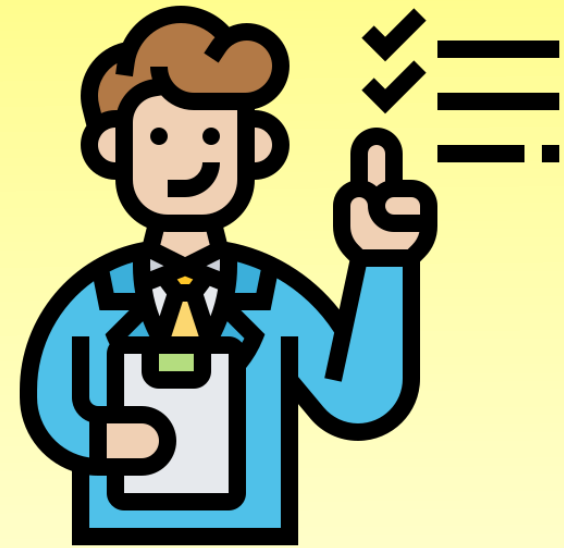


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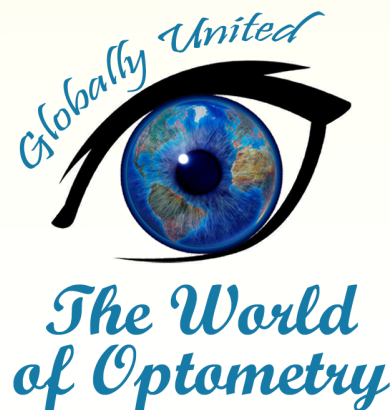


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Diagnosis



OS: Central Serous
Chorioretinopathy (CSCR)



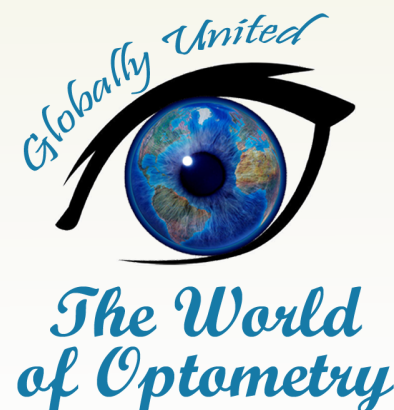
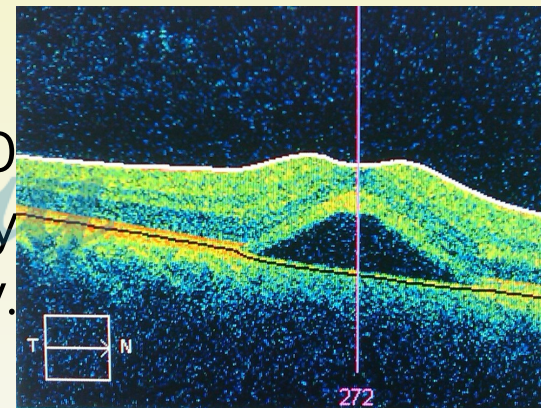
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Discussion

What is CSCR? Is a condition in which fluid accumulates under the retina, causing a serous (fluid-filled) detachment and vision loss. CSCR most often occurs in young and middle-aged adults. For unknown reasons, men develop this condition more commonly than women. Vision loss is usually temporary but sometimes can become chronic or recur.

Etiology:

- Idiopathic: Usually occurs in men aged 25 to 50 years. In women, CSCR typically occurs at a slightly older age and has an association with pregnancy. Increased incidence in patients with lupus.
- Increased endogenous cortisol: This helps explain a possible association with psychological or physiologic stress (type A personality). Rare cases exist with cortisol producing adrenal adenomas.
- Exogenous cortisol: Corticosteroid use, including nasal corticosteroid sprays and topical creams..

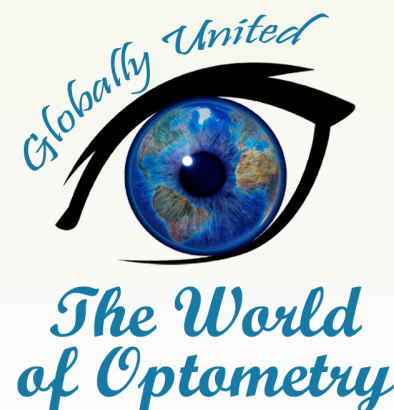
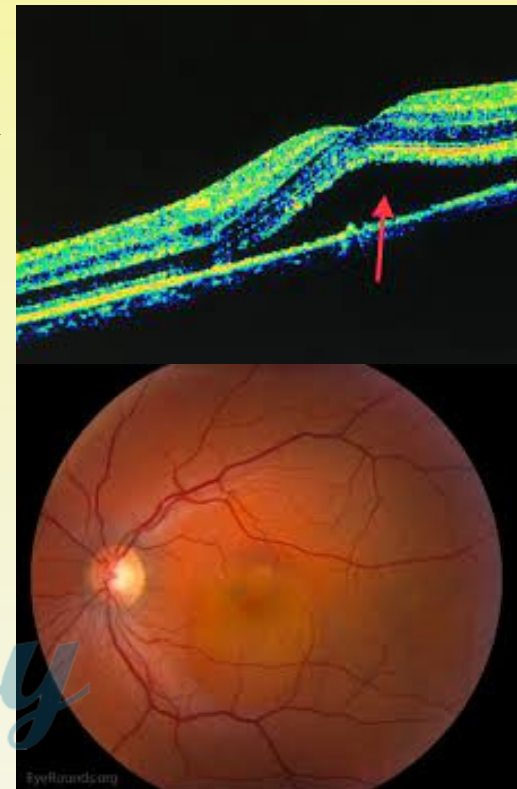


Discussion

Symptoms: Central scotoma, blurred or dim vision, objects appear distorted (metamorphopsia) and miniaturized (micropsia), colors appear washed out. Usually unilateral but 30% to 40% have evidence of bilateral disease (although may not be symptomatic at the same time). May be asymptomatic. Migraine-like headache may precede or accompany visual changes.

Signs:

- **Critical.** Localized serous detachment of the neurosensory retina in the region of the macula without subretinal blood or lipid exudates. The margins of the detachment are sloping and merge gradually into the attached retina.
- **Other.** Visual acuity usually ranges from 20/20 to 20/80. Amsler grid testing reveals relative scotoma and distortion of straight lines. May have a small RAPD, a serous RPE detachment, deposition of subretinal brin. Focal pigment epithelial irregularity may indicate sites of previous episodes.



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Differential Diagnosis

These entities may produce a serous detachment of the neurosensory retina in the macular area.

- **ARMD**: Patient usually ≥ 50 years old, drusen, pigment epithelial alterations, may have choroidal (sub retinal) neovascularization, often bilateral.

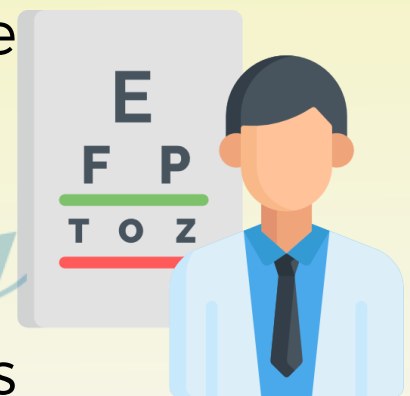
- **Macular detachment** as a result of an RRD or macular hole: In RRD, a hole in the retina can be found.

- **Choroidal tumor**

- **Hypertension**

- **Pigment epithelial detachment (PED)**: The margins of a PED are more distinct than those of CSCR, and the RPE is elevated. Occasionally, PED may accompany CSCR or ARMD.

• **Others**: Idiopathic choroidal effusion, inflammatory choroidal disorders, and chronic renal failure.



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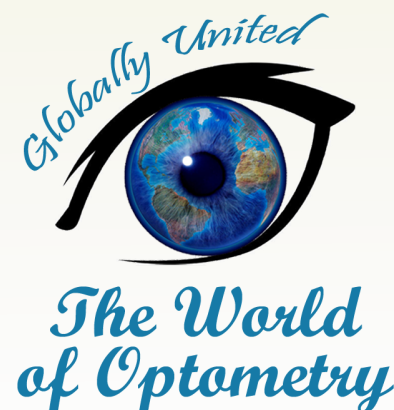
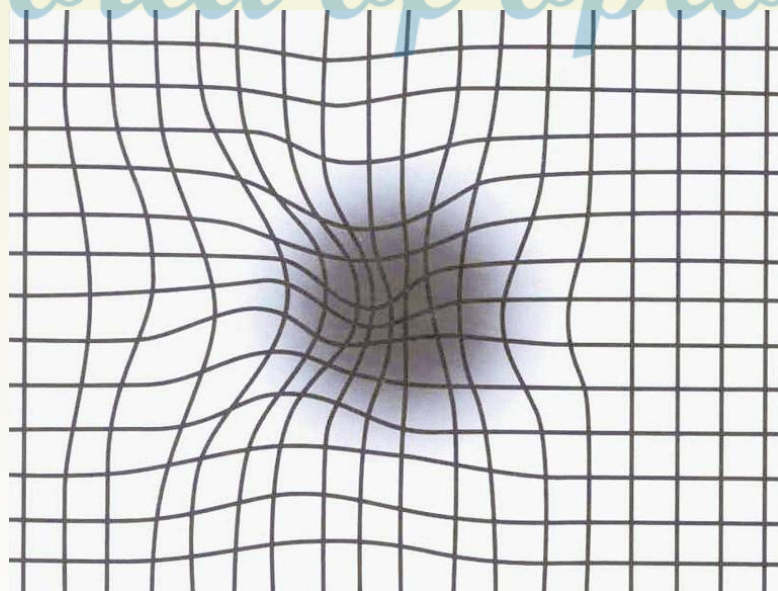


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#TwoCaseStudy Differential Diagnosis

Work-Up

1. Amsler grid test to document the area of field involved.
2. Slit lamp examination of the macula with a fundus contact, Hruby, or 60- or 90-diopter lens to rule out a concomitant CNV. In addition, search for an optic pit of the disc.
3. Dilated fundus examination with indirect ophthalmoscopy to rule out a choroidal tumor or RRD.
4. In cases of chronic CSCR, a systemic work-up including cortisol levels and renal function should be considered



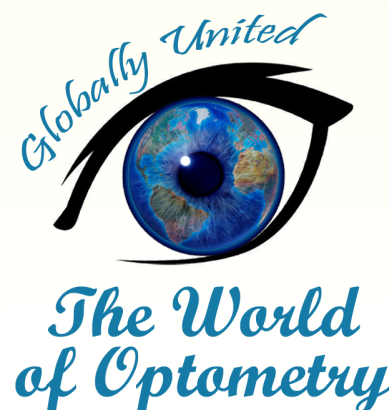
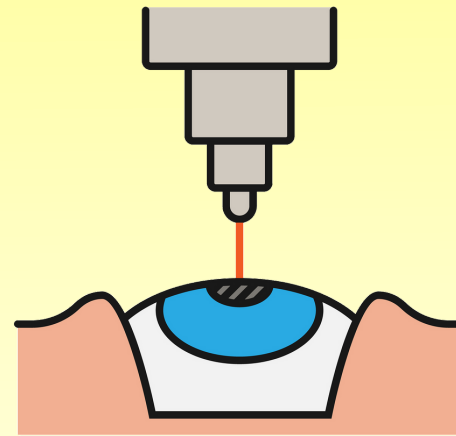
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Management & Treatment

1. Observation: Prognosis for spontaneous recovery of visual acuity to at least 20/30 is excellent. Worse prognosis for patients with recurrent disease, multiple areas of detachment, or prolonged course.

2. Laser therapy: Accelerates visual recovery. Does not improve final visual outcome. May increase risk of CNV formation. Given the CNV risk, use low laser intensity. Consider laser for:

- Persistence of a serous detachment for several months.
- Recurrence of the condition in an eye that sustained a permanent visual deficit from a previous episode.



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Management & Treatment

Occurrence in the contralateral eye after a permanent visual deficit resulted from a previous episode.

- Patient requires prompt restoration of vision (e.g., occupational necessity).

3. Stop steroids, if possible, including topical skin preparations and nasal sprays.

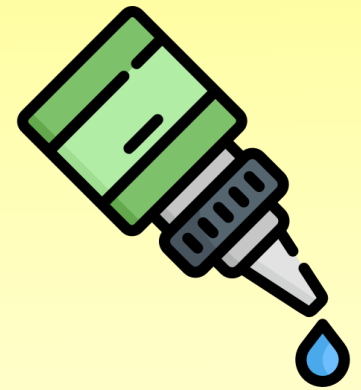
4. If CNV develops, consider anti-VEGF therapy.

5. Chronic CSCR may respond to treatment with photodynamic therapy (PDT).

6. In small, uncontrolled observational case series, treatment with mineralocorticoid receptor antagonists (e.g., eplerenone) have been associated with improved anatomic and visual outcomes in chronic CSCR.

Follow-Up

1. Examine patients every 6 to 8 weeks until resolution.



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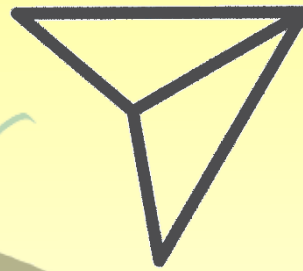
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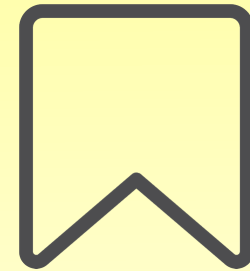
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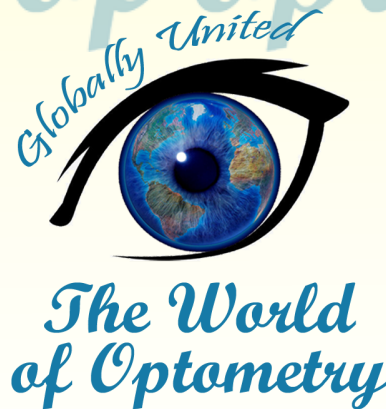


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