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Case Report

Solar Maculopathy

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Chief Complaints

A 30 year old patient resident of Ganj Basoda Vidisha, housewife by occupation presented with chief complaints of diminution of vision in right eye since 11 yrs & in left eye since 1 yr.

History of Presenting Complaints

- Patient was apparently alright 11 yrs back then she started diminution of vision in RE eye which was gradual in onset, painless & progressive in nature. It was associated with floaters, micropsia, metamorphopsia, flashes of light & frontotemporal headache with sudden deterioration of vision in last 6 months.
- She had complained of diminution of vision in LE since one year which was gradual in onset, painless and progressive in nature & was associated with floaters, metamophosia and headache.
- No history of ocular trauma and ocular surgery.
- No history of redness &watering.
- No specific field defects.
- No history of spectacle use.

Past History

• No H/O HTN, TB, Asthma, DM

- H/o breast carcinoma for which sx done 1 yr back
- H/o watching solar eclipse 11 yr back.

Personal History

Sleep, Appetite– Normal, Diet–vegetarian, Bowel and bladder habits – Normal, No history of any addiction

Family History

No similar history in family.

Drug History

- Patient took? ocular injection in 3 doses with 1 month interval.
- She was taking treatment for breast carcinoma since 1.5 yrs.

General Examination

- Average built.
- Conscious, oriented to time, place, person.
- Afebrile
- Pulse-85/min, BP-130/90 mmhg, RR-16/min
- No pallor, icterus, cyanosis, clubbing & lymphadenopathy.
- Respiratory system-wnl.
- CVS-wnl.
- Per abdomen-wnl.

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• CNS-no neurological deficient.

Ocular Examination of RE

VISION	Counting finger 1 ft PR accurate
RETINOSCOPY	+2.25 +2.75 no improvement with glasses
POSITION OF HEAD	Normal
POSITION OF EYE BALL	Central
OCULAR MOVEMENTS	present in all cardinal gazes
LIDS	Normal
LACRIMAL PASSAGE	ROPLAS -ve
CONJUNCTIVA	Normal
CORNEA	Clear
SCLERA	Normal
ANTERIOR CHAMBER	Normal in depth
IRIS	ICPN
PUPIL	PCCRTL
LENS REFLEX	GREY WHITE
DIGITAL TENSION	Normal NCT: 16.00 mmHg

Ocular Examination of LE

VISION	6/12with pinhole 6/9
RETINOSCOPY	+2.25 +2.75 BCVA: +0.50 DS- 6/9
POSITION OF HEAD	Normal
POSITION OF EYE BALL	Central
OCULAR MOVEMENTS	present in all cardinal gazes
LIDS	Normal
LACRIMAL PASSAGE	ROPLAS -ve
CONJUNCTIVA	Normal
CORNEA	Clear
SCLERA	Normal
ANTERIOR CHAMBER	Normal in depth
IRIS	ICPN
PUPIL	PCCRTL
LENS REFLEX	GREY WHITE
DIGITAL TENSION	Normal NCT: 14.00 mmHg

Fundus Examination of BE

- Media: clear
- Disc margin: distinct circular
- CDR:0.3:1
- Blood vessels: both arteries and veins dilated and tortuous.
- FR: not appreciable
- GF: Tessellated,
- RE: Pigmentary deposits over macula, subretinal haemorrhage.
- LE: circular distinct red reflex in macula, suggestive of macular hole.



RE Fundus



LE Fundus

Investigations

Hb: 12.0 gm% Tlc: 5700/cumm Dlc: P52, L40, M05, E03, B0. Platelets: 2.5lac/cumm Rbs: 99mg/dl. Blood Urea: 21mg/dl S.Creatinine:1.24mg/dl. ESR: 24 at the end of first hour. Urine RM: wnl

Provisional Diagnosis

Solar Maculopathy

Conclusion

There is no systemic illness & no similar complaints in family, there is history of watching solar eclipse 11 yr back and the presentation is in both eye so the fundus finding is suggestive of both eye solar maculopathy.