a toxic or dominant negative effect of the truncated protein is possible. It is difficult to propose that the complete unilaterality of the disease in this patient is due to differences in environmental or genetic exposures between the two eyes. One possibility might be a somatic mutation in a progenitor cell during the development of the unaffected retinal tissue that ameliorates the effect of the mutation.

To conclude, this represents the first report to our knowledge of unilateral disease occurring in a patient with a germline mutation for a known RP-associated variant. The phenotype, even when investigated carefully, is entirely normal in the unaffected eye. A somatic, embryonic mutation causing mosaicism at this locus is proposed.

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Rod-Cone Dystrophy in Spinocerebellar Ataxia Type 1

Spinocerebellar ataxia type 1 (SCA1) is a rare autosomal dominant neurodegenerative disease caused by a CAG triplet repeat expansion in the SCA1 gene on chromosome 6, encoding for a protein called ataxin-1.1 Spinocerebellar ataxia type 1 typically produces a progressive cerebellar syndrome, with prominent ataxia, dysarthria, and bulbar palsy.2 Early ophthalmologic manifestations include saccadic hypermetria, gaze-evoked nystagmus, and rebound nystagmus, with saccadic slowing and ophthalmoplegia developing in the later stages of the disease.2,3 Decreased visual acuity, dyschromatopsia, and optic atrophy are less commonly reported, with attenuation of oscillatory potentials on full-field electrotoretinography (ERG) also reported in 6 patients.4 We describe a patient with genetically confirmed SCA1 who developed progressive painless binocular vision loss and had evidence of rod and cone photoreceptor dysfunction on full-field ERG.

Report of a Case. A 56-year-old woman had an 8-year history of progressive painless binocular vision loss, blepharospasm, and cerebellar ataxia. There was a strong history of cerebellar ataxia with associated vision loss on the paternal side of her family.

On examination, best-corrected visual acuity was 20/70 OU. She identified only the control Ishihara color plate bilaterally. Confrontational visual fields revealed bilateral central scotomas. External examination revealed blepharospasm and occasional facial grimacing. Anterior segment examination findings were unremarkable. The pupils were normal. Ocular motor examination revealed slow saccades and impaired smooth pursuit, without nystagmus. General neurologic examination revealed dysarthria, head titubation, and appendicular, truncal, and gait ataxia. Funduscopic examination revealed absent foveal light reflexes, drusen and subtle pigmentary changes in the posterior poles, and retinal arteriolar attenuation (Figure 1). The optic discs were normal and no pigmentary changes were noted in the retinal peripheries (Figure 1).

Goldmann visual fields showed central depression and constriction of all isopters. Brain magnetic resonance imaging showed brainstem, cerebellar, and cervical spinal cord atrophy. Full-field ERG showed attenuated responses to all stimuli in both eyes, with prolonged implicit times for dim white flashes and maximal white b-waves (Figure 2 and eTable, http://www.archophthalmol.com). Genetic testing revealed an increased CAG repeat number of 46 (normal <34) in 1 SCA1 allele, confirming the diagnosis of SCA1. Genetic testing results for SCA7 were negative. Other laboratory studies were unrevealing.

Comment. Prior to the era of molecular diagnosis, it was known that vision loss in the SCAs could result from primary optic neuropathies or, less commonly, retinal degeneration.3 Detailed studies of vision in the different SCA genotypes have not yet been performed, although it is well established that SCA7 is the only genotype in which retinal degeneration commonly occurs.5 In a prior series of patients with genetically confirmed SCA1, decreased visual acuity, dyschromatopsia, and optic atrophy were reported, but no other funduscopic abnormalities were noted.4 All 6 patients in that series had attenuated oscillatory potentials and some had decreased b-waves,4 possibly indicating inner retinal dysfunction. Another report described a patient with genetically confirmed SCA1 who had progressive vision loss and a pigmentary macular dystrophy, similar to that described in SCA7.3 Full-field ERG revealed photoreceptor dysfunction and genetic testing had negative results for SCA7, suggesting that a pigmentary macular dystrophy can occur in SCA1.4 Our patient with genetically confirmed SCA1 had progressive binocular central vision loss and subtle funduscopic changes suggestive of retinal de-
generation, without optic atrophy. Full-field ERG revealed rod and cone dysfunction. The presence of vision loss in other family members with cerebellar ataxia and presumably SCA1 suggests that the vision loss was a manifestation of SCA1 and not due to a second pathology. Our findings therefore suggest that vision loss in

Figure 1. Posterior pole photographs from the right and left eyes demonstrate absent foveal light reflexes, superior greater than inferior drusen, subtle macular pigmentary changes, and retinal arteriolar attenuation but normal optic discs.

Figure 2. Full-field electroretinogram tracings from the right and left eyes. Responses to dim white (A), red (B), scotopic white (C), photopic white (D), and 30-Hz flicker (E) stimuli are shown.
SCA1 can be due to rod-cone dystrophy and should prompt evaluation by ERG, even in the absence of obvious retinal changes.

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Online-Only Material: The eTable is available at http://www.archophthalmol.com.

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