Patients with systemic cancer may have a variety of ocular complaints. Most commonly these are metastases or adverse effects of therapy. Paraneoplastic syndromes, like cancer-associated retinopathy, rarely cause ophthalmic symptoms. We describe a patient with a malignant mixed müllerian tumor and cancer-associated retinopathy who had circulating serum antibodies to recoverin and cells positive for recoverin in the tumor. We discuss the typical clinical symptoms as well as the pathophysiology of this uncommon disorder.


REPORT OF A CASE

A 60-year-old white woman arrived in the emergency department complaining of 3 weeks of progressive, painless dimming of her vision and swirling flashes of light. Further history revealed 8 months of postmenopausal bleeding with associated malaise, weight loss, and anorexia. On physical examination the emergency department physician found a large, firm, uterine mass similar in size to an 18-week pregnancy. An abdominal computed tomographic scan demonstrated the uterine mass, diffuse adenopathy, and hepatic lesions consistent with metastases. A transvaginal endometrial biopsy revealed a malignant mixed müllerian tumor.

On ophthalmologic examination, best-corrected visual acuity was 20/40 OD and 20/50 OS, with searching required to find the letters on the Snellen chart in a dark room. She scored 0/15 on color plates for both eyes. Slitlamp examination and biomicroscopy demonstrated a quiet anterior chamber, a mild vitritis, weight loss, and anorexia. On physical examination the emergency department physician found a large, firm, uterine mass similar in size to an 18-week pregnancy. An abdominal computed tomographic scan demonstrated the uterine mass, diffuse adenopathy, and hepatic lesions consistent with metastases. A transvaginal endometrial biopsy revealed a malignant mixed müllerian tumor.

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Goldmann visual fields testing demonstrated central and peripheral islands of severe visual dysfunction illustrates this rare disorder.
vision separated by a midperipheral ring scotoma (Figure 2). Suspecting a diagnosis of CAR, electoretinography and serum 23-kd antibodies (anti-recoverin) were ordered. The electoretinogram showed no rod function and minimal cone function (Figure 3). The patient’s 23-kd antibody titer was strongly positive to a dilution of approximately 1:3200 (oral communication, Charles Thirkill, PhD, 1998).

She was treated with palliative radiation for her cancer and oral prednisone for the CAR. After 3 days of oral prednisone, she noted significant improvement of her vision. She stated she could better recognize faces, more easily walk down stairs, and had improved ability to read. She maintained a visual acuity of 20/30 OU until her death 6
months later, at which time an autopsy was performed.

**HISTOPATHOLOGIC FINDINGS**

The patient’s globes were removed a few days post mortem and autolysis was evident. Hematoxylin-eosin–stained sections through the globe demonstrated nearly complete loss of photoreceptor outer and inner segments, as well as the outer nuclear layer in the retina (**Figure 4**). A small island of cone inner segments and cell bodies was identified in the central macula. Of interest, a few areas of the choriocapillaris demonstrated mononuclear inflammatory cells consistent with lymphocytes extending into the photoreceptor layer of the retina. The peripheral retina also contained rare areas of lymphocytes. Immunohistochemistry confirmed a mixed population of B and T lymphocytes in these areas. The remainder of the inner retina was intact. Occasional drusen were noted along Bruch’s membrane. Results of an examination of the anterior segment and optic nerve were unremarkable.

Hematoxylin-eosin staining of the original endometrial biopsy specimen revealed sheets of poorly differentiated cells with marked nuclear pleomorphism, abundant mitotic figures, and no glandular differentiation (**Figure 5**, left). Large areas of necrosis and hemorrhage were present. In addition, a distinct focus of well-differentiated adenocarcinoma was noted in a fragment separate from the poorly differentiated cells (**Figure 5**, right). To determine the histogenesis of the poorly differentiated foci, immunohistochemical stains were performed with the following antibodies using the avidin-biotin method: pancytokeratin (dilution 1:25; Vector Laboratories, Burlingame, Calif) and cytokeratin AE 1-3 (dilution 1:80; Boehringer Mannheim, Indianapolis, Ind). The poorly differentiated cells failed to stain with either keratin antibody, with appropriate positive and negative controls. The final diagnosis was a mixed sarcoma and carcinoma (mixed malignant mullerian tumor).

A sample of the patient’s uterine tumor was also obtained post mortem. Frozen sections were processed for immunofluorescence with rabbit anti-recoverin antibody (1:500; provided by A. S. Polans, PhD, University of Wisconsin, Madison) and secondary anti-rabbit IgG labeled with Cy-3 (1:50; Jackson Immunoresearch Laboratories, West Grove, Pa). Sections processed with anti-recoverin antibody (**Figure 6**, left) showed strong fluorescence of scattered tumor cells surrounded by
nonfluorescent cells. Control sections processed with nonimmune rabbit serum showed very weak background fluorescence of all tumor cells (Figure 6, right).

Cancer-associated retinopathy is a rare paraneoplastic process in which antibodies are thought to be formed against a protein produced by the tumor that has homology to specific retinal proteins. Patients with CAR were initially found to have antibodies to a 23-kd retinal protein, later identified as recoverin. Recoverin is a retinal photoreceptor calcium-binding protein that is involved in light and dark adaptation through the regulation of rhodopsin phosphorylation. Recoverin has been identified in the tumor of a patient with endometrial cancer as the first manifestation of their underlying neoplasm. However, our histopathologic findings, as well as those of others, demonstrated inflammatory infiltrates in the eyes of patients with CAR. Further, other cases have included the presence of an active vitritis. Most likely these are secondary cellular response to the initial humoral response, but nonetheless both mechanisms may play some role in the process.

The presentation of CAR typically involves a few key symptoms. First, patients report dimming of their vision occurring over days to weeks. Second, they also complain of acute-onset nyctalopia. Finally, patients often describe positive visual symptoms such as swirling and flashing lights.

On examination, patients have decreased acuity, diminished color vision, and ring scotoma visual field defects. The posterior segment of the eye can appear totally normal, but occasionally there is a mild inflammatory reaction in the vitreous and the retinal vasculature is attenuated. The electroretinogram, a test of retinal function, is markedly reduced. Serum antibody testing may confirm the diagnosis. Histopathology of the retina demonstrates loss of the photoreceptors.

Treatment for CAR involves modulation of the immune system to reduce the autoimmune response. The most widely reported therapy consists of 250 mg of intravenous methylprednisolone 4 times daily or 60 to 80 mg of oral prednisone daily, followed by a slow taper to a low maintenance dose. Other options being investigated include intravenous immunoglobulin and plasmapheresis. Most recently, Tolpa Torf preparation (Tolpa Norway Ltd, Honefoss, Norway), a naturally occurring immunomodulator, has been shown to be effective in reducing antibody levels.

Overall, the clinical course of CAR is one of deterioration. Patients typically experience progressive visual loss, worsening of their visual field defects, and flattening of their electroretinogram. Despite this grim prognosis for visual function, patients who receive adequate treatment may maintain useful vision until the time of death. Overall survival depends on the underlying tumor and its staging at diagnosis.

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Reprints: Nasreen A. Syed, MD, Scheie Eye Institute, 51 N 39th St, Philadelphia, PA 19104.

Correction

Error in Figure Legend. In the Special Article by Brodsky titled “Dissociated Vertical Divergence: A Righting Reflex Gone Wrong,” published in the September issue of the ARCHIVES (1999;117:1216-1218), proper acknowledgment of the source of Figure 2 on page 1218 was inadvertently omitted from the legend. The acknowledgment is as follows: “Reprinted with permission from Graf and Meyer. Copyright 1983, Springer-Verlag.” The journal regrets the error.