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Figure. A, Sagittal T1-weighted magnetic resonance image (MRI) without contrast shows a pineal cyst (arrow) of 1.2 cm in diameter in a child with retinoblastoma, which is isointense relative to CSF. B, Axial T2-weighted FLAIR (fluid-attenuated inversion recovery) image shows contents of cyst (arrow) hyperintense relative to CSF. C, Sagittal T1-weighted postgadolinium MRI shows no internal cyst enhancement (arrow).

Photodynamic Therapy for Exudative Hamartoma in Tuberous Sclerosis

Tuberous sclerosis is a systemic disorder characterized by hamartomas in multiple organs, commonly including the skin and brain, as well as additional cardiac, renal, pulmonary, and ocular findings. Approximately 50% of cases with tuberous sclerosis have ocular involvement with unilateral or bilateral retinal astrocytic hamartomas. Although most retinal astrocytic hamartomas remain asymptomatic or gradually regress during life, some exceptional cases may develop symptomatic alterations by an enlarged tumor with leakage, macular edema, accumulating lipid exudates, serous retinal detachment, or vitreous hemorrhage. Persisting macular edema and lipid accumulation may cause permanent visual impairment. This article highlights the novel approach with photodynamic therapy.

Report of a Case. A young boy developed multiple petit mal seizures at age 2 years and was diagnosed with tuberous sclerosis based on typical cerebral lesions including subependymal, paraventricular astrocytomas as seen with computed tomography. He later experienced additional symptoms of the disease, including multiple slightly elevated, yellow-red, butterfly-shaped papules distributed on his face (sebaceous adenoma), multiple small nodules in the right kidney, and 2 discrete cardiac calcifications, all of which are tumors typical for tuberous sclerosis.

Annual ophthalmic examinations were initiated when the patient was aged 17 years. By then, his best-corrected visual acuity was 20/25 OD and 20/32 OS. Extensive fundus examination in the right eye disclosed a retinal type 3 hamartoma at the superotemporal arcade and 4 type 1 lesions. The type 3 hamartoma had a typical mulberry appearance and a peripheral semitranslucent rim of approximately 1 disc diameter. Three other astrocytic type 1 hamartomas were present at the inferior arcade of the fundus in the left eye.

At age 22 years, the patient had progressively blurred vision with metamorphopsia in his right eye; this was present for 2 weeks. On examination, his visual acuity was 20/80 OD, and it had remained 20/32 OS. Biomicroscopical analysis of his right eye displayed a normal optic disc with well-perfused retinal vessels. The previously described retinal type 3 hamartoma had remained unchanged.

However, one of the type 1 hamartomas localized inferior to the type 3 hamartoma had changed its appearance. This lesion, still showing the characteristics of a retinal type 1 hamartoma, had increased in size and was surrounded by subretinal fluid accumulation with multiple small, whitish dots of lipid exudates extending close to the center of the macula.
As our patient described his symptoms as starting only 2 weeks previously, we decided to observe the natural course for at least another 5 weeks before considering any therapy. During this follow-up period, his visual acuity decreased to 20/200 OD. The size of the type 1 hamartoma increased, and the serous retinal detachment expanded beyond the center of the macula (Figure 1A). One set of fluorescein angiographic images (Heidelberg Retina Angiograph; Heidelberg Engineering GmbH, Heidelberg, Germany) was acquired 5 weeks before photodynamic therapy (PDT), and the other set was taken 1 day before PDT. Comparing these 2 sets, it was obvious that the tumor's vascularization was rapidly growing (Figure 2A and B). Based on positive treatment results with PDT in choroidal neovascularizations and choroidal hemangiomas, the patient and his parents decided to try this novel approach and signed an informed consent form.

Photodynamic therapy was performed using a modified doubled exposure time of 166 seconds.3

Two weeks after PDT, the patient reported no more metamorphopsia. Nine weeks later, the macula was without signs of a serous detachment, and the lipid exudates continued to decrease in number and size. One year after PDT, the patient's visual acuity increased to 20/32 OD. On biomicroscopical analysis, the macula remained dry with only a few small lipid exudates inferior to the treated retinal hamartoma. At this time, the flattened, noncalcified tumor became extremely subtle and appeared only as an ill-defined, translucent thickening of the retinal nerve fiber layer resembling healthy chorioretinal tissue (Figure 1B and Figure 2C).

Comment. This is the first description of applying PDT to a symptomatic retinal hamartoma in the case of tuberous sclerosis. Although the natural course of the disease with increasing macular edema was documented for 7 weeks prior to PDT, no recurrence of tumor vascularization has been observed during the following 4 years. A close follow-up was also important so as not to miss the diagnosis if a malignant transformation into an astrocytoma were to occur, which has been described for these lesions and could not have been ruled out by histological analysis.3
Conventionally, the therapy of symptomatic retinal astrocytic hamartomas would have been treatment by laser, which has the undesirable adverse effect of thermal destruction of the neurosensory retina. Delay of treatment, however, could have resulted in vitreous hemorrhage, a possible late complication of growing retinal hamartomas. Our case demonstrates the successful outcome of a symptomatic astrocytic hamartoma after 1 session of PDT that resulted in the resolution of subretinal fluid, disappearance of tumor vessels, and improved vision.

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Systemic Sarcoidosis Manifested as Unilateral Eyelid Retraction

Upper eyelid retraction is a common manifestation of thyroid-related orbitopathy with a limited differential diagnosis. We report an unusual case of isolated, unilateral eyelid retraction that was the first manifestation of systemic sarcoidosis.

Report of a Case. A 45-year-old African American woman had unilateral, left upper eyelid retraction for 3 years. She denied any history of thyroid disease, trauma, or previous surgery to the eyelids. She was taking no medications, and her family history was noncontributory. Review of systems was unremarkable for a history of asthma, chronic cough, shortness of breath, photophobia, fever, or night sweats. The patient reported some weight gain and fatigue over the preceding few months.

Visual acuity was 20/20 OD and 20/25 OS, and intraocular pressure at applanation was 12 mm Hg OU. Pupillary reactions, ocular motility, and visual fields in response to confrontation were normal. Exophthalmometry was 20 mm OU with a base of 100 mm, with no increased resistance to repositioning. There was left upper eyelid retraction with 2 mm of scleral show (Figure 1) and left upper eyelid lag on downgaze, with a higher upper eyelid crease on the right. There was no change in the position of the left upper eyelid with manual elevation of the right upper eyelid. In addition, instillation of 2.5% topical phenylephrine hydrochloride in the right eye did not result in change in the eyelid position of either eye. Eversion of both upper eyelids showed no lesions or papillary conjunctivitis. There were no palpable anterior orbital masses, and the lacrimal glands appeared normal. Slitlamp biomicroscopy showed normal anterior segments in both eyes. Fundus examination yielded unremarkable findings.

Results of investigations, including thyroid function tests (total triiodothyronine, free thyroxine, and thyroid-stimulating hormone) and complete blood cell count, were normal. Magnetic resonance images of the head and orbits showed no enlargement of the extraocular muscles or any abnormality in the area of the superior sulcus or levator–superior rectus muscle complex. The lacrimal glands were not enlarged. There were no intracranial abnormalities.

The patient was followed up for 3 months, and results of repeated thyroid function tests were normal. There was no change in the eyelid position. She underwent levator muscle recession with excision of Müller muscle of the left upper eyelid. The

Figure 1. A, Left upper eyelid retraction with superior scleral show. B, Left upper eyelid lag on downgaze.