Comment. We found no association between plasma levels of Lp-PLA₂ and incident AMD. Because of the small number of participants with late AMD, the possibility of an effect on late AMD cannot be ruled out. If confirmed in other studies, our findings suggest that Lp-PLA₂ levels are not an important risk factor for AMD despite the partly inflammatory pathogenesis of AMD.

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Report of a Case. A 20-year-old man had a 3-week history of an enlarging central scotoma in the left eye, followed by similar symptoms in the right eye. He denied any viral prodrome but reported a history of migraines. Visual acuity at the initial visit was 20/400 OD and 20/50 OS. Ophthalmic examination revealed white placoid lesions within the posterior pole resembling APMPPE, with no evidence of vitritis (Figure 1A-C). Three weeks later, visual acuity deteriorated to 1/200E OU with multiple new peripheral lesions in each eye (Figure 1D-F). Prednisone, 60 mg/d, was initiated at this time. Six weeks later, visual acuity was 20/800 OD and 6/200E OS. Ophthalmic examination revealed progressive retinal disease with 2+ vitreous cells in each eye and multiple new oval peripheral lesions amidst widespread large regions of retinal pigment epithelial scarring and atrophy. The patient also reported headaches, which he ascribed to migraines.

Complete blood cell count, erythrocyte sedimentation rate, angiotensin-converting enzyme level, syphilis IgG level, rapid plasma reagin level, Lyme titers, purified protein derivative test results, chest radiography results, and urinalysis results were unremarkable. Magnetic resonance imaging showed multiple hyperintense lesions in the right temporal lobe, left frontal lobe, and left corpus callosum (Figure 2). A magnetic resonance angiogram and cerebral arteriogram were performed because of concern for cerebral vasculitis, but they failed to show any cerebrovascular abnormalities. A lumbar puncture showed reactive lymphocytosis.

Mycophenolate mofetil, 1000 mg twice daily, was started, and prednisone was maintained at a dosage of 20 mg/d. The prednisone was then tapered off over 2 months. Visual acuity improved to 20/160 OD and 20/100 OS, and no new lesions were seen. At the 18-month follow-up, the patient has remained free of disease recurrence. His visual acuity and ophthalmic examination results have remained stable (Figure 1G-I). Additionally, a follow-up magnetic resonance image showed complete regression of the CNS lesions (Figure 2).

Comment. Our patient’s clinical course was consistent with features of RPC with progressive disease while he was receiving corticosteroid therapy. Furthermore, several subcortical white matter lesions were seen during the acute phase of his disease, which were possibly due to transient ischemia from small-vessel vasculitis or inflammatory lesions. The differential diagnosis of multiple placoid chorioretinal lesions includes APMPPE, serpiginous choroidopathy, multifocal choroiditis, lymphoma, metastases, sarcoidosis, tuberculosis, and syphilis. An extensive medical workup was unrevealing in our patient.

Relentless Placoid Chorioretinitis Associated With Central Nervous System Lesions Treated With Mycophenolate Mofetil

Relentless placoid chorioretinitis (RPC) is characterized by retinal lesions similar in clinical and angiographic appearance to acute posterior multifocal pigment placoid episcleropathy (APMPPE) and serpiginous choroidopathy but differing in its widespread distribution, the numerous lesions typically seen, and the rapidly progressive clinical course. No consistent systemic manifestations have been described in prior reports. We describe a patient with RPC accompanied by central nervous system (CNS) lesions requiring immunosuppressive medication to achieve disease remission.

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Comment. Our patient’s clinical course was consistent with features of RPC with progressive disease while he was receiving corticosteroid therapy. Furthermore, several subcortical white matter lesions were seen during the acute phase of his disease, which were possibly due to transient ischemia from small-vessel vasculitis or inflammatory lesions. The differential diagnosis of multiple placoid chorioretinal lesions includes APMPPE, serpiginous choroidopathy, multifocal choroiditis, lymphoma, metastases, sarcoidosis, tuberculosis, and syphilis. An extensive medical workup was unrevealing in our patient.
Because of lesion progression despite prednisone, mycophenolate mofetil was initiated and showed effectiveness for both the retinal and CNS findings. The natural history of RPC is unknown, and it is unclear whether disease resolution would have occurred without immunosuppressive therapy. A prior series of RPC reported a mean duration of disease activity of 9 months with continued appearance of new lesions for up to 24 months. In our patient, new lesions appeared for 3 months after his initial visit despite receiving prednisone. Remission was achieved following 2 months of mycophenolate mofetil treatment.

The precise mechanisms underlying the CNS and retinal findings are unclear, and no definite evidence of vasculitis was found. However, the temporal relationship between the CNS lesions and retinal lesions suggests a related inflammatory disease mechanism, possibly a small-vessel vasculitis or other focal inflammatory disease. Previously, APMPPE has been associated with cerebral vasculitis, and APMPPE and RPC could reflect differing ends of a disease spectrum. Our case report supports the consideration of immunosuppressive therapy for RPC and highlights the importance of neuroimaging in certain patients with RPC.

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Figure 1. Fundus photographs show several cream-colored chorioretinal lesions involving the posterior pole of the right (A) and left (B) eyes with no involvement of the superotemporal retina in the left eye (C). One month later, numerous new lesions appeared within the macula in the right (D) and left (E) eyes and the peripheral retina including the superotemporal retina in the left eye (F). Following immunosuppressive therapy, numerous chorioretinal scars developed with no new lesion formation (G-I).
Intraocular Involvement of Mycosis Fungoides

Mycosis fungoides (MF) is a malignant cutaneous T-cell lymphoma characterized by erythematous patches, plaques, and tumors. In later stages, noncutaneous involvement can ensue with visceral spread, lymphadenopathy, and Sézary syndrome.1 Intraocular extension is rare,2 and anterior chamber involvement has not been reported. We describe a case of bilateral hypopyon from intraocular MF involvement.

Report of a Case. A 68-year-old man with MF, stage T+3N+M0 by TNMB classification,3 complicated by inguinal lymphadenopathy and epiglottal involvement had worsening vision over 2 weeks. He had previously been treated with UV light therapy enhanced with psoralen, gemcitabine hydrochloride, interferon, methotrexate sodium, and liposomal doxorubicin hydrochloride. Visual acuity was 20/25 OD and hand motions OS. His skin was diffusely hyperemic and edematous with several tumors (Figure 1A). Dense, bilateral, lobular-appearing hypopyon with admixed blood was present in each eye. Both irides had prominent neovascularization with rubeotic appearances and dense posterior synechiae (Figure 1B and C). B-scan ultrasonography showed no significant vitreous opacification or retinochoroidal infiltration, and ultrasound biomicroscopy revealed bilaterally thickened iris roots.

Biopsies of the aqueous humor and vitreous as well as intravitreous injection of vancomycin hydrochloride, cefazidime, and dexamethasone were performed in the left eye. Vitreous cultures were negative, but aqueous humor smears showed large, pleomorphic lymphocytes with irregular, convoluted nuclei and nuclear clefts. Immunocytological staining was positive for CD3 (Figure 2A) and negative for CD20. Monoclonal T-cell gene rearrangement of the T-cell receptor γ locus was identified by polymerase chain reaction. Peripheral blood smear and flow cytometry results were within normal limits. Magnetic resonance imaging of the brain showed right optic nerve sheath enhancement. The patient was treated with 30 Gy of external beam irradiation in 10 fractions (to convert gray to rad, multiply by 100) to the orbits and brain with complete resolution of hypopyon in both eyes on day 10 of therapy with visual acuities of 20/25 OD and 20/60 OS (Figure 2B and C). He declined further treatment.

Comment. The malignant cell in MF, distinguished by its hyperconvoluted nucleus, derives from mature CD4 postthymic lymphocytes with a propensity to home to...