Bilateral Uveal Effusion Associated With Scleral Thickening Due to Amyloidosis

Simon C. K. Liew, MMed, FRACO; Peter J. McCluskey, MD, FRACO; Geoffrey Parker, FRACR; R. Frank Taylor, FRCS, FRACO

A 45-year-old man with primary systemic amyloidosis was found to have bilateral uveal effusions secondary to thickened sclera according to magnetic resonance imaging of the orbits. The patient was treated with bilateral sclerectomies and vortex vein decompression, and had an excellent outcome. Light microscopy of excised sclera revealed severe infiltration of the tissue by amyloid. To our knowledge, this is the first report of amyloid infiltration of the sclera leading to uveal effusion.


Amyloid deposition has been reported both in ocular adnexae such as the eyelids, conjunctiva, and lacrimal gland, and components of the globe such as the cornea and vitreous body.1,2 Deposits in the cornea may result in recurrent erosion and visual impairment while vitreous involvement may be misdiagnosed as uveitis or old hemorrhage.2 Amyloid infiltration of the sclera has also been described, although there is no mention of any deleterious effect on the eye or vision.1,2 This clinicopathologic report describes a patient with primary systemic amyloidosis and scleral infiltration by amyloid, resulting in massive uveal effusion that responded to scleral surgery.

From the Departments of Ophthalmology (Drs Liew, McCluskey, and Taylor) and Radiology (Dr Parker), Royal Prince Alfred Hospital, Sydney, Australia.

©2000 American Medical Association. All rights reserved.

Downloaded From: https://archopht.jamanetwork.com/ by a Non-Human Traffic (NHT) User on 10/14/2019
of suprachoroidal fluid. Fifty percent sulphahexafluoride gas was injected into the vitreous to repressurize the eye.

One day after surgery the retinal detachment in the right eye had almost completely resolved, and by 3 days after surgery there was no evidence of retinal detachment or choroidal effusion. Four months after surgery, visual acuity had improved to 20/60 OD, and the retina remained completely flat. Subsequently, scleral resection surgery was performed in the left eye with a similar outcome (Figure 1).

Microscopy confirmed the presence of Congo red–positive amyloid material in all the scleral specimens (Figure 5). In addition, the material was resistant to potassium
permanganate oxidation, confirming that the amyloid protein was of the primary type. Technical difficulties prevented typing the amyloid protein using immunohistochemistry.

**COMMENT**

Amyloid deposition in the sclera is uncommon, with only a small number of reports of patients with secondary amyloidosis. Other ocular structures that may be affected by amyloid deposition include the cornea, choriocapillaris, the optic nerve dural sheath, and vessels of the optic nerve. Vitreous involvement is found in hereditary transthyretin-related amyloidosis. Globe involvement is usually asymptomatic, though pain and visual disturbance may complicate corneal and vitreous amyloidosis. To our knowledge, this case is the first report of uveal effusion secondary to scleral infiltration by amyloidosis.

Medical treatment and conventional vitreoretinal surgery are ineffective in treating the uveal effusion seen in idiopathic uveal effusion syndrome and nanophthalmos. Partial-thickness sclerectomy and vortex vein decompression is a well-documented procedure for uveal effusion associated with abnormally thickened sclera. The presence of uveal effusion in this patient with ocular amyloidosis and the success of scleral surgery in relieving the effusions supports the theory that an abnormally thickened sclera interferes with the normal transcleral flow of fluid. This disturbance of bulk fluid flow across the choroid and sclera leads to accumulation of proteinaceous fluid in the choroid and subretinal space and the clinical appearance of shifting subretinal fluid characteristic of nonrhegmatogenous retinal detachment.

This case report also highlights the importance of MRI scans in the investigation of patients with uveal effusion. In contrast to CT scanning, it is possible with MRI to differentiate a retinal detachment, choroidal and scleral thickening, and to show subtle ciliochoroidal effusions (Figures 2 and 3).

**REFERENCES**