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Lava cake sans ice-cream

Case Description

A 34-year-old, asymptomatic, apparently healthy man was diagnosed elsewhere with a choroidal lesion in the right eye (OD) during his routine eye check-up and referred for further management. Best-corrected visual acuity (BCVA) was 20/16 in both eyes. The left eye (OS) examination was unremarkable. In OD, the anterior segment was within normal limits, whereas the fundus examination showed clear media with a solitary parafoveal orange-yellow subretinal lesion of 1 mm × 1.5 mm in size, about 1.5 mm inferonasal to the fovea with no evidence of subretinal fluid (SRF) or exudation [Fig. 1a, white arrow].

What is Your Next Step?

A. Fine needle aspiration biopsy (FNAB)
B. Photodynamic therapy
C. Systemic evaluation
D. Investigations including fundus autofluorescence (AF), ultrasound-B scan (USG), swept-source optical coherence tomography (SSOCT) through the lesion, fundus fluorescein angiography (FFA), and indocyanine green angiography (ICGA).

Findings

Fundus AF revealed speckled autofluorescence [Fig. 1b]. FFA showed early isofluorescence [Fig. 1c] and late hyperfluorescence [Fig. 1e], whereas ICGA revealed early hypo and late hyper-cyanescence [Fig. 1d and f, white arrow]. Ultrasound B scan showed a well-defined intrascleral lesion with hyperechoic borders and low internal reflectivity [Fig. 1g, white arrow]. Swept-source optical coherence tomography showed an abruptly elevated lesion of "volcanic" configuration, arising from the sclera and outer choroid with thinning of choroidal vasculature and, trace subretinal fluid (SRF) [Fig. 1h]. Although tuberculin skin test was negative, positive interferon-gamma release assay test (Quanti-FERON) and high-resolution computed tomography (HRCT) chest findings of mediastinal lymphadenopathy and pulmonary ectatic changes were suggestive of probable tubercular etiology. He was treated with systemic steroids and anti-tubercular therapy (ATT).

Diagnosis

Right eye solitary idiopathic choroiditis (SIC) (morphological diagnosis) with probable tubercular etiology.

Correct Answer

D.

Discussion

SIC, a descriptive morphological entity could be harbinger of myriad underlying aetiologies.[1] Active lesions appear as dull-yellow, ill-defined subretinal lesions with exudate/SRF whereas inactive lesions are nummular, discrete, yellow-white with a red-orange halo.[1-3] While both active and inactive lesions exhibit early hypo and late hyperfluorescence on FFA (&ICGA), active lesions leak and inactive lesions stain in late-phase.[1,3] AF pattern is variable and appears hyperreflective by infra-red reflectance.[2] SSOCT shows volcanic/dome-shaped scleral/outer choroidal lesion with overlying choroidal thinning.[2] SIC should be differentiated from other inflammatory and neoplastic choroidal lesions by multimodal imaging; active lesions need treatment with systemic corticosteroids and appropriate antimicrobials.[1-3]

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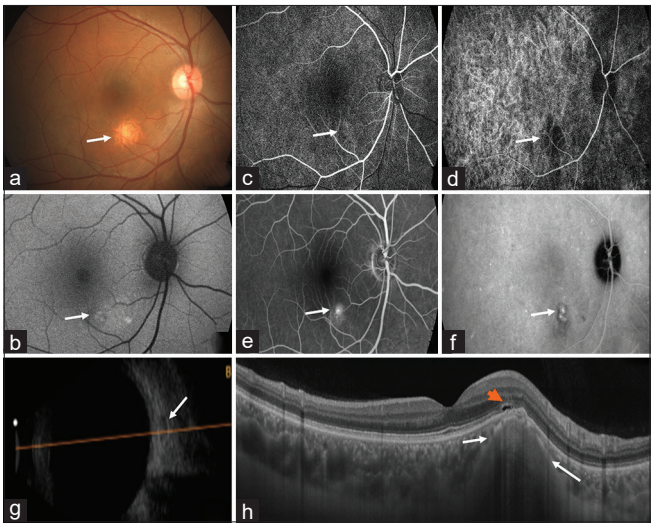

Figure 1: Colour fundus photo (a, white arrow) shows solitary orange-yellow subretinal lesion, inferonasal to fovea which showed mixed fundus autofluorescence (b). FFA showed early iso (c) and late hyperfluorescence (e) whereas ICG showed early hypo and late hyper-cyanescence (d and f). Ultrasound showed a well-defined intrascleral lesion with hyperechoic borders and low internal reflectivity (g). Swept-Source OCT showed abruptly elevated lesion of "volcanic" configuration, arising from sclera and outer choroid with thinning of choroidal vasculature and, trace subretinal fluid (h)

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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