Lichen planus and multifocal choroiditis - A diagnostic dilemma

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Key words: Azathioprine, lichen planus, multifocal choroiditis

A 24-year-old gentleman had a right headache and MFC; for 1 year [Fig. 1a]; being on AKT for 3 weeks with further worsening. Fundus fluorescein angiography (FFA) [Fig. 1b]; optical coherence tomography (OCT), [Fig. 1c] and B-Scan [Fig. 1d] had been done. Serum angiotensin-converting enzyme (ACE), serum uric acid, and QuantiFERON TB Gold Test were normal. Mantoux was 19 mm [48 h/5 *tuberculin* units (TU)]. Oculus sinister (OS) was normal. On presentation to us, OD had finger counting close to face with congestion; mild relative afferent pupillary defect (RAPD); painful movements; disc edema; peripapillary sub-retinal exudation, and MFC [Fig. 1e]. We did contrast magnetic resonance imaging (MRI) brain/orbit, venereal disease research laboratory (VDRL), antinuclear antibody (ANA), antineutrophil cytoplasmic autoantibody (ANCA), and HIV, which were normal. Paradoxical worsening of TB choroiditis (3 weeks AKT) was considered and intravenous methylprednisolone was used. Repeat history-taking, caused him to recall having skin biopsy-proven LP; treated with oral prednisolone; just prior to ocular symptoms; 1 year back. Pursuing the possibility of flare-up of occult systemic TB; after the use of oral steroids to treat LP, a contrast chest CT was done, which was normal. A previously reported; LP associated intraocular inflammation[1] led us to use of azathioprine. One of the treatment protocols could have been the continuation of AKT, but our physician stopped AKT to avoid hepatotoxicity. Intraocular inflammation resolved within 2 months of azathioprine, [Fig. 1f]; which

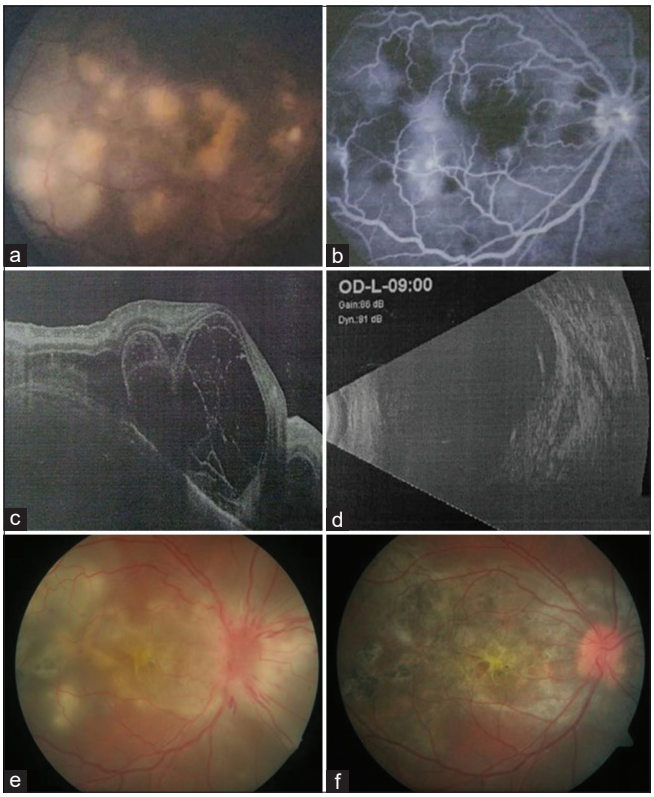

Figure 1: (a) Fundus showing fulminant MFC on treatment with tapering oral steroids for one year. (b) FFA showing late hyperfluorescence; pooling; disc leakage. (c) OCT showing choroidal elevation with macular thickening. (d) B-Scan showing grossly thickened choroid with sub-tenons fluid in macular area. (e) Fundus showing disc edema with peripapillary sub retinal exudation and MFC. (f) Fundus showing resolution of inflammation; 2 months on azathioprine

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Quick Response Code:

Website: www.ijo.in

DOI: 10.4103/ijo.IJO_563_20

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Received: 16-Mar-2020 Revision: 30-May-2020
Accepted: 06-Jun-2020 Published: 20-Aug-2020

Cite this article as: Moreker MR, Sharma TR, Pardasani VP. Lichen planus and multifocal choroiditis - A diagnostic dilemma. Indian J Ophthalmol 2020;68:1942-3.

was continued for 9 months. At 16 months post cessation of azathioprine; he stays in remission.

Discussion

Ocular LP is largely extraocular and involves conjunctiva, cornea, and lacrimal drainage system.[2] The role of cellular immunity in LP and retinal vasculitis[3,4] was believed to be the cause of their once previously reported association.[1] In our patient; there is a diagnostic dilemma of the mere coexistence of LP and MFC with a temporal dissociation (LP occurring just prior to the onset of ocular symptoms) vs possible association between these two otherwise separate immune-mediated clinical entities.

Acknowledgement

The authors wish to acknowledge Dr. Avinash Pathengay, for his technical help in the management of this patient.

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.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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