RETROBULBAR OPTIC NEURITIS IN A PATIENT WITH SYSTEMIC LUPUS ERYTHEMATOSUS: CASE REPORT

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Introduction: Systemic lupus erythematosus (SLE) is an autoimmune, chronic, inflammatory and multisystemic disease with a variable clinical spectrum with prevalence in young women. The ophthalmic manifestations of SLE range from mucocutaneous involvement to neuro-ophthalmic involvement. On funduscopy examination, the presence of microinfarctions and vasculitis, which are not always easy to identify, are considered reflections of systemic vascular damage and require more elaborate propaedeutic complementation in order to identify the active disease at an early stage. The presence of optic neuropathy in SLE is uncommon, but it may be the initial manifestation. Currently, systemic corticosteroids are the option of choice for the initial treatment of the disease and early intervention results in a better visual prognosis, given that vascular and neuronal damage can occur from the initial course of the disease. Objective: To describe an unusual case of unilateral retrobulbar optic neuritis, the funduscopic changes and complementary exams in a patient with discoid lupus erythematosus, elderly and clinically stable. Case report: Woman, 62 years old, referred to a consultation at UNIFACISA, complaining of ocular pain and sudden loss of vision in the right eye (RE) for approximately 6 months. She reported visits to several specialists, without a firm etiological diagnosis. On ophthalmological examination, she had a slowed direct photomotor reflex in the RE and preserved on the left. The best visual acuity (VA) is 2 meters in the RE and 20/20 in the left eye (LE); biomicroscopy without alterations in both eyes with normal intraocular pressure. Fundoscopy with stained optic nerve , well-delimited border, narrowly arteriolar and epiretinal membrane with distortion of the both eyes macular architecture. The laboratory investigation showed positivity for anti-Ro autoantibody (14.0U/mL). Optical coherence tomography showed hyperreflectivity in the internal limiting membrane layer and angiography showed hyperfluorescence due to vascular extravasation in the posterior pole and midperiphery, suggestive of retinal arteriolar vasculitis in the both eyes. The electroretinogram examination revealed involvement of the optic pathways with potential visual acuity of 20/80 to 20/100 in the RE. Scan tomography and magnetic resonance imaging of the skull and orbit showed no alterations. Assessed in conjunction with rheumatology, the diagnosis of SLE with retrobulbar optic involvement was confirmed and was started corticosteroid therapy in immunosuppressive dose, with a gradual decrease in medication. Discussion: Optic neuropathy secondary to SLE is a rare manifestation, secondary to vasculitis or vase-occlusive event related to antiphospholipid syndrome, which may result in axonal necrosis. The main findings are visual loss and pain on eye movement, like as observed in the present case. In the presentation of the disease, it may be that the only objective finding of optic neuropathy is the pupillary defect, therefore, a good history and a complete physical examination are of paramount importance to make the proper diagnosis. The patient in question presented retrobulbar optic neuropathy in the presence of positive anti-Ro antinuclear antibody and absence of clinical manifestations of the underlying disease, in addition to only signs of chronicity in the funduscopic findings. The involvement of the posterior segment, in this case, vasculitis, only evidenced by fluorescein angiography, could reflect lupus disease activity. This case

report shows the value of ocular complaints and recommends periodic ophthalmological examination, including fluorescein angiography, even in chronic, asymptomatic and clinically stable diseases, as it has been proven that damage to retinal vessels is attributable to to systemic vascular injury. Early diagnosis and intervention is necessary in order to prevent visual loss and long-term complications.