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Journal

American Journal of Ophthalmology, 122(4)

ISSN

0002-9394

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Publication Date

1996-10-01

DOI

10.1016/s0002-9394(14)72131-2

Peer reviewed

Recurrence of a Choroidal Neovascular Membrane in a Patient With Punctate Inner Choroidopathy Treated With Daily Doses of Thalidomide

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PURPOSE: To determine whether thalidomide therapy can prevent a recurrence of a choroidal neovascular membrane in a patient with punctate inner choroidopathy.

METHODS: Case report. In a 38-year-old woman with bilateral punctate inner choroidopathy, thalidomide therapy was initiated three days after laser photocoagulation of a choroidal neovascular membrane.

RESULTS: The patient had a recurrence of the choroidal neovascular membrane eight months after the start of thalidomide therapy.

CONCLUSIONS: The failure of thalidomide to prevent a recurrence of a choroidal neovascular membrane in this patient suggests that this medication may have only a limited benefit in preventing recurrences of choroidal neovascular membranes.

PUNCTATE INNER CHOROIDOPATHY, A DISEASE OF UNknown cause, generally affects patients between the ages of 16 and 40 years and is characterized by focal yellow lesions located at the level of the retinal pigment epithelium and inner choroid that develop into deep cylindrical chorioretinal scars months to years after their first appearance. Although symptoms are usually unilateral, the majority of patients ultimately develop bilateral involvement.[1] Approximately 25% of eyes with punctate inner choroidopathy develop choroidal neovascular membranes as a late sequela.[2] Treatment of choroidal neovascular membranes is limited to laser photocoagulation and, in some cases, surgical removal. Medical therapy has not been an option in the past; however, the current Age-Related Macular Degeneration and Thalidomide Study is evaluating the potential of thalidomide as an adjuvant treatment of choroidal neovascular membranes associated with age-related macular degeneration.

Accepted for publication June 4, 1996.

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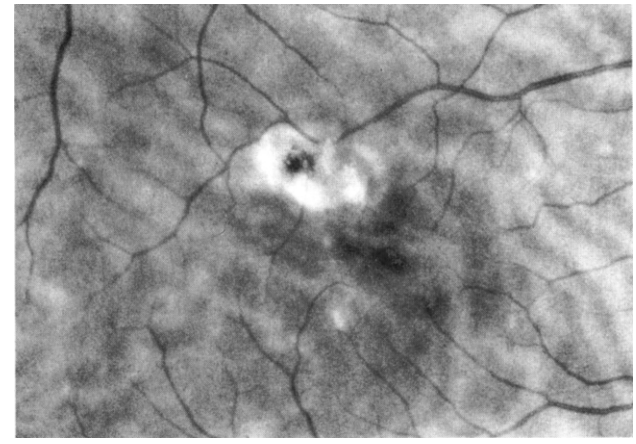

Fig. 1 (Ip and Gorin). Fundus photograph of the right eye taken two weeks after laser photocoagulation of a recurrent choroidal neovascular membrane. Thalidomide therapy was started three days after laser photocoagulation.

A 38-year-old woman with bilateral punctate inner choroidopathy had multiple parafoveal and subfoveal choroidal neovascular membranes despite repeated sessions of laser photocoagulation. In an effort to preserve foveal vision in the patient's less severely affected right eye, a compassionate plea protocol was established to initiate thalidomide therapy after laser photocoagulation of a parafoveal choroidal neovascular membrane. At the start of therapy, the patient's best-corrected visual acuity was reduced to L.E.: 20/80 secondary to a recurrent subfoveal choroidal neovascular membrane that had previously been treated with laser photocoagulation. Best-corrected visual acuity was R.E.: 20/20 but was threatened by a recurrent extrafoveal choroidal neovascular membrane.

The patient, who had had a hysterectomy, received 100 mg of thalidomide on a daily basis for eight months. Therapy was begun within three days of laser photocoagulation to her right eye (Fig. 1). After eight months of therapy, metamorphopsia developed in the patient's right eye. Despite the absence of subretinal

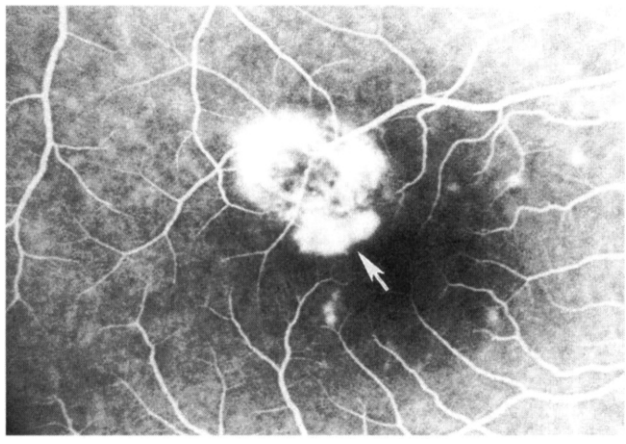

Fig. 2 (Ip and Gorin). Fluorescein angiogram of the right eye shows a recurrent choroidal neovascular membrane eight months after the start of thalidomide therapy (arrow).

hemorrhage or fluid, a fluorescein angiogram confirmed the presence of a recurrent choroidal neovascular membrane along the foveal edge of the previous laser scar (Fig. 2). The time interval between laser therapy and this recurrence was not markedly different from the intervals between previous recurrences in either eye. Thalidomide therapy was terminated and the recurrent lesion was successfully treated with laser photocoagulation. Best-corrected visual acuity after treatment was R.E.: 20/25 and was stable for six months. No further recurrences have thus far been detected.

Punctate inner choroidopathy is similar to the presumed ocular histoplasmosis syndrome, which traditionally has a better response to photocoagulation than age-related macular degeneration. In our patient, whose retinal pigment epithelium was not undergoing the progressive degenerative changes seen in advanced age-related macular degeneration, choroidal neovascular membrane developed despite treatment with daily doses of 100 mg of thalidomide. Optimal dosing for thalidomide has not been established, and therapeutic levels of thalidomide may be greater than that used in our patient.[3,4] The dosing regimen in the current Age-Related Macular Degeneration and Thalidomide Study is 100 mg per day for the first two weeks, followed by 200 mg per day thereafter (Ho AC, unpublished data, 1995). The Age-Related Macular Degeneration and Thalidomide Study is a prospective, placebo-controlled, randomized, double-blind, single-center study that will give further insight into the efficacy of thalidomide in the treatment of choroidal neovascularization for age-related macular degeneration. However, the failure of thalidomide to prevent a recurrence of a choroidal neovascular membrane in our patient suggests that this medication may have only a limited benefit in preventing recurrences of choroidal neovascular membranes.

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Plasmacytoma Manifesting as Recurrent Cellulitis and Hematic Cyst of the Orbit

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PURPOSE: To describe a patient with recurrent periorbital cellulitis and orbital blood cyst as the initial manifestation of primary extramedullary plasmacytoma.

METHODS: The chart, imaging studies, and histopathologic examination results and literature on the subject were reviewed.

RESULTS: Orbital surgery disclosed a hematic cyst along with a solitary plasma cell tumor.

CONCLUSIONS: Periorbital cellulitis and pain can be a manifestation of a plasma cell tumor. Bleeding may occur within a necrotic orbital tumor.