

A Case of Sunset Glow Fundus Following a Choroidal Tumor-Like Lesion

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Abstract: We present an extremely rare case of sunset glow fundus following a choroidal tumor-like lesion in a 47-year-old woman. Fundus examination revealed a pale yellowish elevated lesion with retinal folds in the left eye. Two weeks after the initial visit, the elevated lesion became gradually flattened but spread to the macular region. In addition, the elevated lesion with serous retinal detachment was developed in the right eye. Fluorescein angiography demonstrated the multiple hyperfluorescent spots with late leakage. She was initially thought to have a choroidal tumor. However, in spite of systemic investigation, a diagnosis could not be made. Three months after the initial visit, funduscopy showed a red area, the "sunset glow", in the inferotemporal quadrant. This case resembles Vogt-Koyanagi-Harada disease because of the red coloration in the fundus, iridocyclitis, and human leukocyte antigen-DR4 positivity. However, other findings were not compatible with the criteria of Vogt-Koyanagi-Harada disease.

Keywords: sunset glow appearance, Vogt-Koyanagi-Harada disease, choroidal tumor.

INTRODUCTION

In 1998, Ikebe *et al.* [1] reported a case of segmental sunset glow fundus following a choroidal tumor-like lesion. Since then, there have been no further reports on this rare condition. We present an extremely rare case of sunset glow fundus following a choroidal tumor-like lesion in a 47-year-old woman.

A 47-year-old woman was referred for one week history of visual field disturbance in her left eye. Her best-corrected visual acuity (BCVA) was 1.2 in the both eyes. Slit lamp examination revealed anterior chamber cell inflammation and flare in the left eye. Fundus examination revealed no specific abnormalities in the right eye (Figure 1A). In the left eye, there was a pale yellowish elevated lesion with retinal folds at the inferotemporal region (Figure 1B arrows).

CASE REPORT

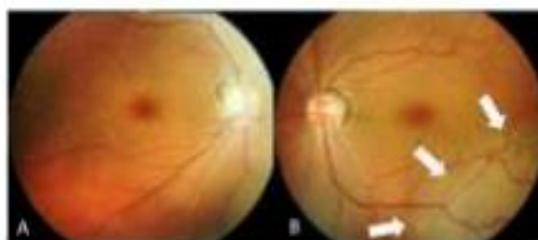


Fig-1: Fundus photographs of the right (A) and left (B) eye

Note an elevated lesion with retinal folds in the left eye (arrows). Ultrasonic B-scan echography

showed an elevated lesion in the left eye (Figure 2 arrows).

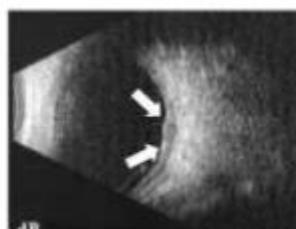


Fig-2: Ultrasonic B-scan echography of the left eye

Two weeks after the initial visit, the elevated lesion became gradually flattened but spread to the macular region in the left eye (Figure 3B). In addition,

the elevated lesion with serous retinal detachment was developed at the inferotemporal region in the right eye (Figure 3A).

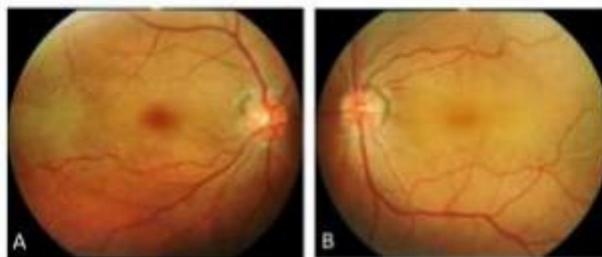


Fig-3: Fundus photographs of the right (A) and left (B) eye

Fluorescein angiography (FA) demonstrated a transmission defect with granular hyperfluorescence at the level of the retinal pigment epithelium (RPE) (Figure 2A–D). In particular, the multiple

hyperfluorescent spots with late leakage at the inferotemporal region in the right eye (Figure 2C arrows).

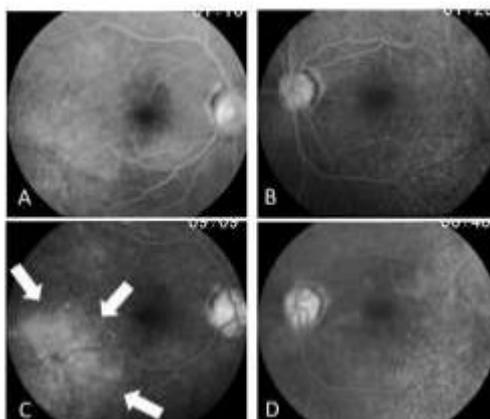


Fig-4: Fluorescein angiography of the right (A, C) and left (B, D) eye

Note the multiple hyperfluorescent spots with late leakage in the right eye (arrows).

One month after the initial visit, her BCVA was 0.8 in the both eyes. Slit lamp examination revealed anterior chamber cell inflammation and flare in both eyes. Fundus examination revealed choroidal detachment and serous retinal detachment at the inferior peripheral retina in the right eye (Figure 5 arrows).

We initially suspected the disease as metastatic choroidal tumor on the basis of the FA findings. However, her blood laboratory findings including tumor markers, chest radiography, and whole body CT were unremarkable.

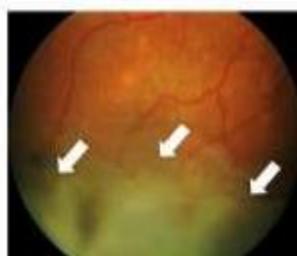


Fig-5: Fundus photograph of the right eye

Note choroidal detachment and serous retinal detachment (arrows).

Although FA demonstrated a transmission defect with granular hyperfluorescence at the level of the RPE (Figure 6A-D), the multiple hyperfluorescent spots were reduced in the right eye (Figure 6C).

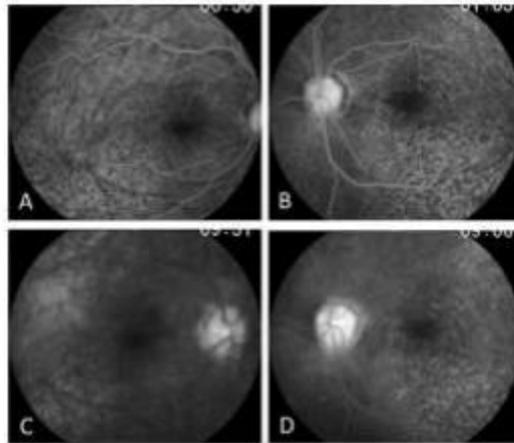


Fig-6: Fluorescein angiography of the right (A, C) and left (B, D) eye

Although she had no aseptic meningitis-like symptoms, hearing disturbance and dermatological findings, we re-evaluated the disease as Vogt-Koyanagi-Harada disease on the basis of iridocyclitis and human leukocyte antigen (HLA)-DR4 positivity. Therefore intravenous bolus therapy with methylprednisolone (1000 mg) was initiated.

Her BCVA improved to 1.2 in both eyes. Three months after the initial visit, funduscopy showed a red area, the "sunset glow", in the inferotemporal quadrant (Figure 7).

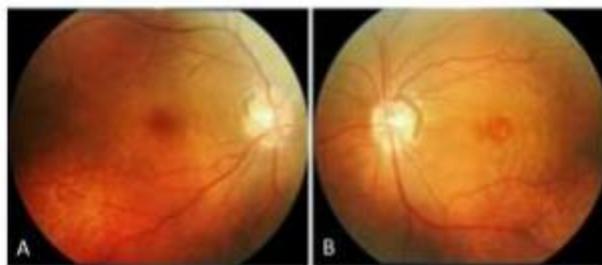


Fig-7: Fundus photographs of the right (A) and left (B) eye

DISCUSSION

Ikebe *et al.* [1] reported a case of segmental sunset glow fundus following a choroidal tumor-like lesion. Since then, there have been no further reports on this rare condition. Fundus changes in this present case were very similar to their report. This case resembles Vogt-Koyanagi-Harada disease because of the red coloration in the fundus, iridocyclitis, and HLA-DR4 positivity. However, other findings were not compatible with the criteria of Vogt-Koyanagi-Harada disease [2, 3].

REFERENCES

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