2/9/26 Mainstream Monday with @CPSolvers

"One life, so many dreams" **Case Presenter**: Sarah B (@sarahkblaine) **Case Discussants**: Youssef (@saklawiMD) & Manaswini (@)

https://clinicalproblemsolving.com/present-a-case/

Scribing (Seeme)

CC: 71-year-old F with acute loss of vision for 1 week.

HPI:

1 wk ago, she experienced acute onset painless complete loss of vision in her R eye. She noticed her vision was completely black in her R eye after waking up from a nap. She went to local eye doctor who advised her to go to the ER.

ROS:

She denies jaw pain, headache, double vision, or proximal muscle weakness. Admits cough, shortness of breath.

PMH:

HTN
COPD
HFpEF (EF>60%)
CAD s/p stent earlier in year
HLD
Ovarian cancer s/p surgical management and remission
Mood disorder

Meds:

Metoprolol
ASA
Atorvastatin
Aripiprazole

Fam Hx:

-

Social Hx:

-

Health-Related Behaviors:

80 pack years, smoked 5 cigarettes per day now

Allergies:

NKDA

Vitals: **T**: nl **HR**:55 **BP**: nl **RR**:nl **Sat**:nl **BMI**: nl

Exam: **Gen**: Patient is lying in bed in NAD. Well-developed, well-nourished. **HEENT**: fundus exam with peripapillary retinal whitening, pale disc, tortuous veins. Her visual acuity is CF at 1' PH NI, 20/25. Normal IOP and +rAPD OD. She has 0.5 mm anisocoria OD>OS stable light/dark. Color plates -1/12, 10.5/12, constricted CVF OD, full CVF OS. Exam and imaging with pallid disc edema OD, peripapillary retinal whitening extending into macula, with inner retinal edema on OCT. Greatest concern for GCA.

CV: nl, **Pulm**: n **Abd**: nl

Neuro: R afferent pupillary defect **Extremities/skin**: nl

Notable Labs & Imaging:

Hematology:

WBC 5.2 HGB 9.1 HCT 28 PLT 135 MCV 96.2

Chemistry:

HbA1c:6.1

ESR: 72 -> nl [on steroids] CRP: <0.5 [never elevated]

Rheumatology was consulted: recommended continue steroids

Imaging:

Echo:. Moderate mitral annular calcification. Trace mitral valve regurgitation. A gelatinous mass 21 x 11 mm on the posterior leaflet of the mitral valve. PFO present

MRI brain: 7 mm avidly enhancing lesion with T2 hyperintense signal in the right intraconal space near the orbital apex- orbital cavernous venous malformation, and less likely venous varix.

Carotid US: less than 50% stenosis

TEE: There is a mobile, pedunculated area under the A1/P1/P2 area of the MV on the ventricular side that is drumstick like in shape and the tip is mobile. Favored to either be a vegetation of part of the calcification of the mitral annulus with embolic potential.

Blood Cx, quantiferon, HCV, HBV: neg, temporal artery biopsy: neg.

Heparin and steroids given, slight improvement in R eye vision

Dx: GCA(giant cell arteritis) Vs NAION (non arteritic anterior ischemic optic neuropathy)

Problem Representation: A 71 year old FM presented with acute loss of vision for 1 week in right eye with RAPD and pale disc with tortuous veins. TEE showed presence of pedunculated area on mitral valve.

Teaching Points (fahed)

CC: Acute onset vision loss:

- **Tempo is important.**
- **Vessel: inside, wall, outside**
- **pressure related: Glaucoma**
- **Retinal and vitreous involvement**

Hyperacute and unilateral? Where does that point to?

- **Vessel high likelihood**
- **painless: less likely to be exterior etiology.**
- **Key investigation: Fundoscopy (will help reach diagnosis faster)**

Systemic disease to vision loss:

- **PAH can cause retinal detachment**
- **Embolic phenomenon**
- **malignancy causing hypercoagulable states**

Ischemia to nerve can present in such way: most relevant being GCA but no systemic evidence in this case.

RAPD: Lesion lies from retina to optic chiasma, can rule out cortical involvement.

GCA: Large vessel vasculitis, takayasu <50yrs, GCA >50yrs

- **Old teaching was Gold standard for diagnosis: Temporal artery biopsy**
- **Ways to diagnose other than biopsy:**
  - **USG with Doppler can be used to diagnose.**
  - **PET scan to see which vessel lights up**
  - **MRI/CTA also useful**
- **Look for signs of PMR**
- **Jaw claudication one of the most sensitive evidence of GCA.**
- **If concern, don't wait to treat.**
- **Big concern is ischemia to retina.**

Lesion in the valves:

- **Pus, calcium, clots (hypercoagulable states), cancer. (PCCC).**
- **Cardiac lesion: Differentiate with history or imaging**
- **If suggestive of clots, start anticoagulation.**