tions is sufficient to achieve disease resolution in inflammatory CNV does not seem to be confirmed by this report. We suggest that a treatment plan similar to the one commonly used for AMD-related CNV with a course of three initial monthly injections of ranibizumab and subsequent adaptation to anatomical and functional response may be also pertinent for SC-related CNV leading to favorable visual outcome.

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Spontaneous resolution of vitreomacular traction syndrome with persistent vitreofoveal adhesion observed on spectral-domain optical coherence tomography

Herein, we report an atypical case of spontaneously resolving vitreomacular traction syndrome (VMTS) that showed persistent vitreofoveal adhesion evident on spectral-domain optical coherence tomography (SD-OCT). This case suggests that symptomatic patients with VMTS should be observed for several months by SD-OCT before deciding on surgical management because spontaneous resolution may develop, even without vitreofoveal detachment.

A 50-year-old man was referred for evaluation of macular edema in the right eye. He had suffered from metamorphopsia and decreased vision for 2 months. The best-corrected visual acuity was 20/40 OD and 20/20 OS with spectacle correction. Myopia with a refraction of −6.00 D OD and −3.75 D OS was recorded. The patient had a history of hypertension but no history of diabetes. Slit-lamp biomicroscopy of the right eye showed myopic degeneration without apparent posterior vitreous detachment. Examination of the left eye showed unremarkable findings. SD-OCT (Spectralis OCT; Heidelberg Engineering, Heidelberg, Germany) revealed cystoid changes in the right macula and partial posterior hyaloid separation with attachment of the posterior hyaloid around the foveal center tenting the inner retina (Fig. 1). Central retinal thickness (CRT) at the center of the fovea, as assessed by SD-OCT, was 356 μm. Although we recommended surgical management, the patient refused and was followed-up monthly. One month later, the patient presented with subjective resolution of metamorphopsia, and his visual acuity had improved to 20/20 OD. SD-OCT (Fig. 2A) revealed normal foveal contour and the absence of a foveal cyst.

Fig. 1—Spectral-domain optical coherence tomography (SD-OCT) at initial presentation shows cystoid space in the macula with vitreous attachment around the foveal center, indicating typical vitreomacular traction syndrome (VMTS).
with decreased CRT (305 μm), despite persistent vitreofoveal adhesion. After 4 months, visual acuity remained 20/20 OD, and normal foveal pit and macular contour was still noted by SD-OCT (Fig. 2B). Over the next 12 months, there was no change in either the patient’s vision or the retinal structure according to SD-OCT (Fig. 2C, D).

**DISCUSSION**

VMTS is a vitreoretinal interface disorder caused by macular vitreoretinal traction associated with incomplete separation of the posterior vitreous. In a recent study, which estimated the natural course of VMTS using SD-OCT, Odrobina et al. found a complete detachment of the vitreous in the maculae in 9 of 19 eyes (47%). They found a complete regression of intraretinal cystic spaces in 6 of 19 eyes, and posterior vitreous detachment occurred in all of these 6 eyes. They suggested that the main factor causing the development of intraretinal cystic spaces is the vitreoretinal traction and that complete vitreomacular separation allows for resolution of cystoid changes and for recovery of normal foveal contour.

All previous reports have shown that the development of complete posterior vitreous detachment precedes spontaneous resolution of VMTS with release of traction. However, in the present case, although focal vitreofoveal adhesion was noted at the follow-up SD-OCT, spontaneous resolution of the retinal cystoid change occurred. Subjective visual symptoms such as metamorphopsia were alleviated subsequent to anatomic resolution according to SD-OCT evaluation. These findings suggest that vitreomacular traction can resolve spontaneously through mechanisms other than complete vitreomacular detachment and that observation of patients with VMTS for several months before could lead to spontaneous resolution.
surgery is crucial because spontaneous resolution can develop with and without vitreofoveal detachment.

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Central visual disturbance associated with transient disruption of photoreceptor inner-outer segment junction

A 31-year-old Caucasian female with no notable ocular or medical history presented with blurring of central vision in both eyes, present since waking that day. She described seeing a purple cloud in the centre of her vision, and the symptoms were identical in both eyes. She had no headache, photopsia, or history of recent illness and no history of exposure to bright light or solar gazing. Her visual acuity was 20/40, unaided, in each eye; the ophthalmic examination was otherwise normal.

She returned 2 days later because her symptoms had not settled. At that time, visual acuity was 20/20, unaided, in each eye. Fundal examination (Fig., A, B) was grossly normal. Spectral domain optical coherence tomography (OCT) was performed (3D OCT-1000, Topcon Medical Systems, Paramus, NJ), and it revealed disruption of the photoreceptor junctions between the inner segment and the outer segment in the hyper-reflective outer retinal band but showed preservation of the external limiting membrane and retinal pigment epithelium (Fig., G, H). This disruption was localized to the foveola in both eyes, and a corresponding anomaly was discernible on the infrared fundus image (Fig., C, D). The results of indocyanine green angiography (ICGA) were normal. Visual field testing (both automated static and manual kinetic perimetry) and color vision (tested by Ishihara pseudoisochromatic plates) was also normal. Returning for review 2 months later, she reported that her symptoms had completely resolved, gradually, over some weeks. The examination was normal, and the OCT findings had resolved (Fig., I, J), with corresponding normalization of the infrared fundus image (Fig., E, F).

The photoreceptor inner segment/outer segment (IS/OS) junction line can be disrupted in a number of pathologic processes, but focal disruption affecting this layer alone is more unusual. The age of our patient and the timing and resolution of symptoms make a degenerative process or early macular dystrophy unlikely and point to a more transient process, possibly inflammatory in nature. Recently described cases of retinal toxicity associated with the use of “poppers” (amyl nitrate) show similar OCT findings, but our patient denied any history of recreational drug use. OCT anomalies reported in acute macular neuroretinopathy resemble those demonstrated here, but in our patient the typical wedge-shaped macular lesion was absent (including on infrared fundus imaging, which is sensitive for that), and the symptoms resolved over a few weeks.

The multiple evanescent white-dot syndrome (MEWDS) and related entities such as acute zonal occult outer retinopathy (AZOOR) have been associated with disruption of the IS/OS line, particularly at the fovea in MEWDS. However, other features of these syndromes, including photopsia, white dots, or persistent retinal changes, were not seen. Visual field testing was also normal. Additionally, our patient underwent ICGA, which failed to show characteristic hypofluorescent changes.

The presenting symptoms, together with a grossly normal clinical examination, might well have been classified as having been caused by migraine, nonorganic sources, or optic nerve disease. Spectral domain OCT is valuable in localizing pathology in such patients, preventing misdiagnosis or unnecessary neuroimaging. The cause remains unclear in this case, but we suggest that it may represent a hitherto unreported variant of the MEWDS/AZOOR spectrum.

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