Management of intra-vitreal cysticercosis

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Abstract

Background: South East Asia is an endemic zone for cysticercosis. Ocular cysticercosis is emerging as a common problem which if untreated can lead to severe visual loss in 3-5 years.

Cases: We describe here a case series of three patients with intravitreal cysticercosis and managed by surgical cyst removal by pars plana vitrectomy.

Observation: The procedure was successful in all cases to maintain anatomical integrity of the globe with some functional gain of vision.

Conclusion: Surgical intervention in ocular intravitreal cysticercosis is an acceptable approach with good results.

Key words: cysticercosis, ocular cysticercosis, intravitreal cysticercosis

We are presenting here a series of three cases of intravitreal cysticercosis seen over a 2 year period (2007-2009) in Biratnagar Eye Hospital. All the cases were managed surgically. After freeing the cyst from vitreous attachment by three ports 20 gauge pars plana vitrectomy (PPV) it was removed by suction with the vitreous cutter. Oral albendazole 400mg BD for 1 month & oral prednisolone in tapering dose starting with 1mg/kg body weight per day were given to each patient. Blood counts, Stool examination and head CT scan had been performed in all cases but Serological tests were not carried out due to lack of test availability and limited diagnostic value. Symptomatic general body review including CNS was within normal limit in all cases.

Case 1

A 22 yr old male from Assam / India presented in our hospital with painless progressive loss of vision since 2 months in his left eye. Visual acuity was 6/6 and 6/24 (right and left eye respectively). Slit lamp examination revealed no abnormality. Ophthalmoscopy of his left eye showed intravitreal cysticercosis temporal to fovea, which was confirmed by B-scan ultrasonography. History of pork diet was absent. Complete blood counts, stool test for microscopy/parasites and CT- brain revealed no abnormality.

Oral albendazole 400mg B.D. with oral prednisolone was started and PPV carried out after 3 days. The
Cyst was removed with vitrectomy probe after clearing all the adherent vitreous. Endolaser was applied to the ischemic parts of the retina. Silicon oil was used as a vitreous substitute and also to keep the edematous retina in the macular region reattached.

Post operative and follow up period was unremarkable. Repeated blood tests showed normal findings. Repeated stool tests were negative for any type of ova or cyst. Silicone oil removal was done after 6 months without any complications. The final visual acuity stabilized at 6/12 in the operated eye.

**Case 2**

A 35-year old female from Jhapa / Nepal presented with HM visual acuity in right eye and 6/6 in left eye. Her complaints were progressive loss of vision in right eye from last few months with pain during last few days prior to her visit. On examination intravitreal cyst was found in her right eye with accompanying vitritis. B-scan confirmed the diagnosis of cysticercosis. History of pork meal was present. Blood and stool tests as well as brain CT-scan found no abnormalities. Oral Steroids and albendazole were started and PPV done with cyst removal by vitrectomy probe as in case 1 after vitritis had resolved. Post operative and follow up period in this case too were uneventful with normal blood counts and stool tests. She is in our regular follow-up and her best corrected vision is 6/36. Silicon oil has not yet removed.

**Case 3**

A 25 year-old male patient from Damak / Nepal presented with progressive painless loss of vision in left eye since last one month with presenting visual acuity of 6/6 and counting fingers (CF) in one meter in the right and left eyes respectively. During examination, we diagnosed intravitreal cysticercosis with associated central tractional retinal detachment. History of pork diet was present. CT brain identified multiple cysts in the brain parenchyma but surprisingly without any symptoms. We managed the case surgically similarly like first two patients. Due to brain parenchyma involvement the patient was initially admitted to a neurosurgical ward for observation during the first two days of treatment with oral albendazole and steroids. Post operative period in this case was also uneventful. On first postoperative day his vision was 6/60. A long term follow up is still pending.
Discussion

The ocular cysticercosis is an important cause of visual morbidity in this region. More work is needed to provide ophthalmologists with proper management guidelines. Our experience is small but nevertheless demonstrated typical clinical pictures of the disease. All our cases presented with a unilateral ocular disease and were consistent with other studies (Grover & Puri, 1996; George et al, 1999) carried out in different parts of the word. For management strategies conflicting reports exist in the literature. Some reports from India advocate early surgical intervention (Shekhar & Honavar, 1999; Sekhar & Lemke, 1997) and our experience is also the same. In all our cases, we surgically removed the cyst by PPV under the coverage of steroids and albendazole. This technique was found simple and reliable. It stabilizes the anatomy of the affected eye and prevents the patient from experiencing severe visual loss or even blindness which would otherwise occur if left untreated. The CNS involvement which can cause severe implication is considered as a rare association. But our case series showed involvement in one patient. We, therefore, advocate CT scan of the head mandatory in all cyst cases to prevent any devastating complication in time.

References


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