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ASSOCIATION OF VITREO- RETINA SPECIALISTS OF SRI LANKA

15th COLOMBO RETINA MEETING

ASSOCIATION OF VITREO RETINA SPECIALISTS OF SRI LANKA

Innovate and Educate to Advance Sri Lankan Retina Care

ABSTRACTS OF E-POSTER PRESENTATIONS

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ABSTRACTS OF E-POSTER PRESENTATIONS

CRM EP01

Beyond CHRPE: Bilateral Giant Retinal Tears in a Teenager with Familial Adenomatous Polyposis Phenotype: Coincidence or Connection?

Mendis BMIU, Dayawansa KR, Upendran N, Munasinghe TD, Guruge KGAU, Aravindika GAD

Background: Familial adenomatous polyposis (FAP) is an autosomal dominant disorder associated with colorectal polyposis and characteristic extracolonic manifestations, including congenital hypertrophy of the retinal pigment epithelium (CHRPE). These ocular lesions are typically benign and confined to the retinal pigment epithelium, with no known association with vitreoretinal interface pathology.

Case Presentation: We report a 14-year-old girl with a strong family history of FAP, whose father and paternal sibling died of colorectal carcinoma. She had previously been noted to have very few bilateral fundus lesions consistent with early CHRPE. She presented with intermittent photopsia in both eyes and was found on examination to have bilateral giant retinal tears with associated localized retinal detachment. There was no history of trauma, high myopia, or other predisposing factors. The patient underwent successful bilateral vitreoretinal surgical repair with satisfactory anatomical outcomes.

Conclusion: The occurrence of bilateral giant retinal tears in a young patient with phenotypic features of FAP is highly unusual and, to our knowledge, has not been previously reported. While this may represent a coincidental finding, a potential association cannot be excluded. This case raises the possibility of an expanded ocular phenotype in FAP and highlights the importance of careful peripheral retinal evaluation in such patients.

CRM EP02

Cytomegalovirus Retinitis as Unmasking IRIS Following ART Initiation in an HIV-Positive Patient

Nilanka KAS, Gurusinghe L, Warnakula PMT, Seneviratne MD, Jithmini KA

Introduction: Cytomegalovirus (CMV) retinitis is a sight-threatening opportunistic infection seen in advanced HIV infection. Following initiation of antiretroviral therapy (ART), immune recovery may trigger immune reconstitution inflammatory syndrome (IRIS), leading to unmasking of previously subclinical infections.

Case Presentation: A 29-year-old retroviral-positive male presented with a 2-day history of progressive, painless blurring of vision in the left eye, occurring two weeks after initiation of ART. There were no associated systemic or neurological symptoms.

Visual acuity was 6/6 in the right eye and 6/12 in the left eye. Anterior segment examination was normal. Fundoscopy of the left eye revealed retinal whitening with yellow-white granular lesions, flame-shaped haemorrhages with retinal vasculitis, and mild vitritis, producing a characteristic "cheese and ketchup" appearance. The right eye was initially normal but later developed similar changes. The patient had been recently diagnosed with retroviral positive and commenced on first-line ART with cotrimoxazole prophylaxis. Baseline investigations excluded tuberculosis and other infections.

Management: The patient was started on intravenous ganciclovir (5 mg/kg twice daily) with intravitreal ganciclovir to the affected eye. When the right eye became involved, intravitreal injections were given to both eyes. Serial fundoscopic examinations showed improvement, and step-down to oral valganciclovir was planned. ART was continued.

Discussion and Conclusion: This case highlights CMV retinitis as an unmasking IRIS shortly after ART initiation. The temporal association, clinical features, and progression support this diagnosis. Early recognition and prompt antiviral therapy are essential to prevent irreversible visual loss and bilateral disease. Routine ophthalmic screening in patients initiating ART is crucial for early detection and improved outcomes.

CRM EP03

Rewiring the Visual Brain Outcomes of Vision Therapy in Post-Traumatic Visual Dysfunction

Roshayni Ashka Jayasinghe, Kumarage CJ

Purpose: To evaluate the effectiveness of structured vision therapy in improving functional visual outcomes in pediatric patients with persistent visual deficits following ocular trauma and surgical intervention, where residual deficits are identified as functional rather than structural in origin.

Methods: A prospective pre–post case series was conducted involving two pediatric patients with visual deficits following ocular trauma.

- **Patient 1 (Age 11):** Left eye pseudophakia with reduced visual acuity despite optimal correction. Underwent phacoemulsification with intraocular lens implantation.
- **Patient 2 (Age 12):** Right eye hypotropia and absent stereoacuity, underwent cryo-buckle surgery for retinal detachment, with a baseline visual acuity of 6/60. Optical Coherence Tomography (OCT) confirmed no structural abnormalities, indicating a functional deficit.

Standardized orthoptic assessments were performed. Patient 2 underwent 25 sessions of office-based vision therapy over 3 months, including VIVID software training, fixation exercises, and vergence rehabilitation.

Results: Both patients demonstrated significant clinical improvements in visual acuity and stereopsis.

- **Patient 1:** Left eye visual acuity improved from 6/18 to 6/12, with stereoacuity improving from 110 to 55 seconds of arc.
- **Patient 2:** Right eye visual acuity improved from 6/60 to 6/18. Stereoacuity improved from absent to 340 seconds of arc.

Conclusions: Structured vision therapy resulted in significant functional visual improvements—including gains in visual acuity, recovery of stereoacuity, and restoration of binocular function—outcomes not achieved by surgical intervention alone. These findings suggest that persistent post-surgical visual deficits may have a functional component requiring targeted rehabilitation. Vision therapy should be considered a routine adjunct in the post-surgical management of pediatric ocular trauma patients.

CRM EP04

Where is the lesion? A rare case of ICA aneurysm originating from clinoid segment

Wathsala Gunasekera, Waruna Wijayasiriwardena

Introduction: It is widely known that oculomotor palsy can be caused by compression of an aneurysm at the junction of the internal carotid artery (ICA) and the posterior communicating artery, the junction of the basilar and superior cerebellar artery, or the cavernous segment of the ICA. We experienced a rare case of an anterolaterally projecting aneurysm at the clinoid segment of the ICA causing oculomotor palsy.

Internal carotid artery aneurysms that arising from the clinoid part may produce a mass effect and consequently a set of neurological deficits, including diplopia from oculomotor nerve involvement, decreased visual acuity from optic neuropathy, facial hypoesthesia from involvement of the trigeminal nerve, and less frequently facial pain.

Methodology: A 52-yr old female presented with sudden onset binocular diplopia and drooping of the left upper eye lid for 1 week duration. On examination VA is 6/9. Left side partial ptosis and pupil affected 3rd cranial nerve palsy. Left abducens nerve impaired. 1st, 2nd and 3rd branches of trigeminal nerve was intact. Fundus examination revealed normal optic nerve. Patient underwent urgent contrast CT which revealed a large mass involving left cavernous sinus which could be meningioma or ICA aneurysm. Patient underwent CT angiogram which revealed large ICA aneurysm at clinoid part. Patient was immediately referred for neurosurgical intervention.

Conclusion: Unruptured intracranial aneurysms account for up to 3% of the general population and are commonly seen at the bifurcation of arteries of circle of Willis. They are generally asymptomatic unless they rupture resulting in subarachnoid hemorrhage which is the most dreaded complication. Aneurysms of the carotid artery that arise from the internal carotid artery particularly supraclinoid Internal carotid artery (ICA) can remain asymptomatic if small (<10 mm in diameter) or may progress and enlarge causing headache and cranial nerve palsies particularly visual deficits caused by the local mass effect of the aneurysm on the anterior optic pathway. Unruptured supra-clinoid carotid aneurysms are more frequently diagnosed with MRI particularly those presenting with compressive symptoms on the visual pathway. MRI is also useful in ruling out other differential diagnoses and follow up. Digital subtraction angiography remains the gold standard for confirmation of diagnosis and assessment for potential surgical or endovascular planning. However, their management is still controversial due to the natural history of these vascular lesionsand associated risks of their repair. There are two types of treatment: surgical clipping and endovascular coiling. Both treatment methods effectively prevent rupture. Otherwise, conservative management is reserved for asymptomatic aneurysms measuring less than 10 mm as they are less likely to rupture.

CRM EP05

Superotemporal Branch Retinal Vein Occlusion Following Electrocution in a Young Healthy Adult Without Vascular Risk Factors: A Rare Case to Report

Banu AMS, Dias JD

Purpose: To report a rare case of superotemporal branch retinal vein occlusion (ST BRVO) following accidental electrocution in a young patient without identifiable systemic or ocular vascular risk factors, and to explore possible underlying mechanisms.

Methods: A single case report of a 32-year-old previously healthy male who presented with sudden painless blurring of vision in the right eye two days following low-voltage electrical injury. Comprehensive ophthalmic evaluation, including fundus examination, optical coherence tomography (OCT), and fundus fluorescein angiography (FFA), was performed. Systemic evaluation excluded hypertension, diabetes mellitus, hyperlipidemia, and thrombophilia.

Results: Best-corrected visual acuity was 6/18 in the affected eye. Fundus examination revealed sectoral intraretinal hemorrhages, dilated tortuous veins, and cotton wool spots localized to the superotemporal quadrant, consistent with ST BRVO. OCT demonstrated macular edema with cystoid changes. FFA confirmed delayed venous filling and capillary non-perfusion in the corresponding area. No embolic source or systemic abnormality was identified. The temporal association with electrocution suggested a causative link. The patient was managed with intravitreal anti-VEGF therapy, showing anatomical improvement and partial visual recovery over follow-up.

Conclusions: Electrical injury, even at low voltage, may precipitate retinal vascular occlusions through mechanisms such as endothelial damage, vasospasm, or thrombotic events. This case underscores the importance of considering retinal vascular complications in patients presenting with visual symptoms after electrocution, even in the absence of traditional risk factors. Early recognition and prompt management are crucial for visual prognosis.

CRM EP06

Bilateral Panuveitis – Ocular manifestation associated with chikungunya

Sahila P, Malaravan M

Purpose: To describe a case of bilateral panuveitis, developed three months after Chikungunya viral infection

Method: A middle-aged female patient with DM presented with reduced vision in her right eye over the last four days. Best corrected visual acuity was 6/18 in her right eye and 6/6 in her left eye. Previous examination by another Ophthalmologist was only a disc edema in the right eye. As she was doing OCT macula the next day, the technician noticed subretinal fluid at macula and suspected a retinal detachment and referred the patient to VR clinic.

On examination she had AC cells 2+ in both eyes. Occasional cells in vitreous with multiple serous retinal detachment with disc edema in the right eye with choroidal detachment. There was minimal subretinal fluid in the left eye with very peripheral choroidal folds were also identified. Patient denied any ocular trauma or surgery. There was an associated right sided headache. No hearing impairment. Patient also mentioned she had suffered from Chikungunya three months earlier.

Results: Basic blood investigations were normal other than thrombocytosis. Blood picture concluded that it was due to reactivity. Other investigations such as CXR, ESR, CRP, HIV, VDRL were all negative. IgG for Chikungunya was weakly positive and IgM was negative. High dose of systemic steroid (oral prednisolone 1mg/kg) was started. And the ocular signs started to improve from 3rd day.

Conclusion: Ocular examination following Chikungunya like viral illness should be carefully done for the features of panuveitis which responds well with timely systemic steroid treatment.

CRM EP07

Likely Lupus Retinopathy

Mathugamage D, Gamage N, de Silva J. de Soyza A, Wewalwala D

Purpose: Systemic lupus erythematosus (SLE) is a complex autoimmune inflammatory disease of unknown etiology. It is characterized by involving multiple organ systems, often with a relapsing and remitting clinical course. Almost one third of SLE patients demonstrate an array of ocular manifestations. The most common manifestation is SLE retinopathy.

Methods: Single case presentation.

Results: 19 yrs old girl treated for suspected Tb lymphadenitis with ATT developed SJS to rifampicin. While managed at ICU she experienced Sub acute vision loss bilaterally. Fundus findings showed pale discs. attenuated vasculature and features of CRAO, vasculitis and macula edema. Currently treated with systemic and periocular steroid and Anti VEGF.

Conclusion: Retinopathy is an important manifestation of SLE, which develops with an incidence of 3-29%. SLE retinopathy points to active lupus, anti-phospholipid antibody syndrome (APS), central nervous system lupus or drug-induced. Fundus examination is important because ocular fundus is the only part of the human body where small vessels can be directly visualized in a noninvasive manner. A characteristic finding of lupus retinopathy is vasculitis of retinal capillaries associated with local microinfarction. Large retinal vessel occlusions (central or branch; vein or arteriole) are more common with APS associated with SLE. The mainstay of treatment is systemic immune-suppression.

CRM EP08

Nutritional Retinopathy in Practice: Electrophysiology-Guided Diagnosis and Recovery

Warnakula PMT, Ragunathan R, Munasinghe TD, Wariyapola D

Nutritional deficiencies are important, potentially reversible causes of retinal dysfunction that are often under-recognized in clinical practice. We present two cases demonstrating electrophysiological and functional retinal changes associated with Vitamin A and Vitamin B12 deficiencies.

Case 1

A 41-year-old male presented with progressive nyctalopia over eight months, with no history of diabetes or systemic illness. Fundus examination revealed peripheral retinal atrophic changes. Humphrey Visual Field (30-2) testing showed peripheral field involvement. Full-field electroretinography demonstrated extinguished b-waves, reduced a-wave amplitudes, and delayed flicker responses, consistent with severe rod-cone dysfunction. Serum analysis confirmed Vitamin A deficiency. Following supplementation, the patient showed marked symptomatic improvement.

Case 2

The second case involved a 33-year-old male, a strict vegetarian, presenting with gradually worsening vision over one year. Electrophysiological evaluation revealed a reduced P50 response, suggestive of macular dysfunction. Laboratory investigations confirmed Vitamin B12 deficiency. Following parenteral Vitamin B12 supplementation, there was improvement in the P50 amplitude along with stabilization of visual symptoms.

Early recognition through careful clinical history and targeted investigations is essential, as timely supplementation can lead to significant functional recovery and prevent irreversible visual loss.

CRM EP09

Searching vision after chasing elephants - A case report of LASER Retinopathy

Wathsala Gunasekera

Objective: LASER retinopathy is increasingly prevalent among general population at present due to free availability of commercial LASER incorporated devices such as pointers, toys, lights, and torches. Even though it is freely available to use there is lack of awareness about how to protect the eyes and the potential damage it can cause among the public. This has led to increased incidence of LASER eye injuries. In our case we studied an accidental LASER injury due to torch usually used to chase wild animals in order to protect crops from them by the farmers.

Methodology: A 25-yr old female presented to eye clinic with sudden loss of left eye vision after accidental exposure to torch containing LASER. Her VA 6/60 left eye. Fundus showed RPE changes. OCT showed disruption of the ellipsoid zone and RPE under the fovea.

Results: Patient was treated with NSAID eye drops and followed up with serial VA and OCT testing. Her VA gradually increased upto 6/18. Patient and family education was done.

Conclusion: LASER retinopathy can happen due to accidental or intentional exposure to LASER light. It can cause mild to severe reduction of vision. Key OCT features are disruption of ellipsoid zones and RPE. No proven treatments available. With time vision can be improved to a varying degree. Public awareness is utmost important in order to prevent LASER injuries.

CRM EP10

Delayed Auto-Closure of a Macular Hole Under Long-Term Silicone Oil Tamponade After Repair of Macular Hole Retinal Detachment

Batuwangala KC, Sriharanathan P

Objectives: To report delayed anatomical closure of a persistent macular hole under long-term silicone oil tamponade following macular hole retinal detachment repair.

Methods: Observational case report of a 62-year-old male with a pseudophakic macular hole retinal detachment associated with proliferative vitreoretinopathy grade A, managed with pars plana vitrectomy, internal limiting membrane peeling, and silicone oil tamponade, followed with serial optical coherence tomography examinations.

Results: The macular hole remained open for at least 6–7 months postoperatively despite complete retinal reattachment. Subsequent OCT demonstrated complete macular hole closure under silicone oil. After silicone oil removal, anatomical closure remained stable with improved visual acuity, with final best-corrected visual acuity of 20/50 (0.4 logMAR) recorded in January 2026.
Conclusion: Macular hole closure may occur after prolonged persistence under silicone oil tamponade. Extended observation with serial OCT may be justified in selected, anatomically stable eyes following macular hole retinal detachment repair.

CRM EP11

Spontaneous peeling of epiretinal membrane (ERM)

Sahila P

Purpose: To describe a case of spontaneous peeling of ERM while awaiting for the surgery for four months with improved vision.

Method: A 50 year old male patient had undergone vitrectomy for rhegmatogenous retinal detachment in the right eye couple of years ago. He also had 360 degree prophylactic barrier laser for his left eye at the same time. He presented with significant visual loss in the left eye from 6/9 to 5/60 over 2-3 weeks. On examination he had an ERM with macula puckering. OCT showed ERM extending over the macula with diffuse macular oedema. He was registered for a routine surgery of Left vitrectomy with membrane peel.
Results: The patient presented 4 months after with the complain of flashes in the left eye. However, the uncorrected visual acuity had improved to 6/9 with the fundus examination showed rolled out ERM towards the temporal aspect and opened up superior break that was anterior to the barrier laser. OCT was done to confirm the rolled out ERM with the macula thickness became normal. The patient was explained the spontaneous peeling of ERM.

Conclusion: Spontaneous peeling or separation of ERM is a rare (1-3%) but well documented phenomenon. The probable mechanism would be completion of PVD which simultaneously pulled the ERM or the contractual forces of the membrane itself. Therefore, it might be worth to follow-up or observe the patients with relatively recent onset of ERM to assess the progression before deciding on surgical intervention.

CRM EP12

Idiopathic Intracranial Hypertension in a Non-Obese Adolescent Male: A Diagnostic Challenge

Jithmini KA, Warnakula PMT, Nilanka KAS, Gurusinghe L, Goonesekara DT

Purpose: To report an atypical presentation of Idiopathic Intracranial Hypertension (IIH) in a non-obese adolescent male, emphasizing the importance of neuro-ophthalmic evaluation and appropriate neuroimaging in atypical demographics.

Methods: A 15-year-old non-obese male with high astigmatism and spectacle use since age six presented with a three-week history of headache, tinnitus, and binocular diplopia. Comprehensive ophthalmic examination, contrast-enhanced CT, MRI brain and orbits, MR Venography, and lumbar puncture were performed. Diagnosis was established using modified Dandy criteria.

Results: Examination revealed bilateral papilledema and left lateral rectus palsy with preserved visual acuity and colour vision. Intraocular pressure was normal bilaterally. Contrast-enhanced CT was unremarkable. MRI demonstrated prominent CSF sheaths surrounding bilateral optic nerves. MR Venography excluded cerebral venous thrombosis. CSF opening pressure was elevated at 26.6 cmH_2O with normal biochemical and cytological composition. BMI was 21.6 kg/m^2, confirming non-obese status. No secondary cause was identified. Diagnosis of IIH was confirmed. Oral acetazolamide 125mg twice daily was initiated with gradual resolution of symptoms.

Conclusions: IIH should not be dismissed in non-obese adolescent males, as this case demonstrates that the condition can occur outside its classic demographic profile. Lateral rectus palsy as a false localizing sign and optic nerve sheath distension on MRI are important diagnostic clues. A high index of clinical suspicion, prompt neuroimaging, and lumbar puncture are essential in atypical presentations. Early diagnosis and timely initiation of acetazolamide can achieve favorable outcomes and prevent irreversible visual morbidity.

CRM EP13

Ocular Syphilis in the OCT Era: A Retinal Window into a Re-emerging Syphilis

Sathiyaraj B, Sriharanathan P, Kanchana Wijesinghe

Purpose: To report a case of ocular syphilis presenting as unilateral intermediate uveitis in a patient and to highlight its relevance in the context of the rising syphilis incidence in Sri Lanka.

Methods: A 54-year-old man presented with two weeks of painless unilateral visual blurring. Clinical examination showed left intermediate uveitis with a quiet anterior segment, no snowbanking, no disc oedema, and no retinal vasculitis. The fellow eye was normal. Because the phenotype was not typical of pars planitis, targeted systemic screening was performed for infectious and inflammatory causes. OCT was used as the primary imaging tool, as fluorescein angiography was declined.

Results: OCT revealed outer retinal changes suggestive of syphilitic outer retinitis (SOR). Serology confirmed active syphilitic infection with a serum VDRL titre of 1:256 and positive confirmatory testing. Although CSF analysis was negative, the ocular phenotype was managed as ocular syphilis/neurosyphilis. The patient received intravenous aqueous crystalline penicillin with corticosteroid cover. Following treatment, ocular inflammation resolved, OCT showed structural recovery of the outer retina, and VA improved from 0.8 logMAR to 0.2 logMAR.

Discussion: A primary diagnostic challenge in SOR is the deceptively normal funduscopic appearance. Our patient presented without systemic symptoms, and no disclosed sexual risk history. Ocular syphilis may present as vitritis, intermediate uveitis, posterior uveitis, outer retinal disruption, subretinal deposits, or subtle OCT changes. National data show an upward trend in syphilis, with 637 early syphilis cases and 832 late syphilis cases reported in 2024, predominantly among males.

Conclusion: The eye is a window—not just to the body, but to the diagnosis. OCT helps us discern. Ocular syphilis should be considered as form of neurosyphilis, and treatment should not be delayed because of negative CSF findings.

CRM EP14

Laser Pointer Maculopathy: A Preventable Threat from Excessive Power in Commercial Laser Pointers

Ranasinghe RMSDK, Sathiyaraj B, Karunarathna KPRP, Bandaranayaka YMTGRS, Kuruppu I

Purpose: To raise awareness of laser pointer maculopathy, its risks and clinical impact, while emphasizing the importance of education, regulation, and prevention to reduce avoidable vision loss.

Introduction: There is a growing trend of laser-related ocular injuries associated with high-powered handheld laser devices. The lack of awareness about their sight-threatening potential increases the risk of both inadvertent and intentional misuse. Strengthening public awareness regarding the hazardous effects of lasers is essential to prevent permanent vision loss as treatment options are currently limited

Case study: A previously well 14-year-old boy presented with a central scotoma in his right eye. The symptoms noticed two days after a direct exposure to a laser pointer through cornea. he experienced no discomfort during or immediately after the incident. The laser, which he had used at school laboratory as pointer, was labelled as class 3B with a wavelength of 650nm. At presentation, visual acuity of the right eye and left eye was 6/18 and 6/6, respectively. Funduscopic examination revealed pale spots in the left maculae involving fovea. Right side oct shows Loss of the normal smooth foveal depression with localized disruption at the fovea, focal hyperreflectivity and disruption of the ellipsoid zone at the foveal center and subtle irregularity of RPE. Fundal autofloroscene showed high uptake.

Discussion: Permanent tissue damage occurs through three mechanisms; ionization, thermal and photochemical. The type of laser used, wavelength, exposure time and spot size are major determinants of the extent of tissue injury. Thermal injury occurs with exposures ranging from microseconds to up to 10 seconds. If exposure exceeds 10 seconds, tissue destruction is due to photochemical, with phototoxic chemical reactions resulting in cell death and permanent vision loss. this patient exposed laser more than 30 seconds Prognosis: At sixth week oct showed thinning and loss of photoreceptor integrity at fovea and visual regain and follow up arranged for monitor the choroidal neovascularization.

Conclusion: Inappropriately used class 3 or 4 lasers should be considered weapons that can cause permanent blindness, even with brief exposures. We advised the school staff and students regarding the laser injuries and letter written to health ministry and government to limit the commercial availabilities of high-power hand-held laser devices.

CRM EP15

Hidden No More: Capturing the Evolution of Pigmented Paravenous Retinochoroidal Atrophy

Vitharana BHNR, Wariyapola DHH, Pavithran S, Iqbal FA, Dias S

Purpose: Pigmented Paravenous Retinochoroidal Atrophy (PPRCA) is a rare retinal disorder of unknown etiology, with diagnosis primarily based on characteristic fundus changes. Serial documentation of fundus evolution in PPRCA is seldom reported. We present an 8-year series of fundus images illustrating gradual pigmentary progression, supported by multimodal retinal investigations.

Methods: A 26-year-old female patient was referred for repeat electroretinography (ERG). Fundus examination and color fundus photography were performed, and previous clinical records were reviewed. Additional investigations included refraction, visual field assessment, optical coherence tomography (OCT), fundus autofluorescence (FAF), and ERG.

Results: Initial fundus photographs demonstrated subtle, non-specific retinal pigment epithelial (RPE) alterations without classical pigment clumping. Sequential imaging revealed gradual development of paravenous pigment clumping with progressive retinochoroidal atrophic changes, eventually evolving into a characteristic PPRCA phenotype. FAF demonstrated increasing hypoautofluorescent paravenous areas corresponding to RPE atrophy. OCT showed peripapillary and temporal peripheral outer retinal layer discontinuity. Visual field testing revealed peripheral defects with preserved central vision. ERG indicated rod–cone dysfunction with possible borderline macular involvement.

Conclusions: This case illustrates the sequential evolution of PPRCA in a symptomatic patient prior to the appearance of classical fundus findings. Serial imaging suggests a progressive pattern of pigmentary change, with abnormalities initially arising in the peripheral retina before extending along retinal veins to produce the characteristic paravenous phenotype.

CRM EP16

Seeing Beyond Redness: A Case of Indirect Carotid-Cavernous Fistula

Aberathna BMTP, Waruna Wijayasiriwardana, Kumudu Anthony

Purpose: To emphasize the importance of early recognition of indirect carotid-cavernous fistula (CCF) in patients presenting with persistent red eye and subtle ocular signs, as delayed diagnosis may lead to progressive ocular and neurological complications.

Methods: A 45-year-old female presented with progressive redness of the right eye, ocular pain, and gradual reduction of vision over five months. Clinical examination revealed a red eye with mild proptosis. Slit-lamp examination showed dilated, tortuous episcleral vessels in the right eye, suggestive of elevated episcleral venous pressure and an underlying vascular cause. Further investigations were performed to evaluate vascular causes, including cerebral angiography and digital subtraction angiography for confirmation of the diagnosis.

Results: Cerebral angiography confirmed a right-sided carotid-cavernous fistula. Digital subtraction angiography demonstrated arterial supply from branches of the bilateral external carotid arteries. The clinical and radiological findings were consistent with a low-flow dural CCF. Following diagnosis, the patient was referred for definitive neuro-interventional management, including embolization.

Conclusions: Indirect CCF should be considered in patients with persistent unilateral red eye, particularly when associated with pain and visual impairment. Anterior segment examination to identify dilated episcleral vessels, along with imaging, is essential for early diagnosis and appropriate management. Delayed recognition may result in persistent venous hypertension, leading to secondary glaucoma, diplopia, and permanent visual deterioration. Early recognition is important to prevent these complications.

CRM EP17

Evolving Diagnosis in a Patient with Optic Disc Edema and Vitritis: From Presumed Tuberculosis to Neurosyphilis

Munasinghe TD, Dayawansa KR, Upendran N, Aravindika D, Guruge A, Fonseka S

Purpose: To describe a case of ocular inflammation with evolving clinical diagnosis, highlighting the challenges in differentiating infectious uveitic etiologies in a tuberculosis-endemic setting.

Methods: A single case report of a patient presenting with progressive visual loss in the left eye associated with optic disc edema. Initial evaluation suggested optic neuritis. Subsequent development of vitritis with vitreous haze and cells, along with elevated inflammatory markers (ESR 60 mm/hr) and a positive Mantoux test (14 mm), raised suspicion of ocular tuberculosis, and anti-tubercular therapy (ATT) was initiated. MRI brain with contrast showed no significant abnormalities involving the optic nerves.

Results: Despite ongoing ATT, further evaluation was undertaken due to diagnostic uncertainty. Serological testing revealed positive treponemal and non-treponemal markers, including syphilis serology with TPPA and VDRL, leading to a diagnosis of neurosyphilis. The patient was commenced on intravenous Penicillin G for 14 days, followed by intramuscular Benzathine Penicillin. Lumbar puncture and further systemic evaluation are ongoing.

Conclusions: This case demonstrates the evolving nature of diagnosis in ocular inflammatory disease and highlights the importance of maintaining a broad differential in patients with disc edema and vitritis. Neurosyphilis should be considered even in the presence of supportive findings for tuberculosis, particularly in regions with overlapping infectious disease burdens.

CRM EP18

When VKH deviates; Blinding atypical VKH requiring early immunosuppressants

Karunarathne M, Niroshan N, Navarathna N, Vaikunthan N, Sidath S

Purpose: To describe the diagnostic challenges and successful therapeutic interventions in a teenage male with blinding bilateral acute VKH features. By detailing a case that was refractory to steroids but responsive to immunosuppressants, this report seeks to provide evidence for escalating treatment protocol when standard of care 'steroids' fail to arrest progressive intraocular inflammation.

Method: A case report is presented. A 23-year-old previously healthy male presented with bilateral granulomatous pan uveitis with exudative retinal detachments. With presenting visual acuity of bilateral HM, clinical data, multimodal imaging (OCT, FFA, MRI, ERG) and therapeutic interventions were analyzed. Patient's clinical course was tracked from initial presentation through corticosteroids failure to successful induction of remission using IV Infliximab. Visual acuity and anatomical resolution were primary outcomes.

Results: Patient was extensively investigated for possible differentials yet all being negative. Left eye TPPV+ SIO done. Initial trial of corticosteroids failed to achieve remission substituted with IV Infliximab monthly 3 doses resulted in BCVA recovery from HM to 6/12 and marked reduction in SRF with complete resolution of exudative RD. Patient was successfully tapered off systemic steroids while maintaining clinical stability on immunosuppressants.

Conclusion: This case demonstrates that steroid refractory VKH in a teenage male can be successfully managed with targeted immunosuppressants. Clinicians must be ready for quick transition to 2nd line agents if SRF persists despite high dose of steroids. Early aggressive management is the key to prevent progression to chronic sunset glow stage and serve favorable visual prognosis.

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