Orbital apex syndrome secondary to aspergillosis

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ABSTRACT

Objective: To highlight the challenges in investigating and managing orbital apex syndrome secondary to fungal sinusitis. **Method:** a Case Report. **Results:** A 59-year-old lady with underlying DM, CKD, HPT and anaemia presented with persistent severe headache for 2 months, associated with right eye progressive loss of vision for 1 month and swelling for 1 week. Further history revealed a chronic clear nasal discharge for 3 months. There was no history of fever, trauma or constitutional symptoms. On examination, the patient was afebrile and GCS full. Right eye showed ptosis and proptosis but not injected and no chemosis. Right, and left eye vision was CF and 6/36 respectively. Relative afferent pupillary defect (RAPD), total ophthalmoplegia and decreased corneal sensation present in the right eye, whereas the fellow eye showed a limitation in the abduction and decreased corneal sensation as well. Blood investigations revealed high ESR, high CRP with normal WBC. Imaging study was limited to non-contrast MRI due to patient's low Estimated Glomerular Filtration Rate and soft tissue intensity was seen at the right orbital apex, posterior ethmoid and sphenoid sinuses. However, the possible underlying aetiologies being infection, inflammation or neoplastic was unable to be differentiated. Initial management includes empirical systemic antibiotics and systemic antifungal. The patient was referred for endoscopic sinus surgery and right orbital decompression as no improvement of clinical features despite treatment. Intraoperatively, culture and sensitivity showed Aspergillus Fumigatus and further treatment was revised accordingly. **Conclusion:** Diagnosing orbital apex syndrome caused by fungal sinusitis is challenging. A high index of suspicion and prompt treatment is important to improve outcome.

KEY WORDS:

Orbital apex syndrome, aspergillosis

Paediatric unilateral isolated abducens nerve palsy: A malignant brainstem tumour with brain herniation

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ABSTRACT

Objective: To report a case of a highly aggressive paediatric brainstem tumour presented with unilateral isolated abducens nerve palsy. **Method:** a Case Report. **Results:** A premorbidly healthy 9-year-old Chinese boy presented with 2 weeks history of left eye inward deviation. He denied blurring of vision or double vision. Clinically, the patient was well with no constitutional symptoms, fever or symptoms of increased intracranial pressure. Examination showed left eye esotropia with restricted abduction. Binocular diplopia was elicited during ocular motility test. Visual acuity was 6/6 in the right eye, 6/9 in the left eye with no relative afferent pupillary defect. Colour vision was normal. Tangent screen perimetry showed superior peripheral scotoma in the left eye. Both optic discs were hyperaemic and swollen, with the presence of glial tissue on right. Neurological examination revealed unsteady tandem gait but with no involvement of other cranial nerves, sensory or motor systems. An urgent computed tomography of the brain showed herniation of the distal medulla oblongata and cerebellar tonsil with a suspicious pontine parenchymal lesion. A subsequent magnetic resonance imaging of brain confirmed a diffuse expansile pontine lesion causing tonsilar herniation and hydrocephalus, consistent with diffuse intrinsic pontine glioma (DIPG). The patient was referred to neurosurgery team for further management. **Conclusion:** DIPG classically presents with the triad of multiple cranial neuropathies, long tract symptoms and ataxia. In cases with a non-classical presentation, awareness of ophthalmologist on this potential deadly paediatric brainstem tumour prompts an urgent detailed neuro-imaging and life-saving management.

KEY WORDS:

Diffuse intrinsic pontine glioma, abducens nerve palsy, brainstem tumour