

Choroidal folds in Graves' ophthalmopathy

To the Editor: We wish to report a case of choroidal folds in Graves' ophthalmopathy. This association is well recognised, being first reported in 1932.¹ This patient first noted sore eyes and a slight ptosis. Approximately one year later he became aware of intermittent vertical diplopia, thyroid dysfunction was recognised, and carbimazole treatment initiated.

Some months later he noticed blurred vision and was first seen here.

His visual acuities were 6/10 right and left. He had a left hypertropia with intorsion and a tight left superior rectus on forceps testing. Fundus examination showed marked symmetric choroidal folds (Figure 1). An orbital surgeon did not consider his orbits to be particularly tense and found no indication for decompression.

A two-week course of 50 mg prednisolone daily resulted in improvement of subjective vision to R

6/6, L6/6-, but had no effect on the folds or his ocular motility.

He had LSR recess sufficient to free the forced duction test, and LIR resect on adjustables. It was hoped that this 'internal decompression' might have lessened the folds and improved his vision, but it had no such effect. The consequences of choroidal folds on vision is variable. Fells, quoting Bird (personal communication), has suggested that striae that persist for longer than three to four weeks have a permanent effect on best visual acuity.

One can accept that increased orbital bulk from inflamed tissues may cause choroidal folds, but this did not seem to be the cause in this case. Our patient did not have significant orbital tension or marked proptosis. The exact mechanism of the development of these folds in mild Graves' ophthalmopathy remains uncertain, as does the management of such cases.

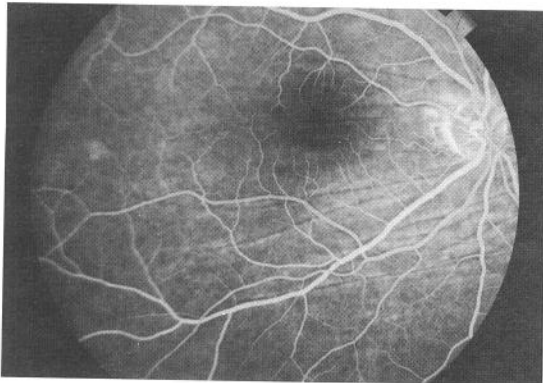


Figure 1

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References

1. Kugelberg I. *Rillenbildung in Retina als Ausdruck einer Deformation des hinteren Bulbaschnittes*. *Klin Monatsbl Augenheilkd*. 1932;89:171-83.