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Vi nerve palsy: a false localizing sign

Sneha Anil Kumar Tiwari
Vinayaka missions medical college, India

A 27 years old female patient came with the complaint of deviation of right eye since 15 days, binocular double vision 15 days and headache which was associated with vomiting since last 15 days. Patient describe the headache as worst headache, present whole day. No history of defective vision, ocular pain, stiff neck, fever, redness, photophobia, transient obscuration of vision. No history of diabetes, hypertension, asthma, epilepsy. Ocular examination showed esotropia in re 15 degree, no facial asymmetry, normal head posture. Anterior segment examination was normal in both yes(eyelid & adnexa, conjunctiva, cornea, anterior chamber, iris, pupil, lens) extraocular movements was restricted in both eyes for abduction (in re abduction was restricted upto -3 and in le -1) Diplopia charting was done which showed diplopia present . Intraocular pressure was 17.3mmhg both eyes cranial nerves examination showed bilateral (sixth) abducent nerve palsy, rest other intact im both eyes cns examination tone, power, gait, reflexes were normal both sides fundus in both eyes suggestive of chronic papilledema i.e., disc margins blurred,disc edematous, splincter hemorrhage present over disc margin. Cup obliterated, vessel tortous, 2:3, foveal reflex present. Mr brain with mr andiogram and venogram was done which showed partial empty sella with thinned pituitary gland in the floor of sella. Tortuous course of bilateral optic nerve with prominent perioptic csf space. No evidence of acute infract, hemorrhage or space occupying lesion noted. Mr angiogram was within normal limits mr venogram showed left transverse is hypoplastic. Impression- benign intracranial hypertension with clinical correlation clinical diagnosis so from case history, clinical finding and investigation i come to my clinical diagnosis – bilateral sixth nerve palsy due to benign intracranial hypertension.

drsnehahrj@gmail.com

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