Severe Graves Orbitopathy (GO)

Leslie Littlefield1* and C Michael Neuwelt2

1Medicine Alameda Health System Oakland, California, USA
2Medicine University of California San Francisco, California, USA

*Corresponding Author: Leslie Littlefield, Medicine Alameda Health System Oakland, California, USA, Tel: 916-862-8883; E-mail: llittlefield@alamedahealthsystem.org

Received date: April 10, 2017; Accepted date: April 11, 2017; Published date: April 18, 2017

Copyright: ©2017 Littlefield L, et al. This is an open access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Clinical Image

A 43 year old Filipino male with rapid onset severe visual decline had no light perception, significant bilateral proptosis and exposure keratopathy. Laboratory tests revealed a TSH of 0.9 mciU/mL, T4 0.59 ng/dL, and a TSI 368% of baseline. His hepatitis BsAg and Quantiferon Gold for TB were both positive and treated. A computerized tomography revealed prominence of bilateral extraocular muscles consistent with GO; biopsy revealed fibroadipose tissue and no infection. A diagnosis of GO was made and he failed multiple tarsorrhaphies and high dose corticosteroids. Although the precise etiology of GO is unknown, the role of T and B lymphocytes is well established. Interleukin 6 (IL6) is present in high concentration in patients with Graves's disease [1]. Two orbital decompressions and Tocilizumab (IL6 receptor inhibitor) improved his sight. He can now perceive light at 1 foot of distance with the left eye, and the right eye continues with complete visual loss (Figure 1).

Figure 1: Showing complete visual loss (Graves's disease).

References