First do no harm...

Yap Yew Chong
MBBS, MRCSEd(Ophth), is Senior House Officer, Department of Ophthalmology, Watford General Hospital, Hertsfordshire, United Kingdom. eyapyc@gmail.com

Evelyn Mensah
MBBS, FRCOphth, MD, is a Consultant, Department of Ophthalmology, Watford General Hospital, Hertsfordshire, United Kingdom.

It is common when practising ophthalmology that we forget to treat the patient as a whole person. We are taught in medical school to take a complete history and to perform a thorough examination before ordering specific investigations. However sometimes, despite our clinical experience, we are tempted to take inappropriate shortcuts. The notion 'first do no harm' highlights to us the importance of gathering all the facts first before performing procedures on the patient. A clinical experience encountered recently reminded us of the importance of a patient's past medical history.

Case history

A lawyer in her late 60s was referred to the urgent eye clinic with a 3 week history of loss of vision in the right eye. Three months prior she complained of right sided temporal headache, ear pain, scalp tenderness and general malaise. There was no history of jaw claudication. She had been treated by the general practitioner with antibiotics, who felt her symptoms were related to an ear infection. Subsequently the GP treated her for symptoms of neuralgia until she developed right visual disturbance. She described her vision as 'fragmented with the appearance of looking through a blue lens'.

Twenty-five years ago the patient was diagnosed with carcinoma of the breast treated with lumpectomy and radiotherapy. Two years previously she developed bilateral recurrence of the breast carcinoma. She was treated again with lumpectomies and she was given anastozole.

On examination her visual acuity was 6/60 in her right eye and 6/9 in her left eye. There was a right relative afferent pupillary defect and loss of colour vision with the Ishihara test plates on the same side. The anterior segments of both eyes were normal. On fundoscopy both optic discs looked normal with no pallor or swelling. Both temporal arteries were pulsatile but there was right sided tenderness. She had a right inferior altitudinal field defect on visual field testing and, with a raised erythrocyte sedimentation rate (ESR) of 56 mm/hr, her condition was suggestive of giant cell arteritis (GCA). A course of oral steroids was commenced and her headache settled within 24 hours.

Three days later, a temporal artery biopsy was performed but subsequent histology was negative for GCA. Her right sided headache recurred despite treatment with steroids. An urgent computerised tomography (CT) scan was requested which showed a mass lesion occupying the frontal lobe with involvement of the right frontal ethmoidal and maxillary sinuses. There was also destruction of the chiasm and the right medial orbital wall causing displacement of the right medial rectus muscle.

Discussion

The diagnosis of GCA is not always straightforward. The history is important, as clinical signs may be few or insignificant. Although an initial history of recurrence of breast carcinoma was elicited, we failed to acknowledge the importance of this. The ESR is raised in most patients with GCA. However, elevated ESR can also be found in patients with anaemia, malignancy, infection, inflammatory disease, or in the elderly. A temporal artery biopsy is the gold standard for diagnosis of GCA. A positive biopsy confirms the diagnosis, but a negative one does not exclude it. It has been reported that there is an incidence of 5–13% false negative biopsies. Headache is not always a reliable symptom to diagnose GCA because it can be due to many other diseases such as infection, malignancy, trigeminal neuralgia, sinus disease, dental conditions and connective tissue disease. The cause of the right sided temporal tenderness in our patient was most likely due to referred pain from metastases in the right frontal lobe.

Conclusion

A patient's past medical history should always be carefully considered before investigating and instituting treatment. Clinicians should be cautious of ocular manifestations not due to ocular pathologies but from other systemic entities.

Conflict of interest: none.

afp **CORRESPONDENCE** email: afp@racgp.org.au