Title: The Great Masquerader: A Case of a Ciliochoroidal Melanoma Masquerading as Panuveitis

Abstract: This case presents an ER referred patient with a painful red eye and blurry vision. Panuveitis is apparent, yet further examination reveals a ciliochoroidal melanoma. Diagnosis and treatment is discussed, long-term multi-disciplinary management is key.

1. Case Hx
   - Demographics: 50 yo WF
   - CC: OD: stable blur at all distances x4 days; redness/pain (2/10) x2 days; referred by ER w/ a conjunctivitis dx
   - Med hx: asthma, osteoarthritis, depression, hypercholesterolemia, acid reflux
   - Oc hx: unremarkable
   - Meds: Visine, Fluoxetine, Simvastatin, Dextilant, ASA
   - Other: ex-smoker

2. Pertinent Findings: OD unless noted otherwise
   - Clinical
     - VA sc: OD 20/70 (PH: NI); OS 20/20
     - Pupils: PERRL (3+ APD)
     - VF: constricted SN
     - EOMs: full, pain in up gaze
     - IOP: 18 OD, 20 OS
     - SLE
       - Adnexa: (-) proptosis
       - Conj: diffuse injection, chemosis, ciliary flush, superior sentinel vessels & scleral pigment (flat, 4x3mm, 5mm posterior to limbus)
       - AC: 4+ cells
       - Vitreous: 4+ cells
       - Periphery: SN, elevated, pigmented, ciliochoroidal mushroom lesion; inferior serous RD
   - Physical: oriented to time/place; WNL mood/affect
   - Testing
     - Transillumination: 18mm elevated lesion from 11-3:00
     - Mac OCT: WNL
     - B scan: ciliochoroidal mass 8.1mm thick, low internal reflectivity
     - Photos: anterior scleral pigment & posterior lesion

3. DDX
   - Primary: ciliochoroidal melanoma with secondary panuveitis
   - Others: choroidal nevus, metastatic lesion, choroidal detachment

4. Dx/discussion
   - Elaboration
     - Ciliochoroidal melanoma
       - Type of uveal melanoma; ciliary body source w/ choroidal extension
       - Abnormal melanocyte proliferation
     - Ciliary body melanoma
       - 10% of intraocular melanomas
       - Risk: Caucasian (especially blonde hair/blue eyes)
       - Iris extension also possible (as opposed to aforementioned choroidal)
       - 10 yr mortality: 30-50% to vascular metastasis (liver/lung/bone commonly)
         - due to frequent ciliary muscle contraction & vast blood supply
• Sxs: blur, floaters, VF loss, pain  
  • Commonly asymptomatic early
• Sis: sentinel vessels, low IOP, elevated mushroom shape, serous RD, scleral extension

• Unique features  
  o >15mm lesions: 56% survival rate (pt above=18mm)  
  o Secondary uveitis=rare; tumor necrosis is the believed cause  
  o Onset:55-62 yrs old (pt above=50)  
  o Enlargement sis: mushroom shape (Bruch’s membrane penetration), scleral pigment (extension occurring)

5. Tx/management
• Tx/response  
  o Cyclogyl 1% tid OD for uveitis: resolved  
  o Refer:Wills Eye Oncology  
  • Protective polycarb specs full time  
  • Plaque radiotherapy w/ iodine-125 (1 wk): successful  
  • Collective Ocular Melanoma Study: for large lesions, no difference in survival spanning 12 yrs exists when enucleation & enucleation/radiotherapy are compared  
  • 4-5% chance of regrowth  
  • Off-label intravitreal Avastin q 4 mo x2 yrs: ongoing  
  • Multiple studies have shown preserved VA w/ post-radiation retinopathy/vasculopathies  
  • PCP exam & liver function test 2x/yr; chest x-ray & liver imaging 1x/yr: ongoing  
  • All exams/testing WNL thus far  
  • Post-radiation sector PRP to ischemic retina: successful

6. Conclusion
• Clinical Pearls  
  o Enucleation WAS the gold standard for tx. Plaque therapy is now common.  
  o Early detection/tx is key. The longer melanomas are let go, the greater the chance becomes for an unfavorable outcome.  
  o A pt’s team of providers must communicate, since multiple will likely be involved. Informing the whole allows for more complete/effective tx plans, and also increases the pt’s confidence.  
  o Be compassionate. Melanoma pts have a long road of doctor’s visits/procedures ahead of them, and (as in the pt above’s case) it may be the first time they are hearing about a possible metastatic condition.

Bibliography
