Solitary choroidal granuloma

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DESCRIPTION

A 28-year-old Caucasian gentleman presented with a 6-week history of right visual disturbance. He had a medical history of psoriasis only, and no systemic symptoms otherwise. Initial impression in the eye emergency department was of central

Figure 1 Ocular coherence tomography scan showing subretinal fluid at the right fovea.

Figure 2 A colour photograph of the right fundus showing a pale, elevated choroidal lesion at the superotemporal vascular arcade.

Figure 3 Ocular coherence tomography scan through the lesion showing choroidal elevation and subretinal exudation.

Figure 4 Coronal view of a high-resolution CT of the thorax showing numerous peribronchovascular nodular opacities throughout the lungs.

Patient's perspective

When I first experienced blurred vision, I never thought that I would end up with a diagnosis of sarcoidosis. The process of getting to the diagnosis, that is, a series of tests and consultations, was a daunting experience due to the unknown. During this time, the symptoms that brought me to the hospital resolved without any treatment. I felt completely fine and was as such confused by the situation. To date, the only impact of the diagnosis were the complications associated with oral steroid therapy. These prevented me from working due to an increased risk during the COVID-19 pandemic. I am now back to living a completely normal life with regular check ups.

Learning points

- ▶ Solitary choroidal granuloma can be a presenting feature of established pulmonary sarcoidosis.
- ▶ Unless secondary involvement of the macula or optic nerve is present, choroidal granulomas may go unnoticed.
- ▶ The finding of a fundus lesion such as this should prompt systemic investigations for granulomatous disease including tuberculosis and sarcoidosis.

serous chorioretinopathy due to subretinal fluid at the right macula, shown on optical coherence tomography scan ([figure 1](#)). His age, sex, history of a recent stressful life event and use of topical corticosteroids for psoriasis (although 5 months prior to the onset of symptoms) contributed to this diagnosis. However, fundus examination subsequently revealed a pale elevated choroidal lesion at the right superotemporal vascular arcade as the cause of the subretinal exudation ([figures 2 and 3](#)). In the absence of typical features of choroidal naevus, melanoma, haemangioma or metastasis, a presumptive diagnosis of choroidal granuloma was made.

Serum ACE was elevated. High-resolution CT of the thorax revealed numerous peribronchovascular nodular opacities throughout the lungs ([figure 4](#)). Transbronchial biopsy confirmed non-caseating granulomas consistent with sarcoidosis. The subretinal fluid in the right eye spontaneously regressed with visual acuity of 6/6. At the most recent follow-up visit, the appearance of the granuloma remained unchanged. Oral steroid treatment was commenced for pulmonary sarcoidosis.

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Solitary choroidal granuloma is a rare presentation of systemic sarcoidosis, with only limited case reports of it in a literature review.^{1–3} It usually occurs without any associated anterior uveitis.⁴ This may be especially significant as it has been shown that sarcoid patients with posterior segment eye disease have twice the incidence of central nervous system involvement when compared with all sarcoid patients.^{5,6} It is difficult to ascertain if this is the case with solitary choroidal granuloma, largely due to small numbers in previous case series.

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