9. Chorioretinal solid tumor: clinical and echographic study

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Abstract

We report the case of a 66-year-old woman with a chorioretinal solid tumour that appeared to be a metastasis. It is hypothesized that the small lesion, which disappeared within 15 days, was a focal benign non inflammatory choroidal lesion.

Key words: Chorioretinal tumour, chorioretinal metastasis, echography, focal fugax choroiditis, pseudolymphoma

Introduction

Primary and secondary chorioretinal tumours can be studied with echography: only echography reveals the entity of thickness and the tissutal acoustic behavior and characteristics of the spikes in the lesion [1]. The differential diagnosis of solid chorioretinal tumours includes [2,3]: melanoma, hemangio-ma, metastatic tumours, hemorrhagic detachment, and macular disciform degeneration. In clinical practice we occasionally find anomalous cases, in which the clinical, instrumental and semeiological signs and symptoms are misleading and diagnosis is difficult. We present one such clinical case.

Case report

A 66-year-old woman was referred to our Division in February 1993 with blurred vision in the left eye that started 10 days earlier. The history documented in the out-patients' records was negative for eye diseases (the last examination in May 1992 showed a normal fundus in both eyes). The physical ocular examination was unremerkable in the right eye with corrected visual acuity = 20/20 and normal fundus. In the left eye corrected visual acuity = 20/20, and there was a prominent dome-shaped solid lesion light pink in colour, oval and 3 disc diameters large in the fundus along the inferior temporal vascular arcade and subretinal. The optic disc, vessel, macula and peripheral retina were
normal. The patient was informed of the suspicion that this 'tumour' with atypical features was a solid chorioretinal malignant disease. The patient underwent laboratory analyses which were within normal limits (VES = 11; hepatic enzymes; rheumatic tests and immunoglobulin).

The visual field (Humphrey strategy full threshold programme) showed a relative scotoma in the superior nasal quadrant. The fluorescein angiography showed a rapid choroidal filling time with irregular spots and a peripheral leakage halo due to serous pigmented epithelial detachment. The "spotted" leakage increased at the late time and the retinal vessels were regular (Fig. 1).

B-scan echography showed a dome-shaped, limited, spongy, solid chorioretinal mass without shadowing or acoustic vacuoles (Fig. 2). A-scan standardized echography showed high reflectivity (80% with irregular spikes); no spontaneous vascular vertical motion of single tumour spikes; maximum thickness was 2.4 mm (Fig. 3).

We made a diagnosis of suspected choroidal metastasis. We excluded angiomas, where the reflectivity is high and regular, and the fluorescent stain rapid, but without irregular staining of the giant choroidal vessels [4].

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