Sudden Bilateral Loss of Vision Postpartum

Sir,

A 30-year-old para 4 live 3 presented with sudden loss of vision soon after delivery and reported after 10 days with severe headache and vomiting. She had a vaginal delivery at home conducted by a traditional birth attendant. There was no history of antepartum complications or postpartum haemorrhage. The sudden loss of vision was preceded by severe headache, vomiting, and blurring of vision. There was no history of fever, convulsions, foul smelling discharge PV, or a past history of hypertension.

On examination, the patient was conscious and well oriented. She was afebrile, not anaemic; there was no cyanosis, but pedal oedema was noted. Pulse was 80/min, regular, and all peripheral pulses felt. BP was 160/130 mm of Hg and RR was 16/min, thoraco-abdominal. Cardiovascular and respiratory systems were essentially normal. CNS examination showed a facial hemi-paresis on the left side, blink reflex was absent and left-sided VI and III nerve palsy were noted. The right side showed paresis of VII, VI and III cranial nerves. Pupils were dilated and not reacting to light. Bilateral plantars were downgoing. No other focal defects were found.

Haematological and biochemical parameters were within normal limits. Platelet count was 112 x 10⁹/L. Gross albuminuria was seen, but urine output was adequate.

On opthalmological examination, corneal sensation was absent with corneal exposure keratitis in the left eye. Fundus examination showed bilateral grade IV hypertensive retinopathy changes with bilateral central retinal vein occlusion, disc and macular oedema. The findings of severe pre-eclampsia, Grade IV hypertensive retinopathy with disc oedema, the cranial nerve palsies, and bilateral central retinal vein occlusion was unusual. A CT-scan of the brain was done (fig. 1). There was a heterogeneously enhancing mass lesion in the left cerebello-pontine angle with surrounding oedema and a mass effect on the IV ventricle. Left-sided internal auditory canal was widened compared to right side. The supratentorial section showed the 3rd and lateral ventricles to be slightly dilated, there was no midline shift and supratentorial brain parenchyma was normal. A provisional diagnosis of cerebellopontine angle mass, probably an acoustic neurinoma, was made.

Comment

Although visual disturbances are common in severe pre-eclampsia, blindness, either alone or accompanying convulsions is rare. The cause of blindness in severe pre-eclampsia is attributed to varying degrees of retinal detachment and/or occipital lobe ischaemia or infarction. Over a 14-year period, 15 cases of blindness due to severe pre-eclampsia/eclampsia were studied and all
recovered vision in 4 hrs to 8 days\(^1\).

Sudden visual loss affecting bilateral vision if not due to trauma is usually the result of multiple lesions in the occipital lobes especially seen in eclamptic hypertensive encephalopathy\(^2\). Pituitary apoplexy can also present with bilateral visual loss accompanied by severe headache and diplopia\(^3\). Pituitary apoplexy is not infrequently seen postpartum in patients with severe PPH. The presence of tumours such as meningioma/acoustic neurinomas can cause visual loss but the presentation is never sudden, though it can be progressive. Bilateral transient visual loss is seen with papilloedema. Total cortical blindness due to eclampsia was recently reported in a young woman persisting for a year after the episode with persistent hypodensities in cerebral white matter\(^4\).

What was unusual in our case was the sudden loss of bilateral vision postpartum with failure to recover even after 14 days. The presence of the CP angle mass with surrounding oedema and mass effect explains the cranial nerve palsies and partially explains the visual loss. We presume the triggering effect of raised intracranial tension and papilloedema due to the CP angle mass and vaginal delivery may have brought about the sudden loss of vision and its persistence. Because brain stem herniation can occur during labour, patients with brain tumours are delivered by caesarean section. Indications for premature termination of pregnancy include increasing intracranial tension and visual failure due to papilloedema\(^5\). A temporary remission in the growth of these tumours can be expected to occur after delivery, as growth slows and vascularity decreases. Surgery is therefore deferred for several weeks. This case was brought to discussion because of its unusual presentation and co-incidental finding of a CP angle tumour that probably triggered the sudden bilateral visual loss.

References:


S Rajaram*
N Goel**

*Associate Professor
** Professor

Dept. of Obstetrics and Gynaecology,
University College of Medical Sciences and Guru Teg Bahadur Hospital, Shahdara, Delhi-110 095.