Published online: 2019-09-26

Commentary

Human cysticercosis is an important cause of neurological and other morbidities all over the world due to poor hygiene, sanitation, slaughterhouse facilities, immigration from endemic areas and travel of local population to endemic areas.[1] Cysticercosis is a pleomorphic disease whose clinical manifestations may vary depending on the number, size, location and stage of cysticerci as well as the intensity of the host's immune response.[2] Intracranial cysticercosis is the one of the most common parasitic cerebral and orbital infestations worldwide; however, cases of intra-orbital and intra-ocular cysticerosis are rare.[3] Cysts occur in striated muscles, subcutaneous tissues, the nervous system and the eye and may become symptomatic almost exclusively in the nervous system or the eye.[3]

In ocular cysticercosis, vision loss may be either due to intraocular cysts, presence of parasite in eye causing acute inflammatory reaction like vitreous uveitis or endophthalmitis, chiasmal lesions causing optic nerve compression, retrochiasmal lesions like large parenchymal cysts, vasculitic cerebral infarcts, or hydrocephalus.[3] The vision loss may be due to the retinal pigment epithelium/choroid disruption secondary to a submacular cysticercus as reported by authors.[4] Disseminated neurocysticercosis presenting for the first time with acute monocular painless vision loss without any signs and symptoms of raised intracranial tension is extremely rare except reports of post-anti helminthic drugs (AHD) treatment acute monocular blindness.[5]

The standard of care for cerebral neurocysticercosis is AHD (albendazole or praziquantel) with steroids and anticonvulsants. However, intraocular cysts if any should be removed prior to starting AHD, or else the tissue reaction to the dying parasite may lead to vitritis, retinal detachment and scarring leading to irreversible blindness.[6] In cases of isolated intraocular cysticercosis surgical removal should be the main treatment as sign and symptoms are marked due to limited space.[6]

There is evidence of clinical and radiological improvement when corticosteroids are used along with albendazole as it limits the adverse effects due to anti-inflammatory action. When used for long period like 6-9 months, subretinal cyst is reduced to symptom-free chorioretinal scar. Also, cysts in the vitreous cavity are killed and due to immobility they are easily removed.[7]

To conclude disseminated neurocysticercosis may coexist with rare ocular involvement so screening of the eye with B-scan should be done to prevent this treatable blindness.

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