# A CASE OF RIGHT EYE TOTAL OPTHALMOPLEGIA WITH ACUTE LOSS OF VISION IN A YOUNG MALE – A RARE PRESENTATION OF SINONASAL CARCINOMA


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**AIM**:To evaluate a case of Acute Monocular Vision Loss and total Ophthalmoplegia in a Young Adult.

**MATERIALS:-** 27 yrs. old male with no comorbidities and habits, presented with blurring of vision with occasional bifrontal headache for Past 01 month with complete loss of vision in right eye for Past 04 days.

Clinical Examination :

**CN I:Loss of smell- right side of nose**

**CN II:non- perception of light in the right eye, optic disc pallor**

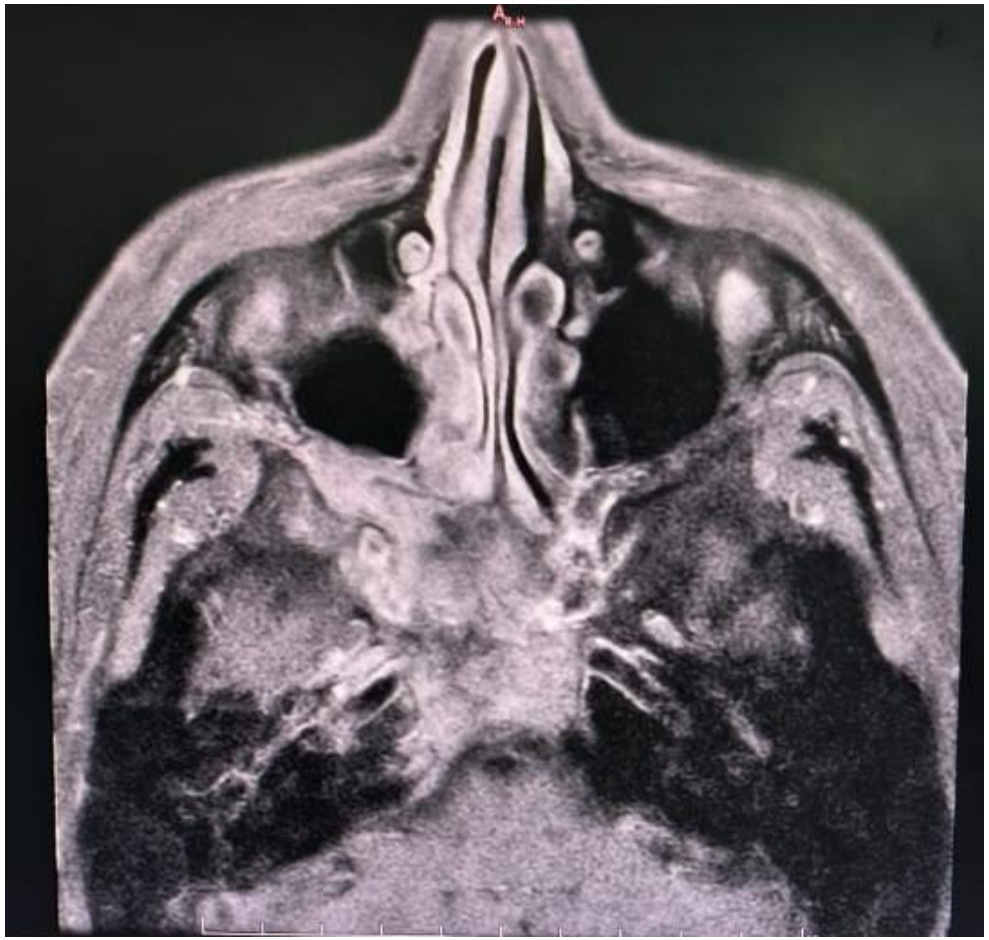
**CN III, IV, VI: Complete ophthalmoplegia in the right eye with mild proptosis and dilated non-reactive pupil.**

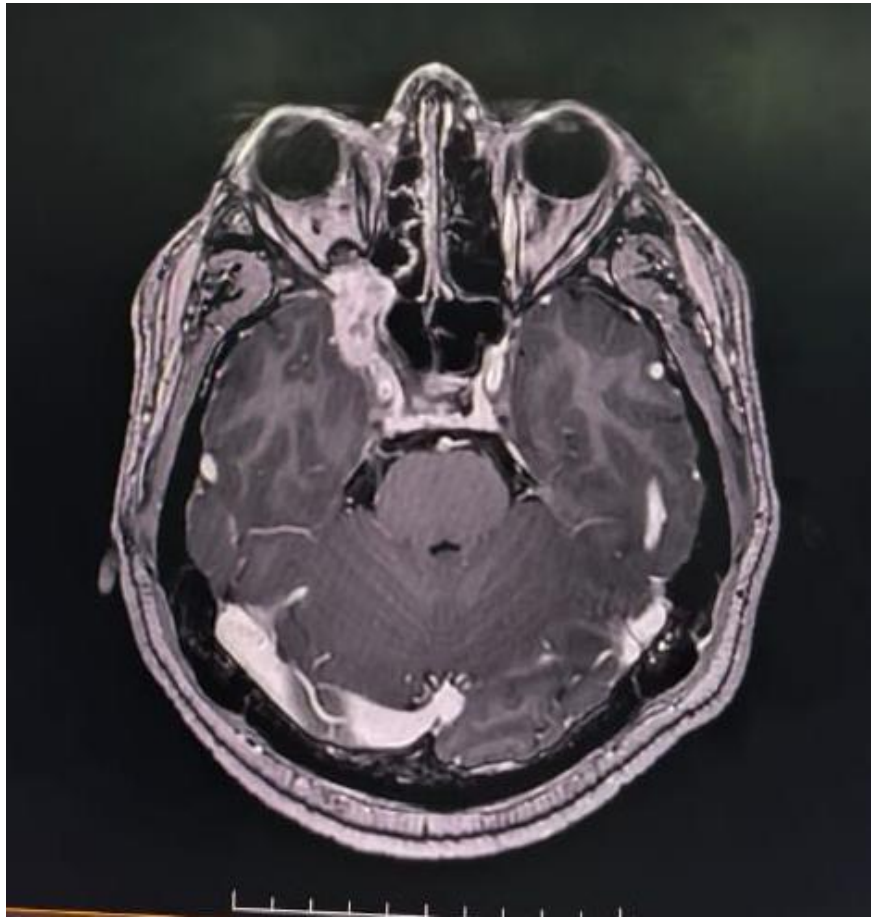
**CN V: Decreased touch and pain sensation on the right face(V1,V2,V3); corneal an conjunctival reflex absent**; .

There was no other neurological deficits

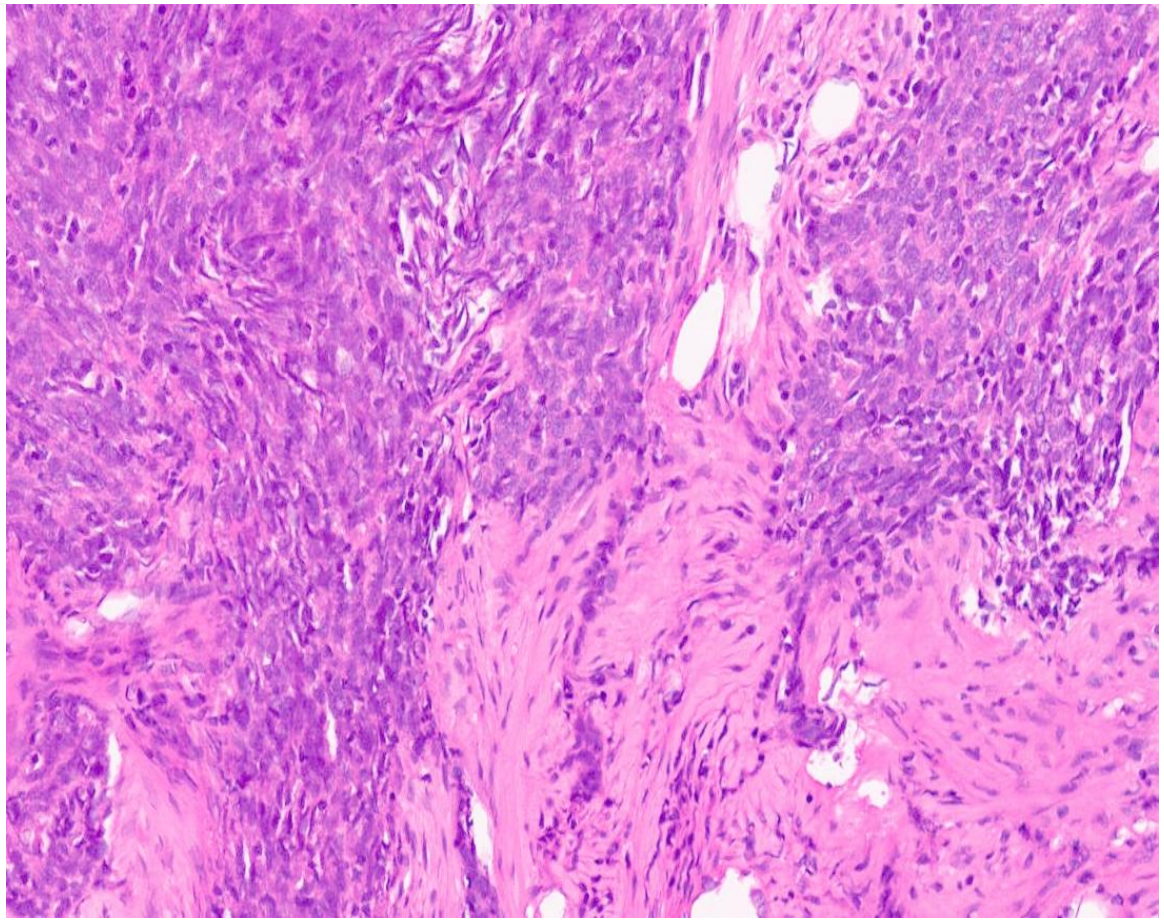
**METHODS:**

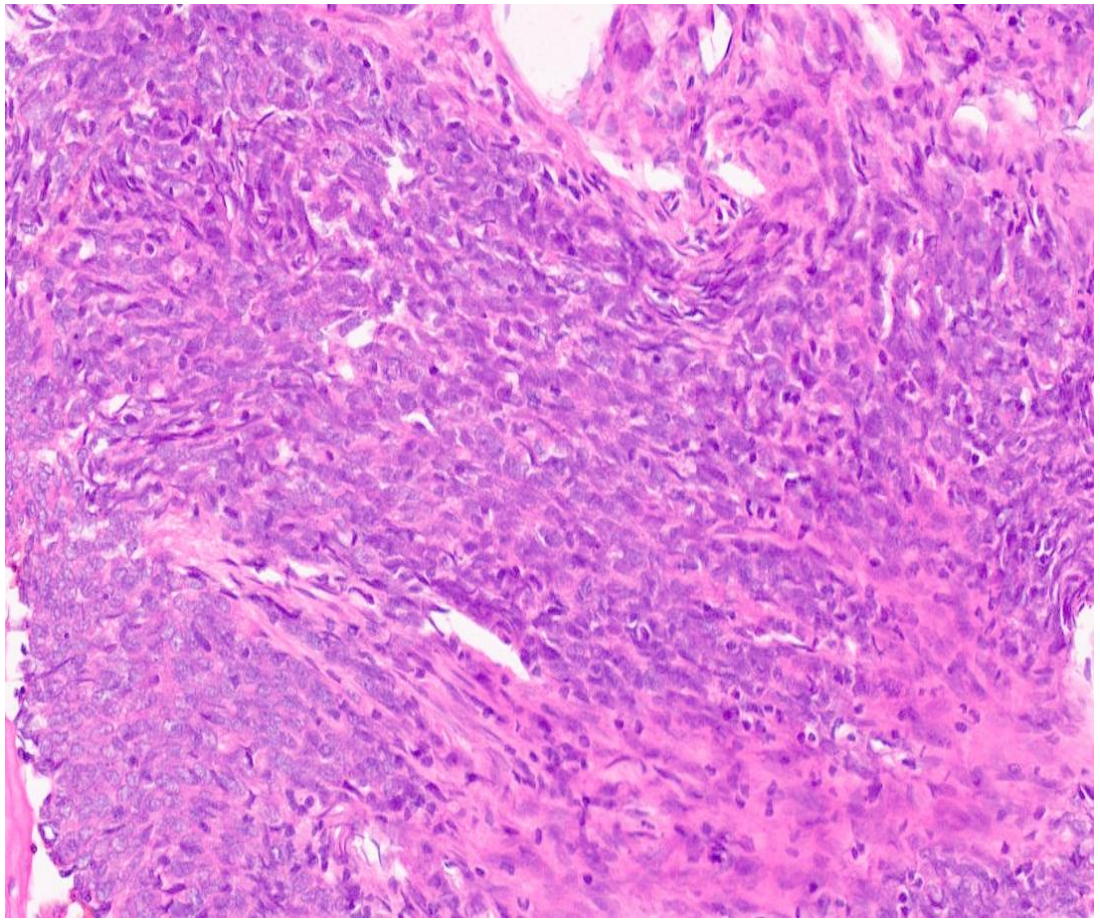
**M.R. I. Brain with orbit (P & C) Showed enhancing soft tissue mass extending into Right orbital apex, superior orbital fissure, cavernous sinus and posterior choana. Bone lysis and sclerosis seen, Involving Right Pterygoid Plate and greater Wing of Sphenoid. Considering infective etiology ,higher IV Antibiotics were started, and ENT did biopsy of the mass through trans nasal endoscopy.**





**Histopathology and Immunohistochemistry** with P40 and P63 showed strong and diffuse nuclear positivity in the tumour cells. P16, INSMI, Synaptophysin, CD34 are negative. INI1: retained, IDH1: positive, EBER-ISH was positive, **Suggestive of poorly differentiated Sino nasal lymphoepithelial carcinoma**.





H&E section show tumor cells composed of medium sized cells arranged in nests and cords which are relatively monomorphic.There was increase  in mitosis with area of necrosis ,high grade undifferentiated  malignancy.

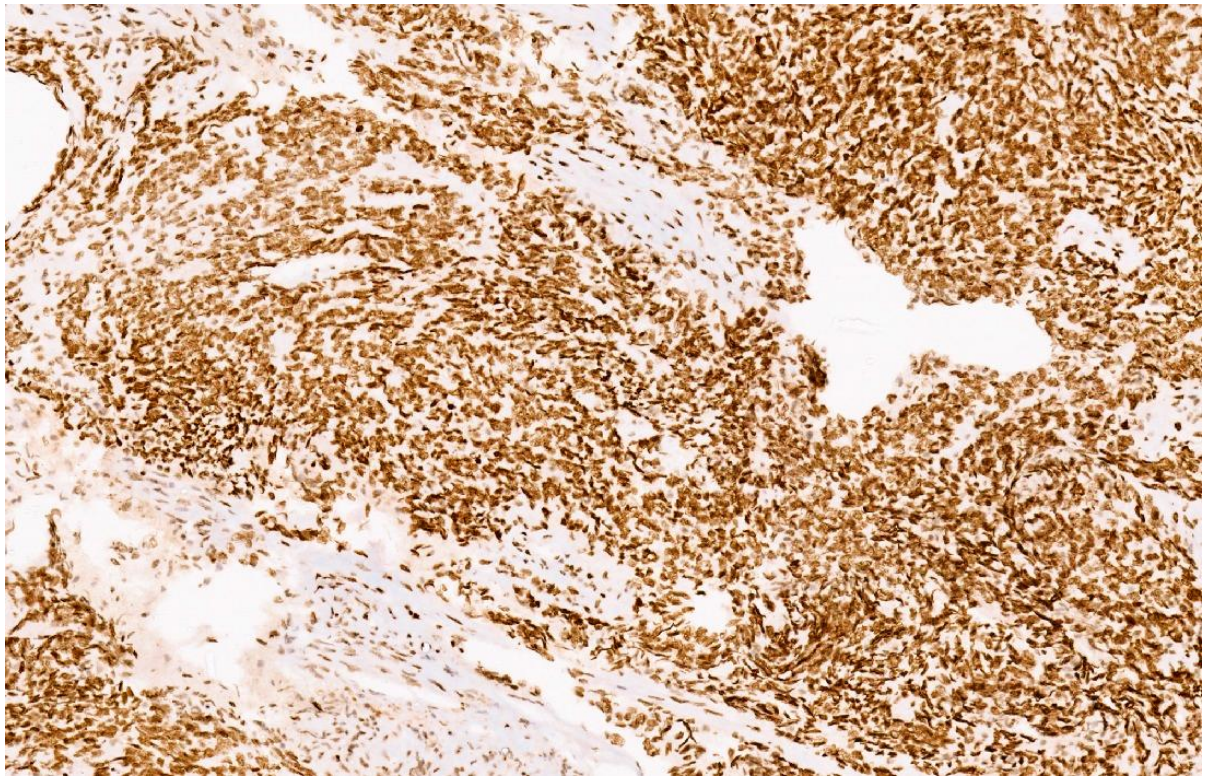


Fig. 1

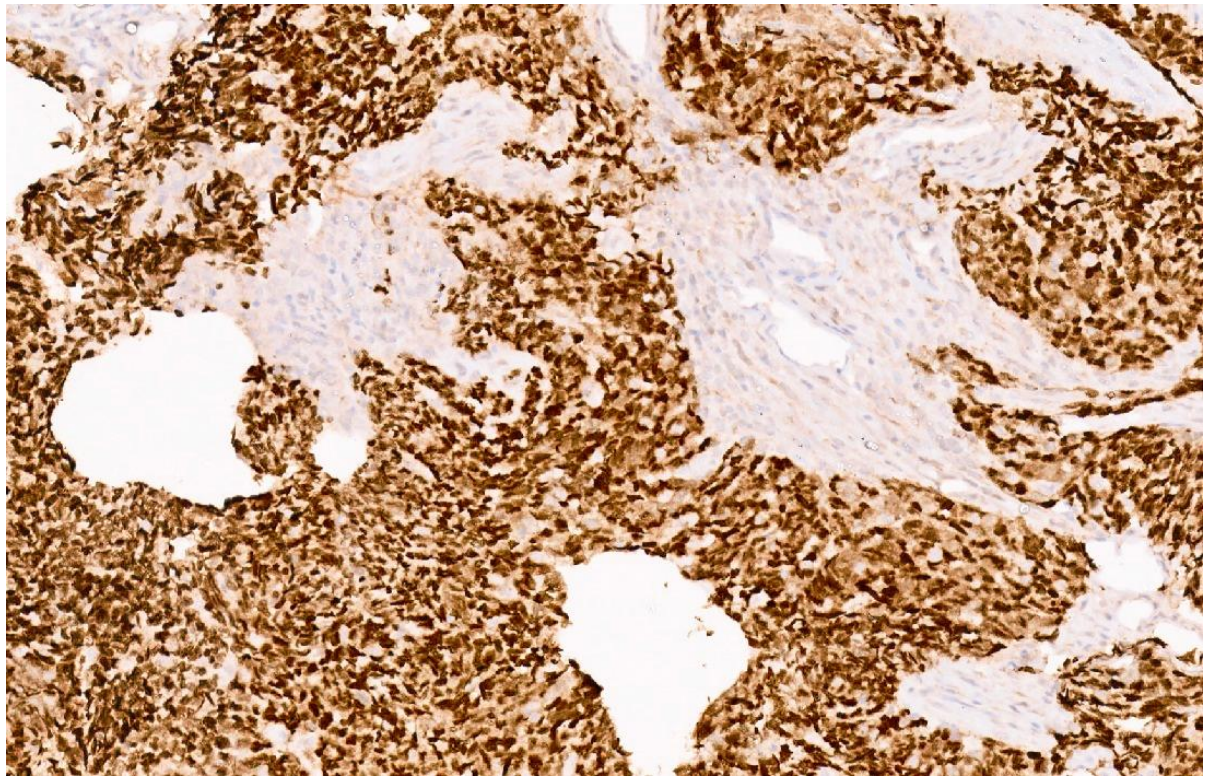


Fig. 2

P40 and P63 showed strong and diffuse nuclear positivity in the tumour cells.

# FDG PET-CT Scan

- FDG avid (SUVmax 10.0) heterogeneously enhancing lesion that appears to arise from the roof of nasopharynx (measuring 30 x 15 mm - AP x TR) on right side, causing erosion and extending into the right sphenoid sinus. The soft tissue is seen to obstructive right posterior choana.
- Superiorly the lesion is seen to cause subtle erosion of the entire clivus and body of sphenoid.
- Antero-superiorly it is seen to cause erosion of the posterolateral wall of orbit extending into the superior orbital fissure and orbital apex – there is erosion of the right posterior ethmoidal sinus.
- Laterally the lesion appears limited by body of pterygoid showing sclerotic changes.
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**Results:**

He received 05 Cycles of Chemotherapy (cisplatin and gemcitabine) and 35 Cycles of radiotherapy, along with 05 days of pulse dose of intravenous Methyl prednisolone.

At 09 months follow up , he had impaired visual acuity 4/60 in right eye, RAPD right eye and normal extra ocular movements,

**Conclusion**: This case is noteworthy due to its initial presentation as subacute monocular blindness with total ophthalmoplegia, a rare occurrence in NPC.

NPC often remains undiagnosed until it invades surrounding structures due to its deep anatomical location and vague early symptoms. Cranial nerve involvement, particularly of CN II, III, IV, and VI, indicates skull base invasion and often presents in advanced disease.. MRI findings were critical in delineating the extent of disease and guiding diagnosis. Early systemic chemotherapy (cisplatin + gemcitabine) was initiated to prevent further neurological compromise and tumour progression.

Multidisciplinary approaches involving Neurologist, Neurosurgeon, Ophthalmologist, ENT, pathologist, Oncologist, play a Crucial Role in managing this case in Preserving the Neurological function.