

Recurrent Painful Ophthalmoplegic Neuropathy

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Abstract: *Recurrent painful ophthalmoplegic neuropathy is a rare condition mostly seen in children and young adults. Usually affects the oculo-motor nerve¹. Here we describe a case of recurrent painful ophthalmoplegic neuropathy.*

Keywords: headache, ophthalmoplegia, migraine, recurrent

1. History

40 years old male from Chennai, India presented with chief complaints of headache and right Eyelid droop and blurring of vision for 3 days. There is no history of giddiness, neck stiffness, Facial asymmetry, slurring of speech, no problems with swallowing, limb weakness, double Vision, numbness or difficulty with gait.

On further enquiry or question, patient admitted that having pain over the right side of the face for the past two days. Headache is associated with nausea, vomiting and photo phobia.

He had similar headaches at the age of 17yrs (2 episodes of similar headache started at the age of 17 yrs) prior to the onset of headache he could not identify any precipitating factors or Exaggerating factors. That time also headache followed by episode of ptosis which lasted for 3

Months and then spontaneously improved.

His mother, father and grandfather had similar complaints of headache followed by ptosis.

2. Physical Examination

Patient conscious, obeying commands and oriented to time place person. Patient had right complete third nerve palsy and adduction of right eye is impaired. No history of double vision. Pupils are normal in size 3mm and reacting to light. No RAPD. Fundus is normal. Examinations of other cranial nerves are normal. TDAC, Power, DTR and sensory systems are normal as well as cerebellar examination. No neck stiffness and gait is normal.

Investigations

FBS, FSR, CRP, VDRC and Anti.Achr antibodies are normal.

RNS was normal.

MRI brain (P+C) with orbital cuts and MRV are normal.

CT Angio of neck and Intra cranial vessels done to rule out aneurysm is normal.

CSF analysis were done is normal.

Diagnosis

Clinical diagnosis of ophthalmoplegicmigraines was made on the basis of recurrent attacks of migraine and followed by ptosis with strong family history. Headache is managed with pain killers and was started on FLUNARAZINE.

3. Discussion

3rd edition of International classification of headache disorders (ICHD III) recently introduced the term “Recurrent painful ophthalmoplegic neuropathy” previously called “Ophthalmoplegic Migraine” is a rare condition, classifies it as recurrent attacks of headaches with migrainous characteristics associated with paresis of one or more ocular cranial nerves without any demonstrable. Intracranial lesion in the MRI. Approximately 75% of patients with typical clinical presentation shows gadolinium enhancement of the cisternal segment of the affected nerve in the MRI.²

The old term ophthalmoplegic migraine was rejected when it was reclassified as a cranial neuralgia. The third nerve paralysis during the attack is often complete or nearly so, but partial third nerve paresis, includes superior divisions third nerve parasis may occur.³Even though, very rare trochlear nerve, multiple ocular motor nerve involvement has been described.⁴With ophthalmoplegic migraine, the third nerve paresis revealed a maximum of the headache began to resolve and persisted for 1 to 4 week.³

This patient was diagnosed as recurrent painful ophthalmoplegic neuropathy, a rare disorder as his clinical symptoms and signs were consistent with the criteria set by the ICHD III, which are

- 1) At least two attacks.
- 2) Unilateral headache accompanied by ipsilateral paresis of one, two or all three ocular Motor nerves.
- 3) Orbital, para seller or posterior fossa lesion has been excluded by approximate investigation¹.

The diagnosis of ophthalmoplegic migraine is a clinical one and diagnosis of exclusion, mainly through from a good history of present as well as past.

The role of investigations is primarily to exclude other causes of ptosis like tumor, aneurysm, Tolosa hurt syndrome and myasthenia gravis.

We treated this patient with NAPROXYN to get relief from pain and T. Sibellium to prevent episodes of migraine. After 1 week patient had improvement of ptosis and blurring of vision is decreased. His previous episodes were spontaneous resolved probably reflects the natural course of this disorder.

The etiology of the cranial neuropathy in the ophthalmoplegic migraine is still not known.

References

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