ponentaneous Suprachoroidal Hemorrhage
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AIM:
Suprachoroidal hemorrhage is a well-known complication of intraocular surgery or ocular trauma. In very rare occasions massive suprachoroidal hemorrhage can occur spontaneously but usually associated with other systemic or ocular factors. We present a case report of spontaneous suprachoroidal hemorrhage (SSCH) in a patient who is known to be hypertensive and diabetic and was taking aspirin.

Method:
A 52-year-old Filipino man was presented to the emergency department in June 2015 with sudden loss of vision in the right eye after waking up from sleep. His medical history was significant for diabetes mellitus and hypertension for the past five years which were well controlled on oral medication including aspirin. The patient was seen in the eye clinic for diabetic retinopathy screening four months prior to presentation. His examination at that time revealed visual acuity (VA) 6/6 in both eyes, unremarkable anterior segment. His fundus examination was free from any diabetic changes, however there were multiple old chorioretinal scars in the posterior pole of both eyes (Fig. 1). OCT showed intact unevent retinal pigment epithelium (RPE) (Fig. 2).

The day of presentation to A&E, the vision in the right eye was PL, quiet anterior segment, fundus retinal detachment and the retina was seen behind the lens with subretinal blood. B-scan showed large choroidal mass filling the vitreous cavity (Fig. 3). MRI was ordered and confirmed the detachment in the right eye, with subretinal collection of blood (Fig. 4).

Two weeks after presentation the patient underwent Pars Plana Vitrectomy right eye and drainage of suprachoroidal hemorrhage (Fig. 5). Perfluorocarbon liquid (PFCL) was used to evacuate the suprachoroidal bleeding (Fig 6), the lens was removed as it became cataractous during surgery. However, we were unable to evacuate all the bleeding. Silicon oil was injected. The patient was taken again to the theater 3 weeks later for repeat the vitrectomy and remove the subretinal clots through retinectomy on the nasal side.

Discussion:
The suprachoroidal hemorrhage is one of the catastrophic complications of intraocular surgery. For Spontaneous suprachoroidal hemorrhage to occur there are some risk factors which is summarized by Yang et al (1) under three groups:

1. Fragile Choroidal Vasculature: this is seen in patients with systemic hypertension, atherosclerosis, diabetes mellitus, age-related macular degeneration (ARMD) retinal telangiectasia, high myopia.
2. Mechanical Factors: such as Valsalva maneuver.
3. Pharmacologic Factors: such as using anticoagulants, antplatelet and thrombolytic agents which increases the blood lysis.

In our case there was more than risk factor present i.e. he was diabetic, hypertensive and using aspirin.

Treatment of these cases is indicated either to relieve pain which occur as a result of high intraocular pressure or to save the vision. However, the prognosis of these cases is poor, especially if the vision during the first presentation was markedly reduced. Some case can end with enucleation or evisceration due to intractable pain or globe rupture. (1)

In our patient the intraocular pressure was not elevated so surgery was done almost after three weeks giving time for lysis of the clot which was monitored by the B-scan. We needed to take the patient back to the theatre to evacuate a residual clot. Early intervention is not recommended because of the risk of rebleeding and incomplete lysis of the clot.

References:
3. Lim LT, Agarwal PK, Rotschild A. Angle-closure glaucoma due to suprachoroidal hemorrhage.
4. Lim LT, Agarwal PK, Rotschild A. Angle-closure glaucoma due to suprachoroidal hemorrhage secondary to disseminated intravascular coagulation.

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