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P-65 A case of relapse of Graves ophthalmopathy due to an ophthalmic herpes zoster infection in a thyroidectomized patient with multiple comorbidities

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Introduction: Graves ophthalmopathy usually occurs in patients with hyperthyroidism or a history of Graves disease, but it can appear in euthyroid patients or patients with chronic thyroiditis also. It is a possible cause of sight-threatening eye disease. Its incidence is 16 for women and 3 cases for men, per 100 000 population but more severe in men, and it’s higher among smokers. In mild forms, treatment can be local, but in severe cases and recurrences, systemic glucocorticoids are compulsory, with or without immunosuppressive drugs, surgery or radiotherapy. In recurrences. Clinical Case: We present the case of a 76-year-old male, former smoker, diagnosed with Graves disease in 2017. He was treated with anti-thyroid treatment and in 2018 he was thyroidectomized. He also developed a progressive Graves ophthalmopathy from April to July 2017 with a reduced visual acuity for both eyes, conjunctival erythema, palpebral edema and erythema. He received methyl-prednisolone (MP) pulse therapy 6x125 mg weekly with favorable outcome. In 2019, he underwent a recession of internal rectus and inferior rectus for both eyes to correct a divergent strabismus and his eye-sight improved. He presents now for an aggravation of the ophthalmopathy after an episode of a herpes zoster infection affecting the ophthalmic branch of the trigeminal nerve. He also suffers from heart failure NYHA III, permanent atrial fibrillation, large aortic stenosis, asymptomatic hyperuricemia, secondary pulmonary hypertension and chronic kidney disease stage IIIb. His medical history revealed hypercholesterolemia, hyperuricemia, heart failure, insufficient status of vitamin D3 and confirmed the chronic kidney disease stage IIIb; normal thyroid function but with high anti TSH receptor antibodies (TRAb=18.37 U/L). Given the age and the co-morbidities but also the high activity of the Graves disease and the orbital CT that revealed a great hypertrophy of the ocular muscles, our ophthalmologist suggested methyl-prednisolone pulse therapy in a standard regimen, but our cardiologist contradicted it because of the heart conditions. As the patient’s left eye sight was only 2% and for the right one 20%, we decided to adapt the doses of the pulse therapy and closely monitor the patient. The first dose was 125mg MP, after that 7 doses of 250mg MP weekly was followed by 3 doses of 125mg MP weekly. After a total of 2250 mg MP at a 3 months follow-up, the patients’ eyesight improved to 60% on the left eye and 75% on the right eye and a lower level of TRAb=5.59 U/L. Conclusion: Even in patients with comorbidities where corticosteroid therapy may be detrimental, there is a possibility to adapt the doses in a safe way and with a continuous clinical monitoring so that the patients’ eyesight can be saved, therefore increasing the quality of life.