

### Fundus changes in systemic lupus erythematosus

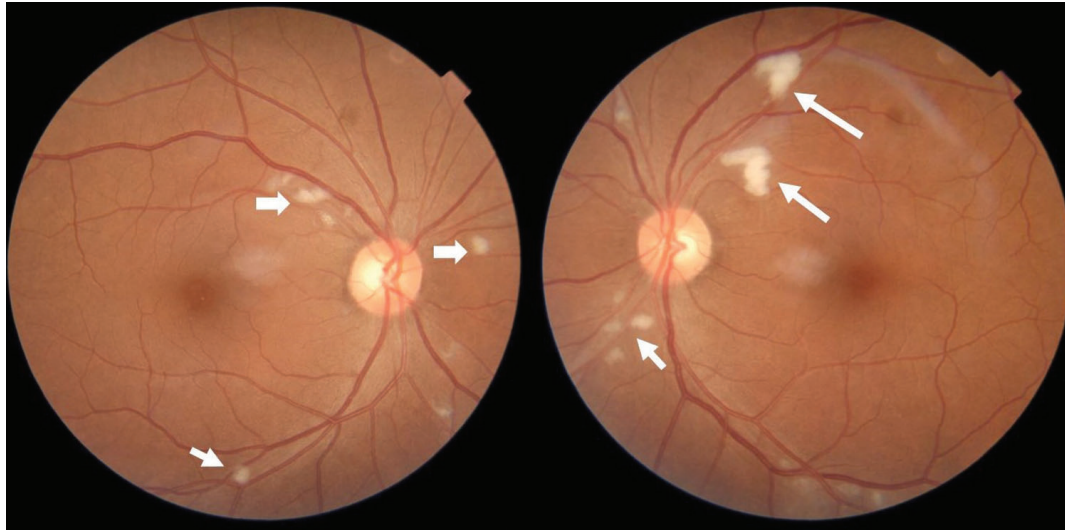


FIG 1. Clinical fundus photograph of the posterior pole of both eyes in a patient with systemic lupus erythematosus showing multiple cotton wool spots (white arrows)

A 42-year-old woman presented with fever, malar rash, and arthralgia of 1 month duration. She also gave history of photosensitivity and hair loss for the past 2 weeks. Cutaneous examination showed a malar rash, photosensitive lupus erythematosus rash, painless oral ulcers, chill blain lupus over the toes, and lupus hair. She was found to have elevated erythrocyte sedimentation rate (75 mm/hour; normal 0–20), C-reactive protein (1.15 mg/dl; normal <1.0), and creatine phosphokinase (344 units/L; normal 30–170), and was antinuclear antibodies positive, with antibodies to Smith, double-stranded DNA, ribonucleoprotein, and sjogren syndrome-A. Testing for anti-cardiolipin antibody, anti- $\alpha$ 2 glycoprotein 1 antibody, and lupus anticoagulant was negative. She was diagnosed with systemic lupus erythematosus (SLE) based on American College of Rheumatology (ARA) criteria. Although she did not have ophthalmologic complaints, her corrected vision was 20/80 in the right eye and 20/20 in the left eye. On dilated fundus examination of both eyes, multiple cotton wool spots were noted without neovascularization (Fig. 1), suggesting had retinal vasculitis associated with SLE in both eyes. She was managed with photoprotection, oral steroids, and hydroxychloroquine.

SLE retinopathy, occurring in 7%–26% of patients, manifests as ‘classic’ cotton-wool spots or larger vessel thrombosis. It indicates higher disease activity and systemic vascular damage, worsening prognosis, and survival. Regular ocular fundus examinations are vital as they can signal severe complications like cerebral lupus and lupus nephritis, aiding in early detection and management.<sup>1,2</sup>

#### REFERENCES

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