Bilateral macular drusen in acquired partial lipodystrophy with type 2 membranoproliferative glomerulonephritis

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SUMMARY
A 35-year-old woman with acquired partial lipodystrophy (PLD) and features of type 2 membranoproliferative glomerulonephritis (MPGN-II), presented with difficulty in her fine detailed vision over the past year. She had right amblyopia from a hypermetropic anisometropia with astigmatism, displaying a best-corrected visual acuity of 0.50 and 0.00 LogMAR, in the right and left eye, respectively. Funduscopy showed bilateral symmetrical drusenoid deposits most prominent in the temporal macula with clusters in the superior and inferior retina, outside the temporal vascular arcades. Multimodal retinal imaging was performed, which confirmed hyperautofluorescent drusen located between the retinal pigment epithelium and Bruch’s membrane. Electroretinography showed bilateral mild peripheral macular dysfunction, but normal central macular function on the pattern electroretinogram. Both PLD and macular drusen, are rare as distinct disease entities, but an association does exist and may be linked to MPGN-II.

BACKGROUND
Lipodystrophy is an ultrarare condition characterised by generalised or partial loss of adipose tissue (lipoatrophy), often with corresponding pathological accumulation of adipose tissue (lipohypertrophy) elsewhere in the body. The global prevalence of lipodystrophy is approximately 1.3–4.7 per 1 000 000.1 The condition can be acquired or inherited, with the ratio of affected men to women varying significantly depending on subtype; congenital generalised and familial partial lipodystrophy (PLD) 1:1–2, acquired generalised lipodystrophy 1:3 and acquired PLD 1:4.2 Changes in the AGPAT2, LMNA and PPARγ genes give rise to familial forms of the condition.3 There are no known monogenic causes for acquired PLD, but risk alleles in LMBN2 have been associated with an increased likelihood of developing the condition.4 The acquired form is most commonly seen in HIV patients receiving highly active antiretroviral therapy.5

Lipodystrophy is commonly associated with metabolic dysfunction, such as insulin resistance, altered lipid metabolism and renal disease.6 This is unsurprising as the adipose tissue is metabolically dynamic and integral to the endocrine system in regulating metabolic homeostasis. Due to its rarity and heterogeneity, patients with lipodystrophy syndrome may frequently be missed or misdiagnosed. This is of concern as the condition is progressive with significant metabolic consequences, which may potentially be life-threatening.

Very little is known about the ocular manifestations of lipodystrophy syndrome. Previously, retinal drusen, retinal pigment epithelium (RPE) atrophy, choroidal neovascularisation (CNV), vitreous haemorrhage and enophthalmos secondary to lipodystrophy have been reported.7 Here we provide a detailed structural and functional correlation for macular drusen associated with acquired PLD syndrome, a rare and important differential for inherited macular dystrophies.

CASE PRESENTATION
A 35-year-old woman had noticed over the past year that she was straining to see the fine details and suffering from evening tension headaches. She visited an optician who noted bilateral retinal drusen and referred her to Moorfields Eye Hospital NHS Foundation Trust. She reported photosensitivity, but no issues with dark adaptation, photopsia, colour vision, distortion, nyctalopia or visual field loss. Her previous oculary history included right amblyopia from childhood. The patient had a medical history of acquired PLD, in a cephalothoracic distribution, which was diagnosed at age 7 years. Her condition was managed by the National Severe Insulin Resistance Service at the Addenbrooke’s Hospital, Cambridge. She had previous cosmetic treatment involving adipose tissue transposition from the thighs to the face. She suffered from renal dysfunction with one affected kidney, and was found to be C3 nephritic factor positive with a low serum C3 suggestive of type 2 membranoproliferative glomerulonephritis (MPGN-II). She had no drug history or known allergies. She was a non-smoker with no alcohol intake, and worked as a graphic designer. She was born full-term and the pregnancy had been uncomplicated. Her mother is of Scottish descent and her father is Syrian; no consanguinity. She had a family history of diabetes on her paternal side. Otherwise, there was no relevant family history other than her older sister had a squint and amblyopia.

INVESTIGATIONS
The best-corrected visual acuity was 0.50 and 0.00 LogMAR in the right and left eye, respectively. Refraction was +4.50/–1.00 ×115 in the right eye and +2.50/–1.00 ×85 in the left eye, indicating a hypermetropic anisometropia with astigmatism. General inspection of the face revealed bilateral...
deep sulci. Examination of the eyelids revealed bilateral anterior and posterior margin blepharitis. Anterior segment examination was remarkable for punctate epithelial erosions and an abnormal tear film breakup time of <10 s consistent with evaporative dry eyes. Funduscopy showed bilateral drusen, most dense in the temporal macula with clusters superior and inferior to the temporal vascular arcades (figure 1); there was no evidence of RPE atrophy, macular haemorrhage, exudation or CNV. Multimodal retinal imaging was performed including ultra-widefield colour fundus and autofluorescence, which revealed hyperautofluorescent macular drusen (figure 1). Spectral domain optical coherence tomography confirmed the location of the drusen between the RPE and Bruch’s membrane, and the absence of intraretinal and subretinal fluid (figure 2). Humphrey visual field was normal in both eyes. Full-field and pattern electroretinogram (ERG) was performed. The full-field ERG was normal, suggesting normal generalised retinal function. The pattern ERG was within normal limits to a standard field stimulus; however, to a large field stimulus, it did not demonstrate the expected increase in amplitude in either eye, suggesting mild peripheral macular dysfunction with intact central macular function (figure 2). Multifocal ERG was also performed and confirmed no central macular dysfunction, but far eccentric areas were subnormal. Given the higher density of drusen in the peripheral macula, we postulated that this accounted for the mild peripheral macular dysfunction. The patient underwent genetic testing with a retinal and macular dystrophy-targeted gene panel consisting of 236 causal genes, but no pathogenic variants of significance were detected.

Figure 1  Multimodal imaging of the patient with acquired lipodystrophy and macular drusen. (A,B) Ultra-widefield colour images demonstrating bilateral drusen, contained mainly within the arcades and involving the macula. (C,D) Short wavelength autofluorescence also demonstrating bilateral macular drusen.

Figure 2  (A) Infrared reflectance (IR) demonstrating macular drusen in the right eye. (B) Optical coherence tomography (OCT) demonstrating macular drusen in the right eye. (C) IR demonstrating macular drusen in the left eye. (D) OCT demonstrating macular drusen in the left eye. (E) Pattern electroretinogram to a standard stimulus field is normal and relatively symmetrical. A large stimulus field response shows some increase in amplitude bilaterally, but not quite as much as would be expected, suggesting the possibility of mild peripheral macular dysfunction with no evidence of central macular dysfunction. The right eye has existing amblyopia.
DIFFERENTIAL DIAGNOSIS
Sorsby fundus dystrophy is a progressive autosomal dominant macular dystrophy. This condition is caused by mutations involving the TIMP3 gene. It is known to present between the third and sixth decade of life with characteristic thickening of the basement membrane and drusenoid deposits that later develop into areas of atrophy. Typically, patients demonstrate disrupted dark adaptation and nyctalopia, progressing to a loss of central vision.11

Doyne honeycomb retinal dystrophy, also known as dominant drusen or malattia leventinese, is caused by one specific variant in EFEMP1 (p.Arg345Trp). Characteristically, small radial and large round drusen are visible in the posterior pole and juxtapapillary area.11 12 Patients are generally asymptomatic. If visual symptoms are apparent, these may include reduced central vision, metamorphopsia, and photopsia.

Familial benign fleck retinopathy is an autosomal recessive condition that belongs to the group of flecked retina syndromes. It is caused by biallelic variants in the PLA2G5 gene.11 Affected individuals do not suffer from visual dysfunction nor do they demonstrate electrophysiological deficits. They present from an early age with non-progressive subretinal drusenoid deposits that extend far into the peripheral retina; however, unlike our patient, these deposits are foveal sparing.

Pattern dystrophy is an autosomal dominant condition, comprising a heterogeneous group of macular disorders with various patterns of macular pigmentary alterations. The most common mutation is in the PRPH2 gene although variants in other genes, such as CTNNAL1 have been reported.13 It is often an incidental finding on routine examination as affected individuals are often asymptomatic, although mild reduction in vision and metamorphopsia may occur.

Certain systemic disorders, such as MPGN-II and lipodystrophy can manifest as early-onset retinal drusen or drusen-like deposits. MPGN-II can present with basal laminar (also known as cuticular) drusen in the second decade of life. These small yellow–white clustering drusen are found in the macula and peripheral retina. They are easily visualised by fluorescein angiography and were first described as having a ‘starry sky’ appearance. Over time, reduced central vision secondary to CNV, serous macular detachment and macular atrophy may ensue.11

TREATMENT
Despite the extensive macular drusen, the patient retained normal vision in her left eye, hence no intervention was required. An Amsler grid was provided so the patient could monitor for any changes such as distortion or scotomas associated with a possible CNV. The patient was advised to maintain a healthy, balanced diet rich in antioxidants and avoid cigarette smoke. Lid hygiene advice and ocular lubricants were prescribed for her blepharitis and dry eyes.

The mainstay metabolic management of lipodystrophy includes dietary macronutrient restriction and regular exercise, as well as the use of hypoglycaemic and hypolipidemic medications where indicated. Currently, the only drug approved for metabolic control in lipodystrophy is metreleptin, which can also be used as an adjunct to diet, and has been found to be more effective in those with general rather than PLD.6 Additional first-line treatments include metformin for treatment of diabetes and insulin resistance, statins for hyperlipidaemia, and ACE inhibitors or angiotensin receptor blockers for hypertension. Consideration should be given to the psychological impact of the condition and referrals should be made accordingly for psychological therapy and cosmetic surgery.6

OUTCOME AND FOLLOW-UP
Annual follow-up was arranged to monitor the retinal findings. The patient remained stable without any deterioration in vision or associated symptoms over a 1-year period. There was no evidence of CNV or RPE atrophy. The blepharitis was well controlled with conservative management.

DISCUSSION
Generalised and acquired lipodystrophy have a prevalence of 0.23 and 2.84 cases per 1 000 000, respectively.1 The percentage association with retinal drusen is unknown but it is ultrarare, with few reported cases.14–23 This case highlights the importance of knowing the associated ocular and systemic features of lipodystrophy, including the following: diabetes, dyslipidaemia, non-alcoholic fatty liver disease, cardiovascular disease, renal disease and reproductive dysfunction.12 This ensures input from the correct multidisciplinary teams. It also helps to forewarn patients that macular drusen may develop, allowing for annual retinal screening to be pre-emptively organised with a local optometrist.

The association between lipodystrophy syndrome and MPGN-II is described in the literature,24 with 22% of lipodystrophy patients developing this condition.25 MPGN-II, also known as dense deposit disease, is a rare renal disorder with 2–3 cases per 1 000 000, arising from nephritic factor-induced dysregulation of the alternate complement pathway and consequent low levels of serum C3. This condition presents with proteinuria and haematuria in childhood, often progressing to renal failure. It is characterised by electron-dense deposits in the glomerular basement membrane of the kidney and, owing to the systemic nature of the disease, can also be found within the spleen, and between the choriocapillaris and Bruch’s membrane of the retina.26 MPGN-II and age-related macular degeneration are known to share a common pathophysiological process through dysregulation of the alternate complement cascade. Patients with MPGN-II can present with early-onset macular drusen from their second decade, which advances peripherally and is associated with thickening of the Bruch’s membrane.24 Interestingly, there is no correlation between the degree of retinal disease and severity of the renal disease. However, a correlation between the duration of renal disease and the likelihood of retinal disease developing has been described.19

In a long-term follow-up study by McCaoy and Silvestri in 2005 nearly 80% of their patients with MPGN-II (n=20) exhibited cuticular drusen.27 As such, it is recommended that patients presenting with this feature undergo screening for nephropathy.24 Previous attempts at systemic treatment of MPGN with intravenous immunoglobulins, plasmapheresis and B-cell suppression have all been relatively unsuccessful. Nevertheless, recent studies on eculizumab, a monoclonal antibody that prevents formation of the membrane attack complex by binding C5, and compstatin, a C3-targeted complement inhibitor, have demonstrated promising results.

Ophthalmic management involves monitoring of drusen and associated complications such as CNV. Treatment of CNV involves the use of vascular endothelial growth factor antagonists to control the underlying neovascular process and prevent central vision loss. Signs of dry eyes, such as disruption of the tear film, keratitis and blepharitis are common among lipodystrophy patients, with up to 87%, of patients suffering from them.28 Treatment of lipodystrophy-associated keratitis varies depending on severity. Mild symptoms may be managed with the use of lubricating eye drops and/or ointments to maintain tear film stability and reduce ocular irritation.

In summary, due to the extremely low prevalence of lipodystrophy syndrome, accurate diagnosis remains a challenge to
Lipodystrophy is an ultrarare, progressive disease with severe metabolic sequelae that may be life-threatening if not appropriately diagnosed and managed. Management of patients with acquired partial lipodystrophy (PLD) may require regular screening for metabolic and renal complications such as type 2 membranoproliferative glomerulonephritis (MPGN-II). Ocular manifestations of acquired PLD, especially in those with renal involvement (MPGN-II), include dry eyes and retinal drusen. Long-term follow-up to monitor for complications such as choroidal neovascularisation, which can lead to severe visual impairment, should be considered.

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