Heterochromia iridis, asymmetry of iris pigmentation, has been well described with congenital Horner's syndrome. Interruption of the second order neuron of the sympathetic pathway early in life has also resulted in heterochromia. Acquired heterochromia associated with lesions in the ocular sympathetic pathways in adulthood, however, must be exceedingly rare. We report two cases in which sympathectomy resulted in ipsilateral Horner's syndrome and heterochromia. In each case, pharmacological testing with cocaine and Paredrine was performed. The sympathectomy occurred at the level of the second order neuron, but Paredrine testing suggested at least partial third order neuron involvement. The question of transsynaptic degeneration will be discussed.

REFERENCES:

ACROMEGALIC SMORGASBORD WITH MOET & CHANDON PAPILLEDEMA

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A 50 year old Philippine internist noticed loss of reading vision in his left eye. He also complained of increased thirst. Over several years, others had noticed changes in his facial contours and deepening of his voice. Brain MRI in Manila showed a cystic tumor in an enlarged, partially empty sella. Skeletal and cranial bone changes indicated metabolic bone disease. Prostatic ultrasonography was normal. Growth hormone was 16 ng/ml (normal range 0-5), alkaline phosphatase was 2438 IU (36-92)

He presented at UCSF with acromegalic facial changes, large hands and a hoarse voice. Visual acuity was 20/70 RE and 20/40 LE. Left eye showed conjunctival injection over lateral muscle insertion and proptosis with 5 mm asymmetry in Hertel readings. Eye movements were mildly and symmetrically restricted in all directions. There was massive bilateral papilledema with hemorrhages and macular exudates. Visual fields demonstrated marked enlargement of the blind spots.

CT and MRI of brain and orbits showed no optic nerve or chiasmal compression from the pituitary adenoma. Orbital bones, particularly the lateral walls, were prominently thickened. A diffuse soft tissue mass was seen adjacent to the lateral orbital walls, most marked on the left side, substantially reducing left orbital volume. Eye muscles were not enlarged, but the lateral rectus were displaced medially by the orbital changes. The calvarium was grossly thickened with periosteal proliferative reaction. There was no signs of dural sinus obstruction. The ventricles appeared normal. The cerebrospinal fluid pressure exceeded 600 mm water. A large non-invasive pituitary adenoma was removed trans-sphenoidally.

Only two cases with papilledema associated with acromegaly have previously been reported. However, the papilledema was subtle and in neither case was the intracranial pressure measured.

The mechanism for the high cranial pressure in our patient remains obscure. Further, his extraordinary bone changes, not easily explained by acromegaly alone, have led to the university-wide dilemma whether he in fact has two or even three concurrent diseases.