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CML WITH DIABETES

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A 42-year-old diabetic male presented with gradual onset, painless, progressive diminution of vision in both eyes for 6 months. There was no history of trauma. The patient has type 2 diabetes mellitus which was diagnosed 5 years back, was on oral medication. Patient was diagnosed as CML 8 months back and started on Tab Dasatinib 100mg OD. The BCVA was 1/60 in the right eye and 4/60 in the left eye with an IOP of 14 in both the eyes. Anterior segment of both the eyes was normal. Fundus evaluation in both the eyes showed severe hemorrhages in all 4 quadrants of the retina, hemorrhages and hard exudates at the fovea.

FFA was done and multiple beading and large capillary non-perfusion areas were noted in both the eyes. Macular OCT was done, in the right eye hard exudates were noted with a normal central macular thickness. However in the left eye, macular edema was noted with a central macular thickness of 1054um.

A diagnosis of both eyes PDR with venous stasis with left eye cystoid macular edema was made. Pan retinal photocoagulation was done in the right eye. In the left eye, intravitreal anti-VEGF avastin injection and injection triamcinolone acetonide 2mg was given for cystoid macular edema. Pan retinal photocoagulation was done after 2 weeks in the left eye. One one week follow up, macular edema reduced to half in the left eye. His vision in the right eye was the same, left eye vision improved slightly to 6/60.

Accelerated proliferative retinopathy was seen in cases of diabetes with CML at the very initial ophthalmic evaluation. There is a need to alter screening guidelines for retinopathy in cases of diabetes with chronic myeloid leukaemia. Early detection and aggressive management may help preserve visual acuity in such cases.