Short communication

Retinal capillary hemangioma and von Hippel-Lindau disease: Diagnostic and therapeutic implications

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ABSTRACT

Clinical case: Man carrier of the von Hippel-Lindau (VHL) gene, with long-onset loss of vision in left eye. He had a retinal capillary haemangioma (HCR) and diffuse cystic edema in posterior pole. The systemic study revealed bilateral kidney tumors. Laser photocoagulation was performed which produced a subretinal and vitreous hemorrhage that required vitrectomy.

Discussion: Retinal capillary haemangioma (HCR) is the earliest and most frequent manifestation of the von Hippel-Lindau disease. Its detection requires it to be treated early and to rule out other visceral lesions. Laser photocoagulation is the most recommended treatment of small size HCR. The most frequent complications are vitreous and subretinal hemorrhages.

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Palabras clave:
Hemangioma capilar retiniano
Enfermedad von Hippel-Lindau
Fotocoagulación láser
Vitrectomía

RESUMEN

Caso clínico: Varón con disminución de visión en ojo izquierdo de larga evolución. Portador del gen de VHL. Presenta hemangioma capilar retiniano (HCR) y edema quístico difuso en polo posterior. El estudio sistémico revela la existencia de masas renales bilaterales. Se inicia fotocoagulación con láser argón, produciéndose hemorragia subretiniana y hemorragia vítrea que precisó vitrectomía.

Discusión: El HCR constituye la manifestación más frecuente y precoz en la enfermedad de VHL. Su detección obliga a su tratamiento precoz, así como a descartar otras lesiones viscerales. La fotocoagulación láser es el tratamiento de elección en el HCR de pequeño tamaño. Entre sus complicaciones destaca la hemorragia vítrea y subretiniana.

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Introduction

The von Hippel-Lindau (VHL) disease is a hereditary disease caused by germinal mutations in the VHL tumor suppressing gene. The prevalence is estimated at 1/36,000 births and penetration is nearly complete by age 65. Approximately half of VHL cases are familial, with the other half being sporadic due to new mutations.1,2

The clinical expressions of VHL are highly diverse, with more than 40 lesions being described in 14 different organs, including retinal capillary hemangioma (RCH), cerebellum or spinal hemangioblastoma, renal pheochromocytomas and carcinomas (the main cause of death). Even though 50% of patients exhibited only one characteristic and very few develop the complete syndrome, all must undergo a systematic detection protocol (Table 1).1,3

Frequently, RCH is the first expression and is present in 70% of patients, with its frequency increasing with age. RCH can appear in isolation or as a part of the VHL disease, where one-third are multiple and half are bilateral. In the presence of familial history, the existence of RCH is considered to be a diagnostic criteria for the syndrome (Table 2). Possible ophthalmological expressions also include other vascular hamartoma and what is known as “twin vessels”. Optic pathway alterations are rare, although one case has been described with an optic nerve tumor.1–4

<table>
<thead>
<tr>
<th>Table 1 – Von Hippel-Lindau disease detection protocols.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td>Ophthalmoscopy</td>
</tr>
<tr>
<td>AFG</td>
</tr>
<tr>
<td>Physical exploration and cate-cholamines in 24 h urine</td>
</tr>
<tr>
<td>NMR/CAT brain and spinal chord</td>
</tr>
<tr>
<td>Echography/abdominal CAT</td>
</tr>
</tbody>
</table>

Table 2 – Diagnostic criteria for the von Hippel-Lindau disease.

With familial history
One or more of the following lesions are required:
- RCH
- SNC hemangioblastoma
- Organ lesions: kidney carcinoma, pheochromocytoma, renal/pancreatic cysts, pancreatic islet tumors, paragangliomas, epididymis cystadenomas, endolymphatic sac tumors

Without familial history
- RCH and/or SNC hemangioblastoma (if only one of these tumors expresses, a second organ lesion is necessary)

Clinical case

A male, 26, exhibited visual acuity reduction in the left eye with a 2-year evolution. The subject is a bearer of the mutation causing the VHL disease, father and brother with systemic syndrome expressions. Upon exploration, the VA of the LE is of 0.4. The LE ocular fundus exhibits orange-colored endophytic tumoration of two papilla diameters in the superior temporal arch with dilated nutrition vessels (Fig. 1). Optic coherence tomography (OCT) evidences a diffuse cystic edema in the posterior pole and angiography (AFG) reveals early hyperfluorescence of the lesion with delayed losses (Fig. 2). A systemic study was requested which in addition revealed solid nodules in both kidneys suggesting bilateral hypernephroma (subsequently confirmed after performing radical left nephrectomy), a hypercapturing nodule in the right supra-renal gland, a likely neuroendocrine pancreatic tumor and multiple
hemangioblastomas in protuberance and spinal chord, with slight medullar edema associated.

Argon laser photocoagulation was initiated in 2 sessions, during which subretinal hemorrhage occurs along the vascular arch and vitreous hemorrhage (VH). Two months later and due to the lack of absorption of the VH, it was decided to perform a 23G vitrectomy during which the treatment for the lesion was completed with endolaser. Three months after the surgery, the patient VA was of 0.6. OCT showed a good foveal profile, with resolution of the macular edema (Fig. 3). AFG confirmed the closure of nutrition vessels, the lesion exhibited a cicatricial appearance (Fig. 4), and even though capture began early, there is no loss, and substituted vessels can be appreciated in the periphery of the lesion.

Discussion

RCH is an angiomatous hamartoma which histopathologically consists in a proliferation of capillary vessels that alters the normal sensory architecture of the retina. These lesions frequently exhibit endophytic growth and mainly are located in
the peripheral and superior temporal area, although the juxtapapillary hemangioma has been described in 11–15% of VHL cases.\textsuperscript{1,2}

The visual loss associated to RCH could be due to several causes, including exudative (25%) or tractional (9%) phenomena, the development of epiretinal membranes and HV. It has been recently demonstrated that the retinal function of patients with VHL could be affected even in the absence of RCH. The RCH diagnostic requires completing the systemic study in search of other organ lesions which could limit survival, such as kidney carcinoma.\textsuperscript{1,3}

In general, lesions increase progressively in size and rarely regress spontaneously. Accordingly, it is recommendable to establish prophylactic treatments when they are still small. Laser photocoagulation is the most adequate method for small lesions under 3 mm in size, although a maximum size of 4.5 mm can be considered. The prognosis is generally uncertain in larger tumors. Several sessions are required and the risk of therapeutic failure is high. Large size burns are utilized, with low intensity and extended duration. It is recommended to begin by limiting the lesion and then acting on the vessels (which requires several sessions) and finally on the tumor surface, although the effects are not permanent in all cases. Cryotherapy is reserved for larger size tumors, pre-equatorial locations or when opacity prevents photocoagulation, although exudation can temporarily increase after the application thereof. Additional options include brachytherapy, reserved for selected cases, and vitrectomy indicated in cases of HV and massive tractional or exudative retinal detachment.\textsuperscript{1,3–5}

Conflict of interests

None of the authors have declared any conflict of interests.

References