Acute Onset of Complex Ocular Migraine Associated with A Nasal Bone Spur

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INTRODUCTION

Migraines are the most common type of primary headache disorder seen clinically. A migraine is differentiated from an ocular migraine in that the hallmark sign of an ocular migraine is unilateral visual loss that is accompanied or followed by a headache. The visual loss is shorter than that of a migraine, lasting less than 5 minutes. The visual symptoms in an ocular migraine are typically complete vision loss, blurring, and/or dimming of vision. The headache accompanying the vision loss will typically be ipsilateral and concurrent to the visual loss. Although typically additional investigation is not required in patients under 40 years of age, this case illustrates the importance of neuroimaging in patients with acute ocular symptoms of an atypical ocular migraine or migraine with aura.

CASE REPORT

A 23 y/o white male presented with transient blurry/diminishing vision for the past month. Symptoms worse OS, sporadic, and initial episode lasting 1 minute. The next episode occurred 2 weeks after with similar visual symptoms along with slurred speech x 10 minutes. The following occurrence was 1 week after with blurred vision lasting less than a minute and no associated speech deficits. Headache and nausea reported with each episode. Poor sleep quality and alcohol consumption reported the day prior to each episode. LME was 1 month prior, yielding normal blood work, thyroid function, and CT scan.

TABLE 1
Pertinent Initial Presentation

	OD	OS
Visually Acuity (cc)	20/20	20/20
Pupils	Equal, round, reactive, no APD	Equal, round, reactive, no APD
CVF	FTFC	FTFC
EOMs	FULL, (-) pain	FULL, (-) pain
Anterior Segment	wnl	wnl
IOP	16mmHg	28mmHg
Fundus	wnl – Optos Figure 1A	wnl – Optos Figure 1B
Diagnostic Testing	24-2 SITA Fast HVF – Figure 2A Cirrus ONH OCT – Figure 3A	24-2 SITA Fast HVF – Figure 2B Cirrus ONH OCT – Figure 3A

FIGURE 1A

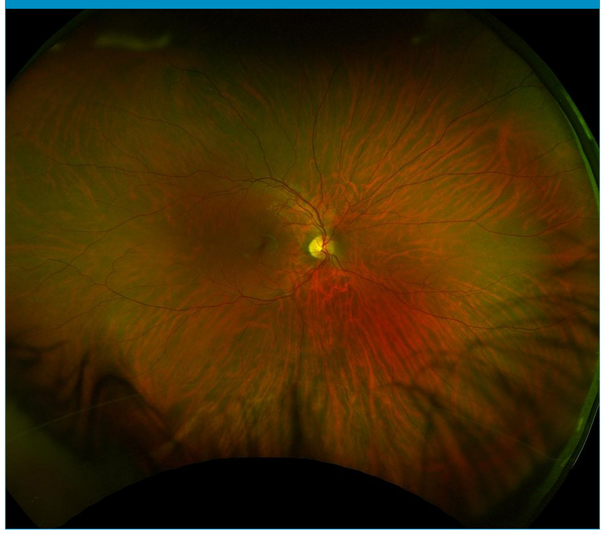


FIGURE 1B

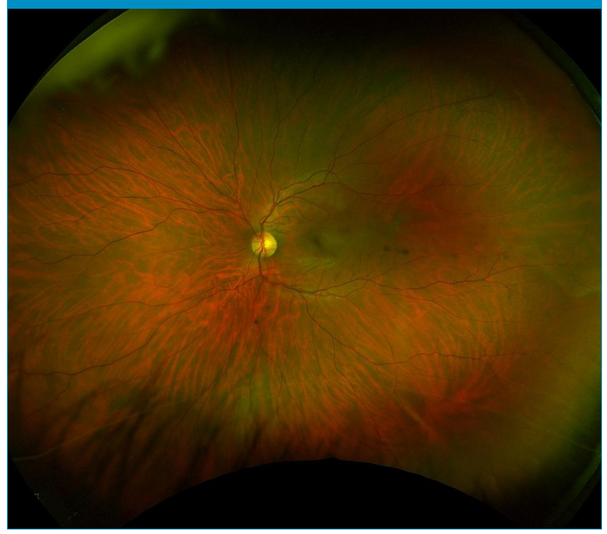


FIGURE 2A

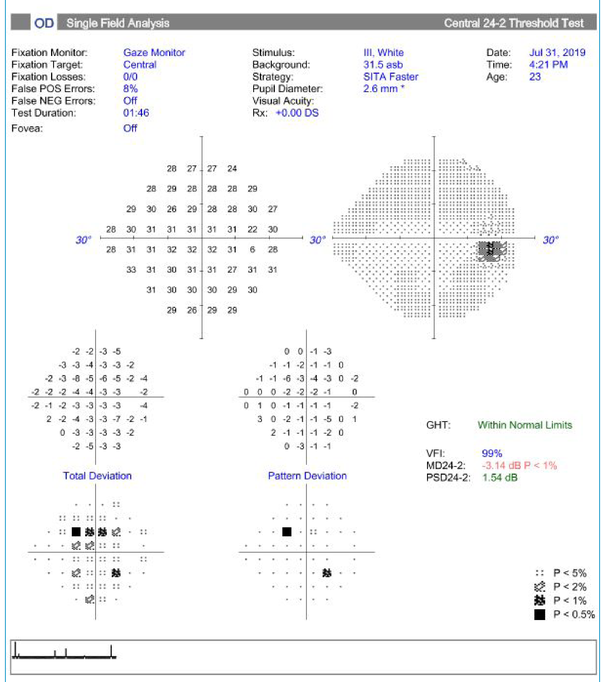
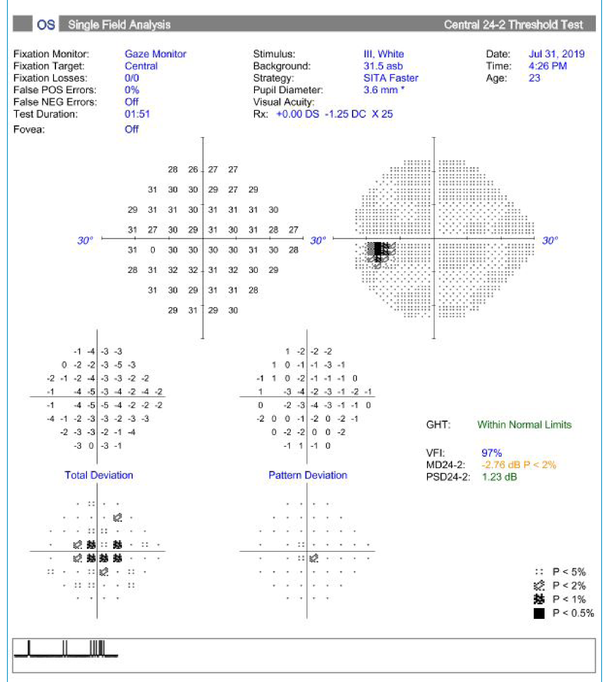


FIGURE 2B



DIAGNOSIS

The patient was referred for neuroimaging and neurology consultation urgently along with continued care with his PCP. Recommended neuroimaging included MRI/MRV/MRA of brain and orbits to rule out neurologic complications due to acute onset of symptoms and stroke-like symptoms associated with visual changes.

The MRI results of the brain revealed a moderate-sized rightward directed nasal spur, which may be associated with chronic migraine symptoms. The patient was referred for an ENT consultation to discuss treatment options.

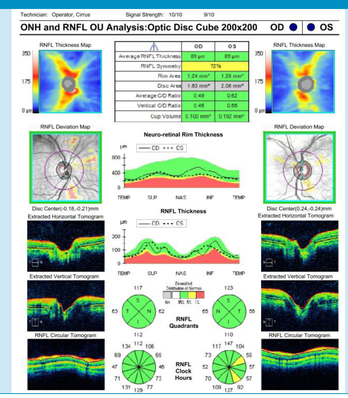
CONCLUSION

Contact between the nasal spur and the adjacent mucosa of the nasal wall may cause migraines, though patients may first present for an ocular evaluation due to associated visual symptoms. Thus, highlighting the significant role of the optometrist in the interprofessional health care team. Patients presenting with urgent symptoms including abrupt onset and neurological symptoms should be further evaluated with neuroimaging to rule out secondary causative etiologies.

REFERENCES

Available upon request.

FIGURE 3



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