

A 23-year-old healthy woman presented with vision loss in her left eye (OS) following a prodrome consisting of fever, malaise, and maculopapular rash on her chest and shins 3 weeks prior. Visual acuity OS was 20/100, and fundus examination revealed an elevated circular area in the left macula (**A**) without vitritis. Fluorescein angiography (**B**) demonstrated speckled fluorescence pattern and pooling consistent with a neurosensory detachment. OCT (**C**) illustrated outer retina intraretinal fluid, subretinal fluid, and a bacillary layer detachment (arrows). Serologic testing was positive for Coxsackie A immunoglobulin G titers (titers ranged from 1:800–1:1,600; reference < 1:100) (Magnified version of **Figure A-C** is available online at www.aaojournal.org).

A



B



Figure 1

Palmar-vesicle images.

Notes: (A) At 3 days after initial symptom presentation; (B) at 12 days after initial symptom presentation.

Clinical course of hand-foot-mouth disease

Incubation period 3–5 days

Initial fever, headache, and malaise

Sore throat and mouth

Vesicular rash develops after 1–2 days, beginning as a red macule and then progressing to vesicles

Vesicles present on hands, palms, and soles, and less commonly on limbs, buttocks, and genitals

Lesions resolve in 3–5 days and heal without scarring

Virus is excreted in feces and saliva for several weeks, and children are infectious until blisters have disappeared

Case report | [Open access](#) | [Published: 07 May 2019](#)

Acute unilateral maculopathy associated with adult onset of hand, foot and mouth disease: a case report

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a



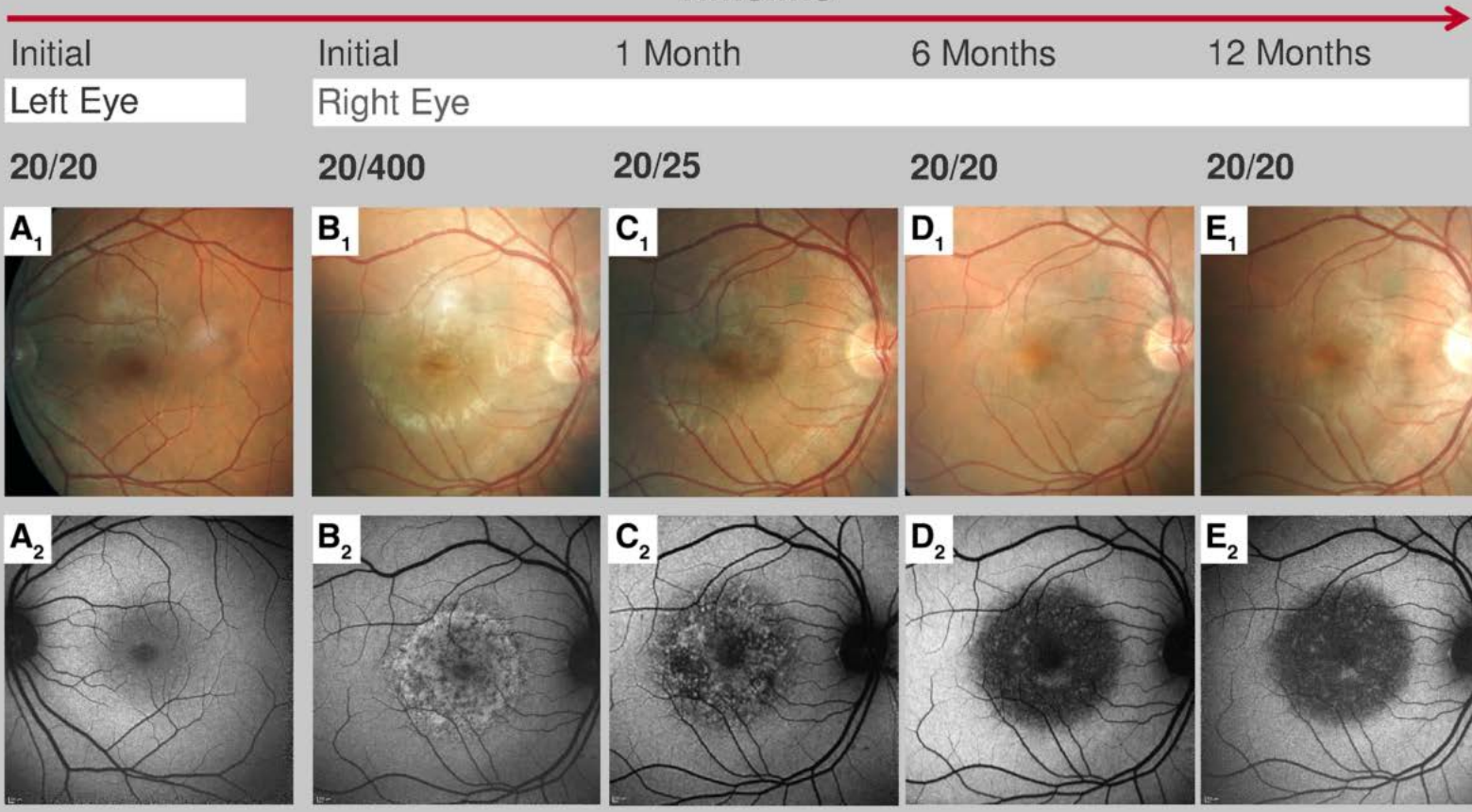
b



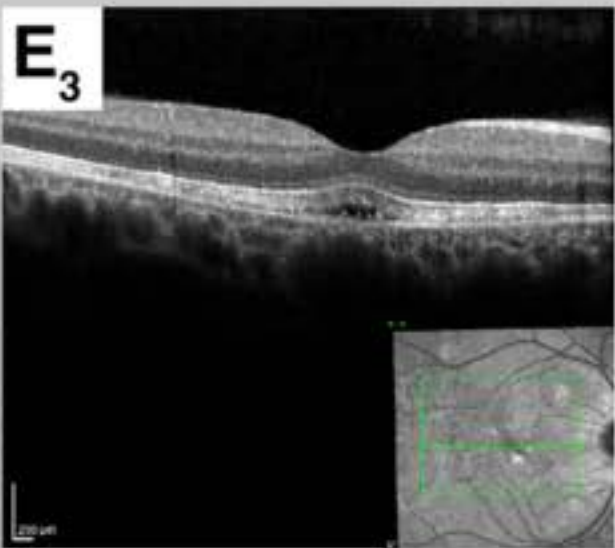
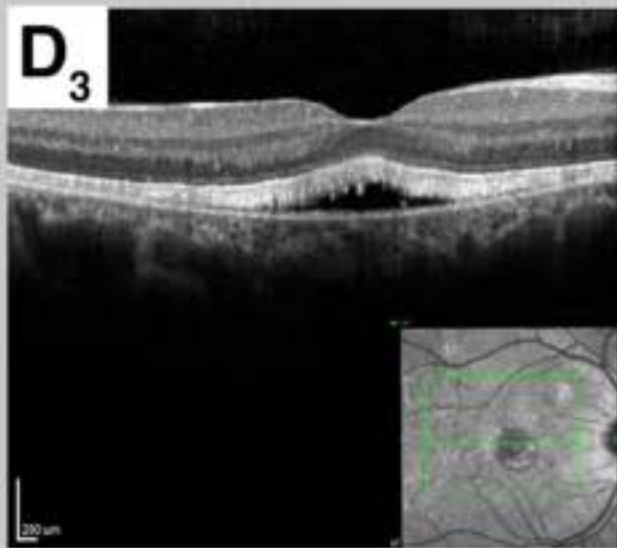
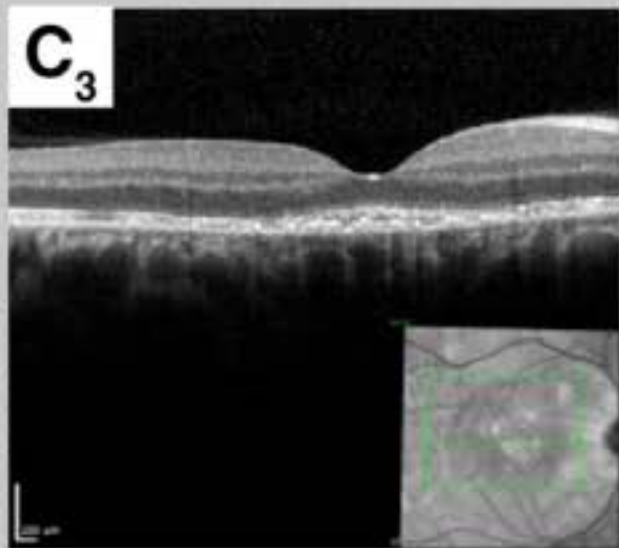
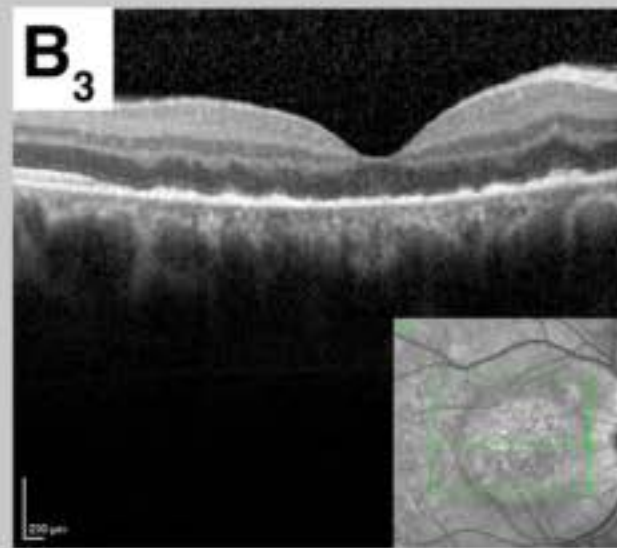
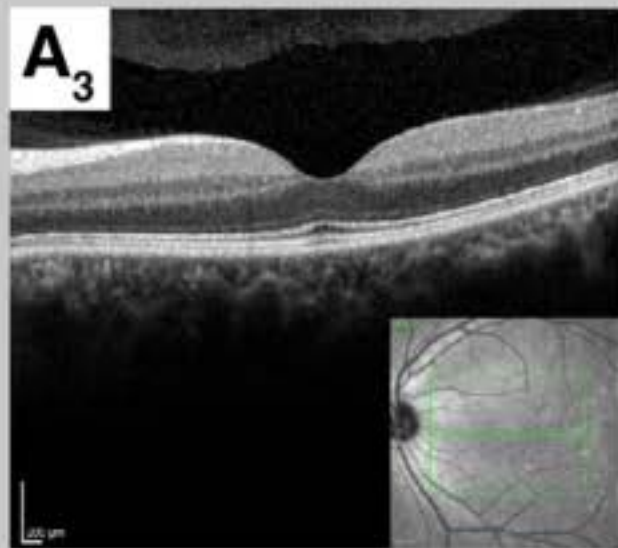
Nine days after the onset of clinically highly probable but not laboratory-verified HFMD, a 31-year old male noticed a central scotoma, distorted lines and loss of visual acuity (Snellen visual acuity 20/400) in his right eye. Funduscopy revealed focal alterations in the retinal pigmented epithelium (RPE) and yellow retinal dots corresponding to focal dots of decreased fundus autofluorescence (FAF) surrounded by increased FAF. Spectral domain optical coherence tomography (SD-OCT) demonstrated irregularities in the ellipsoide zone, hyperreflective dots above the RPE and RPE thickening. Fundus fluorescein angiography (FAG) revealed central hypofluorescence in the macular area in the early phase, as well as increasing focal hyperfluorescence in the late phase corresponding with RPE defects observed in FAF.

Indocyanine green angiography (ICGA) showed central hypofluorescence in the early and late phase, corresponding with areas of reduced flow in the choroidea and choriocapillaris as apparent in OCT-A. Visual acuity improved within 3 months without any systemic or local therapy. At his three-month follow-up, SD-OCT revealed subtle subretinal fluid that resolved spontaneously over time. No signs of choroidal neovascularization were observed. Twelve months following the onset of symptoms Snellen visual acuity was 400/400. Multimodal imaging revealed subtly changed, decreased FAF while the choroidal architecture recovered completely as demonstrated by OCT-A.

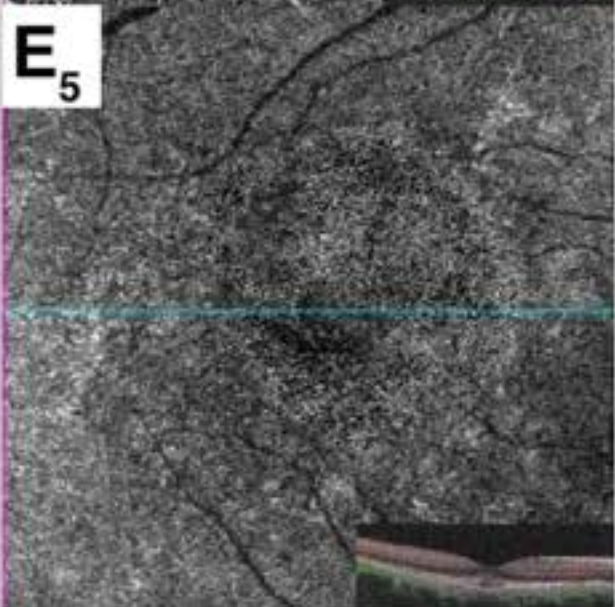
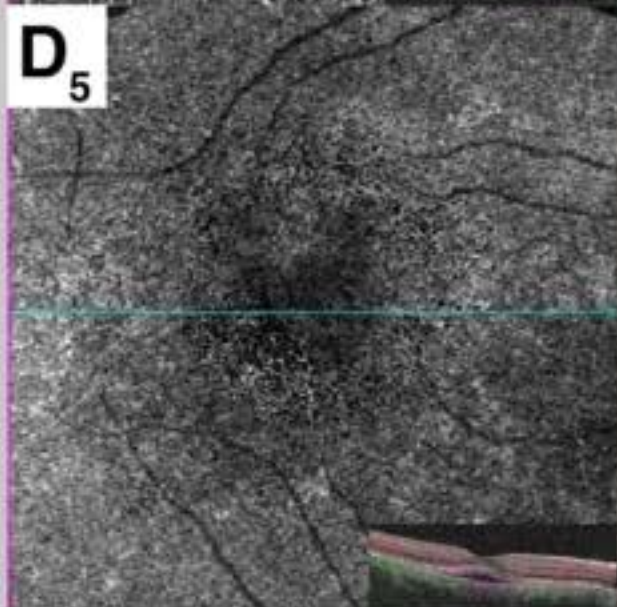
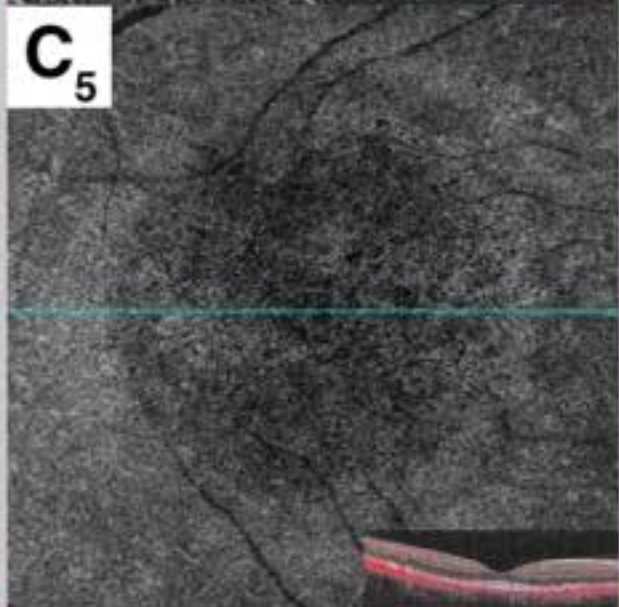
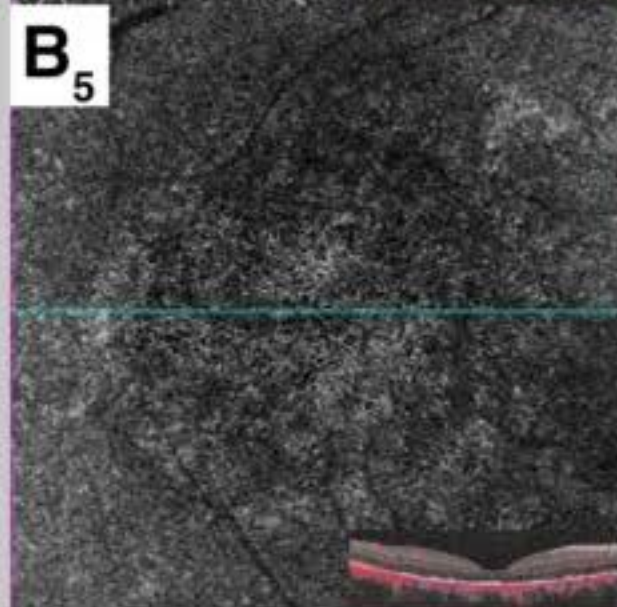
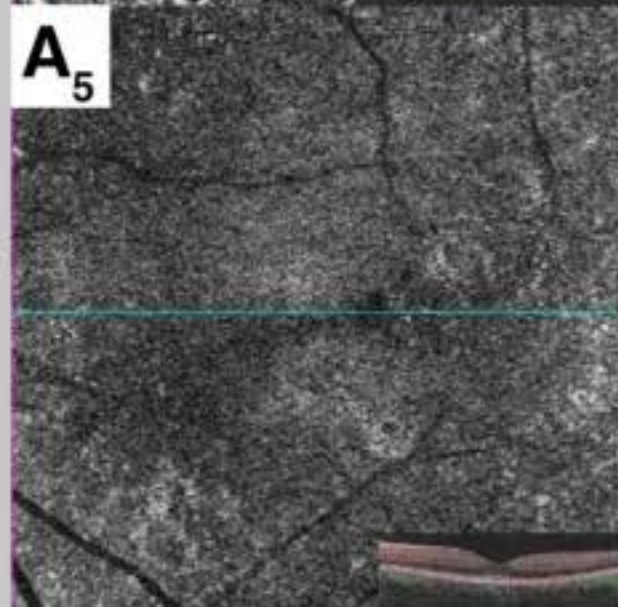
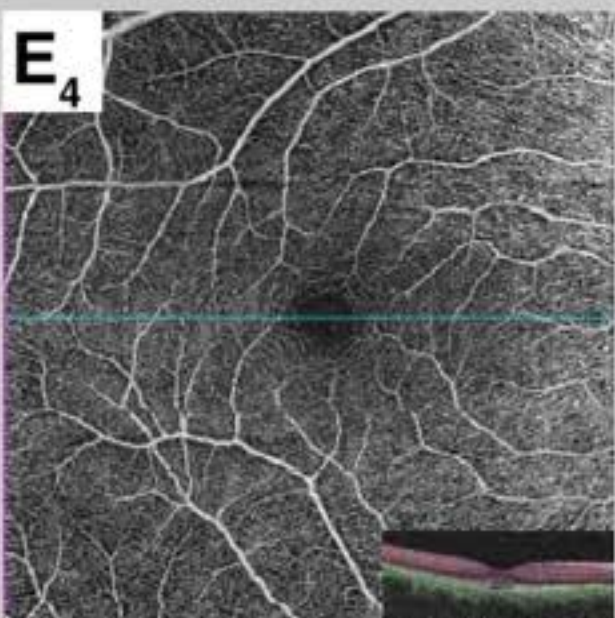
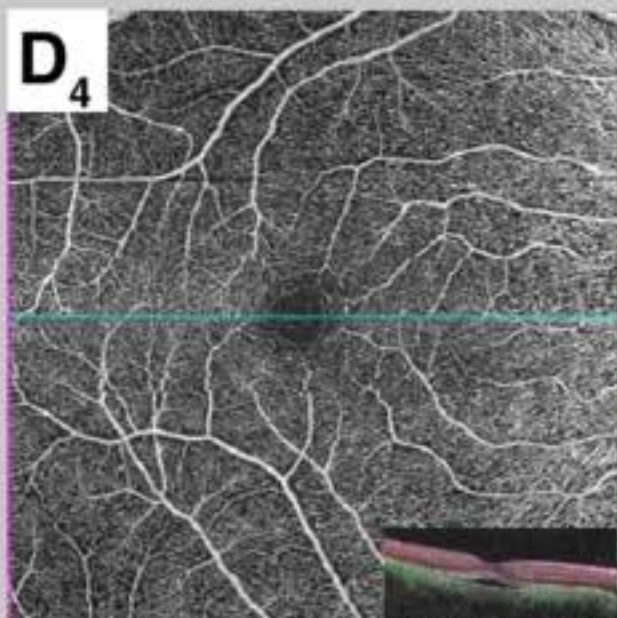
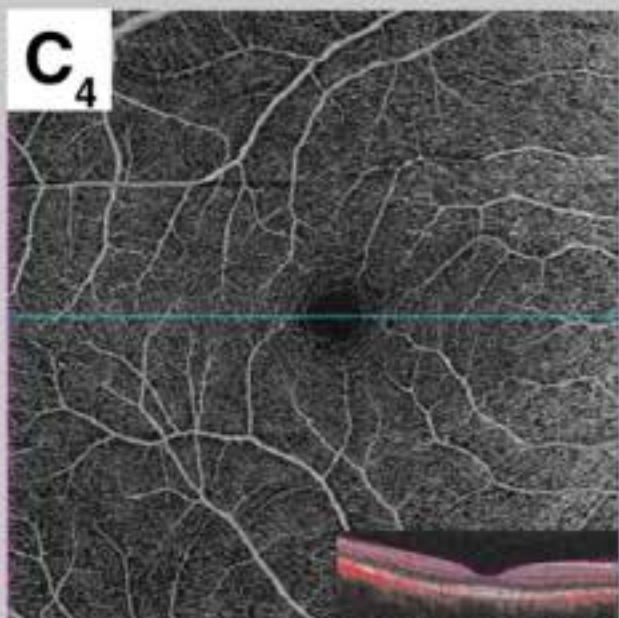
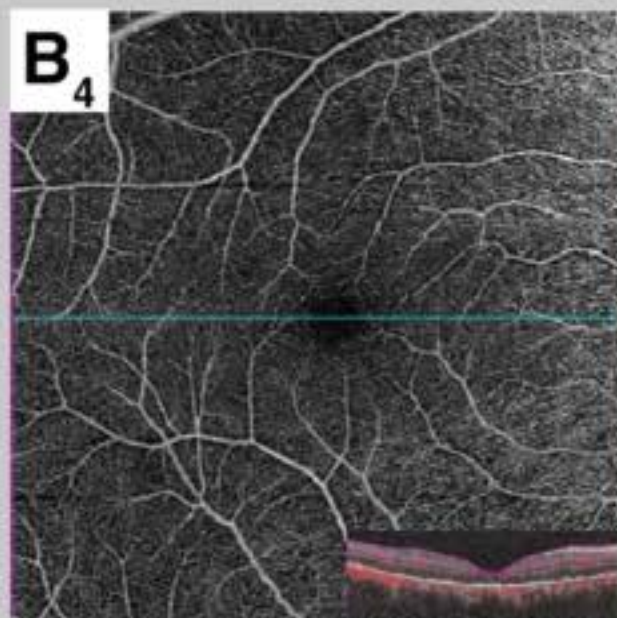
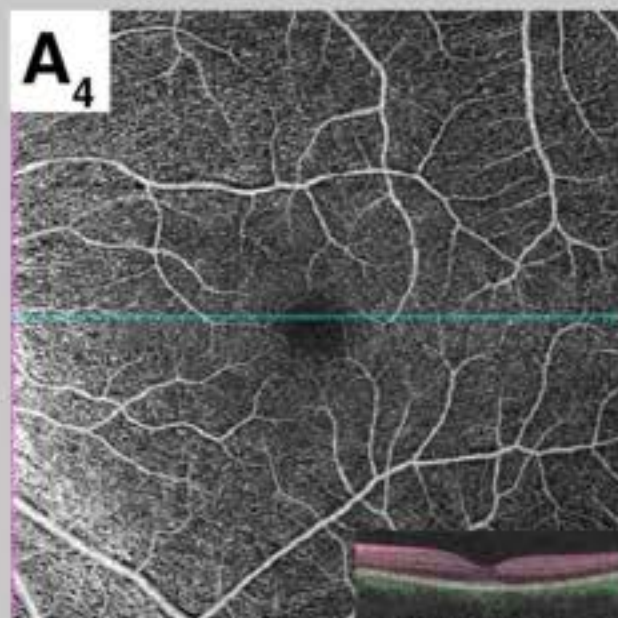
Timeline



SD-OCT



OCT-Angiography
superficial
Choriocapillaris



Initial

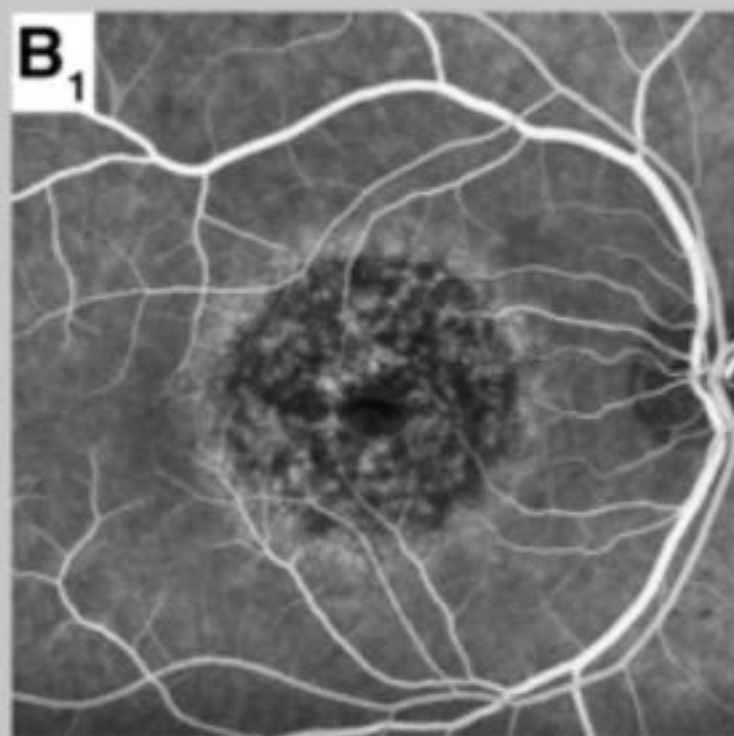
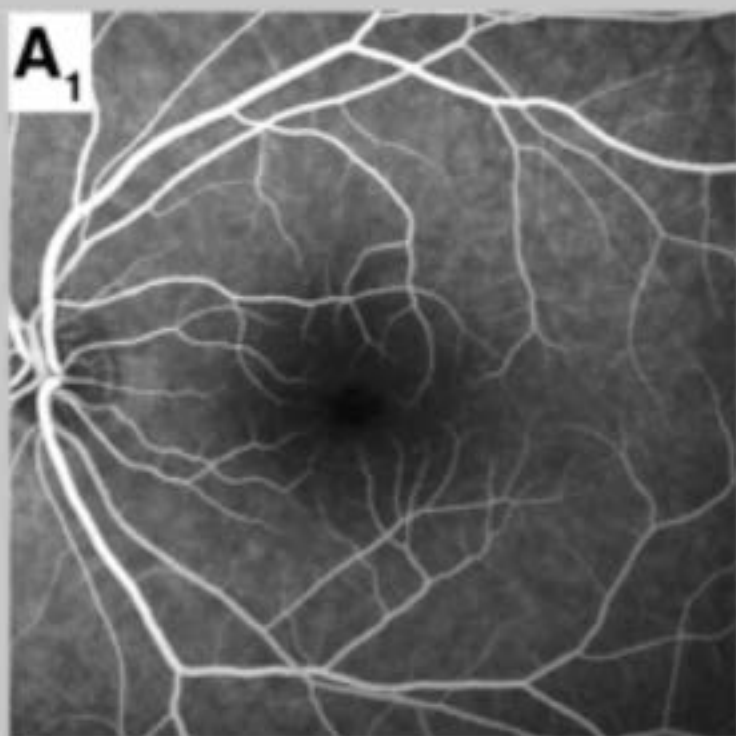
Initial

6 Months

Left Eye

Right Eye

FAG



ICG

