



When Migraine Paralysis The Eye-A Rare Case Of Recurrent Ophthalmoplegic Migraine In A 56 -Year Old Female

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Abstract

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Introduction

Ophthalmoplegic migraine, now classified under recurrent painful ophthalmoplegic neuropathy (RPON), is a rare neurological disorder characterised by recurrent headache attacks associated with paresis of one or more ocular cranial nerves. Although traditionally considered a variant of migraine, recent studies suggest it may represent a demyelinating cranial neuropathy with migraine-like headache as a prominent feature.

This report discusses a case of a 56-year-old female who presented with recurrent headache episodes accompanied by right-sided third cranial nerve palsy, emphasising the diagnostic approach, clinical course, and management strategies.

Aims and Objective:

To describe the clinical presentation, diagnostic evaluation, and therapeutic response in a rare adult case of ophthalmoplegic migraine with recurrent third cranial nerve involvement, and to highlight the importance of differentiating it from other causes of painful ophthalmoplegia such as aneurysm, neoplasm, and inflammatory neuropathies.

Method and Materials:

A 56-year-old female presented with recurrent, severe, unilateral, throbbing headache over the right frontotemporal region for the past 2 years. Each episode lasted several days and was followed by diplopia and ptosis of the right eye. Neurological examination revealed complete right-sided ptosis,

limitation of eye movement in all directions except abduction, and a dilated, sluggishly reactive pupil—consistent with third cranial nerve palsy. MRI brain with contrast plus venogram along with bilateral temporal artery doppler were performed to exclude compressive and vascular lesions. Laboratory investigations including ESR, CRP, blood glucose were within normal limits. The patient was managed with corticosteroids during the acute phase and prophylactic migraine therapy with beta blockers.

Results:

Neuroimaging revealed no evidence of aneurysm, mass lesion, or demyelination. The patient's headache subsided with corticosteroid therapy, and ocular motor function gradually improved over six weeks. Follow-up at six months showed no residual deficit. The recurrence pattern and radiological findings were consistent with recurrent painful ophthalmoplegic neuropathy. The patient remained asymptomatic under migraine prophylaxis at one-year follow-up.

Conclusion:

Ophthalmoplegic migraine remains a diagnostic challenge due to its rarity and overlap with more serious intracranial pathologies. This case underscores the importance of thorough neuro imaging to exclude secondary causes of third nerve palsy. Early recognition and prompt corticosteroid therapy may lead to faster recovery and prevent permanent cranial nerve damage. Clinicians should consider ophthalmoplegic migraine in adults presenting with

recurrent unilateral headache and cranial neuropathy, especially after excluding compressive and vascular etiologies. Continuous follow-up is essential for monitoring recurrence and evaluating the long-term

outcome. This case reinforces that ophthalmoplegic migraine, though rare in older adults, should remain within the differential diagnosis of recurrent painful ophthalmoplegia.