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► To cite this version:

Mona Hedreville, Philippe Connes, Marc Romana, Guillaume Magnaval, Thierry David, et al.. Central retinal vein occlusion in a sickle cell trait carrier after a cycling race.: SCT and ophthalmologic complications. *Medicine*

Science in Sports

exercise, ACSM, 2009, 41 (1), pp.14-8. <10.1249/MSS.0b013e31818313d0>. <hal-00698572>

HAL Id: hal-00698572

<https://hal.univ-antilles.fr/hal-00698572>

Submitted on 16 May 2012

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Editorial Manager(tm) for Medicine & Science in Sports & Exercise
Manuscript Draft

Manuscript Number: MSSE-D-08-00064R2

Title: Central retinal vein occlusion in a sickle cell trait carrier after a cycling race

Short Title:

Article Type: Clinical Investigation/Case Study

Keywords: hemoglobinopathy; exercise; ophthalmologic complications; red blood cell; coagulation

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Case studies

Central retinal vein occlusion in a sickle cell trait carrier after a cycling race

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Running title: SCT and ophthalmologic complications

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4 **Abstract**
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7 A 26-year-old man with sickle cell trait (SCT) suddenly lost visual acuity in the left eye after a
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9 cycling race in hot tropical environment. The cause was massive central retinal vein occlusion
10 (CRVO) with hemorrhaging that rapidly worsened to neovascular glaucoma. Although medically
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12 treated, the eye is now marked by total retinal detachment. Cardiovascular function assessment
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14 shown no electrocardiographic abnormalities, no anomaly in the supra-aortic tree and no evidence
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16 of structural heart disease. Although normal coagulation markers values (i.e. activated partial
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18 thromboplastin time, prothrombin time, fibrinogen concentration, antithrombin III, factor V,
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20 protein C and S) were observed **two and a half months after the clinical event**, a trans-esophageal
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22 echocardiogram performed few hours after the incident revealed the presence of four thrombi in
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24 the left atrium suggesting a post exercise hypercoagulable state at that time. Hemorheological
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26 measurements at distance of the events demonstrated high red blood cell rigidity at baseline.
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28 Therefore, marked blood rheological impairment and activation of the coagulation pathway in
29
30 response to the heavy and prolonged cycling race could have promoted CRVO in this cyclist
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32 carrying SCT. **These data suggest** that SCT could be considered as a risk factor for **significant**
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34 ocular complications when severe exercise is performed and support the idea that **SCT is a**
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36 **contributing factor in blood rheology and vascular dysfunctions.**
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55 **Key words:** hemoglobinopathy, exercise, ophthalmologic complications, red blood cell,
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4 **Introduction**
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9 *Paragraph 1:* The heterozygous form of sickle cell anemia (sickle cell trait; SCT) is usually
10 considered as a benign disorder by ophthalmologists, as compared with other forms of sickle cell
11 disease known to be associated with ocular complications (38). We report the first case of CRVO
12 (central retinal vein occlusion) coincident with prolonged and intense exercise that rapidly
13 worsened to neovascular glaucoma and painful blindness, in a young athlete with SCT. Since SCT
14 carriers are often marked by coagulation activity imbalance (36), blood rheological disorders
15 (28,35) and abnormalities in vascular adhesion processes (29,34), both at rest and in response to
16 exercise, we propose that blood and vascular dysfunctions might have contributed to the
17 occurrence of this adverse event.
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33 **Case report**
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38 *Paragraph 2:* A previously healthy 26-year-old Afro-Caribbean male cyclist was admitted to the
39 Ophthalmology Department of the University Hospital of Pointe-à-Pitre the day after a prolonged
40 and intense cycling race in Guadeloupe, a French West Indies island. The competition consisted of
41 138 kilometers in mountainous terrain and high ambient temperature (35°C) with 60% of
42 humidity. The patient felt himself particularly thirsty all along the race. At hospital admission, he
43 presented a sudden loss of visual acuity (VA) of the left eye (6/20). VA of the right eye was
44 normal (20/20). Intraocular pressure (IOP) was normal in both eyes (14 mmHg). Ophthalmoscopy
45 and fluorescein angiography of the left eye documented CRVO with massive retinal hemorrhage
46 (Figure 1). The clinical interview revealed that 1) the patient had already experienced a loss of
47 visual acuity of his left eye two months earlier with spontaneous recovery within two days and 2)
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4 he was a SCT carrier. Blood sampled was obtained to confirm the SCT status by isoelectric
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6 focusing and high performance liquid chromatography (Table 1). Hematological parameters,
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8 inflammatory and biochemical markers were normal (Table 1). The anticardiolipin antibody test
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10 was negative (Table 1). Unfortunately, a technical problem occurred during the analysis of the
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12 blood coagulation parameters that deprived us of data at that time. An in-depth assessment of
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14 cardiovascular function was also performed. The electrocardiographic measurements demonstrated
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16 sinus rhythm, normal QRS and repolarization. Neither anomaly in the supra-aortic tree using
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18 arterial echo Doppler, nor evidence of structural heart disease on echocardiography was detected.
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20 The trans-thoracic echocardiogram was normal but the trans-esophageal echocardiogram revealed
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22 the presence of four thrombi in the left atrium. Medical treatment associating troxerutin
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24 (Veinamitol®), a venotonic agent, and acetylsalicylic acid (Kardégic®) was prescribed by the
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26 Department of Ophthalmology. Anti-vitamin K medication was also given by the cardiologists to
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28 treat the left atrial thrombi. The patient was instructed to avoid physical exercise until the next
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30 visit. One month later, because of a severe ischemic form of the disease, panretinal
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32 photocoagulation treatment was given in emergency to manage CRVO.
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43 *Paragraph 3:* The patient returned one month later to the Department of Ophthalmology for
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45 headache, nausea and vomiting, blindness and eye pain in the left eye. The interview revealed that
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47 the patient had been doing heavy weight lifting, such as 3-5 maximal repetition method, when
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49 these medical signs suddenly appeared. Biomicroscopic exam demonstrated important iris rubeosis
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51 and neovascular glaucoma with corneal edema. The neovascular glaucoma was confirmed by
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53 gonioscopy. The patient was immediately hospitalized and hypotonic medication was given
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55 intravenously (acetazolamide, Diamox®) as well as locally (timolol maleate, Ophtim®), which
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57 decreased IOP to 20 mmHg. A complement of panretinal photocoagulation was performed in
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4 emergency as soon as the corneal edema was sufficiently reduced. Despite anticoagulation
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6 medication, a new trans-esophageal echocardiogram performed three days later revealed two
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8 remaining thrombi in the left atrium suggesting that blood coagulation disturbances were still
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10 persistent.
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16 *Paragraph 4:* Two weeks later, the IOP was still high (> 21 mmHg) and the patient complained of
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18 eye pain. Cryotherapy was performed on both the ciliary body and retina. One month later,
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20 assessment of blood rheology by viscometric method (10,28) demonstrated high red blood cell
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22 (RBC) rigidity (Table 2). Blood coagulation parameters (activated partial thromboplastin time,
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24 prothrombin time and antithrombin III) were also successfully measured and showed normal
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26 values (Table 2).
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31 *Paragraph 5:* The eye pain disappeared at this time, and the patient has since been chronically
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33 medicated with rimexolone (Vexol®), dorzolamide (Trusopt®), brimonidine tartrate (Alphagan®)
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35 and latanoprost (Xalatan®) to stabilize the IOP. Medication for platelet anti-aggregation was also
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37 prescribed for the patient and exercise is not currently recommended. The patient is followed by
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39 the Department of Ophthalmology and the Department of Cardiology every two months to monitor
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41 IOP and cardiovascular function. The IOP is now stabilized (12 mmHg) but the left eye is marked
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43 by total retinal detachment and very low visual acuity, which is limited to weak luminous
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45 perception.
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50 *Paragraph 6:* Informed consent was obtained from the patient and DNA studies were conducted.
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52 Briefly, DNA from blood sample was extracted using standard procedure and detection of the
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54 prothrombin A 20210, methyltetrahydrofolate reductase T 677 and factor V Leiden alleles were
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56 performed as previously described (15,30,31). DNA analysis revealed that the patient did not carry
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58 any of these genetic risk factor for retinal vascular occlusion and thrombotic event (6).
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4 **Discussion**
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9 *Paragraph 7:* We report the first identified case of CRVO associated with prolonged and intense
10 exercise in a SCT carrier with no past history of treatment for ocular complication or other disease.
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12 The patient was well trained in endurance cycle and performed 3 cyclists outing per week (2 short
13 ones of 60 – 80 km and a longer one of more than 100 km). In addition, he practiced weight lifting
14 twice a week to complete his training regimen. The situation rapidly deteriorated to neovascular
15 glaucoma and blindness of the eye. Several studies have reported ocular complications in SCT but
16 these complications have usually been described as the consequence of traumatic hyphema
17 (19,27,38). Ophthalmologists therefore consider SCT as a benign condition compared with SS or
18 SC hemoglobinopathy (38). However, this issue is still debated since several reports suggest that
19 SCT could be viewed as a potentially dangerous disorder (2,37), particularly in response to
20 prolonged and intense exercise (7,12,20,21,23,24,37).
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38 *Paragraph 8:* Interestingly, impaired blood rheology was suggested to be a risk factor for CRVO
39 (25). Gaudard et al. (17) recently demonstrated that hemorheological disturbances are likely to be
40 involved in CRVO. SCT carriers usually have impaired RBC deformability in basal conditions
41 (28), as confirmed by the high RBC rigidity found in the present study. Unfortunately, it was not
42 possible to assess RBC rigidity closer to the ocular incident (i.e., the day after the cycling race).
43
44 Exercise is known to further impair blood rheology in SCT carriers because of the increased
45 sickling of erythrocytes, particularly in hot environment (4), and we recently demonstrated that
46 RBC deformability is further impaired 24 hours after strenuous exercise (35). Therefore, it is
47 conceivable that RBC deformability was also impaired the day after the cycling race and that such
48 abnormality would have been favorable to the occurrence of CRVO. Moreover, the patient
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4 reported that, despite its efforts to drink water, he felt particularly thirsty during and after the race.
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6 Sherry (33) hypothesized that dehydration might contribute to the development of sickling and that
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8 SCT carriers might be naturally more predisposed to dehydration due to their inability to
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10 concentrate their urine when deprived of water (33). This defect might make SCT carriers less able
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12 to conserve water than non-carriers and could have played a role in the occurrence of CRVO.
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14 Indeed, higher amount of water intake with appropriate amount of electrolytes (notably sodium)
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16 (32) may be required for exercising SCT carriers in comparison with control subjects.
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24 *Paragraph 9:* Abnormal coagulation activities are also among the several risk factors associated
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26 with CVRO (16) The role of hemostasis-fibrinolysis balance in CRVO is supported by the recent
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28 results of Ghazi et al. (18), who demonstrated that intravitreal tissue plasminogen activator
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30 injection may have a beneficial role in the management of CRVO. Westerman et al. (36) reported
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32 elevated d-dimers, thrombin-antithrombin complexes and prothrombin fragments 1.2 in SCT
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34 carriers at rest, suggesting that they may be prone to a hypercoagulable state in resting conditions
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36 (36). In addition Austin et al. (3) recently provided strong evidences of higher risk to develop
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38 venous thromboembolism (odds ratio: 1.8) and pulmonary embolism (odds ratio: 3.9) among
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40 African Americans with SCT than in non SCT carriers, in agreement with the reported
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42 disequilibrium between coagulation and fibrinolytic activities in SCT carriers. Nevertheless, these
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44 results contrast with the present finding of no disorder of blood coagulation two and a half months
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46 after the incident (Table 2). Our patient did not carry any of the known genetic risk factor for
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48 retinal vascular occlusion, namely prothrombin A 20210, methyltetrahydrofolate reductase T 677
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50 and factor V Leiden variants.
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4 *Paragraph 10:* Due to technical problems, the markers of coagulation could not be obtained at the
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6 time of the incident and it is possible that, had we obtained them, the blood coagulation properties
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8 would have been different. The presence of four thrombi in the left atrium after the occurrence of
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10 CRVO strongly suggested the hypercoagulable state of the patient when the incident occurred.
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12 Prolonged exercise usually causes changes in coagulation activity in healthy persons (14).
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14 Mandalaki et al. (26) previously reported a decrease in antithrombin III activity after a marathon.
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16 Therefore, the stress caused by the cycling race could have disturbed the balance between
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18 hemostasis and fibrinolysis (36), leading to increased risk for CRVO. We recently demonstrated
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20 no difference in prothrombin time, activated partial thromboplastin time, antithrombin III activity
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22 and yield stress between SCT carriers and a control population, before and after a strenuous
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24 cycling exercise test conducted in laboratories condition (11). Although large hemostatic
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26 dysregulations in SCT carriers following exercise, such as disseminated intravascular coagulation
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28 (22), have already been reported, we did not investigate fibrinolytic activity in that study (11).
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30 Therefore, no conclusion regarding the coagulation activity of the patient at the time of the
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32 incident is possible.
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43 *Paragraph 11:* Despite the panretinal photocoagulation and the venotonic and platelet anti-
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45 aggregating agent treatment, the CRVO rapidly worsened to rubeosis iridis and neovascular
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47 glaucoma, which led to a second emergency hospital visit. Interestingly, the signs of ocular
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49 complication (blindness, eye pain, headache, nausea and vomiting) appeared immediately after a
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51 session of resistance training. Although it may prove difficult to tease out whether it was the
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53 intensity or just the type of exercise that contributed to this second incident, resistance training
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55 (and particularly heavy weight lifting) is also known to alter blood rheological parameters and
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57 blood coagulation (1,13). These alterations could have been involved in the surprising and rapid
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4 ocular complication observed in our patient. Despite anti coagulation medication, two thrombi
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6 were present at that time in the left atrium suggesting, again, disequilibrium of the balance
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8 between hemostasis and fibrinolytic activity. Despite clear medical recommendations, the patient
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10 did not stop practicing intense physical activities, which illustrates the problem of preventing and
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12 managing further exercise related medical complication in a sportsman.
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19 *Paragraph 12:* Although under multiple medical treatments, the patient unfortunately lost his left
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21 eye. The exact reasons for this severe ocular incident are not clearly understood, and the most
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23 surprising event was the rapid deterioration of CRVO to neovascular glaucoma. Usually, the
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25 occurrence of CRVO (whether induced by exercise or not) in young men is well managed, leading
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27 to recovery (17) with minimal visual after effects. However, this was not the case in the present
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29 study and the poor outcome for our patient could be related to its SCT carrier status. Indeed, the
30
31 concomitant occurrence of hypoxia, dehydration and acidosis, conditions occurring during
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33 exercise, is favorable to the sickling process (5) and coagulopathy (20). The presence of SCT and
34
35 the associated hemorheological disorders could have played a role in the complications (i.e.,
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37 retinal detachment and blindness).
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46 *Paragraph 13:* Altogether, the data presented in this case study suggest that SCT status could be
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48 another genetic risk factor for severe ocular complications, particularly when severe exercise is
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50 performed in extreme climatic conditions. While SCT carriers often participate in sports and
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52 related training, particular attention to preventing dehydration and starting exercise gradually may
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54 be warranted. These recommendations have to be applied to the general population; but we do
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56 advocate that physicians and trainers should pay a greater attention to people (trained or untrained)
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58 carrying SCT. The recommendation on adequate hydration is particularly important for SCT
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carriers because they are naturally more predisposed to dehydration due to their inability to concentrate their urine when deprived of water (33). This defect might make SCT carriers less able to conserve water than non-carriers. Blood rheological disorders and coagulation imbalance following intense physical exercise such as heavy and prolonged cycling race could promote CRVO in SCT carriers. This report provides data suggesting that SCT could be considered as a risk factor for severe ocular complications when severe exercise is performed. Several forms of clinical complications related to exercise or not, have already been described in SCT carriers and might be related to different blood and vascular dysfunctions (8,9).

Acknowledgments: This work was supported by our academic funding. The results of the present study do not constitute endorsement by ACSM.

Conflict of interest: We state that there is no conflict of interest.

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Figure legends:

Figure 1: Hemorrhagic form of an inferior-predominating central retinal vein occlusion. To be noted: the papillary stasis oedema, the extreme dilation and twisting of the veins and the large retinal bleeding areas are signs of severe ischemia.

Responses to the reviewers and list of changes

Med Sci Sports Exerc – MSSE-D-08-00064R1

Central retinal vein occlusion in a sickle cell trait carrier after a cycling race

Mona Hedreville, Philippe Connes, Marc Romana, Guillaume Magnaval, Thierry David, Marie-Dominique Hardy-Dessources, Marie-Sylvaine Belloy, Maryse Etienne-Julan, and Olivier Hue.

We would like to thank the reviewers for their critical appraisals and interesting comments on our manuscript. We have attempted to fully answer all the questions and to respond with more details where required. The changes introduced in the reviewed manuscript are in red to make the reviewing process easier.

Reviewer 1:

No further comments

Reviewer 2:

First, the authors would like to thank the reviewer for her/his additional comments.

General comments

1) Regarding the "centered" or "middle dot" ("·") character, perhaps this was converted to a "period" in the submission process, and copyediting will take care of this. In any case, the units of measure in the tables should be in a format such as "g·l⁻¹ (superscript)". A few additional specific changes need to be made (indicated below).

We apologize for this mistake. We made the corrections everywhere in the tables.

Specific comments

2) Abstract Line 24: It would be cleaner to change to read "observed two and a half months after the clinical event."

We made the corrections.

3) Abstract Line 38: Change to read "These data suggest that SCT."

We made the changes.

4) Abstract Line 41: Change to read "factor for significant ocular ."

As requested, we replaced "severe" by "significant".

5) Abstract Line 43: Do the authors mean to say "SCT is a contributing factor in blood rheology and vascular dysfunctions"?

Yes, the reviewer is correct. We replaced our sentence by the sentence proposed by the reviewer.

6) Page 3 Line 14: CRVO needs to be defined here.

Line 24: Change to "we propose."

Line 26: Change to "might have contributed."

Line 36-44: Again, it is a little confusing having the phrase "practicing cycling" and then mention a "race" and "competition" (Was this practice or competition?). Do the authors simply mean to say "Afro-Caribbean male cyclist was admitted."?

As requested, we made all the modifications.

7) Page 7 Line 16: Use the most current position statement on exercise and fluid replacement which replaces the 1996 statement cited here (Sawka et al. Med Sci Sports Exerc. 2007).

We agree with the reviewer and we inserted the proposed reference.

8) Page 9 Line 50-3: Change to read "general population; but we also advocate."

We made the corrections.

9) Table 2 - Use "incident" vs. "accident" in the legend.

We made the changes.

Table 1: Hematological, inflammatory, biochemical parameters measured the day after the cycling race (day of the initial accident)

Parameter	Patient value	Normal value
Red blood cells ($10^{12} \cdot l^{-1}$)	4.9	4.5 – 6.5
Hematocrit (%)	44.1	40 – 54
Hemoglobin ($g \cdot dl^{-1}$)	15.4	13.0 – 17.0
Mean corpuscular volume (fl)	89.5	80 – 100
Mean corpuscular hemoglobin concentration (pg)	31.2	27 – 32
Hemoglobin A (%)	50.8	
Hemoglobin S (%)	38.9	
Hemoglobin F (%)	1.2	
Hemoglobin A2 (%)	3.5	
Platelets ($10^9 \cdot l^{-1}$)	183	150 – 500
Sedimentation rate ($mm \cdot h^{-1}$)	5	< 15
Leukocytes ($10^9 \cdot l^{-1}$)	4.4	4.0 – 10.0
Polynuclear neutrophils ($10^9 \cdot l^{-1}$)	1.7	1.8 – 7.5
Polynuclear eosinophils ($10^9 \cdot l^{-1}$)	0.05	0.04 – 0.8
Polynuclear basophils ($10^9 \cdot l^{-1}$)	0.02	0.00 – 0.2
Lymphocytes ($10^9 \cdot l^{-1}$)	2.4	1.0 – 4.0
Monocytes ($10^9 \cdot l^{-1}$)	0.25	0.2 – 1.00
C-reactive protein ($mg \cdot l^{-1}$)	3.1	< 5
C3 fraction of complement ($g \cdot l^{-1}$)	1.11	0.75 – 1.4
C4 fraction of complement ($g \cdot l^{-1}$)	0.14	0.1 – 0.34
Anticardiolipin antibody Ig G (GPL units $\cdot ml^{-1}$)	3	< 11
Anticardiolipin antibody Ig M (MPL units $\cdot ml^{-1}$)	10	< 11

No parameter was outside the reference range

Table 2: Red blood cell rigidity, blood coagulation markers measured two and a half months after the initial incident and one month after the end of anti-coagulation treatment.

Parameter	Patient value	Normal value
Red blood cell rigidity (shear rate of 225 s ⁻¹)*	0.88	< 0.85
Activated partial thromboplastin time (s)	31	< 47
Ratio (healthy subject/patient)	1.10	< 1.52
Prothrombin time (%)	90	70 – 100
Fibrinogen (g·l ⁻¹)	2.50	2.00 – 4.50
Antithrombin III (%)	94	70 - 120
Factor V (%)	104	70 – 120
Protein C (%)	70	70 – 130
Protein S (%)	68	65 – 140
Resistance to activated protein C (normalized ratio)	1.00	> 0.70
C-reactive protein (mg·l ⁻¹)	3.19	< 5.00

* Except for red blood cell rigidity, no parameter was outside the reference range

Figure

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