SYPHILITIC BILATERAL PANUVEITIS: A CASE REPORT

PANUVEÍTIS BILATERAL SIFILÍTICA:
A PROPÓSITO DE UN CASO

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ABSTRACT

Case report: A 57-year-old immunocompetent woman was diagnosed with syphilitic bilateral panuveitis after the onset of dramatic bilateral visual loss with inflammation of the anterior segment of the eye, severe vitritis and chorioretinitis which improved after treatment.

Discussion: Syphilis is a complex disease of increasing prevalence. If diagnosis is delayed ocular syphilis can produce severe visual loss due to neuritis, chorioretinitis with panuveitis, affecting both eyes in 50% of cases. Nevertheless, syphilis is considered one of the few causes of uveitis in which a cure can be obtained with proper treatment (Arch Soc Esp Oftalmol 2009; 84: 101-104).

Key words: Syphilis, bilateral panuveitis, chorioretinitis, blindness, treatment.

INTRODUCTION

Syphilis is a sexually transmitted disease known for centuries, the first epidemic being reported at the end of the 15th Century. In 1905, Schaudinn and Hoffman discovered its causal agent, Treponema pallidum. In 1918, Ygersheimer described «the syphilitic ocular disease». In 1943, the introduction of penicillin altered dramatically the treatment of the disease (1.).

Both congenital and acquired syphilis may result in ocular involvement of all eye structures (1,2.)

The prevalence of syphilitic uveitis in patients suffering from syphilis varies from 4 to 14 percent according to the series and is currently increasing with respect to other types of uveitis.
The characteristics of syphilitic iridocyclitis and chorioretinitis are not pathognomonic. Chorioretinitis may be diffuse, multifocal or deep. Early symptoms include vitritis, multifocal chorioretinitis, optic neuritis, vasculitis, haemorrhage and retinal edema.

Pigmentation appears at a later stage. It is described as panuveitis, cases of unilateral or bilateral, acute or chronic uveitis with blurry vision, pain, reddening, photophobia and floating spots.

CASE REPORT

Fifty-seven year old immunocompetent female admitted to the ER reporting eye discomfort and alteration of bilateral vision. Exploration revealed that visual acuity (VA) was 0.125 for the right eye (RE) and 0.2 for the left eye (LE.) Biomicroscopy revealed keratitis with endothelial folds and posterior synechiae in both eyes (BE), cells with an intensity of 1+ in the anterior chamber (AC.) Ocular tension was normal in BE. Screening of the ocular fundus (OF) revealed intense bilateral vitritis, suggesting the presence of vasculitis. The prescribed topical treatment included dexamethasone, trombrycin and atropine eye drops.

At 48 hours, vision decreased to hand movement in BE with more intense vitritis. The patient was admitted to the hospital and prescribed treatment with topical dexamethasone (dosage schedule of 90 drops), intravenous methylprednisolone (40 mg every 12 h) and ciprofloxacin (200 mg every 12 h.)

Seven days later, a slight improvement in the inflammation of the anterior pole and the breaking of synechias allowed for more accurate visualization of the OF, which revealed vitreous turbidity and a focus of chorioretinitis in the posterior pole (fig. 1.)

Positive infectious serological tests for syphilis, TPHA + (1/320), with no additional analytical findings. Imaging tests, nuclear magnetic resonance imaging of the cranium and orbits, and thoracic x-ray showed no alterations.

During a more detailed anamnesis, the patient reported a gynecological infection that could be compatible with syphilitic chancre 35 years ago.

Faced with the likelihood of neurologic syphilis, a CSF puncture was prescribed, its results being within the normal limits.

Fig. 1: Image of the anterior segment after breaking of synechias and OF.

Fig. 2: Focus of chorioretinitis with hyperfluorescence on FAG in both eyes.
After repeating the serological tests, TPHA + (1/640) with total Ac + for Lues, the patient was treated with a dose of 2.4 million U.I. of penicillin G benzathine via intramuscular injections every week during 3 weeks, in addition to the topical and general corticosteroids administered in decreasing dosage.

Clinical evolution was favorable, with visual acuity increasing to 0.1 in RE and 0.3 in LE after administering the first injection. In spite of VA constant improvement, the visual field (VF) was significantly affected while both generalized and bilateral sensitivity decreased.

In subsequent check-ups, visualization of the focus of chorioretinitis improved. The fluorescein angiography (FAG) showed hyperfluorescent regions in the early phase which remained in the late phase and correspond to the hypofluorescence on the indocyanine green (ICG) angiography in the intermediate and late phases, possibly related to choroidal granulomas, which should scar later on, leading to an atrophy of the pigment epithelium (figs. 2 and 3).

Three months later, VA in RE was 0.8 and 1 in LE, remaining constant at 6, 12 and 24 months.
with dispersed spots of chorio-retinal atrophy, no signs of activity in the vitreous and normal CV in BE (fig. 4).

**DISCUSSION**

Syphilis is known as one of the «great pretenders» in medicine. As its prevalence increases (3,4) it should be considered as a likely etiology of all forms of uveitis.

The most common expression is focal or generalized chorioretinitis, which upon scarring appears as atypical pigmentary retinitis, bilateral in up to 50 percent of cases.

FAG reveals areas of progressive hyperfluorescence, «arteritis» being a typical sign thereof. Whenever ICG reveals inflammatory infiltration of the whole choroidal thickness, the fluorescence is hindered until the late phase, as in the present case.

Diagnosis is obtained through positive specific serological and clinical test results. When serological test results are positive, neuro syphilis should be discarded by means of lumbar puncture and study of the relevant serological markers.

Differential diagnosis of syphilitic panuveitis includes tuberculosis, Lyme’s disease, Sarcoidosis and Vogt-Koyanagi-Harada disease among others.

Whenever faced with ocular involvement caused by syphilis, it is necessary to perform HIV serological tests, which in the present case yielded negative results.

Once diagnosed with syphilitic chorioretinitis, patients shall be treated with the already mentioned dose of penicillin, which should be greater when CSF is positive. Patients allergic to penicillin should be prescribed erythromycin or tetracycline instead (4,5).

**REFERENCES**