TWO CASES OF SYPHILITIC UVEITIS AND HIV

DOS CASOS DE UVEÍTIS SIFILÍTICA Y VIH

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ABSTRACT

Case reports: Case 1: HIV+ patient presenting unilateral panuveitis. Physical examination showed secondary signs of syphilis. The condition was treated with an excellent result.
Case 2: Patient with bilateral panuveitis having received different treatments in another centre for a period of months. In the anamnesis we detected risk factors for AIDS and ordered appropriate tests to be done, with the patient resulting positive for HIV and syphilis. We proceeded to treat.

Discussion: The incidence of syphilis is rising in developed countries and its manifestations in HIV+ patients can be atypical. An adequate clinical history is fundamental for an early diagnosis. Macrolides can be an alternative treatment in penicillin-allergic patients (Arch Soc Esp Oftalmol 2008; 83: 197-200).

Key words: Syphilitic uveitis, panuveitis, syphilis and HIV, neurosyphilis, homosexual.

RESUMEN

Casos clínicos: Caso 1: paciente VIH+ que presenta una panuveítis unilateral. La exploración física muestra signos de sífilis secundaria. Se trata con excelente respuesta.
Caso 2: Paciente con panuveítis bilateral que ha recibido varios tratamientos durante meses en otro centro. En la anamnesis se detectaron factores de riesgo para SIDA, se realizan serologías que son positivas para VIH y sífilis y se procede al tratamiento.


Palabras clave: Uveítis sifilítica, panuveítis, sífilis y VIH, neurosífilis, homosexual.
CASE REPORTS

Case 1

A 38 year-old bisexual patient, diagnosed with HIV infection in 1992, at present in stage C3 (CD 4 291 cells/µl, viral charge 4,400 copies/ml) attends the urgency ward due to a reddened left eye (LE) with reduction of visual acuity beginning 3 days earlier. The condition included an exanthema involving hand palms and feet soles, and general upset beginning one month earlier.

The ophthalmological exploration revealed a visual acuity of hands movements in LE with moderate conjunctival injection, intense cellularity and abundant fibrin in anterior chamber and posterior synechiae (fig. 1). The eye fundus was not explorable. After intense corticoid therapy and topical miidriatic application, the exploration was carried out the following day. It revealed intense vitritis and inferior vitreous condensates. The skin exploration exhibited a erythematous papulous-macula exanthema, with lesions in small oval-shaped plates which involved palms and soles (fig. 2). Serologies were made, with positive results with RPR 1/32, IgG and TPHA positives. A lumbar punction was made for studying the cerebro-spinal fluid, obtaining a cell count of 2 leucocytes /µl and some hematites, total proteins of 295 mg/dl, glucose 65 mg/dl (simultaneous glycemia 104 mg/dl), VDRL e IgG for syphilis negative, anti-HIV positive and increase of intratecal production intratecal of immunoglobulin with IgM 2.1, IgG 47, IgG/albumin 0.32.

Topical treatment was started with corticoids and miidriatics, as well as systemic sodium penicillin G at a dosage of 4 million units every 4 hours for 15 days. The evolution was satisfactory with recovery of visual acuity up to 0.9, resolution of the inflammation and vitritis and disappearance of the exanthema (fig. 3).

Case 2

A 40 year-old patient referred to our hospital after one month of treatment with intravenous and oral corticoids and oral cyprofloxacine for a process

Fig. 1: Case 1. Anterior chamber with fibrin, tyndall 4+ and posterior synechiae.

Fig. 2: Case 1. Maculo-papulous exanthema with Biett’s collar.

Fig. 3: Case 1. Right: intense vitritis 2nd day. left: clear improvement one week later.
which began as bilateral papillitis and evolved to become bilateral panuveitis. The medical history showed that the patient is homosexual with sexual risk practices, has a doubtful allergy to penicillin and tetracyclines and, four months prior to the beginning of the eye symptoms, exhibited a hand and feet exanthema together with acute pharyngitis treated with oral erythromycin for one week.

In the ophthalmological exploration, the visual acuity was of 0.05 in the right eye (RE, amblyopic eye) and finger-counting at 20 cm in the LE. The patient exhibited a relative afferent pupil defect in RE. The biomicroscopy showed moderate cellularity and fine retrokeratitic precipitates in RE, while the LE showed intense cellularity, 1mm hypopion and posterior synechiae. The funduscopic assessment of both eyes revealed vitritis, papillitis and chorioretinitis plates. The physical exploration evidenced the existence of painless, mobile, bilateral cervical adenopathies.

The analytical study produced the following values: CD 4 522 cells/µl, viral charge 35,000 copies/ml, RPR positive 1/64 and TPHA and IgG (ELISA) positive. The diagnostic was HIV+ in stage A1 and possible luetic association with eye involvement. Accordingly, a lumbar puncture was made with cell count of 5 cells/µl, total proteins 234 mg/dl, glucose 80 mg/dl (simultaneous glycemia 89) and VDRL negative.

With the above results, treatment was established with IV benzyl-penicillin at 4 million units every 4 hours, initially at low dosages and in slow infusion in the day care Allergy Unit centre. The second day of this treatment the patient developed arthralgia and self-limited exanthema, interpreted as Jarisch-Herxheimer reaction. On day 9, an exanthema reappeared, suggesting toxicodermia, which forced suspension of treatment. It was decided to continue with oral erythromycin for two weeks, considering the possible allergy history of the patient.

The evolution was favorable and in 2-3 weeks the VA was of 1/3 in RE and 1 in LE with resolution of the skin lesions and eye inflammation ocular. Some under-pigmented plates remained in the area of the retinal lesions (fig. 4).

**DISCUSSION**

Correct anamnesis and exploration of patients is important when considering syphilitic uveitis, particularly in HIV patients. Treatment is that of syphilis (1) with good results as in the first case. With allergic patients, de-sensitization to penicillin is recommended because there are no clear patters about the duration and dosage of other treatments such as macrolides (2). We utilized erythromycin with good results. In both cases a lumbar puncture was performed, essential for ocular syphilis (3).

The increase of syphilis cases is a proven fact in developed countries due to the AIDS epidemic (4). In addition, the non-typical presentation of syphilitic uveitis are frequent in HIV+ patients and could be the initial expression of this infection (5). The ophthalmologist must have a high degree of suspicion and place the eye disease in the context of systemic findings. This requires close cooperation with other specialists attending these patients.

**REFERENCES**


