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Case Report

# Headache as an initial manifestation of Vogt–Koyanagi–Harada disease

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## Abstract

A 29 year-old healthy Saudi female presented with a 1 week history of headache followed by decreased vision in both eyes. Biomicroscopy revealed anterior uveitis without hypopyon, posterior synechia or keratic precipitate. Fundus examinations were remarkable for serous retinal detachment and hyperemic discs. Fundus fluorescein angiogram showed a hot disc with multiple pinpoint leakage in both eyes. CT scan and MRI were normal, all uveitis workups were negative.
Five months later, the patient presented with complete criteria of Vogt–Koyanagi–Harada disease including a 2 weeks history of tinnitus, alopecia, poliosis and vitiligo. Headache alone followed by decreased vision before the onset of neurological and auditory symptoms can be an initial presentation of VKH disease. VKH should be considered in the differential diagnosis of atypical presentation of symptoms.

**Keywords**: Vogt–Koyanagi–Harada disease, Headache, Panuveitis


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## Introduction

Vogt–Koyanagi–Harada disease (VKH) is a bilateral intraocular inflammation usually associated with systemic manifestations such as meningismus, dysacusis, poliosis, and vitiligo.[1–3] It is an autoimmune disease that targets melanocyte rich organs, such as the eye, inner ear, meninges, and skin.[4]

For unknown reasons, there is a greater preponderance in, females compared to males, in patients between the second and fifth decades and in heavily pigmented races.[1]

The diagnostic criteria of VKH disease are categorised into complete, incomplete and probable.[5] Headache alone does not fulfil the diagnostic criteria and is insufficient for the diagnosis.

The Vogt–Koyanagi–Harada disease is clinically divided into four phases, prodromal, acute uveitic, convalescent, and chronic recurrent phase.[1] The longer the duration of the disease, the greater the number of ocular complications associated with worse visual outcomes.[6]

Here we report a case of patient with headache as an initial presentation of VKH disease with typical complete clinical features manifesting later over the course of 1 year follow up.

## Case report

A 29 year old Saudi female not known to have any medical illnesses presented with a 1 week history of headache followed by decreased vision in both eyes. There was no history of previous surgery or ocular trauma. There was no history of tinnitus, weakness, alopecia, vitiligo, poliosis, vomiting, back pain, numbness or joint pain. At presentation, visual acuity was 20/50 and 20/100 in the right eye and left eye, respectively. Anterior segment examination demonstrated +2 cells in anterior chamber bilaterally. Both pupils had normal

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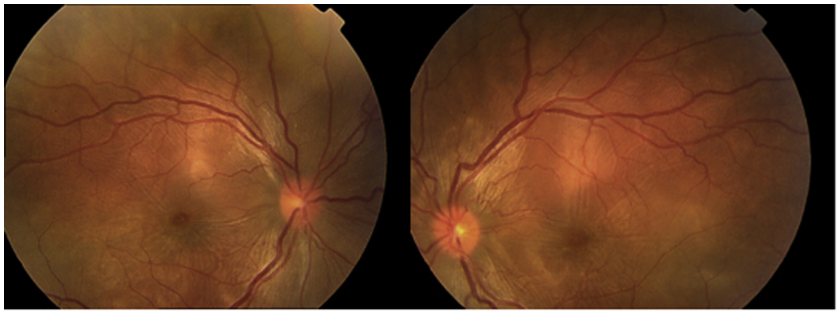

**Figure 1.** Bilateral multiple serous retinal detachment and disc hyperemia.

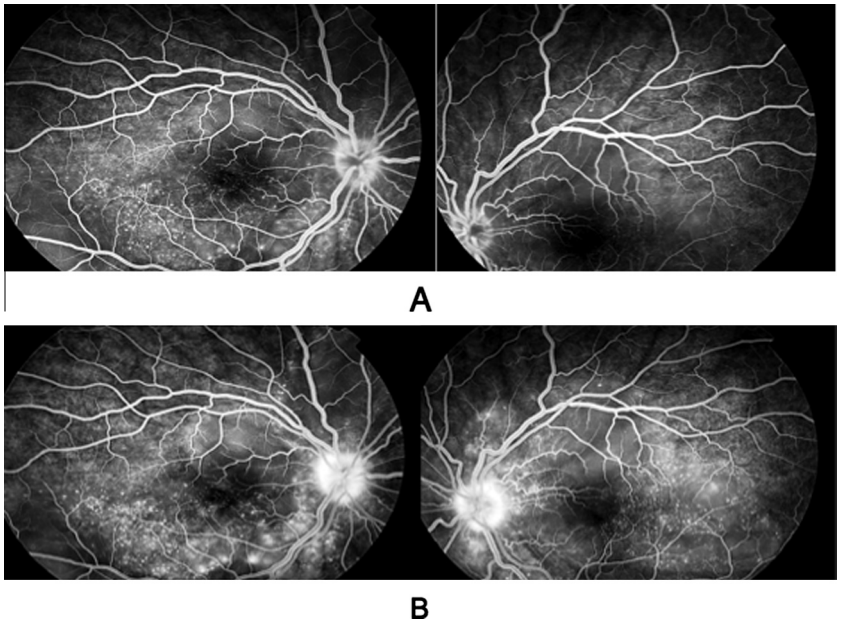


**Figure 2.** Early (A) and late (B) phase of fluorescein angiogram showing hot disc with multiple pinpoint hyperfluorescent area with leakage of dye in both eyes.

reaction to direct light. The automated perimetry, colour vision and the intraocular pressure in each eye were within normal limits. Fundus examination showed multiple serous retinal detachments, deep yellow lesions consistent with choroiditis and hyperemic disc in both eyes without vitritis (Fig. 1).

Fundus fluorescein angiogram (FFA) showed hot disc with the classic findings of multiple areas with pinpoint hyperfluorescent spots at the level of retinal pigment epithelium with leakage and pooling of dye in the subretinal space of both eyes (Fig. 2). Computed tomography (CT) scan and magnetic resonance imagining (MRI) were normal. All appropriate uveitis investigations including tuberculin skin tests, antinuclear antibody, angiotensin converting enzyme, venereal diseases research laboratory, blood titre for toxoplasma, rubella, cytomegalovirus, and herpes were negative.

The patient was diagnosed as a probable case of VKH disease and started on topical prednisolone acetate 1% six times a day and oral prednisone 80 mg/day for 1 week then a weekly taper of 5 mg and cycloplegic agent (homatropine

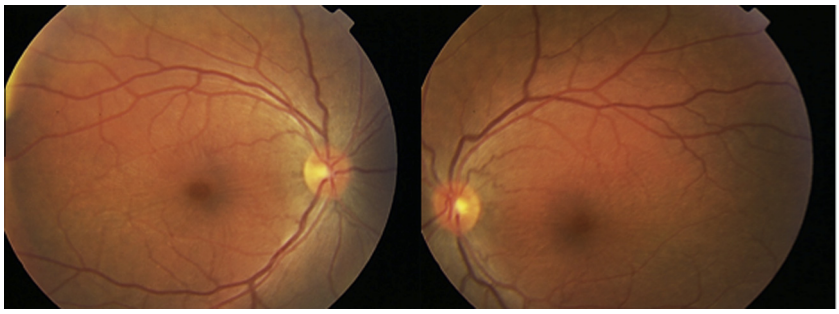

**Figure 3.** Resolved serous retinal detachment and optic disc hyperemia in both eyes, in comparison to Fig. 1.