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Short communication

Syphilitic placoid chorioretinitis. A case-report☆

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ABSTRACT

Clinical case: We report the case of a 45-year-old woman, with unremarkable past medical history, who presented with acute visual loss in her left eye due to bilateral posterior uveitis. After the screening, she was diagnosed with acute syphilitic placoid chorioretinitis and was treated with intravenous penicillin.

Discussion: Clinical manifestations of ocular syphilis are extremely heterogeneous and may mimic several aetiologies. Anti-treponema treatment usually induces a quick and positive response in affected patients. Prompt and proper diagnosis of these patients is crucial, although anatomical and functional damage may persist.

Coriorretinitis placoide sifilítica. Caso clínico

Palabras clave:
T. pallidum
Panuveítis
Bilateral
Coriorretinitis placoide
Aguda

RESUMEN

Caso clínico: Presentamos el caso de una mujer de 45 años sin antecedentes de interés y con una pérdida súbita de visión en su ojo izquierdo secundaria a una uveítis posterior bilateral. Tras despistaje, se diagnosticó de coriorretinitis placoide posterior aguda sifilítica, y recibió tratamiento con penicilina intravenosa.

Discusión: Existen múltiples manifestaciones oculares de la sífilis que pueden simular cuadros y etiologías muy diversas. El tratamiento anti-treponémico normalmente produce una rápida y positiva respuesta en pacientes afectos. El diagnóstico precoz y certero de estos pacientes es por tanto crucial aunque, en ocasiones, los daños anatómicos y funcionales son irreversibles.

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Introduction

The *Treponema pallidum* spirochaete is the etiological agent of syphilis, a sexual transmission disease through direct contact of an active cutaneous-mucosa syphilitic lesion in the primary or secondary stage.[1]

The compromise of any ocular structure has been described.[2] In what concerns uveitis patterns, anterior, intermediate, posterior or diffuse involvement can be found in one or both eyes, which can be granulomatous or non-granulomatous.[3] For this reason, the differential diagnostic comprises a broad range of diseases coursing with ocular inflammation.[4] Acute posterior placoid chorioretinitis is an infrequent expression which is clinically and angiographically different to that of other ocular syphilis involvements.[5]

A female who exhibited acute syphilitic posterior placoid chorioretinitis is described. Despite treatment, both anatomic and functional sequels have remained due to the severity of the condition.

Clinic case report

Female, 45, without relevant personal history, who visited due to sudden loss of central vision in the left eye (LE) with 4 days evolution. Best corrected visual acuity (BCVA) was of 20/20 in the right eye (RE) and light perception (LP) in the LE. Intraocular pressure was normal in both eyes, as well as anterior pole examination. Ocular fundus showed +1 vitritis in both eyes (BE) and bilateral papillitis in addition to intense retinal posterior pole edema in the LE. Macular optic coherence tomography (OCT) revealed LE neurosensory detachment at the subfoveal level and discrete granular hyper-reflectiveness of the retina pigment epithelium (RPE). Fluorescein angiography (FAG) revealed non-obstructive bilateral vasculitis, early hypofluorescence in the placoid lesion area with late staining thereof (Fig. 1).

Multiple screening tests were carried out, including the main infectious and non-infectious etiologies that could cause uveitis in the posterior segment. The results of all these tests

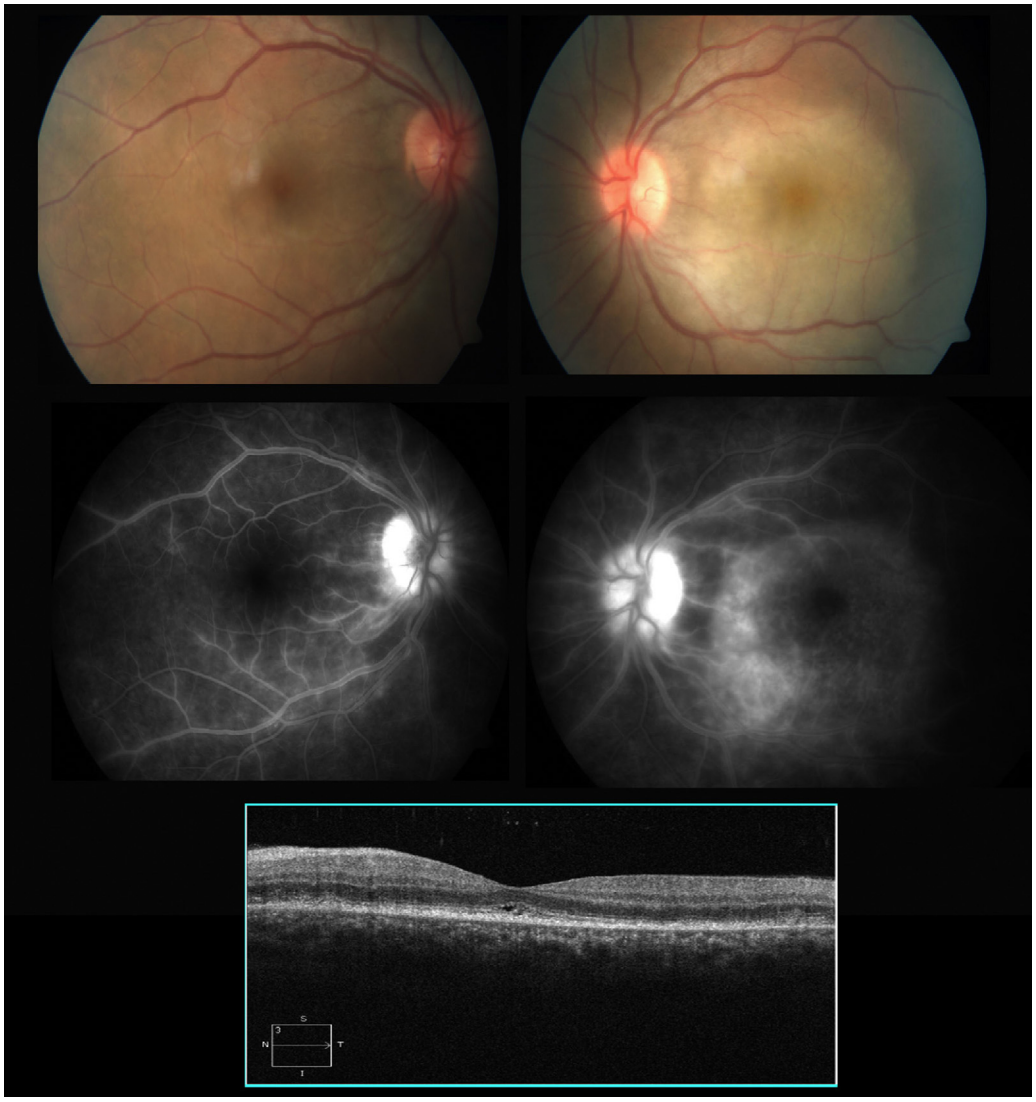

Fig. 1 – Right eye ophthalmoscopic, angiographic and tomographic findings (first visit) showing placoid lesion with intense chorioretinal edema in LE posterior pole and bilateral vasculitis.