Journal français d'ophtalmologie (2017) 40, 126—132

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SFO COMMUNICATION

Steroid treatment in ocular tuberculosis: A double-edged sword?☆

Corticothérapie et tuberculose oculaire : une épée à double tranchant ?

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Received 1st July 2016; accepted 28 September 2016
Available online 18 January 2017

KEYWORDS
Tuberculosis;
Chorioretinopathy;
Papillitis;
White patches;
Type 4 hypersensitivity;
Steroid treatment

Summary
Introduction. — We report the case of a Caribbean patient with an atypical presentation of bilateral tuberculous chorioretinopathy.
Patient and methods. — A 57-year-old woman, with hypertension and non-insulin dependent diabetes, was referred to our center for a sudden loss of vision in the right eye to hand motions. Ophthalmic examination revealed only right papilledema. Brain magnetic resonance imaging was normal. Laboratory examination revealed no signs of inflammation. A right non-arteritic acute anterior ischemic optic neuropathy was first suspected. One week later, the visual acuity (VA) in the left eye dropped from 10/10 to 5/10 with the appearance of papilledema on fundoscopic exam. This bilaterality led us to begin intravenous corticosteroids followed by transition to oral. This improved the left eye VA to 10/10. Numerous bilateral white patches in the posterior pole appeared secondarily, hypofluorescent in the intermediate and late phases of angiography.
Results. — The research of the etiology of uveitis showed a positive tuberculin skin test without any prior vaccination. The vitreous humor sample was negative on direct examination, by culture and by polymerase chain reaction (PCR).
Discussion. — Systemic corticosteroid therapy for ocular tuberculosis is not well described. It may theoretically treat the inflammatory portion of the lesions due to type IV hypersensitivity reaction as in meningeal and pericardial involvement.

☆ Oral communication presented at the 122nd Congress of the French Society of Ophthalmology in May 2016.

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http://dx.doi.org/10.1016/j.jfo.2016.09.012

Conclusion. — The clinical spectrum of ocular tuberculosis is wide and the diagnosis should be considered in any intraocular inflammatory condition of a chronic or acute recurrent nature, whether or not responsive to steroids.

MOTS CLÉS
Tuberculose ;
Choriorétinopathie ;
Papillitis ;
Taches blanches ;
Hypersensibilité de type 4 ;
Traitement stéroïde

Résumé
Introduction. — Nous rapportons le cas d'une patiente antillaise avec choriorétinite tuberculeuse bilatérale de présentation atypique.
Patiente et méthodes. — Une femme de 57 ans, hypertendue et diabétique de type 2, était adressée dans notre centre pour baisse d'acuité visuelle brutale de l'œil droit à « voit bouger la main ». L'examen ophtalmologique retrouvait uniquement un œdème papillaire droit. L'imagerie cérébrale par résonance magnétique était normale. Le bilan biologique ne montrait pas de syndrome inflammatoire. Nous retenions alors le diagnostic de neuropathie optique ischémique antérieure aiguë droite non artéritique. Une semaine plus tard, l'acuité visuelle de l'œil gauche chutait de 10/10^{e} à 5/10^{e} avec un aspect d'œdème papillaire au fond d'œil. Devant cette bilatéralisation, un traitement par corticoïdes intraveineux et relais oral était instauré, ce qui permit une amélioration à gauche à 10/10^{e}. Secondairement apparaissaient de nombreuses taches blanches bilatérales du pôle postérieur, hypocyanescentes aux temps intermédiaire et tardif de l'angiographie.
Résultats. — Le bilan étiologique étendu d'uvéite montrait une intradermoréaction à la tuberculine positive sans notion de vaccination antérieure. L'analyse du vitré par réaction en chaine par polymérase (PCR) était négative.
Discussion. — La corticothérapie systémique n'est pas codifiée dans la tuberculose oculaire. Elle traiterait la part inflammatoire des lésions secondaires à une réaction d'hypersensibilité de type IV, comme pour les atteintes méningées et péricardiques.
Conclusion. — Le spectre clinique de la tuberculose oculaire est important et le diagnostic doit être évoqué devant toute atteinte inflammatoire intraoculaire, d'évolution chronique ou aiguë récidivante, qu'elle soit ou non corticosensible.

Introduction

One-third of the world's population is infected with *Mycobacterium tuberculosis* (MTB), and 10% are likely to develop the disease at some time in their lives. Extrapulmonary involvement occurs for 20% of symptomatic patients [1].

Ocular tuberculosis (TB) is defined as an infection by MTB in the eye, around the eye or on its surface. It explains up to 10% of uveitis in endemic areas [2]. Posterior uveitis is the most common presentation. Indeed, as an obligate aerobe bacterium, MTB requires the choroid due to its high oxygen content and its dense vascular support favorable to its hematogenous dissemination [3]. A protean clinical presentation as well as pathophysiology still obscure raise two difficulties: diagnosis and treatment [4].

Herein, we report a case of tuberculosis chorioretinopathy, which seems atypical both by the unusual clinical features and the unexpected therapeutic response.

Materials and methods

A 57-year-old woman, native of Haiti and resident in Guadeloupe, a hypertensive non-insulin dependent diabetic, consulted for a severely diminished visual acuity (VA) in the right eye to hand motion (HM) with isolated unilateral papilledema (Fig. 1). There was no extra-ophthalmological sign nor any biological inflammatory syndrome and brain magnetic resonance imaging was normal. A non-arteritic acute anterior ischemic optic neuropathy (NAION) was first suspected.

The patient came back a week after, presenting a papilledema bilateralization with no other sign at the ocular fundus (OF). The VA remained at HM in the right eye but 5/10 in the left eye. A temporal artery biopsy was performed and intravenous corticosteroid boluses were to ensue in the event of an arteritic AION. The VA improved to 10/10 in the left eye. It remained unchanged in the right.

Some days later, on fundus examination, bilateral white patches of petal-like appearance with a neuroretinitis