Original Research Article

An exhaustive approach to bilateral idiopathic panuveitis: Rare case report

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Abstract

Blindness due to serious chronic iridocyclitis is known to occur. Inflammatory involvement of complete intraocular structures point words specific entity, to diagnose anterior to posterior involvement of intraocular pathology and to understand exact cause of it tried to walk on the track of exhaustive investigations. Inspite of this the causative factors remain unknown. Intraocular widespread inflammatory reaction in the retinal tissue, vitrious and whole of the uveal body at the same time confirms the panuveitis. To manage such case with drugs for long duration is a next challenge with unavoidable side effects.

Key Words: Idiopathic, panuveitis, exhaustive.

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INTRODUCTION

Uveal tract consist of iris, ciliary body and choroid, anatomically they are countinous and so inflammation of one part may spread to the other, to identify the infected anatomical site may be due to infective or allergic type of reaction represent as iridocyclitis, vitritis, renitochoroiditis at the same time comprise the diagnosis of panuveitis. To label a case of panuveitis it is not easy and here patient had bilateral panuveitis. In our tertiary hospital, 45 years female presented with pain in both eyes with gradual progressive decrease in vision since one and a half year. She received treatment for this in the form of tablet Prednisolon 30mg/bd for 2 months and topical Predfort eyedrop this gives mild relief but not complete relief from symptoms. As soon as treatment stops she developed bilateral attacks of pain repeatedly, she was diagnosed as bilateral chronic iridocyclitis. She visited this hospital to get relief from the ocular infection, she had vision threatening ocular complication due to intraocular inflammation which may be associated with systemic disease, it is challenged to rule out exact cause. Physical examination should not be suggestive of any neurological manifestation. No evidence of vitiligo, ear problem, or oral or genital ulcers. No history suggestive of tuberculosis, diabetes, hypertension, injury to eye or any ocular surgery, joints were normal, no lymphnode enlargement. Ocular examination right eye shows visual acuity counting fingers 2.5m with no pinhole improvement. Lid normal, conjunctival congestion present, cornea clear no e/o keratic precipitates, anterior chamber deep, pupil fix irregular, lens showing complicated cataract. Slit lamp by microscopic exam shows cornea clear, iris colour and pattern altered, pupil festooned, posterior synechiae 360 degree+. Left eye examination shows eye lid normal conjunctival congestion cornea clear anterior chamber deep, no e/o hypopyon, pupil semidialated. On slit lamp by microscopic examination cornea shows fine KPS, iris colour and pattern altered posterior syneria present 360 degrees, lens immature, cataract changes present. Intraocular pressure in right eye 14.6mm/Hg and IOP in left eye 20.6mm/Hg. Due to hazy media fundus exam not possible in both eyes. photographs.

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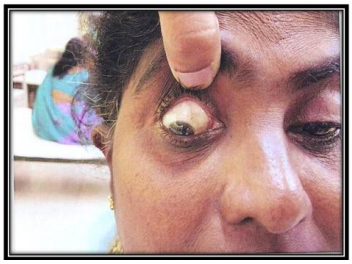
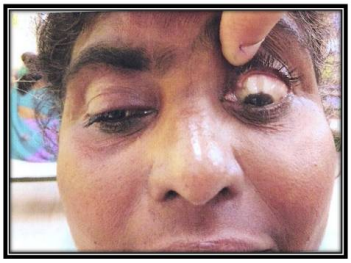


Figure 1



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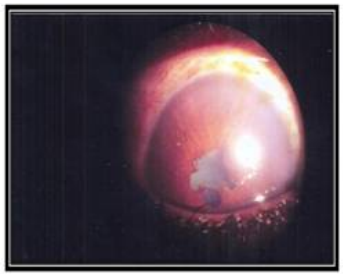

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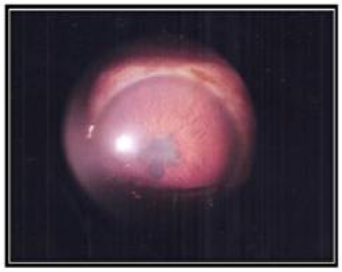

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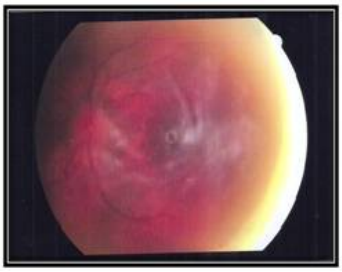

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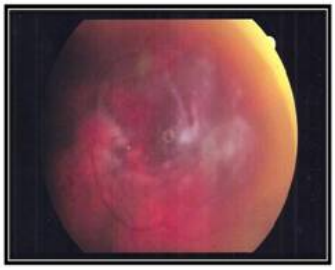

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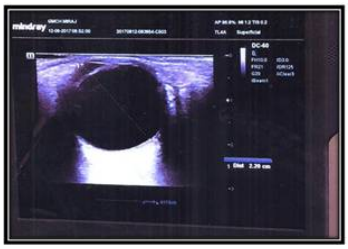

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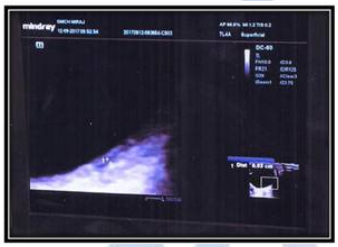

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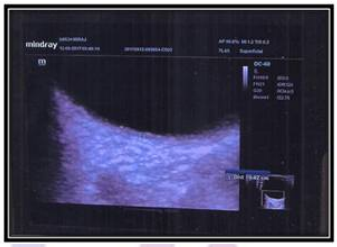

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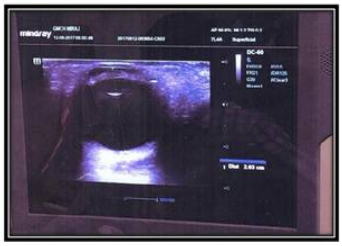

Figure 10

To know unsuspected systemic illness and to confirm the suspected diagnosis may be of viral, fungal, protozoal nature the confirmatory tests carried out along with full blood examination and serological test and unavoidable investigations started to reach the exact cause of infection.

1. Hb 11.5gm%
2. TLC 9800/cumm
3. DLC monocytes 04, neutrophiles 38, lymphocytes 20, eiosinophiles 05, basophile 00.
4. Platelet count 150000/cumm- 450000/cumm= 291000/cumm
5. ESR within normal limits
6. HIV antibodies specimen negative, Hbsag rapid test
7. Mountex test negative
8. VDRL, ELISA test negative
9. TPH test negative
10. Rhumatoid arthritis factor (RA) factor negative
11. ACE ratio in normal limits
12. Albumin 3.9 mg/L and Globulin 2.2 gm%
13. Creatinine 0.8mg%

a. direct billirubin 0.5mg%
b. Indirect billirubin 0.3%
c. Total bilirubin 0.8mg%
d. Total protein 6.1gm%

14. LFT done

A. SGOT 24U/I
B. SGPT 29 U/I
C. Urea 25mg%

15. Blood sugar 64mg% BSL fasting 94mg% and postmeal 108mg%
16. Urine exam within normal limits, microscopy cast crystals, pus cells nil.
17. A] X-ray chest PA new NAD
18. B] ECG within normal range.
19. USG both eyes- Bscan ultrasonography
    - Axial length RE 22mm and choroidal thickness 0.02RE
    - Axial length LE 21mm 0.03LE

Bscan ultrasonography helpful to know extension of the disease in presence of hazy media which may be due to cataract cyclitic membrane may be due to vitreous haemorrhage shows no evidence of vitreous detachement, retinal detachement CDVH, and head of optic nerve seen intact.

20. Colour fundus photography to know day to day fundus changes helpful in follow up this case.
21. OCT due to poor media clearance not used.
22. Specific confirmation test being ordered in endophthalmitis (PCR) polymerase chain reaction which detects viral uveitis mycobacterial

infection or to know protozoal eye disease. PCR is specific tool to diagnose infection and autoimmunity found to be negative.

23. The test like vitrectomy tap not done in this case as patient was on steroid high risk may land in complications like bleeding, rise in intraocular tension, retinal detachement to avoid this and to preserve natural vision so the intraocular fluid not obtained.

Inspite of these exhaustive investigations selective unavoidable investigations carried out to know the possible pathogenesis of disease could not throw any light on cause, here cause remains undiagnosed by all routine investigations called as idiopathic panuveitis and due to lack of diagnostic end point repeat evaluation is must for positive confirmation of disease also causes of differential diagnosis ruled out.

a. Posterior scleritis
b. pars planitis bilateral adult type
c. sympathetic ophthalmitis
d. Ocular tuberculosis
e. Behcets disease
f. Sarcoidosis
g. Toxoplasmosis
h. Vogt koyanagi hardas syndrome
i. Endogenous endoophthalmitis
j. Viral retinitis
k. HIV infection
l. Intraocular lymphoma

Repeated attacks of panuveitis complications known to occur complicated cataract, glaucoma, macular oedema, vitreous hage, retinal detachment. MANAGEMENT: idiopathic panuveitis of long duration needs special attention towards recurrence of inflammatory attacks initial treatment was haphazard thought to be infectious agent anti inflammatory drugs were given no response then she received 30mg Tab prednisolon in tapering dose and steroidal eye drop for two months only and then it was stopped. Adequate dose of steroid is needed to control uveitis but here non responsive steroid therapy so according to severity of pnuveitis IV injection methyl prednisolon 1mg started for 5 days till the eye become quite and then oral prednisolon started to avoid repeated attacks and patient was kept in close follow up also to observe ocular and systemic side effects of steroid. Tab wysilon 40mg in tapering dose, tab neurobionforte bd. The sight threatening nature of panuveitis need attention towards treatment in early phase, gives poor response to conventional therapy. A supportive therapy started along with injection methyl prednisolon, cycloplegic eye drops and atropine eye ointment to decrease attacks of pain due to ciliary spasm and to maintain pupillary dilatation by breaking the posterior synechiae. As cause is idiopathic, prevention of vision from this threatening complication n of panuveitis is really a great challenge, here cause is idiopathic not specific, no response to steroid and increase in relapses of attacks so low dose of immuno suppressive drug like Azathioprine or Methotrexate maybe started but in this case not adviced.

CONCLUSION

Idiopathic bilateral panuveitis is unusual presentation. Loss of useful bilateral vision sight threatening nature of uveitis affects the important years of life need early prevention of attacks. Proper clinical findings and clinical checkups plays an important role in initial phase. To rule out pathogenisis of disease needs investigations, no special test to work out in panuveitis, exhaustive laboratory test need time and disease become chronically active long standing. Recogination of recurrent attacks by the patient is also a new task so need minimal investigations with maximum benefit from short duration treatment and initial clinical approach towards diagnosis is very important in cases of idiopathic panuveitis to prevent vision loss.

Prognosis: Depends on severity of sign and symptoms. Idiopathic bilateral panuveitis is chronically active disease, spontaneous resolution not seen, sight threatening complications due to flare up stages needs special attention towards treatment part. Steroid, cycloplegics and low dose of immuno suppressive drugs play vital roles in life of patient, but to reach the goal exhaustive investigation track should be minimized with specific workup with early laboratory reporting to save time and precious vision and at the same time patient must be warned with idiopathic nature of panuveitis.

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