Severe Presumed Non- Infectious Panuveitis with a Systemic Infection Twist : Case Presentation
Manchester Uveitis Clinic, UK

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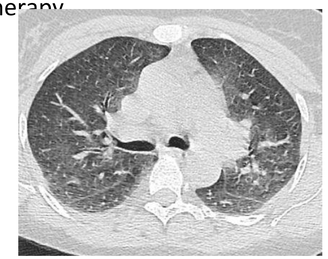
AIM: To describe the clinical course and imaging features of a case of presumed non-infectious panuveitis, in a presumed immunocompetent patient, treated with high dose oral corticosteroid and complicated by the development of a severe non-ocular AIDS defining illness.

CASE: A 53 years old systemically well African female presented with acute left eye blurring of vision (BCVA Right 0.0 Left 0.7logMAR). Severe bilateral non-granulomatous panuveitis with bilateral non-occlusive phlebitis and left eye CMO was evident. Ultra wide-field FFA showed active uveitis with disc hyper-fluorescence and significant non-occlusive phlebitis.

Baseline uveitis screen included negative GIFN, normal chest x-ray and negative syphilis serology. Serum ACE was elevated (81 IU/L). Low WBC, raised ESR (130mm/hr.) and CRP of <1mg/L was detected.

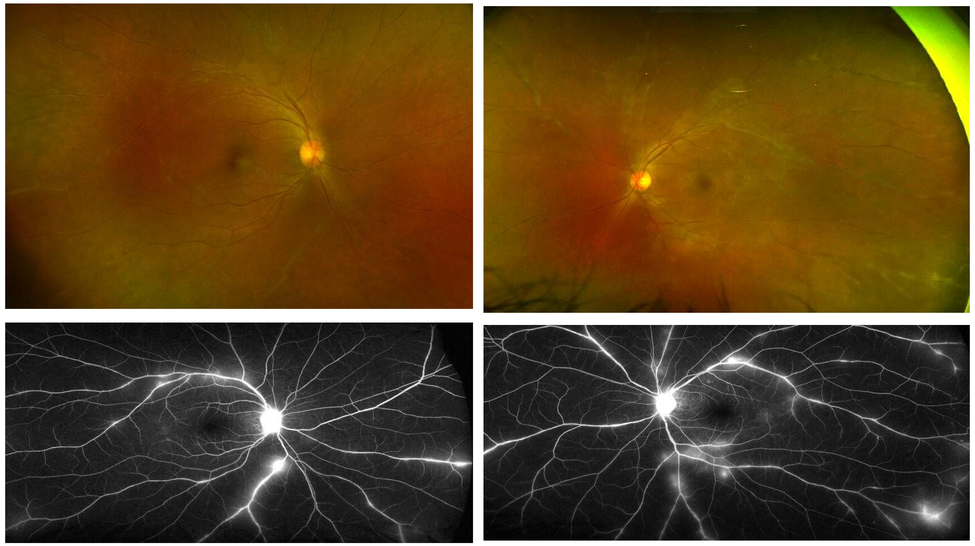
Management: The ocular disease and elevated ACE (with no evidence of TB) supported a diagnosis of ocular sarcoidosis and high dose oral Prednisolone 60mg/day was started and tapered with clinical improvement.

During high steroid treatment (day 42, prednisolone 25mg/day) ,she presented acutely unwell with left orbital cellulitis and rhinosinusitis. She was pancytopenic with raised ESR (133mm/hr) and CRP(133mg/L).CT thorax was consistent with *P. Jirovecii* pneumonia infection. HIV testing was positive with CD4 count 134 cells/UL and HIV viral load 767000copies/ml. Multidisciplinary respiratory and HIV physician management included EBUS bronchoscopy and Bronchoalveolar lavage (TB testing negative), systemic antibiotics and initiation of anti-retrovirals. She responded well to treatment with control of intra-ocular inflammation with functional(final BCVA L 0.06 ,R 0.02 at month 2) and structural improvement (OCT resolution of CMO and FFA reduction and eventual resolution of active leakage) .The patient has finished oral steroid and is demonstrating excellent response to HIV therapy.

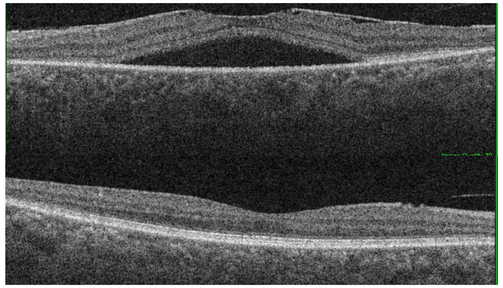


CT Thorax: Bilateral patchy zones of ground glass appearance.

Multimodal Imaging: Ultra-widefield retinal and fluorescein angiography and OCT



Bilateral vitreous haze was evident with significant phlebitis, with marked venous sheathing and cuffing. FFA confirmed significant phlebitis and optic nerve hyper-fluorescence.



Left eye macular OCT: at presentation with macular oedema and ERM. Resolution of CMO was observed following oral Prednisolone and concurrent anti-retroviral therapy.

Conclusion/Learning Points

- HIV testing should be considered prior to high dose systemic corticosteroids to treat severe non-infectious uveitis, especially in high-risk individuals. Always exclude infection before starting high dose systemic steroid.
- Testing for infective causes of uveitis (e.g., syphilis, G-IFN for TB) can be falsely negative in the context of severe immunocompromise
- Serum ACE can be elevated in sarcoidosis and TB and specialist respiratory opinion is advised
- High dose corticosteroid in undiagnosed HIV may precipitate AIDS defining illness. Management of uveitis in such cases requires careful multidisciplinary management.
- Corticosteroid therapy for presumed non-infectious uveitis may exacerbate immunodeficiency and predispose to opportunistic infections.

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