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VOGT-KOYANAGI-HARADA SYNDROME, AN IMPORTANT DIFFERENTIAL DIAGNOSIS

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CLINICAL HISTORY

Female patient, 44 years old, treated in the emergency room of the Neurology service with a 15-day history of bitemporal, throbbing headache, intensity 8/10, associated with nausea, vomiting, hearing loss (HL), low visual acuity (VA) and pain when moving eyepiece in the left eye (OE). After 7 days, she developed low VA in the right eye (RE), with loss of red saturation and the presence of central stocoma.

She reported a history of previous perimenstrual headache, which began more than 20 years ago, mild intensity, without associated ophthalmological complaints, denying other symptoms, medication use, allergies or hospitalizations.

SUMMARY NEUROLOGICAL EXAMINATION

preserved eye movements. AV OD: finger count (CF) at 50 cm. AV OE: CF at 30 cm. Photomotor reflex reduced bilaterally, consensual reflex preserved. No changes to motor, sensory, coordination or gait examination.

Ophthalmological examination: normal RE and LE, but with fine keratic precipitates and posterior uveitis (2+/4).

Optical coherence tomography (OCT): bilateral optic disc edema, with vascular tortuosity and bilateral serous retinal detachment.

Lumbar puncture: opening pressure 23 cmH2O, 1 leukocyte, normal glucose, non-reactive VDRL, total proteins 25.

Magnetic resonance imaging (MRI) of the skull: normal.

Orbital MRI: bilateral chorioretinitis

Audiometry: mixed PA

Negative serological tests and negative anti-aquaporin 4 research.

DISCUSSION

Vogt-Koyanagi-Harada Syndrome (VKHS) is a systemic and autoimmune disease that mainly affects structures rich in melanocytes, such as the retina, inner ear and central nervous system. It contains 4 distinct clinical stages: prodromal, uveitic, chronic and recurrent. The previously healthy patient sought care due to unilateral eye pain, which evolved bilaterally after 7 days, associated with other ocular symptoms and BP. Magnetic resonance imaging rules out tumors or signs of increased intracranial pressure and demyelinating diseases. Furthermore, acute worsening of BP, together with bilateral serous retinal detachments and posterior uveitis, as well as a negative viral serology and negative anti-aquaporin 4 also meet the criteria for VKHS. Treatment with 5 days of 1g of intravenous methylprednisolone was performed with significant results, demonstrated by the improvement in VA and retinal detachments on OCT, together with the absence of new episodes of headache.

FINAL COMMENTS

As it is a rare syndrome, the diagnosis of SVKH requires a complete history and a good physical examination, associated with complementary tests, such as OCT and serological tests, to assist in the diagnosis.