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NON-GRANULOMATOUS KERATE PRECIPITATES OF PAN-UVEITIS DUE TO TOXOPLASMOSIS

Ana Elisa Caldas Gonçalves

Arthur Gomes Pidde

Beatriz Caldas Gonçalves

Carolina Rodrigues de Paula

Cecília Martins Gomes

Celso Gonçalves de Castro Filho

Diandra Cavalcante de Oliveira

Flávio Leão Malheiros

Matheus Lopes da Silva

Samuel de Souza Arraes Rios Pinto

Vitória Caldas Gonçalves

Vitória Rezende Gomes

INTRODUCTION

Toxoplasmosis is one of the main causes of posterior uveitis worldwide, being responsible for 50% of uveitis in Brazil. Usually, ocular toxoplasmosis presents as retinochoroiditis, accompanied by focal necrotizing granulomatous retinitis, with vitreous and anterior chamber involvement. Atypical forms of ocular toxoplasmosis can cause diagnostic difficulties and lead to delays in treatment, which can have important repercussions on the outcome of patients.

OBJECTIVES

To report the case of a patient with non-granulomatous keratic precipitates of Pan-uveitis due to toxoplasmosis.

CASE REPORT

Woman, 73 years old, hypertensive, diabetic and with hyperthyroidism, attended with complaints of sudden loss of vision in the right eye (RE), associated with floaters, hyperemia and eye pain, with an intermittent pattern of worsening. History of cataract correction with a foldable intraocular lens (IOL) in the left eye for 8 years and in the left eye (LE) for 4 years; performed Yag laser in both eyes (AO). On ophthalmological examination: Visual acuity (VA) 0.8/1.0; Biomicroscopy of RE with conjunctival hyperemia, keratic precipitates on the cornea and pseudophakia. Intraocular pressure of 12 mmHg in AO. Fundoscopy: RE with opaque media, pale retina, with exudative lesion in its upper portion; OE without changes. Diagnosis of pan-uveitis was made in OD. As a course of action, sulfamethoxazole + trimethoprim (1 tablet every 12/12 hours for 45 days), Tropicamide (every 8/8 hours) and prednisolone acetate (escalating from 6/6h to 8/8h and 12/12h) were prescribed. Scheduled return for 08/16/2021.

DISCUSSION

Toxoplasma reaches the eye through the blood and, in immunocompetent patients, the first ocular lesion is self-limited and often asymptomatic. It is possible that latent cysts in muscles, as well as in the central nervous system, retina and other foci, may reactivate years after infection, leading to new retinochoroidal changes. In the present report, not only retinochoroiditis was observed, but rather pan-uveitis (inflammation of all layers of the uvea: iris, ciliary body and choroid), in addition to the lesions being non-granulomatous, that is, an atypical presentation of the frame. Differential diagnosis must be carried out with infectious and non-infectious diseases according to the patient's age group. For adults, it is important to remember acute retinal necrosis, fungal retinitis, septic retinitis and ocular toxocariasis. Despite the self-limited condition in most cases, attention must be payed especially to those who present ophthalmological complaints to begin treatment to reduce retinal destruction, the frequency of complications, the severity of crises and the duration of the disease.

CONCLUSION

Complications of ocular toxoplasmosis, such as retinal destruction of the macula and retinal detachment, can lead to visual loss and blindness. Considering the high prevalence of toxoplasmosis as the etiology of uveitis, the disease must be investigated, even in the presentation of atypical conditions, such as pan-uveitis and non-granulomatous lesions. It is important to advise previously diagnosed patients regarding the chance of recurrence and pay attention to visual complaints when seeking ophthalmological care, thus avoiding a poor prognosis of ocular toxoplasmosis.

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