Red eye raise a red flag: A case of scleromalacia perforans secondary to polyarteritis nodosa

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ABSTRACT

Objective: To describe a rare case of scleromalacia perforans secondary to Polyarteritis Nodosa (PAN). **Method:** a Case Report. **Results:** A 59-year-old female with no known medical illness, presented with right eye painless red eye and blurring vision for 3 weeks duration. She denied a history of ocular trauma. She also sustained right foot ulcer concurrently for 1 month. The most prominent ocular finding was right eye sclera thinning with visible underlying uvea tissue located temporal to corneal measuring 14mm longitudinal and 7mm horizontally. It was extending from 7-11 o'clock. Corneal striae were seen adjacent to the scleral thinning. The conjunctiva was white with a few abnormal vessels on top of scleral thinning with anterior chambers cells and flare. The left eye appeared normal. Right foot ulcer was located at the dorsum area measuring 5 x 6 cm with slough. Her Erythrocyte sedimentation rate (ESR) was 56, C-ANCA positive, a biopsy from foot ulcer showed features of Polyarteritis Nodosa (PAN). She was co-managed with rheumatologist where she was started with oral prednisolone 60mg OD and 6 cycles of IV cyclophosphamide. During 6 months follow up, her right eye was quiet and scleral thinning remained the same without worsening. Her right foot ulcer healed well. **Conclusion:** Scleritis can be the first manifestation of life-threatening systemic vasculitic disorder as demonstrated in this case. Thus, the ophthalmologist plays an important role where early recognition and prompt treatment is important.

KEY WORDS:

Scleromalacia perforans, polyarteritis nodosa, red eye

Relapsing Vogt-Koyanagi-Harada syndrome (VKH)

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ABSTRACT

Objective: To illustrate a challenging case of VKH and its outcome. **Method:** a Case report. **Results:** A 45 years old, lady presented with bilateral red eyes associated with photophobia and gradual blurring of vision for 2 months. She denied a history of eye trauma, eye surgery and chronic joint pain. Snellen Visual acuity was 6/18 and IOP was normal in both eyes. The anterior segment showed chronic anterior uveitis with a presence of anterior chamber cells and extensive posterior synechiae. Limitation of fundus view due to seclusio pupillae. B scan showed normal posterior segment. She was treated with intensive topical steroid. However, she developed worsening of vision and loss of hearing. Visual acuity was counting finger (CF) at near. Repeated Bscan showed thickened choroid bilaterally. She was treated as VKH with high dose systemic steroid and then continued with tapering doses of oral steroid over 3 months. Initially, she responded with treatment and showed improvement of vision. She has relapsed VKH whenever she defaulted on treatment or on low dose steroid. Her visual acuity remained poor and fundus showed sunset glow. **Conclusion:** Establishment of VKH diagnosis is difficult at an early stage. Initial presentation can be atypical and it can mimic any cause of chronic anterior uveitis. Relapsing VKH yields poor visual prognosis.

KEY WORDS:

Relapsing Vogt Koyanagi Harada, long-term steroid treatment