

Medical treatment of sight-threatening thyroid eye disease: When 3 days of 1 gram methylprednisolone is not enough

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ABSTRACT

Objective: To report a case series of sight-threatening thyroid eye disease which needed alternate regimen of glucocorticoid therapy. **Method:** Case series. **Results:** Sight-threatening thyroid eye disease (TED) secondary to dysthyroid optic neuropathy can happen regardless of patient's thyroid status and should be recognized early. Glucocorticoids remain the mainstay of medical therapy in managing active sight-threatening TED but there are numerous glucocorticoid treatment regimens up to date. Our common standard practice is the administration of 1g intravenous methylprednisolone for 3 consecutive days. We report two cases of severe TED patients who relapsed during the tapering phase after 3-day treatment of pulsed intravenous methylprednisolone. Subsequently, both patients received a different glucocorticoid treatment regimen of weekly intravenous methylprednisolone 0.5g for 6 weeks followed by 0.25g weekly for another 6 weeks. This case series will highlight and discuss the progress, outcomes and challenges encountered during the course of treatment for both patients. **Conclusion:** Intravenous glucocorticoid is a crucial treatment used to decelerate disease activity in patients with sight-threatening TED. An alternate regimen consisting of 12 weekly infusions should be considered in patients that relapse after a short course of 1g methylprednisolone for 3 consecutive days before considering surgical orbital decompression.

KEY WORDS:

Thyroid eye disease, glucocorticoid therapy

Not a usual viral keratouveitis? Think CMV!

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ABSTRACT

Objective: To report a case of right eye CMV keratouveitis which responded well to topical ganciclovir gel 0.15%. **Method:** Case report. **Results:** We report a case of a 67-year-old immunocompetent gentleman who was treated as right eye recurrent keratouveitis, not resolved with oral Acyclovir and topical steroid. He was covered for low grade chronic endophthalmitis, given a course of intravitreal amphotericin-B, three courses of intravitreal ceftazidime and vancomycin. However, his condition didn't improve. His first aqueous tap for HSV-1 and HSV-2, bacterial and fungal cultures were negative. His second aqueous tap was performed 3 months later. This time, CMV DNA was detected with viral load of 3.59 million IU/ml. He was then treated as CMV keratouveitis. He was prescribed topical ganciclovir gel 0.15% 5 times per day for 3 months, together with topical steroid. After 3 months, he was maintained with the gel tapered down to 3 times per day for a month. Four months later, his right eye improved from vision of CF to 6/9. His cornea was initially oedematous diffusely with many pigmented kerato-precipitates. During his last visit, his cornea was clear with only few fine keratic precipitates remaining, anterior segment was quiet. **Conclusion:** Cytomegalovirus may cause retinitis, iritis, trabeculitis, and keratitis in immunosuppressed and immunocompetent patients. Often misdiagnosed as herpes simplex or herpes zoster, patients experienced unnecessary treatments. Systemic or intravitreal ganciclovir treatment of CMV keratouveitis is expensive and the risk of toxicity is high. This is a report of proven CMV keratouveitis highly responsive to topical ganciclovir gel 0.15%.

KEY WORDS:

Cytomegalovirus keratouveitis, topical ganciclovir gel 0.15%