RETINAL OCCLUSIVE VASCULITIS AND PANUVEITIS WITH SECONDARY NEOVASCULAR GLAUCOMA AFTER HEART TRANSPLANT

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INTRODUCTION

Retinal vasculitis is an inflammatory disease of the blood vessels of the retina that may be associated with primary ocular conditions or with inflammatory or infectious systemic diseases (Behget, sarcoidosis, and multiple sclerosis). During ocular examination we can find: variable vitritis, vascular sheathing, bleeding in peripheral retina, narrowing of retinal vessels, etc. A mild anterior uveitis may also be seen. If mild inflammation and good visual acuity the attitude should be observation and/or corticosteroid drops. If severe: systemic therapy (oral or intravenous), even immunosuppressive agents in refractory systemic or as steroid-sparing agents.

OBJECTIVE

To report a case of unilateral retinal occlusive vasculitis and panuveitis with secondary neovascular glaucoma in a patient with heart transplant.

METHODS

A 58-year-old man with a history of previous cardiac transplantation seven months ago, under treatment with immunosuppressive agents, presented with blurred vision in his right eye (RE) for seven days. A complete ocular examination, including determination of Visual Acuity (VA), anterior and posterior biomicroscopy and fluorescein angiography (FA) was performed.

RESULTS

AT FIRST VISIT, VA was 0.4 in RE, and 1.0 in left eye (LE). Anterior segment examination revealed the presence of tyndall++, and keratic precipitates distributed on the inferior corneal endothelium, with no further abnormalities. Funduscopy examination showed intense vitritis, perivascular sheathing and peripheral retinal hemorrhages associated with yellowish areas of exudation. FA showed areas of non-perfusion in periphery. SLOW TAPERING OF TOPICAL STEROIDS AND MYDRIATIC TREATMENT WERE STARTED AND COMPLEMENTARY EXAMINATIONS PERFORMED. Complementary exams included: blood/autoimmune tests, infectious serology (including CMV, HSV, Toxoplasma, EBV-VCA, syphilis, VIH and VZV), carotid Doppler Scan and cranial and thoraco-abdominal imaging. All the complementary exams were negative.

ONE MONTH LATER, VA improved one line (Snellen chart), and funduscopy exam revealed no changes, except for a mild increase in the number of obliterated vessels in retinal periphery.

ONE YEAR LATER, VA declined to 0.1, intraocular pressure raised, and neovascularization appeared. Topical hypotensive drops were prescribed, and panretinal photocoagulation performed.

CONCLUSIONS

Occlusive retinal vasculitis, which develops in different clinical settings, may result in diffuse capillary nonperfusion, retinal ischemia and, consequently, may cause neovascular glaucoma. The presence of an unilateral panuveitis and occlusive vasculitis in a immunodepressed patient should include the differential diagnosis with acute retinal necrosis and CMV retinitis, among others. However, AN IDIOPATHIC OCCLUSIVE VASCULITIS WITH SECONDARY NEOVASCULAR GLAUCOMA, AS HAPPENED IN OUR CASE, CAN ALSO OCCUR.