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Full Length Case Report

AN UNUSUAL PRESENTATION OF HERPES ZOSTER OPHTHALMIA: UVEITIS WITH HYPHEMA

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Abstract

We present a Case Report of a 65 year old immunocompetent woman presenting with Herpes Zoster skin lesions along with Uveitis and Hyphema. The condition resolved in 3 weeks with oral acyclovir therapy and topical steroids

Keywords: Immunocompetent, Acyclovir, Herpes Zoster

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INTRODUCTION

Spontaneous hyphaema can result from a variety of causes, but it is rarely seen as a complication of anterior uveitis. Cases have been reported in association with associated with Reiter's syndrome, juvenile chronic arthritis, ankylosingspondylitis, idiopathic anterior uveitis, Fuchs iridocyclitisand herpes simplex. Hyphema as a complication following herpes zoster uveitis has been reported in a few cases. These were usually cases of herpes zoster sine herpete i.e. without the characteristic skin lesions and diagnosis was confirmed by the presence of varicella antibodies in the aqueous humor. We encountered a case of acute anterior uveitis with severe hyphema following herpes zoster in an immunocompetent woman.

Case Report

A 65 year old woman presented to the Out-patient department of Guru Nanak Eye Centre with a 10 day history of painful skin lesions on the left side of her face and dimunition of vision in the left eye since 1 day. The patient gave a history of treatment with oral acyclovir for the past 10 days. On examination, the right eye was within normal limits. Left eye visual acuity was FC 2m with accurate projection of rays; conjunctival congestion was present, cornea was within normal limits, anterior chamber showed the presence of 4+ cells along with 4mm hyphema; lens showed early cataractous changes with pigment deposition on the anterior capsule; intraocular pressure was 24mmhg by applanation tonometry, Fundus was not visible through the hazy media and partially healed lesions of herpes zoster were seen on the left side of the forehead.

A clinical diagnosis of Herpes Zoster Uveitis was made. A complete blood count was performed and was found to be within normal limits. The patient was HIV negative. Treatment was started with oral acyclovir 800mg 5 times daily, topical timolol 0.5% bd, topical atropine 2% TDS, topical prednisolone 0.1% 2 hourly and topical moxifloxacin 0.5% qid. Within 1 week, the hyphema decreased to 2mm in height and AC cells reduced to 2+.

After 2 weeks of treatment, the hyphema and the anterior chamber reaction had completely disappeared and visual acuity in the left eye improved to 6/9, intraocular pressure was 16mmHg and fundus examination showed a healthy disc with a cup-disc ratio of 0.3:1. Treatment was tapered and stopped over the next 10 days.

DISCUSSION

In most cases of uveitis with hyphema, the cause of bleeding is supposed to be rubeosis. Inherpes zoster uveitis, however, iris fluorescein angiography suggestsocclusive vasculitis to be the main pathogenesis of the iris lesion causing bleeding.Sectoral iris atrophy is usually seen on resolution of the hyphema. The hyphema is usually associated with keratouveitis and glaucoma.Pecularities of our case were the absence of corneal involvement and absence of iris atrophy.

Our patient regained excellent visual function on oral acyclovir therapy along with topical steroids. Intraocular pressures were controlled on topical timolol and no ensuing glaucoma was seen in this patient.

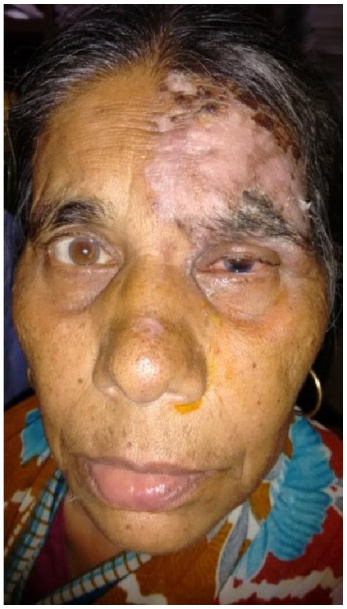

Fig. 1. Patient presenting with partially healed herpes zoster lesions and hyphema

Fig. 2.Complete resolution of the skin lesions and the hyphema in 3 weeks

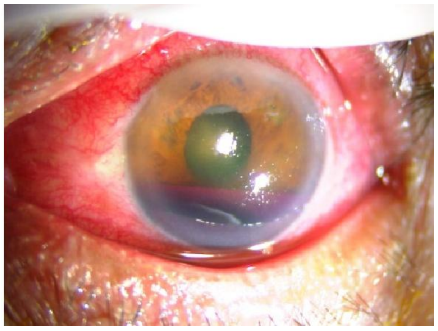

Fig. 3. 4mm hyphema seen with uveitis

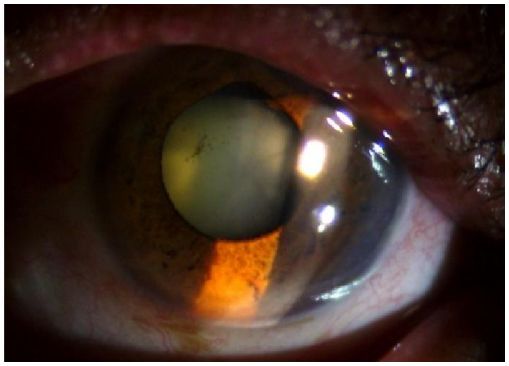

Fig. 4. Complete resolution of the uveitis and hyphema in 3 weeks

Conclusion

The diagnosis of herpes zoster uveitis must be borne in mind in a patient with hyphema and uveitis even in the absence of skin lesions. Conservative management with acyclovir usually leads to a full recovery.

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