Management of Bilateral Uveitis Secondary to Intraocular Filaria

Management of uveitis secondary to filariasis has been inadequately described as these cases are rare. We report a case of bilateral uveitis due to intraocular filariasis and discuss its medical and surgical treatment. We also document the use of doxycycline hydrochloride, which sterilizes adult worms by eliminating their symbiotic bacteria and may prevent recurrences of uveitis.

Comment. Uveitis secondary to intraocular filariasis in the Indian subcontinent is mainly due to *W. bancrofti* and *Brugia malayi*. Intraocular filariasis is caused more commonly by microfilariae than by adult worms. This is an unusual case of microfilariae causing bilateral uveitis, which to our knowledge has been reported in only 1 other article. The role of antifilarial drugs is controversial because of the possibility of increased uveitis due to the killing of microfilaria as seen in the Mazzotti reaction. However, several reports have used these successfully under steroid cover without untoward effects. Diethylcarbamazine and ivermectin clear the microfilaria from the lymphatic system for 10 to 15 years. Therefore, repeated treatments may be necessary to prevent recurrent episodes of uveitis. Albendazole can reduce the microfilaria possibly due to its embryotoxic effect on the adult worms. Recently, an endobacterium of the Wolbachia species that belongs to the family Rickettsiaceae...
was found in some of these nematodes. These are mutualistic symbionts. Treatment with tetracyclines clears the Wolbachia from the worm, affecting embryogenesis and resulting in worm sterility. This may prevent future episodes of uveitis. Doxycycline treatment showed no effect on Loa loa infections in humans because they do not possess Wolbachia. Therefore, accurate identification of the nematode is essential when planning treatment.

In conclusion, we report a case of bilateral uveitis due to intraocular filariasis treated with corticosteroids and antifilarial drugs (diethylcarbamazine, albendazole, and doxycycline) to prevent recurrences. Also, cataract extraction with intraocular lens implantation performed under steroid cover did not increase the postoperative uveitis.

Zia Sultan Pradhan, DNB
Pushpa Jacob, FRCS(Edin), FRCS(Glasg)
Smita Dikshit, MBBS

Author Affiliations: Department of Ophthalmology, Christian Medical College, Vellore, India.
Correspondence: Dr Pradhan, Department of Ophthalmology, Christian Medical College, Schell Eye Hospital, Arni Road, Vellore 632001, Tamil Nadu, India (zedpradhan@gmail.com).

Financial Disclosure: None reported.


Cutaneous γδ T-Cell Lymphoma With Bilateral Ocular and Adnexal Involvement

Subcutaneous panniculitis-like γδ T-cell lymphoma (SPTL-GD) is a rare subtype of primary cutaneous non-Hodgkin T-cell lymphoma caused by a clonal proliferation of mature activated cytotoxic γδ T cells. It typically manifests with skin nodules or plaques over the extremities and has an aggressive clinical course. Although rare, reports exist of other metastatic cutaneous T-cell lymphomas with periocular or intraocular manifestations. However, to our knowledge, we report the first case of SPTL-GD manifesting this way. Furthermore, the simultaneous adnexal, intraocular, and neuro-ophthalmic involvement described here has not been reported for any manifestation of ocular lymphoma.

Report of a Case. A 62-year-old woman had a 7-month history of bilateral red eyes with blurred vision. She was diagnosed as having bilateral nongranulomatous anterior uveitis and began treatment with topical steroid eye-drops. However, her vision continued to slowly deteriorate and she additionally began to experience night sweats, fevers, and weight loss. Two months later, she also noticed 2 firm swellings by her right eyebrow and described sequential bilateral pupillary enlargement.

When examined at this stage, her visual acuity was counting fingers OD and 20/80 OS. Both pupils measured 4.5 mm and were poorly reactive to light with no light-near dissociation but hypersensitivity to pilocarpine, 0.125%. There was no ptosis, eyelid malposition, proptosis, globe displacement, or limitation of eye movements. Anterior segment examination revealed bilateral punctate epitheliopathy with reduced corneal sensation, corneal edema, and no infiltrates. There were multiple small nongranulomatous keratic precipitates with 2+ to 3+ of anterior chamber cells in both eyes but no fibrin or hypopyon. Views of the posterior segments were difficult but showed no abnormalities.

Facial examination revealed 2 right subbrow, subcutaneous lesions that were well circumscribed, firm, nontender, and immobile (Figure 1A). No lymph nodes were palpable, and no other systemic abnormalities were detected. However, during the ensuing weeks, 2 other smaller subcutaneous masses developed around the right lower punctum and left cheek.

Her erythrocyte sedimentation rate, C-reactive protein level, full blood cell count, and renal and liver function test results were normal except for an increased platelet count of 679 × 10^9/µL (reference range, 150-400 × 10^9/µL; to convert to × 10^3/µL, multiply by 0.1); a serum angiotensin-converting enzyme level of 124 U/L (reference range, 8-65 U/L; to convert to nanokatals per liter, multiply by 16.667); and a computed tomographic scan of the head, chest, abdomen, and pelvis showing no abnormalities.

Computed tomographic imaging of the head revealed smooth perineural enhancement of both optic nerve sheaths along their intraorbital portion (Figure 1B). An anterior chamber paracentesis was...