Another differential diagnosis is tuberculosis, which can be manifested as both anterior and posterior uveitis or as conjunctival nodules and phlyctenules. However, the majority of ocular tuberculosis is unilateral, and cases of ocular involvement is only rarely noted in systemic tuberculosis. One study reported only 28 cases of iris among 10,535 patients with tuberculosis. The chest x-ray film and a purified protein derivative skin test in this patient showed no evidence of tuberculosis.

Gout, known to deposit urate crystals in ocular tissues, can cause conjunctival nodules, band keratopathy, and rarely anterior uveitis. However, deposits in the conjunctiva, as well as in the cornea, have been described within interpapillary areas. The location of urate deposition differs from our patient with conjunctival nodules only in the superior bulbar conjunctiva.

This article describes a patient with VKH syndrome with an initial manifestation of bilateral conjunctival nodules and anterior uveitis. The diagnosis was supported by the fulfillment of the diagnostic criteria of VKH syndrome and the exclusion of other possible diseases. To the best of our knowledge, this article represents the first case of conjunctival nodules in VKH syndrome. We thereby stress the importance of clinical awareness of conjunctival nodules as the initial sign of VKH syndrome.

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Multifocal Choroiditis and Acute Posterior Multifocal Placoid Pigment Epitheliopathy Occurring in the Same Patient

The white spot syndromes are a group of idiopathic inflammatory diseases of the retina characterized by visual loss in association with areas of retinal whitening. This category includes diseases such as multifocal choroiditis (MFC), punctate inner choroidopathy, multiple evanescent white dot syndrome (MEWDS), serpiginous choroiditis, and acute posterior multifocal placoid pigment epitheliopathy (APMPPPE). To our knowledge, no definite infectious or immune etiology has been proved for these various entities. There have been reports of 2 of these entities occurring in the same patient (acute macular neuroretinopathy and MEWDS) and MFC and MEWDS. Patients have been described as having overlapping features of these various conditions, eg, MEWDS and MFC. We describe a patient who at age 18 years showed findings consistent with APMPPPE, with visual loss in both eyes. This resolved with a return of vision to 20/20 OU. Sixteen years later, he developed new symptoms and exhibited lesions of MFC. The old APMPPPE lesions remained unchanged.

Report of a Case. An 18-year-old man sought care because of headaches and bilateral central scotomas of 1 week’s duration. He reported
having had an upper respiratory tract infection 1 month earlier. Visual acuity was 20/80 OD and 20/30 OS. Ophthalmoscopy showed scattered active foci of whitening of the outer retina in both eyes (Figure 1A and B). Fluorescein angiography showed hypofluorescence during the early phases of the angiogram with late staining of the lesions (Figure 1C and D). A diagnosis of APMPPE was made, but no treatment was given. During the next 3 months, his symptoms gradually resolved and visual acuity returned to 20/20 OU. The patient had no additional eye symptoms until 16 years later, when he noted the onset of a temporal scotoma and peripheral shimmering in the left eye. Best corrected visual acuity was 20/25 OD and 20/30 OS. The vitreous body was clear. The macular area showed the old lesions of APMPPE (largely unchanged and without the development of significant atrophy). However, both eyes showed atrophic punched-out choroidal scars (Figure 2) in the macula, midperiphery, and far periphery. The appearance of these scars and the patient’s symptoms were consistent with a diagnosis of MFC.

Comment. Gass4 has proposed that many of these white spot syndromes, including MEWDS, punctate inner choroidopathy, and MFC, as well as acute zonal occult outer retinopathy, have common characteristics and may be part of the spectrum of a single disease. He has suggested an infectious cause, in which an unknown virus enters the retina from the peripapillary area or perhaps the ora serrata.5 Jampol and Becker1 have suggested that these entities are distinct inflammatory diseases, although overlapping cases and the occurrence of 2 of the entities in a single patient may occur. They concurred with the common genetic hypothesis that autoimmune inflammatory disease may explain these findings.3 These patients may have genetic loci that predispose them to immune dysregulation and ocular and systemic autoimmune disease. This may explain the potential for 2 entities occurring in a single patient or overlapping symptoms. The case presented herein is a demonstration of unusual concordance of 2 rare diseases, APMPPE and MFC, in the same patient, separated by 16 years. Although the patient’s initial appearance at age 18 years was highly suggestive of APMPPE, this may have been an atypical presentation of MFC. However, the clinical course was most consistent with APMPPE. The fact that the APMPPE lesions, even 16 years later, did not resemble the MFC lesions supports our conclusion that 2 distinct entities occurred in this patient. This occurrence is consistent with the common genetic hypothesis of a genetic predisposition to autoimmune diseases, which allowed both diseases to occur in a single individual.

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