were also bilateral, multifocal, stellate areas of hypoautofluorescence that were not appreciated clinically in either eye (Figure 1E and F).

Optical coherence tomography through the lesion in the right eye demonstrated outer retinal thinning with associated attenuation of the inner segment–outer segment junction (Figure 2). Full-field electroretinography findings were normal in both eyes.

Comment. The first report of unilateral RPE dysgenesis was published in 2002. In this report, 3 young men and 1 woman aged 16 to 34 years were noted to have a round leopard-spot lesion contiguous with the optic nerve. In 2009, the typical characteristics of unilateral RPE dysgenesis were described in a set of 9 affected patients, 6 males and 3 females aged 14 to 42 years. The margin of the lesion is pathognomonic, with a scalloped reticular fringe of mild fibrosis and atrophy with inverted FAF imaging relative to fluorescein angiography, and is identical to the lesion in our patient.

The differential diagnosis of this lesion includes acute zonal occult outer retinopathy. However, acute zonal occult outer retinopathy typically has a smooth curvilinear border on autofluorescence and the electroretinographic findings are abnormal. Alternative differential diagnoses include traumatic retinal pigment epitheliopathy and combined hamartoma of the retina and RPE.

This case is unique in that it shows bilateral loss of the RPE in a multifocal, scattered, stellate fashion, best appreciated with FAF imaging. To our knowledge, this is the first reported case of unilateral RPE dysgenesis with abnormal findings on FAF imaging in the fellow eye. In the previously reported series of 9 patients by Cohen et al., only 3 cases were evaluated with FAF imaging and no evidence of bilateral disease was seen. However, as most patients in the series did not have FAF imaging performed, some of these unilateral cases may have had subclinical bilateral disease.

The etiology of this condition remains elusive. It may be an RPE dysgenesis or dystrophy, or it could reflect previous inflammatory, infectious, or autoimmune insult to the RPE. It is intuitive that a dysgenesis should ultimately be bilateral, and this is the first report to our knowl-

edge illustrating this for RPE dysgenesis, which perhaps should no longer be termed unilateral.

Jennifer Renz, MD
Jordana G. Fein, MD, MS
Robin Vora, MD
Harold Woodcome Jr, MD
Elias Reichel, MD
Jay Duker, MD

Author Affiliations: Department of Ophthalmology, New England Eye Center, Tufts Medical Center, Boston, Massachusetts (Drs Renz, Fein, Vora, Reichel, and Duker); and Department of Ophthalmology, Brown University, Providence, Rhode Island (Dr Woodcome).

Correspondence: Dr Reichel, Department of Ophthalmology, Tufts University School of Medicine, 800 Washington St, PO Box 450, Boston, MA 02111 (ereichel@tuftsmedicalcenter.org).

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Levofoxacin-Associated Panuveitis With Chorioretinal Lesions

Drug-induced uveitis is a rare complication of many commonly prescribed medications, including bisphosphonates, sulfonamides, multiple vaccines, and topical β-blockers. Recently, a uveitis-like syndrome with iris transillumination defects and pupillary mydriasis associated with oral moxifloxacin use has been described. Fluoroquinolones are an increasingly recognized cause of bilateral uveitis, although the visual significance is often minimal. Herein, we describe a visually disabling but reversible manifestation of levofoxacin-associated panuveitis.

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Report of a Case. In July 2010, a 68-year-old woman without pertinent medical or ocular history visited our uveitis clinic because of decreased vision and floaters bilaterally for 5 days. Two weeks prior, she was bitten by a dog and was prescribed prophylactic levofloxacin. After 4 days of therapy, she noted painless bilateral palmar macules and pustules, followed a day later by blurred vision and floaters in both eyes. She discontinued levofloxacin and was referred to us. Other long-term medications she had been receiving at the time of the initial visit included atenolol, amlodipine besylate, rabeprazole sodium, diphenhydramine hydrochloride, and low-dose aspirin; however, none of these represented a new exposure. Further, the patient was bitten by her own dog whose immunizations were up to date, so rabies vaccination was not necessary.

Figure. Retinal images before and after 2 months of oral prednisone therapy. Fluorescein angiography (FA) of the patient’s right (A) and left (B) eyes at the initial visit demonstrated early staining of punctate foveal lesions (arrows). The spots have nearly completely resolved in both the right (C) and left (D) eyes with therapy 3 months later. Optical coherence tomography, shown for only the right eye before (E) and after (F) therapy, reveals the retinal pigment epithelial location of these lesions (arrowheads) and similar resolution.
Her visual acuity was 20/500 OU and intraocular pressure was 8 mm Hg OU. Biomicroscopic examination revealed small, nongranulomatous keratic precipitates, 1+ anterior chamber flare, 1+ to 2+ vitreous cells and 1+ haze, and multiple hypopigmented punctate lesions in the foveae in both eyes. These lesions demonstrated early staining on fluorescein angiography (Figure A and B) and nodular increased reflectivity at the level of the retinal pigment epithelium on optical coherence tomography (Figure E). Color fundus photographs were not available.

After confirming negative results on chest radiography and syphilis serology, we initiated oral prednisone, 60 mg/d with an extended taper. At each successive visit, her visual acuity and symptoms improved. After completion of a 2-month prednisone taper, her visual acuity was back to baseline (20/40 OU), limited only by preexisting cataracts. The punctate lesions had nearly completely resolved on both examination and ancillary testing (Figure, C, D, and F).

Comment. To our knowledge, this is the second reported case of levofloxacin-associated uveitis; moreover, we are aware of no other cases of drug-induced choroidal lesions. Quite atypical of drug-induced uveitis, our patient had temporary legal blindness in both eyes, which responded to antibiotic dechallenge and oral corticosteroid therapy. However, visual recovery was not prompt, resulting in many weeks of disability and anxiety in the face of an uncertain prognosis. As prescription rates of other antibiotic classes have decreased during the past 2 decades with increased attention toward antibiotic-resistance prevention, fluoroquinolone use has increased as much as 5-fold in the ambulatory setting owing to its broad-spectrum coverage. As such, levofloxacin-associated uveitis, although rare, may be increasingly encountered. Health care practitioners should be aware of this entity and promptly refer any suspected cases for ophthalmological evaluation.

Nicholas J. Butler, MD
Eric B. Suhler, MD, MPH

Author Affiliations: Wilmer Eye Institute, Johns Hopkins University School of Medicine, Baltimore, Maryland (Dr Butler); and Casey Eye Institute, Oregon Health and Science University and Portland VA Medical Center, Portland (Dr Suhler).

Correspondence: Dr Butler, Wilmer Eye Institute, Johns Hopkins University School of Medicine, Division of Ocular Immunology, 1800 Orleans St, Woods Bldg, Room 472, Baltimore, MD 21287 (nbutle10@jhmi.edu).

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