Review of treatment history revealed posterior suturenon injection of Triamcinolone acetate and a month long course of oral steroid given two months back. The recorded vision of his LE was 6/9 that time. When his eye got worse with this treatment, he went to another hospital from where he was referred. There under the diagnosis of Toxoplasmic retinochoroiditis he was given a combination of sulfamethoxazole (800 mg) and trimethoprim (160 mg) along with oral prednisolone 50 mg daily dose since 1 week.

His medical history was significant for multiple penile sores which had appeared some 7 to 8 months prior to the onset of his eye problem, for which he had taken some over the counter medication.

He is heterosexual having multiple sex-partners.

Physical examination was also WNLs.

Investigations done before coming to us were: Total leucocytic count (TLC) of 7100/cumm, Neutrophil 65%, Lymphocyte 23%, Eosinophil 02%, ESR 17 mm/hr, negative mantoux test with no induration, non-reactive VDRL (Venerology disease research laboratory) test and HIV (1+2), weakly positive (1:4) antitoxoplasma antibodies titer.

With the provision of these reports, TPHA (Treponema pallidum hemaglutination) test was ordered which came out positive. Immediately his oral medication was discontinued. The CSF study showed positive VDRL and TPHA, 65 mg% protein, 45 mg% glucose. With the final diagnosis of Neurosyphilis with panuveitis, he was treated with intravenous (IV) injection of crystalline penicillin G 24 million units daily in divided doses for 14 days.

From 7th day of penicillin treatment, oral prednisolone was started in 50 mg daily dose, tapering 10 mg every week.

By third week, his vision improved to finger counting at 1 meter, and only few pre-retinal lesions remained. After 2 months, LE vision was 6/9/partial with -0.75 DS correction. The AC, lens and vitreous were clear, disc swelling was no more although a bit of pallor remained, the pre-retinal lesions were all gone, most of the blood vessels, except for the macular branches, were still occluded, but no new vessels were seen in the disc or elsewhere (Fig 2). But the retina still had mottled appearance. Repeat FFA showed normal disc, no areas of capillary drop-out or leakage of dye.

DISCUSSION

Syphilis is a sexually transmitted disease caused by a spirochete called treponema pallidum (TP). Eye is one of the many organs affected by Syphilis. The incidence of ocular syphilis is about 2.5%.

Eye is considered the part of brain, then uveitis, particularly the posterior ones with the involvement of optic nerve and retina, constitute neurosyphilis.

Syphilitic uveitis can present as anterior, intermediate, posterior, panuveitis, and the incidence of each type varies from study to study. There are several reports on Acute syphilitic posterior placoid chorioretinitis (ASPPC) from different times. Other commonly found posterior segment findings are focal or multifocal necrotic retinitis, optic neuritis or neuroretinitis, retinal vasculitis.

So far, the fundus picture similar to our case has been described only in 5 (2 HIV positive) cases of syphilitic posterior uveitis. All those gay men had acute retinal arteriolsis and inner retinitis, with distinctive, inner retinal and pre-retinal white dots. The arteriolsis and pre-retinal white dots were prominent findings in our case as well. The only difference is that this case is not a gay.
Syphilitic uveitis needs to be considered in the D/ Ds of unresponsive acute iritis, not exclusively granulomatous, all neuroretinitis and chorioretinitis, unexplained optic neuritis and optic atrophy, and unexplained pupillary abnormalities.

Although Toxoplasmosis is one of the most common causes of retinitis or retinochoroiditis in Nepalese population, Syphilis should always be suspected and ruled out in such cases.

History of sexual habit, genital sore and skin rashes are important clues for the syphilitic uveitis diagnosis. However it is quite difficult to get these histories from patients many a time, particularly in conservative societies.

The only reliable way of diagnosing ocular syphilis is the performance of serological tests which are fortunately highly sensitive and specific. There are two set of tests: non-treponemal and treponemal. Non treponemal test includes VDRL and RPR (rapid plasma reagin). It detects antibody to cardiolipin –lechitin cholesterol antigen in blood or CSF. Treponemal tests are TPHA test, Fluorescent treponemal antibody absorption (FTA-ABS ) test, Treponema pallidum microhemaglutination (MHA-TP), Treponema pallidum particle agglutination (TP-PA) test, Treponema pallidum immobilization (TPI) test. They detect antibodies against the treponemal antigen.

Non-treponemal tests are usually positive during primary stage, uniformly positive during secondary stage and progressively non-reactive in later (latent and tertiary) stages even without treatment, whereas the reactivity of treponemal tests is as high as 95 to 100% even in the latent and tertiary stages. Just to remind, syphilitic uveitis occurs in latent and tertiary stages. In four papers reviewed, minimum of 14% and maximum of 46% of syphilitic uveitis cases with reactive treponemal (FTA-ABS or MHA-TP) test, had negative VDRL. This explains why there is a chance of Syphilis being missed on ordering only a non-treponemal test for the uveitis investigation. Therefore the important point to be noted is that, ordering one treponemal test for the diagnosis of syphilitic uveitis is mandatory. In this cases also, the diagnosis was initially missed because of ordering VDRL test only.

Syphilis being a bacterial infection with direct invasion of bacteria in the ocular tissue evidenced by the detection of TP in aqueous PCR, treatment with steroid without getting rid of the spirochetes worsens uveitis. Same thing had happened to this case.

CSF study is advised for every case of ocular syphilis. Many advise treating ocular syphilis as Neurosyphilis by intravenous (I/V) aqueous Penicillin irrespective of CSF finding. This case showed definite improvement with IV penicillin treatment.

CONCLUSION

In every case of focal or multifocal retinitis or chorioretinitis, syphilis has to be included in the D/D of causes. For the diagnosis of syphilitic uveitis, one treponemal test along with one non-treponemal test is mandatory. Periocular and or oral steroid needs to be used very cautiously in retinitis or chorioretinitis cases. Along with necrotic retinitis, placoid chorioretinitis, retinal vasculitis, optic neuritis and neuroretinitis, syphilitic uveitis can present with multiple pre-retinal lesions.

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