



Clinical Image of Tuberculous Uveitis

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Clinical Image

A 22-year-old male patient presented with decreased vision and mild pain in both eyes for 1 month. We learned from his history that he was a restaurant waiter and coughed for 10 days with suffocation, chest pain, dizziness and headache. On ophthalmologic examination, his Best Corrected Visual Acuity (BCVA) was 0.8 (Snellen chart) in both eyes. Intraocular Pressure (IOP) was normal in both eyes. Slit-lamp examination showed no inflammatory response in the anterior chamber of both eyes, and only mild vitreous infiltrations were observed. Fundus photograph demonstrated retinal vascular segmental white sheath with scattered hemorrhage (Figure A1 and A2), while Fluorescence Angiography (FA) revealed leakage at the optic nerve and branch vein in both eyes (Figure B1 and B2). OCT showed mild macular edema in both eyes (Figure C1 and C2). The Purified Protein Derivative (PPD) test resulted in a 15 mm in duration (no blisters). Interferon- γ Release Assays (IGRAs) resulted 26/20 SFCs/2.5 \times 1 (T-SPOT.TB, normal <6). Chest Computed Tomography (CT) revealed circular high-density shadow near the hilar (Figure D1). The patient was diagnosed with

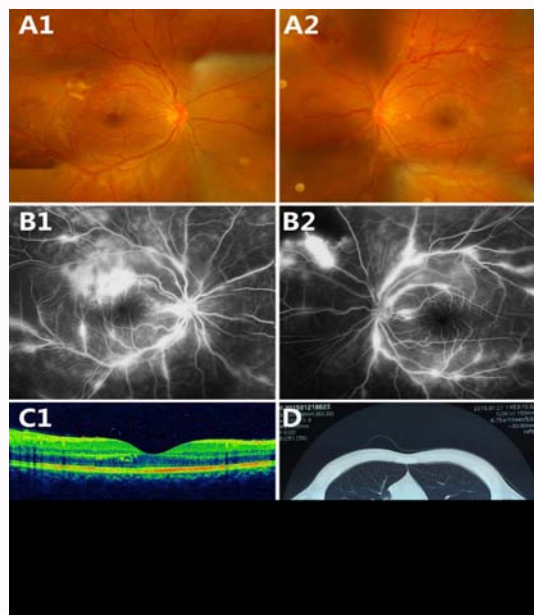


Figure 1: Fundus photograph revealed retinal vascular segmental white sheath with scattered hemorrhage (A1, A2). FA revealed leakage at the optic nerve and branch vein in both eyes (B1, B2). OCT showed mild macular edema in both eye (C1, OD; C2, OS). Chest CT revealed circular high-density shadow (arrow) near the hilar (D).

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primary pulmonary tuberculosis and tuberculous uveitis. The typical Anti-Tuberculous Therapy (ATT) combined with oral corticosteroids were administrated for 9 months. The patient recovered completely at the end of the therapy. The diagnosis of tuberculous uveitis is challenging in most cases because of the deficiency of direct evidence of Mycobacterium tuberculosis infection. The decision to administrate anti-tuberculous therapy is always made with supportive ocular clinical findings, past history of tuberculosis and tuberculosis exposure, positive PPD and/or IGRA results, resistance to immunosuppressive therapy, and the absence of other plausible causes [1-3]. It is important to note that we report a case with active pulmonary tuberculosis that is rare.

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