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VOGT-KOYANAGI HARADA SYNDROME

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A 35-year-old patient, presented with 2 years history of vitiligo and poliosis on the right forehead with one week history of pain in both eyes and progressive dimness of vision of the right eye. He is diagnosed to have Vogt-Koyanagi Harada syndrome and is reported for its rare clinical features.

Key Word : Vogt-Koyanagi Harada syndrome

Introduction

Vogt-Koyanagi Harada syndrome consists of uveitis, alopecia, vitiligo, poliosis, tinnitus and deafness.[1] This may precede a febrile illness with symptoms of meningoencephalitis. An abnormal response to a virus and immunological mechanisms were postulated to be responsible for this process.[2] Melanocyte destruction occurs in the leptomeninges which releases pigment cell products, with resultant antibody formation. This evokes an immunological response to other pigment cells in the eyes, ear, skin and hair.[3]

Case Report

A 35-year-old male farmer presented with history of depigmented patch over the right eyebrow for 2 years and progressive dimness of vision in the fight eye for 15 days. He also complained of tinnitus and intermittent hearing loss for 1-2 years. There was no history of meningoencephalitic symptoms. Cutaneous examination revealed a depigmented patchy lesion of 2 X 1 cm size, on the right eyebrow, extending to the forehead, and poliosis on the right eyebrow and eyelashes (Fig. 1). Ophthalmic examination revealed circumcorneal congestion in the right eye. Pupilary size was 4 mm with ill sustained contraction. The findings were consistent with Marcus Gunn pupil.

Slit lamp examination showed flare on the right side with few cells. Fundus

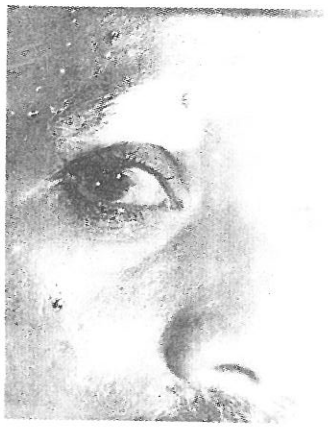

Fig. 1. Showing vitiligo, poliosis and circumcorneal congestion

examination revealed a hazy media, with ill defined disc margins. Cup-disc ratio was normal. Foveal reflex was absent. Vision was 2/60 on the right side. Left eye was normal with a vision of 6/6.

ENT examination was done which did not reveal sensorineural deafness. Routine investigations including complete hemogram, urine analysis, blood sugar and VDRL test were within normal limits. Skin biopsy from the depigmented patch was non-specific. Special stains for melanocyte could not be done.

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Patient was treated with tab. prednisolone 120 mg on alternate days and atropine eye ointment with topical steroids. After two weeks of treatment, the right eye vision recovered to 6/12 and slit lamp examination did not show ciliary injection, cornea was clear, no keratic precipitates, no cells or flare. Pupil was dilated and not reacting to light because of atropine ointment. After four weeks, patient recovered to near normal vision and treatment was stopped. Patient had no relapse of visual symptoms even after six months of followup.

Comments

In Vogt-Koyanagi Harada syndrome vitiligo and poliosis may rarely precede uveitis even by as much as 3 years.[2] Our patient had an interval of 2 years before developing loss of vision. Though he complained of tinnitus and intermittent episodes of hearing loss, there was no convicing evidence of sensorineural deafness and the audiometry was within normal limits. Corticosteroids have been found to be very useful as the pathogenesis could be an autoimmune process.[4] Our patient's visual problems cleared completely with high doses of oral corticosteroids.

Reterences

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