

Case Report

Syphilis presenting as optic neuritis in an immunocompetent patient: Case report

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The purpose of this report was to present a case of optic neuropathy as a manifestation of secondary syphilis in an human immunodeficiency virus (HIV)-negative patient. A case of gradual loss of visual acuity in the left eye (LE) in a 53-year-old healthy woman was described. The patient present with visual acuity of 20/20 in the right eye and hand movements in the LE. Fundoscopy revealed swollen optic disc in the LE. Fluorescein angiography showed leakage of dye from the optic disc. Optical coherence tomography (OCT) confirmed the oedema in the left optic disc. Serologic testing was positive for venereal disease research laboratory (VDRL) and fluorescent treponemal antibody absorption (FTA-ABS), and negative for HIV antibodies. Ophthalmologic findings, including disc oedema, may be the presenting features of syphilis, therefore ophthalmologists have the opportunity to play a key role in the diagnosis and management of this disease, important for a good visual outcome. This study reports an infrequent case of unilateral optic neuropathy as presenting symptom of syphilis in an immunocompetent patient.

Key words: Syphilis, optic neuropathy, immunocompetent, penicillin.

INTRODUCTION

Syphilis is a sexually transmitted, systemic infection caused by the spirochete bacterium *Treponema pallidum* (Lutchman et al., 2011). The incidence of syphilis continues to rise in the USA and Europe, and it is estimated that around 20% of patients with syphilis in the USA also have human immunodeficiency virus (HIV) infection (Foti et al., 2009; Ghanem, 2010; Puech et al., 2010). Ocular involvement may be silent or present as anterior uveitis, choroiditis, interstitial keratitis, retinal vasculitis, retinitis, optic neuritis, dacryoadenitis, or scleritis (Tamesis and Foster, 1990; Lukehart et al., 1988; Margo and Hamed, 1992). The observation of optic nerve abnormalities in an ophthalmological examination in a

patient with syphilis is highly suggestive of central nervous system (CNS) involvement and should be considered synonymous with neurosyphilis (Gaudio, 2006; Bandettini di Poggio et al., 2010).

The purpose of this report is to present a case of optic neuropathy as a manifestation of secondary syphilis in an HIV-negative patient.

CASE REPORT

The authors obtained written consent from the patient for the publication of her anonymised clinical data. A 53-year-

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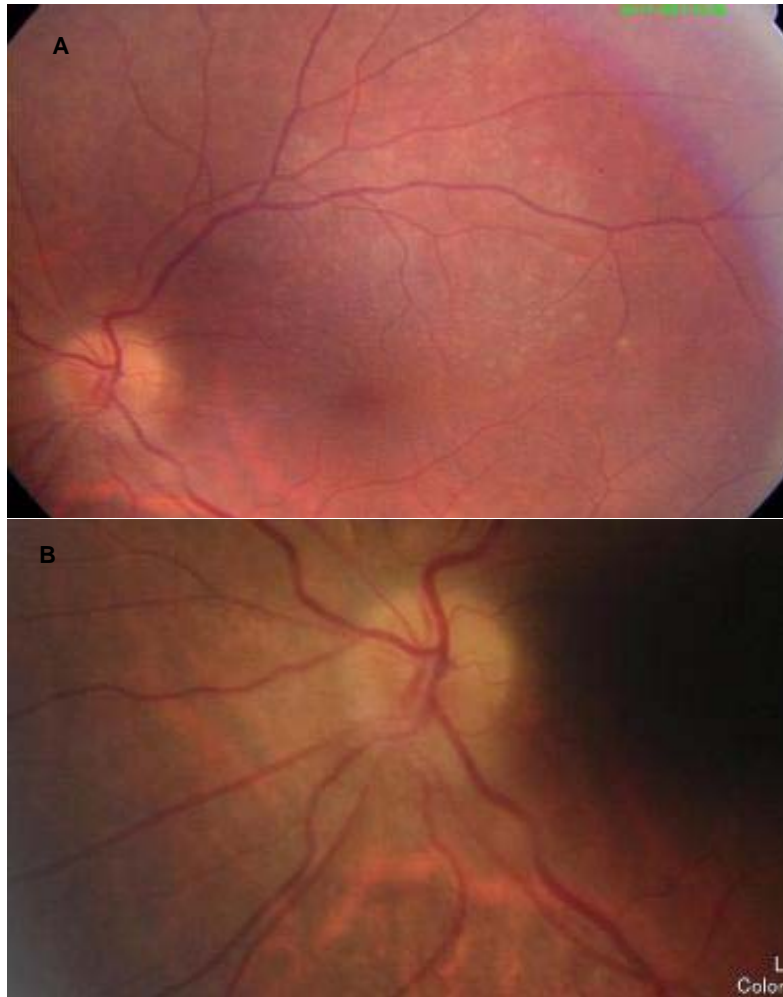


Figure 1. Colour fundus, left eye.

old healthy woman present with complaints of decreased visual acuity in the left eye (LE) which she had begun to notice 2 weeks earlier. In a general examination, a rash on the palms and soles was detected. Best corrected visual acuity of 20/20 in the right eye (RE) and hand movements in the LE. Biomicroscopy of the anterior segment was unremarkable in both eyes, and intra-ocular pressure was 12 mmHg in both eyes. Fundoscopy showed a swollen optic disc in the LE (Figure 1), with no abnormalities detected in the RE. A left relative afferent pupillary defect was present.

Fluorescein angiography (Figure 2) showed leakage of dye from the optic disc. Optical coherence tomography (OCT) confirmed the oedema in the left optic disc (Figure 3). Serologic testing was positive for venereal disease research laboratory (VDRL, 1:128) and FTA-ABS, and negative for HIV antibodies. No abnormalities were detected during magnetic resonance imaging of the cranium and orbits. Cerebrospinal fluid (CSF) examination revealed normal opening pressure, and that CSF

protein, glucose and white cell count were within the normal range. The CSF VDRL was negative and CSF *T. pallidum* particle agglutination technique (TP.PA) was reactive at 1:160. CSF results were thus inconclusive of neurosyphilis.

The diagnosis of optic neuropathy associated with secondary syphilis in the LE was made and the patient was treated with intravenous aqueous penicillin G (four million units given every 4 h for 2 weeks). Three months after the treatment, fundoscopy revealed the absence of oedema in the LE, with a visual acuity of 20/20 in both eyes, and VDRL titre was 1:32.

DISCUSSION

Ocular involvement in syphilis is rare and typically occurs with secondary or tertiary syphilis (Gaudio, 2006; Kiss et al., 2005; Klig, 2008). Tamesis and Foster (1990) reported that uveitis was the most common ocular manifestation

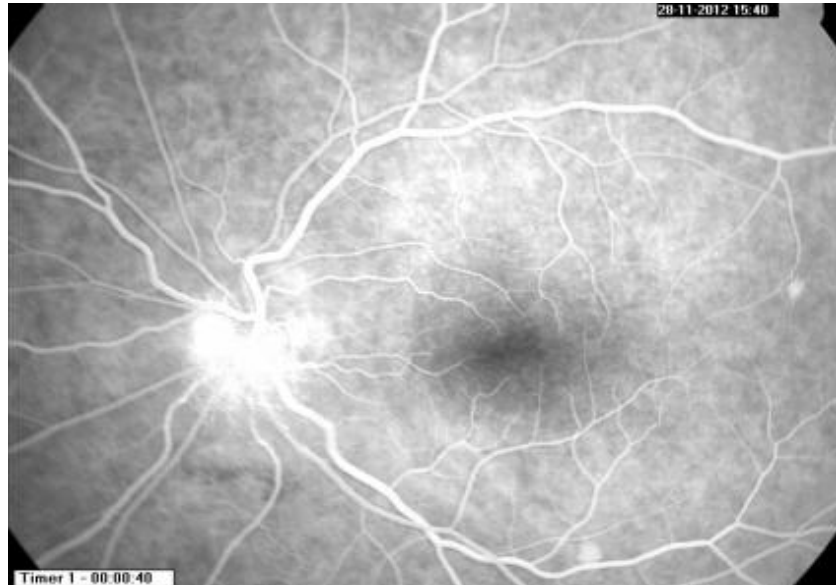


Figure 2. Fluorescein angiogram, left eye.

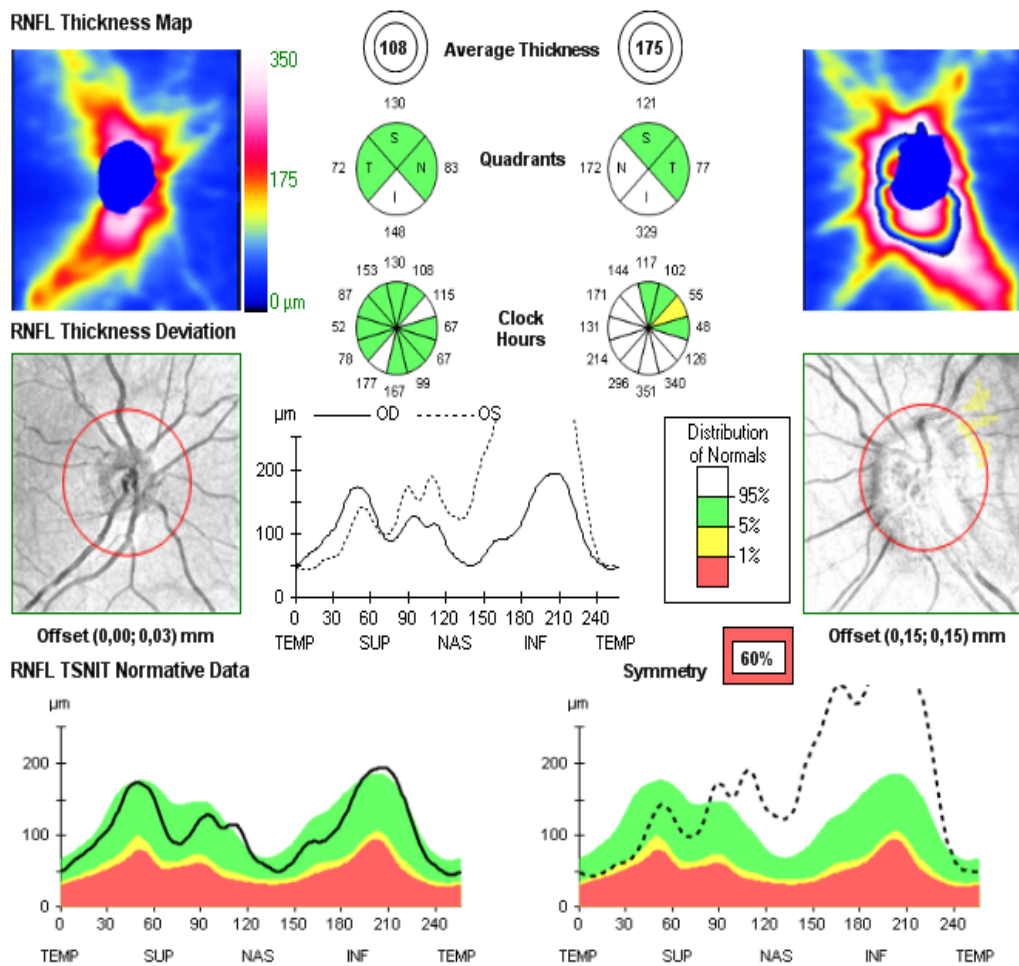


Figure 3. Optical coherence tomography optic nerve, right and left eyes.

in ocular syphilis. CNS involvement can occur at any stage of syphilis. Ocular syphilis has been reported in both immunocompromised and immunocompetent individuals (Foti et al., 2009), therefore patients should be tested for HIV (Gaudio, 2006; Barile and Flynn, 1997; Aldave et al., 2011).

The authors question the relevance of performing lumbar puncture on immunocompetent patients present with ocular manifestations who are subsequently diagnosed with syphilis, because the CSF analysis does not change the treatment regimen. Standard treatment of ocular syphilis is intravenous penicillin, as recommended for patients with neurosyphilis, regardless of immune status (Shalaby et al., 1997). There is limited data on the use of systemic corticosteroids as an adjunct for posterior uveitis, scleritis and optic neuritis associated with syphilis (Margo and Hamed, 1992).

Conclusion

This report describes an infrequent case of unilateral optic neuropathy as presenting symptom of syphilis in an immunocompetent patient. Epidemiological data indicates a worldwide reemergence of syphilis and a high degree of suspicion is necessary in view of its multitude of presenting ocular signs without pathognomonic features. Ophthalmologic findings may be the presenting features of syphilis therefore ophthalmologists have the opportunity to play a key role in the diagnosis and management of this disease, important for a good visual outcome.

Conflict of interest

Authors declare no conflict of interest.

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