

## CLINICAL PRACTICE

## Clinical Images

## More to Mutton than Meets the Eye

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A 64-year-old Mexican fisherman with a history of syphilis is diagnosed with panuveitis of the right eye after presenting with unilateral blurry vision, redness, and pain. A PPD was 35X30mm, and chest X-ray suggested tuberculosis. The patient's pain and vision improved with 4-drug anti-tuberculous therapy, topical steroids, and cycloplegic eye drops.

**KEY WORDS:** panuveitis; conjunctival injection; slit lamp; tuberculosis.

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## CASE DESCRIPTION

A 64-year old Mexican fisherman with previously treated syphilis presented with six weeks of unilateral blurry vision, redness, and pain in his right eye. He endorsed night sweats, but denied cough, purulent eye discharge, headache, trauma, chemical exposures, weight loss, GI symptoms, or rash. A right-eye exam revealed visual acuity to movement only, conjunctival injection, mild photophobia, and inflammation obscuring the retina. The patient was diagnosed with panuveitis in the right eye based on dilated slit lamp (see Fig. 1) and retinal exam findings (*not shown*). A PPD was 35X30mm, and chest X-ray suggested tuberculosis. The patient's pain and vision improved with 4-drug anti-tuberculous therapy, topical steroids, and cycloplegic eye drops.

## IMAGE

Slit-lamp exam of the right eye showing mutton-fat keratic precipitates (clumps of inflammatory cells in the anterior chamber, *arrows*) consistent with granulomatous uveitis, see Fig. 1.

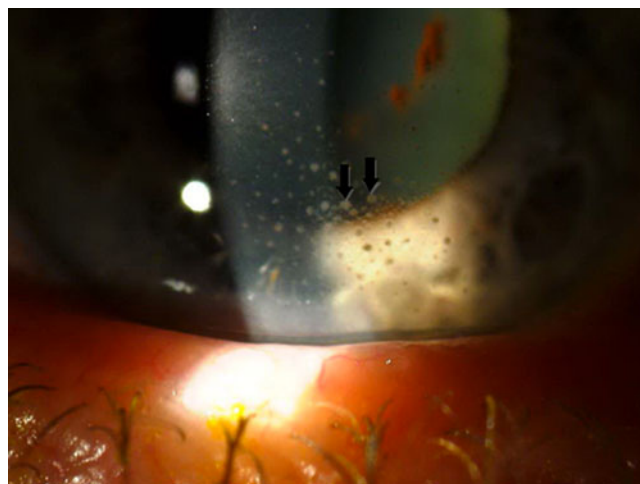


Figure 1. Mutton-fat keratic precipitates in the right eye of patient based on dilated slit lamp.

## DISCUSSION

Monocular vision loss without trauma is concerning for infection, rheumatologic disease, hemorrhage, vascular insult, or optic nerve disease. A red, painful eye suggests an inflammatory process involving the anterior chamber. Diagnosis relies on dilated ophthalmologic examination. Uveitis, or inflammation of the uveal tract (iris, ciliary body, choroid), may involve anterior structures (iris, ciliary body), posterior structures (choroid), or both (panuveitis), as in this case. Toxoplasmosis is the most common infectious cause of panuveitis, followed by herpes simplex virus, tuberculosis, and syphilis. An exam of the anterior chamber typically shows keratic precipitates (KPs), representing leukocyte deposits on the posterior cornea. Granulomatous uveitis causes large KPs appearing like fat globules, named mutton-fat KPs, which suggest tuberculosis, syphilis, or sarcoidosis. Additional exam findings may include hypopyon, synechiae between the iris and cornea or lens, inflammatory iris nodules, and retinal granulomas. Treatment for infectious panuveitis is directed at the underlying cause, often requiring intraocular treatment and/or systemic antimicrobials plus steroids to prevent permanent inflammatory damage. Cycloplegics are helpful for preventing synechiae formation.

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