Syphilitic Retinitis resulting in Blindness in an HIV infected Patient

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Case Presentation

33 yo Caucasian woman residing in Mexico with her boyfriend presented to the ED in 1993 with headache, chronic eye pain, near blindness, and a non-pruritic rash on her arms and legs. She first noted bilateral blurry vision, more prominent in R eye, in June 1992. In October 1992, she had seen a local ophthalmologist who prescribed her eye drops without improvement. In March 1993, she crossed the US Border and presented to the UCSD ED where she was diagnosed with neurosyphilis (serum RPR titer 1:32) and HIV (CD4 count 391, 30%). She had acquired HIV from her boyfriend.

Ocular examination revealed vitritis. She was able to see shapes at the time. Lumbar puncture was performed with positive VDRL. She was immediately started on iv penicillin x 21 days. Repeat serum RPR a month later was 1:8. For her HIV, in 1993, she was started on AZT monotherapy.

Histology

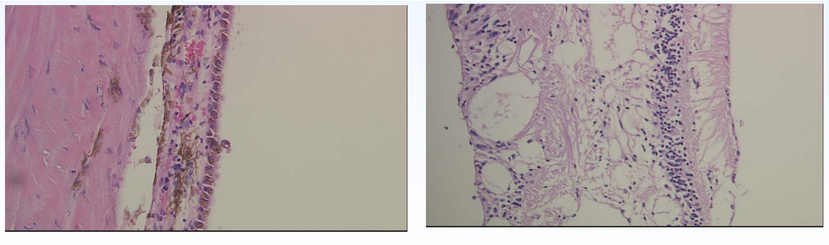

Figure 1: Extensive retinal atrophy from R eye. Unremarkable cornea and iris. Optic nerve is atrophic.

Ophthalmology

Over the years she was followed closely by ophthalmology. She had undergone retinal detachment repairs on both eyes and trans pars plana vitrectomy (twice on the R eye and three times on the L eye).

She continued to report bilateral eye pain, more prominent in the R eye. Ophthalmology was unable to reduce her intraocular pressure.

For a blind painful eye, there are two therapies 1) alcohol injection or 2) enucleation. They first attempted intraocular scleral alcohol injections x 2 in her R eye. Unfortunately, her pain persisted. Finally, 14 years later, in May 2007, she had undergone a R eye enucleation. Ophthalmology attempted to save her left eye by performing a corneal transplant in May 2008. She remains legally blind.

Pain Management

In 2007, prior to enucleation, she was referred to a pain specialist for her chronic eye pain, requiring multiple narcotic regimens. The pain specialist believed that enucleation fourteen years later would not alleviate her chronic neuropathic pain as her CNS would have remodeled by then. She would continue to have phantom pain even with enucleation.

As predicted, she continued to have phantom pain, requiring narcotics resulting in two hospitalizations for altered mental status from polypharmacy. Her psychiatrist, pain specialist, and HIV PCP initiated a team approach to manage her pain, both emotional and physical. To date, her medical team has had limited success in controlling her pain. She is currently taking gabapentin 900mg TID and percocet 1-2 tablets four times a day as needed.

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Patient Follow-Up

The patient is now 53 years old. Her HIV is well controlled with a CD4 816, 39% and undetectable viral load on darunavir, ritonavir, truvada, and raltegravir.

Unfortunately, she is unable to live independently. She now resides in an HIV group home. Her last RPR on 4/29/2010 was non-reactive.

This case highlights the importance of early diagnosis and treatment of neuro-ocular syphilis to prevent chronic disability and pain.

References

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