

Subretinal abscess due to presumed tuberculosis in an immunocompetent young diabetic

Yogish Kamath, Archana Sushama, Shailaja Bhat Shenoy, Krishna Rao Addoor

Department of Ophthalmology,
Kasturba Medical College,
Manipal University, Manipal,
Karnataka, India

Correspondence to

Dr Yogish Kamath,
dryogishkamath@yahoo.co.in

Accepted 27 September 2016

DESCRIPTION

A man aged 28 years with type 2 diabetes mellitus presented for a baseline ophthalmological evaluation during initiation of antitubercular treatment (ATT). He had undergone a drainage of an abscess in his left elbow and psoas muscle. The PCR analysis of the exudate had revealed *Mycobacterium tuberculosis* and he had been initiated on ATT (rifampicin 450 mg, pyrazinamide 750 mg, isoniazid 600 mg and ethambutol 1600 mg per day). He had mild pain and diminution of vision in his right eye. On examination, visual acuity of the right eye was 1/60 with near vision <N36 and left eye was 6/18 with near vision N8. Slit-lamp examination showed congested right eye with clear cornea and grade 2 cells in the anterior chamber. Dilated fundus examination showed a choroidal abscess with overlying exudative retinal detachment temporal to the optic disc (figure 1). Left eye

examination was unremarkable (figure 2). As he refused to undergo ocular fluid analysis, a tubercular aetiology was presumed, considering his associated systemic infection. The ATT regimen was continued for 9 months. Oral prednisolone 1 mg/kg body weight was initiated after 3 weeks and tapered slowly, in consultation with his physician. After 7 months, the lesion resolved with residual chorioretinal scarring (figure 3).

Posterior segment manifestations of ocular tuberculosis commonly include choroiditis, tuberculomas, neuroretinitis and retinal vasculitis.¹

Subretinal abscesses are usually seen in immunocompromised individuals, due to bacterial or fungal infections, with a rapidly progressive course.² Rarely, they may occur due to necrosis within a tuberculoma.

The chronic course in our immunocompetent patient, with concurrent isolated extrapulmonary tuberculosis foci, and response to antitubercular therapy are suggestive of tubercular aetiology.³



Figure 1 Fundus photograph of the right eye showing subretinal abscess in macula.

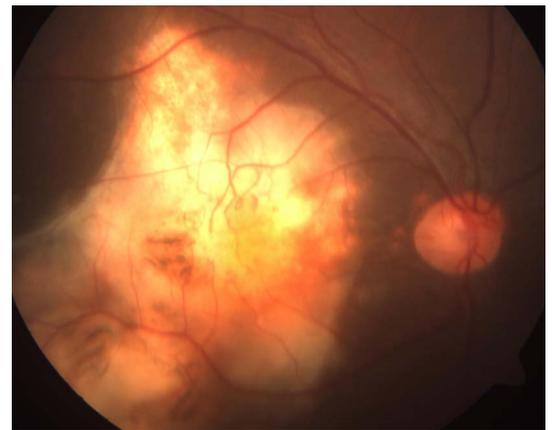


Figure 3 Fundus photograph of the right eye showing chorioretinal scar following treatment.

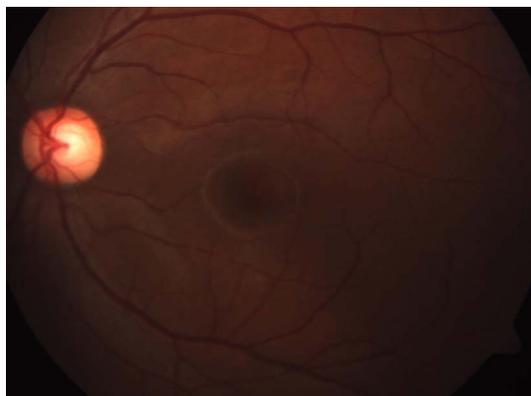


Figure 2 Fundus photograph of the left eye with normal macula.



CrossMark

To cite: Kamath Y, Sushama A, Shenoy SB, et al. *BMJ Case Rep* Published online: [please include Day Month Year] doi:10.1136/bcr-2016-217274

Learning points

- ▶ Subretinal abscess due to tuberculosis is a rare entity.
- ▶ PCR analysis of ocular fluid for *Mycobacterium tuberculosis* would have been confirmatory.³
- ▶ Detailed ocular evaluation in all cases of tuberculosis, especially extrapulmonary variant, may help in prompt management.

Acknowledgements Mr Suresh, Photographer, Department of Ophthalmology, Dr S Kavitha, Department of Internal Medicine.

Contributors YK and AS are responsible for substantial contributions to the conception, design of the work, the acquisition, analysis and interpretation of data. YK, AS and SBS are responsible for drafting the work, revising it critically for important intellectual content. YK and KRA are responsible for final approval of the version published.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

- 1 Shakarchi FI. Ocular tuberculosis: current perspectives. *Clin Ophthalmol* 2015;9:2223–7.
- 2 Arai Y, Sato Y, Yoshida A, *et al*. Bilateral endogenous *Candida albicans* subretinal abscess with suspected mixed bacterial infection. *Clin Ophthalmol* 2014; 8:2151–4.
- 3 Majumder PD, Biswas J, Bansal N, *et al*. Clinical profile of patients with tubercular subretinal abscess in a tertiary eye care center in Southern India. *Ocul Immunol Inflamm* 2016:1–5.

Copyright 2016 BMJ Publishing Group. All rights reserved. For permission to reuse any of this content visit <http://group.bmj.com/group/rights-licensing/permissions>.

BMJ Case Report Fellows may re-use this article for personal use and teaching without any further permission.

Become a Fellow of BMJ Case Reports today and you can:

- ▶ Submit as many cases as you like
- ▶ Enjoy fast sympathetic peer review and rapid publication of accepted articles
- ▶ Access all the published articles
- ▶ Re-use any of the published material for personal use and teaching without further permission

For information on Institutional Fellowships contact consortiasales@bmjgroup.com

Visit casereports.bmj.com for more articles like this and to become a Fellow