

Intermediate Uveitis Revealing Asymptomatic Ulcerative Colitis

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Abstract

Ulcerative colitis (UC) is a chronic inflammatory bowel disease (IBD) that can be associated with extra-gastrointestinal manifestations. Intermediate uveitis during IBD is very rare, and has never been reported as revealing UC. We report a case of a 48-year-old patient who presented with deep unilateral decrease in visual acuity related to intermediate uveitis complicated by macular edema, in whom the etiological explorations concluded to an ulcerative colitis.

Keywords: Intermediate uveitis; Macular edema; Ulcerative colitis

Introduction

Ulcerative colitis (UC) is a chronic inflammatory bowel disease (IBD) that can be associated with extra-gastrointestinal manifestations. Ocular involvement is more common in Crohn's disease than in UC. The main manifestations are scleritis, episcleritis, keratoconjunctivitis, marginal keratitis, and non-granulomatous anterior uveitis [1]. Intermediate uveitis during IBD is very rare, and has never been reported as revealing UC. We report a case of a 48-year-old patient who presented with deep unilateral decrease in visual acuity related to intermediate uveitis complicated by macular edema, in whom the etiological explorations concluded to an ulcerative colitis.

Case Report

48-year-old patient, with no particular pathological history, presented with decrease in visual acuity (VA) in his right eye since one week, getting progressively worsening, with no extra-ocular signs. At presentation, best-corrected visual acuity was 20/100 in the right eye and 20/20 in the left one. Anterior segment and intraocular pressure were normal. Fundus examination of the right eye revealed discrete vitritis of 1+, snowballs, and peripheral snow banks in the inferior pars plana, there was no obvious retinal vasculitis or chorioretinal lesion. Fundus examination of the left eye was unremarkable. Fluorescein angiography confirmed cystoid macular edema (CME) and did not show signs of retinal vasculitis (Figure 1). Optical coherence tomography (OCT) of the macula revealed, in addition to the CME, a retrofoveolar serous detachment (Figure 2). Apart from an elevated sedimentation velocity at 50 mm at the first hour, laboratory investigations, including infectious, inflammatory and immunologic markers and HLA-B27 test failed to disclose any abnormal results, as well as the radiological investigations including chest radiography and brain magnetic resonance imaging. We retained initially the diagnosis of idiopathic unilateral intermediate uveitis complicated by macular edema.

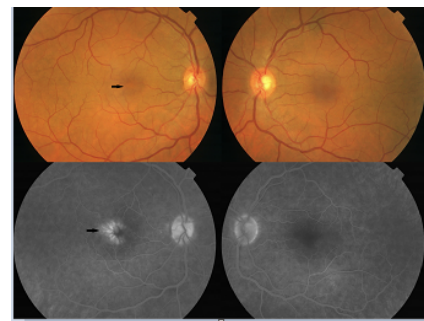


Figure 1: color fundus photographs and in late stages of the fluorescein angiography showing cystoid macular edema in the right eye (arrow).

The patient was treated with local and general corticosteroids (intravenous: 1 g/day during three successive days and relayed orally with progressive degression). Evolution was favorable: progressive and complete resorption of the macular edema (Figure 2), and improvement of a visual acuity to 20/20. At 15 mg/day of méthylprednisone, the patient reported a decrease in the VA in the same eye. Fundus examination found a recurrence of macular edema. The etiological investigations were complemented, amongst others, by ileo-colonoscopy that revealed some macroscopic lesions suggestive of UC that biopsy and histological study confirmed (Figure 3). The patient received second bolus corticosteroids, and then treated with azathioprine at 150 mg/day with a good evolution. There was no recurrence of uveitis at 9 months follow-up.

Discussion

Ulcerative colitis is a chronic inflammatory bowel disease (IBD) of multifactorial origin, the exact pathogenetic mechanism remains uncertain. Abdominal pain, bloody diarrhea and rectal syndrome are the main digestive signs [2]. These symptoms are often the first warning signs of the disease and alter significantly life-quality of patients [2]. In addition to digestive manifestations, 11.9 to 36% of patients with IBD develop varied extra-digestive disorders:

ophthalmologic, cutaneous, osteoarticular, hepatobiliary, thromboembolic and neurological [2-4]. Some extra-intestinal manifestations evolve in parallel with IBD, while others evolve independently, reflecting a common autoimmune susceptibility [3].

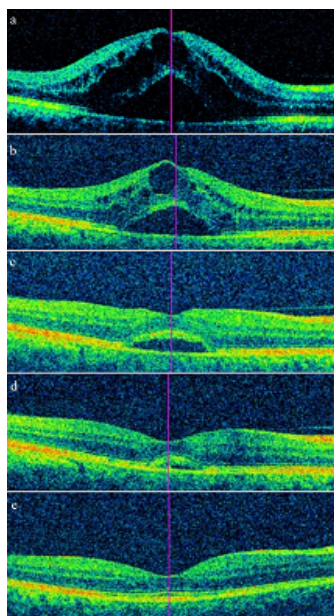


Figure 2: OCT of the macula showing initial macular edema with retinal serous detachment, and its favorable evolution after treatment: a-Initial aspect; b-2 weeks later; c-4 weeks later; d-6 weeks later; e-4 months later

Ocular involvement occurs in approximately in 3 to 10% of IBD, they are more common in Crohn's disease than in UC. The main manifestations are scleritis, episcleritis, keratoconjunctivitis, marginal keratitis, and non-granulomatous anterior uveitis [1]. Rare cases of posterior uveitis, choroiditis, venous or arterial occlusions, optic neuritis, and retinal vasculitis have been reported [1,5-7]. In the majority of cases, the digestive signs are the first to appear. In our knowledge, isolated intermediate uveitis has never been reported as revealing UC.

The diagnosis of UC is based on the clinical aspect of mucosa on colonoscopy, and the pathological study of staged biopsies realized on macroscopically pathological and normal rectal and colonic mucosa [1]. Therapeutic management consist of two parts: treatment of the intestinal disease and the uveitis. The treatment of intestinal disease is based on salicylate derivatives and corticosteroids, which are the treatment of choice for inflammatory bowel flare-up, and immunosuppressants as long-term treatment, such as azathioprine or methotrexate, and more rarely immunomodulators such as anti-TNF (tumor necrosis factor) [2,8].

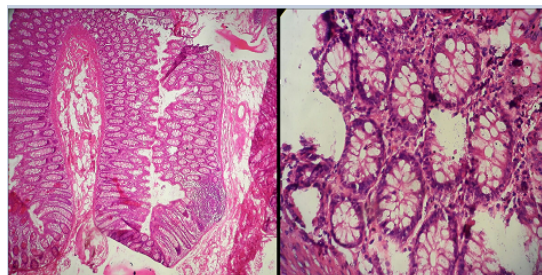


Figure 3: Histological lesions evocative of ulcerative colitis

Surgical treatment by colectomy is indicated in acute circumstances or in chronic cases with failure of medical treatment. According to some authors, this surgical treatment would also have a favorable effect on the evolution of extra-intestinal manifestations [9], but there are no studies that have proved this effect. The treatment of uveitis depends on its severity. Local corticosteroid treatment with eye drops or locoregional injections is generally sufficient for unilateral anterior uveitis. Bilateral anterior forms, intermediate or posterior forms, are indications for systemic corticosteroid therapy, or even immunosuppressant and immunomodulators drugs [8,10]

Conclusion

It is clear that interrogation and careful examination are crucial times to realize targeted Para clinical explorations. However, given the lack of etiological orientation in many cases, explorations should be exhaustively extended. Thus, ulcerative colitis can remain asymptomatic and manifest itself, in the foreground, by severe ophthalmologic manifestations involving visual prognosis.

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