CLINICAL PRACTICE
Clinical Images

Ocular Tuberculosis

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A 35-year-old man from China presented with a 1-month history of night sweats, weight loss, fever, abdominal bloating, and progressive left eye vision loss. He had started infliximab 3 months prior for Crohn's disease. Physical examination revealed mild hepatomegaly and a left eye visual field defect over the superior nasal quadrant. Fundoscopy demonstrated a choroidal tuberculoma with retinal detachment (Fig. 1). Abdominal computed tomography revealed multiple hepatic and splenic hypodensities (Fig. 2). Biopsy of the choroidal mass demonstrated caseating granulomas with acid-fast bacilli, and cultures growing *Mycobacterium tuberculosis*. HIV testing was negative. Infliximab was stopped, and he was started on quadruple antituberculous therapy.

The most common cause of ocular tuberculosis is hematogeneous spread from a distant site, although primary isolated disease can also rarely occur.[1, 2] Many parts of the eye can be affected including the iris and choroid. Choroidal tuberculomas are typically white, cream, or yellow colored, and may be associated with retinal detachment.[2, 3] Ocular tuberculosis should be suspected in patients with ocular complaints and risk factors for tuberculosis or evidence of systemic infection. Confirmation with microbiologic or histopathologic testing is often challenging and most diagnoses are presumptive.[2–4] Quadruple antituberculous therapy can achieve cure rates above 90%. Although often used to suppress ocular inflammation, treatment with systemic corticosteroids remains controversial.[5]

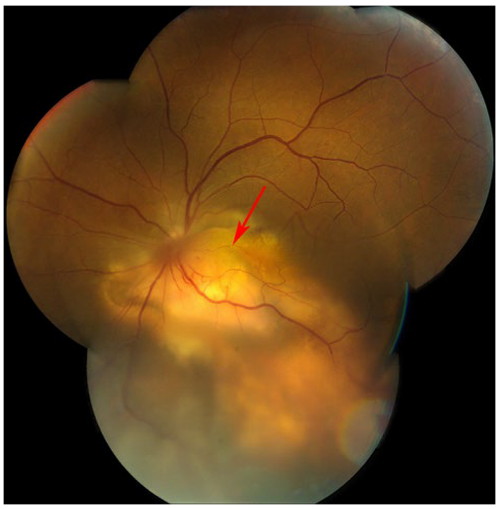

Figure 1 Fundoscopy demonstrating tuberculoma with associated retinal detachment (red arrow).

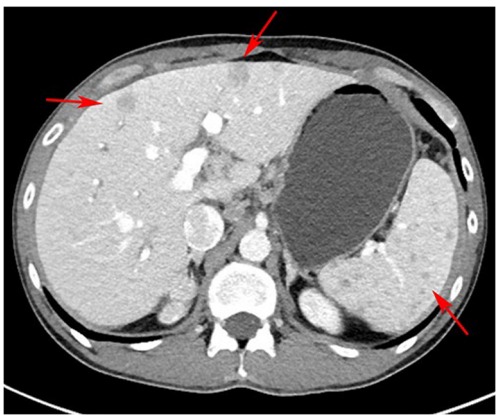

Figure 2 Abdominal computed tomography demonstrating multiple hepatic and splenic hypodensities (red arrows) suggestive of extrapulmonary tuberculosis.

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