

# Uveitis: *TB*

## Basics

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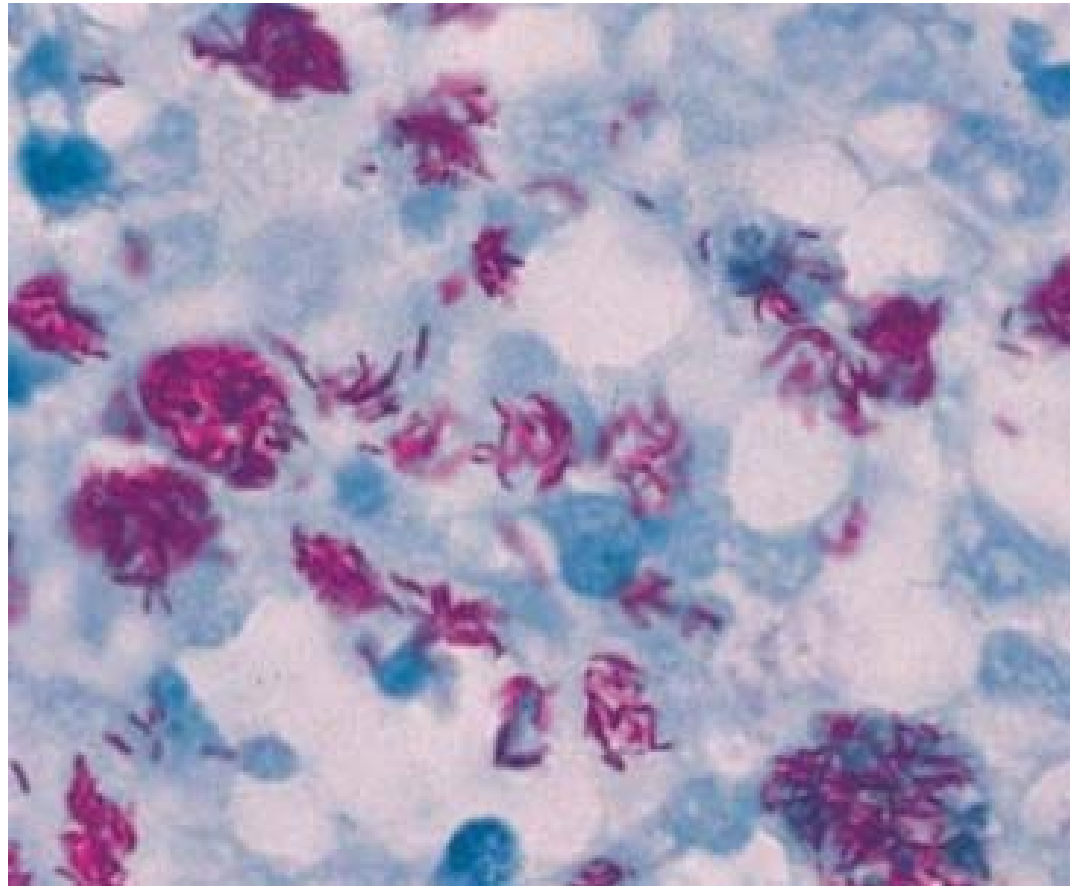
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*M tuberculosis*, acid-fast stain



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- Recently emigrated from a developing nations
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*TB has a special affinity for what portion of the lungs?*

*Which orga*

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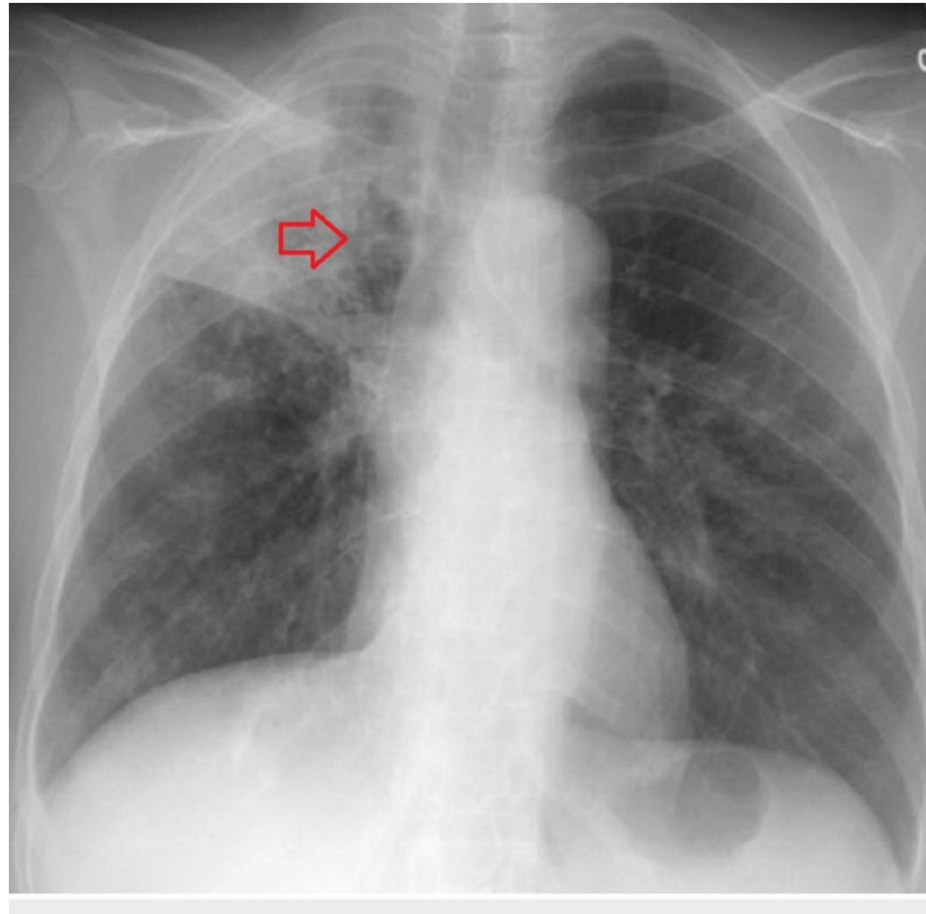
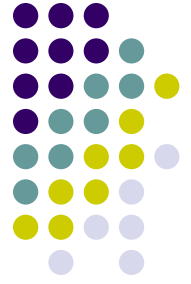
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TB: Cavity in the right lung apex with evidence of consolidation

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TB thrives under conditions of high O<sub>2</sub> tension, and pulmonary O<sub>2</sub> levels are highest at the apices

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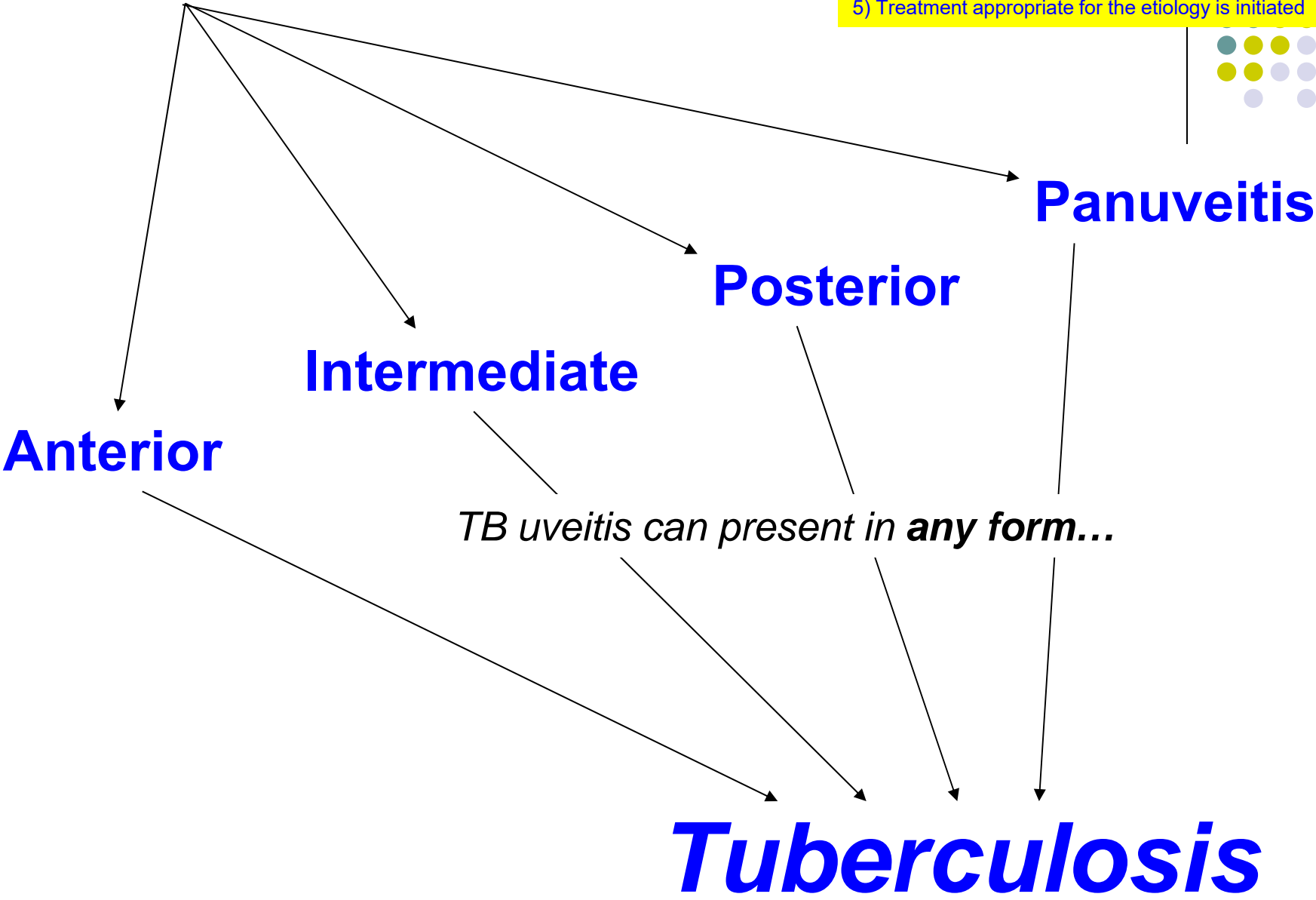
Fever, night sweats and weight loss

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Panuveitis

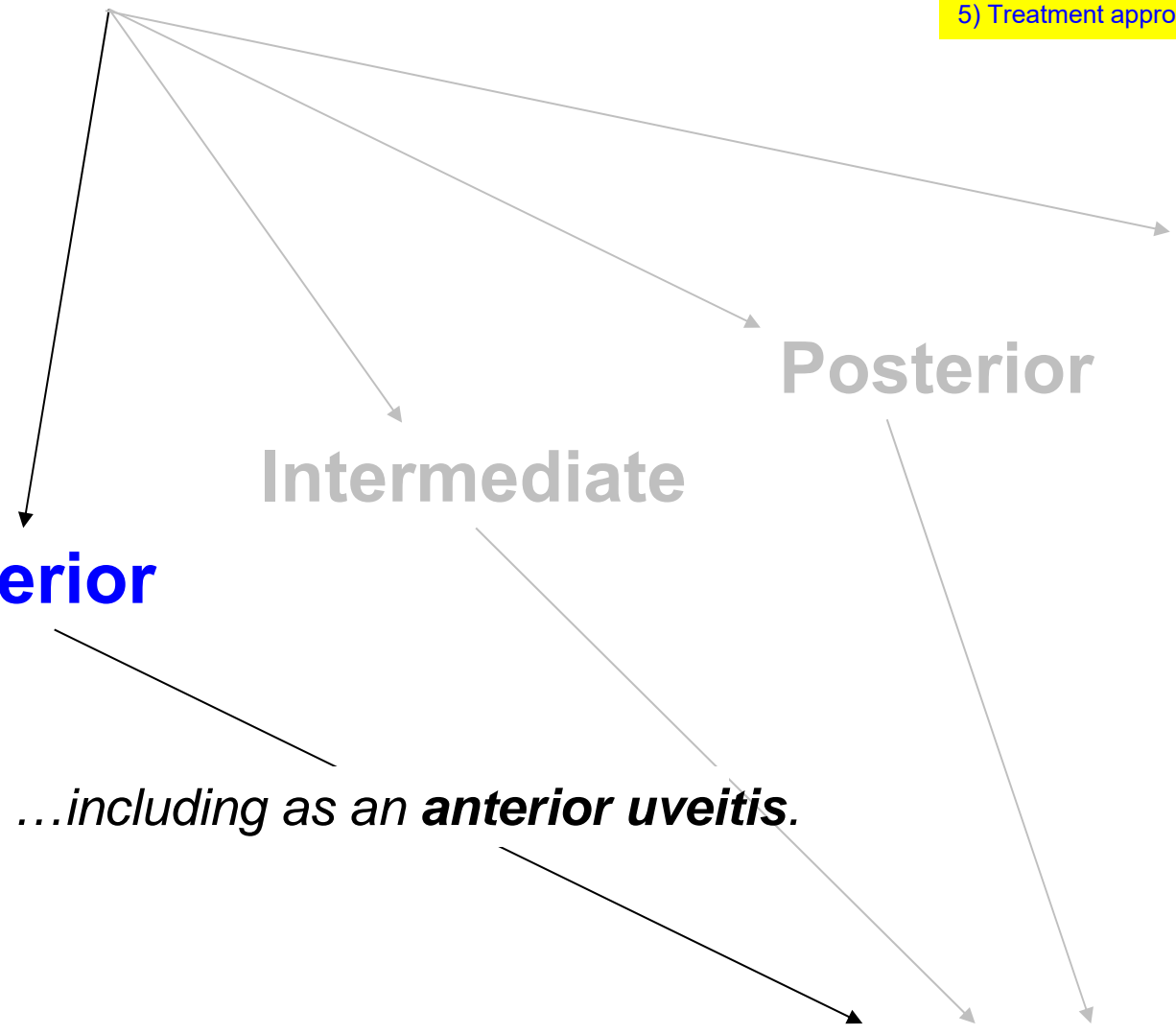
Posterior

Intermediate

**Anterior**

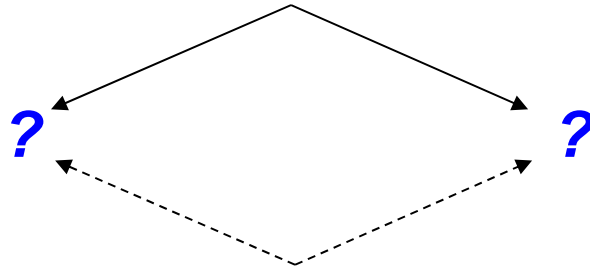
*...including as an **anterior uveitis**.*

***Tuberculosis***





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*(Start here, with the first distinction the book makes)*

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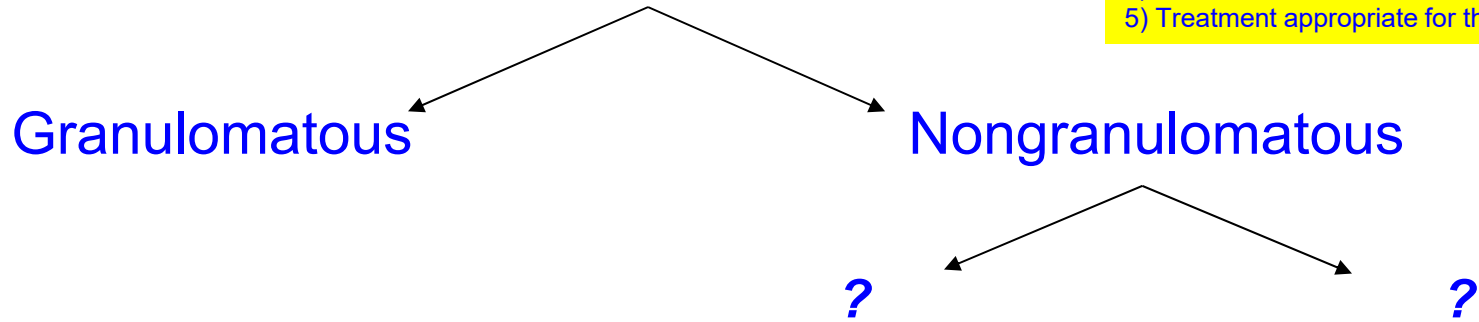
Nongranulomatous

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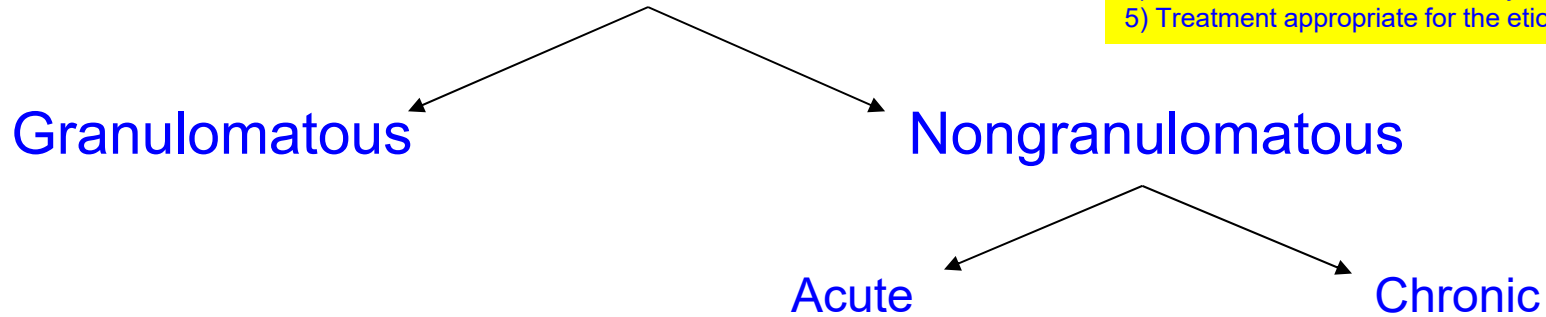


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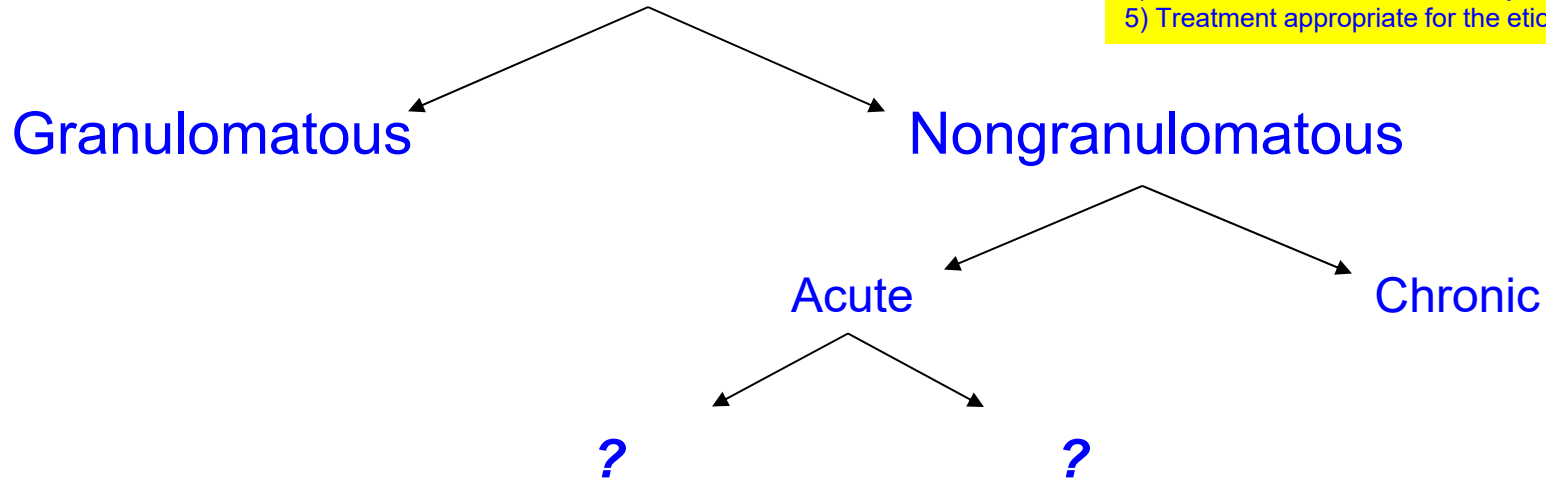
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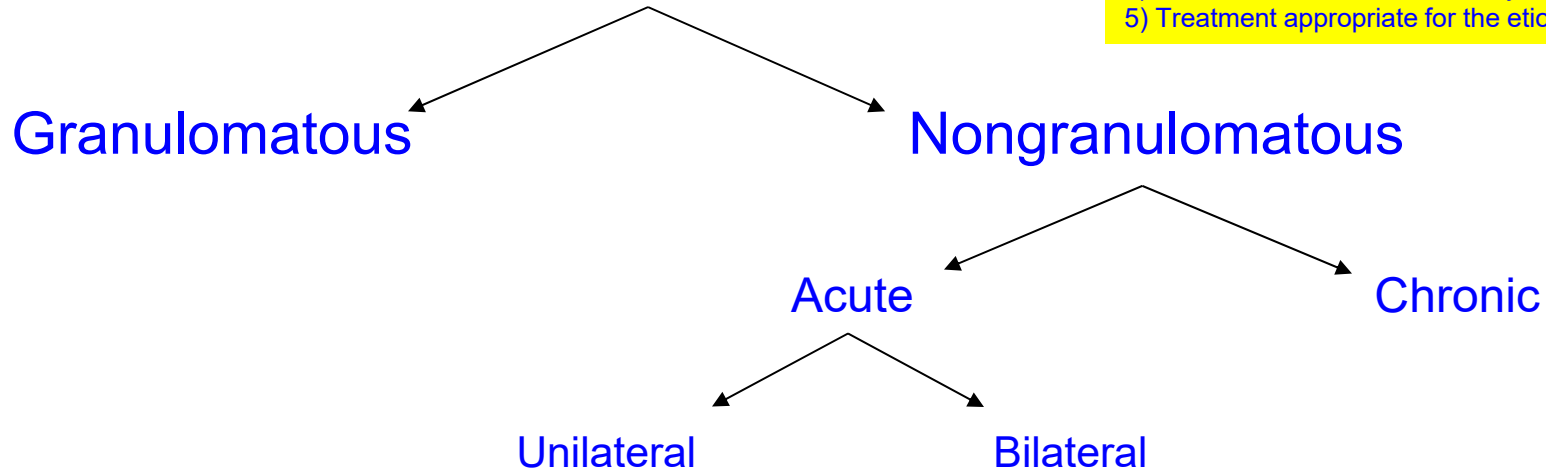
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## Granulomatous

- ?
- Syphilis
- Sarcoid
- HSV
- VKH
- Toxoplasmosis
- Lyme

## Nongranulomatous

### Acute

#### Unilateral

- HLA-B27 dz
- Posner-Schlossman
- Sarcoid
- Syphilis
- HSV/VZV
- ?

#### Bilateral

- TINU
- Behçet
- Drug rxn
- Leptospirosis
- Sarcoid
- Syphilis
- IBD/PA
- ?

### Chronic

- JIA
- FHI
- IBD/PA
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*On the diagram above, where can TB present?*

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## Granulomatous

- **TB**
- Syphilis
- Sarcoid
- HSV
- VKH
- Toxoplasmosis
- Lyme

## Nongranulomatous

### Acute

#### Unilateral

- HLA-B27 dz
- Posner-Schlossman
- Sarcoid

#### Bilateral

- TINU
- Behçet
- Drug rxn
- Leptospirosis
- Sarcoid
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- IBD/PA
- TB

### Chronic

- JIA
- FHI
- IBD/PA
- Sarcoid
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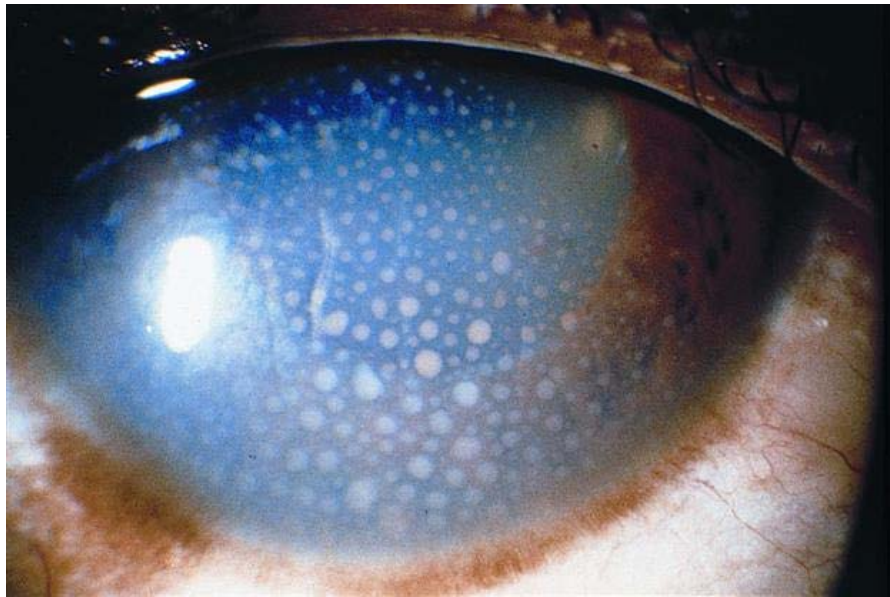
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Sarcoid: Mutton-fat KP



TB: Mutton-fat KP (note also the AC granuloma)

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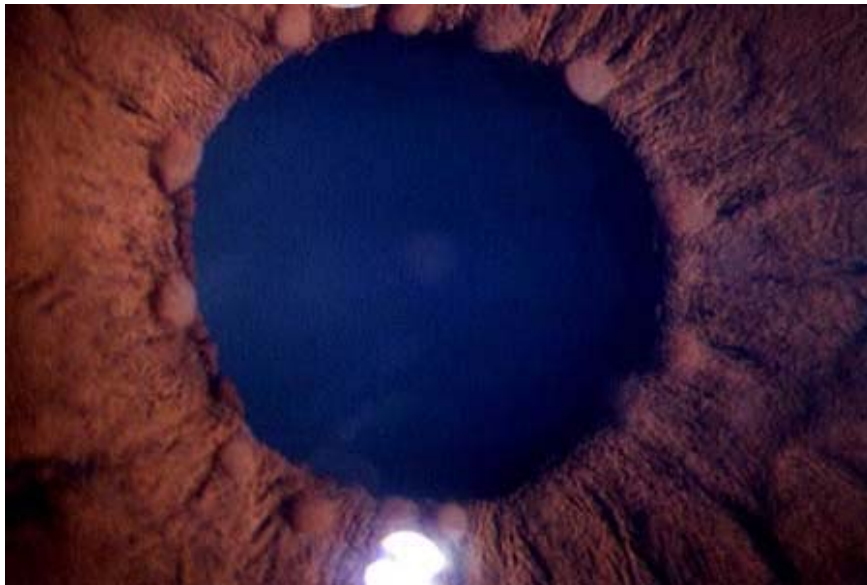
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# Uveitis: *TB*



Sarcoid: Iris nodules

TB: Iris nodules

(I couldn't find any pics, but they should look like the sarcoid ones)

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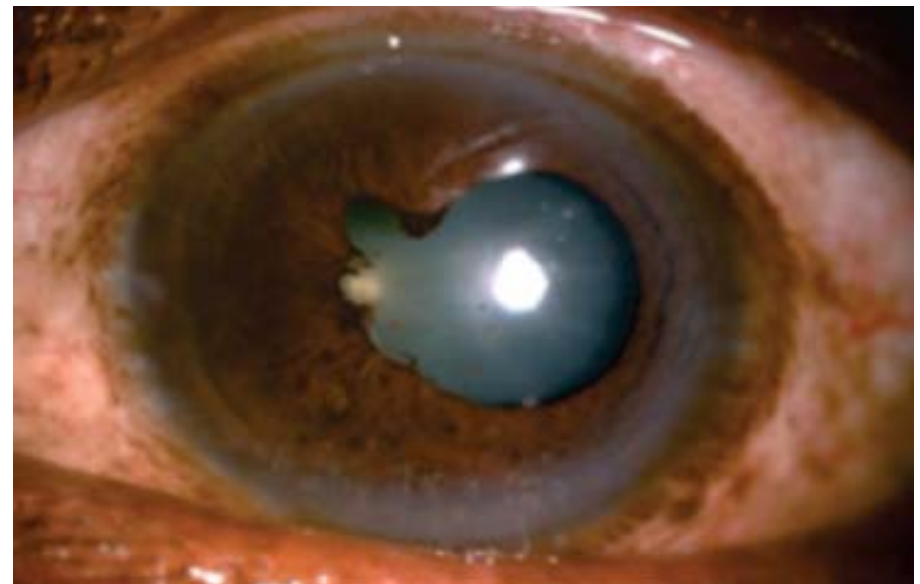
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# Uveitis: *TB*



Sarcoid: Posterior synechiae  
(and the world's largest  
Busacca nodule)



TB: Posterior synechiae

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Panuveitis

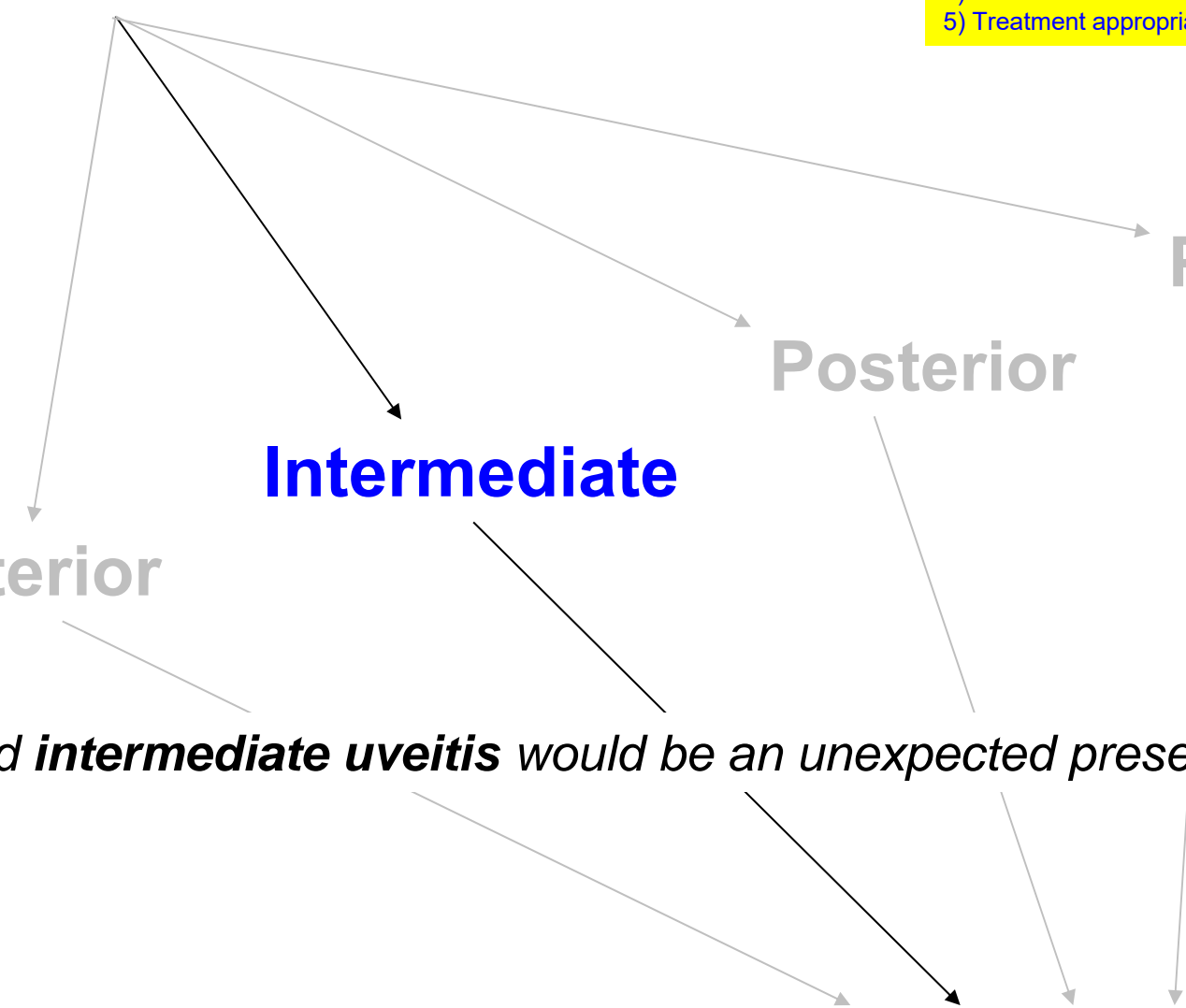
Posterior

**Intermediate**

Anterior

*Isolated **intermediate uveitis** would be an unexpected presentation in TB...*

**Tuberculosis**



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Panuveitis

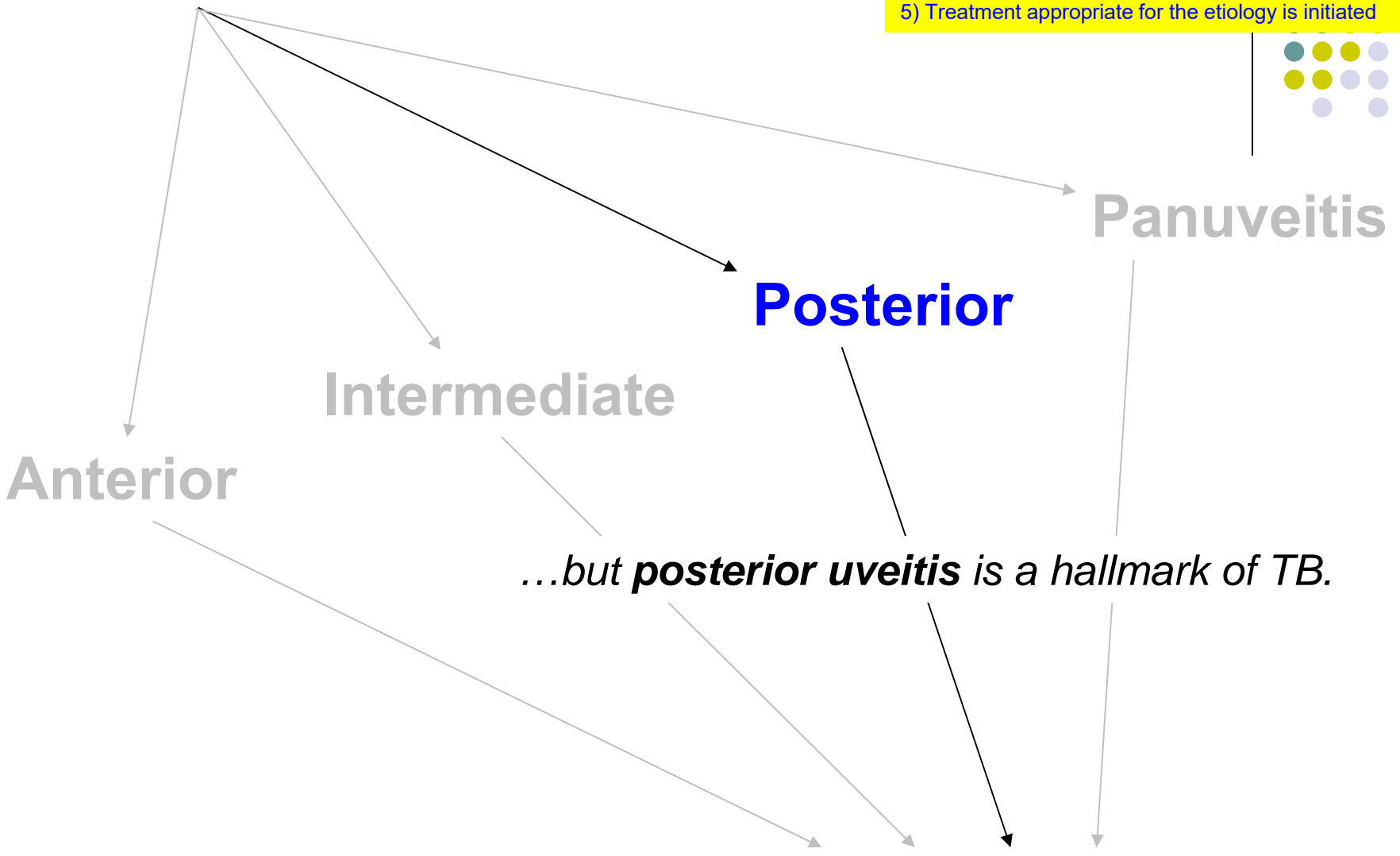
**Posterior**

Intermediate

Anterior

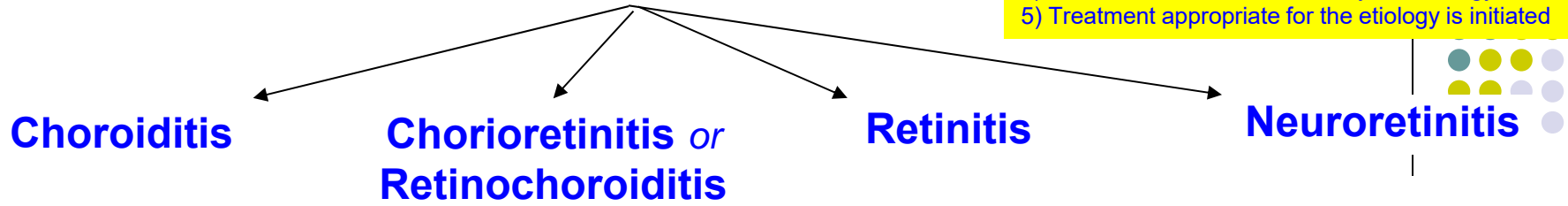
*...but **posterior uveitis** is a hallmark of TB.*

***Tuberculosis***



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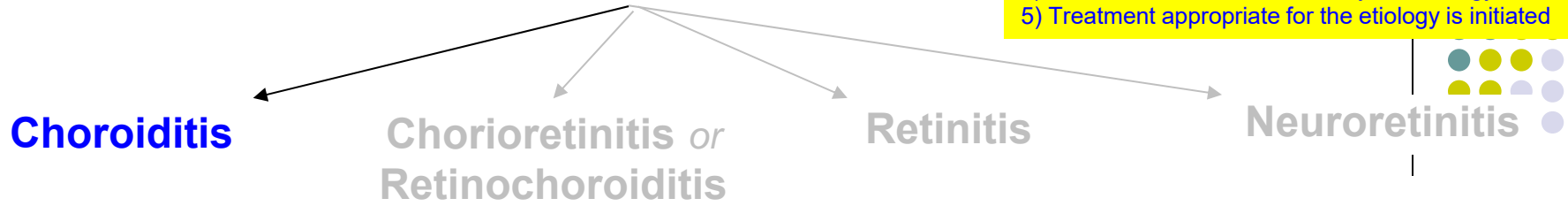


*What is the classic posterior manifestation of TB?*



# Uveitis: *Posterior*

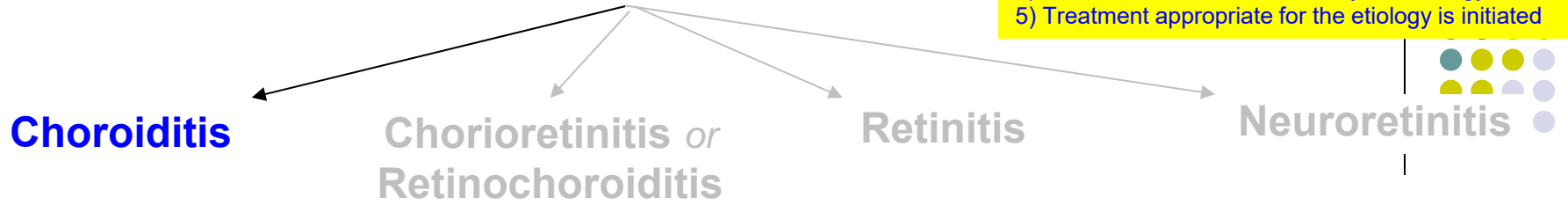
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*What is the classic posterior manifestation of TB?*  
Choroiditis

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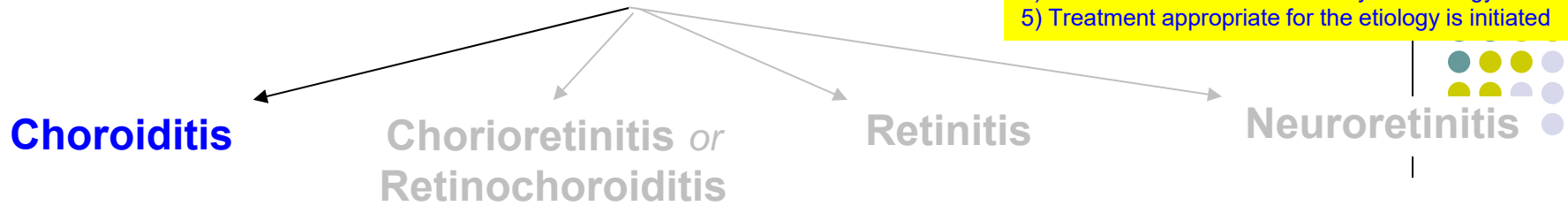


*What is the classic posterior manifestation of TB?*  
Choroiditis

*Why does TB have a special affinity for the choroid?*

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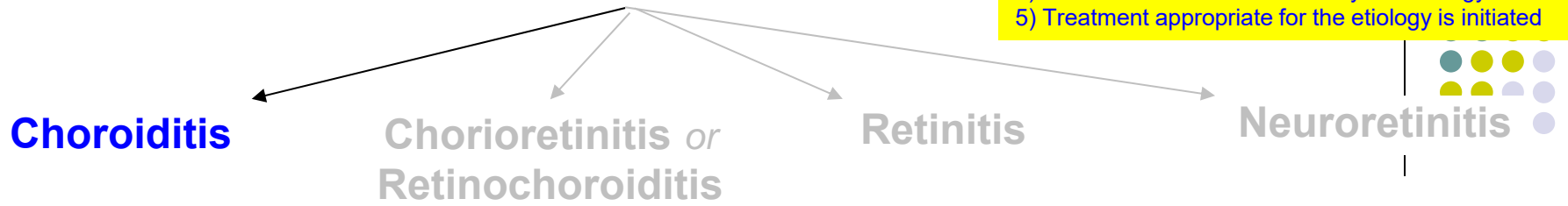
Choroiditis

*Why does TB have a special affinity for the choroid?*

TB has an affinity for those areas of the body with especially high O<sub>2</sub> tension (eg, the lung apices). The choroid has the highest blood flow in the entire body, and thus is extremely well oxygenated.

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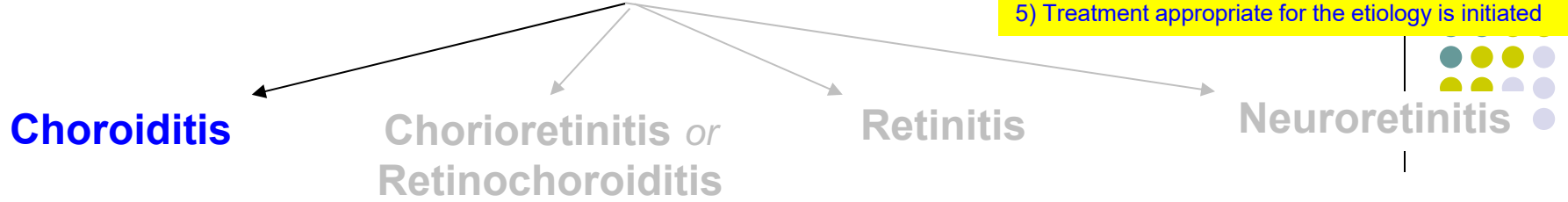
*Foreshadowing alert payoff!*

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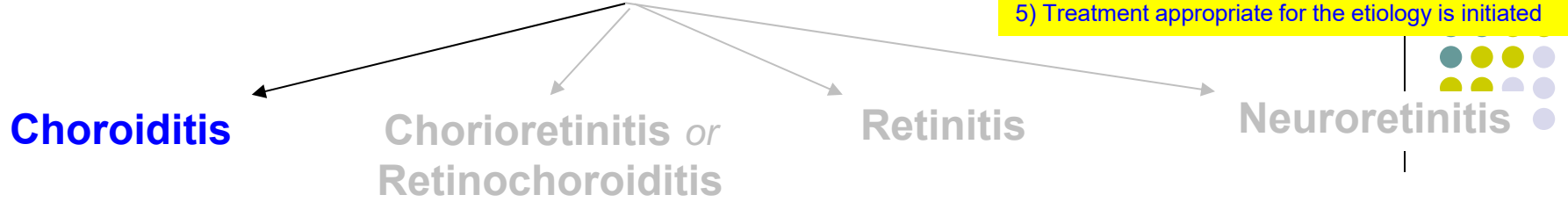
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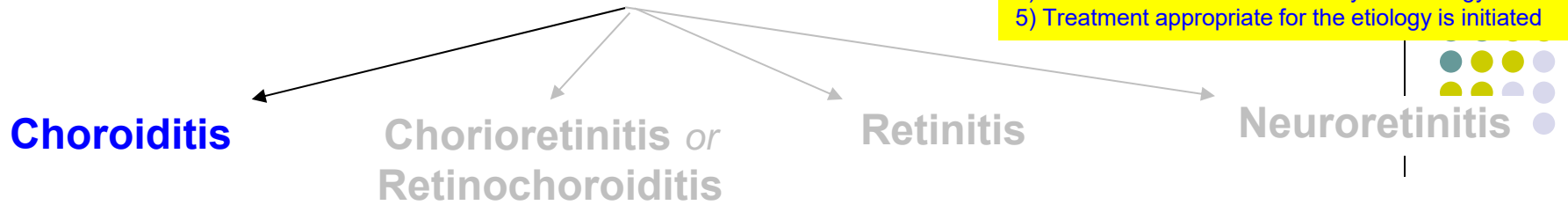
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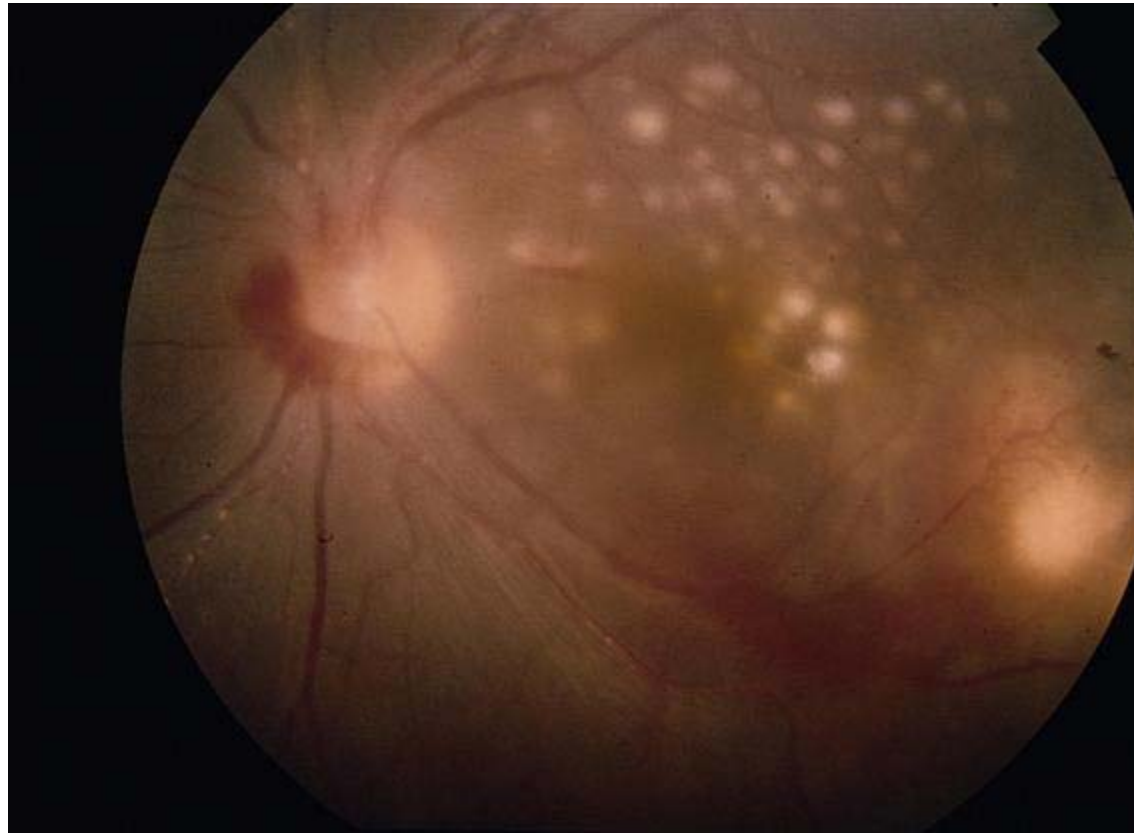
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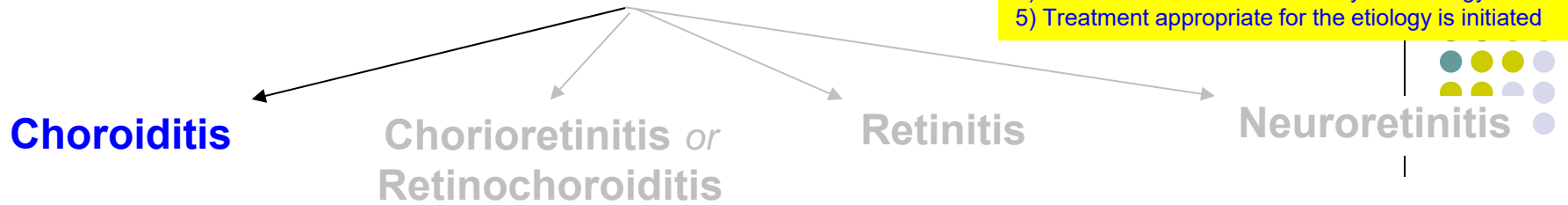


Choroidal tubercles



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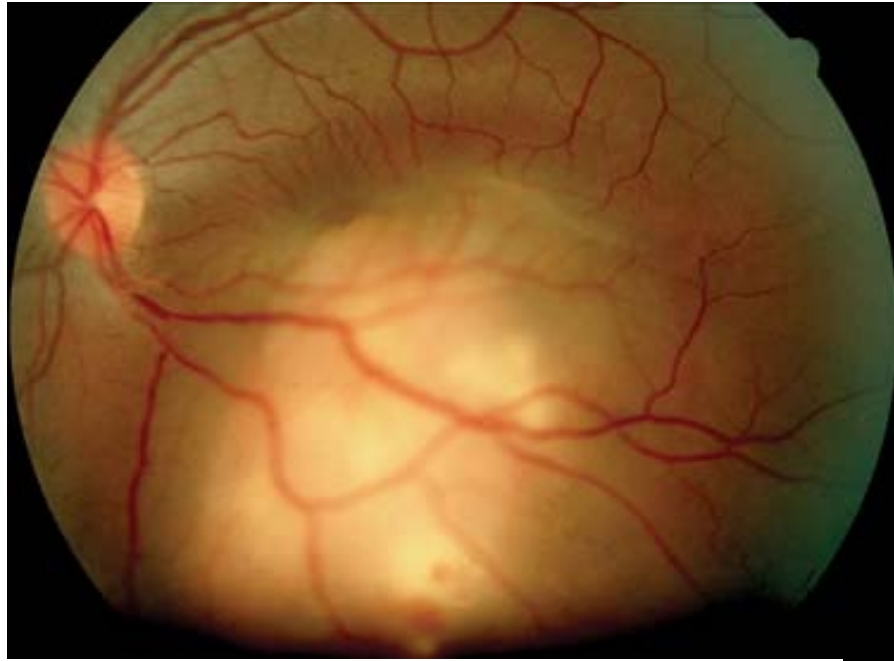
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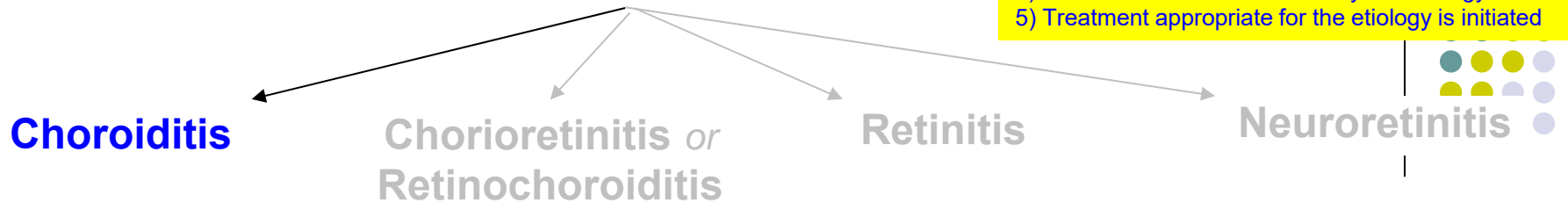
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TB choroiditis: Single large tubercle pre- and post-tx

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Chorioretinitis *or*  
Retinochoroiditis

Retinitis

Neuroretinitis



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Yes; retinal hemorrhages, edema (sometimes in the form of a macular star), and/or serous RD can result.

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Macular star 2ndry to TB chorioretinitis



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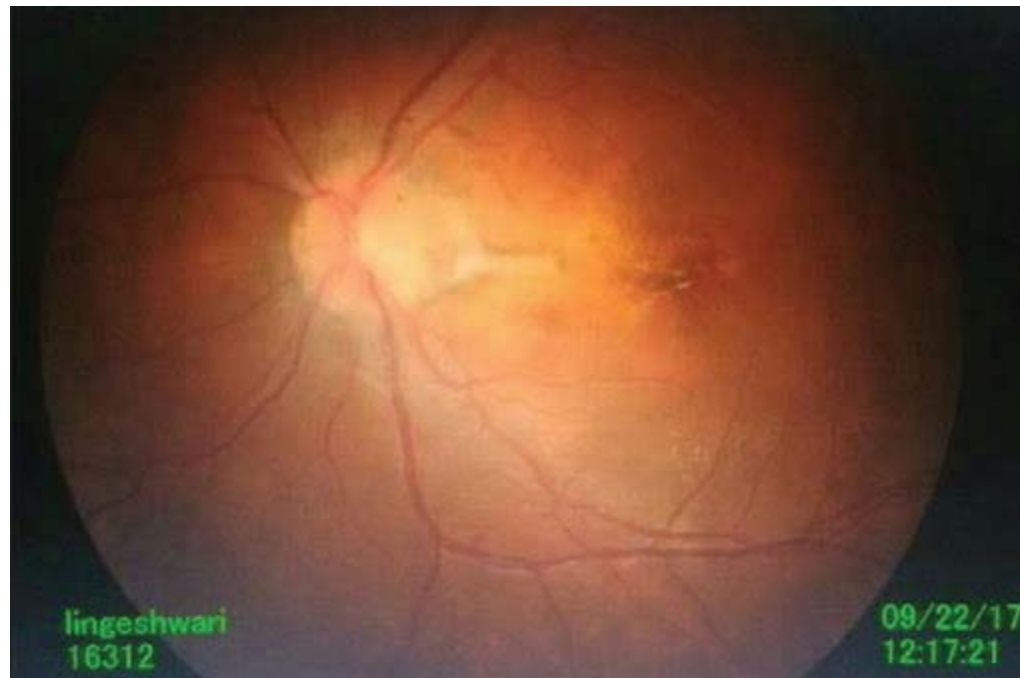
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*Can the ONH be affected?*

Yes; disc edema is a common occurrence

# Uveitis: *TB*



Dis edema in TB

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**So, TB can present as a neuroretinitis**

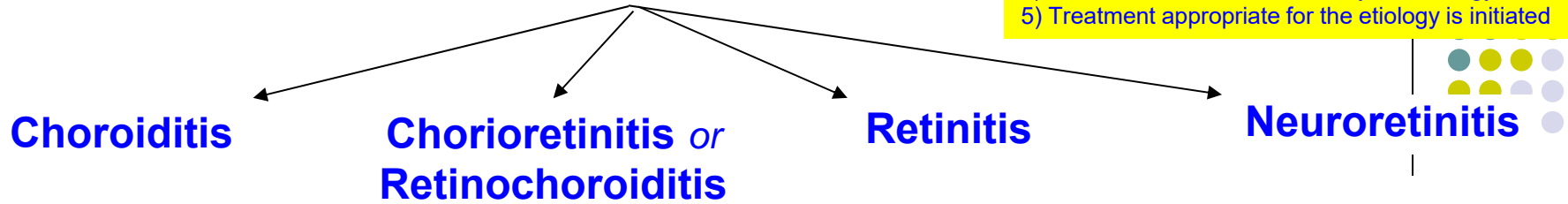
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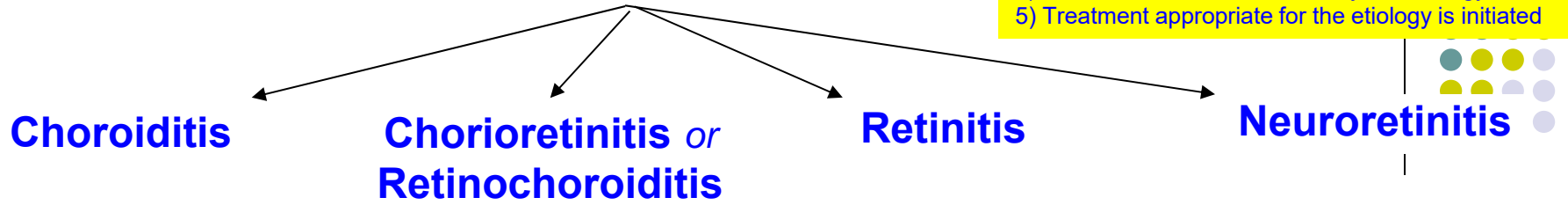
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*There is another classic posterior manifestation that involves the retina. What is its eponymous name?*

# Uveitis: *Posterior*

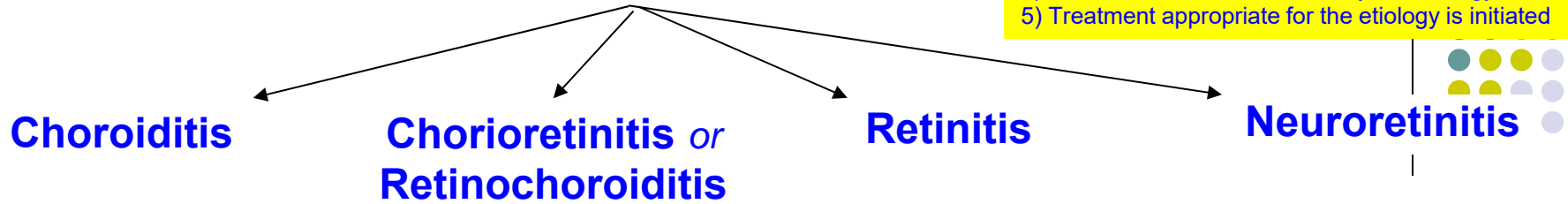
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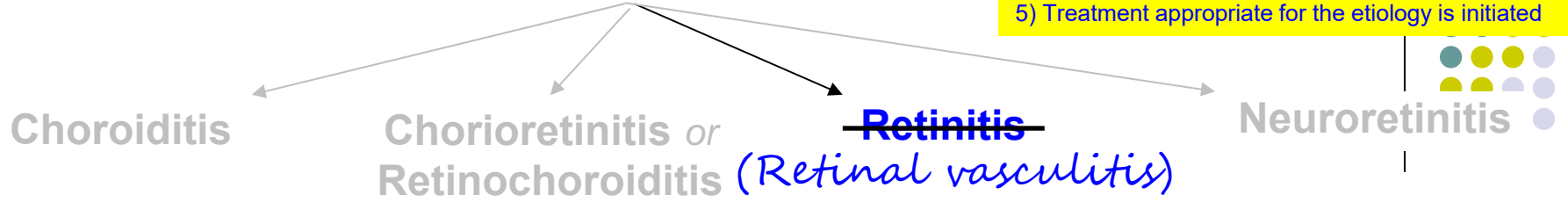


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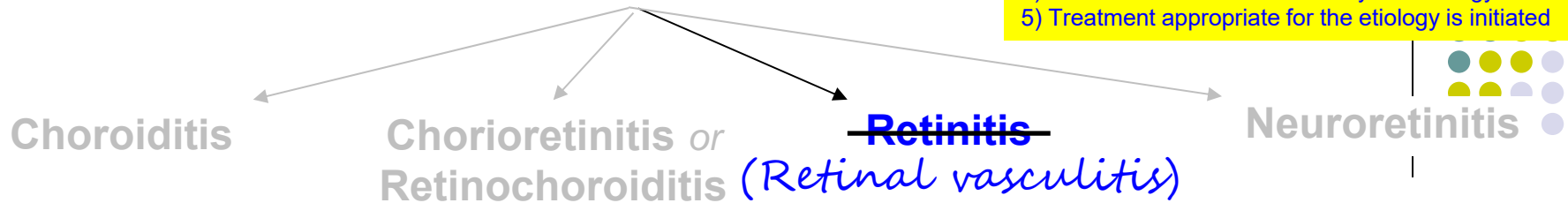
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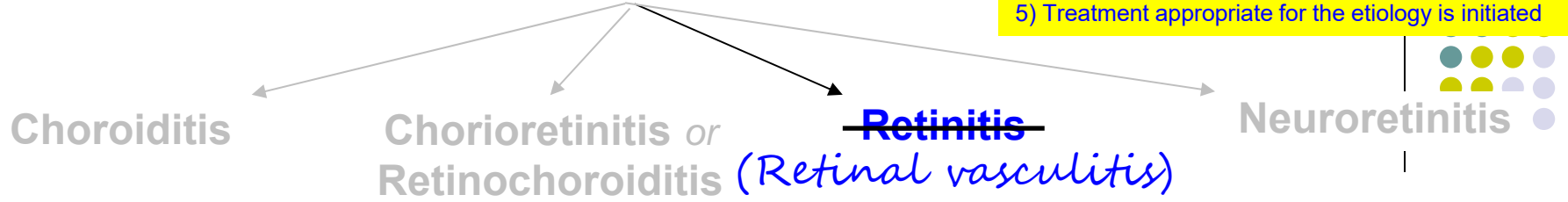
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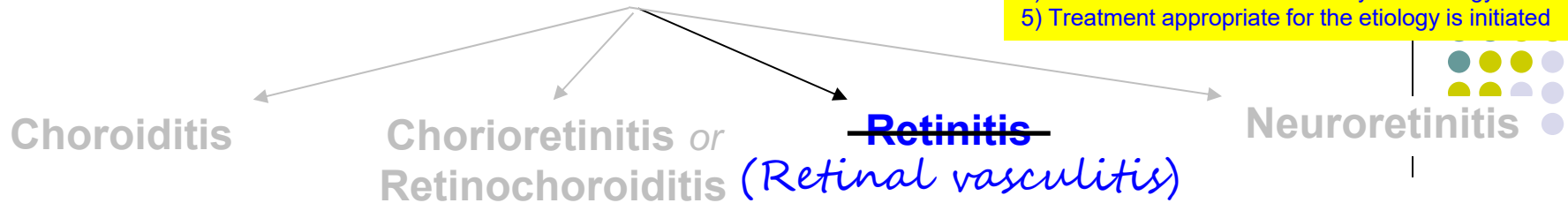
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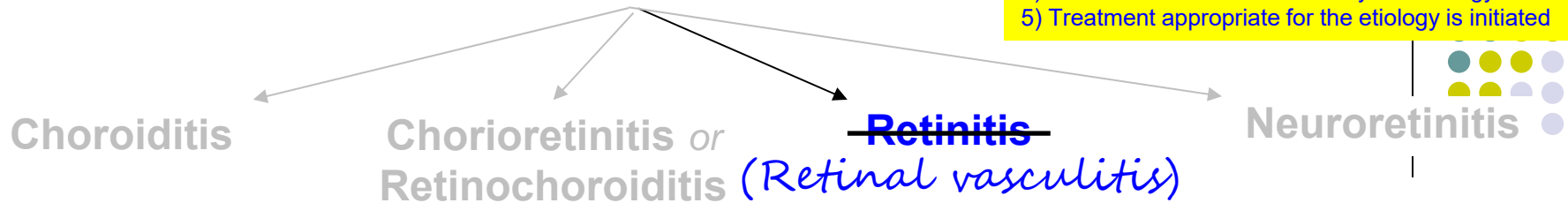
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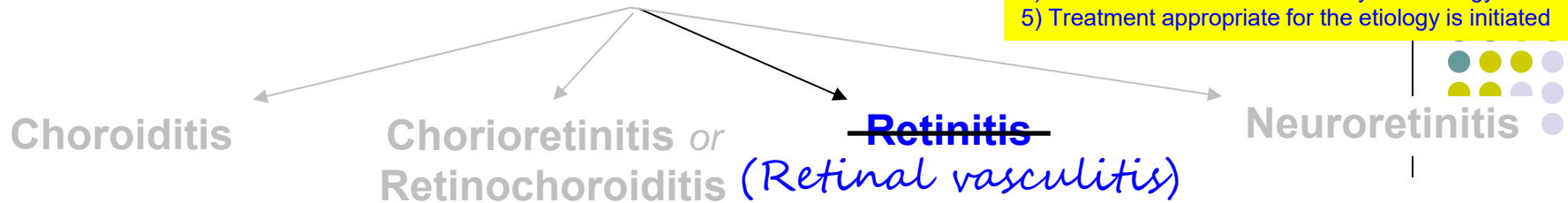
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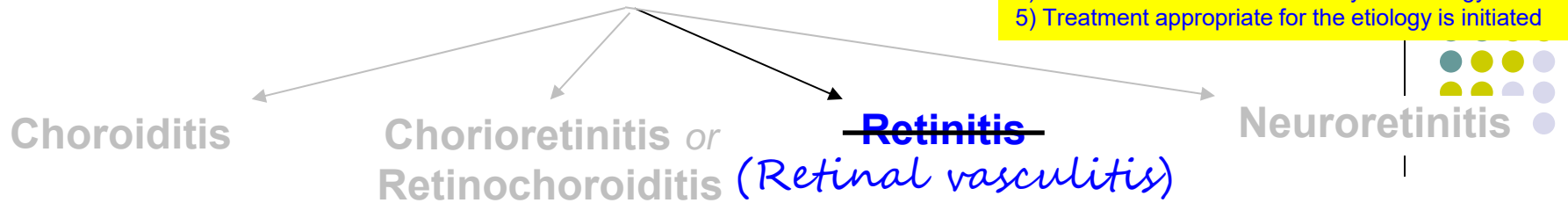
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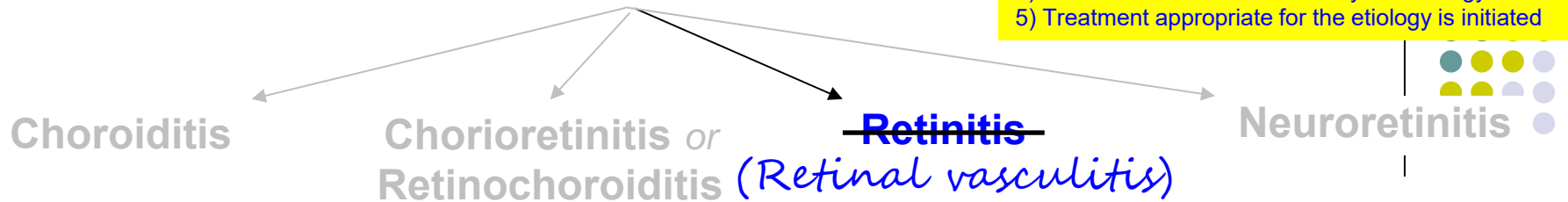
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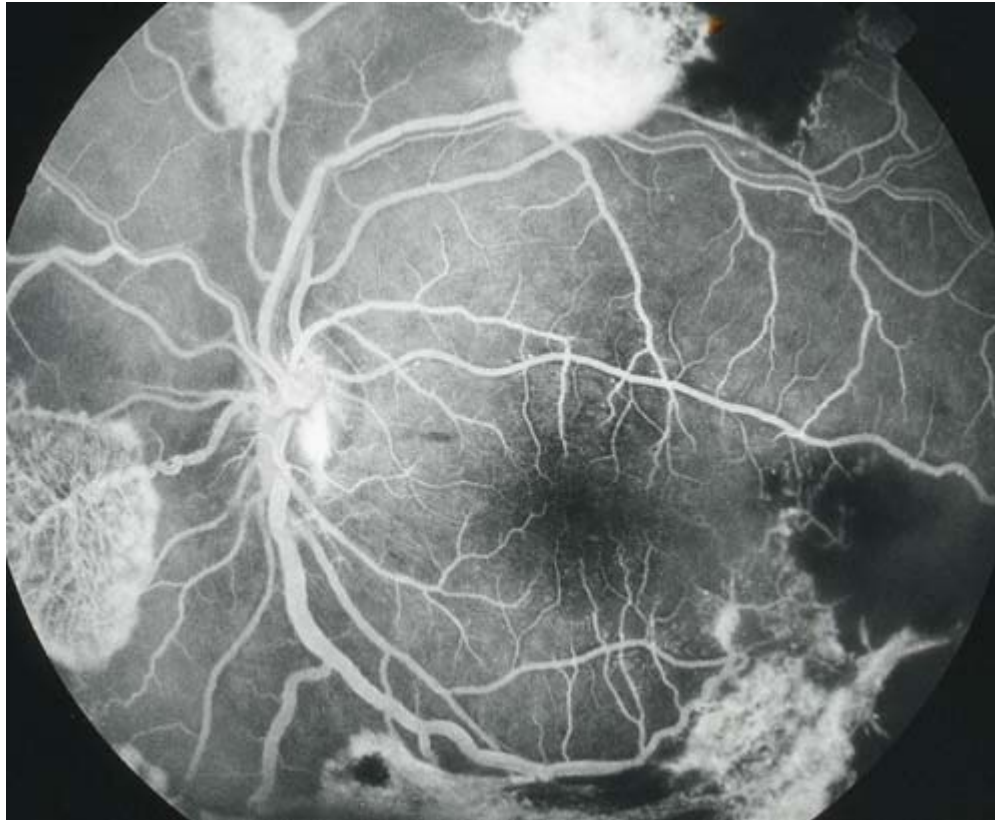
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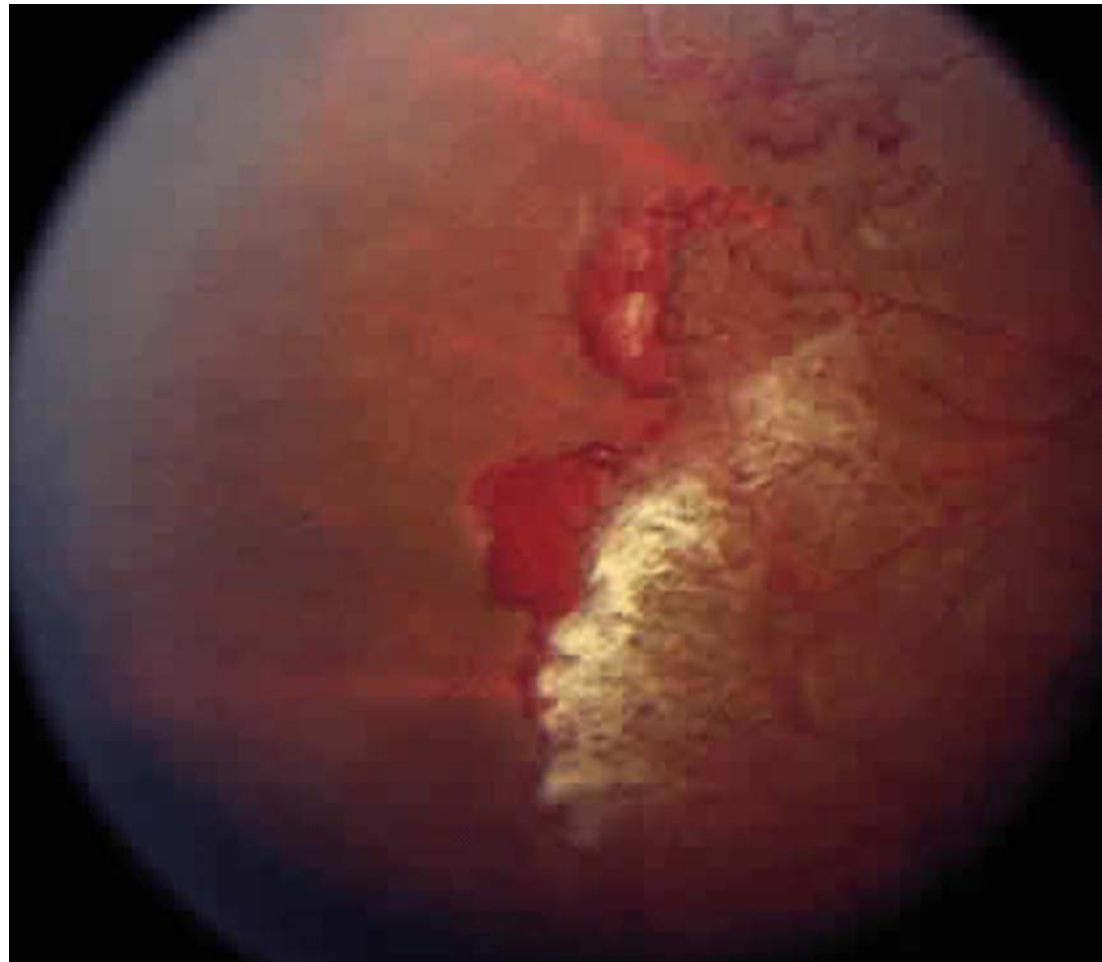
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*How does Eales dz present?*  
As a peripheral vascular occlusive disease with retinal hemorrhages. In time, retinal nonperfusion can lead to neovascularization and tractional RD

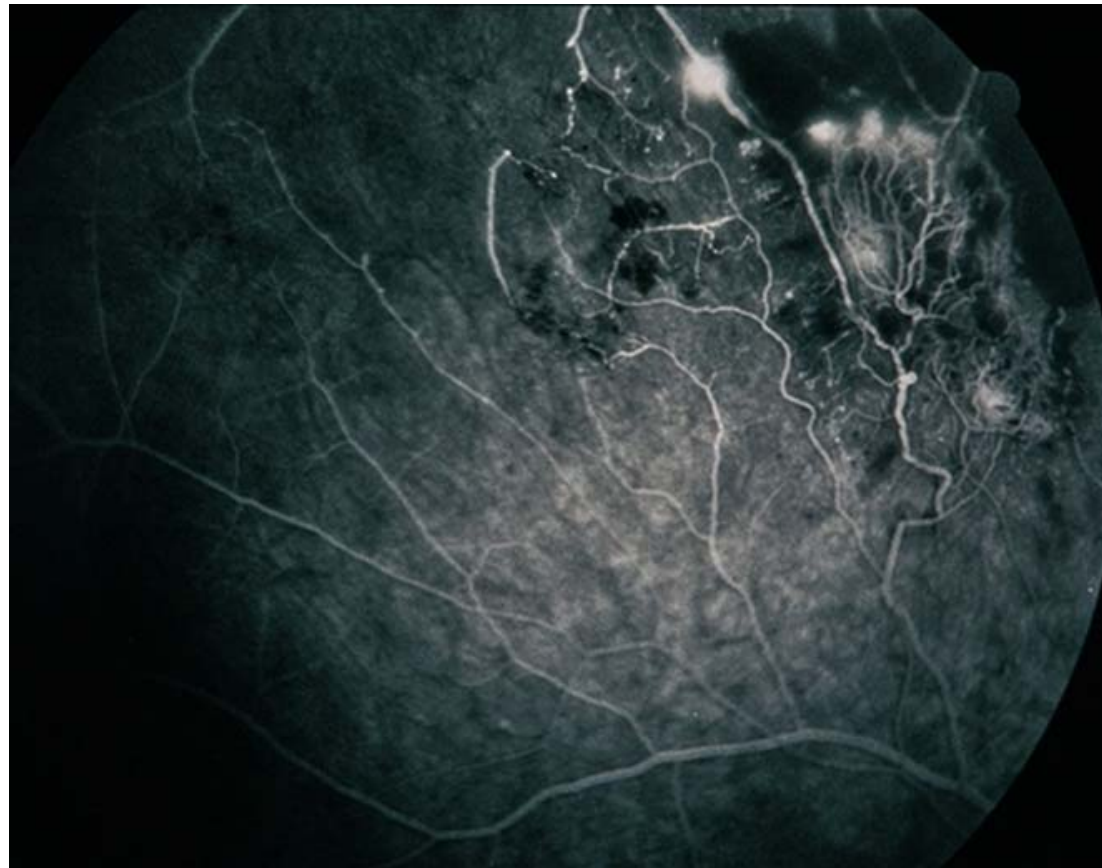


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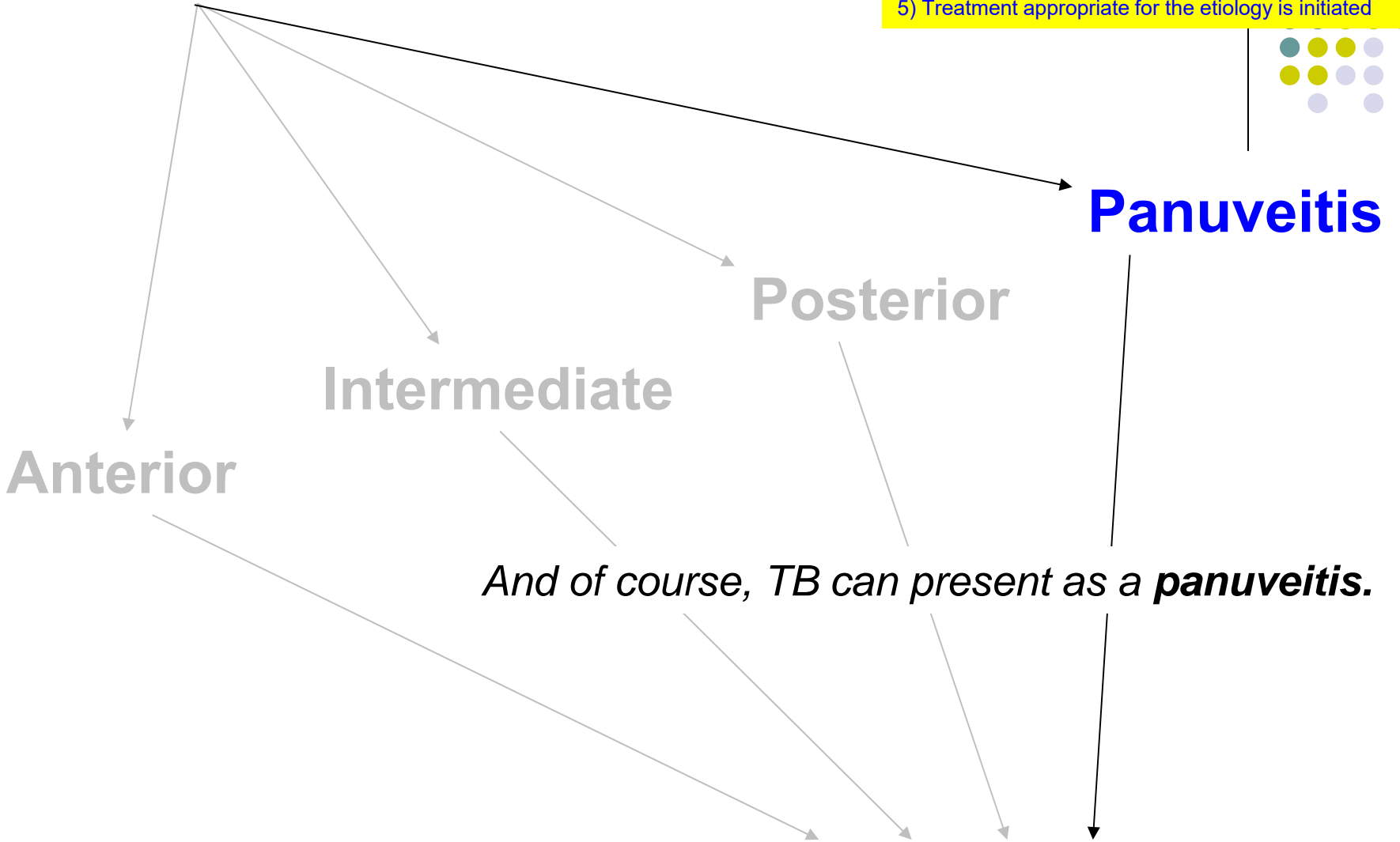
### Posterior

### Intermediate

### Anterior

*And of course, TB can present as a **panuveitis**.*

## Tuberculosis



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*Note that the characteristics that increase the risk of a false-negative PPD are the same as those that put someone at risk of having TB in the first place!*

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- Being immunosuppressed
- Advanced disease
- Marginal infection
- 

*Given a high index of suspicion and a positive PPD, the uveitis-managing clinician should proceed by searching for further evidence of systemic infection via:*

or other

- Under what circumstances?
- Pts exposed to TB
- Pts infected with TB

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*How is the diagnosis of TB made?*

Definitively, only via observation of the organism on a specimen. More commonly, the diagnosis is made presumptively on other, indirect evidence.

*What 'presumptive evidence' tests are commonly employed?*

- PPD
- QuantiFERON Gold

*Does a positive PPD and/or QuantiFERON test prove the pt has active TB?*

No--it only proves they have been infected by/exposed to it

*The PPD has a high false-negative rate. What characteristics put a TB-positive individual at risk for a false-negative PPD?*

- Being immunosuppressed or other
  - Advanced disease
  - Marginal disease
- Given a high index of suspicion and a positive PPD, the uveitis-managing clinician should proceed by searching for further evidence of systemic infection via:*
- Chest imaging
  - PET scanning
  - Culture and staining of sputum, urine, and gastric samples
  - Lymph node biopsy for microbiologic analysis

*Under what circumstances should PPD testing be employed?*

- Pts exposed to TB
- Pts infected with TB

*Given the vagaries of PPD testing, how should it be employed in a low-prevalence country like the US?*

Thoughtfully; ie, only in those cases where the clinical index of suspicion is fairly high

# Uveitis: *TB*

## Diagnosis

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- 2) The profiled case is meshed
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*Under what circumstances should the clinician consider the following?*

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  - Pts infected with TB
- If all of the above are negative, what should the uveitis-managing clinician do next?*

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*Under what circumstances should the uveitis-managing clinician consider aqueous, vitreous or even chorioretinal sampling for microbiologic analysis?*

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*What two overarching principles guide TB treatment?*

- Multidrug regimen is employed
- Directly-observed therapy (DOT) is utilized

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In a word, resistance. There is already widespread resistance to isoniazid (INH); in some locales, TB is resistant to several agents. Multidrug regimens reduce the risk of development of further resistance.

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Again, because of resistance. One of the chief causes of resistance is noncompliance with the long-term treatment regimen needed to eradicate the exceedingly slow-growing *M. tuberculosis*. DOT is intended to ensure compliance.

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INH, rifampin and pyrazinamide for 6-9 months. Additional agents are included if the TB strain is drug-resistant.

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