Uveitis by *Mycoplasma pneumoniae* in Tenerife, Canary Islands: Report of Two Cases

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Abstract

**Purpose:** In this study, two cases of uveitis due to *Mycoplasma pneumoniae* (MP) are described including the clinical and therapeutic management of both affected patients.

**Methods:** Retrospective study of two cases of uveitis by MP from a uveitis unit in a University Hospital in Tenerife, Canary Islands, Spain. Two female patients of 46 and 49 years old respectively were admitted to the Canary Islands University Hospital Ophthalmology unit due to the manifestation of acute anterior uveitis, intermediate uveitis and papillitis in their left eyes showing resistance to topical treatment with steroids. Both patients reported to suffer acute pharyngitis that healed without any prescribed treatment a week before admission.

**Results:** A systemic study was carried out showing IgG and IgM levels against *Mycoplasma pneumoniae* and thus therapy was started. Both patients recovered after treatment with doxycycline and prednisone, without recurrence after a year follow-up.

**Conclusions:** Mycoplasma pneumoniae is a pathogen capable of producing atypical pneumonia that occasionally manifests by ocular involvement such as uveitis, optic neuritis or papillitis. In the reported cases in this study, positive levels of antibodies levels and previous history of prior infection was able to lead us to a diagnosis and recovering of both patients after treatment.

Keywords: *Mycoplasma pneumoniae*, Uveitis; Optic neuritis; Papillitis

Introduction

*Mycoplasma pneumoniae* (MP) is a pathogen capable of producing the so-called atypical pneumonia, which is a type of pneumonia with an overall prevalence of 22.7% [1]. It is also a causative agent of acute pharyngitis [2]. Extrapulmonary manifestation of this disease has been reported for years and it is often related to neurological complications even fatal encephalitis [3]. Other neurological manifestations of MP include meningitis, poliaridculitis, cerebellar ataxia, myelitis, and Guillain-Barre syndrome as well as haematological disorders such as leukocytoclastic vasculitis or mono or polyarthritis [4,5]. Furthermore, ocular disorders associated to MP have been also reported such as conjunctivitis, anterior uveitis, optic neuropathy, paralysis of the third or sixth cranial nerve, homonymous hemianopia and nystagmus [6]. Interestingly, most of the previously MP reported cases showing extrapulmonary involvement have presented symptoms of respiratory tract infection [7]. Even though, the pathogenic mechanisms involved in this manifestations have not been elucidated although direct invasion, immune system mechanisms, vascular damage and toxic effects due to hypercoagulability have been postulated as possible pathways.

Methods and Case Reports

In this work, a retrospective study of two unusual cases of optic neuritis and posterior uveitis induced by MP in two patients who were admitted at ophthalmology unit of the University Hospital of the Canary Islands (HUC), Tenerife, Canary Islands is presented.

Case 1

A 49 year-old female patient referred to the ophthalmology unit for evaluation of a case of acute anterior uveitis in the left eye and was under treatment by topical prednisone. A week before admission, the patient reported to suffer acute pharyngitis that healed without any prescribed treatment. The patient referred a personal history of allergy to NSAIDs, Arnold neuralgia and lumbar disc herniation.

At this stage, visual acuity in the right eye (RE) was 20/25 (Snellen) and 20/30 in the left eye (LE). Moreover, acute anterior uveitis was observed with Tyndall ++++ without sinuequia, with pigment deposits in the anterior anterior membrane of the lens and funduscoppy showing mild vitritis and initial papillitis without macular edema in the LE (Figure 1). Performance of fluorescein angiography in the LE, showed a stage of papillitis with early peripapillary hyperfluorescence and a start of cystic changes in the macular area by OCT (Figure 2).
Case 2

A 46-year-old female patient with a previous history of Hashimoto thyroiditis was referred to the ophthalmology unit due to a gradual loss of visual acuity. A week before admission, the patient reported to suffer sore throat that healed without treatment. At this stage, visual acuity was 20/100 in the RE and 20/70 in the LE and patient observation ended up with diagnosis of a case of posterior uveitis with multiple serous detachments located peri-papillary to the posterior pole (Figure 1 and 2). Therefore, patient was admitted for the administration of intravenous corticosteroids bolus showing a significant improvement in her condition after treatment. At this stage, uveitis due to Vogt-Koyanagi-Harada syndrome was discarded since analyses were negative to CBC, ESR, CRP, RF, C3, C4, Bartonella, Coxiella, Borrelia, Chlamydia pneumoniae, HSV-1 and 2, NMR and Mantoux. However, IgG and IgM levels for MP were 1/320 in both cases and thus patient was prescribed prednisone in decreasing doses and 100 mg of doxycycline every 24 h for a month. Examination of the patient after treatment showed improvement in visual acuity 20/25 in both LE and RE. Moreover, intrinsic motility with a slightly reactive to light bilateral mydriasis with no light-near dissociation was observed. Eye fundus showed disappearance of serous detachments, residual visual field exhibited bilateral arciform scotoma (Figure 3) and macular OCT did not displayed serous detachments (Figure 4). Two months later, MP IgM and IgG were analyzed again, being the patient negative at this stage. The patient was followed-up for a year without showing any signs of recurrence.
Figure 3: a) Case 1: perimetry performed by TOP strategy (Octopus®) showed a small residual superior arciform defect in the Left eye. b) Case 2: perimetry performed by TOP strategy (Octopus®) showing that the residual visual field exhibited bilateral arciform scotoma.
authors [15]. Additionally, it has been shown that MP induces a strong inflammatory response in macrophages derived from the Toll-like receptors 2 and 4 [16]. This fact suggests that the immune mechanism could probably be the cause of uveitis and optic neuritis in our patients. Thus, this possible immunological reaction mechanism supports the beneficial use of corticosteroids treatment if MP infection is suspected in cases of uveitis [14, 16].

In conclusion, patients reporting a previous stage of pneumonia or pharyngotonsillar involvement followed by uveitis should be checked for MP infection using antibody tittering since early treatment could improve the prognosis of these patients.

References
