CASE NOTES

SYMPATHETIC OPHTHALMITIS SIMULATING HARADA'S DISEASE*

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SINCE Harada (1926) described the syndrome bearing his name, several cases have been recorded, and more recently abundant evidence has been forthcoming to convey a relationship between Harada's disease, Vogt-Koyanagi's disease, and sympathetic ophthalmitis. They are considered on both a clinical and pathological basis to be variations of the same disorder which justifies the descriptive title of uveo-meningitis or uveo-encephalitis.

The reason for presenting this case is to illustrate the association between Harada's disease and sympathetic ophthalmitis.

Case Report

A married woman aged 56 had noticed for 6 months what she described as slight dullness of vision for near and distant objects. She was seen by an optician who noticed slight cataracts. Since then she had noticed dazzling in bright lights and quite distinct haloes. 4 weeks before attending hospital she had an attack of influenza which lasted one week, but there had been no history of headaches. The patient maintains that she has been in good health all her life.

Clinical Course

February, 1961.—The patient was seen in the out-patients' department and her refraction was as follows:

Right eye—with small correction = 6/6.

Left eye—with small correction = 6/9.

There were slight lens opacities in both eyes, particularly in the left. Ocular tension 60 mm. Hg in the right eye and 25 mm. Hg in the left. (All tensions were taken on a Schiötz tonometer, using the pre-1954 standard.)

Slit-lamp examination showed no sign of inflammation or other disorder.

Treatment.—Intensive eserine to the right eye, and eserine 1 per cent. three times daily to the left eye, also 50 mg. Daranide three times daily. 7 days later the tension in the right eye was 22 mm. Hg, and in the left eye 25 mm. Hg. An iris inclusion was performed on the right eye. The operation was uneventful but the right pupil remained dilated post-operatively for 2 weeks, in spite of the use of pilocarpine. After 2 weeks the pupil remained semi-dilated, but the tension was normal, the cornea clear, and the eye almost white and quite comfortable. 5 days later the patient was discharged from hospital, with no treatment to the right eye, but with pilocarpine 2 per cent. twice daily to the left.

Progress.—At the next visit to the out-patients' department after one week, the tension was normal in both eyes, the eyes were white and comfortable, and the visual acuity with

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correction = 6/6 part in each eye. The right pupil was still slightly dilated, so she was given 2 per cent. pilocarpine twice daily to both eyes. 9 days later she complained that for 2 or 3 days she had noticed blurring of vision in both eyes in the mornings, and she was found to have iritis in the right eye with an exudate in the anterior chamber. In the left eye there were no cells, but the iris was partly down to the lens. It was considered that she had sympathetic ophthalmitis and she was re-admitted to hospital, and treatment was instituted with oral prednisolone 10 mg. twice daily, and local homatropine 2 per cent. and prednisolone three times daily to both eyes together with hot steam bathing. After 2 or 3 days the exudate disappeared from the right eye, but she continued to have cells and a flare. After one week she had nausea and vomiting each day, for a further 6 or 7 days. At the same time she showed emotional instability, with episodes of crying and distress over minor incidents.

The tension was not raised in either eye during this period, but the vitreous became cloudy, so that the fundus details could not be seen. After 2 weeks the vitreous exudate was still present, but the cells and the flare had disappeared. It was noticed that there were extensive exudative detachments of both retinæ occupying the lower two quadrants together with swelling of the discs. Vision was reduced to hand movements in each eye, and the patient stated that blurring was particularly noticeable in the mornings, from the time of waking until 10 or 11 a.m., and that then there was improvement for the rest of the day.

Lumbar puncture gave the following results:

White blood cells—250 per c.mm.
C.S.G.—clear.
Cells—100 per cent. lymphocytes.
Excessive globulin.
Protein 130 mg. per cent.
Sugar 90 mg. per cent.
No organisms seen.

The situation remained unchanged for a further 5 or 6 days, but the tension in the left eye then rose to 70 mm. Hg, for which a full iridectomy was performed. After this the tension remained normal in both eyes, and the density of the vitreous gradually diminished. At no time was there vertigo, poliosis, or deafness, and during the period of vomiting, headache was not a conspicuous feature. The patient was discharged after 3 weeks.

One week later she was re-admitted to hospital on account of dizziness. The tension in the left eye had risen to 50 mm. Hg, so one pillar of the iris was included in the wound; tension remained in the region of 35 mm. Hg, post-operatively but since then with gutt. pilocarpine 2 per cent. three times daily it has remained at 30 mm. Hg in both eyes. The visual acuity in each eye with correction is 6/60. The eyes are white and comfortable and there are no general symptoms.

This case illustrates the clinical features of Harada's disease which was preceded by a form of trauma, namely an iris inclusion. The fact that an operation was performed supports the diagnosis of sympathetic ophthalmitis, which in this instance mainly involved the posterior segments of both eyes and was associated with general reactions. While it must be unusual or even rare for sympathetic ophthalmitis to manifest itself in this way, Yuge (1957) has mentioned that it may present as Harada's or Vogt-Koyanagi's disease and the essential difference between sympathetic ophthalmitis on the one hand and Vogt-Koyanagi's and Harada's disease on the other is

the presence of injury in the former and the absence of injury in the latter. Swartz (1955) agreed with Cowper (1951) that sympathetic ophthalmitis and Vogt-Koyanagi's and Harada's diseases are basically the same entity and of the same aetiology, although Hager (1957) suggested a virus to be a common cause, the entry being either directly through a wound or *via* the blood stream from the respiratory or intestinal systems.

A feature of interest in the clinical course is the complaint of blurring in the mornings. This could not be attributed to any particular cause; there was no rise in the tension and no change in the fundus appearance. Cordes (1955) mentions a similar condition in his case report of a Japanese woman who noticed blurred vision in the mornings for 4 days.

Skin reactions associated with Harada's disease (vitiligo, alopecia, and poliosis) have not appeared so far, but these features may be delayed for 9 months (Cowper) and seldom appear before one month. There has been slight deafness but no tinnitus.

So far the disease has run a protracted course complicated by glaucoma in both eyes, and the ultimate outlook is uncertain; there is no evidence of active uveitis but the vision is still defective from persistent vitreous haze and retinal changes. Glaucoma is the main hazard as it has been incompletely controlled by medical means and further operative procedures to the right eye might excite an undesirable reaction; however, there is no cupping of the discs and vision does not seem to be suffering from this cause.

The prognosis in Harada's disease would appear to be variable (Sudarsky, 1959). In this instance immediate change for the better or for the worse is not expected, and in the course of time there may be a growing threat from secondary cataract and glaucoma.

Summary

A patient developed signs and symptoms of Harada's disease after an iris inclusion. The cerebrospinal fluid showed some evidence of meningeal irritation.

The relationship with sympathetic ophthalmitis is discussed and attention is drawn to the clinical feature of blurred vision in the mornings.

REFERENCES

- BRONSTEIN, M. (1957). *A.M.A. Arch. Ophthalm.*, **57**, 503.
 BRUNO, M. G., and MCPHERSON, S. D. (1949). *Amer. J. Ophthalm.*, **32**, 513.
 CASEY, T. A., and SAMMAN, P. D. (1960). *Proc. roy. Soc. Med.*, **53**, 963.
 CORCELLE, L. (1947). *Brit. J. Ophthalm.*, **31**, 366.
 CORDES, F. C. (1955). *Amer. J. Ophthalm.*, **39**, 499.
 COWPER, A. R. (1951). *A.M.A. Arch. Ophthalm.*, **45**, 367.
 GITTNER, R. (1949). *Klin. Mbl. Augenheilk.*, **115**, 333.
 HAGER, G. (1957). *Ibid.*, **131**, 89.
 HARADA (1926). *Nipp. Gank. Zass.*, **30**, 356. (Cited by Gittler, 1949).
 SUDARSKY, R. D. (1959). *A.M.A. Arch. Ophthalm.*, **62**, 5.
 SWARTZ, E. A. (1955). *Amer. J. Ophthalm.*, **39**, 488.
 YUGE, T. (1957). *Ibid.*, **43**, 735.