Vogt-Koyanagi-Harada disease during pregnancy

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Patients with Vogt-Koyanagi-Harada disease (VKH) usually receive treatment with high doses of systemic corticosteroids.¹ Steroid treatment in early stage of pregnancy can precipitate spontaneous abortions and fetal abnormalities. The case of a woman with VKH during pregnancy who recovered successfully without the use of either systemic or topical corticosteroids is described.

Case report

A 24-year-old Japanese woman was first examined in her 12th week of pregnancy for a complaint of blurred vision in both eyes accompanied by headache and hearing loss. Her visual acuity was 6/10 right eye and 6/12 left eye. She had 1+ cells and flare in both anterior chambers. Serous retinal detachment involved the macular areas of both eyes (Fig 1). Intraocular pressure was 20 mm Hg in each eye. General physical and neurological examinations revealed no abnormalities, and blood pressure was 110/72 mm Hg. The pregnancy progressed normally and she had no toxæmia of pregnancy. The results of blood cell counts, chemical examinations, and serum electrophoresis were normal. The serum levels of the female hormones were high as is typical in many normal pregnant women, and other hormones were within the normal ranges.

The diagnosis of VKH was confirmed on the basis of the typical ocular findings and above mentioned clinical signs. She was treated with neither systemic nor topical corticosteroids under close observation.

Fundusoscopic findings at 5 days after disease

onset remained unchanged in the right eye, but macular oedema of the left eye had developed and visual acuity worsened to 6/200. Her blood pressure was 108/70 mm Hg. Although serous retinal detachment could occur in severe hypertension, this patient's blood pressure was within the normal range throughout her course. Two weeks later, the visual acuity improved to 6/9 in each eye. Disseminated yellow-white nodules were seen in the subretinal regions (Dalén-Fuchs) (Fig 2). On the 26th day, the anterior chambers were clear and the serous retinal detachment had completely disappeared; the visual acuity was 6/6 right eye and 6/7 left eye. The uveitis has not recurred since the delivery of a normal baby.

Comment

Cellular immune responses to self systemic melanocytes are supposed to play an important immunopathological role in VKH. On the other hand, cellular immunity was reported to be depressed during pregnancy. The relation between autoimmune diseases and pregnancy deals with the mutual influence of these diseases or pregnant patients; however, immunological influence of pregnancy on VKH has not been clarified yet.

The previous cases²⁻⁵ of VKH during pregnancy can be classified into two patterns of prognosis. In some cases, patients with VKH became pregnant and their ophthalmic findings improved during pregnancy in spite of tapering of systemic corticosteroids.^{2,3} However, VKH recurrence developed after delivery. In other cases, VKH developed in already pregnant women who were completely cured by the treatment with systemic or topical corticosteroids without post-delivery recur-

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Figure 1 Right eye. Serous retinal detachment is seen to involve the disc and macular areas.

Figure 2 Left eye. Two weeks later, there was a decrease in serous retinal detachment and disseminated yellow-white nodules were seen in the subretinal regions (Dalén-Fuchs).

rence.^{4,5} Because the results reported by several authors cannot be equally compared because of differences in their detailed records of courses of diseases, it is hard to select a unique factor affecting the ophthalmic findings in these patients.

Recently, massive corticosteroid treatment of VKH was clinically reinvestigated.⁶ Yamamoto *et al*⁶ found a similarity in the prognosis of patients treated with non-steroidal anti-inflammatory agents and those treated with massive doses of systemic corticosteroids. Therefore, it was difficult to determine if the remission of the disease during pregnancy in our patient was spontaneous or due to the pregnancy.

Although a good clinical result has been

obtained without the systemic administration of high doses of corticosteroids or topical corticosteroids on the basis of careful examinations of a patient with VKH in early pregnancy, further discussions will be required about its treatment during pregnancy.

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Fatal bilateral necrotising fasciitis of the eyelids

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Necrotising fasciitis is an uncommon soft tissue infection usually affecting the trunk, perineum, or legs after surgery or trauma. Infection spreads rapidly along subcutaneous fascial planes and produces overlying skin necrosis. Head and neck involvement is rare, with scalp and neck fasciitis almost always after trauma or dental sepsis. Midfacial and peri-orbital infection is notable in that a history of trauma may be absent or such trauma may be minor. We report a fatal case of bilateral necrotising fasciitis of the eyelids with no history of preceding trauma in which *Streptococcus pyogenes* (β haemolytic streptococcus

Lancefield group A) was cultured from the eyelids, blood, and throat.

Case report

A 40-year-old man with a history of alcoholic liver disease presented with a 24 hour history of increasing bilateral painful periocular and facial swelling. On examination he was afebrile, mildly jaundiced with ascites and hepatomegaly. The lid skin was markedly swollen with a small patch of dusky skin on the right lower lid. Intravenous benzylpenicillin and flucloxacillin were commenced and the facial swelling began to subside over the next 24 hours so the eyes could be opened revealing normal globes. However, within 48 hours the lid skin became dusky, and progressed to frank lid gangrene (Fig 1). Investigations revealed anaemia (haemoglobin 9.7 g/dl), a white blood count of $8.2 \times 10^9/l$, thrombocytopenia ($82 \times 10^9/l$) and an abnormal clotting screen (INR 2.4). *Streptococcus pyogenes*, sensitive to penicillin and erythromycin, was isolated from the cultures of the eyelids, blood, and throat. A diagnosis of necrotising fasciitis was made. Clinically the patient began to deteriorate and surgical debridement was delayed until 7 days after presentation. Under local anaesthesia all necrotic periorbital skin and subcutaneous tissue were debrided revealing healthy orbicularis muscle beneath (Fig 2). However, renal and circulatory failure developed and, despite intensive supportive measures, he died 15 days after his admission.

Figure 1 Severe bilateral gangrene of the periorbital skin and subcutaneous tissue.