

A toxic effect of Baerveldt GDI, which could lead to the alteration in pigmentation, has not been considered because the patient received a bilateral GDI placement. The presence of a serous-haemorrhagic choroidal detachment should be considered after unexplainable iris colour change and looked for with an echographic evaluation especially to detect the peripheral and flat forms.

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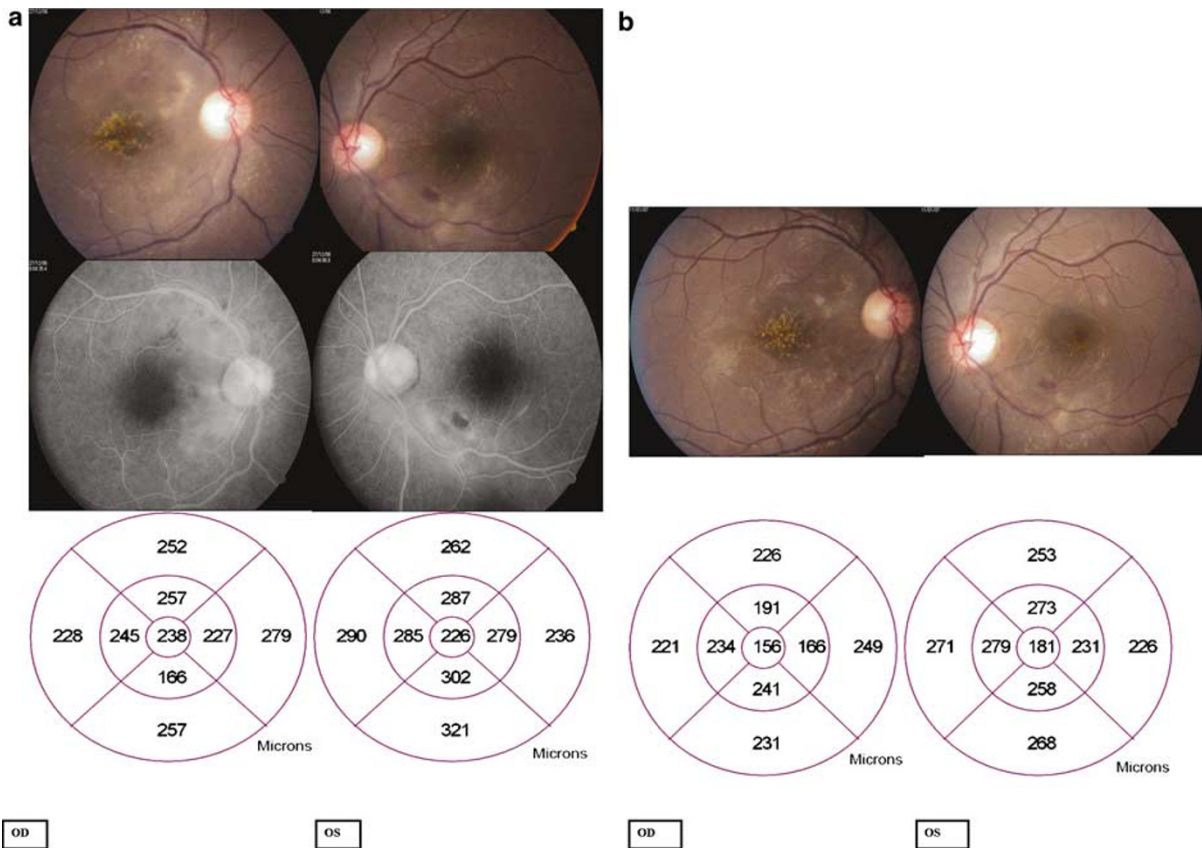
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Sir,  
**Bilateral macular choroiditis following Chikungunya virus infection**

Chikungunya virus, transmitted by Aedes mosquito, is known to cause a self-limiting febrile illness. We present a case of macular choroiditis following Chikungunya infection. We are unaware of such finding in world literature.

**Case report**

A 16-year-old male patient presented with complaint of decreased vision bilaterally for 1-month duration. The



**Figure 1** (a) Fundus photograph (top) and fluorescein angiography (middle) showing areas of active choroiditis bilaterally. OCT (bottom) reveals macular edema. (b) Post-treatment fundus photograph and OCT showing resolving choroiditis and macular edema.

patient had a history of acute fever associated with pain in the knees 2 months before. He was diagnosed to have Chikungunya based on positive ELISA IgM titres.

The best-corrected visual acuity (BCVA) was 20/400 OD and 20/40 OS. Slit lamp biomicroscopy revealed mild anterior chamber inflammation with the absence of keratic precipitates and 5–10 retrolenticular cells in the right eye. The intraocular pressure was 16 mmHg bilaterally. Fundus examination showed macular choroiditis with submacular exudates bilaterally. The lesions on fluorescein angiography showed early hypofluorescence with late leakage of dye. The central macular thickness (CMT) measured on optical coherence tomography (OCT) was 238  $\mu$  OD and 226  $\mu$  OS (Figure 1a).

Laboratory investigations showed haemoglobin of 14.4 g/dl, leucocyte count of 14 600/mm<sup>3</sup>, platelet counts of 330 000/mm<sup>3</sup>, and ESR of 3 mm. Serum calcium was 8.7 mg/dl. VDRL for syphilis and ELISA for HIV were negative. Chest X-ray was normal.

The patient was started with oral prednisolone 1 mg/kg. In 2 weeks, BCVA improved to 20/120 OD and 20/30 OS. Fundus showed evidence of resolving choroiditis bilaterally. CMT decreased to 156  $\mu$  OD and 181  $\mu$  OS (Figure 1b). Inflammation resolved within 6 weeks of treatment but the vision did not improve further.

#### Comment

Chikungunya infection is an acute febrile illness that develops 4–7 days after the infecting bite. Symptoms include headache, arthralgia, myalgia, a diffuse maculopapular rash, and rarely haemorrhagic signs.<sup>1</sup> The temperature subsides within 6–7 days.

After 20 years, an epidemic of Chikungunya has been reported in India and in several islands in the Indian Ocean. Many complications and deaths have been reported in the current outbreak.<sup>2</sup> The increased virulence has been attributed to absence of herd immunity as well as the possible emergence of a new strain.<sup>3,4</sup> Also a new genotype with an A226V mutation in the membrane fusion glycoprotein E1 has been

reported, enabling the virus to survive better in mosquito species.<sup>4</sup>

In this case, other conditions like primary HIV infection, tuberculosis, sarcoidosis, and syphilis that could be associated with such a clinical picture were ruled out. Cases of meningoencephalitis have also been reported during the recent epidemic, and hence posterior segment involvement could also be attributed to this new virulent strain. Infective endothelitis has been postulated as a possible mechanism for viral choroiditis.<sup>5</sup>

The only known ocular complication of Chikungunya is conjunctivitis; hence the development of posterior uveitis may be a matter of concern considering the widespread outbreak of the infection.

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