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Sir,

Bilateral hypopyon and vitritis associated with rifabutin therapy in an immunocompetent patient taking itraconazole

Uveitis is a rare complication of rifabutin therapy when given in conjunction with fluconazole and clarithromycin in patients with mycobacterium avium complex infection.[1,2,3] Typically, these patients are immunocompromised and present with anterior uveitis, hypopyon, and occasionally, vitritis.[4] The pathophysiology of this condition is unknown. We describe a case of bilateral, sequential rifabutin-associated uveitis (RAU) with severe vitritis in an immunocompetent patient taking rifabutin, itraconazole, and clarithromycin.

Case report

A 73-year-old man with chronic obstructive pulmonary disease complicated by mycobacterium avium complex infection and aspergillosis presented with painless, blurred vision OD. Current drugs included clarithromycin 500 mg b.d., rifabutin 300 mg o.d., and itraconazole 200 mg. These drugs were started at the beginning of November 2006.

BCVA was CF OD, 6/6 OS. There was 1 mm hypopyon, fine keratitic precipitates, and severe vitritis. Retinal detail was not visible. The left eye was unremarkable. Endogenous endophthalmitis was suspected and vitreous biopsy with intravitreal voriconazole 100 mcg/0.1 ml and ceftazidine 2 mg/0.1 ml were performed. Postoperative drops were prednisolone 1% q.d.s. and cyclopentolate 1% b.d. No organisms were seen on microscopy or culture. BCVA improved from CF to 6/6 over 8 weeks. All signs of inflammation resolved. There was no evidence of any retinal or choroidal inflammation at any stage.

One day following discharge, the patient presented with an identical history and findings in the left eye as in the right eye and was managed in the same way. The outcome was the same.

Considering the history, a retrospective diagnosis of RAU was made.

Plasma rifabutin levels were elevated (Predose level 0.16 mg/l, 3-h postdose levels 0.44 mg/l and 0.73 mg/l on two separate occasions). Autoimmune markers were negative. Rifabutin and itraconazole administrations were discontinued. There was no recurrence of uveitis at 6 months.

Comment

RAU is well recognised in immunocompromised patients taking fluconazole and clarithromycin, but unusual in an immunocompetent patient taking itraconazole and clarithromycin. RAU responds well to topical steroids and/or cessation of rifabutin therapy. RAU should be considered in immunocompetent as well as immunocompromised patients with an appropriate pharmacological history. Itraconazole as well as fluconazole can be a predisposing feature in this condition.

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Sir,

UBM study in spontaneous bleb formation and blebitis after cataract surgery in Werner syndrome

Werner syndrome is a rare disorder characterized by premature ageing. It is associated with bilateral cataract. Impaired wound healing is a feature of this syndrome.[1]

We reported a female who had presented with this rare disorder and undertook lensectomy and subsequent bleb formation and blebitis several years later. Ultrasound biomicroscopy (UBM) was carried out to evaluate the aetiology of bleb formation.