

9.10.5. Ocular Involvement in AIDS (II)

Multifocal Choroiditis and Systemic Dissemination

- multifocal choroidal lesions from a variety of infectious agents are found in up to 10% of patients with AIDS
- most common organisms:
 - C neoformans
 - P jiroveci
 - M tuberculosis
 - atypical mycobacteria
- multiple infectious agents may cause simultaneous infectious multifocal choroiditis
- choroid is a site of opportunistic disseminated infections and thus needs to be carefully examined
- multifocal choroiditis is frequently a sign of disseminated infection

Ocular Adnexal Kaposi Sarcoma

- human herpesvirus 8
- before availability of potent antiretroviral therapy:
 - prevalent in Kenya and Nigeria (endemic)
 - in renal transplant recipients (epidemic)
 - in patients with AIDS (epidemic)
- 2 aggressive variants:
 - skin lesions
 - visceral organs (the gastrointestinal tract, lung, and liver) (≤50% of patients)
- ocular adnexal involvement occurs in ~20% of AIDS-associated systemic Kaposi sarcoma
- clinical presentation:
 - Figure 11-5 (© 2020 American Academy of Ophthalmology)
- histology: spindle cells mixed with vascular structures
- treatment:
 - excision
 - cryotherapy
 - radiation

Syphilitic Chorioretinitis

- clinical presentation:
 - uveitis
 - optic neuritis
 - nonnecrotizing retinitis:
 - unilateral or bilateral
 - pale-yellow, placoid retinal lesions
 - preferentially involve the macula
 - syphilitic posterior placoid chorioretinitis
 - dense vitritis without clinical evidence of chorioretinitis
 - exudative retinal detachment
 - dermatologic and CNS symptoms
- treatment:
 - 18–24 million units of intravenous penicillin G/day x 10–14 days
 - followed by 2.4 million units of intramuscular benzathine penicillin G weekly x3 weeks
 - monitor for recurrence with rapid plasma reagin (RPR) test

Pneumocystis jiroveci Chorioiditis

- patients with AIDS are at much greater risk for Pneumocystis jiroveci pneumonia
- rarely can result in chorioiditis
- contain the microorganisms
- clinical presentation:
 - choroidal infiltrates:
 - slightly elevated, plaque-like, yellow-white lesions
 - minimal vitritis
- fluorescein angiography:
 - hypofluorescent in the early phase
 - hyperfluorescent in the later phase
- management:
 - infectious diseases specialist
 - intravenous trimethoprim (20 mg/kg/day) and sulfamethoxazole (100 mg/kg/day) x 3-week
 - or
 - pentamidine (4 mg/kg/day) x 3-week
 - within 3–12 weeks, most of the yellow-white lesions disappear leaving mild overlying pigmentary changes
 - vision is usually not affected

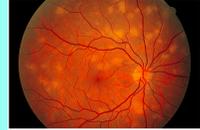


Figure 11-4 (© 2020 American Academy of Ophthalmology)

Cryptococcus neoformans Chorioiditis

- Cryptococcus neoformans
- multifocal chorioiditis:
 - solitary or multiple discrete yellow-white chorioretinal lesions
 - varying markedly in size
 - postequatorial
- some patients show choroidal lesions before clinical evidence of dissemination
- CSF infection:
 - secondary optic nerve edema as a result of increased intracranial pressure
 - optic atrophy
 - direct invasion of the optic nerve is also possible
 - more rapid vision loss
- treatment: amphotericin and flucytosine

