Pediatric unilateral Vogt Koyanagi Harada syndrome: The second case in the world

Abstract

Vogt Koyanagi Harada syndrome is a systemic autoimmune granulomatous disorder of adults that affects melanocyte-rich, pigmented tissues which contain melanin including the eye, skin, inner ear, meninges, and hair. The most characteristic feature of the syndrome is the bilateral ocular manifestations which include diffuse uveitis presenting with an acute or subacute onset of bilateral visual impairment with or without pain and redness.

Vogt Koyanagi Harada syndrome has not been documented in Iraq. The aim of this paper is to report the first patient with pediatric Vogt Koyanagi Harada syndrome who is the case number 106 and the second case with unilateral Vogt Koyanagi Harada syndrome in the world.

Keywords: ocular manifestations, Vogt Koyanagi Harada syndrome, retinal pigmentation

Introduction

Vogt Koyanagi Harada syndrome is a systemic autoimmune granulomatous disorder of adults that affects melanocyte-rich, pigmented tissues which contain melanin including the eye, skin, inner ear, meninges, and hair. The syndrome was first described by a Swiss ophthalmologist Alfred Vogt and was named after him and a other two Japanese ophthalmologists. The most characteristic feature of the syndrome is the bilateral ocular manifestations which include diffuse uveitis presenting with an acute or subacute onset of bilateral visual impairment with or without pain and redness.

In 1911, Dr. Jujiro Komoto, a Japanese professor of ophthalmology at the University of Tokyo published in a German language journal “Klinische Monatsblätter für Augenheilkunde” a paper about the condition. In, 1914, Yoshizo Koyanagi, an other Japanese doctor published a paper in the Nippon Ganka Gakkai Zasshi, but his second paper published in 1929 led to the definite association of his name with the syndrome.

In 1926, Einosuke Harada published a paper in Nippon Ganka Gakkai Zasshi included several case reports that was credited for being comprehensively described the syndrome. During the 1970s and 1980s childhood Vogt Koyanagi Harada syndrome has been increasingly recognized. Vogt Koyanagi Harada syndrome has not been documented in Iraq. The aim of this paper is to report the first patient with pediatric Vogt Koyanagi Harada syndrome who is the case number 106 and the second case with unilateral Vogt Koyanagi Harada syndrome in the world.¹

Case report

A seven-year old girl who developed uveitis manifested by unilateral loss of vision in the right eye associated with retinal pigmentation and blurring of the optic disc was observed (Figure 1).

In 1926, Einosuke Harada published a paper in Nippon Ganka Gakkai Zasshi included several case reports that was credited for being comprehensively described the syndrome. During the 1970s and 1980s childhood Vogt Koyanagi Harada syndrome has been increasingly recognized. Vogt Koyanagi Harada syndrome has not been documented in Iraq. The aim of this paper is to report the first patient with pediatric Vogt Koyanagi Harada syndrome who is the case number 106 and the second case with unilateral Vogt Koyanagi Harada syndrome in the world.¹

Figure 1 A seven-year old girl (A) who developed uveitis manifested by unilateral loss of vision in the right eye associated with retinal pigmentation and blurring of the optic disc (B,C).

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The primary pathogenesis of Vogt Koyanagi Harada syndrome is T-cell-mediated autoimmune response directed towards melanocyte or melanocyte-associated antigens causing diffuse inflammatory condition involving most parts of eye. The diagnosis is achieved mainly by clinical features.

Early treatment with systemic corticosteroids and early non-steroidal immunosuppressive drug therapy can reduce vision threatening ocular complications and lead to good visual recovery.

Treatment of Vogt Koyanagi Harada syndrome include.

a. Corticosteroids which are associated with good results in the acute and chronic phases of the disease.

b. Anti-metabolites including azathioprine, mycophenolate mofetil and methotrexate.

c. T-cell inhibitors including cyclosporine and tacrolimus.

d. Biologic agents including infliximab.

Review of the available evidence suggested that mycophenolate mofetil can provide the same therapeutic benefit, but without the development of gingival hyperplasia.

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Conflict of interest

There is no conflict of interest.