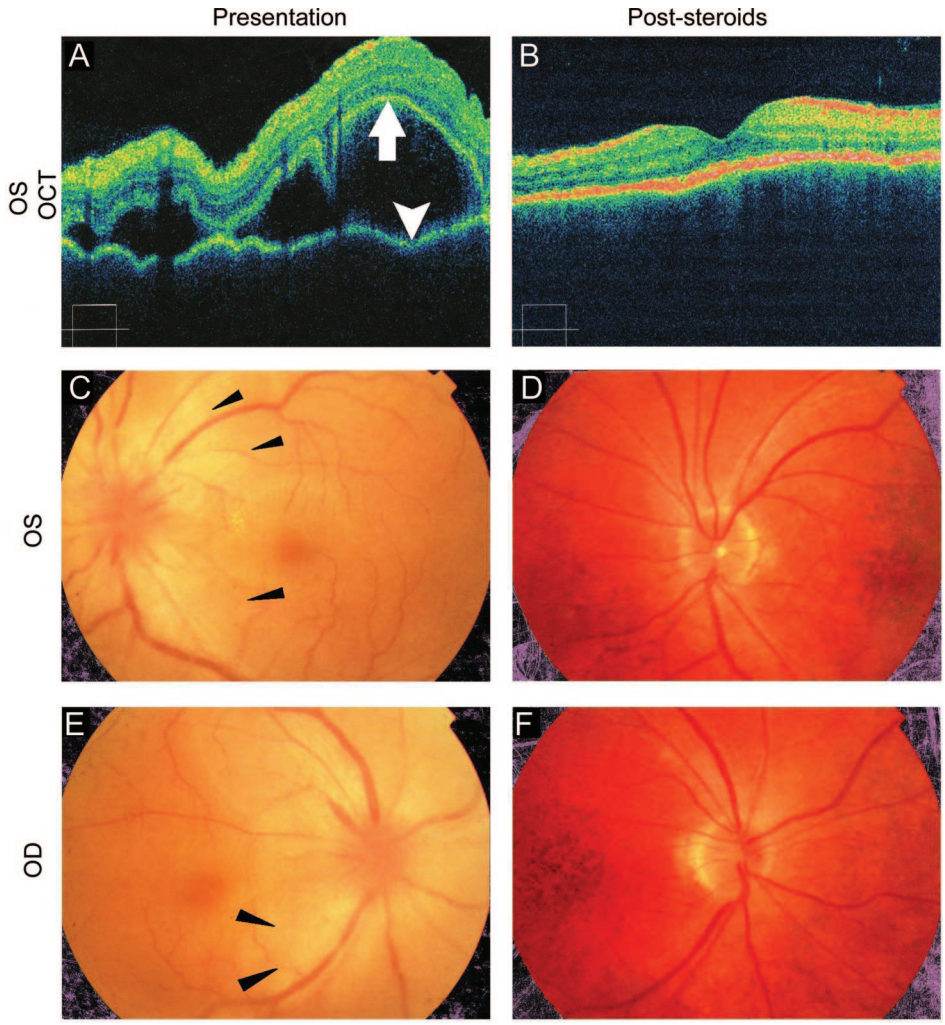
Basilar leptomeningitis in Vogt-Koyanagi-Harada disease

Figure 1 Optic coherence tomography (OCT) and funduscopy

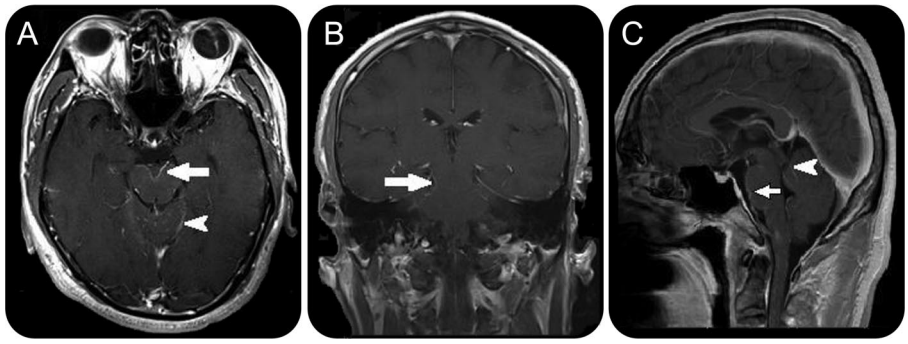


OCT and funduscopy on presentation (left) and following steroids (right). OCT (A) demonstrates serous exudate detaching the retina (arrow) from the pigmented layer (arrowhead) with normalization after steroids (B). The left (C) and right (E) fundi show retinal detachments (black arrowheads) and papillitis, which resolve with steroids, (D) and (F).

A 35-year-old Filipino man had acute visual loss, tinnitus, dysacusis, and severe horizontal vertigo. Examination revealed bidirectional gaze-evoked nystagmus and panuveitis with bilateral inferior serous retinal detachments (figure 1) characteristic of Vogt-Koyanagi-Harada disease.[1] Brain MRI demonstrated mesencephalic, pontine, and cerebellar leptomeningeal enhancement (figure 2). There was cerebrospinal lymphocytic pleocytosis. Following IV Solu-Medrol, his fundus was significantly improved.

Vogt-Koyanagi-Harada disease is a uveomeningeal syndrome of panuveitis with bullous serous retinal detachment, meningitis, and dysacusis.[1] Although the targets of inflammation, melanin-containing cells,[1,2] are predominantly located over the ventral medulla,[3] our patient demonstrated a ponto-mesencephalic and cerebellar predilection of inflammation.

Figure 2 Gadolinium-enhanced MRI of the brain



(A) Axial, (B) coronal, and (C) sagittal gadolinium-enhanced magnetic resonance brain images demonstrate leptomeningeal enhancement of the midbrain (arrow), ventral pons (outline arrow), and cerebellum (arrowheads).

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