Chapter 30

Harada syndrome and its ophthalmologic repercussions: a case report

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1 INTRODUCTION

Also known as uveomeningoencephalic syndrome, its ocular involvement is marked by severe bilateral panuveitis associated with serous retinal detachment (Mota et al, 2010). SVKH is divided into four distinct phases: prodromic, which precedes ocular inflammation by 3 to 5 days, extends for 1 to 2 weeks,(2, 3) mimics a viral infection, and presents as characteristics: fever, headache, orbital pain, photophobia, tinnitus, meningismus and liquoric pleocytosis; uveitic (acute), which begins 3 to 5 days after the prodromic phase and lasts weeks to months, in which there is diffuse inflammation of the choroid, responsible for the subsequent accumulation of subretinal fluid, characteristic of this phase of the disease, and variable extension of the inflammation, usually granulomatous, to the anterior segment; the convalescent phase follows gradually with regression of inflammation and depigmentation of the uvea and skin; this quiescent stage is interrupted in 17 to 73% of cases by the chronic phase of the disease, presenting mostly as recurrent anterior uveitis (Costa et al, 2018). Women are commonly more affected, in a ratio of 2 to 1 compared to men, and the most affected age group is between the third and sixth decade of life, as described in the following case.

2 CASE REPORT

A 30 year-old woman came to the ophthalmologist's office complaining of vision problems, headache and vertigo. In the anamnesis, the patient was diagnosed with a condition suggestive of uveitis in both eyes and the presence of ulcerative precipitate, where treatment with antibiotic and corticoid for fifteen days was recommended. Upon return, the patient showed improvement of the uveitis after the end of the recommended treatment. Later, she returned to the ophthalmologist's office claiming blindness, the doctor performed angiofluoresceinography and retinal mapping in which was observed serous detachment of the retina, justifying the symptom of blindness and proving Harada's syndrome during the convalescent phase.

Treatment was passed to the patient doses with high concentrations of corticoid, observing an improvement in the clinical picture, returning to see.

3 DISCUSSION

The clinical course of Harada's disease is variable, from a limited period of intraocular inflammation with rapid depigmentation and no previous crises, to a chronic, prolonged and recurrent disease as evidenced in the literature (Almeida et al, 2011). From the moment that symptoms of blindness due to serous retinal detachment, headache and vertigo appear, it can be said that it is a rare eye disease of unknown etiology, characterized as Harada's disease, which may be in four stages: prodromic, uveitis, chronic and convalescent, as in the aforementioned case (Mota et al, 2010). Sometimes misdiagnosis of this syndrome occurs due to its unknown etiology, requiring the physician to always have a broad knowledge of the literature and a relentless desire for research.

4 CONCLUSION

Thus, because it is an ocular syndrome with several stages, different symptoms and unknown etiology, it is important to always report cases so that the ophthalmologist and those responsible for public health can alert society to a more frequent routine to the doctor's office, assisting in diagnosis as soon as possible to make the disease as less invasive as possible to the patient.