



A review on Ocular Tuberculosis: Epidemiology, Clinical Features and Treatment

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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Review Article

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ABSTRACT

Background: globalization and migration movements are intimately linked to the expansion of tuberculosis. Tuberculosis has also been the primary cause of death in patients with HIV infection and the leading cause of death related to antibiotic resistance. Tuberculosis may affect any part of the uveal tract. T cell activity is of significance in Tuberculous infection. The phagocytosis of bacilli by macrophage is a significant factor in limiting the spread of infection. However, in patients who have had a previous tuberculous infection, the cell-mediated response is also associated with tissue damage due to the direct effect of sensitized T lymphocytes on the cell containing the ingested bacilli. Ocular tuberculosis is extrapulmonary tuberculosis with a wide range of symptoms. Tuberculosis is considered to infect the lungs of the patients in 80% of cases, and 20% of cases affect other organs like the eye. Ocular tuberculosis is an infectious disease with bacterial etiology that has a chronic case with a poor prognosis. Even the most effective treatment can cause vision loss, and clinical recovery is not always permanent. Ocular tuberculosis frequently results in permanent impairment, lowering patients' quality of life.

Objective: This article reports the various known presentations of ocular TB and reviews essential epidemiology, diagnosis, and treatment elements.

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Methodology: The present study is a systematic review of literature searched from electronic databases and highly reputed websites like PubMed, researchgate, Elsevier, etc. Medical Subject Headings (MeSH) and the trial registry in the English language.

Conclusion: Ocular tuberculosis (OTB) diagnosis and treatment are difficult to come by. The disease's current uncertainty is due to mixed ocular tissue involvement, a lack of consensus on best practice diagnostic tests, and global variations in medical management. The present evaluation intends to provide an update on OTB's recent progress.

Keywords: Tuberculosis; ocular tuberculosis; orbital tuberculosis; eye infections and visual acuity.

1. INTRODUCTION

Around 1.7 billion people are diagnosed with tuberculosis. Tuberculosis is a severe social health problem that affects people worldwide. According to the World Health Organization (WHO), tuberculosis is the most common cause of death worldwide, with tuberculosis being the sole infectious agent to blame. This obligate aerobe is a slow-growing, non-spore-forming, non-mobile bacterium.

TB is the most frequent opportunistic infection among HIV-positive individuals in many developing countries, owing to poor sanitation, hygiene, treatment resistance, and poverty. Tuberculosis was identified in 24% of patients out of 450 HIV-infected adults examined in a recent research done in Cambodia from January 2004 to February 2005. According to a Chicago study, around 15% of newly diagnosed patients with tuberculosis will also have HIV-positive testing, implying a relationship between TB and HIV. WHO recommends treating HIV infection with tuberculosis as "two diseases - one patient" and providing complete treatment [1].

Multiple organs in the body can be affected by tuberculosis. A rare variant of extrapulmonary tuberculosis is ocular tuberculosis that should not be overlooked due to the possibility of a [2] loss of vision in patients. Due to its various clinical signs, such as mixed ocular tissue involvement, lack of gold standard testing, diagnostic criteria, and lack of agreement on therapy strategy, OTB remains a significant diagnostic and therapeutic challenge [3].

OTB can develop as a primary infection (with the eye as the entrance point) or due to hematogenous dissemination [4].

The most prevalent ocular symptom of the disease is occlusive retinal vasculitis, multifocal

serpiginous choroiditis, and granulomas are the most common Ocular Tuberculosis lesion [4].

2. ETIOLOGY

2.1 Any of the Following ways Causes Ocular Tuberculosis

1. Direct infection due to an exogenous source although uncommon, primary exogenous eye Infection can arise in the lids or conjunctiva. Cornea, Sclera, and lacrimal sac are other exterior tissues less usually affected.
2. Hematogenous spread because of its high vascular load; the uveal tract is the most commonly implicated eye coat.
3. Hypersensitivity reaction in the eye structure due to other forms of ocular tuberculosis like phlyctenular disease and Eale's disease.

Alan Woods was the first to apply Rich's law to ocular TB and classify it into four separate groups (22). The following is a summary of Woods' four categories.

A reaction that is similar to that of a foreign body [2].

1. Sclerokeratitis or Eales' disease are examples of acute restricted inflammation that can reoccur if the patient diminishes resistance.
2. Repeated recurrences of chronic inflammation.
3. Acute, quickly spreading inflammation characterized by necrosis, caseation, and, on rare occasions, tuberculous panophthalmitis.

The most prevalent kind of ocular involvement is hematogenous spread. Seeding can happen due to a primary infection or a dormant lesion reactivating [5].

Aerosolized droplets are used to spread *M. tuberculosis*. Inhaled microorganisms engage alveolar macrophages in the respiratory alveoli. It is primarily an airborne disease and spreads by coughing and sneezing from one person to another. Approximately 1 to 5-micron droplets are suspended in the air for several hours. Usually, 5 to 200 inhaled bacteria are sufficient to cause infection. About 90% of infected people are asymptomatic or latent TB. About 5% of the remaining 10% will get sick during the first several years of exposure. As host immunity deteriorates, the remaining 5% may show symptoms years later.

M. tuberculosis avoids eradication by preventing phagolysosome fusion, even though bacteria are phagocytosed by alveolar macrophages and emit some cytokines to draw circulating monocytes to the infection site. This allows the bacteria to multiply in macrophages that aren't fully activated or partially active. Through erosions in the alveolar epithelium, bacteria-laden macrophages eventually disperse to the lymphatic and venous circulation and travel to the oxygen-rich areas of the body. Example: apex of lungs, various organs, and the eye [5].

3. EPIDEMIOLOGY

An incidence of ocular involvement varies, depending on the criteria used for diagnosis and the sampled population [2].

Based on epidemiology, ocular morphologies, and positive supporting tests like Purified Protein Derivative PPD or Interferon Gamma Release Assay IGRA, the significant population are diagnosed with presumptive ocular TB [3].

According to the Centers for Disease Control and Prevention (CDC), *Mycobacterium tuberculosis* infects one-third of the world's population of nearly two billion people, and 10% of those infected will get ill at some point in their lives. Extrapulmonary signs include 16–27% of patients, including those with orbital and external eye illness. India, China, Japan, Thailand, Philippines are the most densely populated Asian Pacific Countries with the prevalence of Ocular TB as 0.4-9.8%, 4%, 7%, 2.2%, and 6.8%, respectively [6].

Ocular TB is not common in the general population, but it is treated in referral centers regularly.

Donahue reviewed the ophthalmic records of over 10,000 with primary pulmonary TB inspected in the eye clinic of the Mattapan Sanatorium in Boston, Massachusetts, USA. He analyzed 154 (1.4%) patients with ocular TB [7]. Bouza and his colleagues discovered that eye tuberculosis was more common in Spain; 100 patients were randomly selected and observed in an emergency clinic; 18 had eye injuries, including choroiditis, retinitis, and scleritis [1].

Rosen et al. described 12 individuals with intraocular tuberculosis, 9 of which had retinal vasculitis, 2 had choroidal tubercle, and 1 had chronic anterior uveitis, in a more recent series published in 1990.

4. PATHOPHYSIOLOGY

Attempts to understand the pathophysiology of OTB have proven to be substantially more complex than clinical discoveries. Even though the mechanism of *Mycobacterium tuberculosis* dissemination has been challenging to prove, it is widely thought that hematogenous *M.tb* dissemination to the eye causes intraocular inflammation, but the molecular evidence of *M.tb* is scarce to be found in the given sample of ocular fluid.

In diverse kinds of granulomatous uveitis, the diagnostic effectiveness of traditional polymerase chain reaction (PCR) for *Mtb* is as low as 37.7%. Despite significant advancements in molecular diagnostic techniques over the year, the routine *Mtb* Polymerase chain reaction utilization has remained modest [8].

Humans are the only natural host. End organs with high oxygen tension, i.e., lungs apices, kidney, bone, meninges, eye, are typically infected. In the eye, the ciliary body and choroid are mainly affected [9].

The mechanism of infection determines the causes of *mycobacterium tuberculosis* on the eye. Extraocular involvement indicates that the patient has a primary ocular infection caused by direct contact with the eye.

The iris and anterior part (ciliary body), as well as the choroid, make up the uveal tract (posteriorly), which is most usually affected by TB dissemination from pulmonary or extrapulmonary locations (posteriorly). When *M. tuberculosis*-infected macrophages enter the eye, they

deposit in the first available capillary beds, causing posterior uveitis, a commonly occurring ocular TB symptom. Bacilli grow and cause local inflammation, resulting in a choroidal tubercle.

Pathogenesis of ocular tuberculosis is classified into five stages which are as follows:

In stage 1, Alveolar macrophages phagocytosis bacteria can either lead to its growth or get destroyed. If bacteria grows, it will destroy the macrophages and form the initial nidus of developing the tubercle.

In stage 2, circulating monocytes are deposited at the nidus, phagocytosed but not destroyed [10].

In stage 3, bacteria-laden macrophages are destroyed due to a delayed type of hypersensitivity, leading to tissue damage causing caseous necrosis.

In stage 4, if the response of a delayed-type of hypersensitivity is poor, it may break open into lymphatic and blood vessels.

In stage 5, liquefaction of caseous necrosis and erosion of the bronchial wall occurs.

5. CLINICAL FEATURES

5.1 History

In recent years, immunocompromised persons are at the highest risk of getting ocular tuberculosis, with more than half of the total individuals with AIDS and Tuberculosis having extrapulmonary involvement.

Therefore whenever we are suspecting ocular TB, it is critical to obtain a detailed prior medical and social history, as well as to question about the patient's HIV status [11].

5.2 Presenting signs and Symptoms

5.2.1 Extraocular involvement

This type of infection is acquired either through direct inoculations followed by hematogenous dispersion or through a hypersensitive reaction. On the outside of the eye, the extraocular sign of tuberculosis can be seen as persistent blepharitis, lid abscess, or atypical chalazion [12].

5.3 Orbit

Based on its performance, ocular tuberculosis can be classified into five groups:

Orbital periostitis causes erythema and Ed's an of conjunctiva and lid and the involvement of the vascular structure of the orbit [13].

1) In long-term situations, it can also appear as cortical abnormalities that progress to thickening and sclerosis of the orbital bones [14].

2) Tuberculosis of the soft tissue of the Orbit without bone degeneration

3) Orbital tuberculosis with bone involvement in which it can present as proptosis secondary to the mass effect

4) Paranasal sinus is responsible for orbital spread.

5) Inflammation of the lacrimal gland [13].

The skin of the eyelids and periorbital area: In children, involvement of the eyelids is most commonly seen. The TB on the eyelid might manifest as lid abscess, persistent blepharitis, or atypical chalazion (nodules resembling chalazion) on the outside of the eye. When pressure is applied to the skin of the eyelids, it resembles lupus vulgaris, with red-brown nodules that blanch to an "apple jelly" hue. The clinical form is thought to be an add-on of tuberculosis affecting the skin, including subepithelial protuberance, plaque, and ulcers [12].

5.4 Conjunctiva

Inflammation of the thin membrane covering the eyeball and lining the eyelid, subconjunctival nodules, polyps, tuberculomas, and ulcers are all symptoms of conjunctival tuberculoma. While conjunctivitis has become more widely popular w.r.t the context of systemic disease, atypical conjunctivitis with no systemic signs has been documented. Phlyctenulosis can also be caused by an exaggerated hypersensitive response which isn't always linked to infection [14]. Reddening of eyes, distress, suppuration of mucus and pus, and swelling of the eyelids, are the widely prevalent clinical presentations [12].

5.5 Sclera

Tuberculosis is responsible for around 10.6% of cases of Infectious Scleritis [12]. Ocular symptoms of tuberculosis include scleritis and scleral nodules. Episcleral nodules may occur as a result of the reaction with mycobacterial

proteins. Scleritis comes in two forms: nodular and diffuse, with nodular scleritis being the most prevalent. The sclera can weaken or possibly perforate due to the lesion's necrosis [13].

5.6 Cornea

Involved corneal patients may experience photalgia, and their exams may reveal profound stromal keratitis and corneal erosions. Patients may develop mycobacterial infections as a result of the body's immunological reaction to the bacteria, which can further lead to interstitial keratitis, disciform keratitis, and phlyctenular keratoconjunctivitis [14].

5.7 Investigation

5.7.1 There is various Investigation which is as follows

Histopathological evidence: Acid-fast bacilli on direct smear or culture of mycobacterium T.B from the given sample. This is the gold standard and conclusive method but also has limited sensitivity, delayed diagnosis due to bacteria's slow growth.

Tuberculin skin test(TST): This method determines whether M T.B Infection is latent or active based on immunological evidence. It is low cost and easy to access.

Interferon-Gamma Release assay: It is the test used to measure the amount of Interferon Gamma released into the body. It is more specific, resistant to atypical mycobacteria, and unaffected by prior BCG immunization. But there are some drawbacks, including low sensitivity, very expensive, and quite burdensome. It also cannot differentiate between latent and active forms of the disease.

PCR: It is a method that is used to detect the genome of Mycobacterium even from a tiny sample of ocular fluid. It provides fast detection and quantification of pathogen burden in samples with minimum carryover and cross-contamination danger. It can also be used to detect drug-resistant mycobacterium strain.

Chest X-ray: When lungs are the dominant location of tuberculosis infection, this method is

used to examine patients with suspected tuberculosis intraocularly.

6)Fluorescein angiography is mainly used to determine retinal vascular leakage and active choroidal lesion [15].

6. TREATMENT

Generally, the treatment for ocular tuberculosis is comparable to the active pulmonary and extrapulmonary tuberculosis in which there are four drugs regimen which includes Rifampicin, Isoniazid, Pyrazinamide, and Ethambutol, which are provided for two months daily and then continued for a period of four months [5].

Patients with pulmonary tuberculosis who shows sign of medication resistance are moved to a different regimen based on culture results; the same can be done if drug resistance is detected in patients with increasing ocular infection [15].

Oral steroids are complicating, mainly in patients with suspected tuberculous uveitis. The inflammation worsened or recurred in patients who were only given systemic corticosteroids [5].

Reassessment of patients every two to three months should be done for the following: [16-23].

- 1 Control and reduction of inflammation
- 2 Reducing the use of corticosteroids
- 3 Reduction in the outburst of illness and rate of recurrence or decreasing the severity and prolonging the illness-free period.

Central Fibres of optic nerves are usually affected, resulting in impaired or loss of vision, reduced visual acuity, and patients cannot identify the red and green colors.

Ethambutol is a joint antibacterial agent against actively growing T.B bacilli. It acts by preventing cell walls from forming.

Optic neuropathy is the most well-known Ethambutol toxicity, widely thought to be rare and reversible in the medical literature [17]. Ethambutol is contraindicated in optic neuritis because renal illnesses are a risk factor for optic neuropathy since Ethambutol is excreted through the kidney [18].

7. CONCLUSION

Due to tuberculosis, ophthalmologists can expect cases of disease if the population sample is huge. Assessing the degree of dissemination of the disease is also a vital role which an ophthalmologist does. Eye T.B is not a contagious disease. Scleritis and other ocular Inflammatory symptoms may be caused by tuberculosis, particularly latent type. Delayed diagnosis can result in eyesight loss and infection-related systemic problems.

CONSENT

It is not applicable.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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