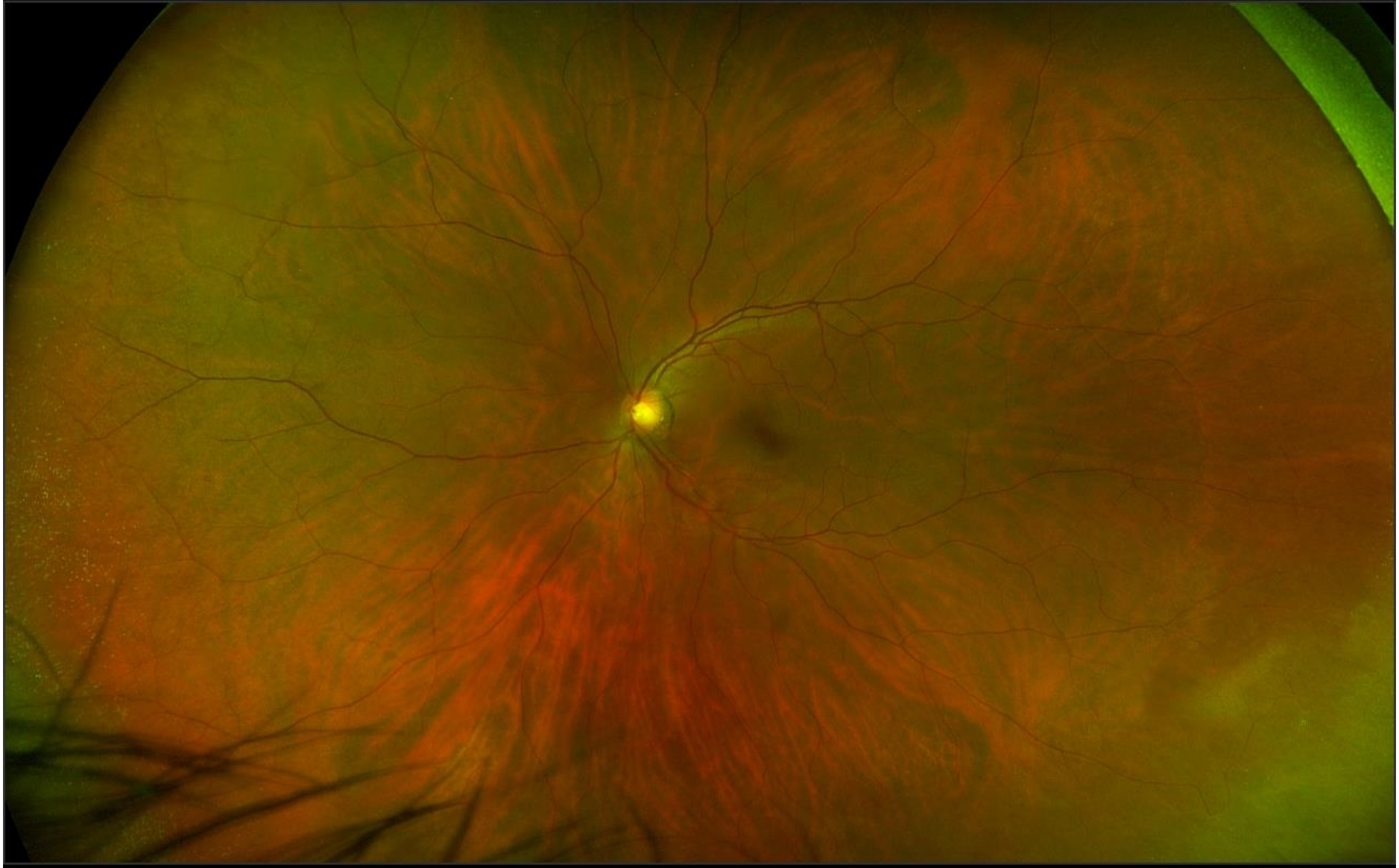
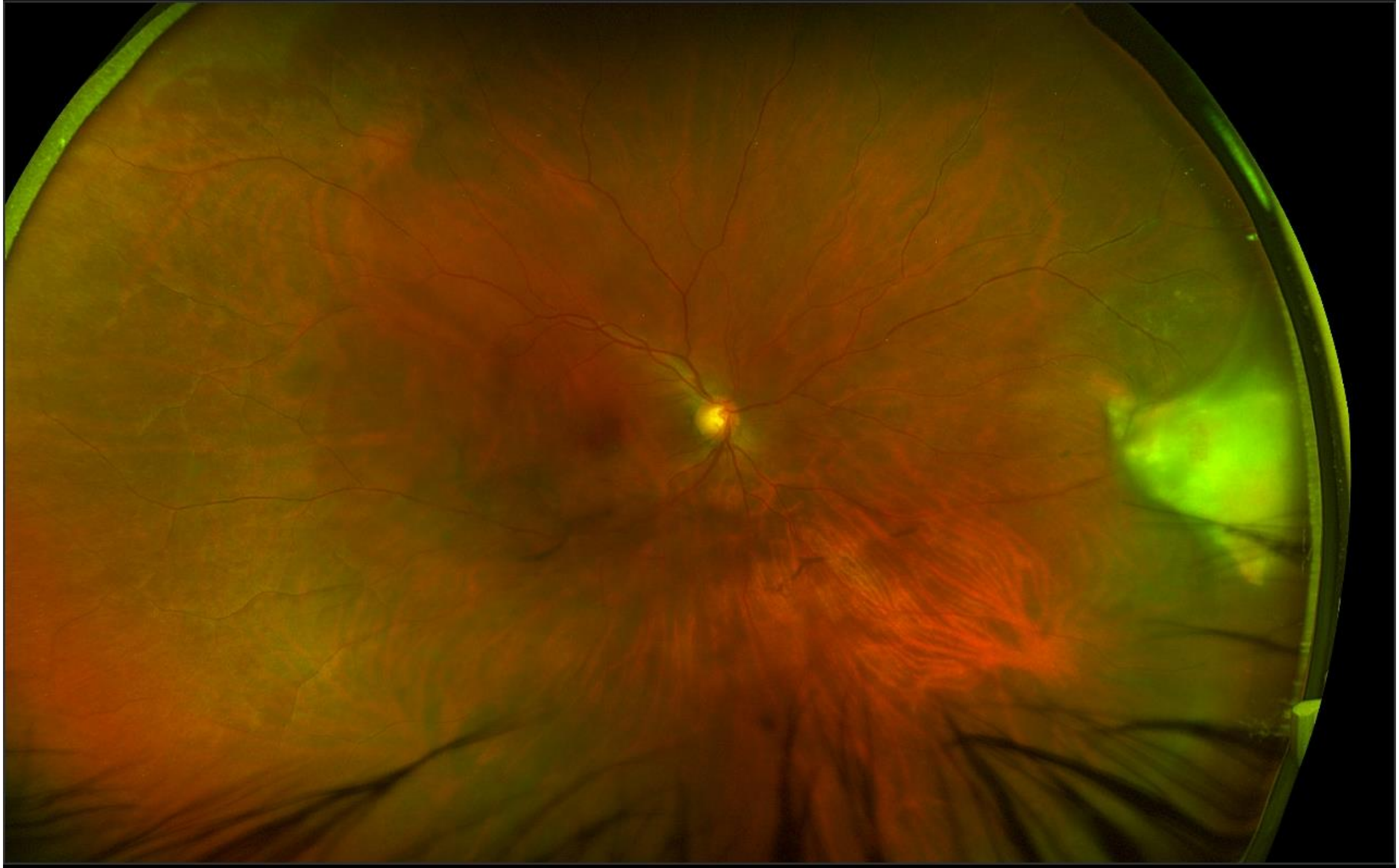
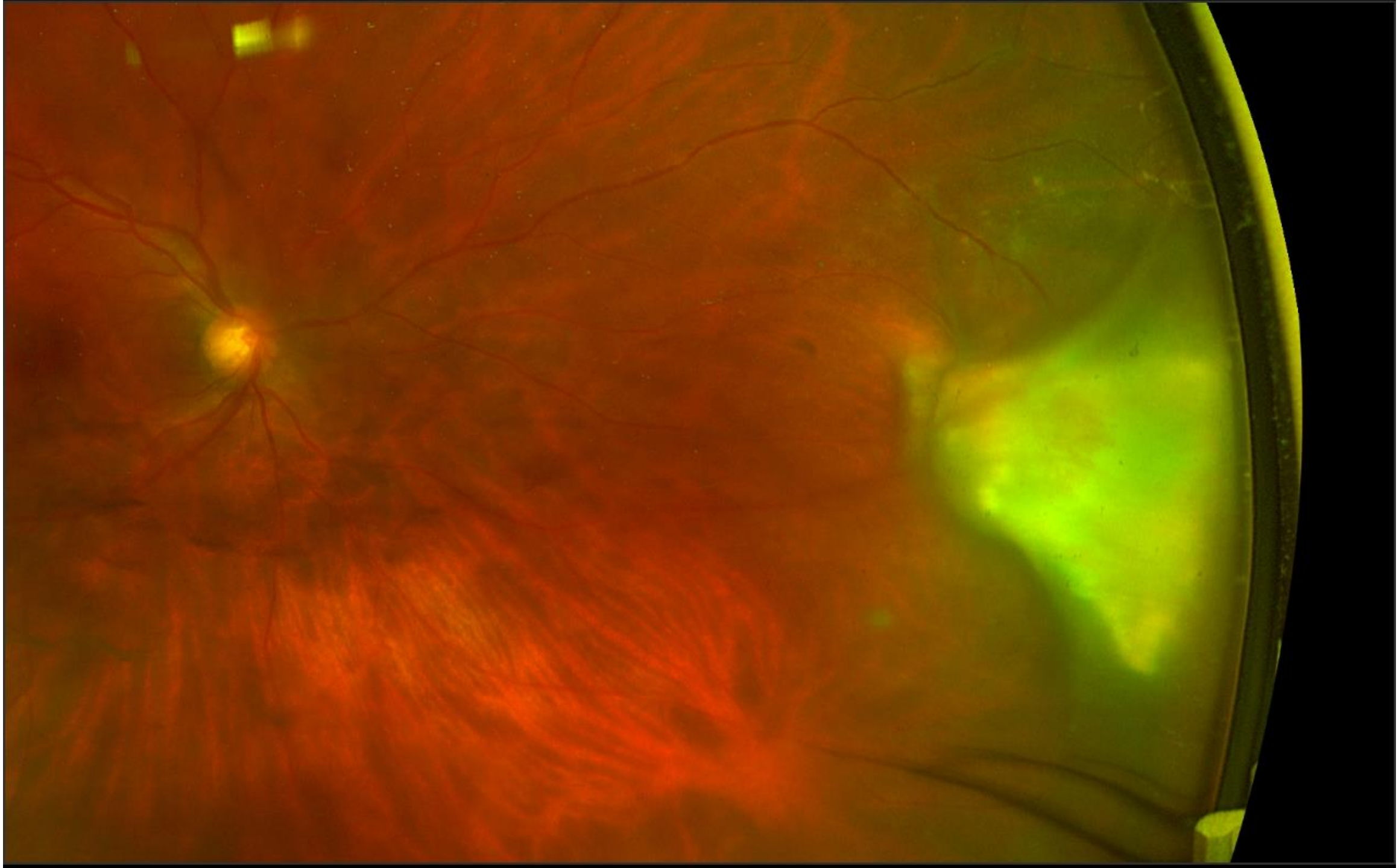
Rétinites et choriorétinites infectieuses

- N°1



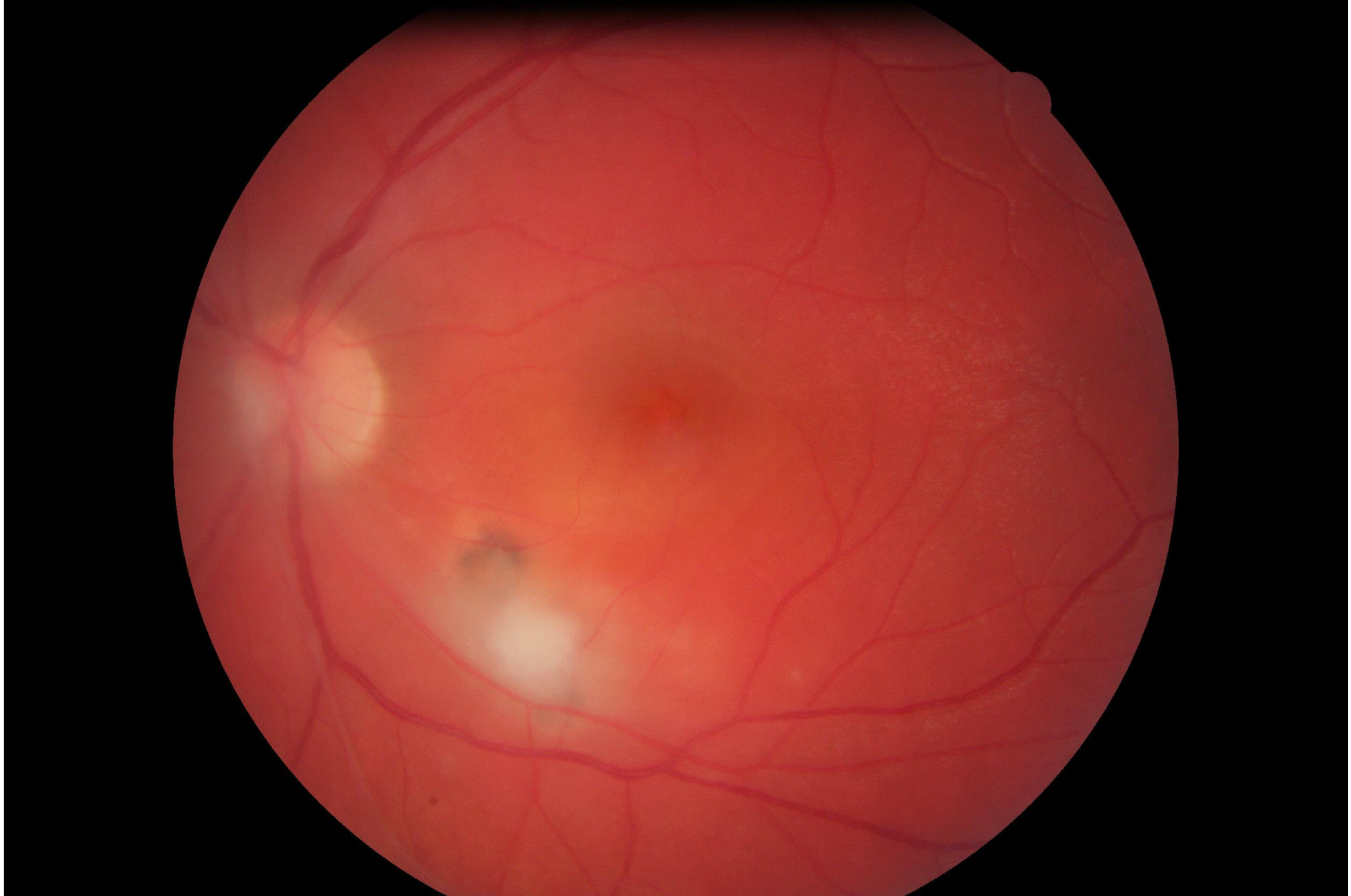


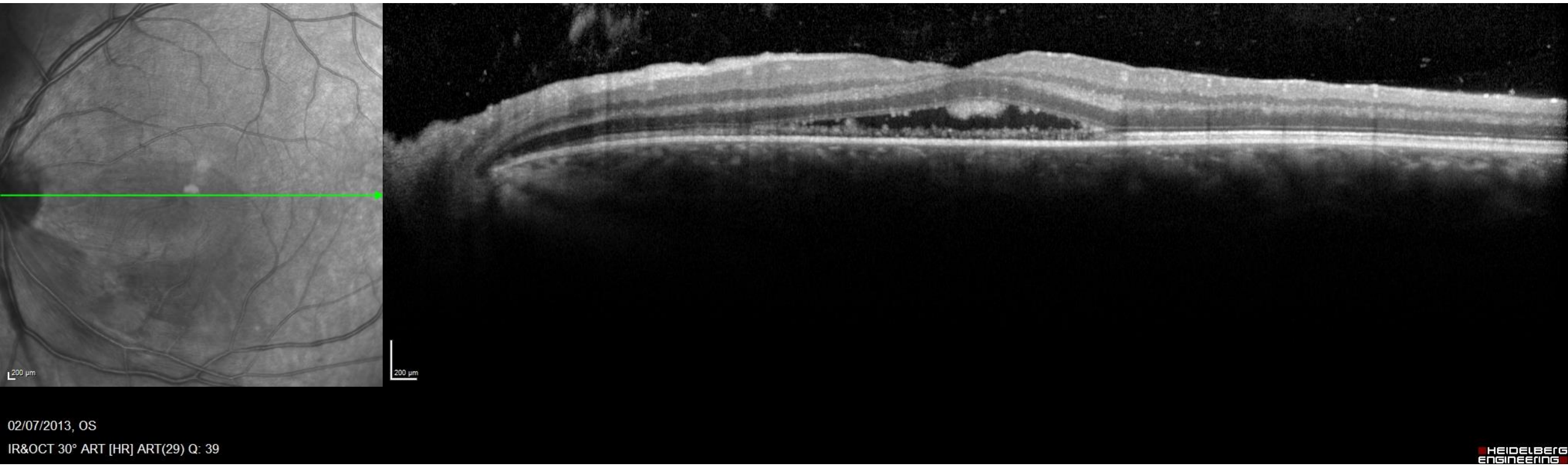


Toxocarose prouvée (2 bandes positives dans le western blot de l'humeur aqueuse)
Récidives inflammatoires (hyalite prédominante), malgrè traitement par albendazole.
Traitement chirurgical après 5 récidives

6 Toxoplasmoses

- N°2

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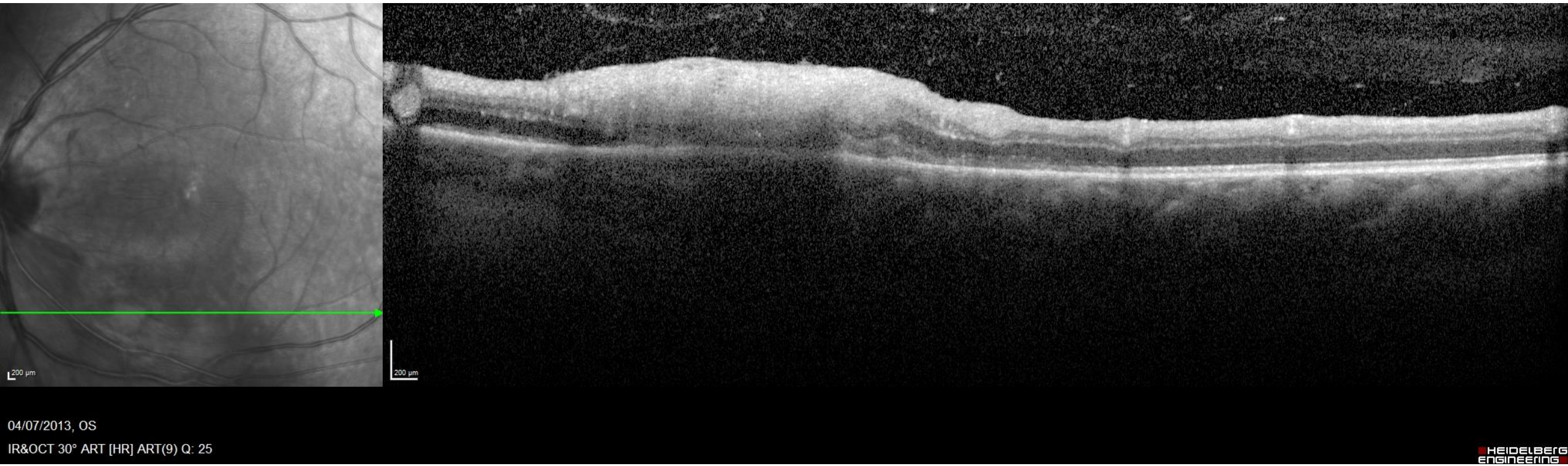
02/07/2013, OS
IR&OCT 30° ART [HR] ART(29) Q: 39
HEIDELBERG ENGINEERING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IR&OCT 30° ART [HR] ART(9) Q: 25
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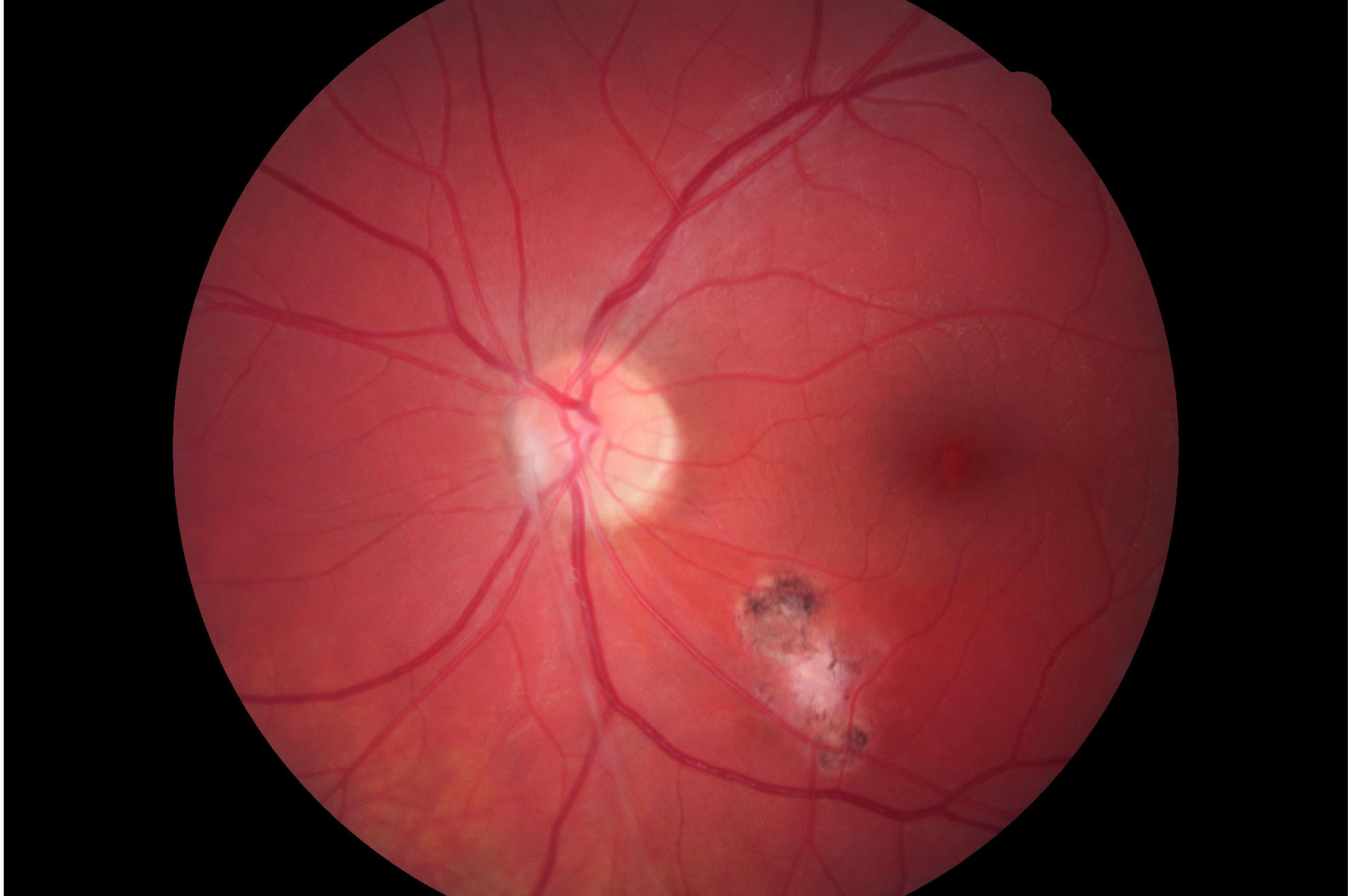

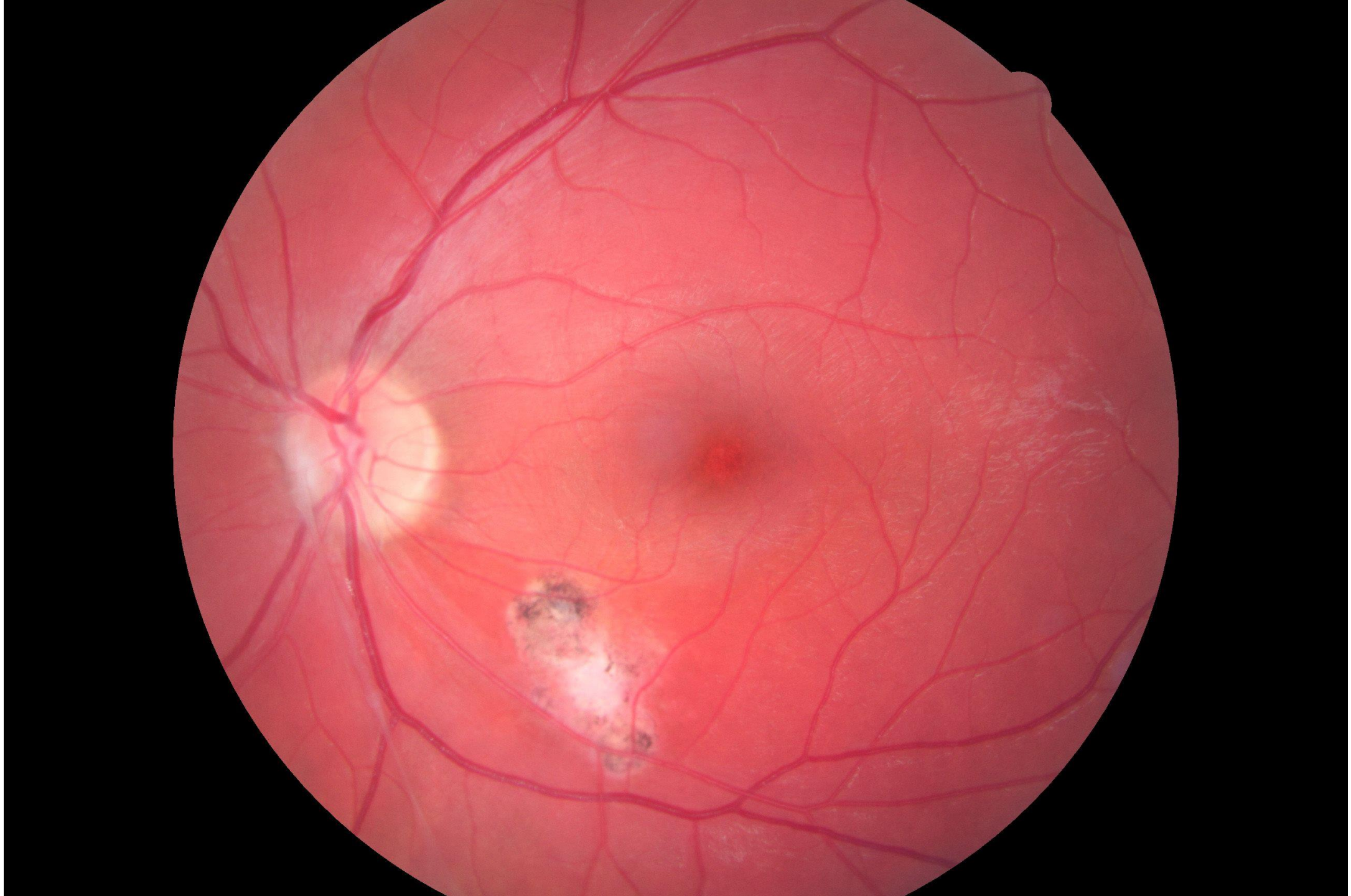

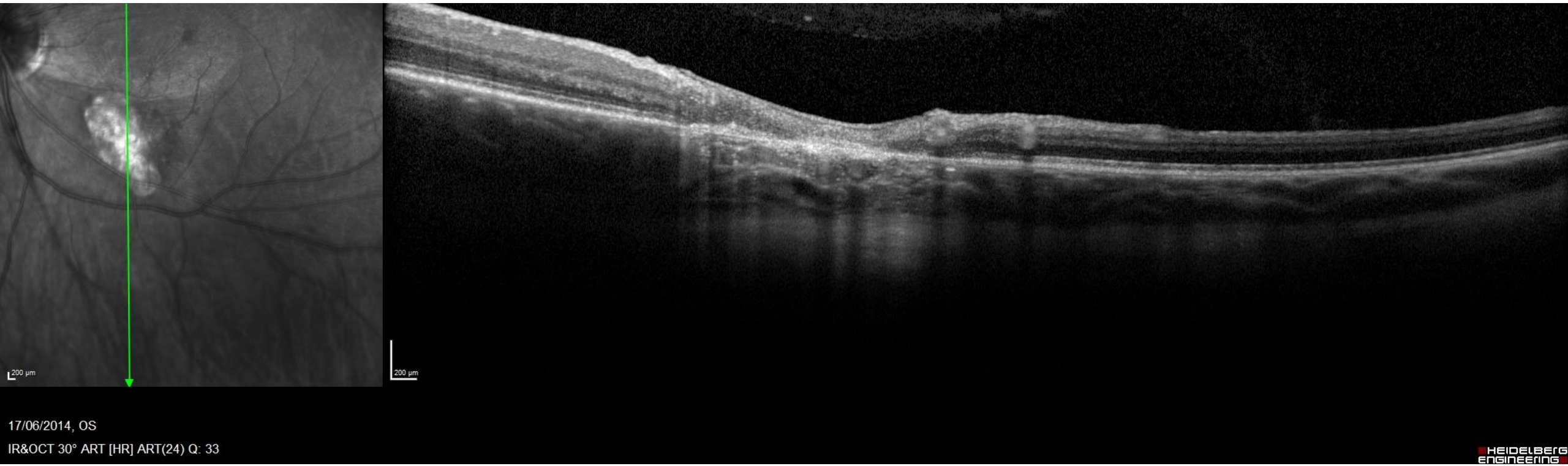
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17/06/2014, OS
IR&OCT 30° ART [HR] ART(24) Q: 33
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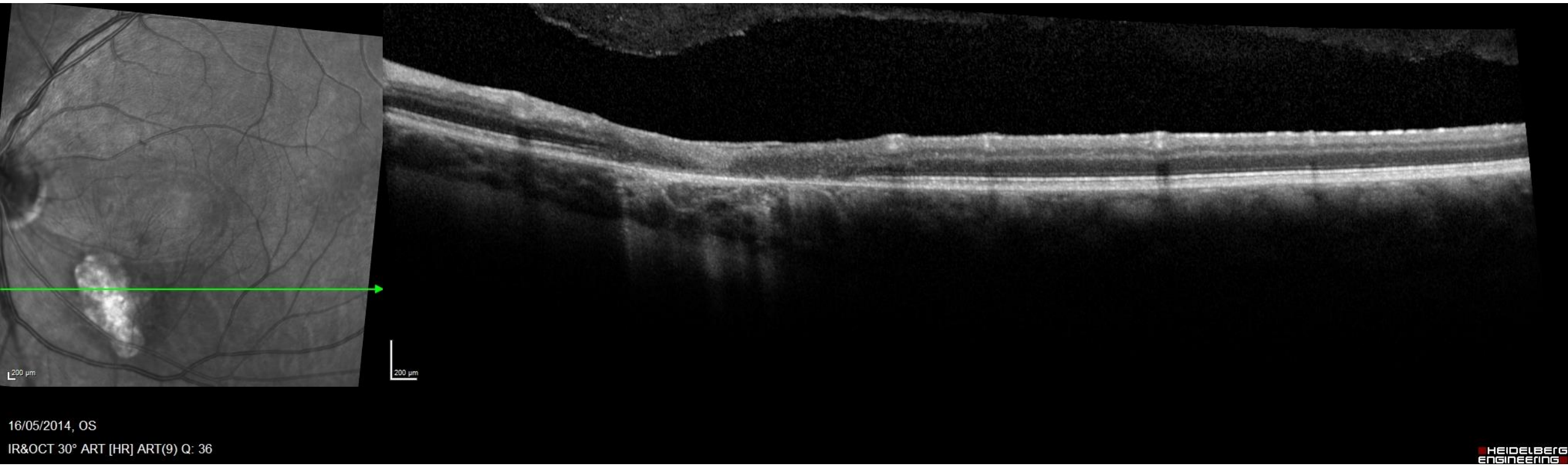
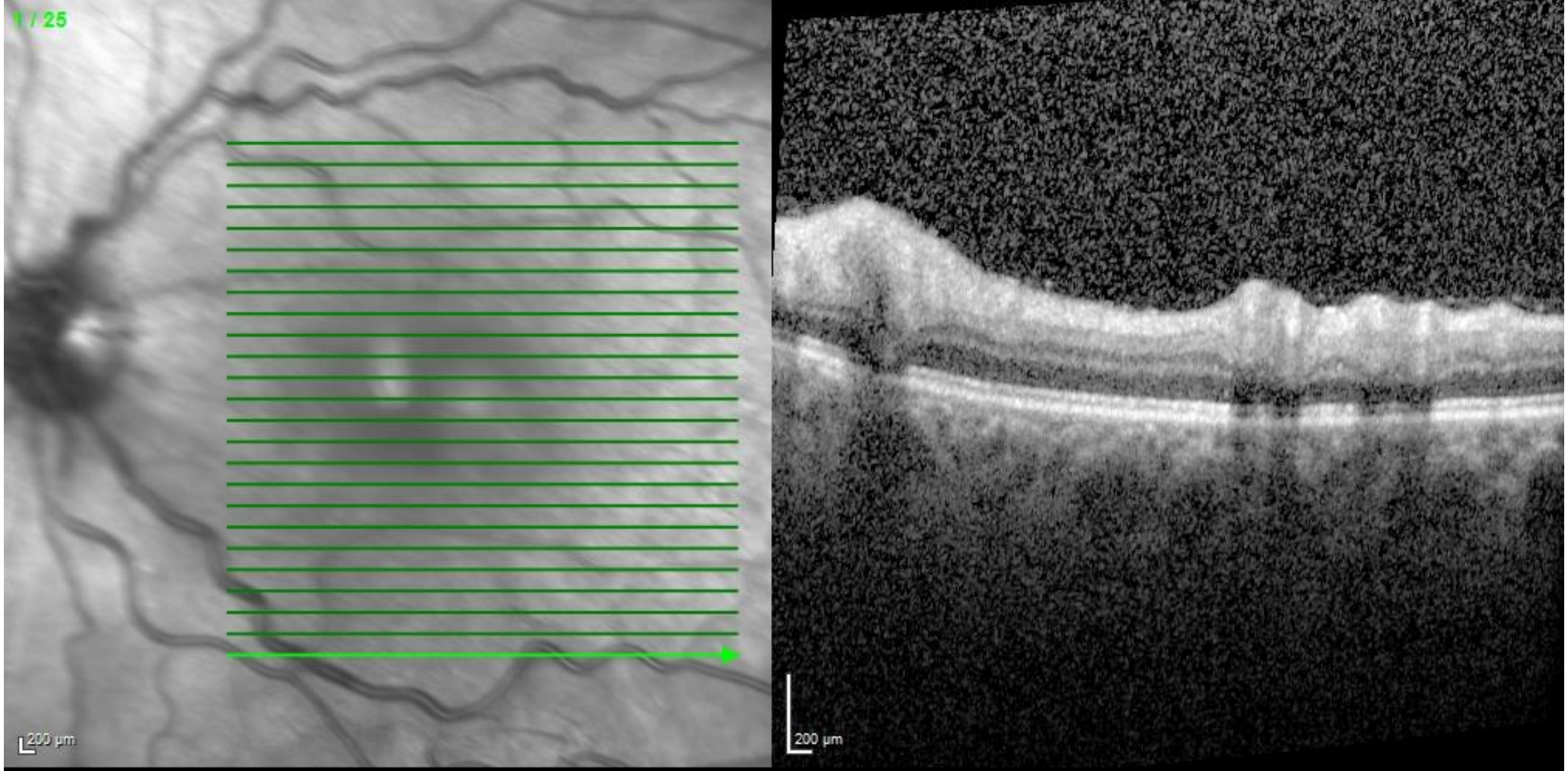

200 µm
200 µm
16/05/2014, OS
IR&OCT 30° ART [HR] ART(9) Q: 36
HEIDELBERG ENGINEERING

N°3


Hopital Cochin
OPTOS, P200DTx
Laterality: R
Red: 50%
Green: 50%
Zoom: 1,50
Type: PLUS
Presentation: Approved 7 févr. 2018
1/2
4


Hopital Cochin
OPTOS, P200DTx
Laterality: L
Red: 50%
Green: 50%
Zoom: 1,50
Type: PLUS
Presentation: Approved 7 févr. 2018
1/1
4



07/02/2018, OS

IR&OCT 30° ART [HS] ART(7) Q: 17

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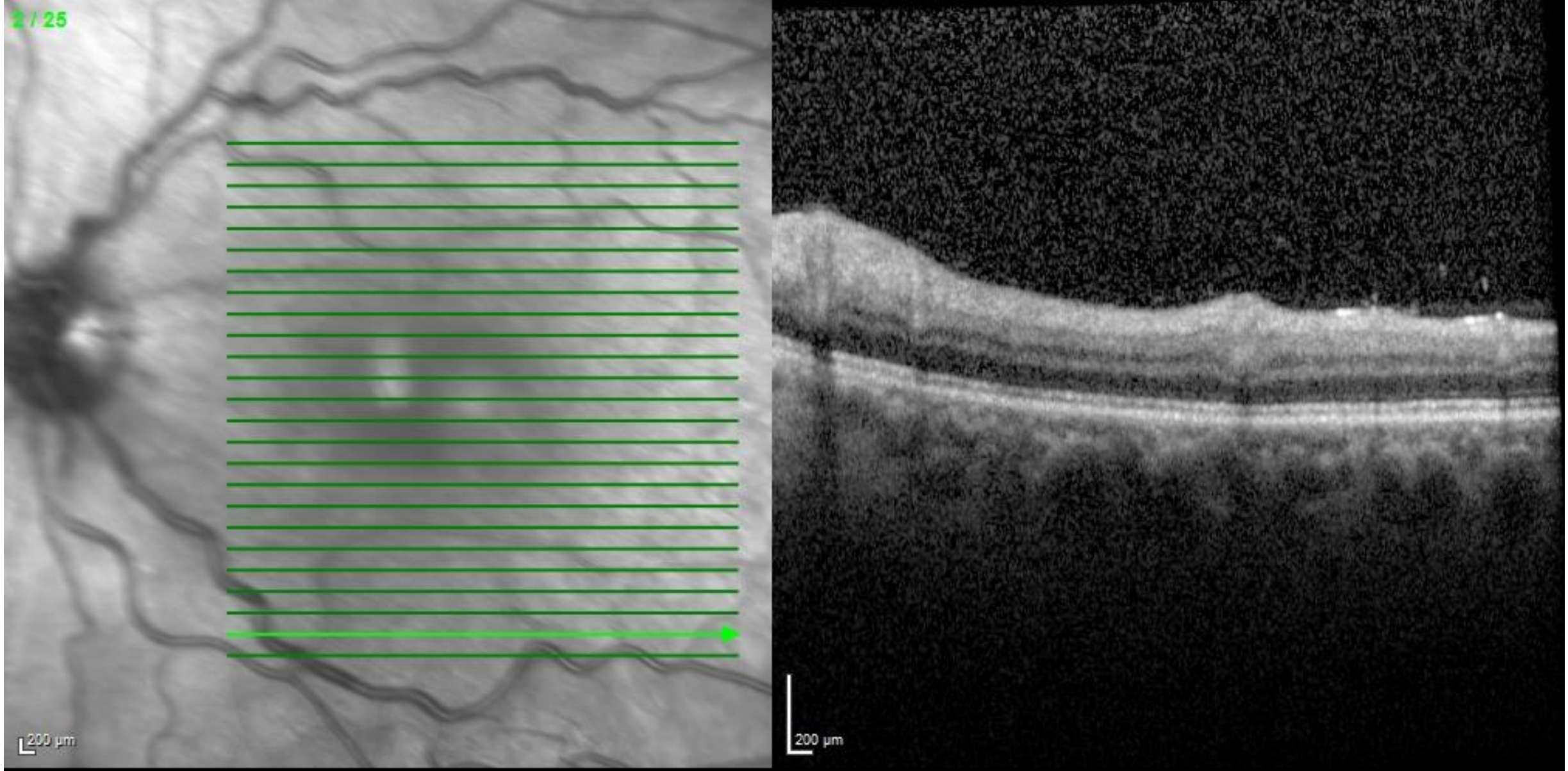

07/02/2018, OS

IR&OCT 30° ART [HS] ART(9) Q: 22

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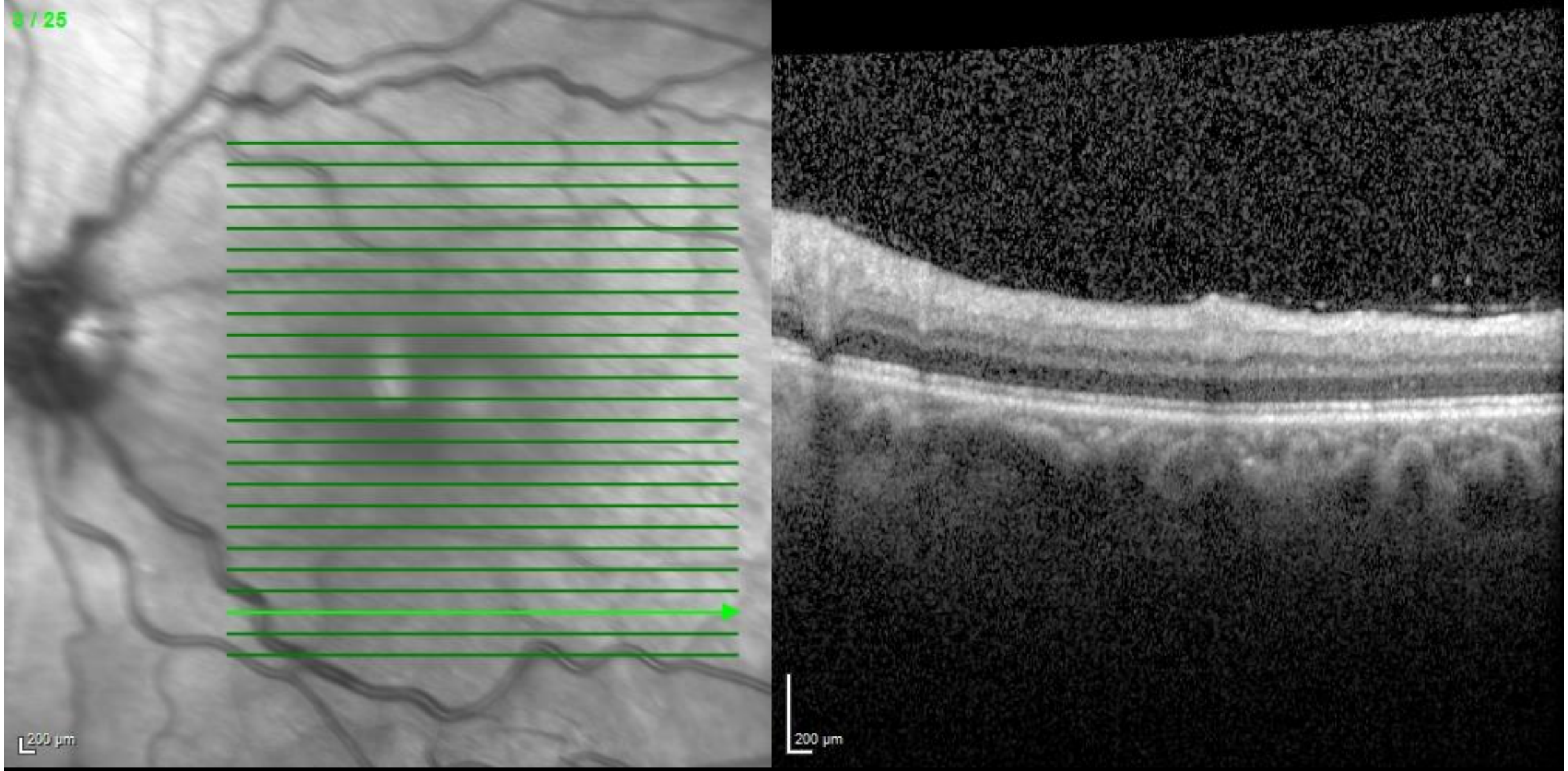

07/02/2018, OS

IR&OCT 30° ART [HS] ART(10) Q: 20

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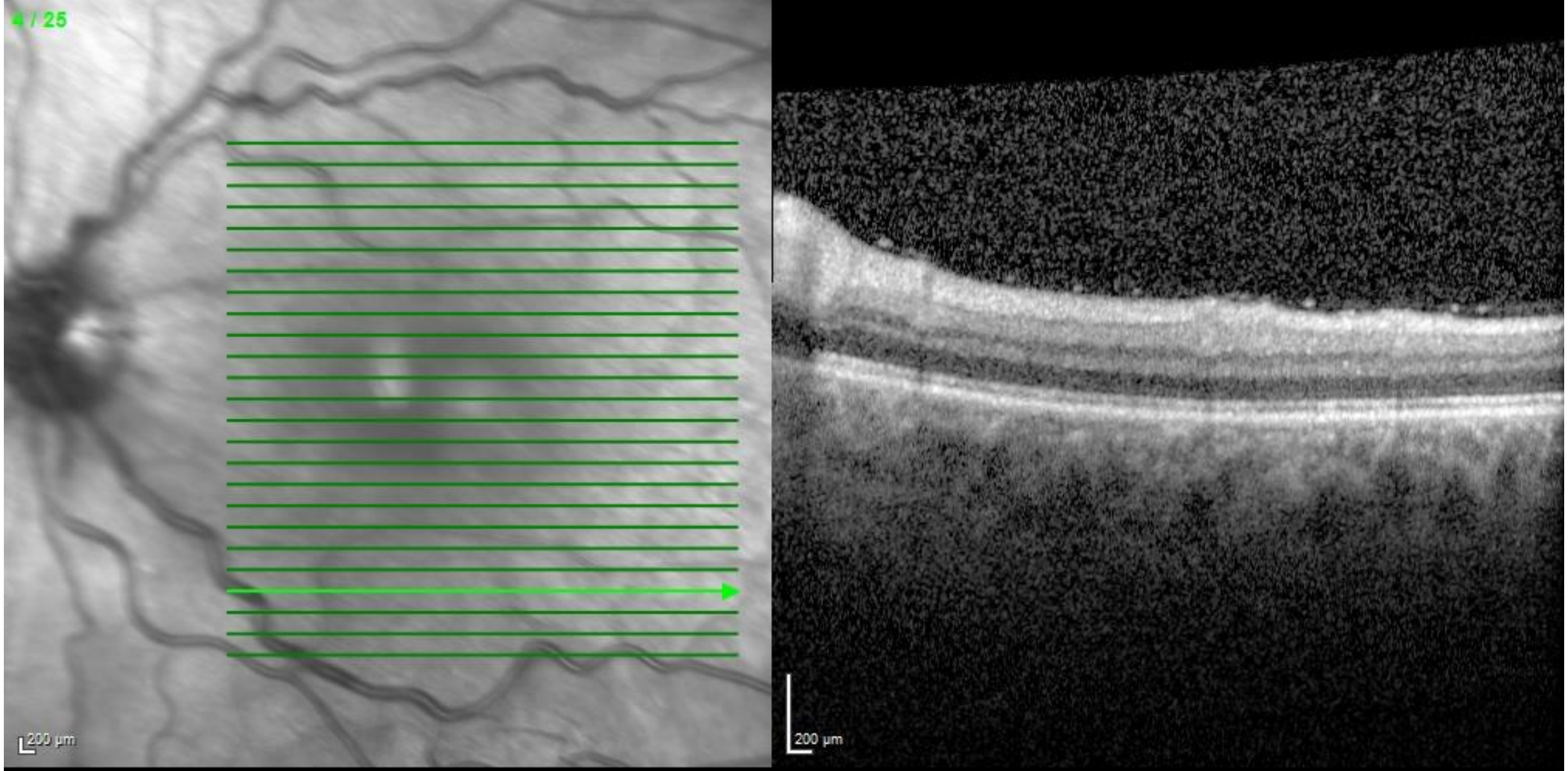

07/02/2018, OS

IR&OCT 30° ART [HS] ART(8) Q: 18

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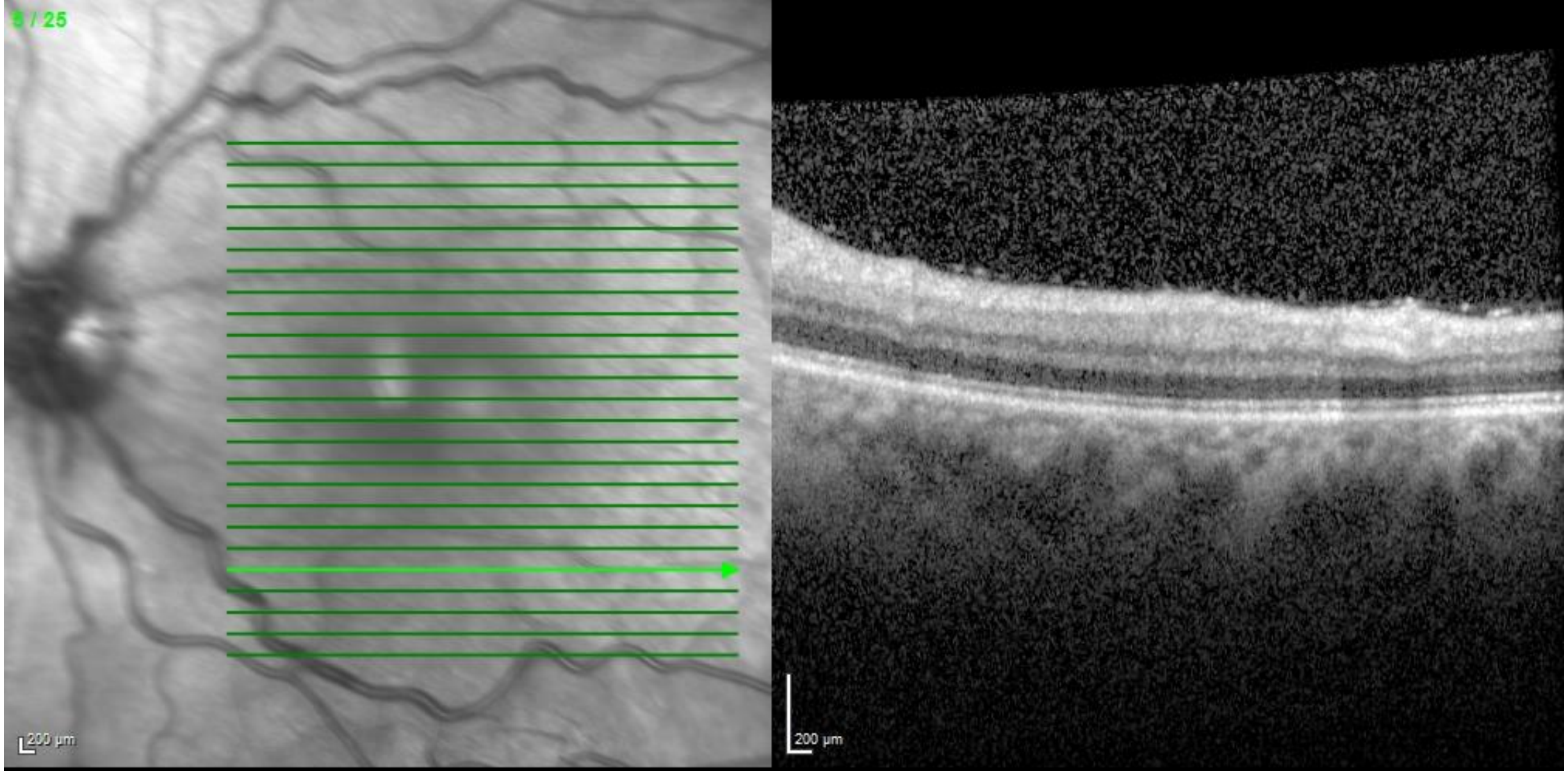

07/02/2018, OS

IR&OCT 30° ART [HS] ART(11) Q: 18

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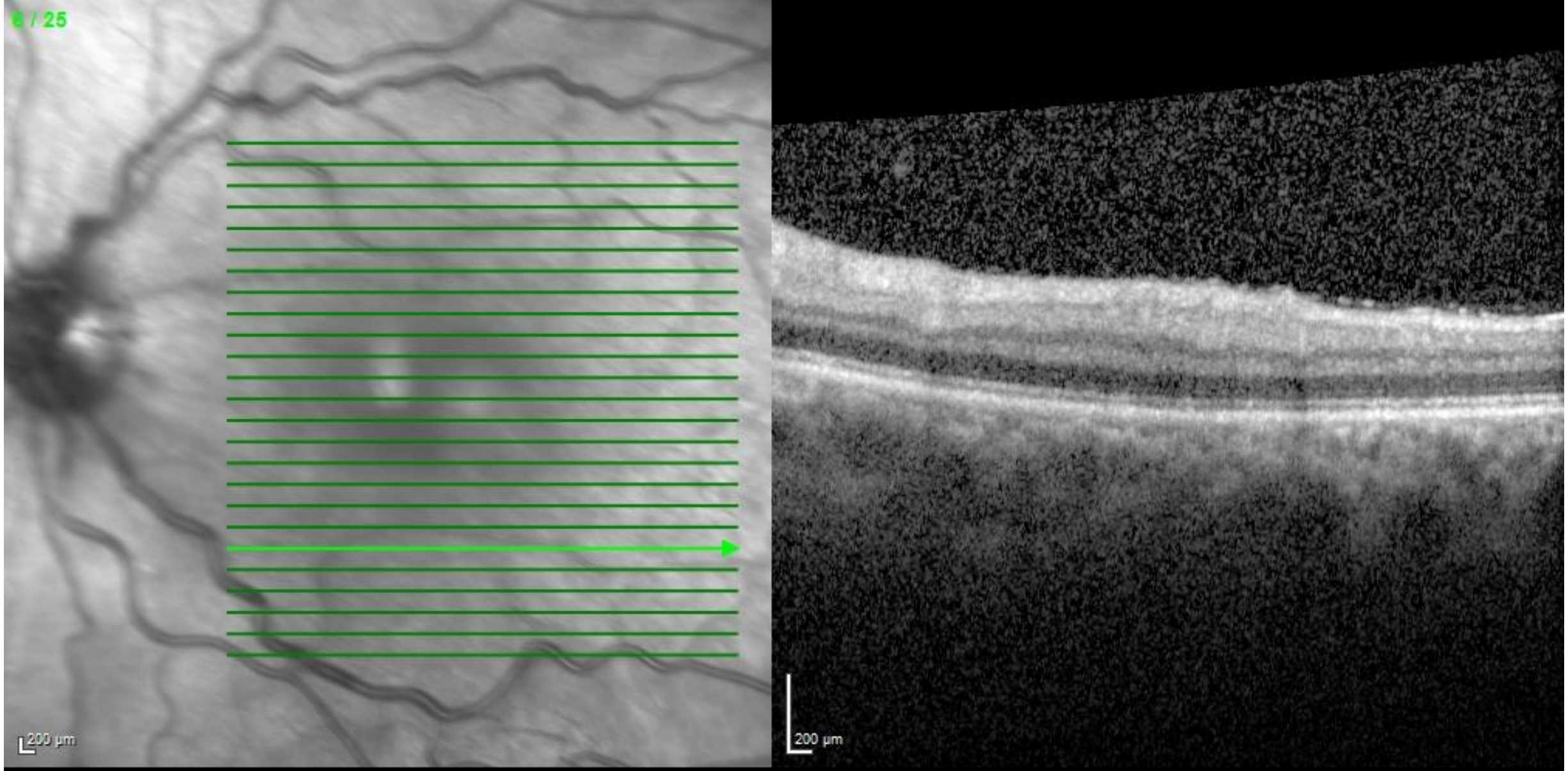

07/02/2018, OS

IR&OCT 30° ART [HS] ART(9) Q: 21

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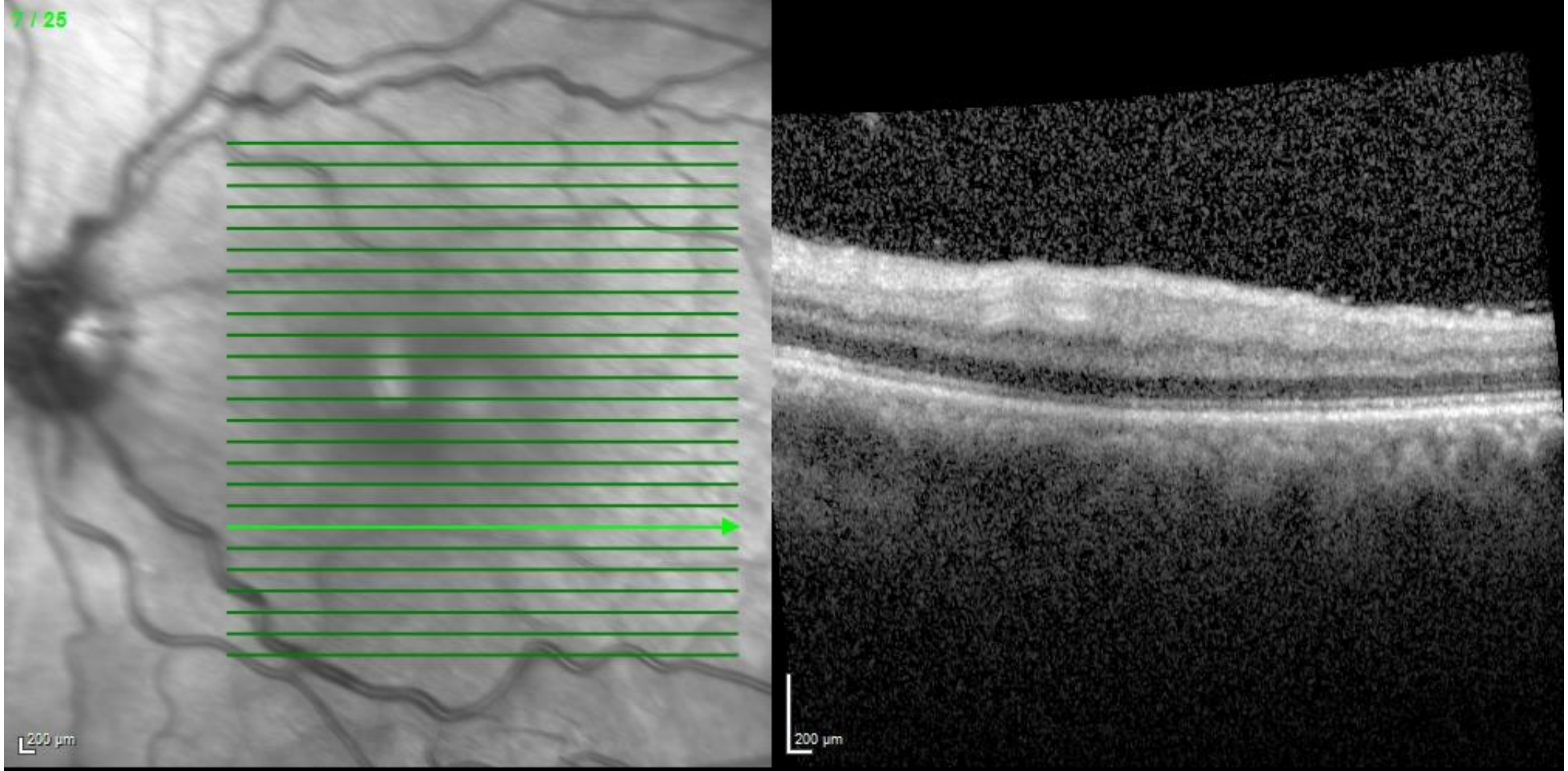

07/02/2018, OS

IR&OCT 30° ART [HS] ART(7) Q: 21

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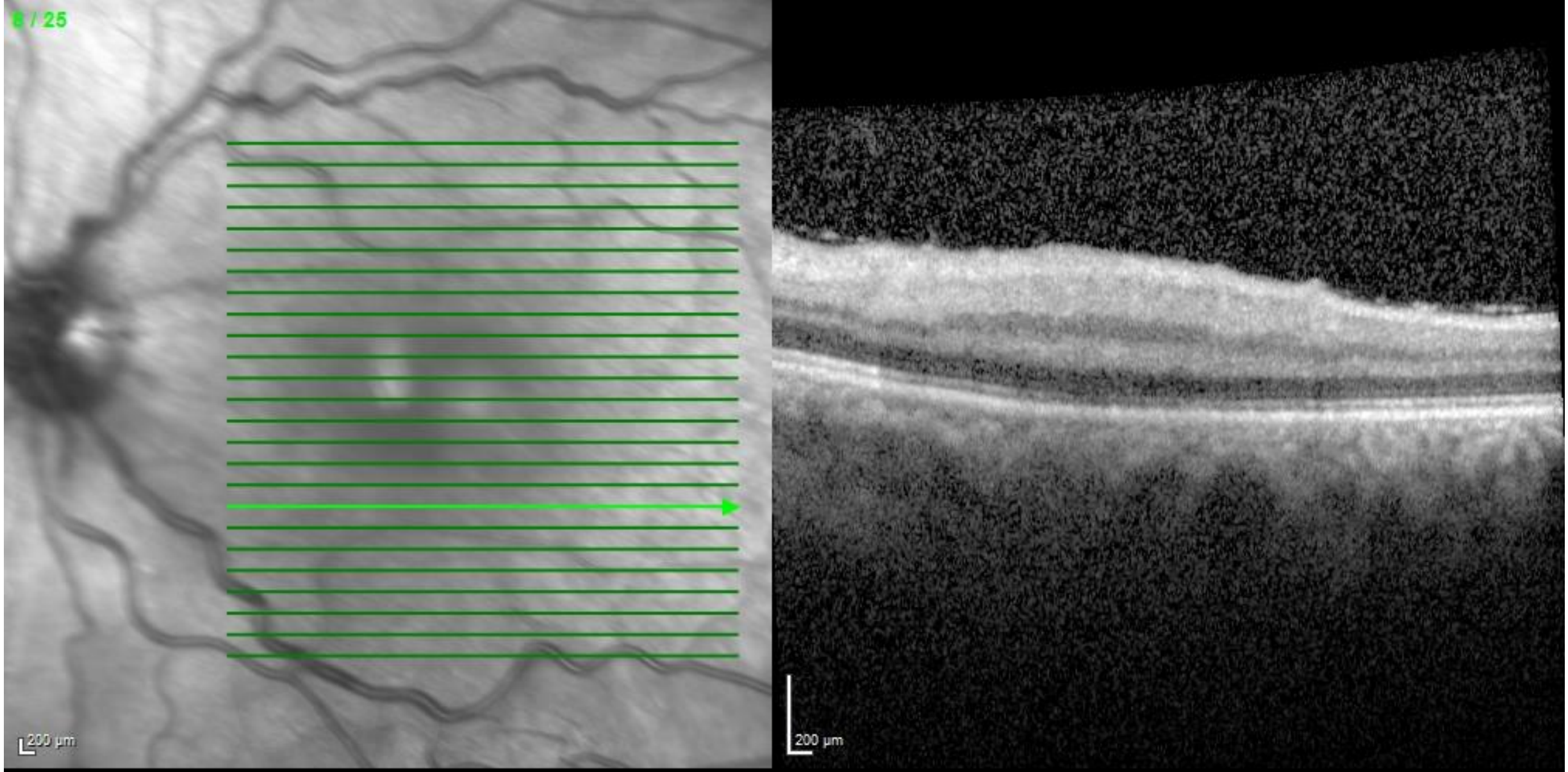

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IR&OCT 30° ART [HS] ART(10) Q: 17

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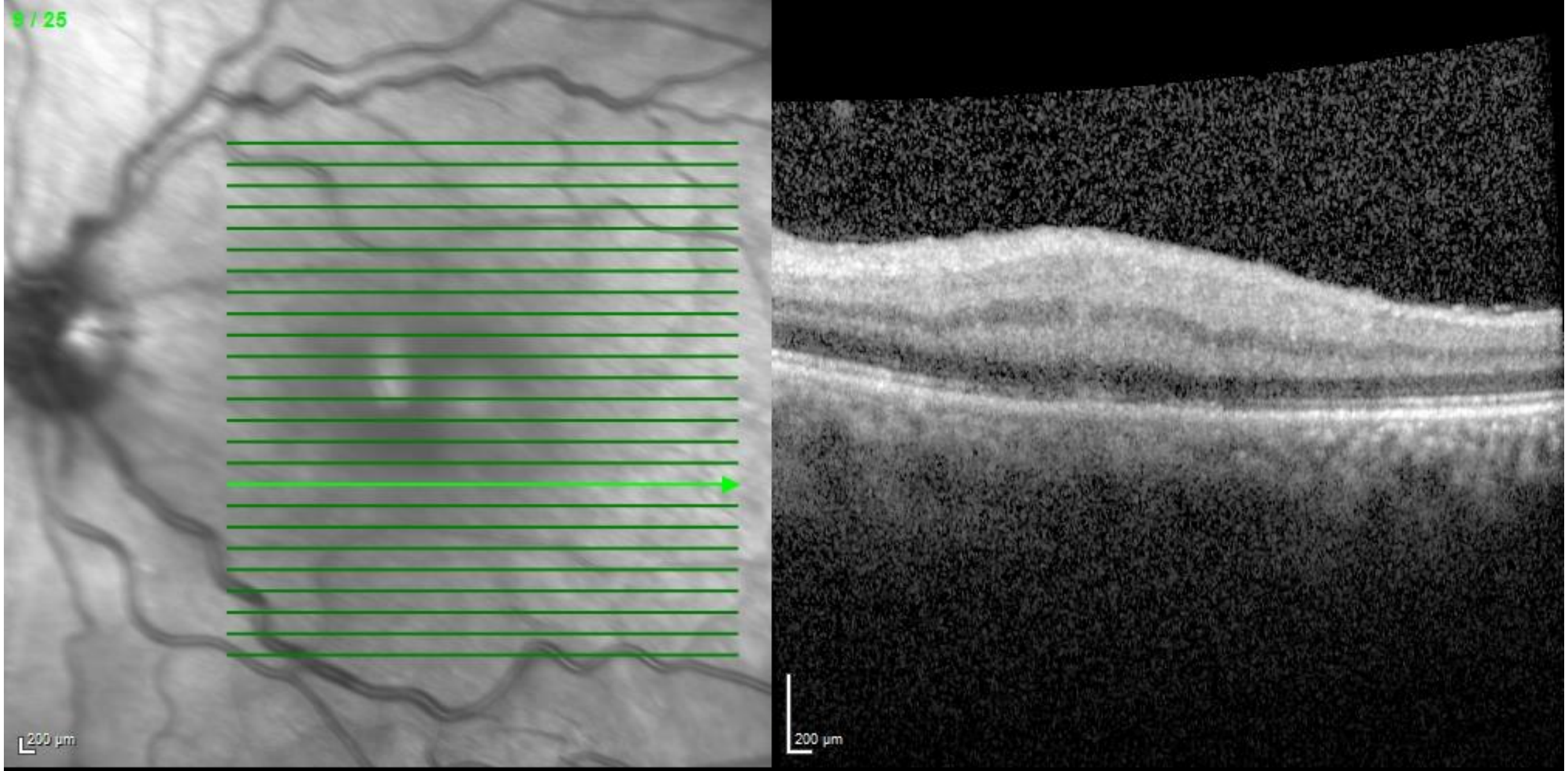

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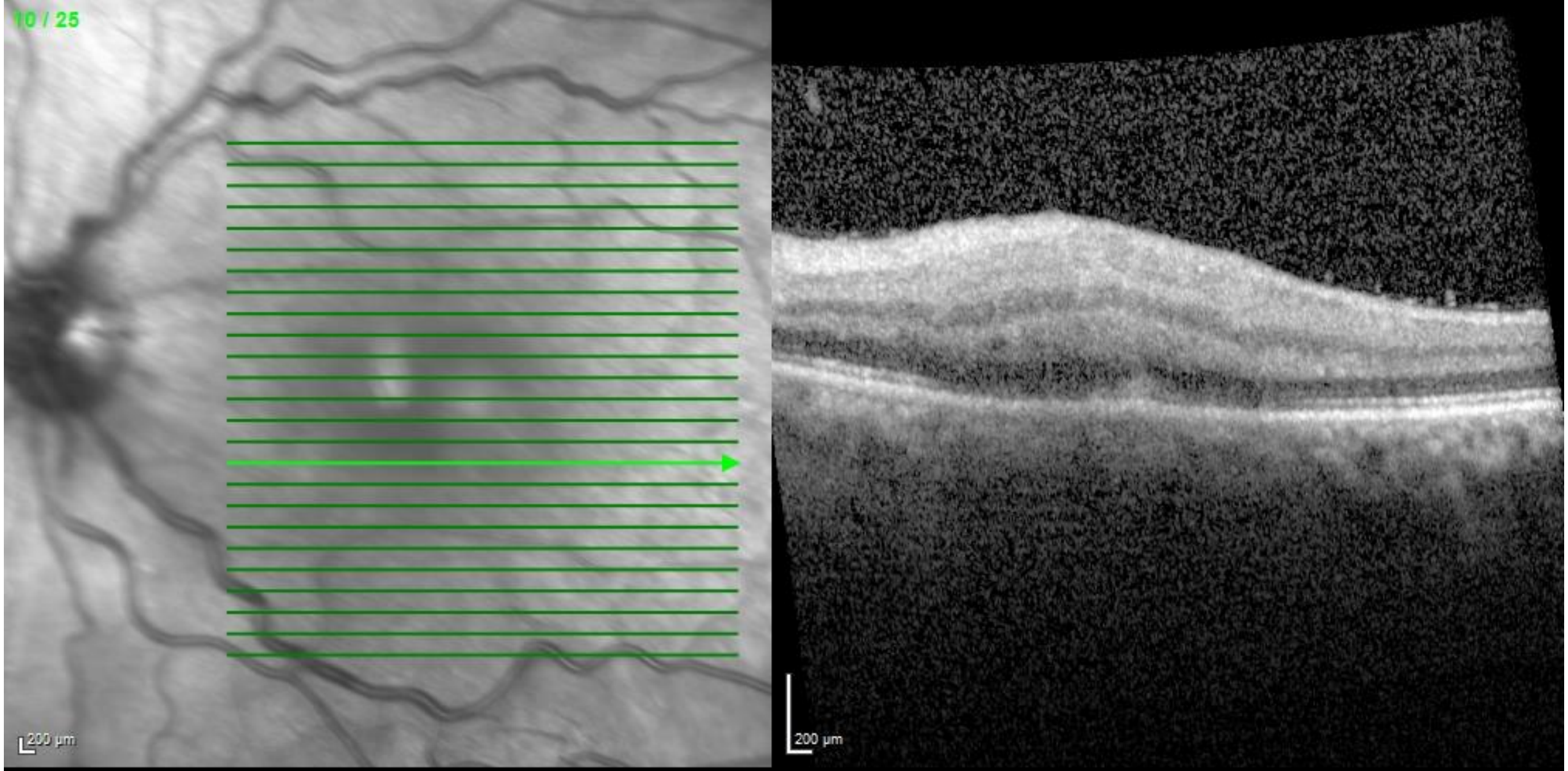

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IR&OCT 30° ART [HS] ART(10) Q: 17

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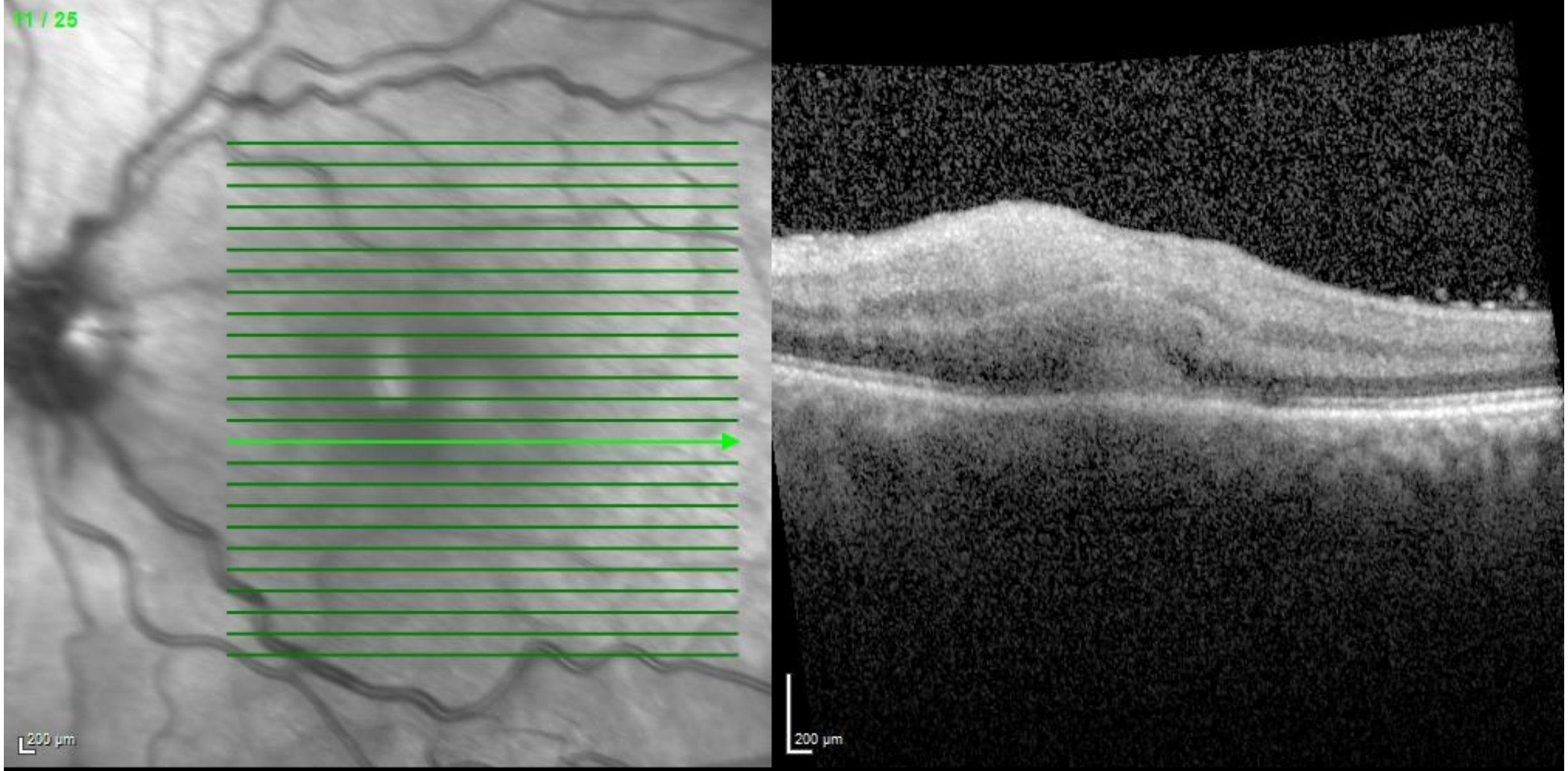

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IR&OCT 30° ART [HS] ART(8) Q: 21

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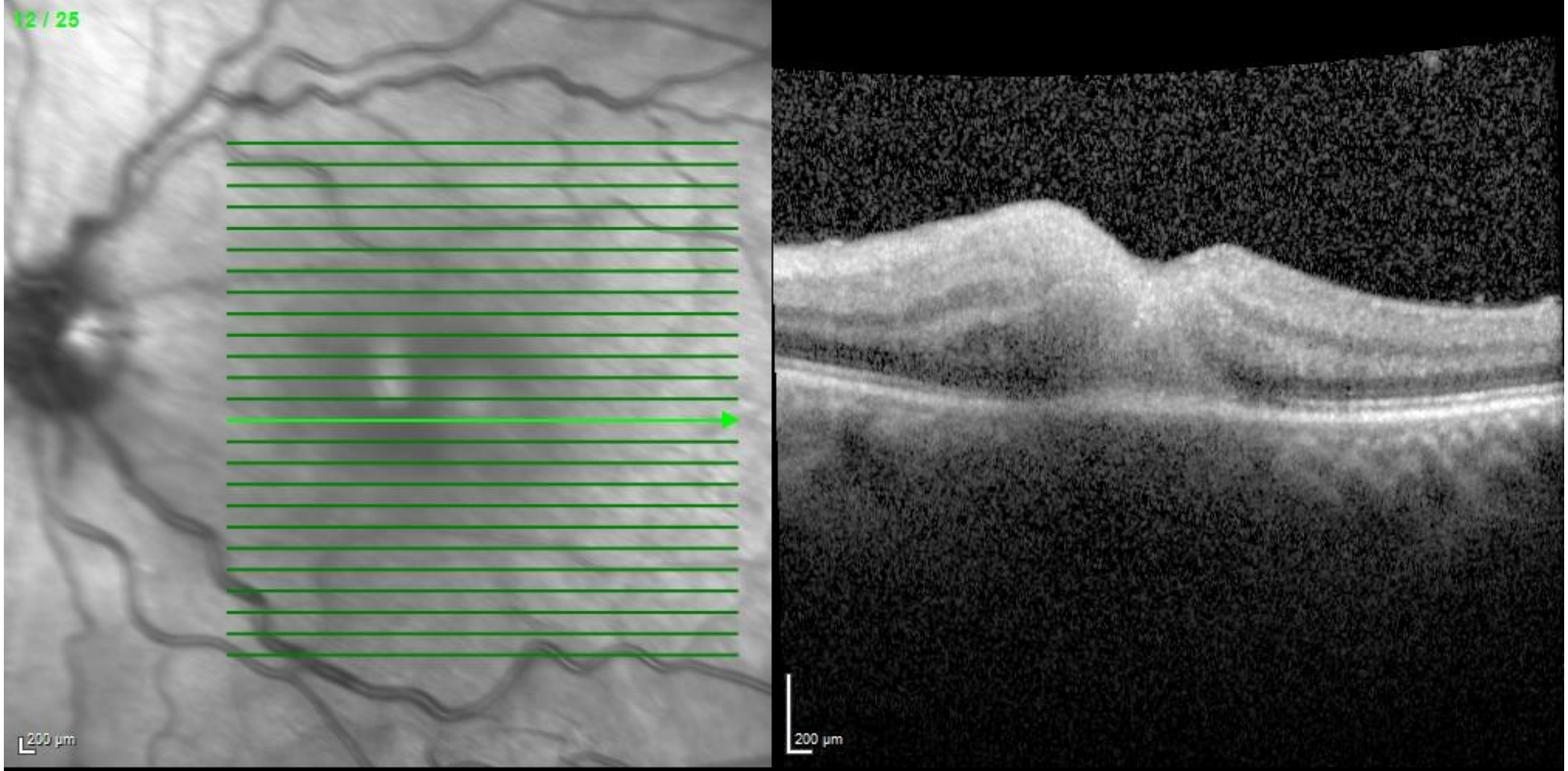

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IR&OCT 30° ART [HS] ART(11) Q: 19

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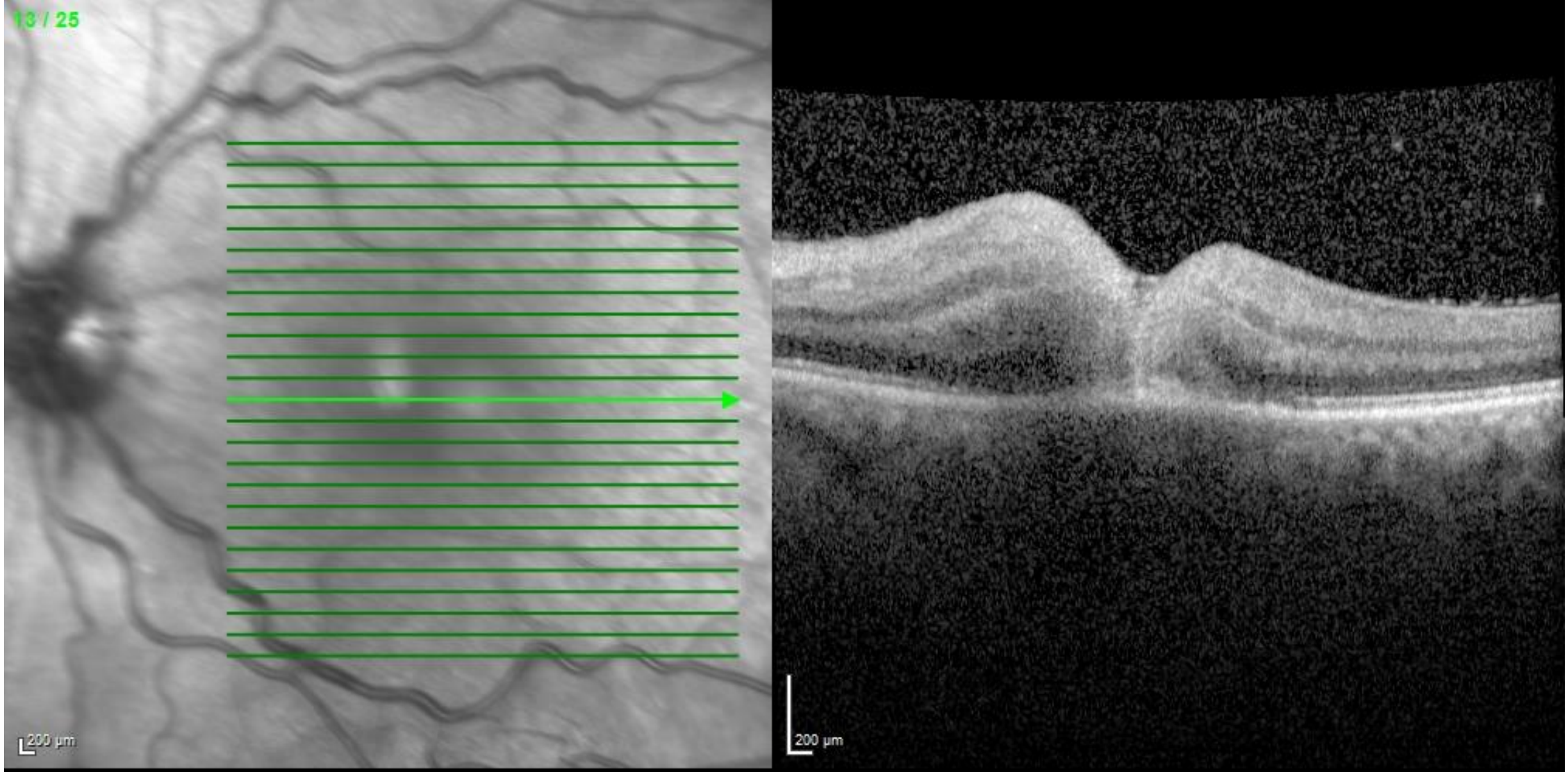

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IR&OCT 30° ART [HS] ART(7) Q: 23

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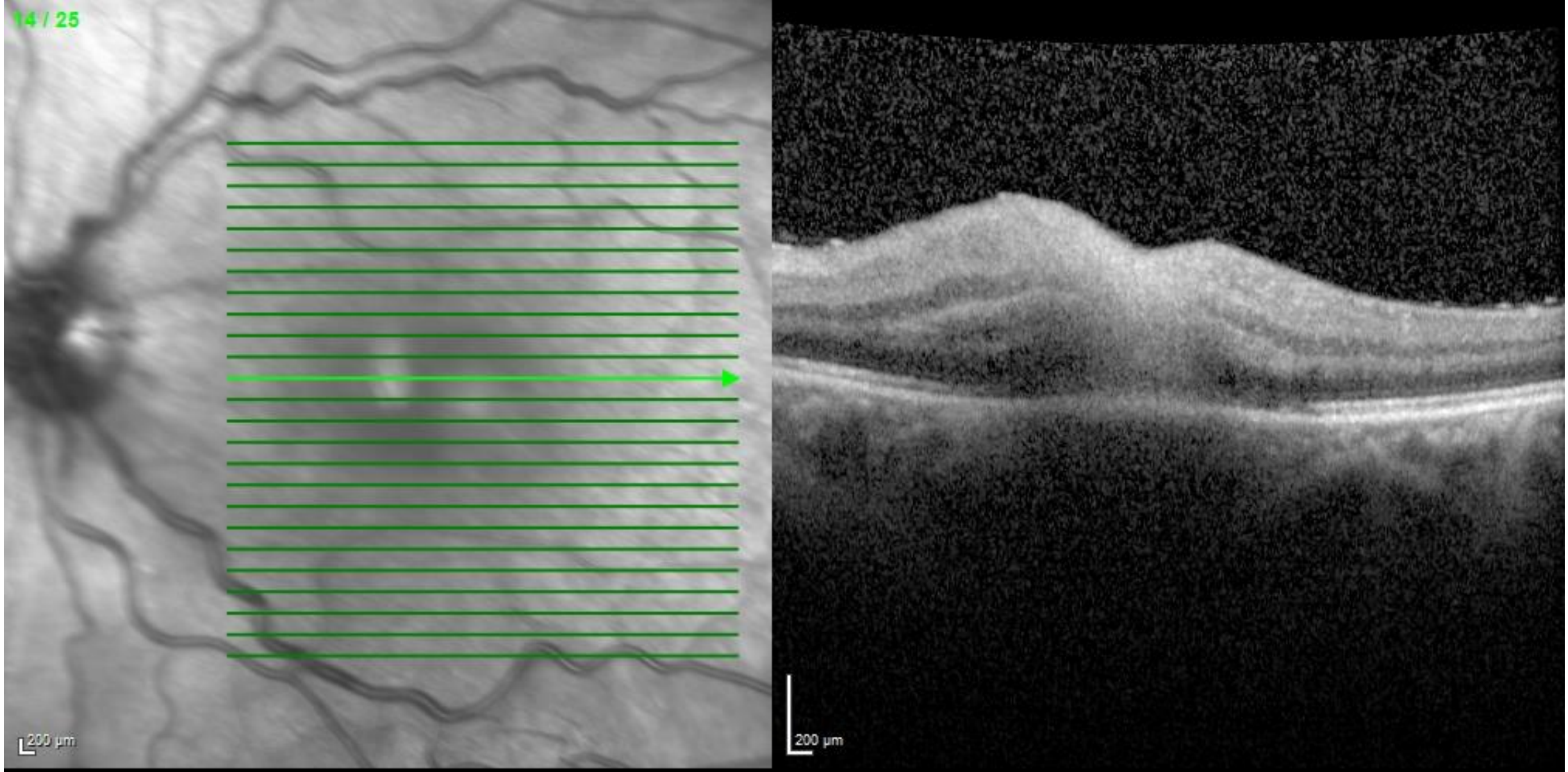

07/02/2018, OS

IR&OCT 30° ART [HS] ART(10) Q: 22

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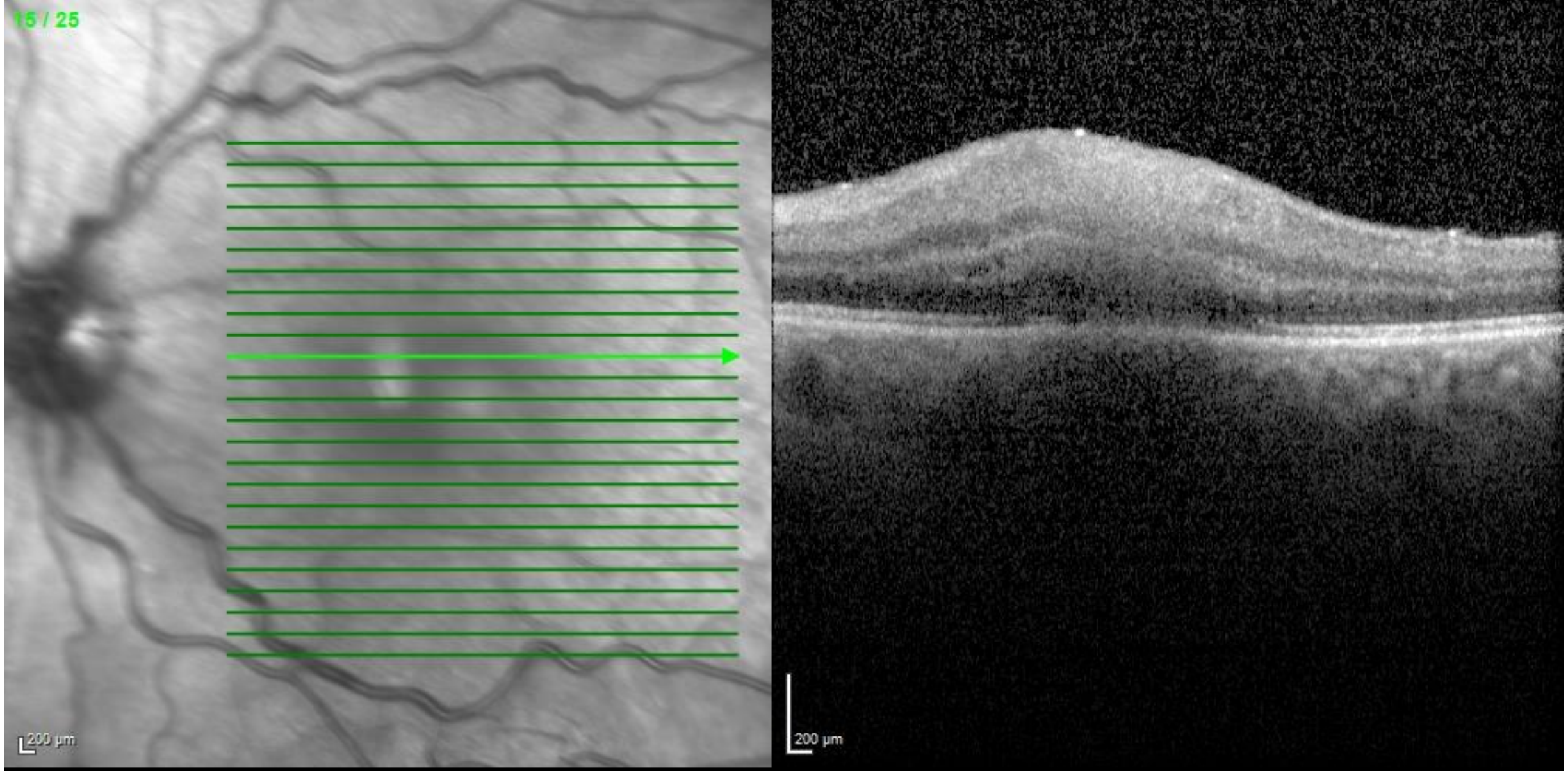

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IR&OCT 30° ART [HS] ART(9) Q: 20

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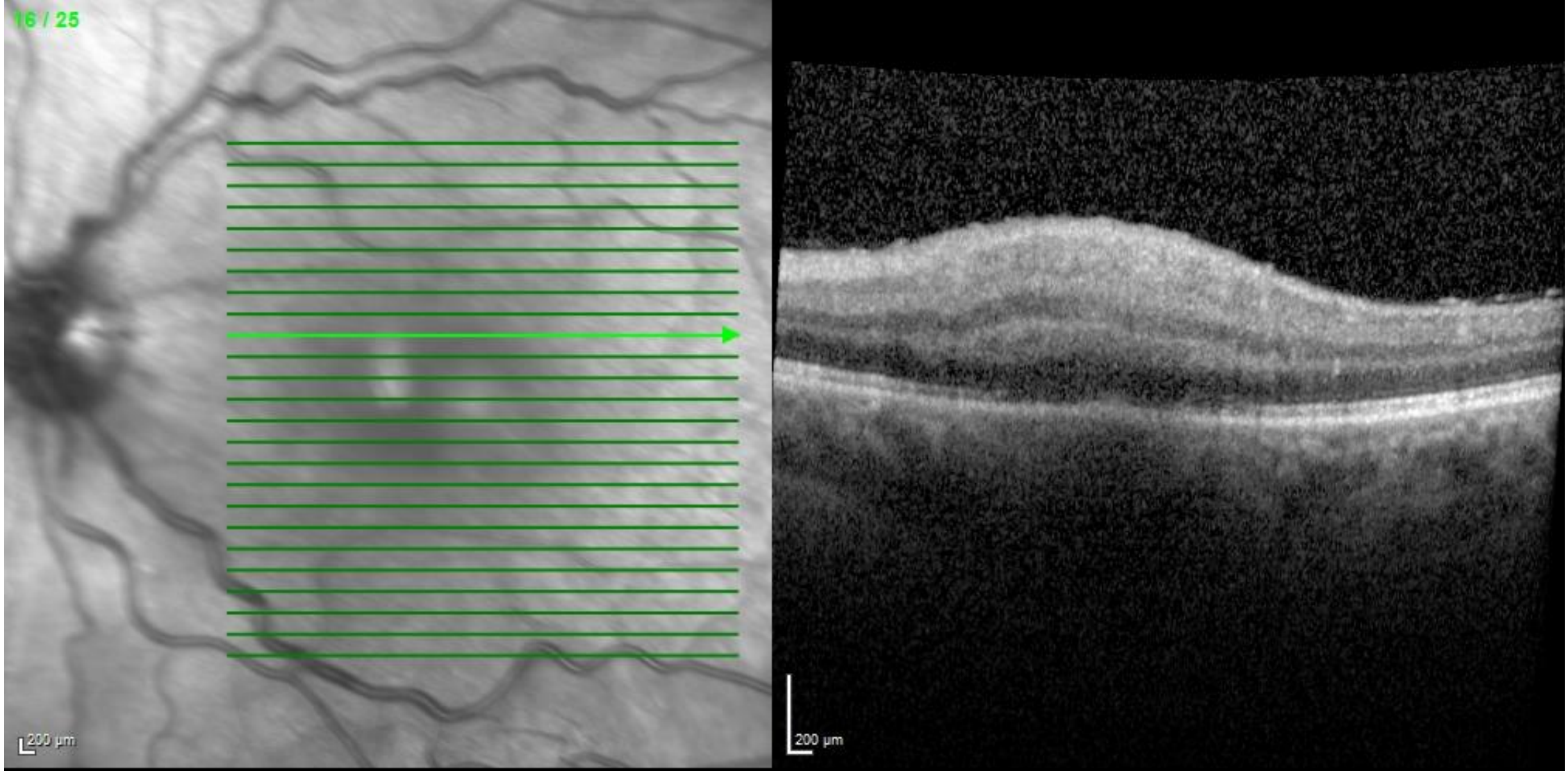

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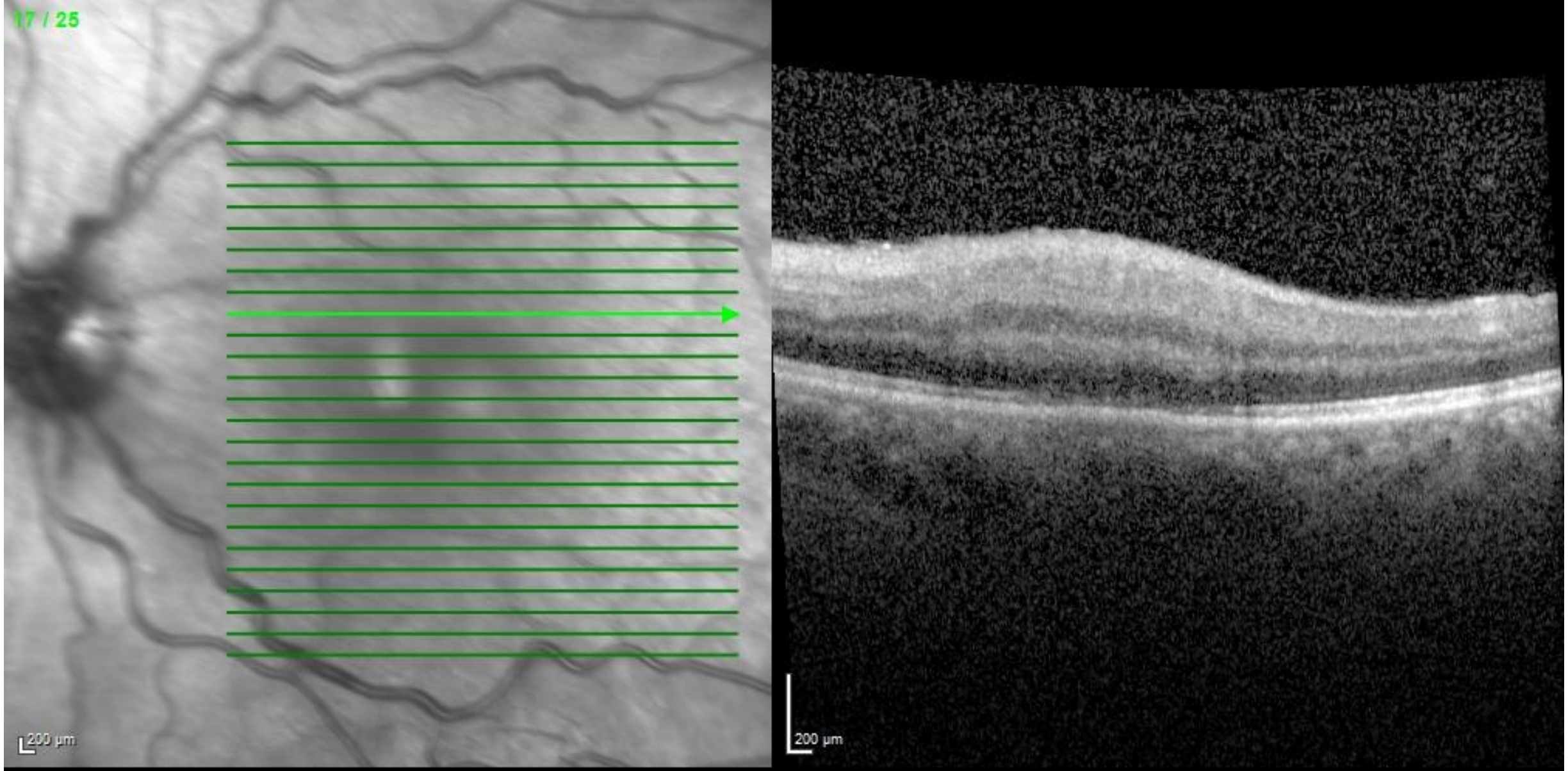

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IR&OCT 30° ART [HS] ART(7) Q: 17

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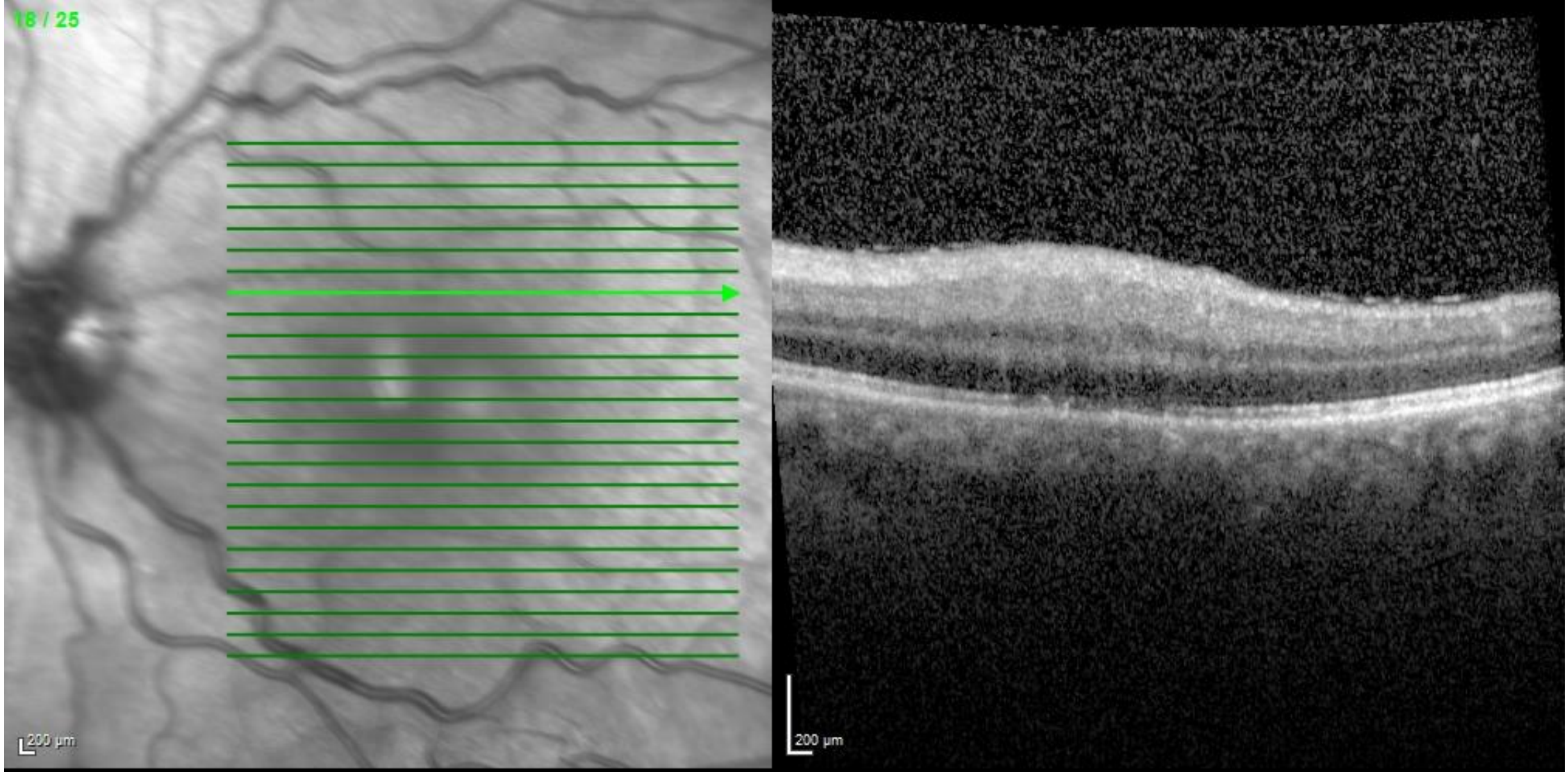

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IR&OCT 30° ART [HS] ART(8) Q: 19

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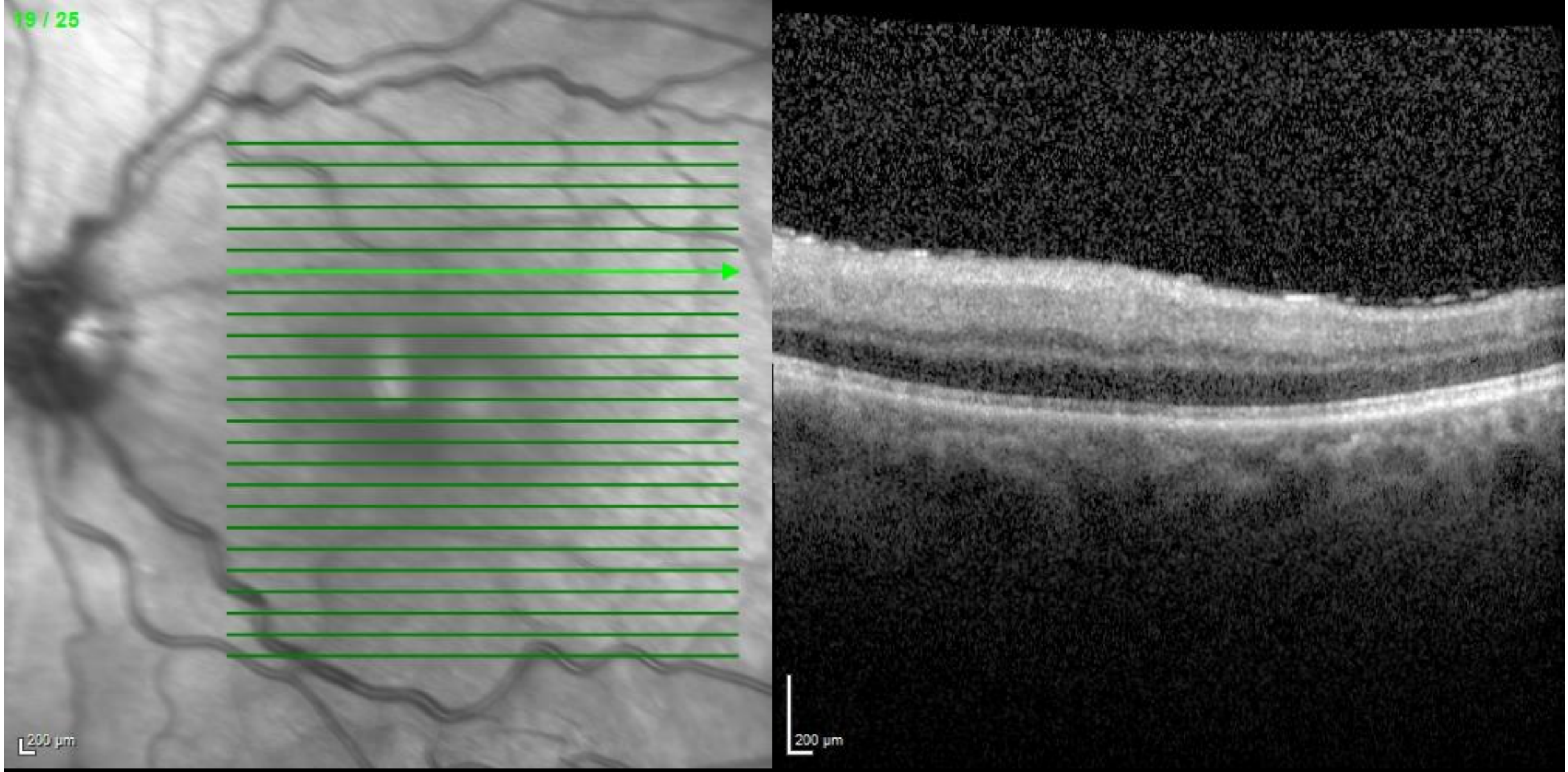

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IR&OCT 30° ART [HS] ART(10) Q: 21

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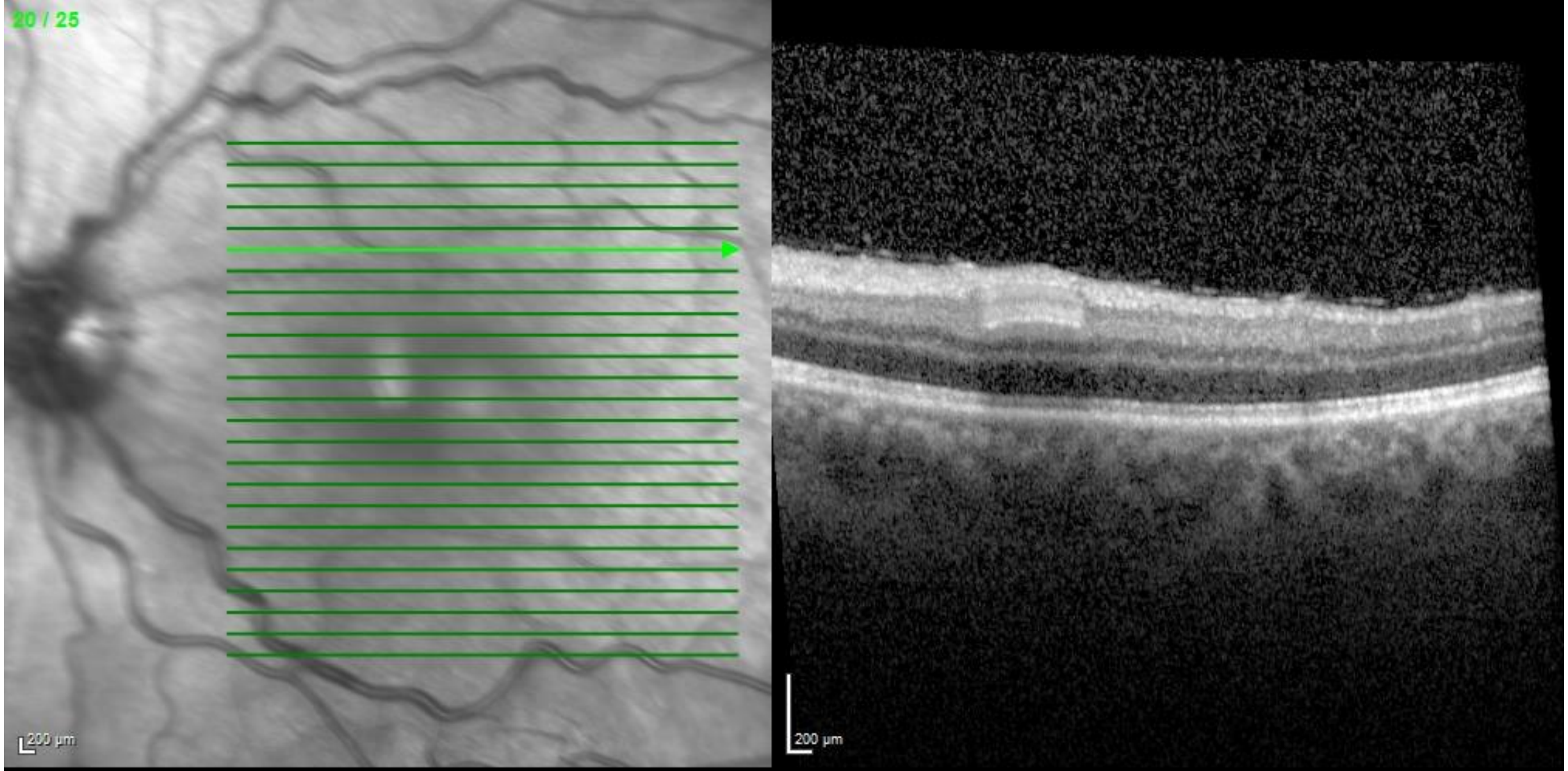

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IR&OCT 30° ART [HS] ART(11) Q: 20

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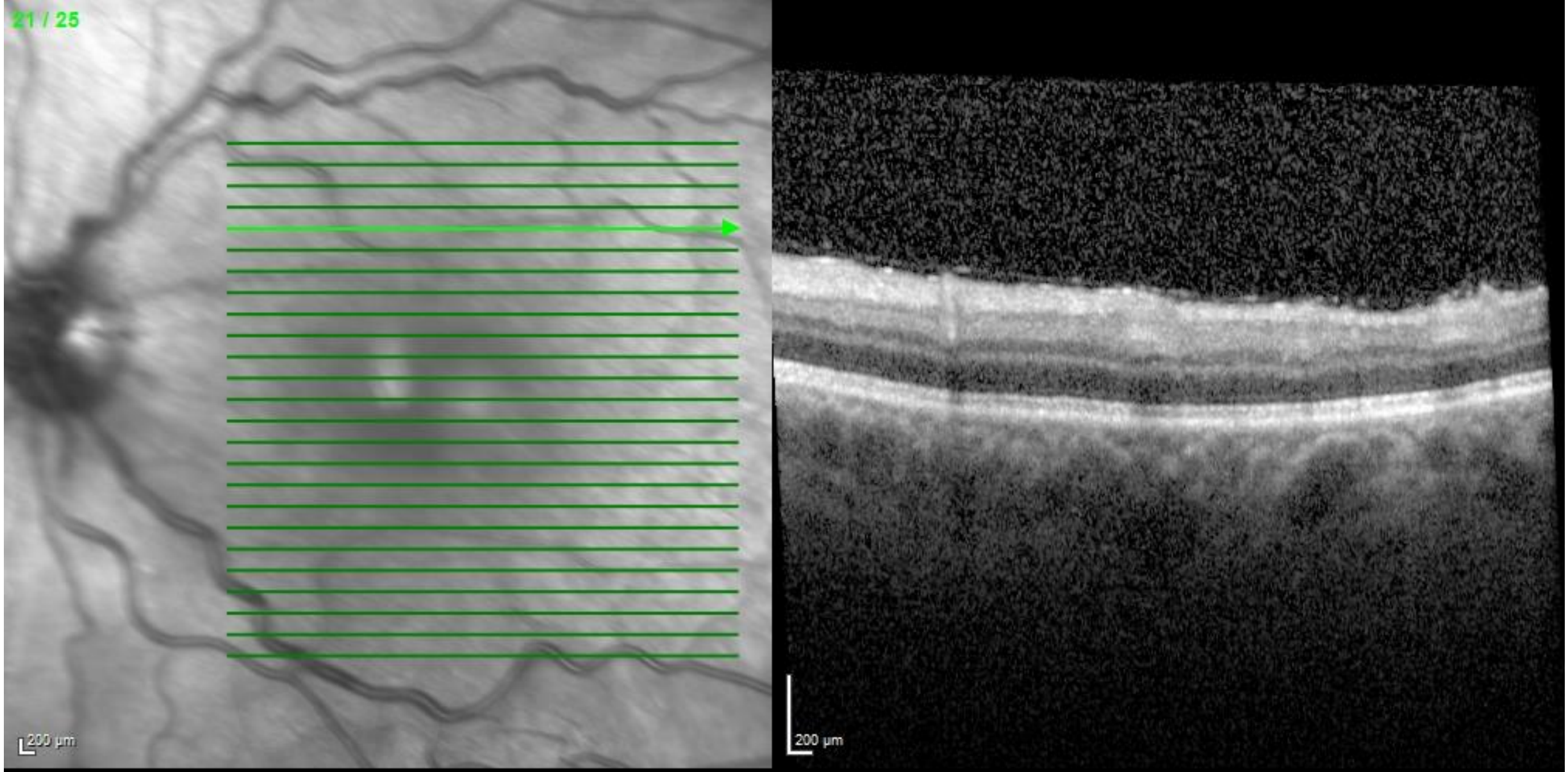

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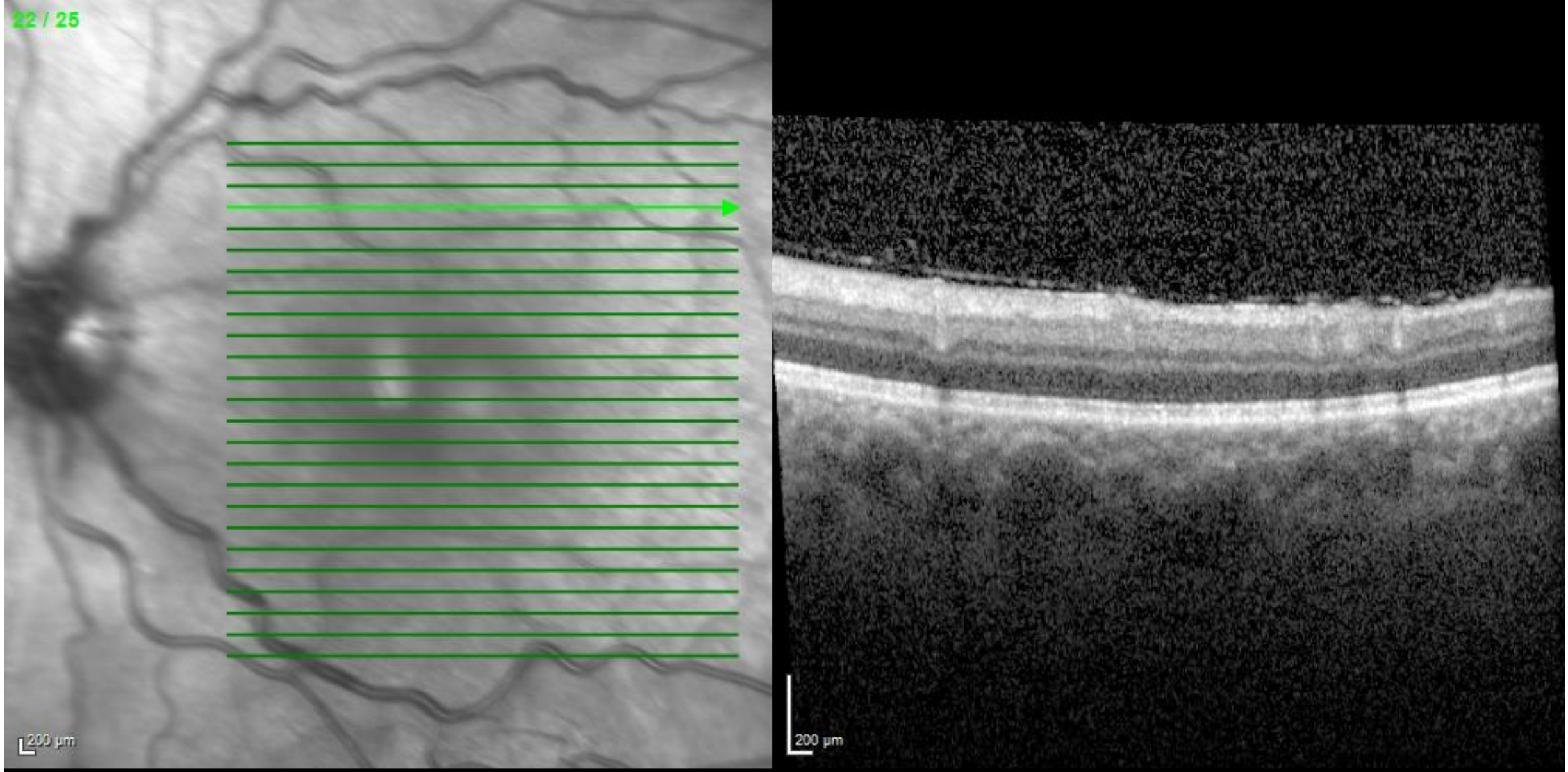

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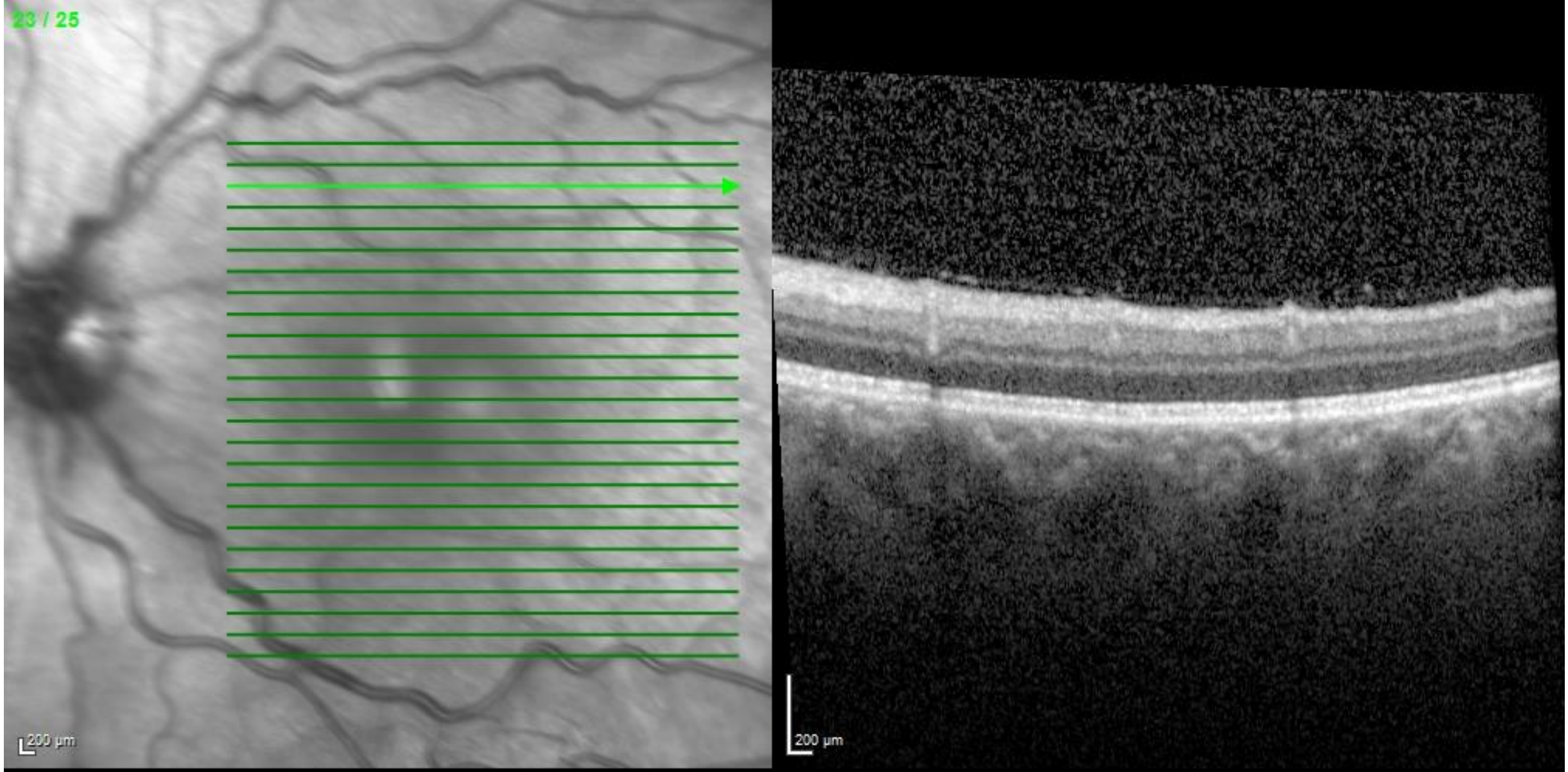

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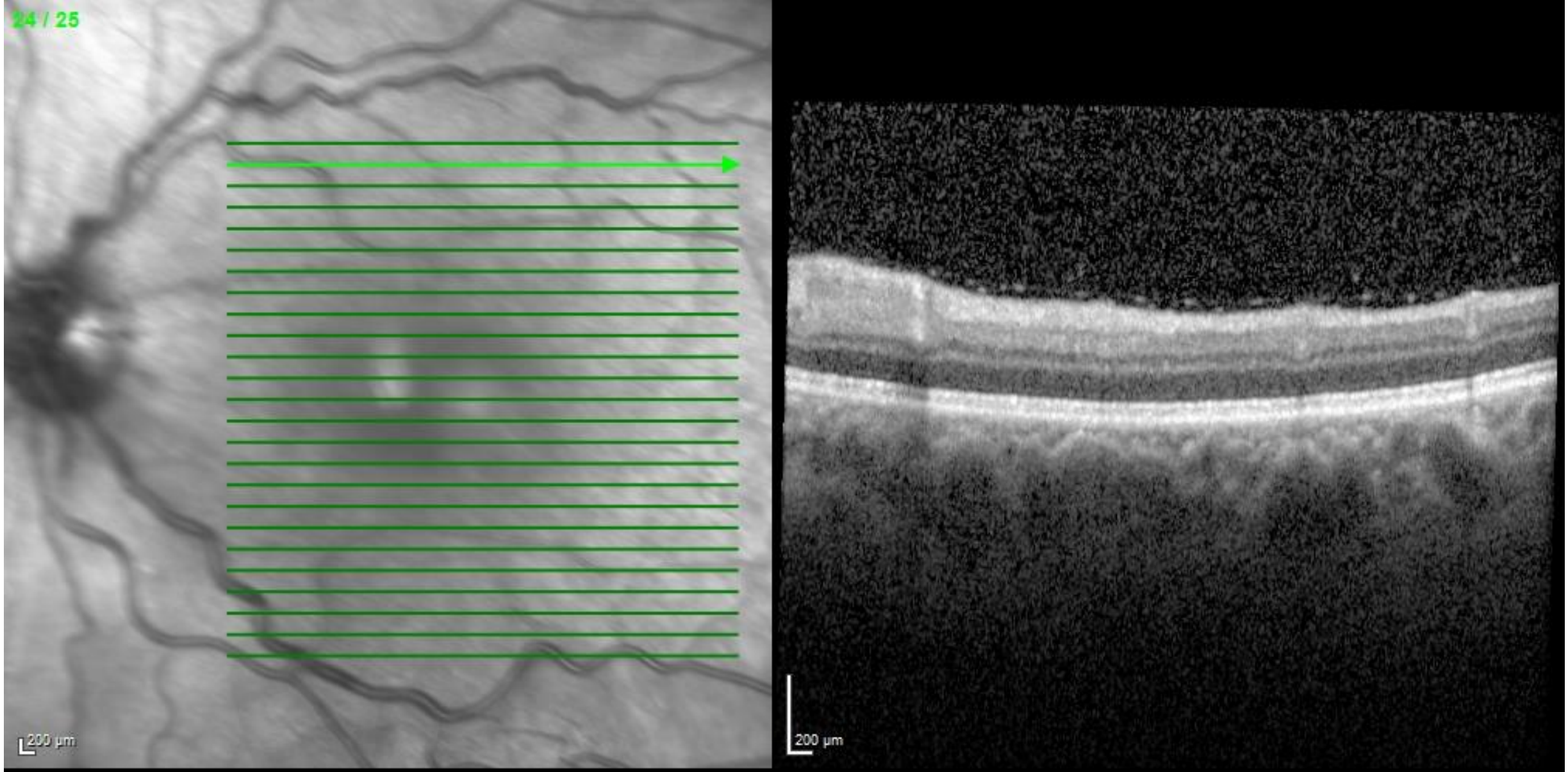

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IR&OCT 30° ART [HS] ART(11) Q: 22

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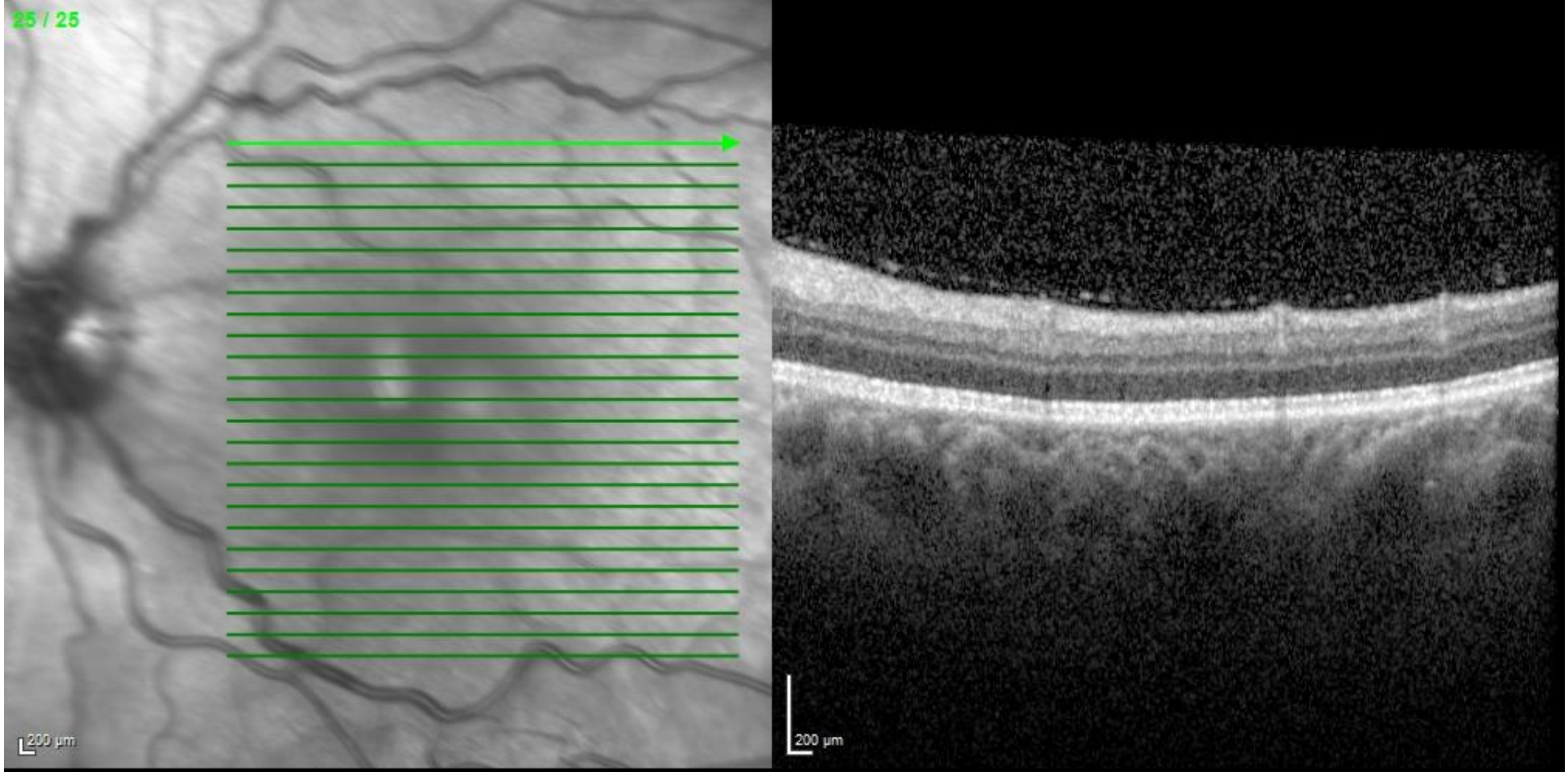

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IR&OCT 30° ART [HS] ART(9) Q: 25

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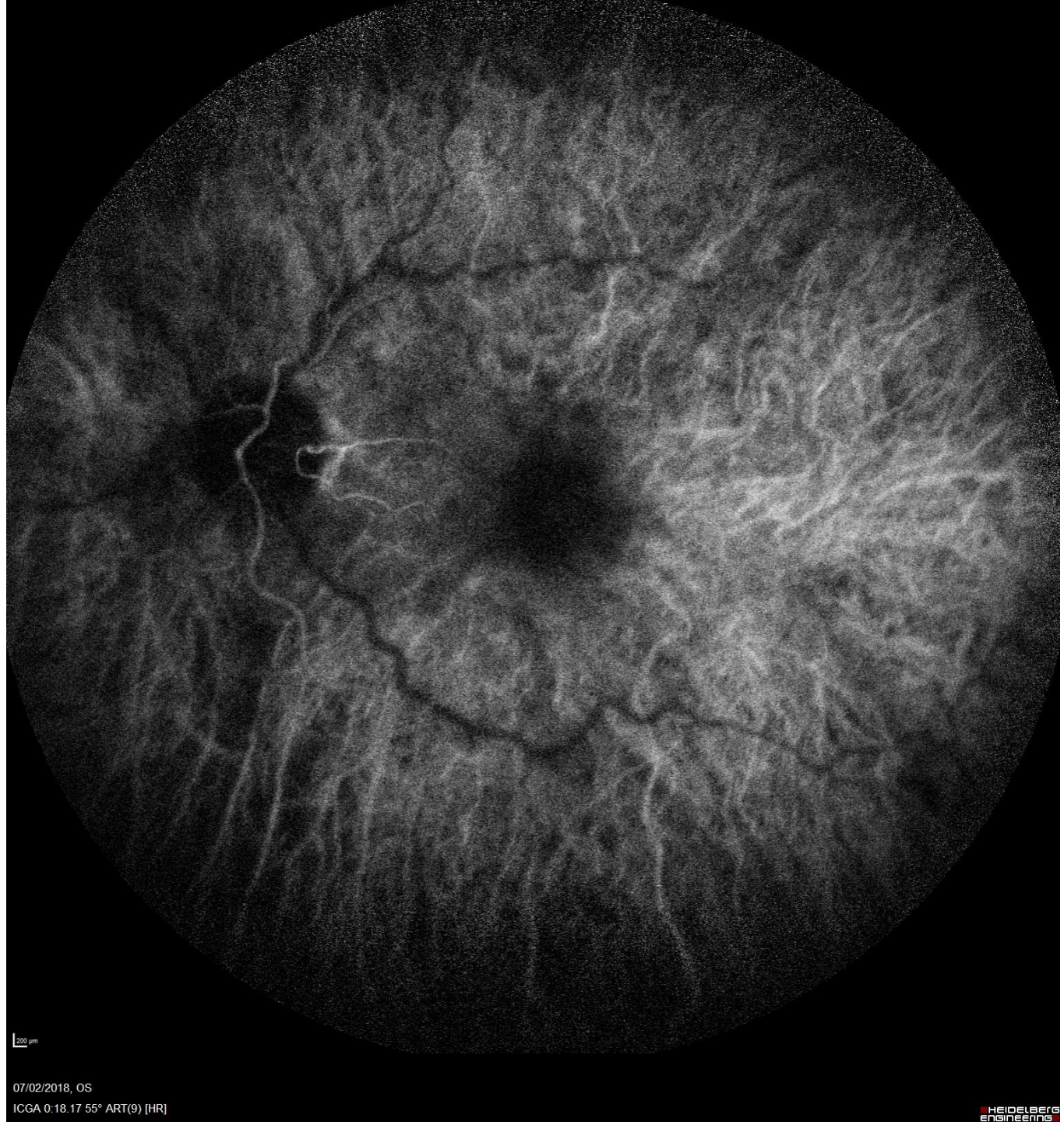
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07/02/2018, OS
ICGA 0:18.17 55° ART(9) [HR]
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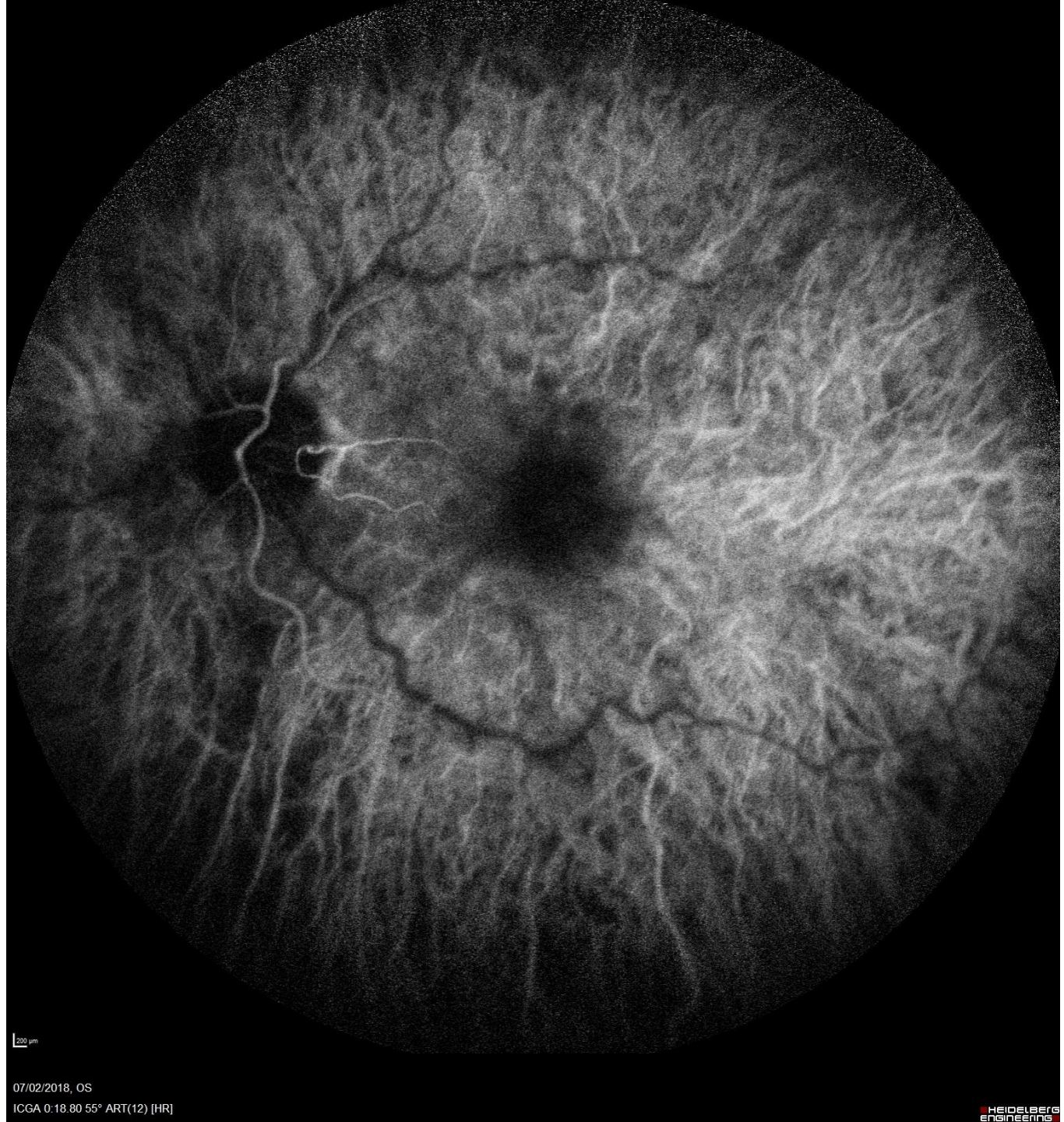
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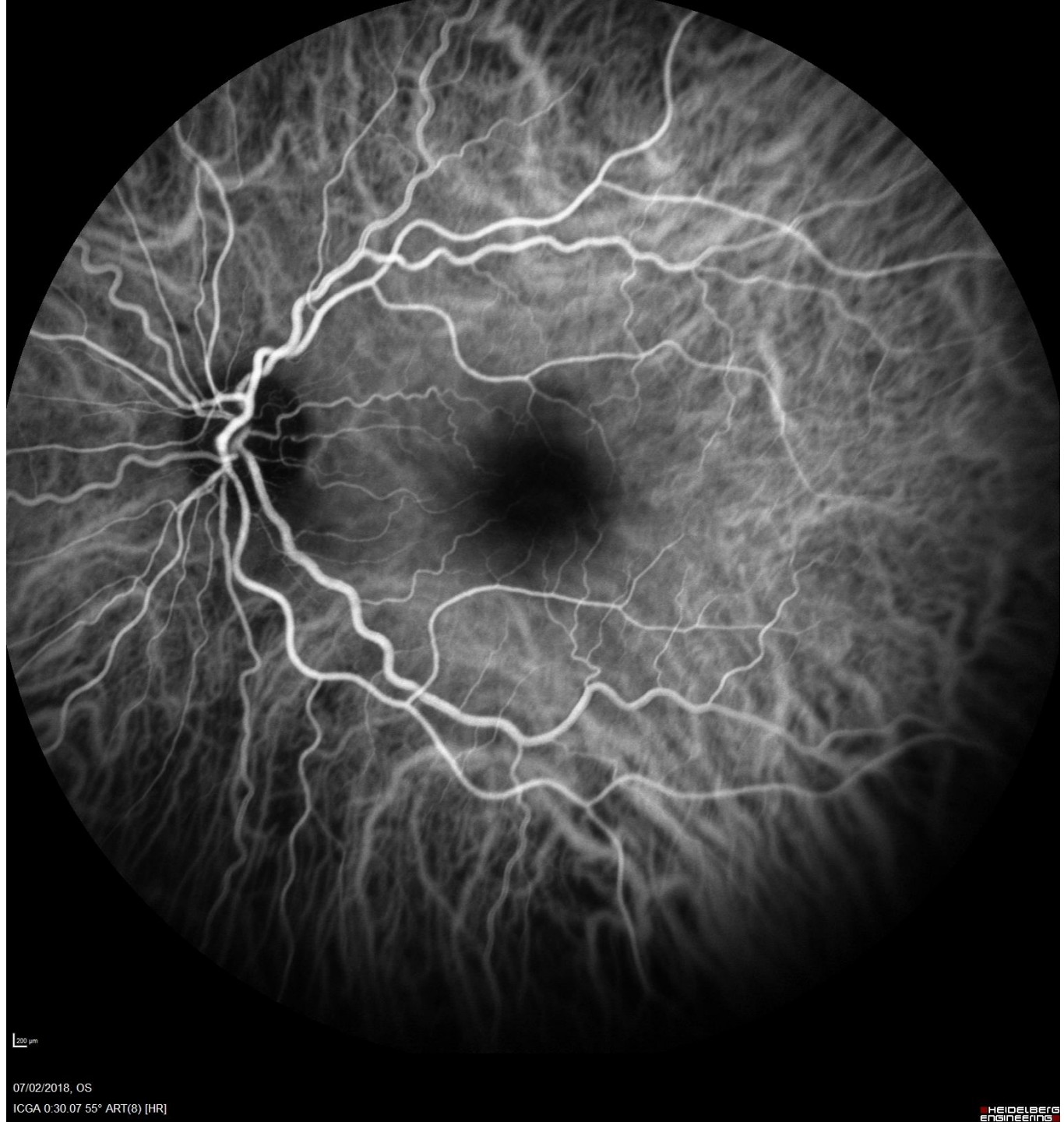
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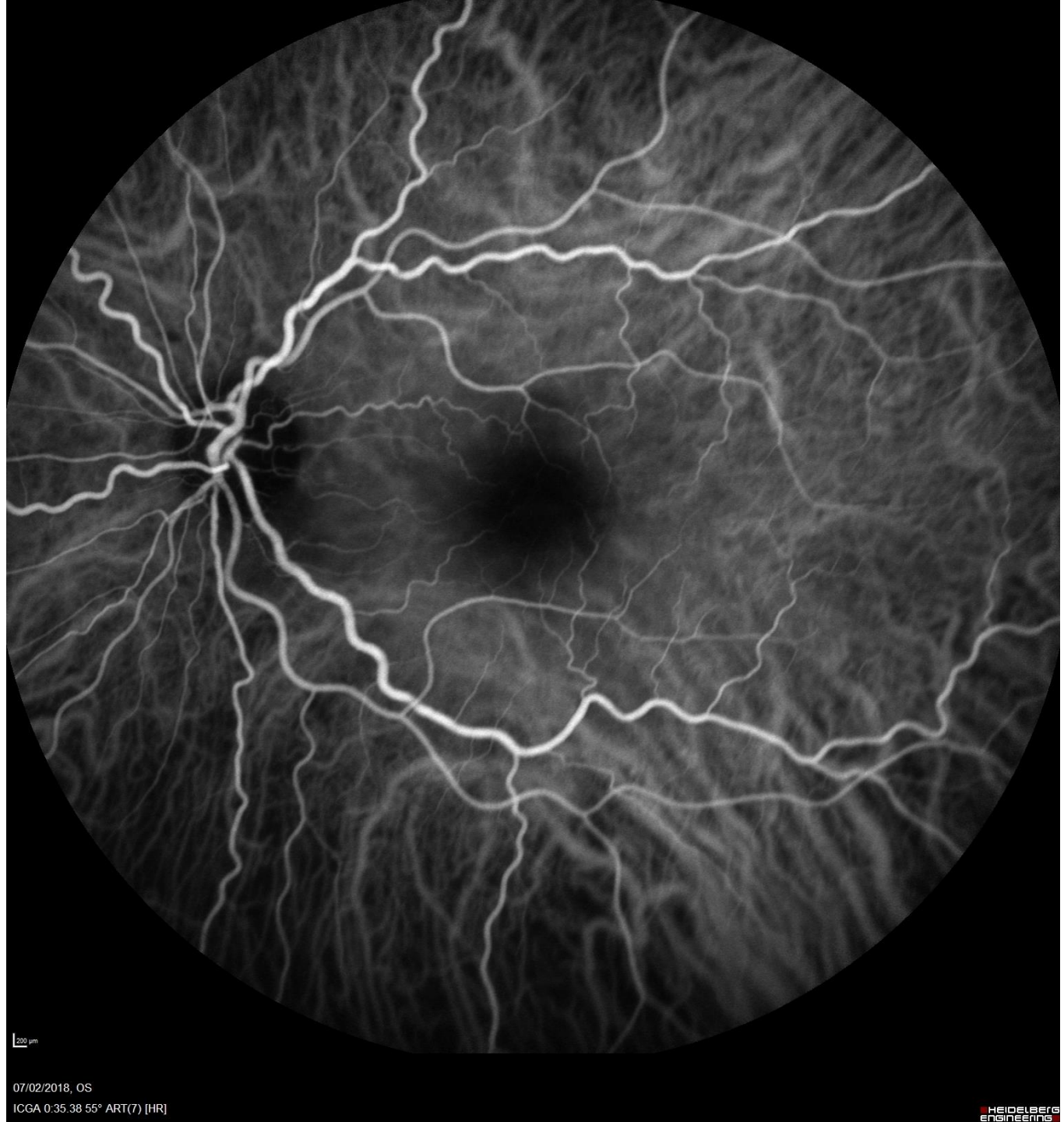
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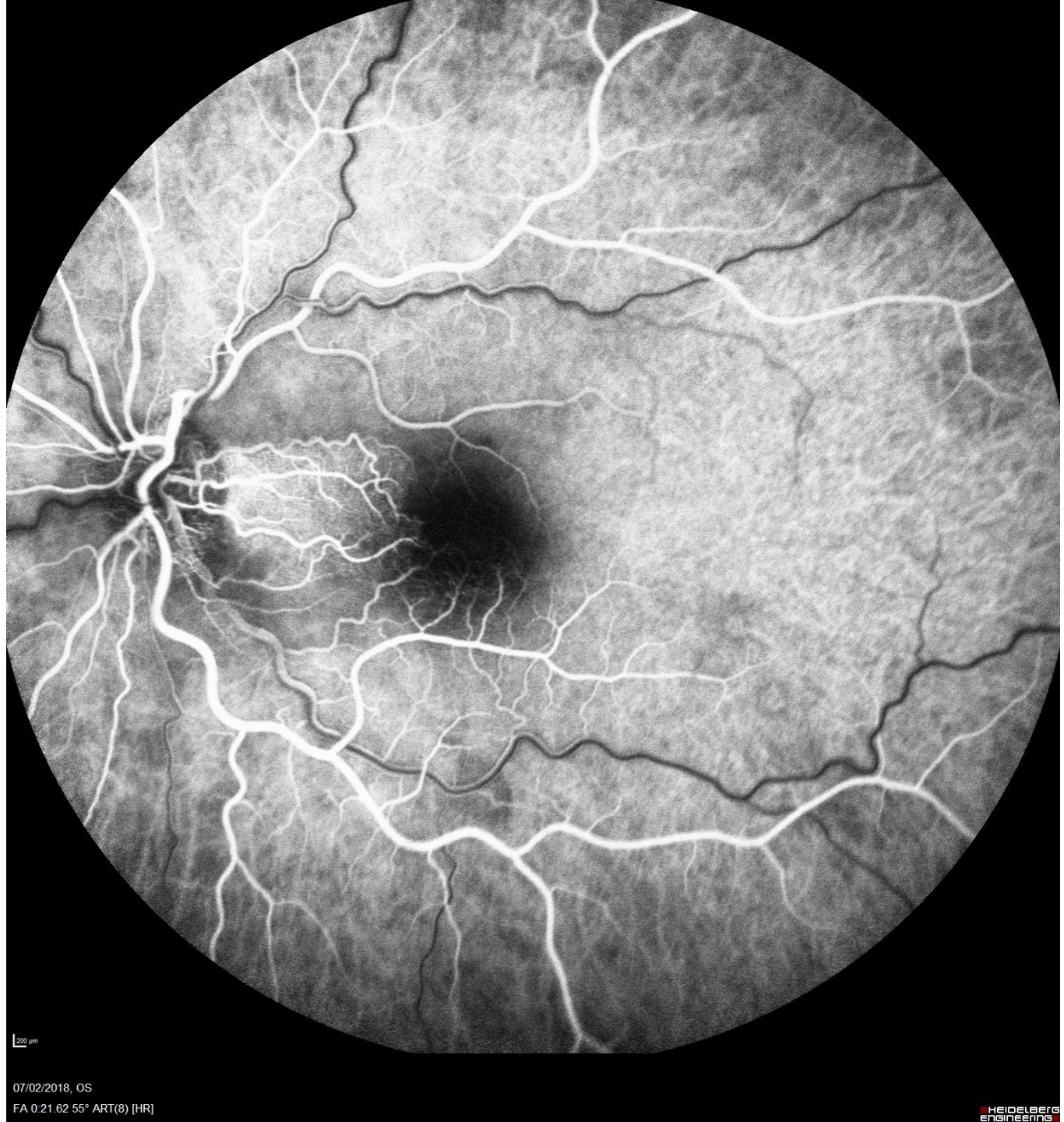
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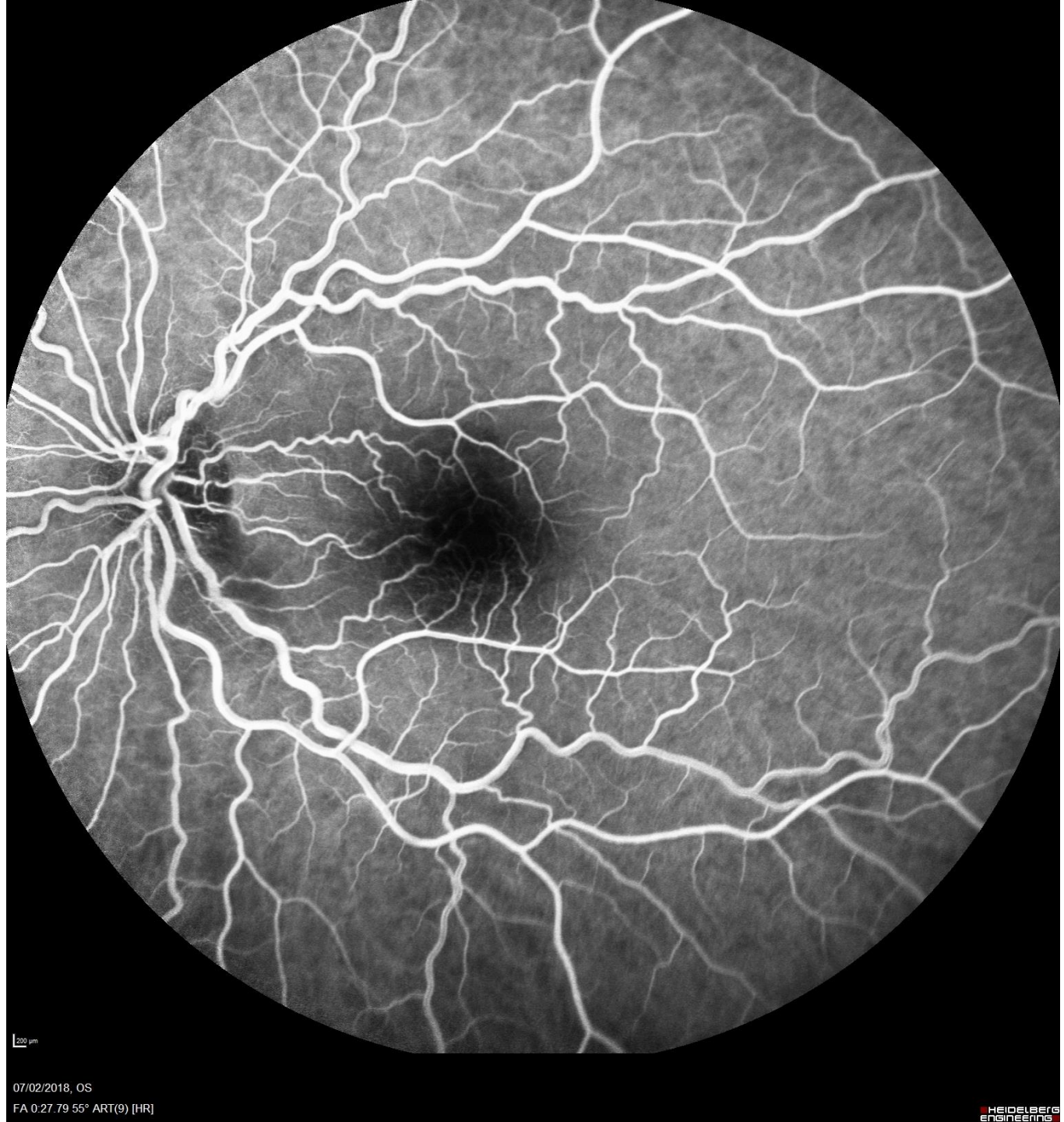
HEIDELBERG ENGINEERING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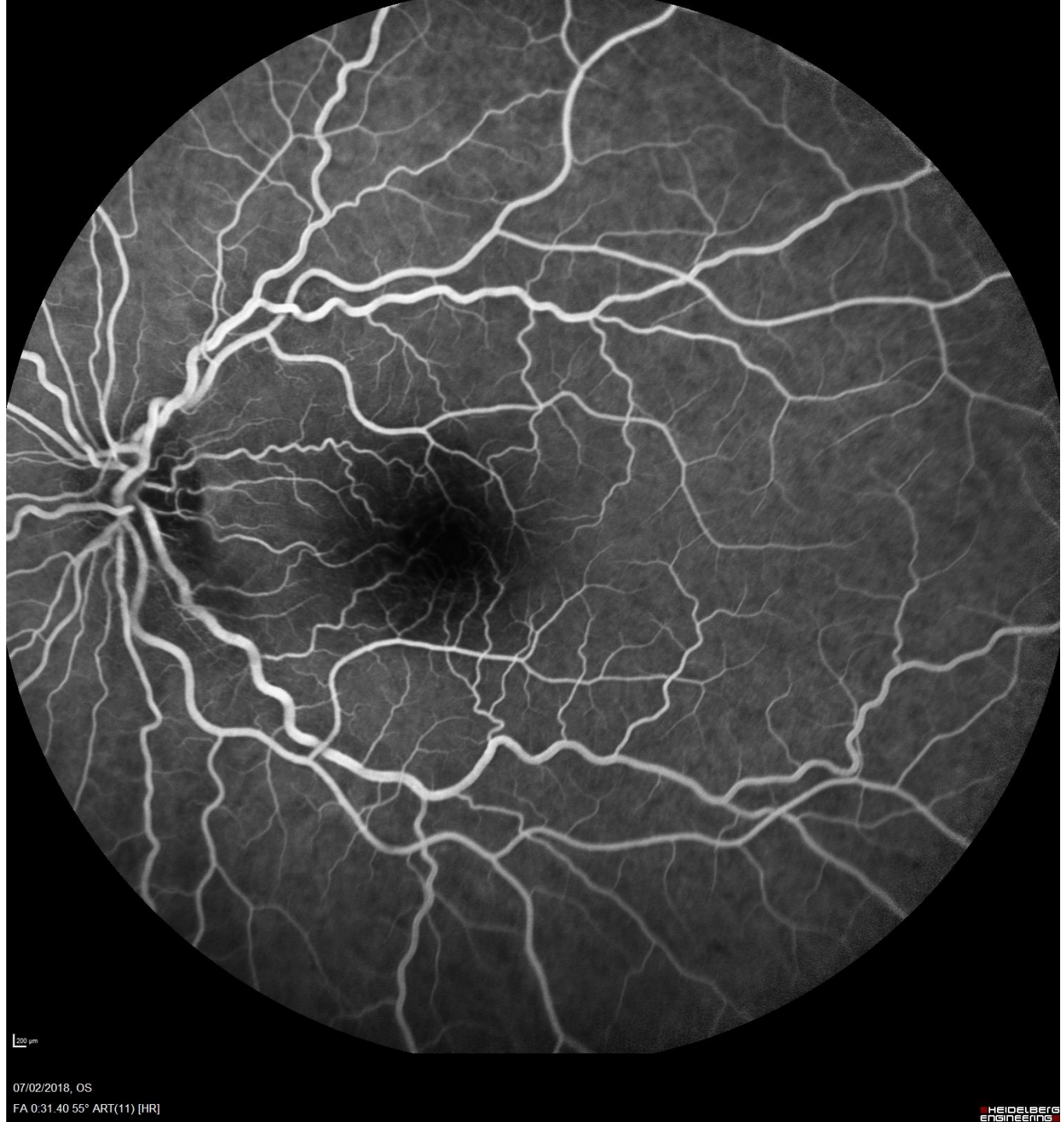
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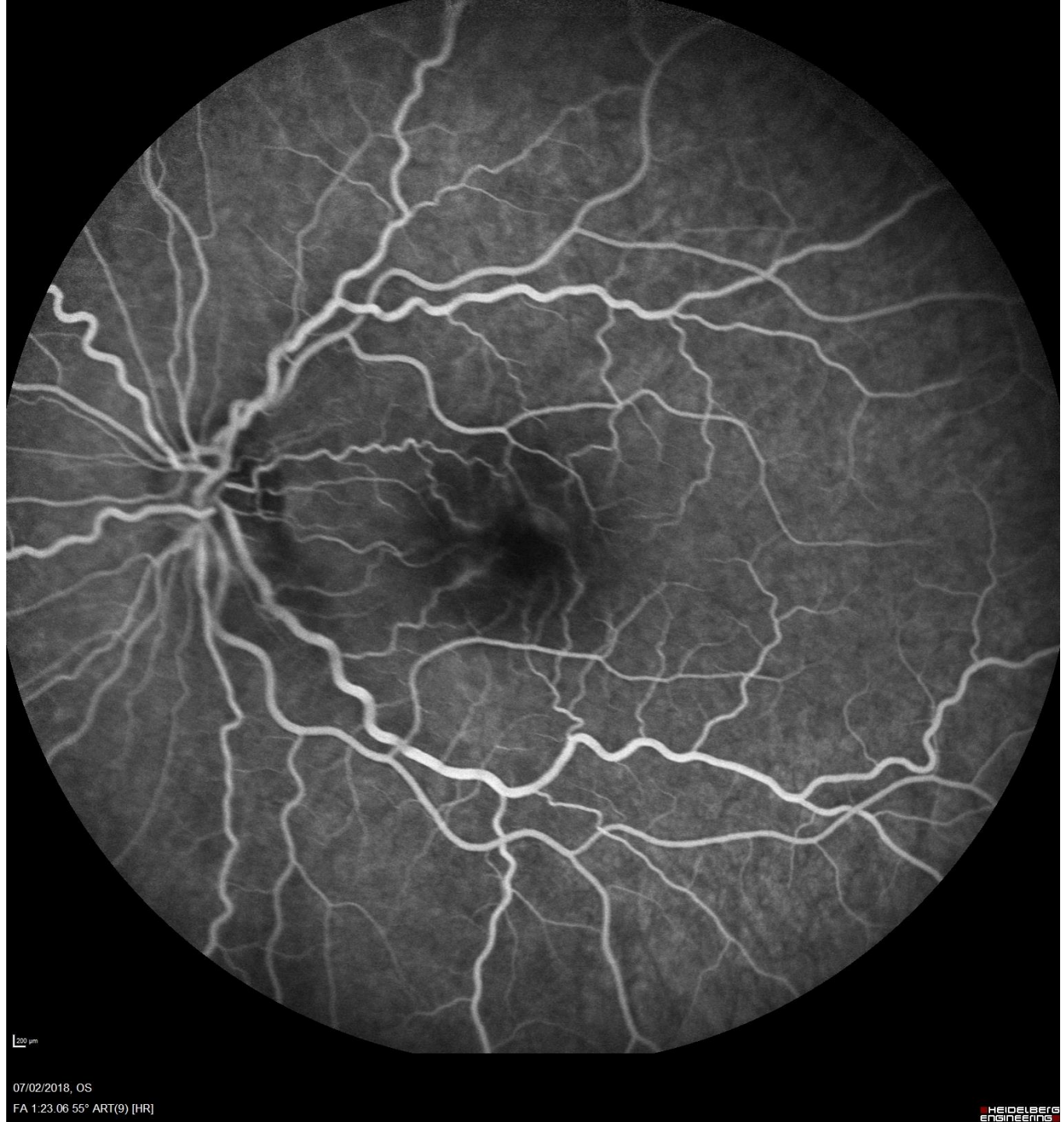
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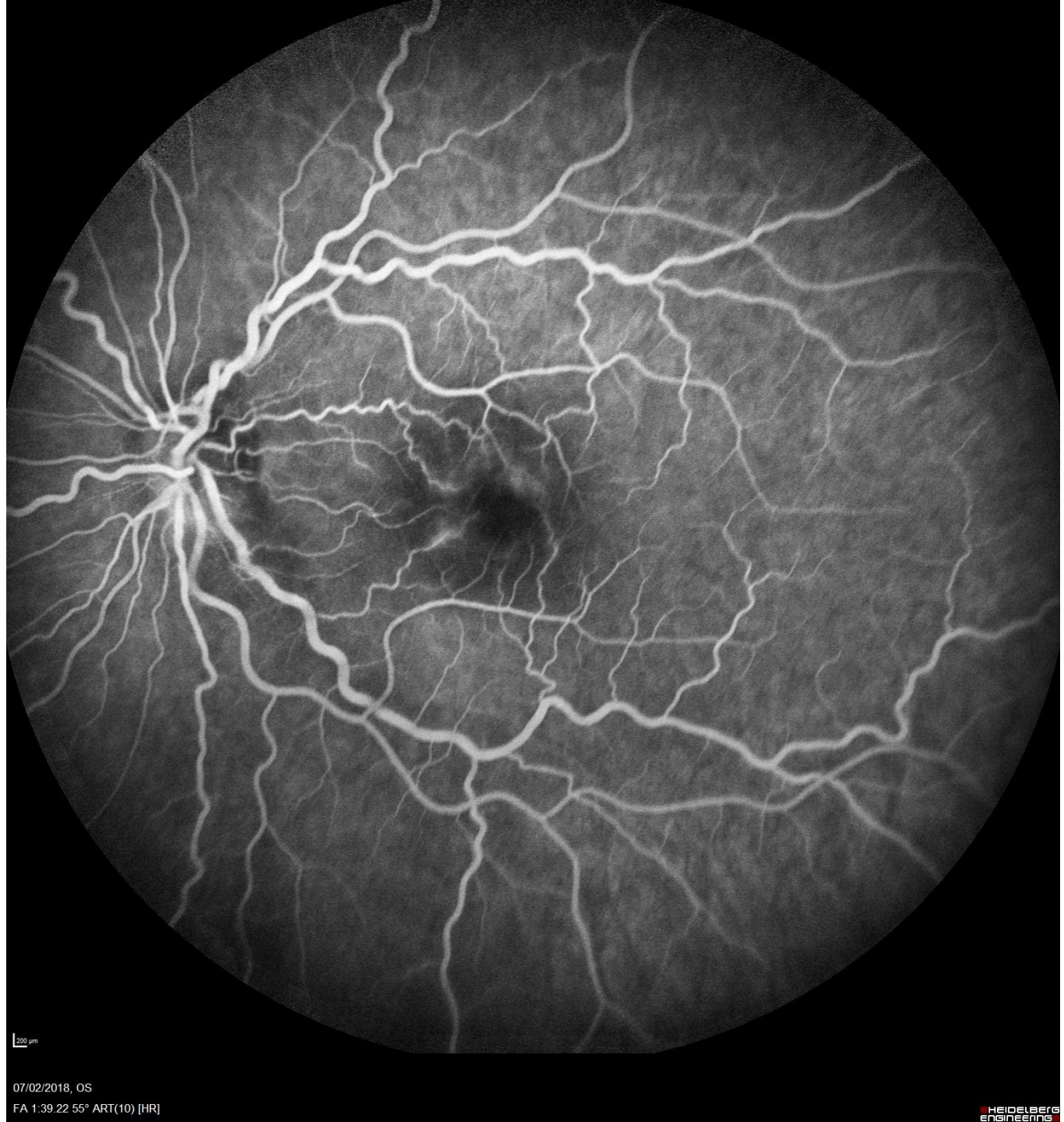
HEIDELBERG ENGINEERING


200 µm
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FA 1:39.22 55° ART(10) [HR]
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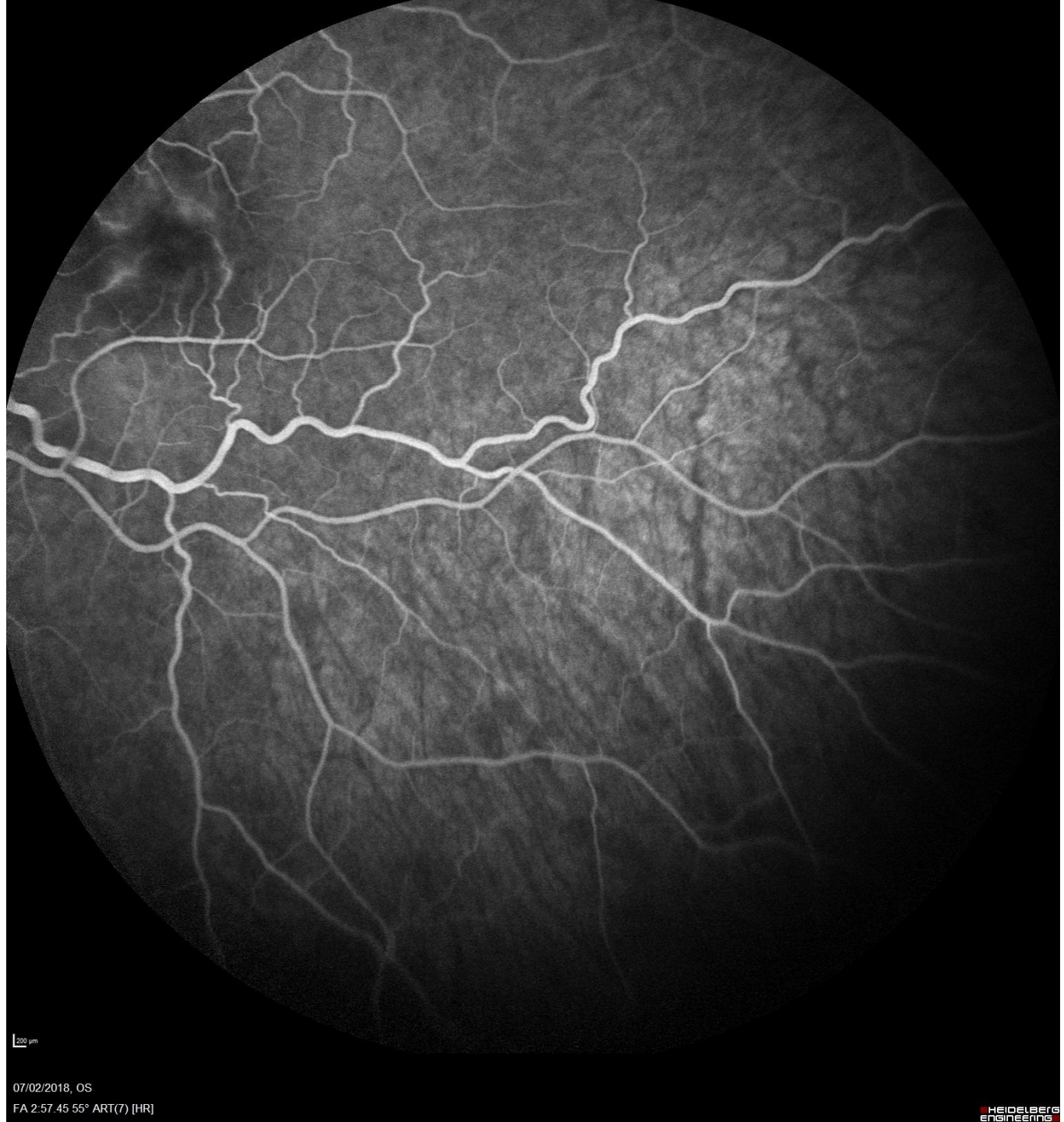
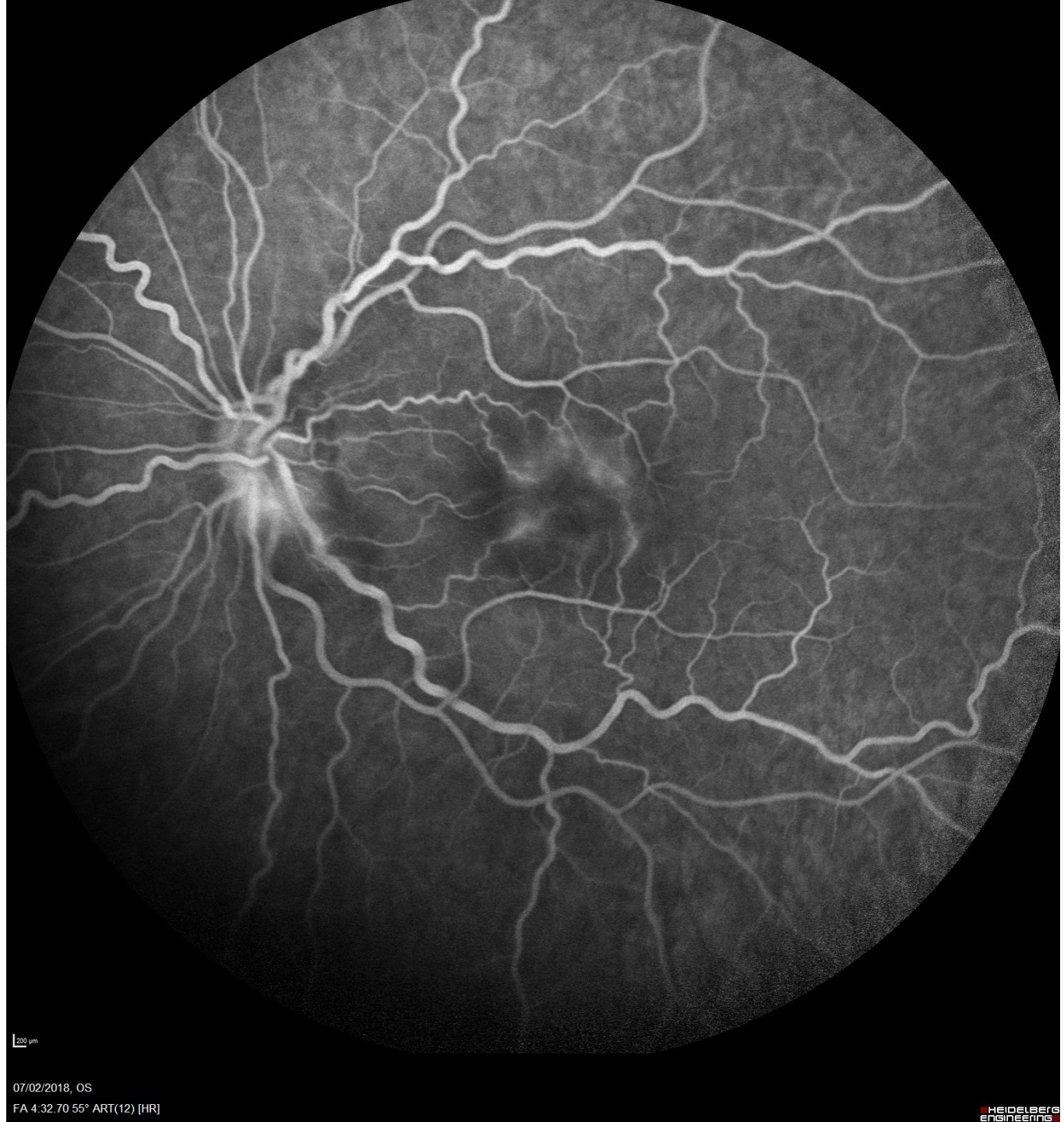

200 µm
07/02/2018, OS
FA 2:57:45 55° ART(7) [HR]
HEIDELBERG ENGINEERING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07/02/2018, OS
FA 4:32.70 55° ART(12) [HR]
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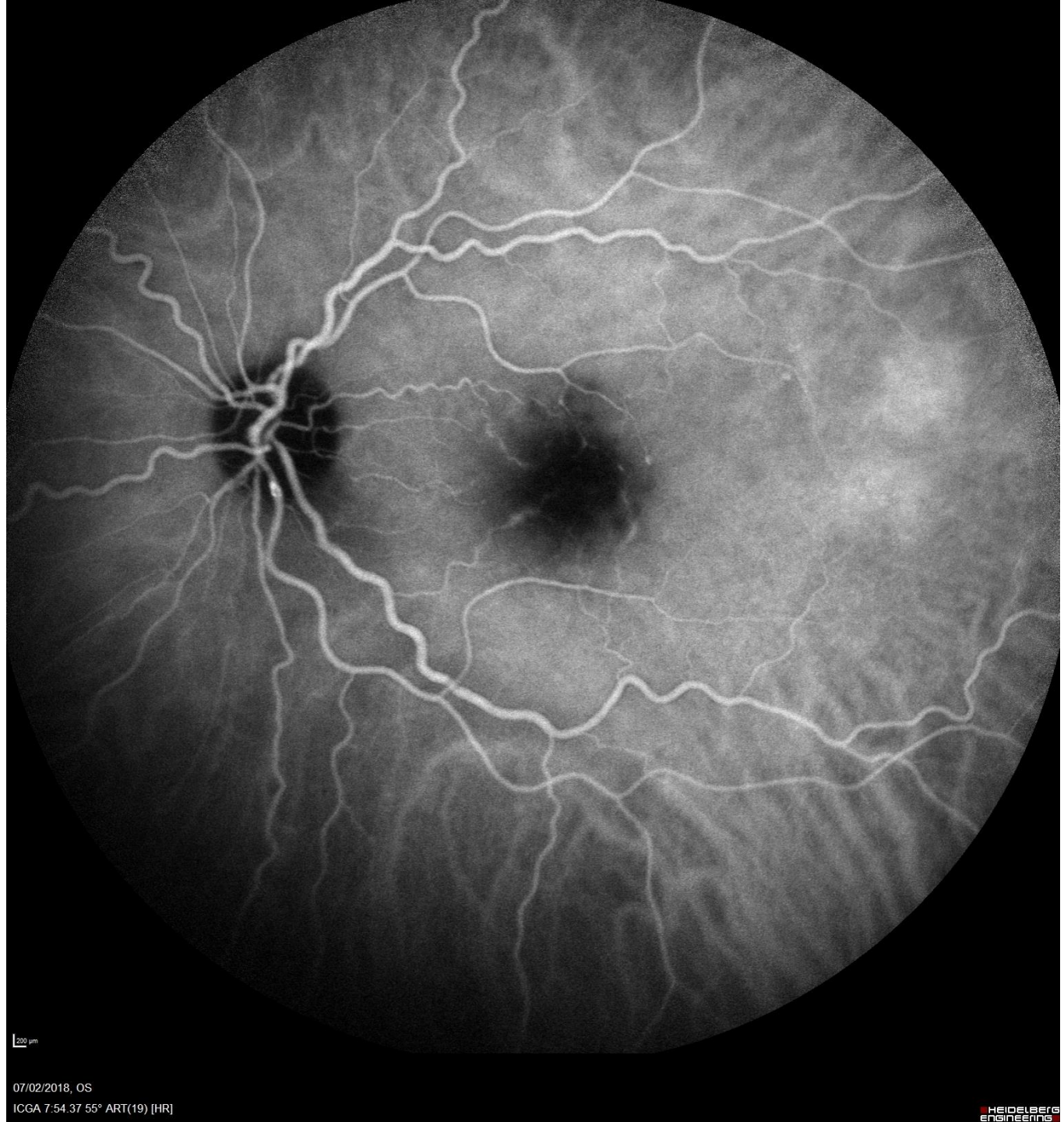
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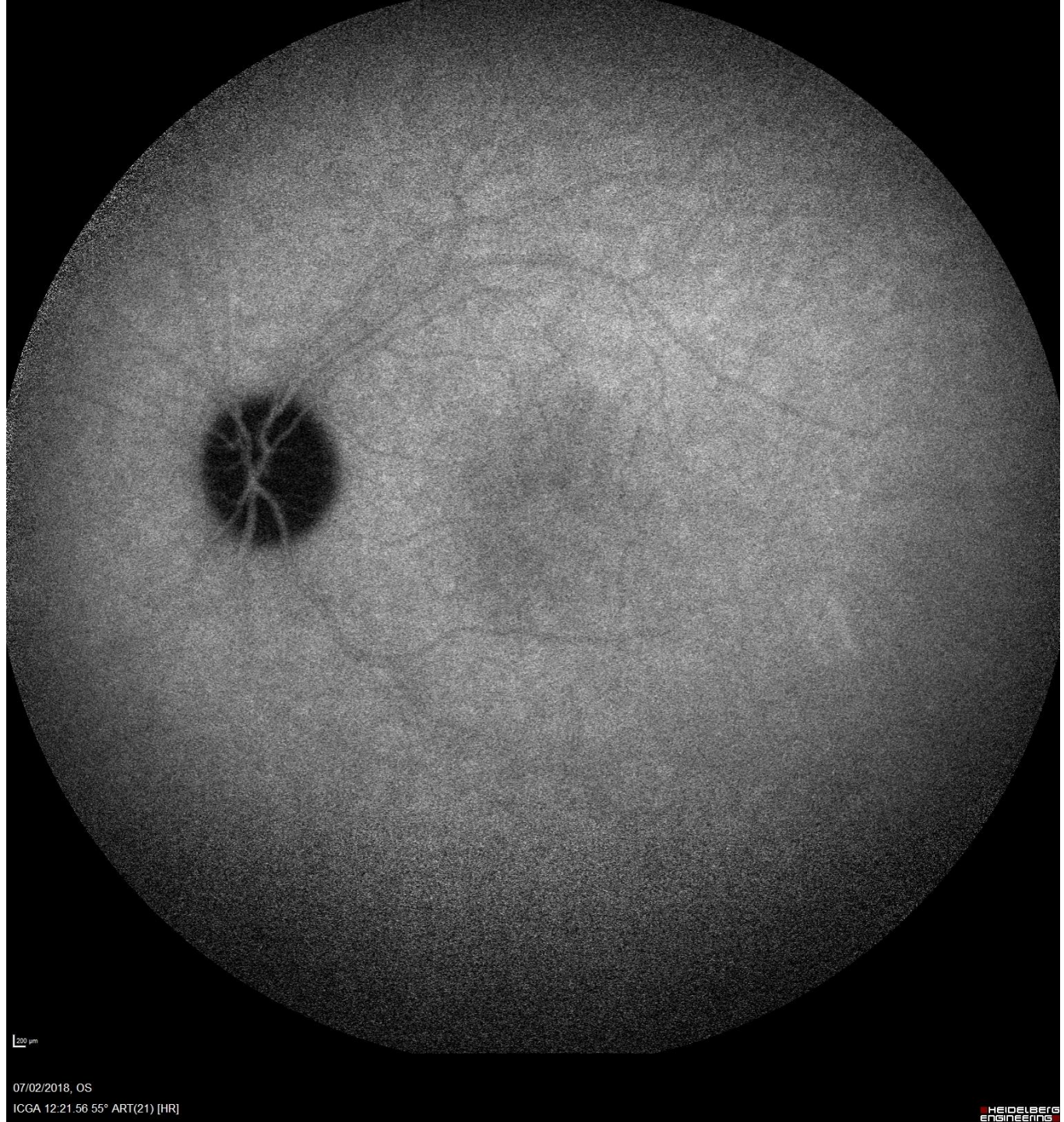
ICGA 7:54.37 55° ART(19) [HR]
HEIDELBERG ENGINEERING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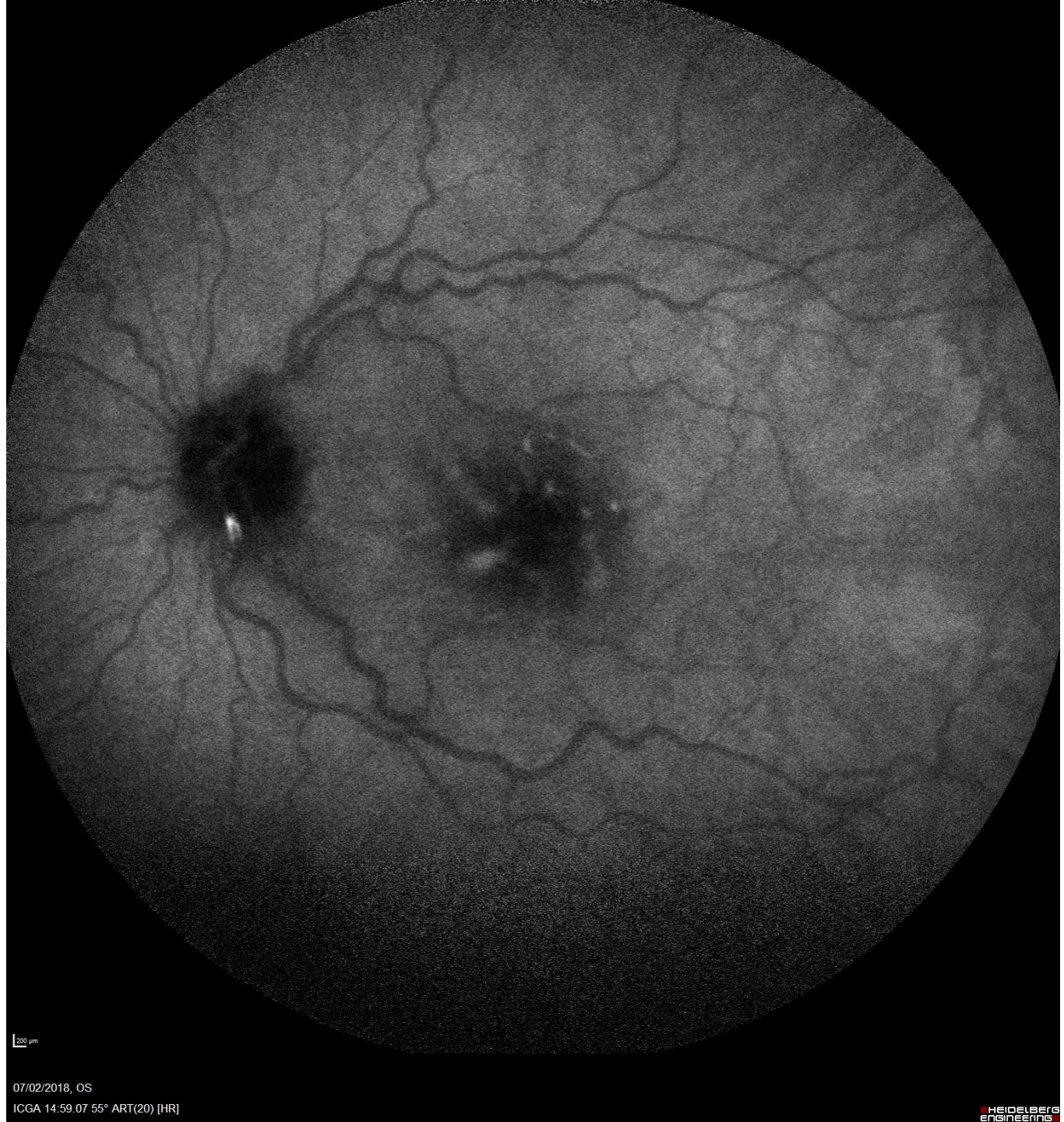
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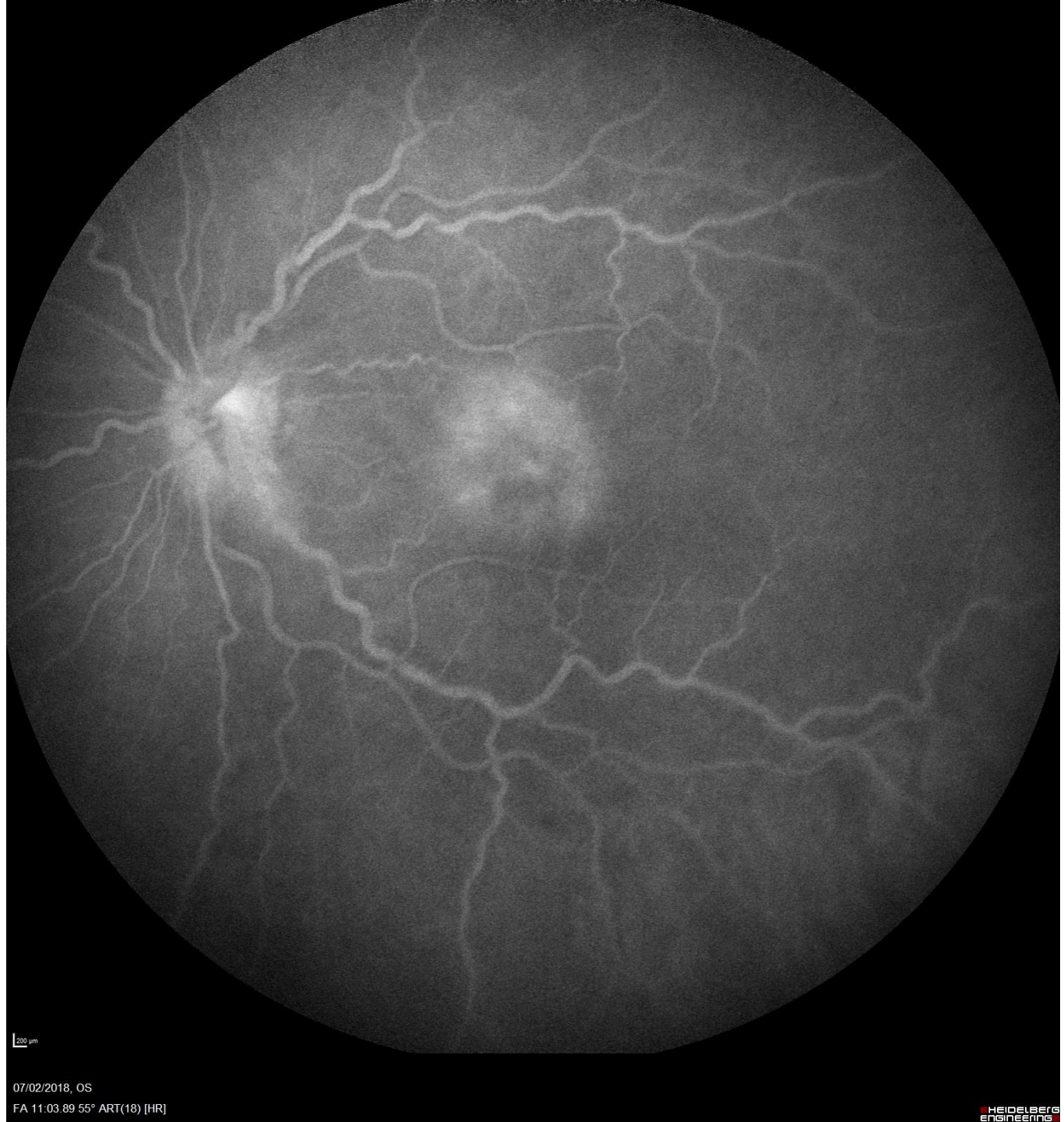
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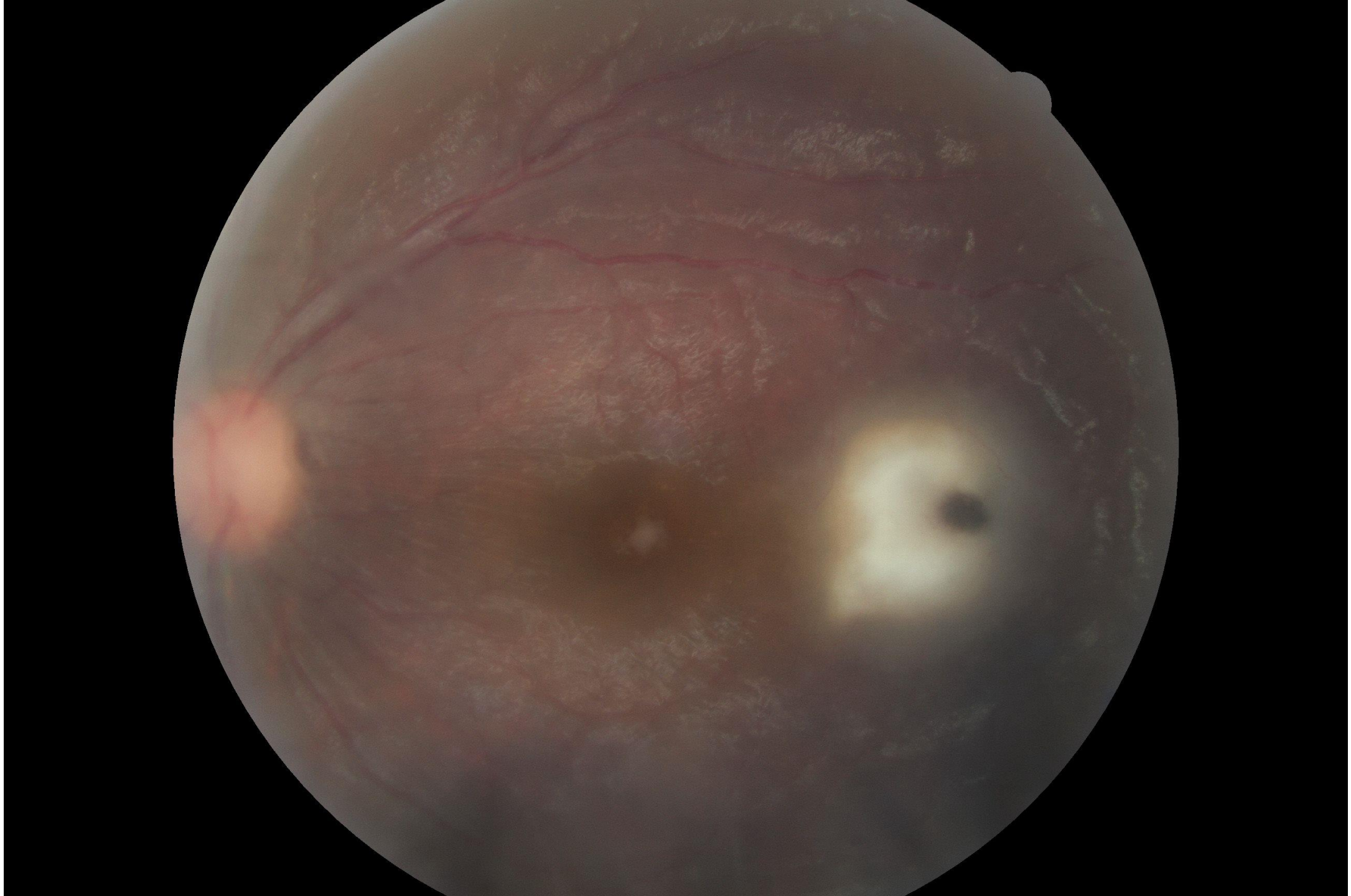
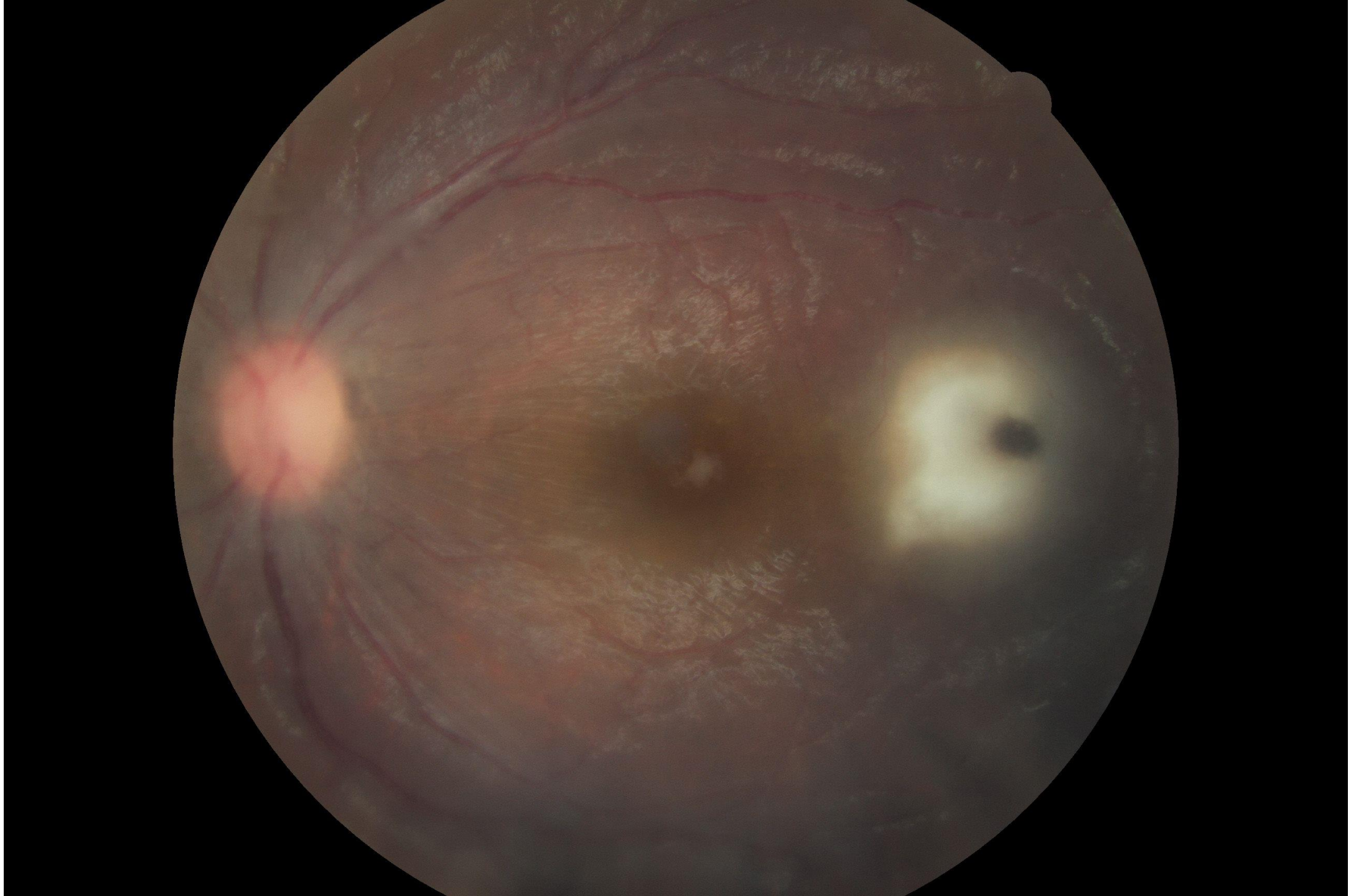
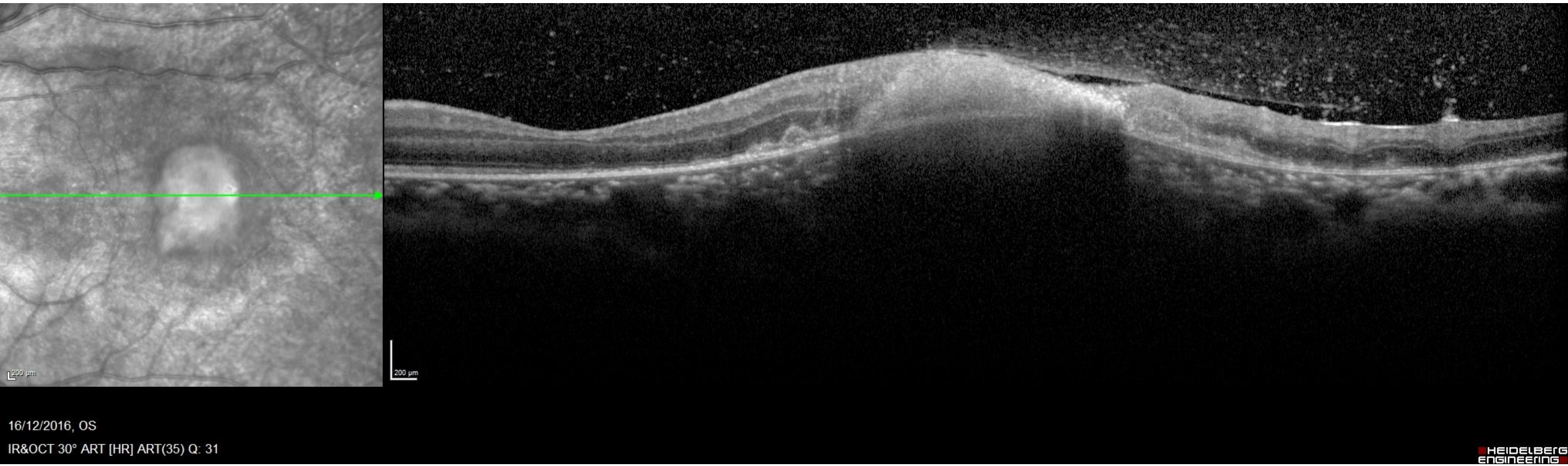
FA 11:03.89 55° ART(18) [HR]
HEIDELBERG ENGINEERING


Hopital Cochin
OPTOS, P200DTx
Laterality: R
Red: 50%
Green: 50%
NEWER
Zoom: 7,00
Type: PLUS
Presentation: Approved 7 mars 2018
1/1
1
Hopital Cochin
OPTOS, P200DTx
Laterality: L
Red: 50%
Green: 50%
NEWER
Zoom: 7,00
Type: PLUS
Enhancement: 2,99
Gamma: 0,84
Presentation: Approved 7 mars 2018
1/1
1

N°4



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200 µm
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IR&OCT 30° ART [HR] ART(35) Q: 31
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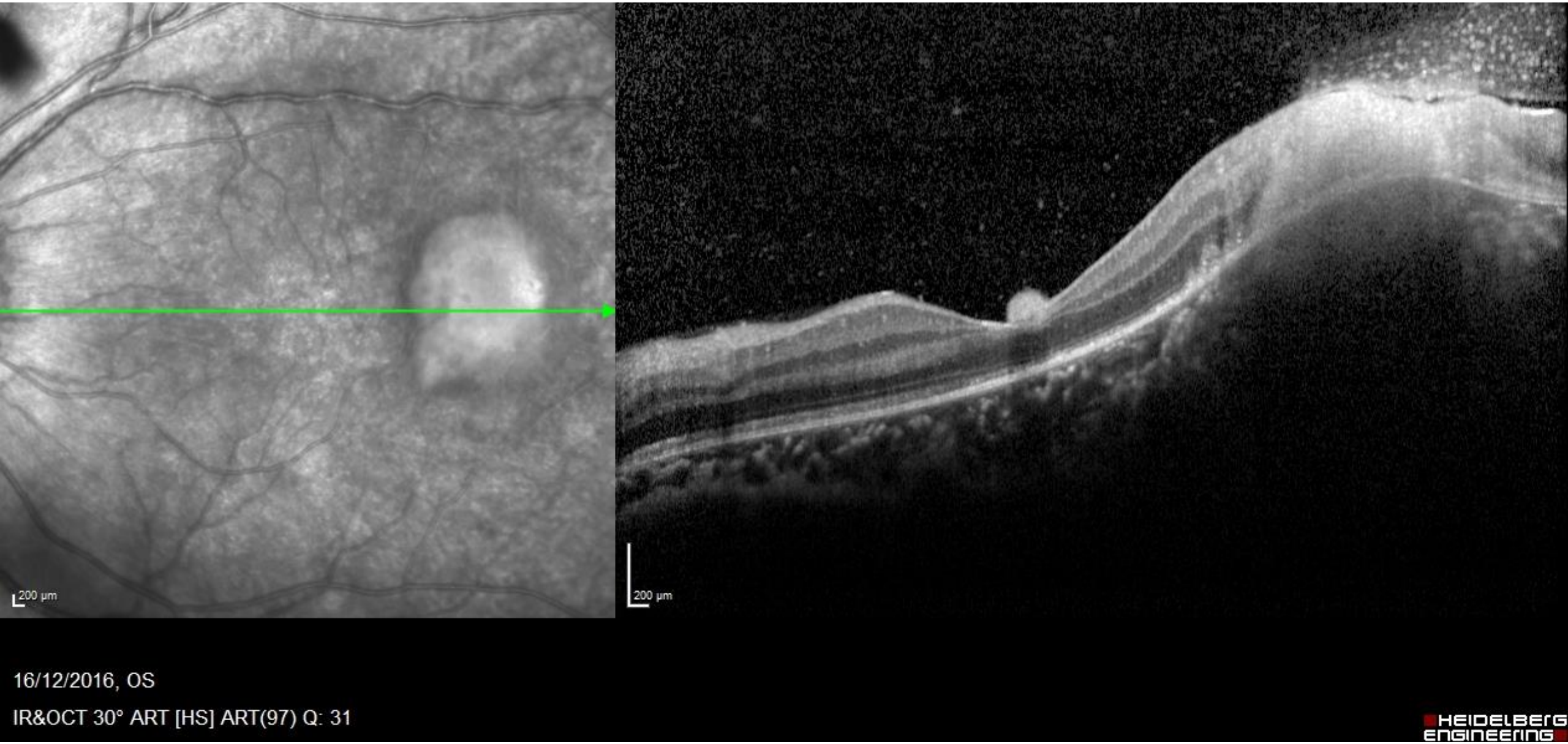

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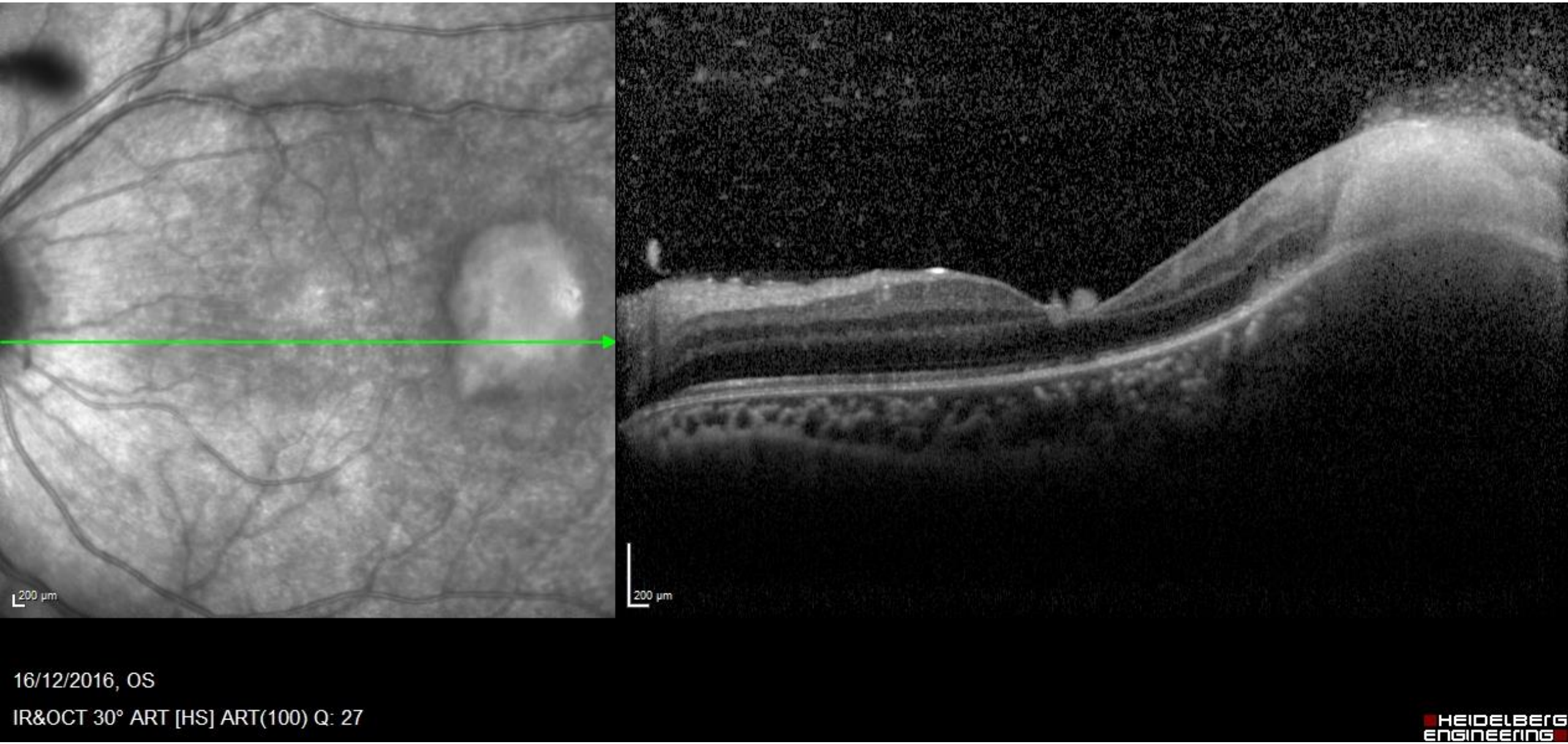

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IR&OCT 30° ART [HS] ART(100) Q: 27

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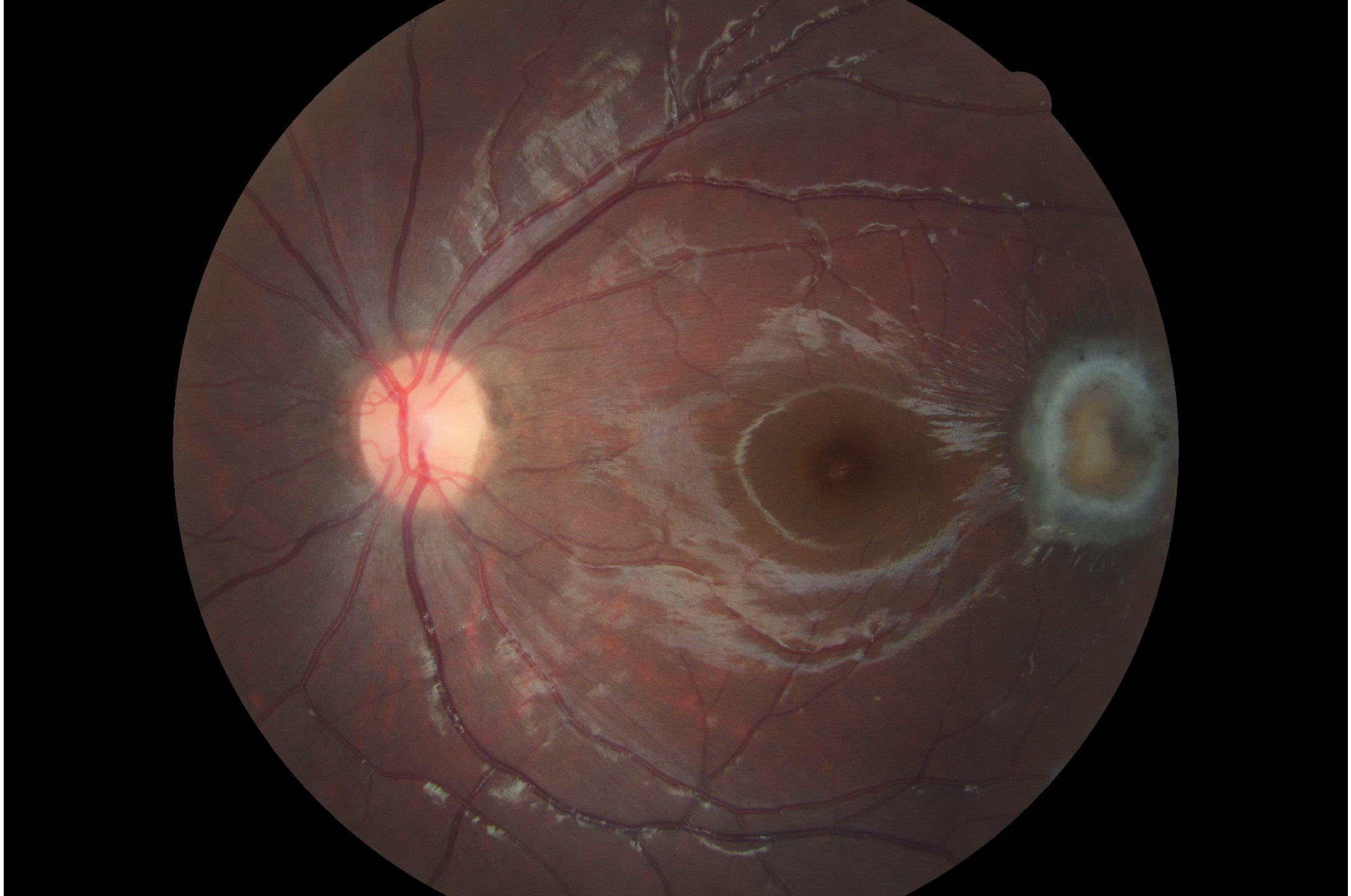

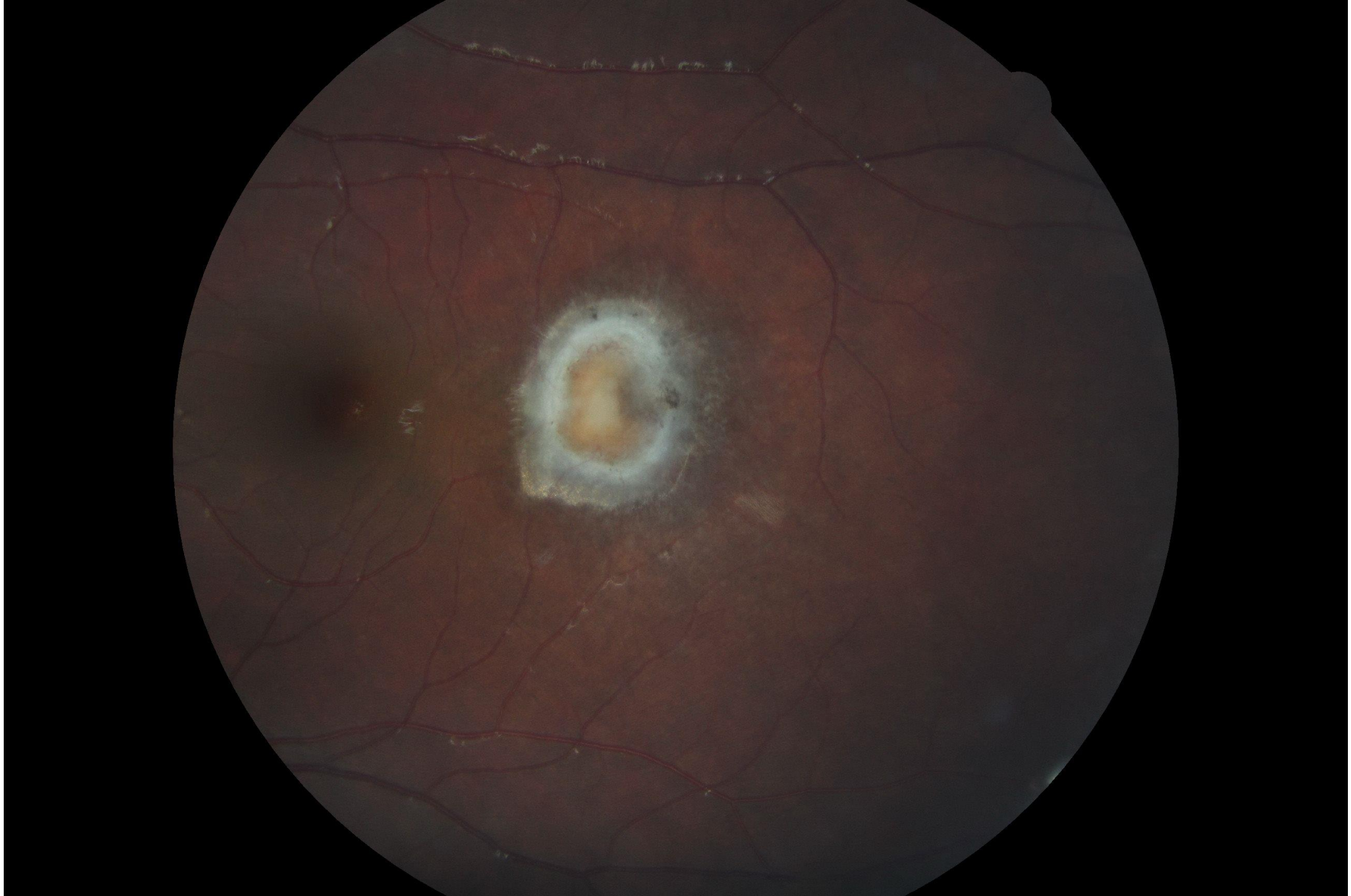

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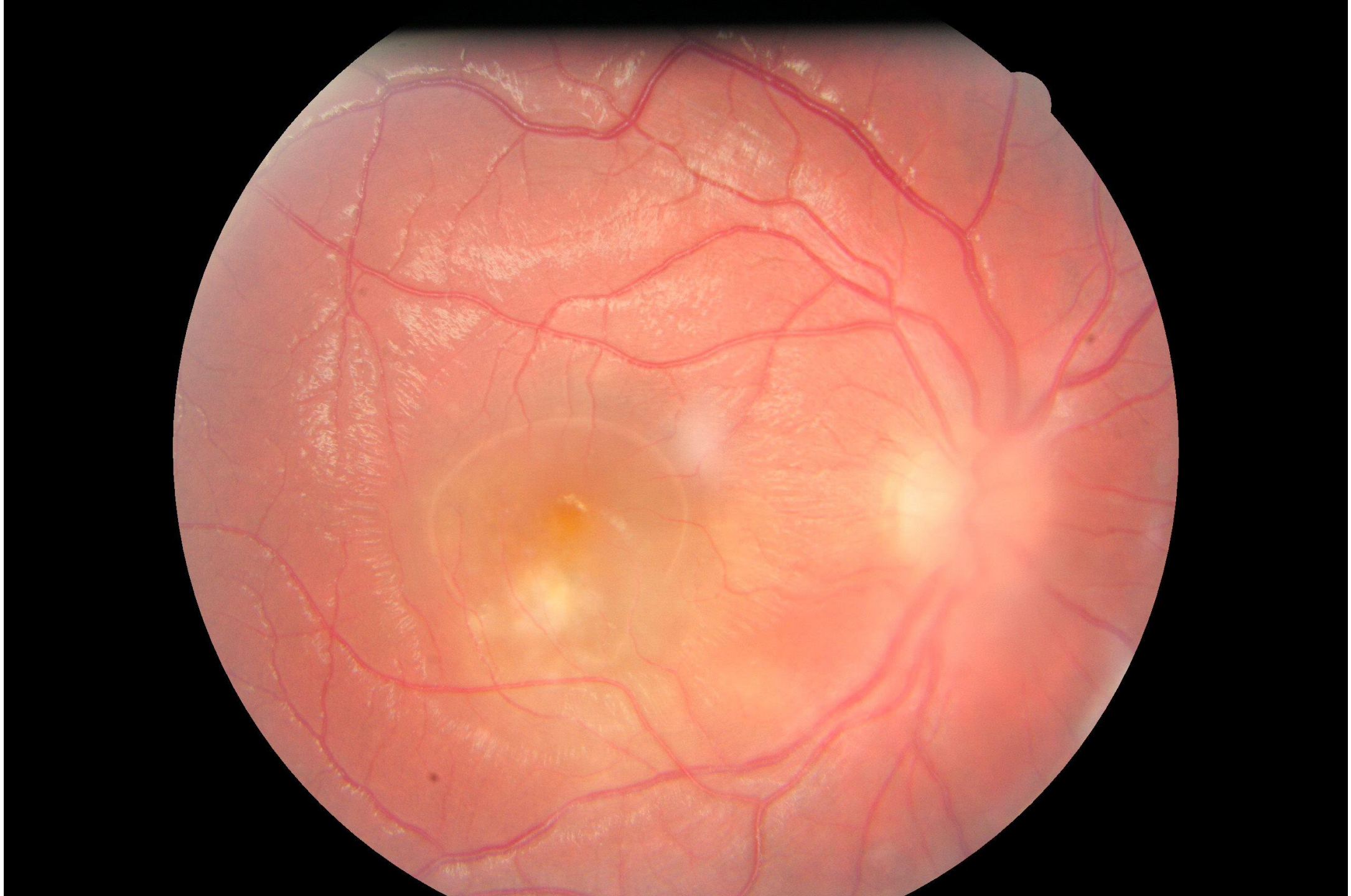

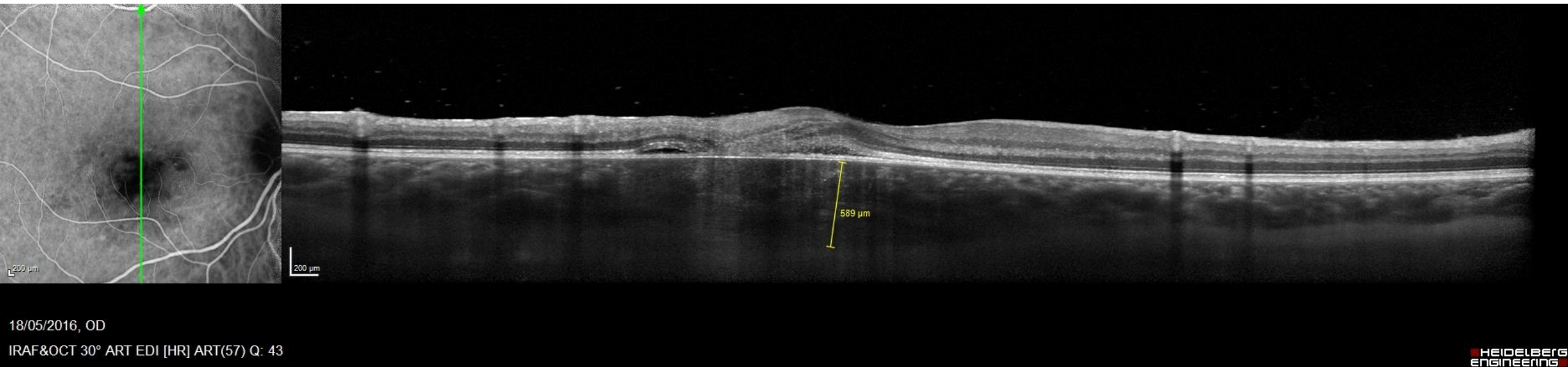
589 µm
200 µm
200 µm
18/05/2016, OD
IRAF&OCT 30° ART EDI [HR] ART(57) Q: 43
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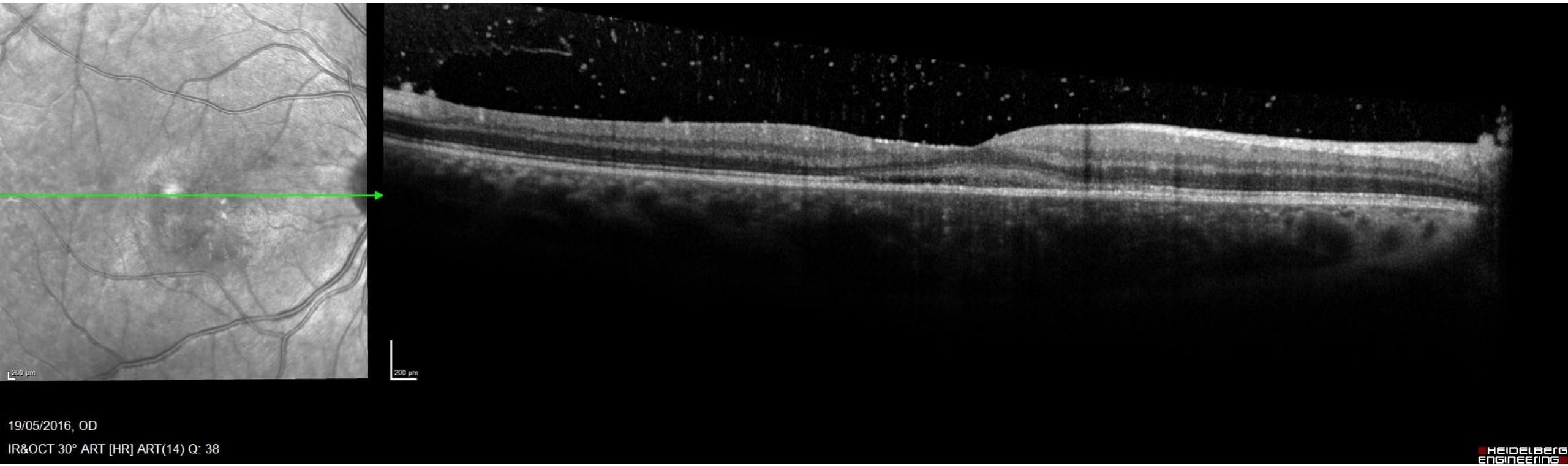
200 µm
200 µm
19/05/2016, OD
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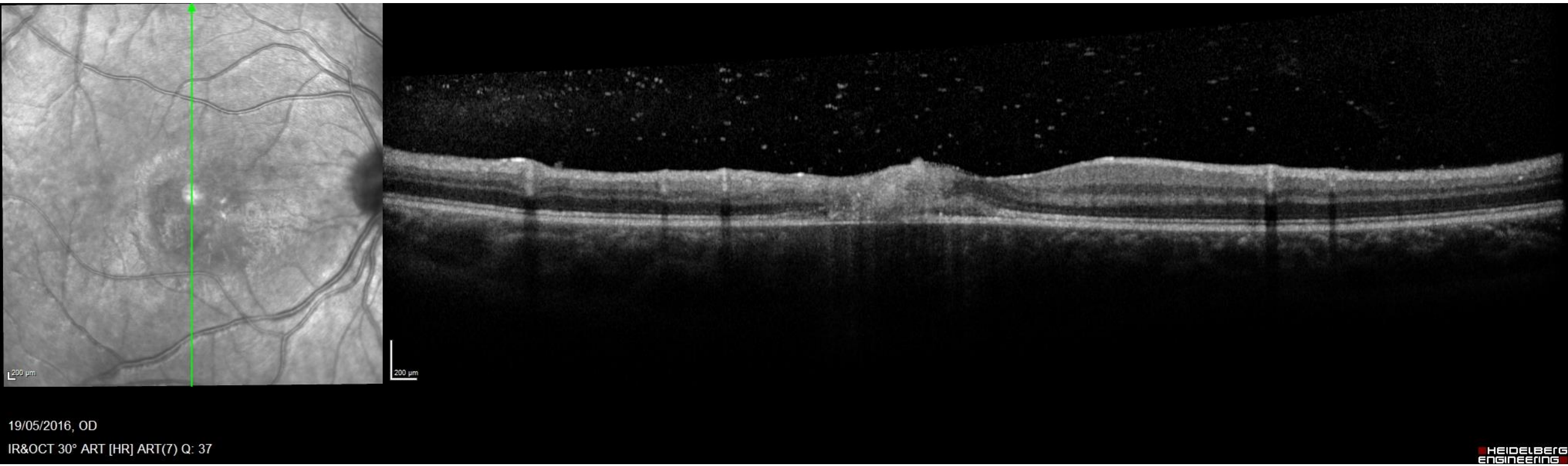
200 µm
200 µm
19/05/2016, OD
IR&OCT 30° ART [HR] ART(7) Q: 37
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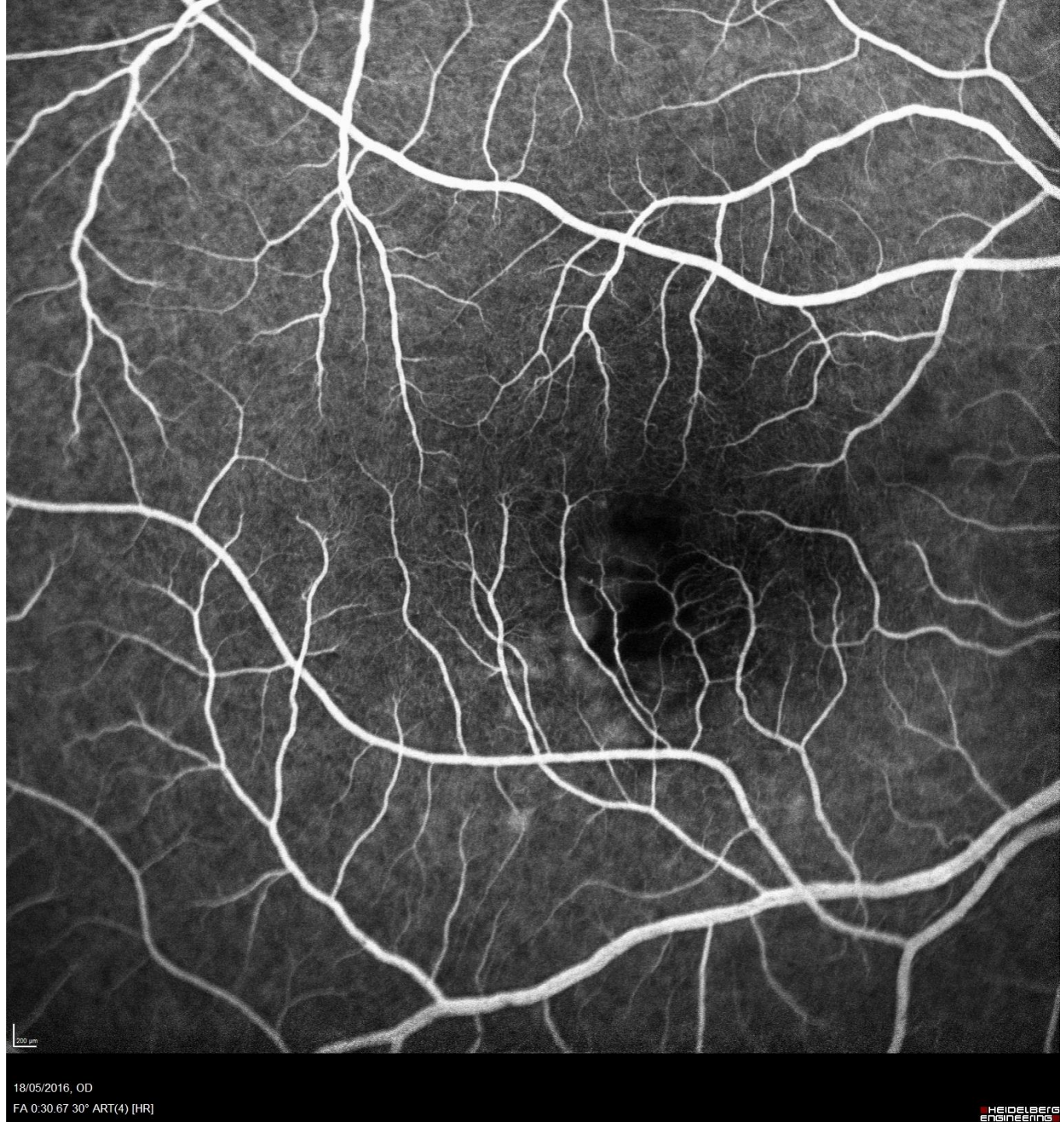
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FA 0:30.67 30° ART(4) [HR]
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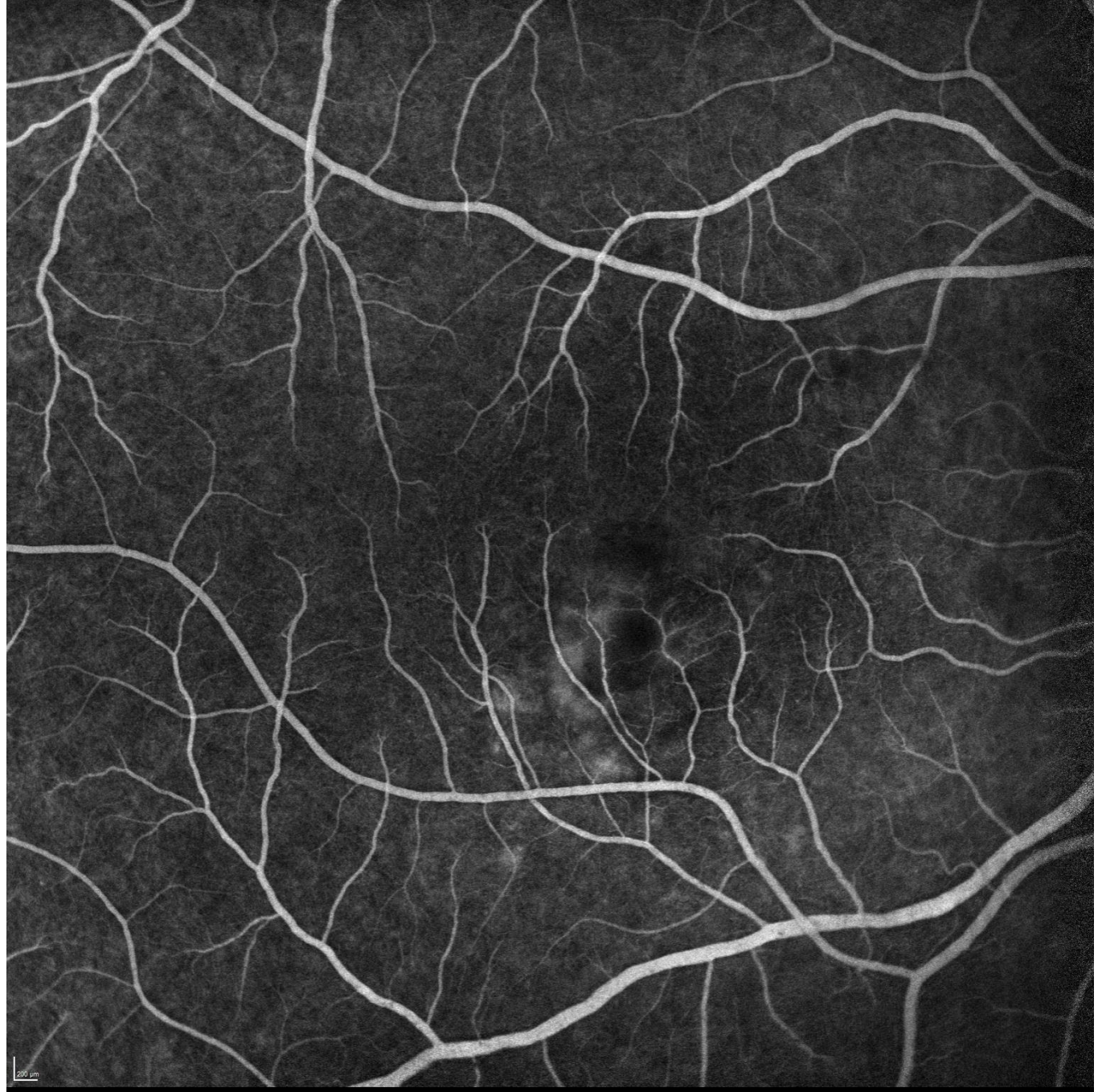
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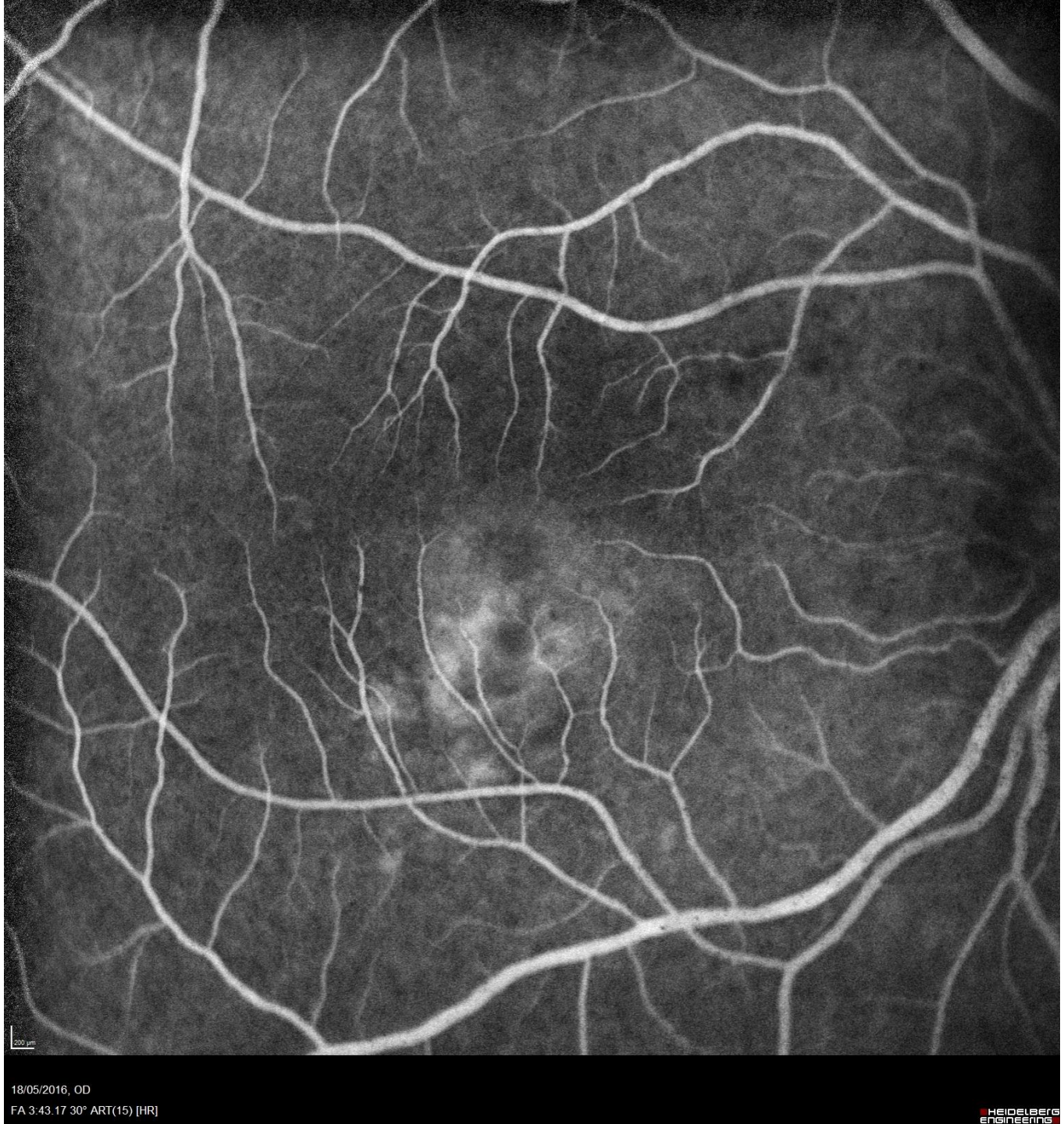
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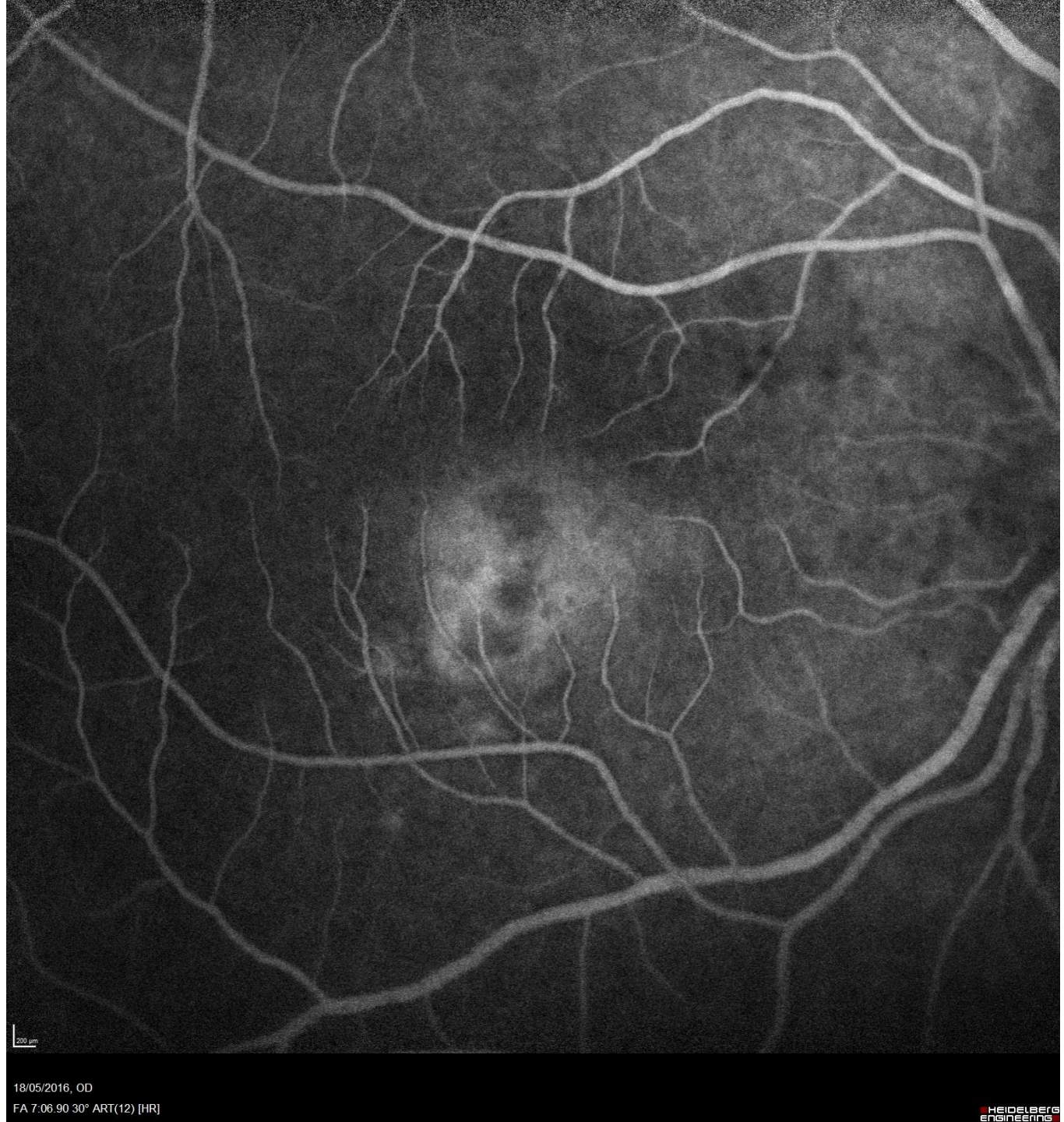
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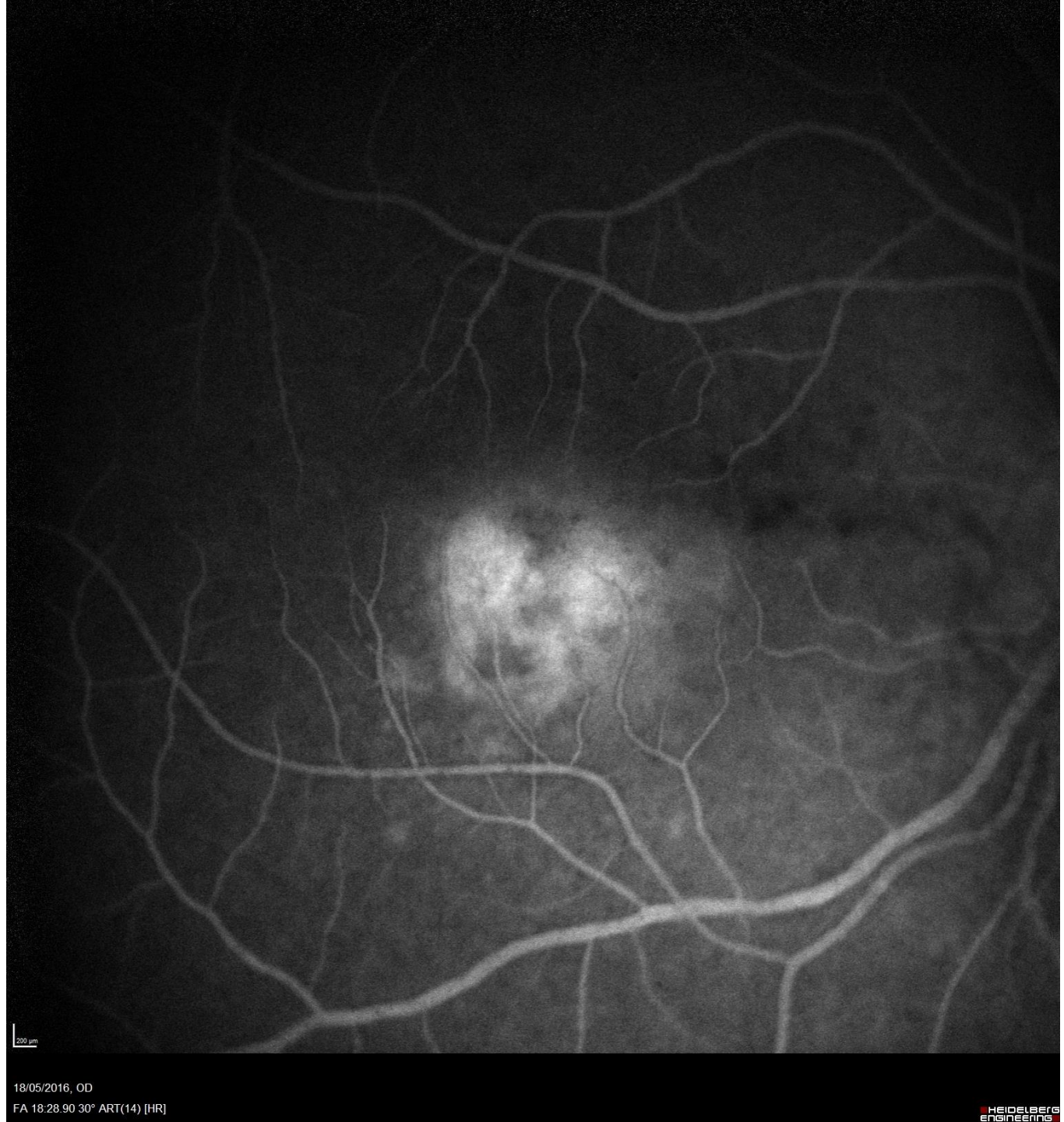
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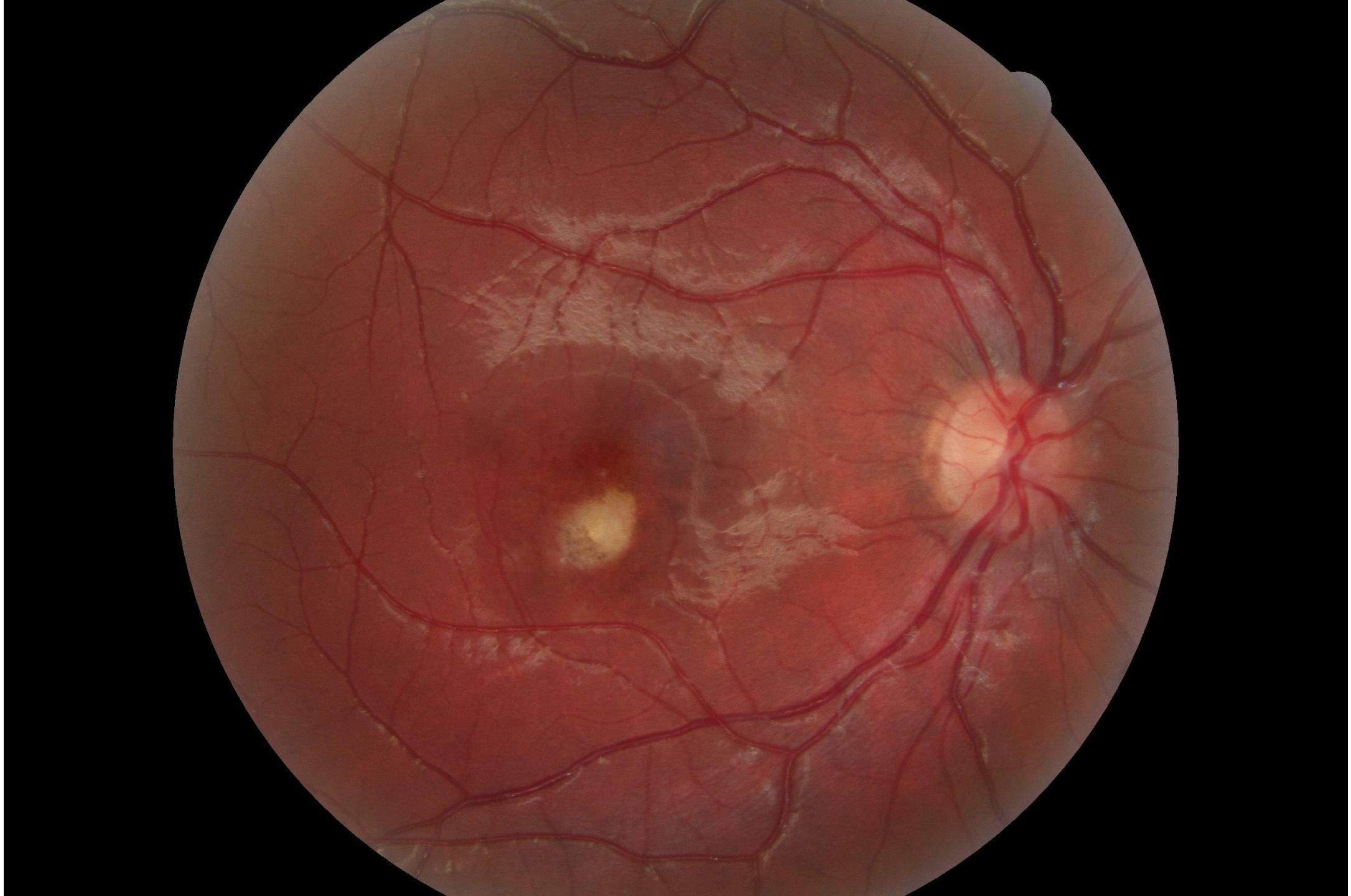
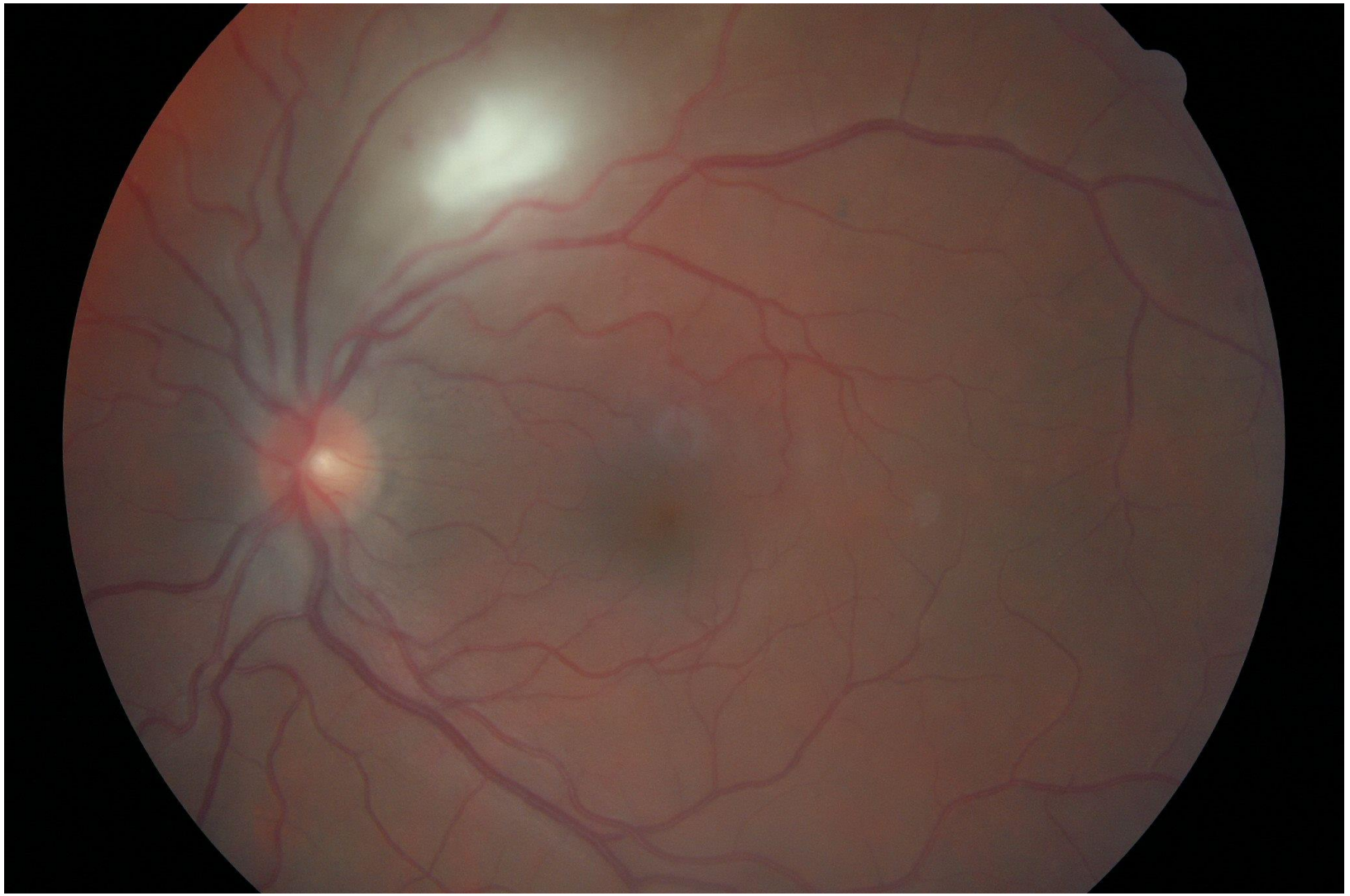
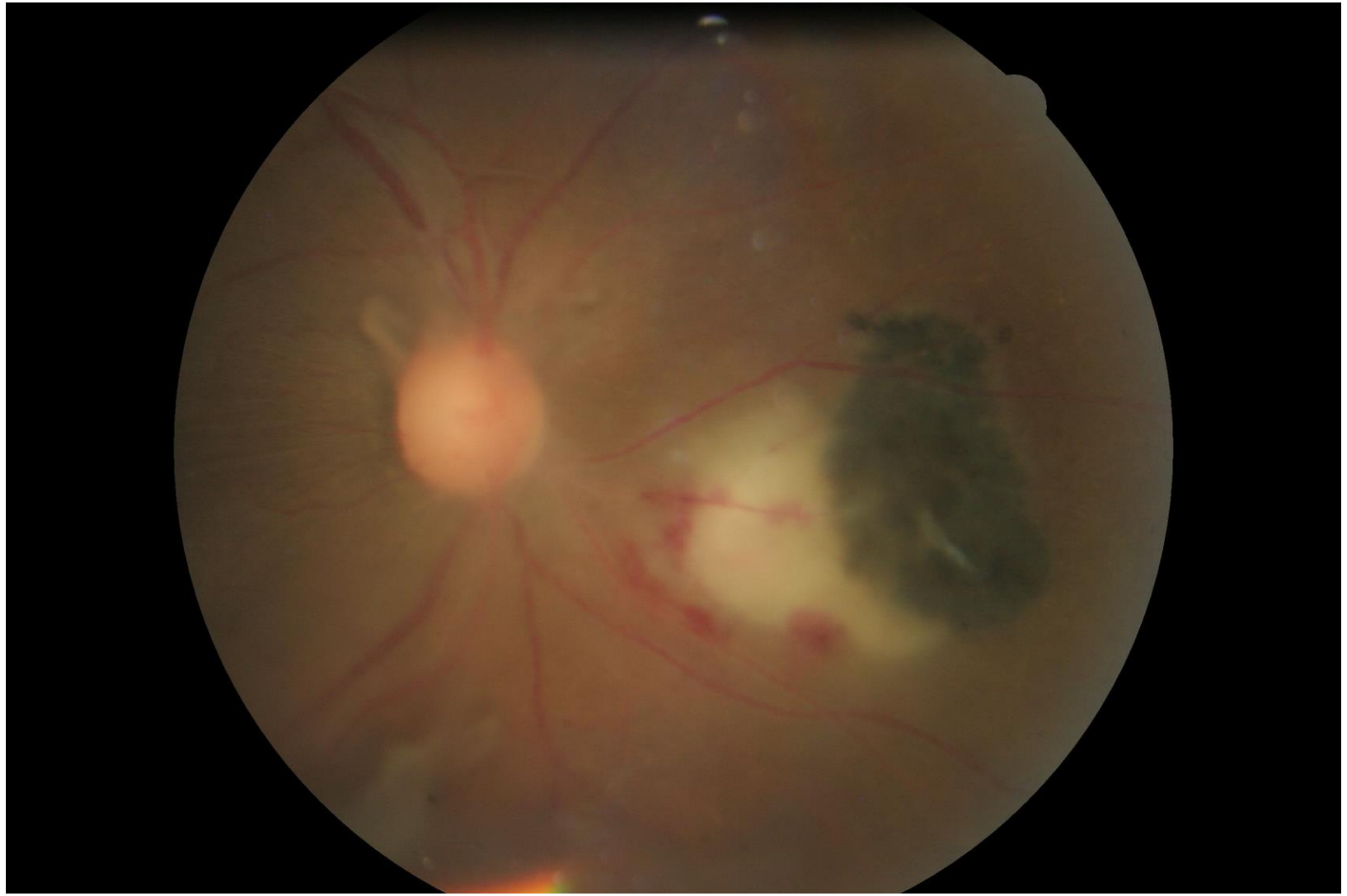


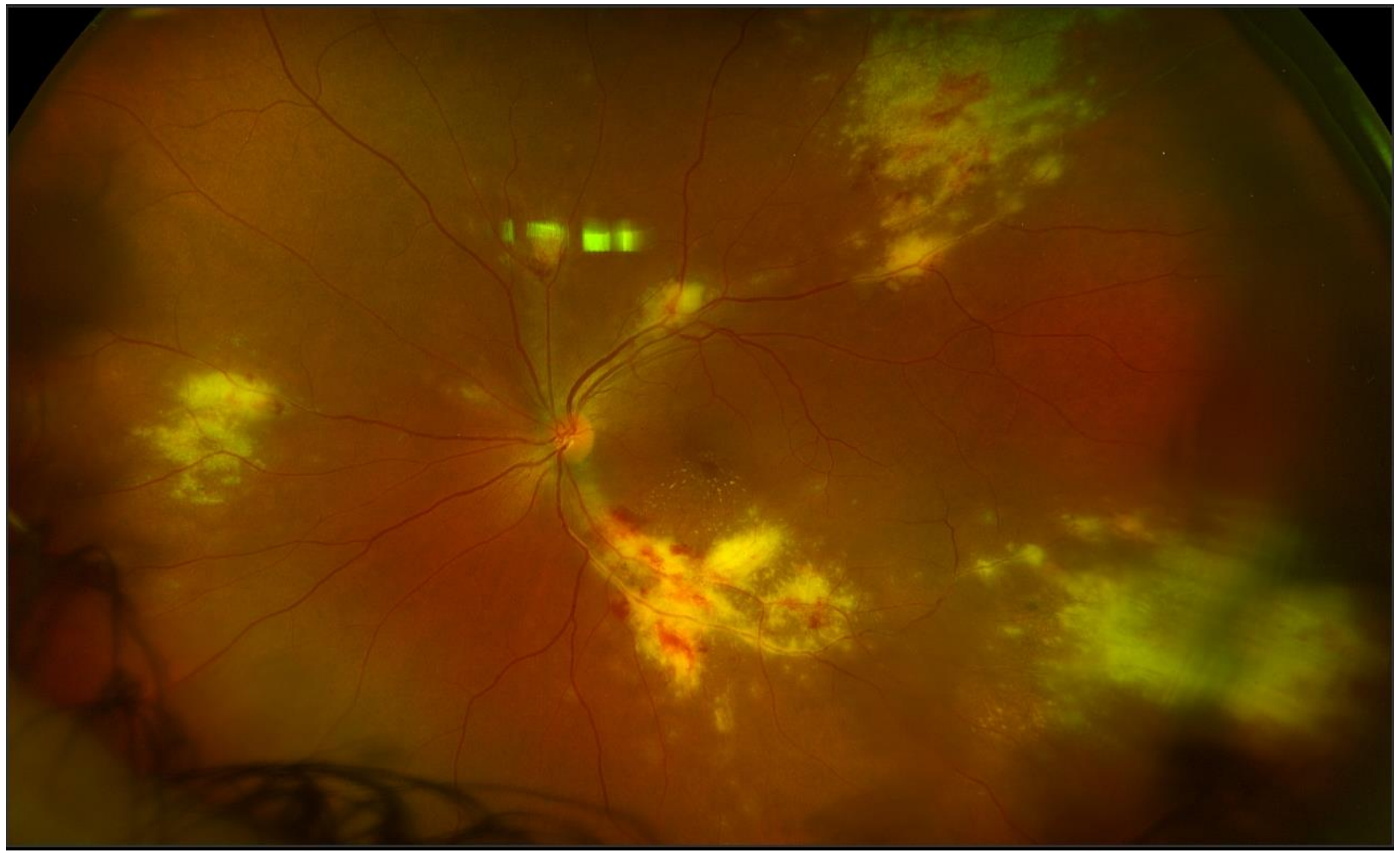
N°6

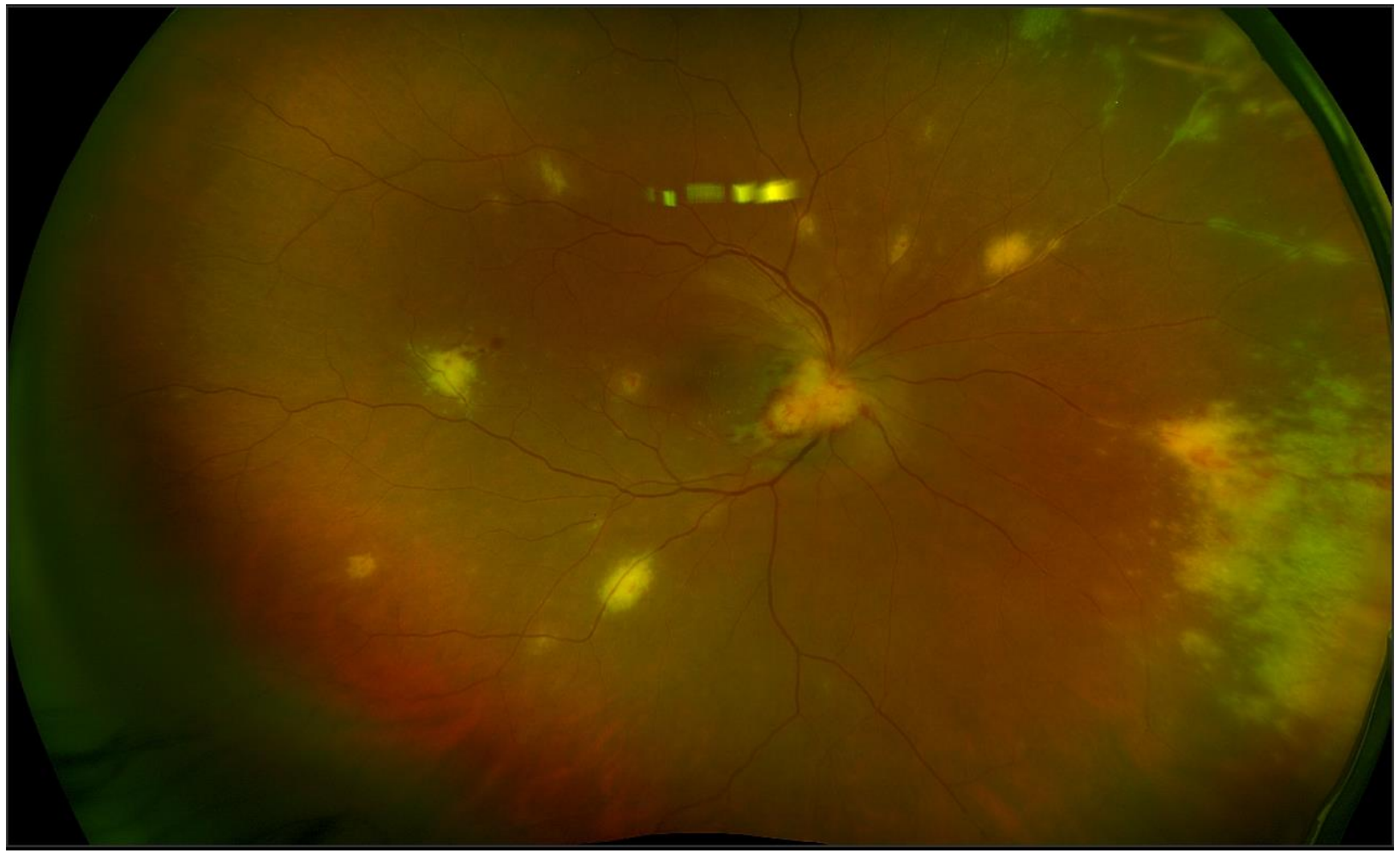


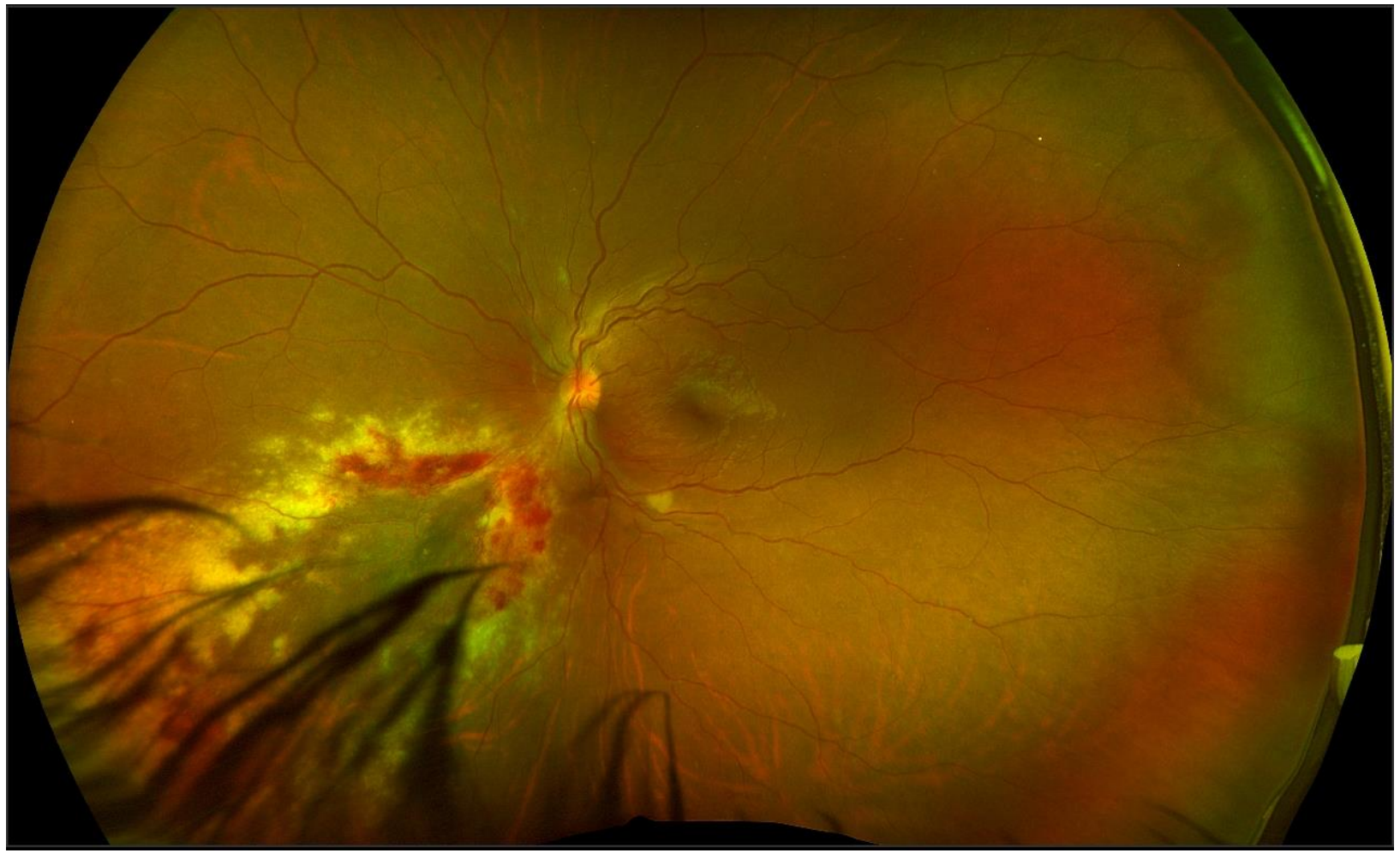
N°7

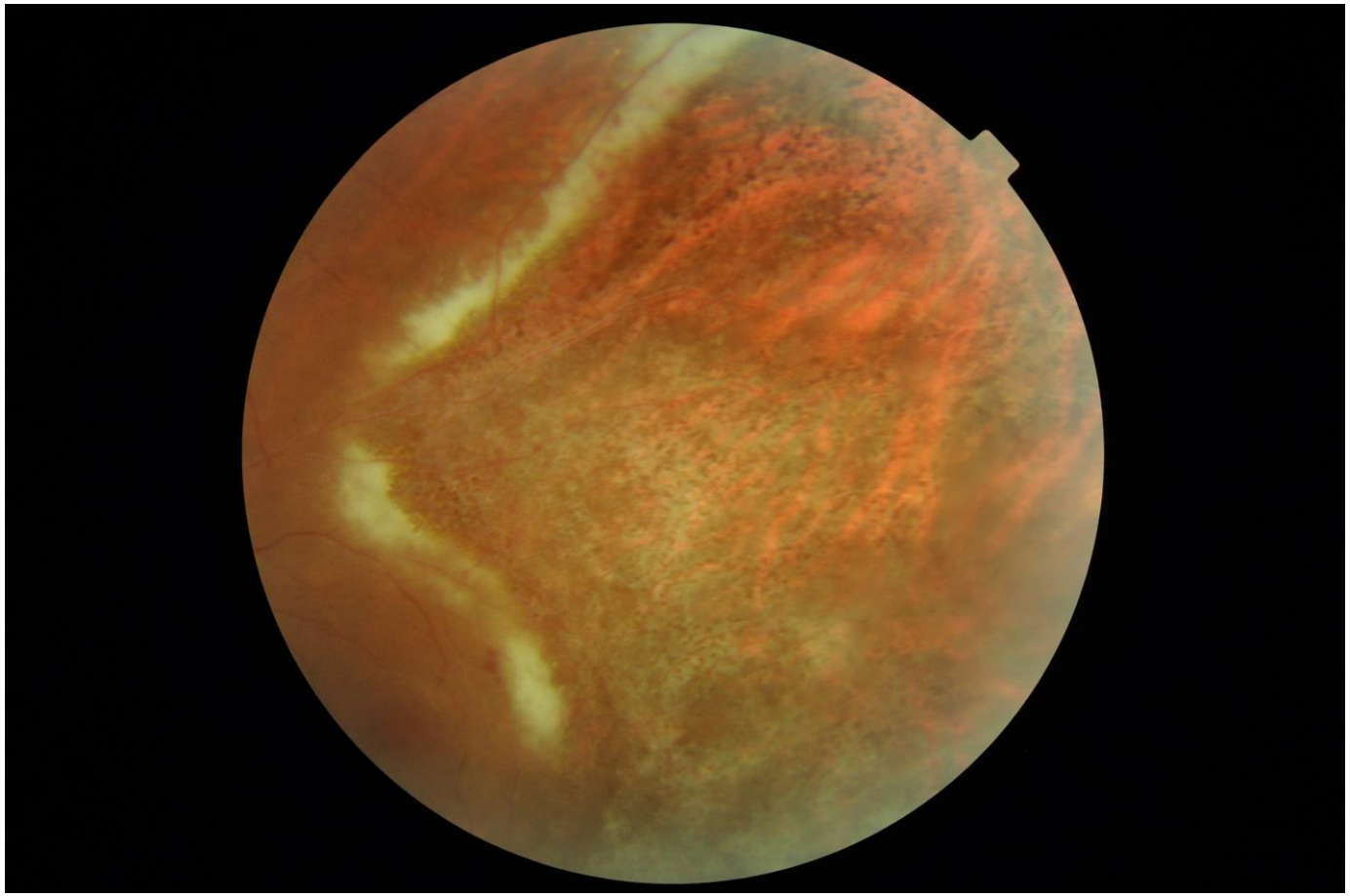


Rétinites à CMV









Cas clinique N°6

M. G 51 ans, écrivain

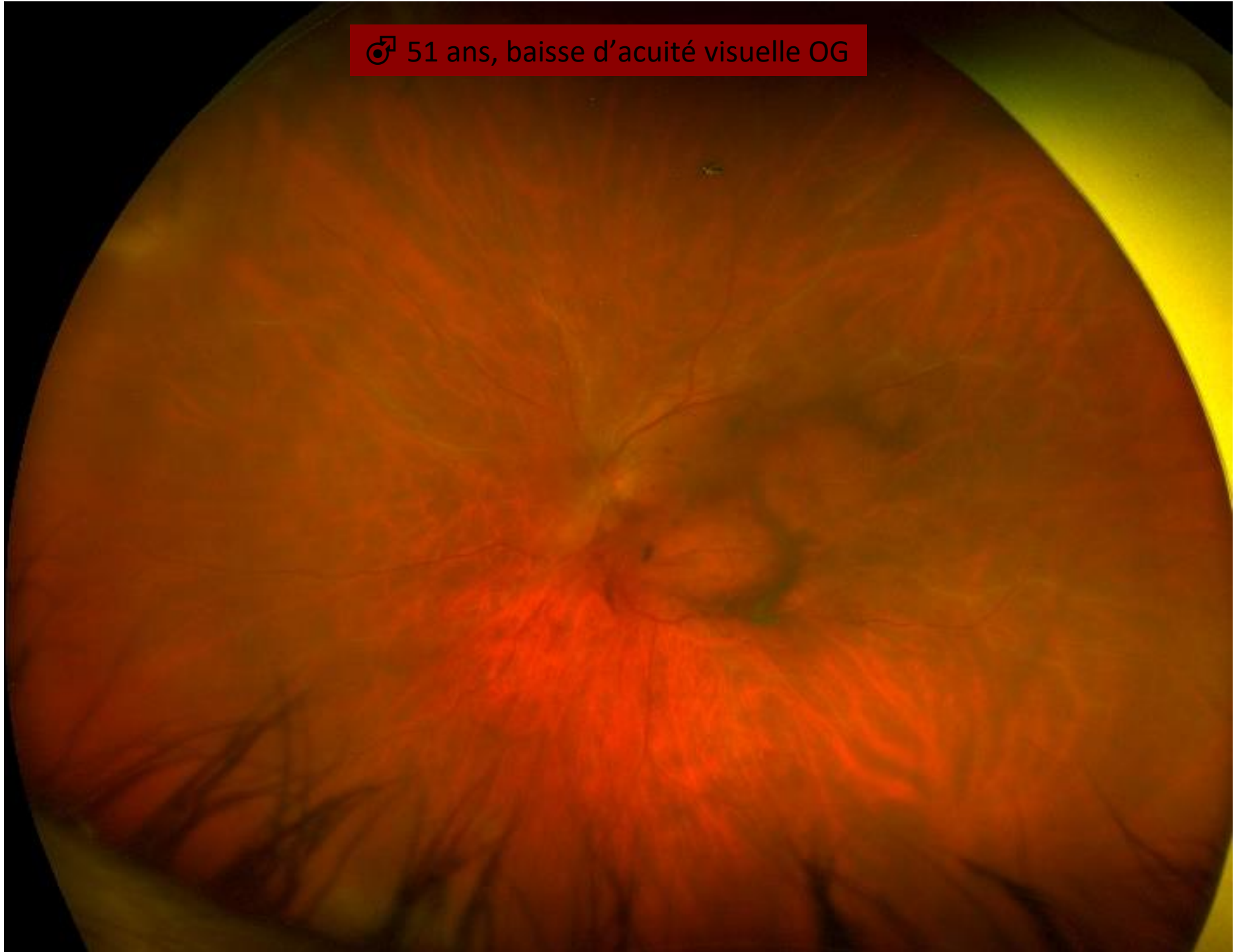
A 35 ans : Leucémie aiguë myéloïde (LAM). Allogreffé en rémission
A 48 ans : Rechute de sa LAM. Allogreffé en absence de rémission
Par ailleurs :
Zona interfessier droit en 2004. Apergillose en 2015.
Hypogammaglobulinémie à 2.8g/L
Insuffisance rénale chronique

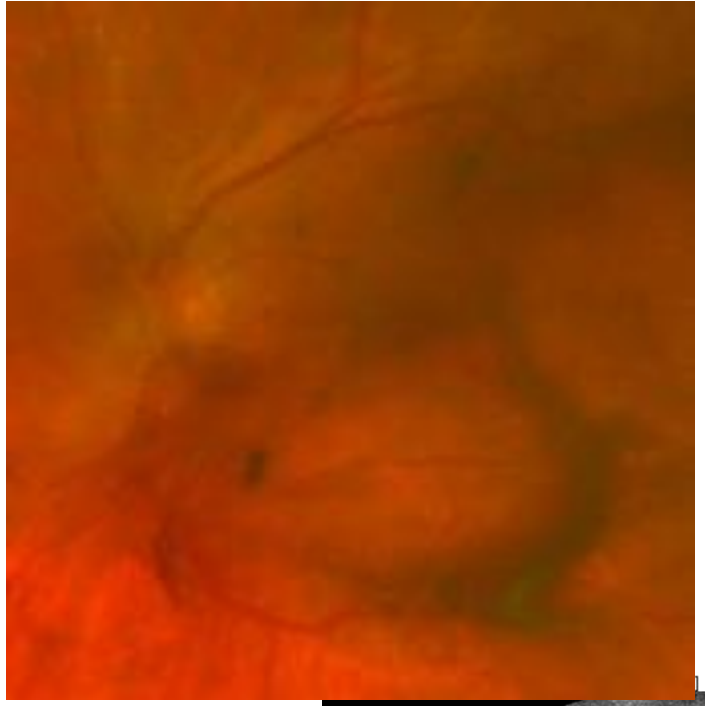
Absence de traitement depuis l'arrêt du Zelitrex et de la Wellvone le 2/10/2018.

Consultation hématologie le 17/10/2018 : Déficit du releveur du pied droit et paresthésie du membre supérieur gauche sans déficit moteur depuis 5 jours.

→ IRM médullaire normale. Demande d'EMG en attente

Consultation en ophtalmologie le 13/11/2018: Baisse acuité visuelle à gauche avec voile

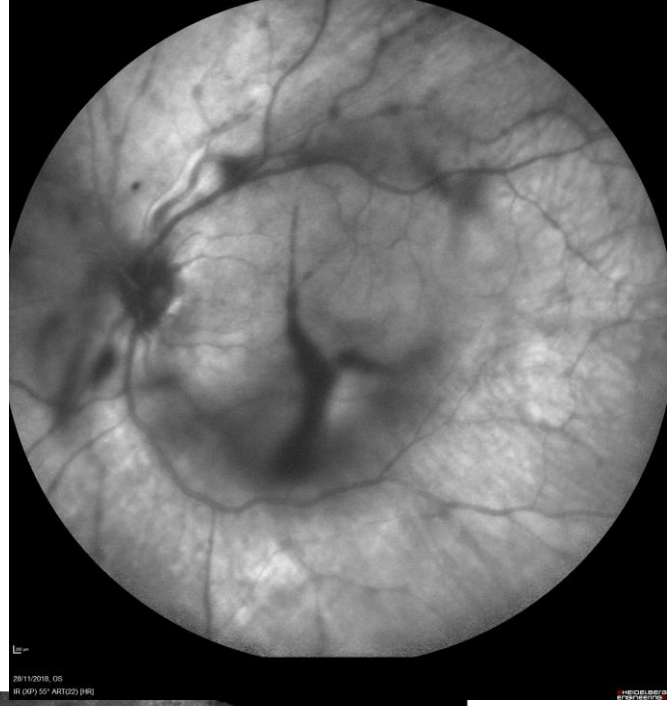

♂ 51 ans, baisse d’acuité visuelle OG

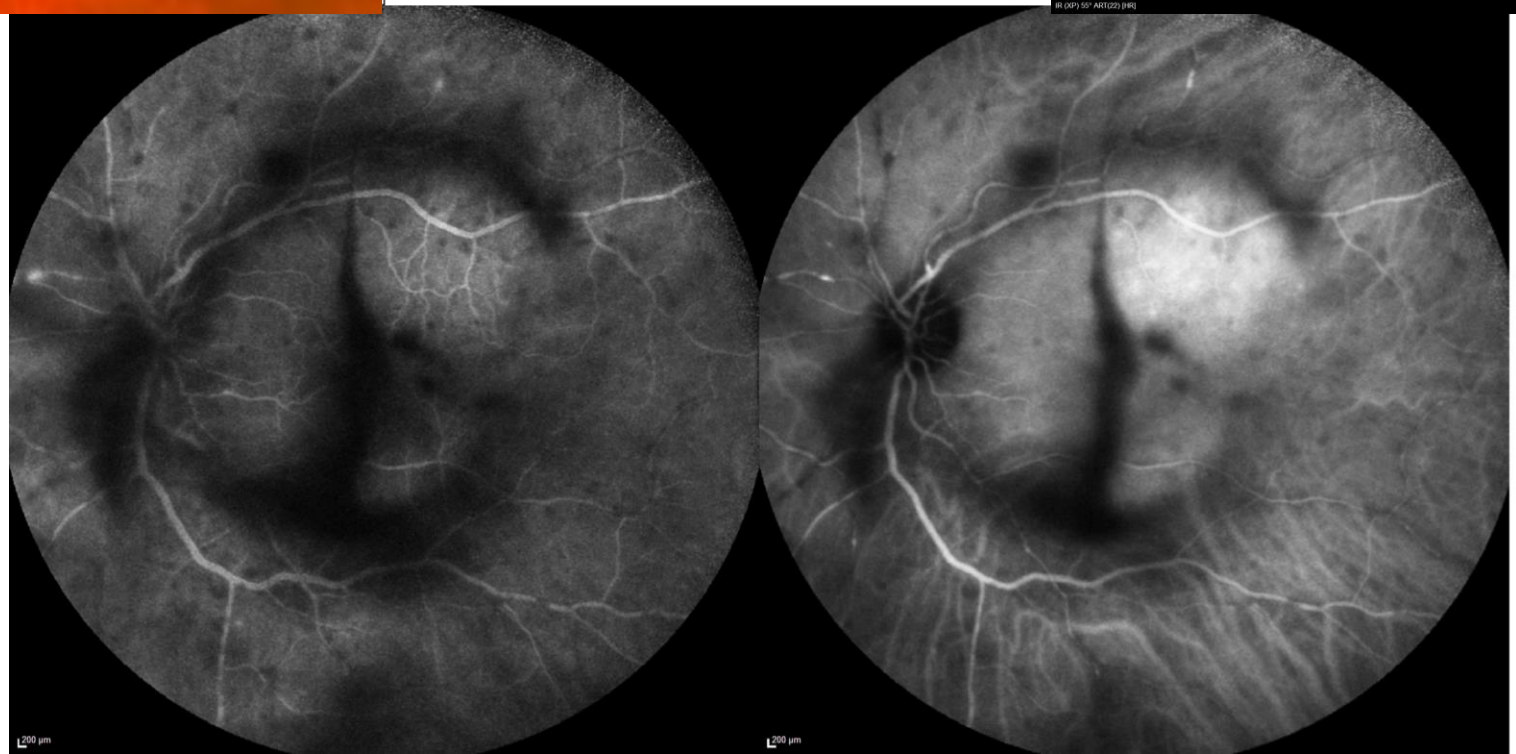


OD : 10/10 OG : 7/10

OD : normal

OG : Œdème cornéen
Tyndall 2+
PIO 55 mmHg
Hyalite 2+





EN MEDECINE INTERNE ….

Clinique

Pas d'anomalie des paires crâniennes

Déficit moteur 3/5 de flexion et extension des 3 premiers doigts main gauche.

Déficit à 1/5 du releveur du pied droit

Pas de zona

Biologie

NFS normale. CRP à 7. ANCA, AAN, FR –
VIH -, VHC -, VHB -, TPHA VDRL –
Méningite lymphocytaire : 50 éléments

Autres

IRM cérébrale et médullaire normales
EMG : polyneuropathie démyélinisante

Diagnostic ?

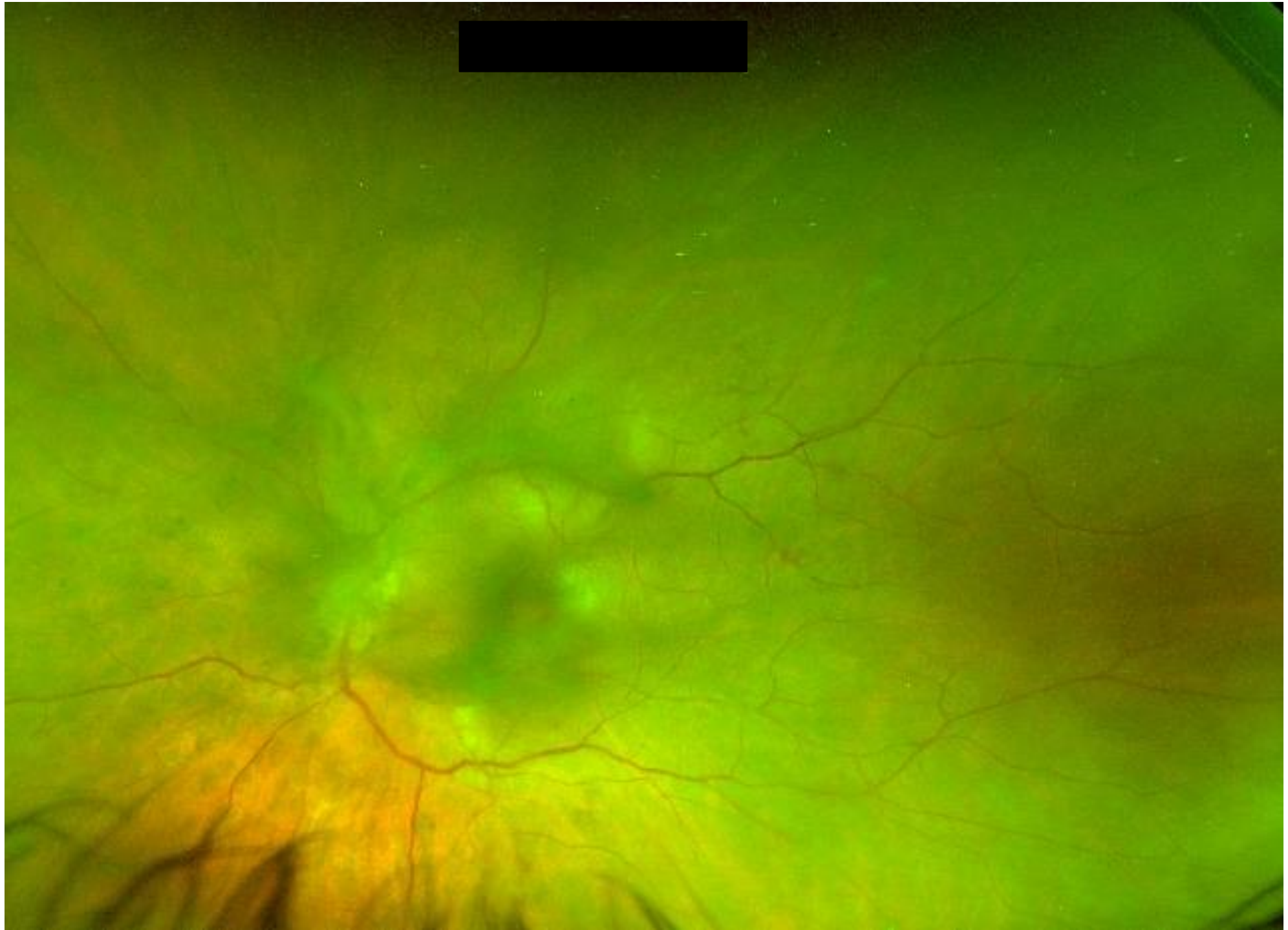
Ponction de chambre antérieure à gauche : PCR + / VZV
Ponction lombaire : PCR + / VZV

<u>Traitement :</u>

Systémique : Aciclovir IV à 15 mg/kg/8h pendant 21 jours

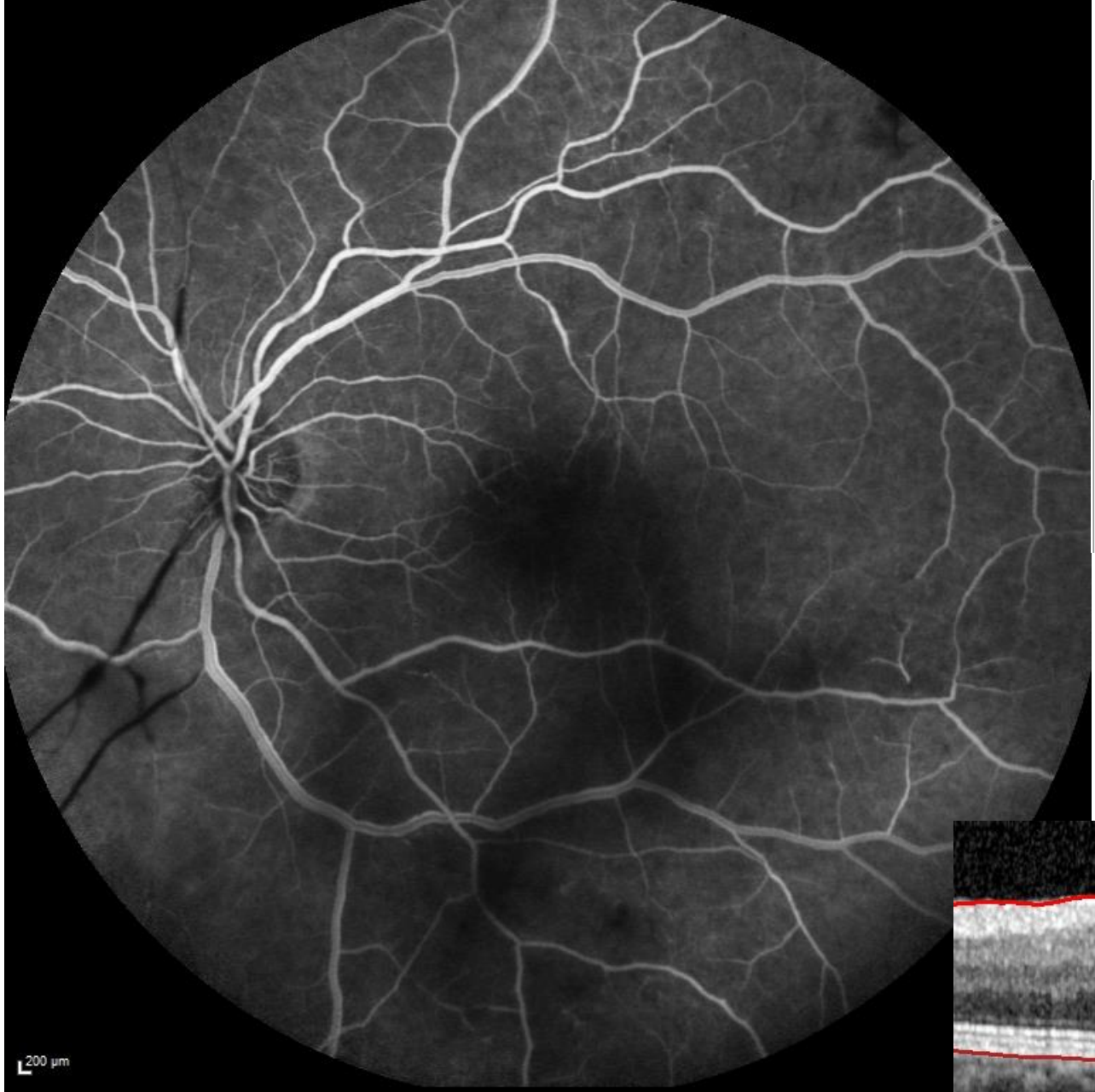
Devant l'absence d'amélioration à J7

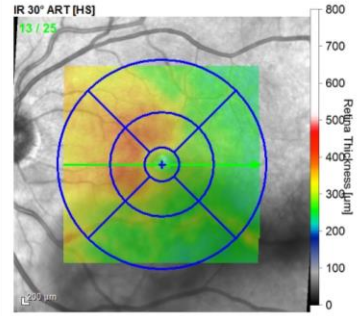
Foscavir 2,4mg / injection intravitréenne x 4 (2 fois /semaine)
Avec surveillance de la décroissance de la charge virale VZV
+
Corticothérapie systémique

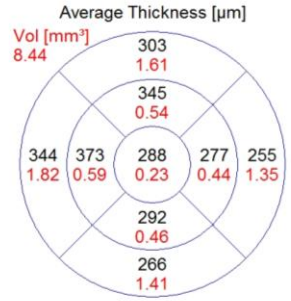


[redacted]

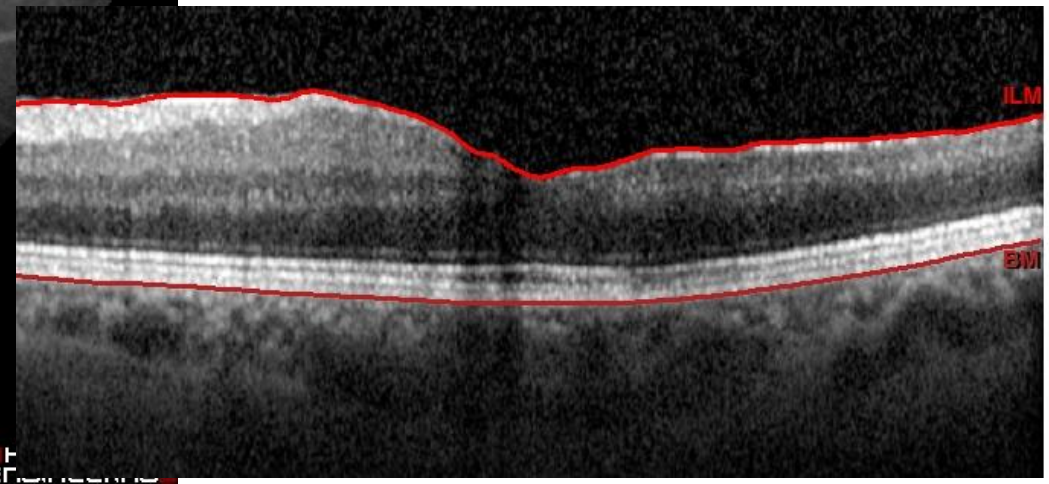
OS

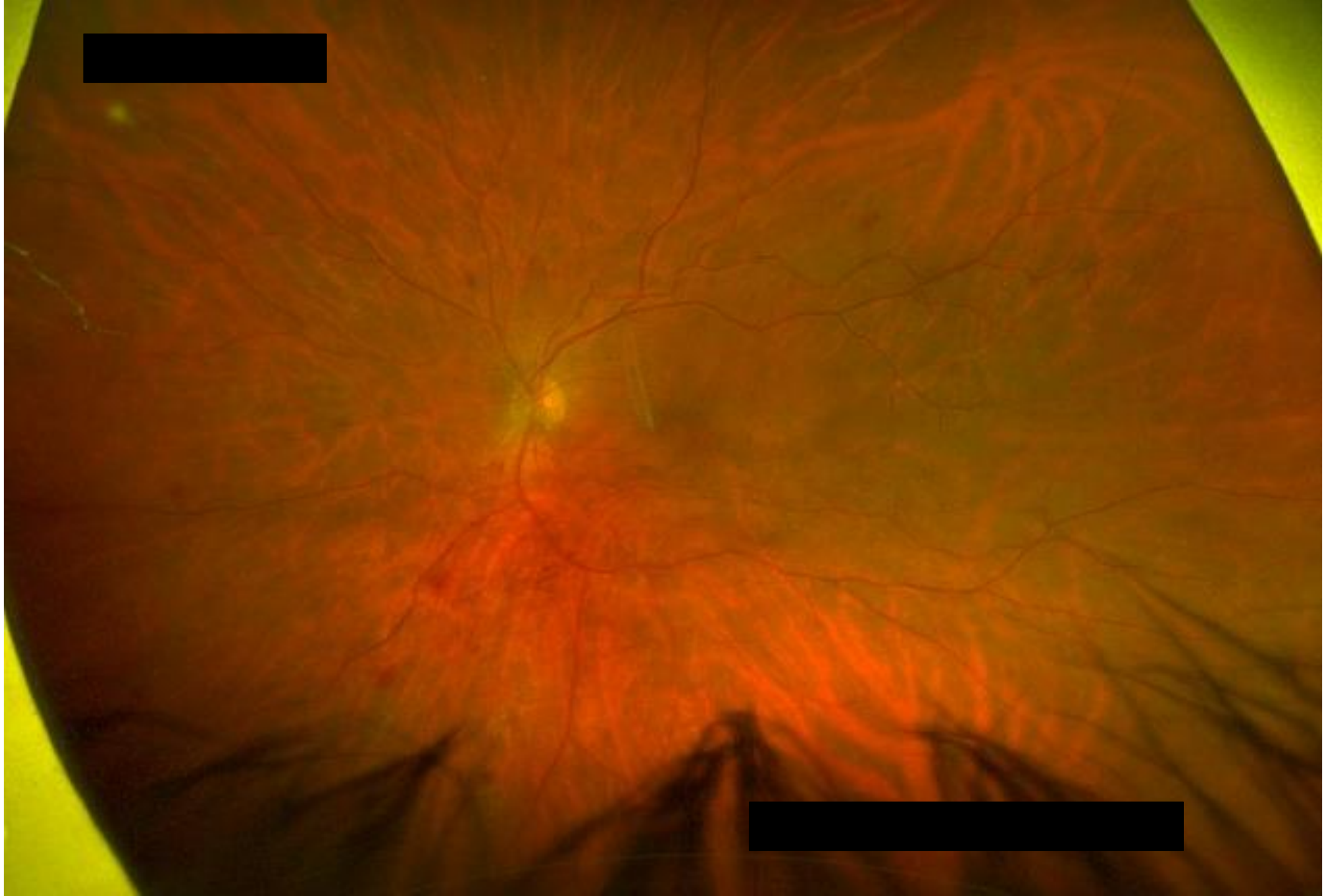






Center: 245 µm
Central Min: 237 µm
Central Max: 344 µm
Circle Diameters: 1, 3, 6 mm ETDRS



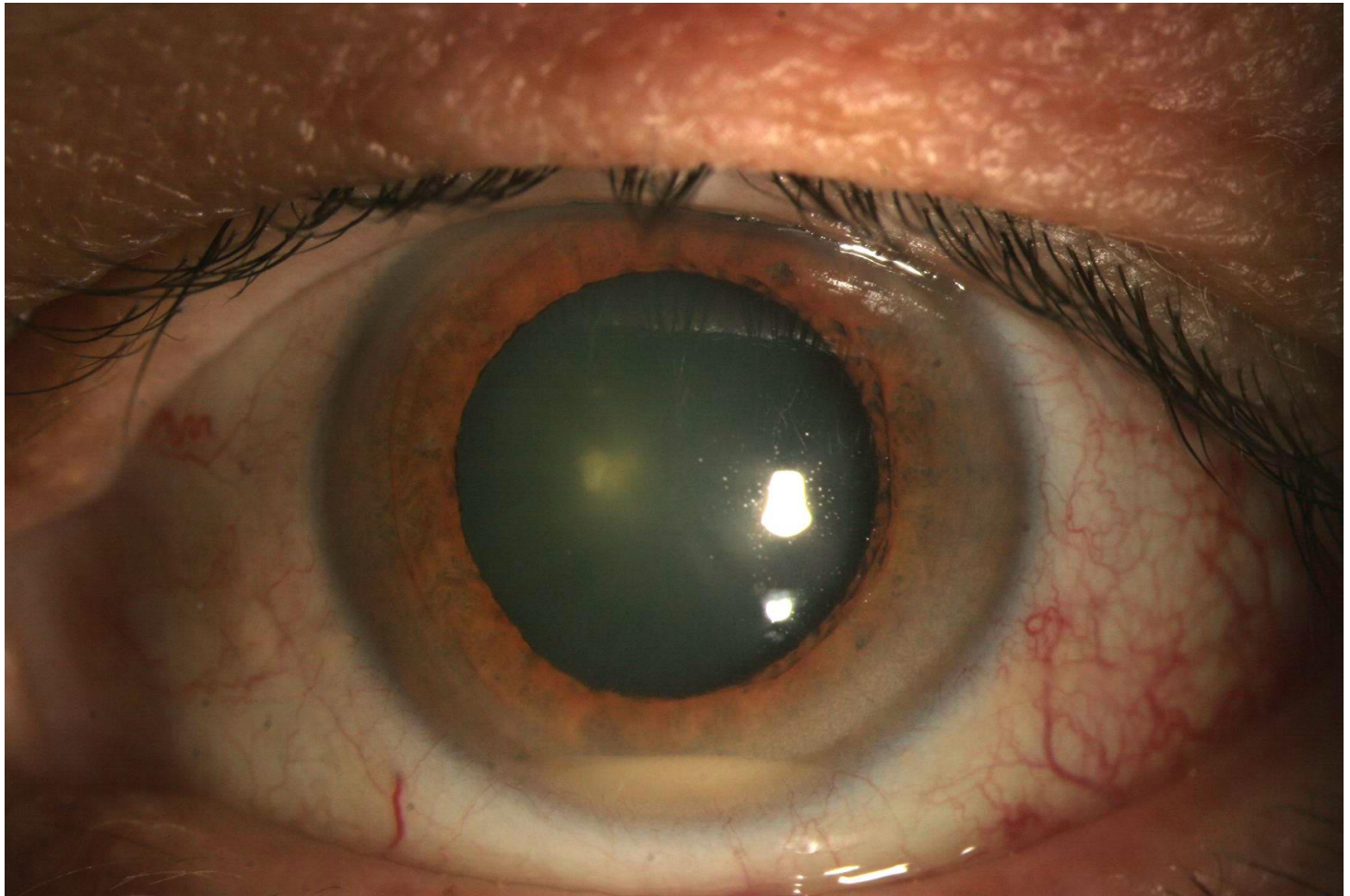


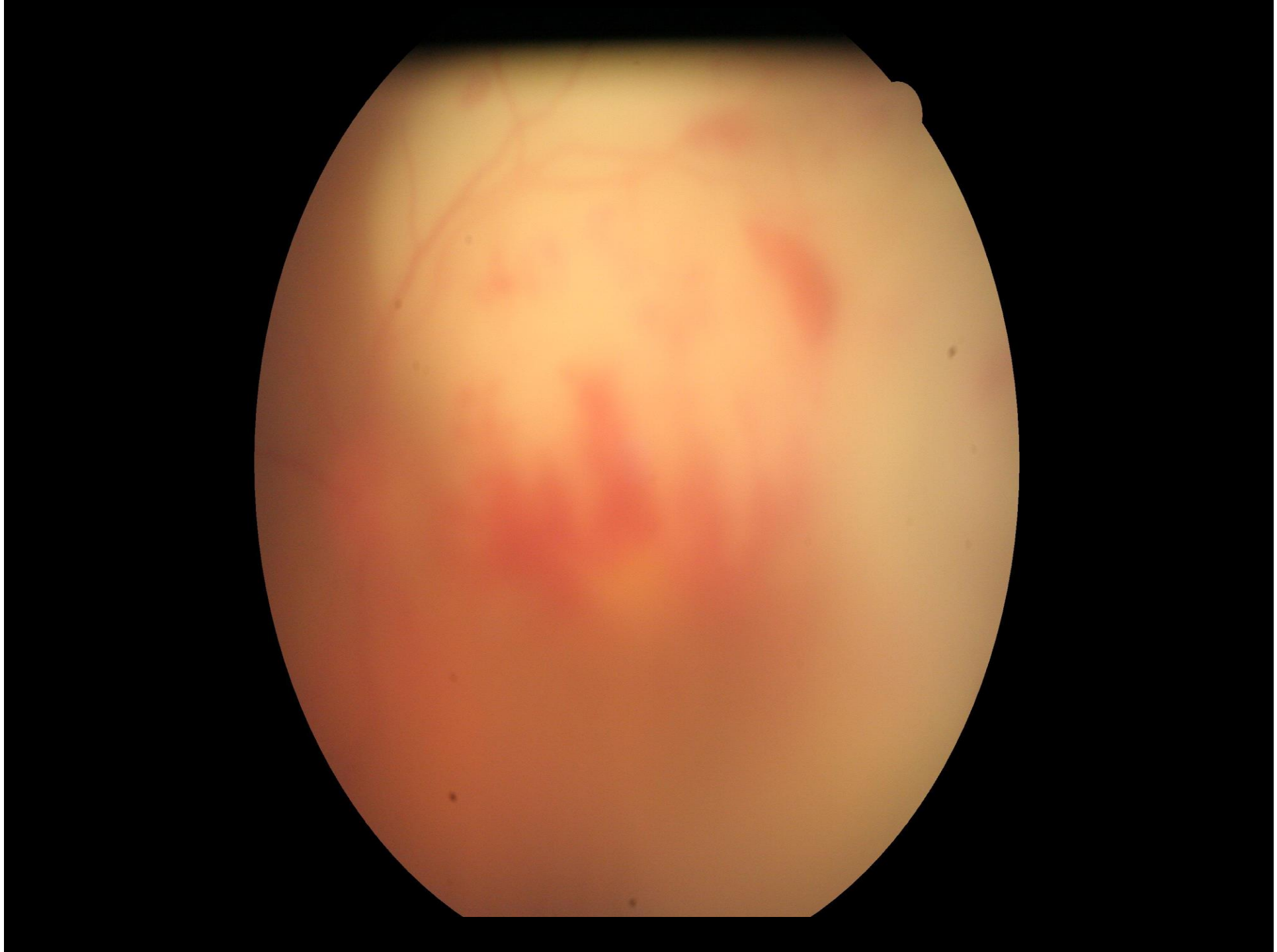
Merci

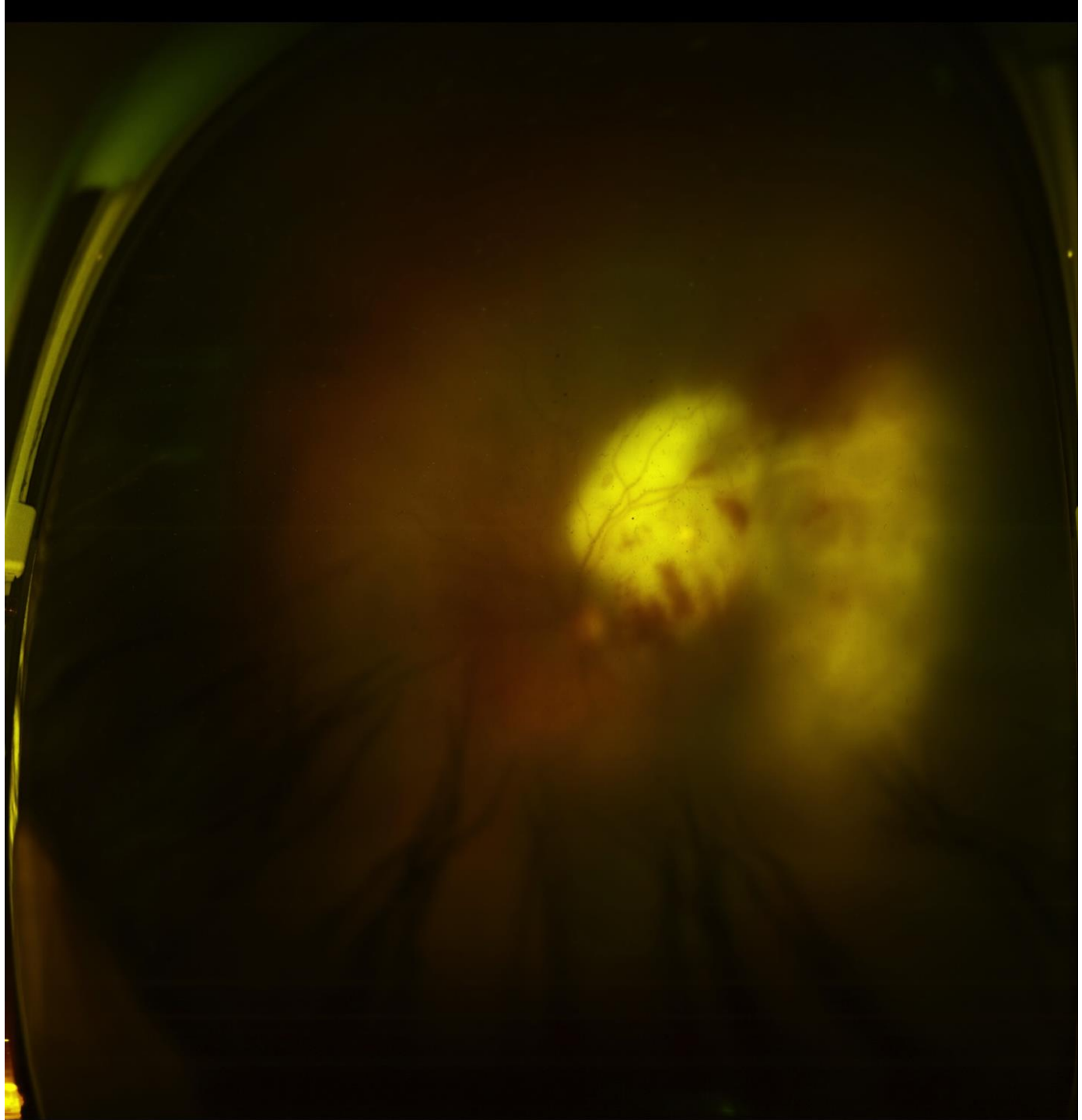
Monsieur C, 54 ans

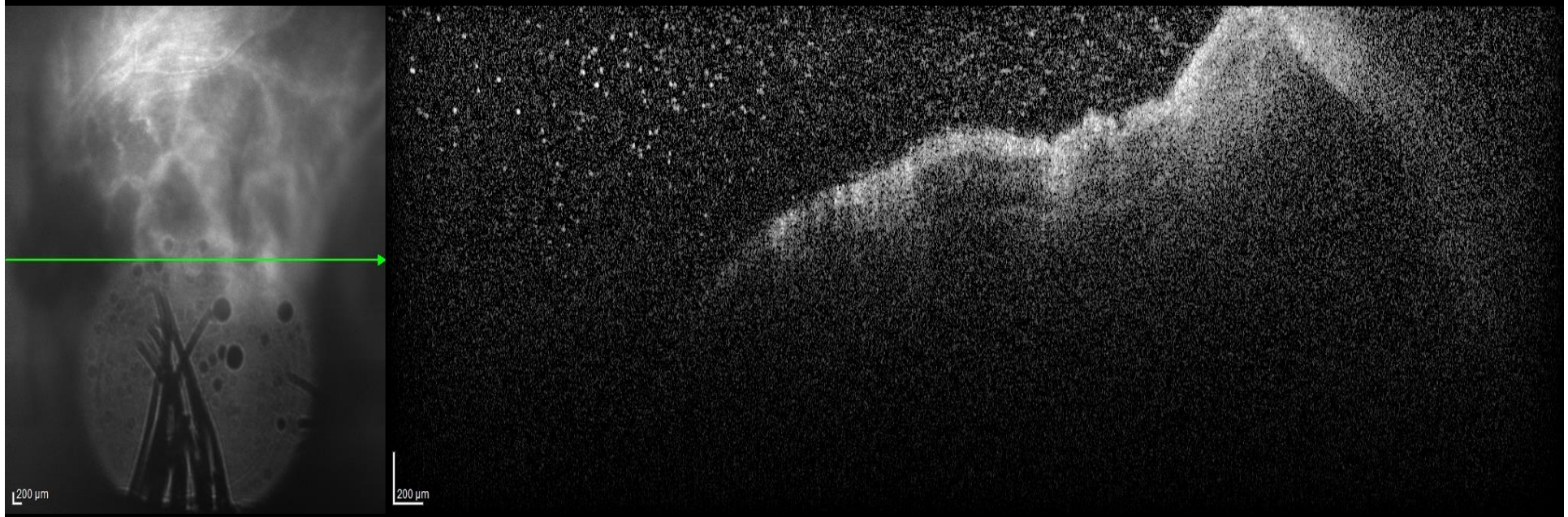
Baisse d’acuité visuelle installée en quelques jours du côté gauche

AV OD 1,0 OG VBLM








200 µm
200 µm

Mr C., 54 ans

- **Suspicion initiale de rétinite virale, atypique devant :**
  - **Hypopion**
  - **Hyalite (atypique si CMV)**
  - **Contexte fébrile**
  - **Importante altération de l'état général**
  - **Syndrome inflammatoire biologique**

Hospitalisation pour bilan étiologique et enquête infectieuse

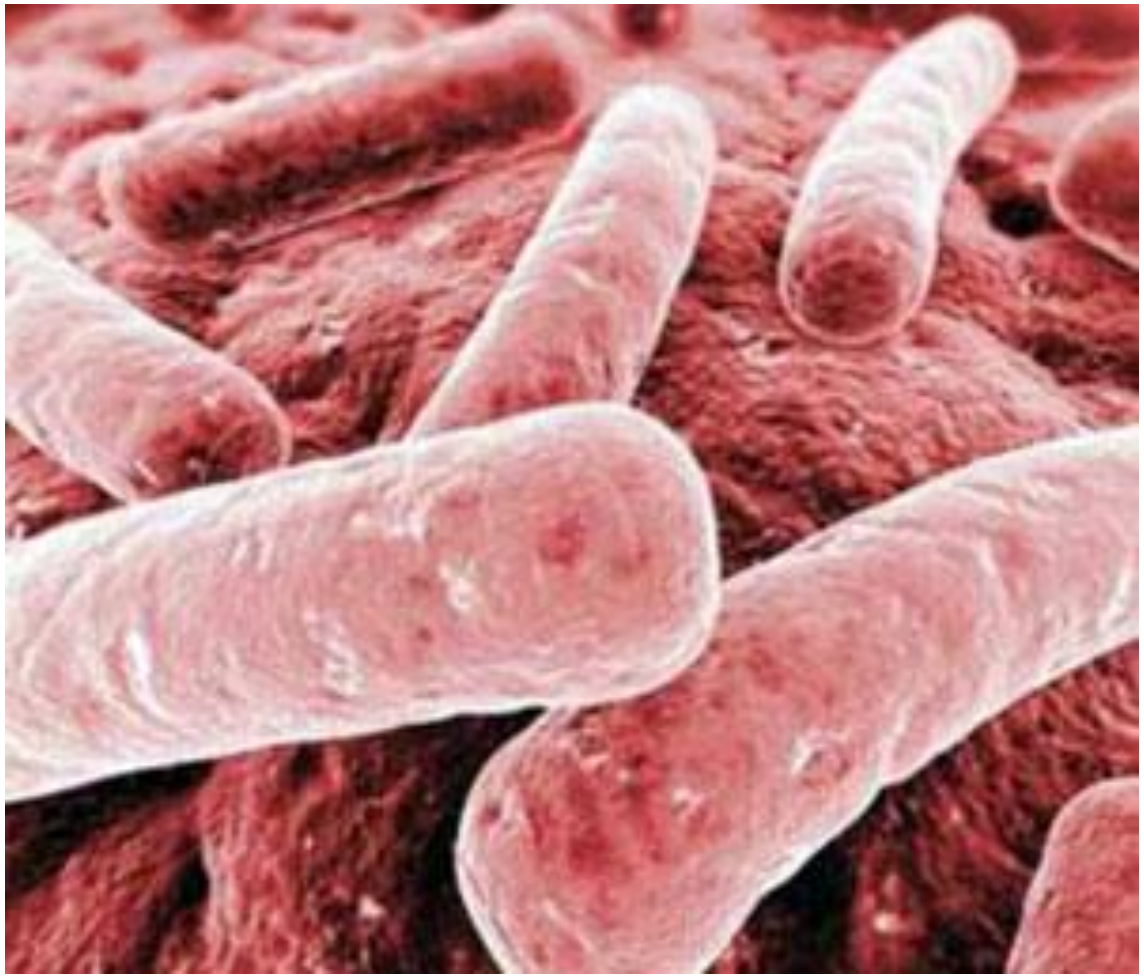
Mr C., 54 ans

- **Antécédents**
  - **Cardiopathie ischémique, pose de *stents***
  - **Hypertension artérielle**
  - **Diabète de type 2**

- **Mode de vie**
  - **Patient d'origine Française**
  - **Gendarme, père de 2 enfants en bonne santé**
  - **Pas de voyage à l'étranger**

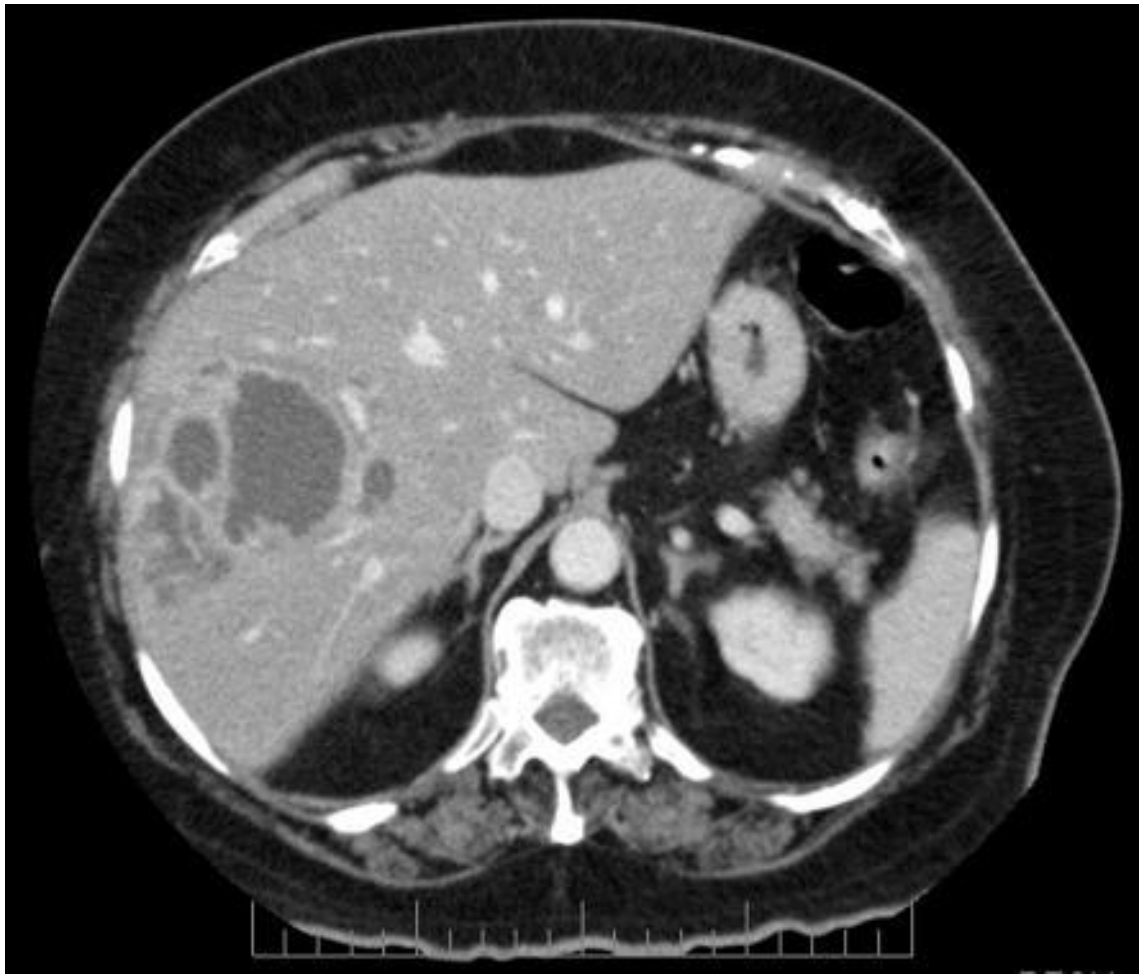
Explorations complémentaires

- **ECBU et Hémocultures positifs à Klebsiella pneumoniae**



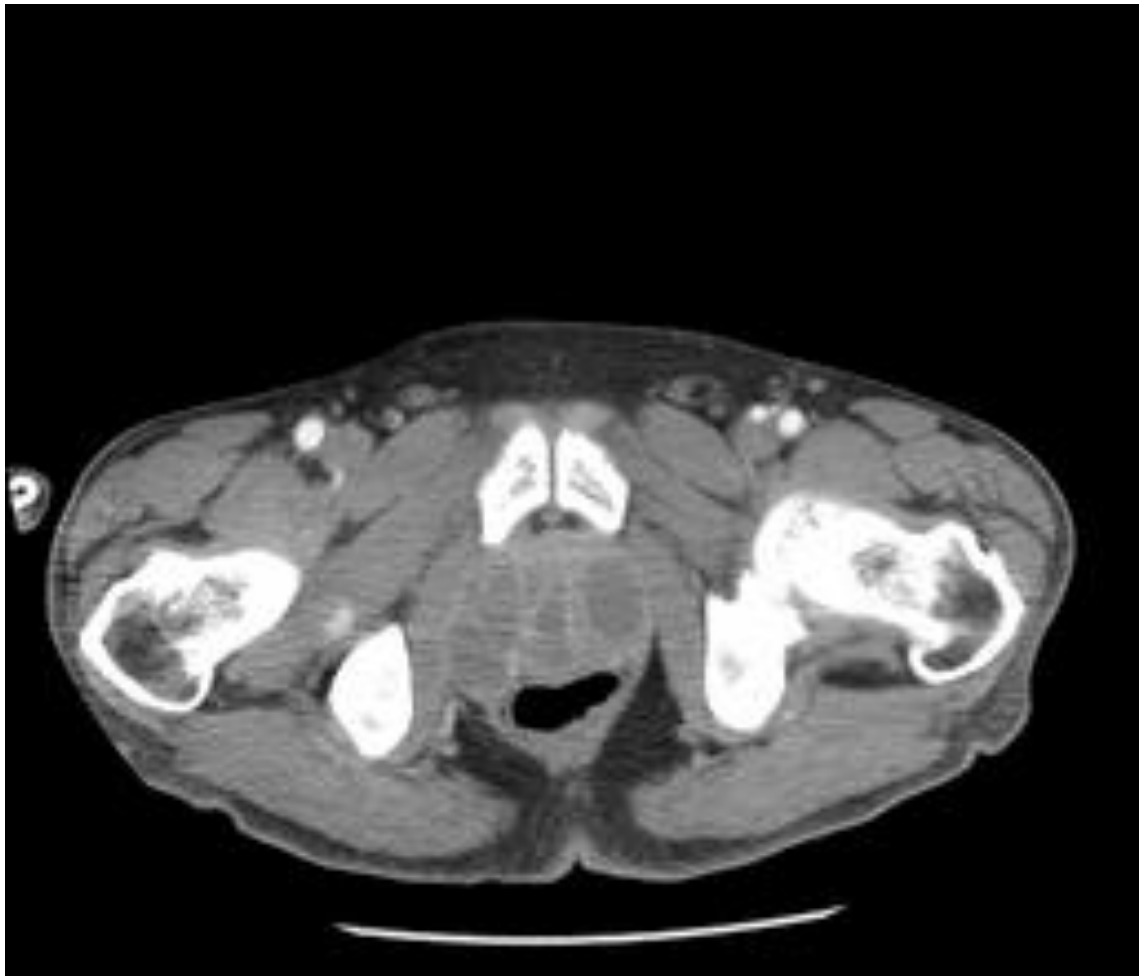
Explorations complémentaires

- **ECBU et hémocultures positifs à Klebsiella pneumoniae**
- **TDM thoraco-abdomino-pelvien : multiples abcès hépatiques**



Explorations complémentaires

- **ECBU et hémocultures positifs à Klebsiella pneumoniae**
- **TDM thoraco-abdomino-pelvien : multiples abcès hépatiques**
- **Abcès prostatiques**



Prise en charge thérapeutique et évolution

- **Antibiothérapie efficace**
  - **Initialement par Imipénème + Levofloxacine**
  - **Relais après identification et antibiogramme par C3G puis quinolones**

- **Evolution favorable du point de vue général avec contrôle du syndrome infectieux**

Klebsiella pneumoniae hypervirulente

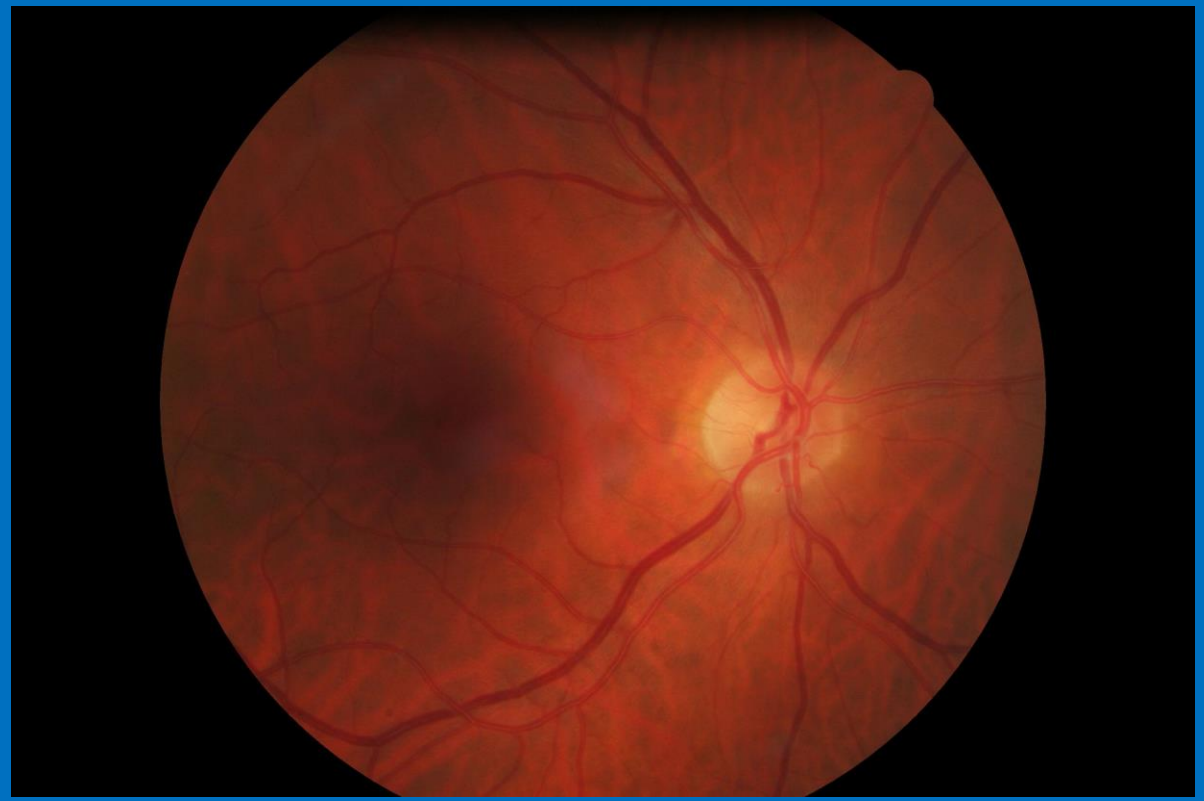
Fréquent en Asie du Sud-Est

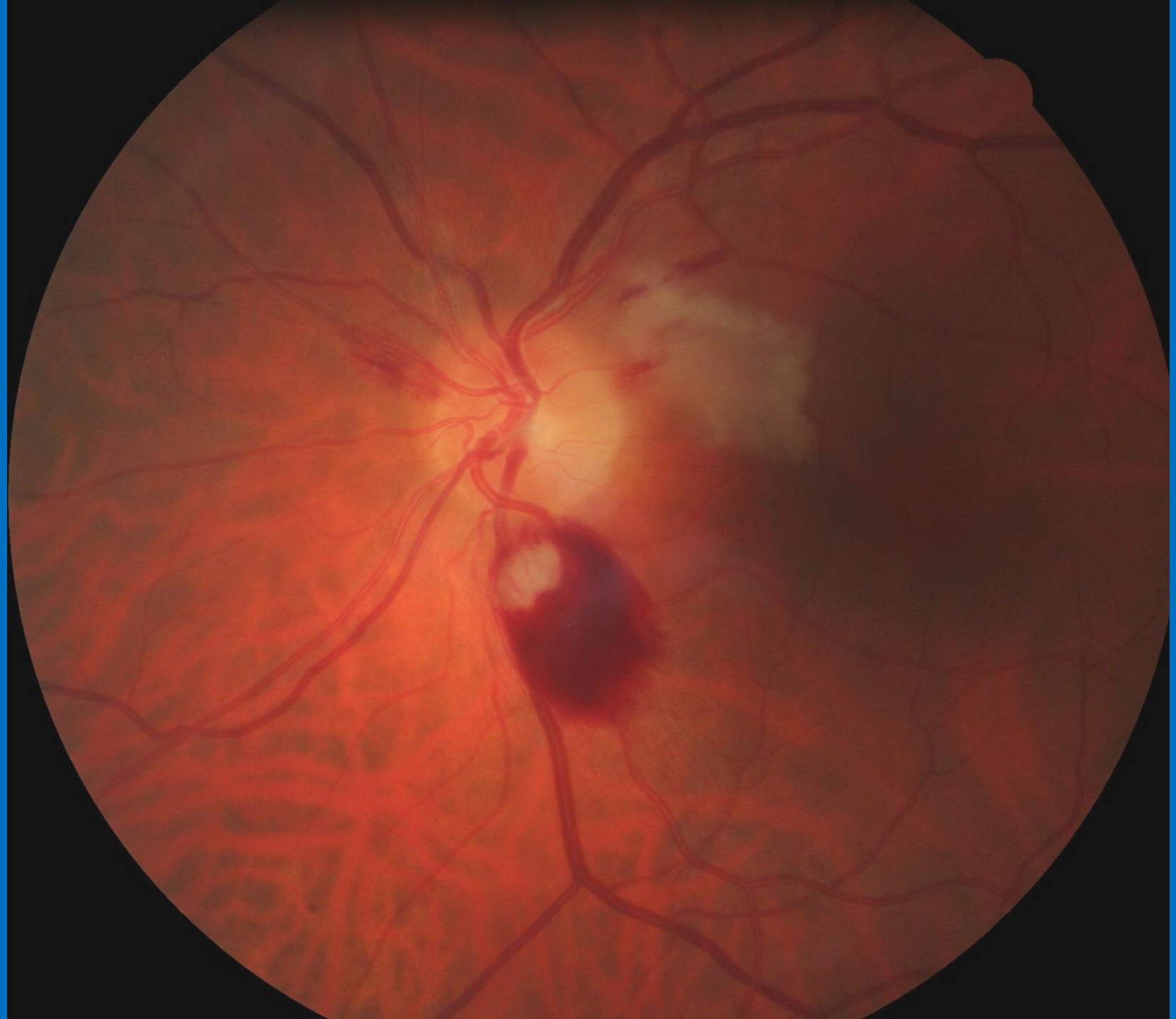
Rôle suspecté des pousses de soja

Mr L….. , 53 ans, est adressé pour 2ième avis oph devant une atteinte du nerf optique (!)
Antcdts : Tabagisme actif 3 PA - RAS
Histoire de la maladie :
Depuis 3 semaines, le patient signale une AEG, sueurs nocturne

OPH : Depuis 4 jours, le patient rapporte un scotome positif central œil gauche, + myodesopsies atypiques (« cheveux fixes »)

AV : 10/10 P2 10/10 P2





Confirmez vous le diagnostic de NOIAA ? par quel(s) moyen(s) ?

Quelles sont vos hypothèses diagnostiques ?

A. **Une candidose oculaire**
B. **Un syndrome d'IRVAN**
C. **Une pseudo-rétinopathie de Purtsher**
D. **Une rétinopathie hypertensive**
E. **Une tache de Roth**

Réponse :

A. **Une candidose oculaire**

B. **Un syndrome d'IRVAN**

C. **Une pseudo-rétinopathie de Purtsher**

D. **Une rétinopathie hypertensive**

E. **Une tache de Roth**

Endocardite aortique à stretocoque Galloticus ou Bovis:

-Insuffisance aortique asymptomatique
-IRM : emboles cérebelleux

Mr L., 57 ans

- **Antécédents**
  - Aucun

- **Mode de vie**
  - Patient d'origine Française
  - Intoxication alcoolo-tabagique modérée
  - Pas de voyage à l'étranger

Mr L., 57 ans

- **Adressé en Médecine Interne pour bilan étiologique**

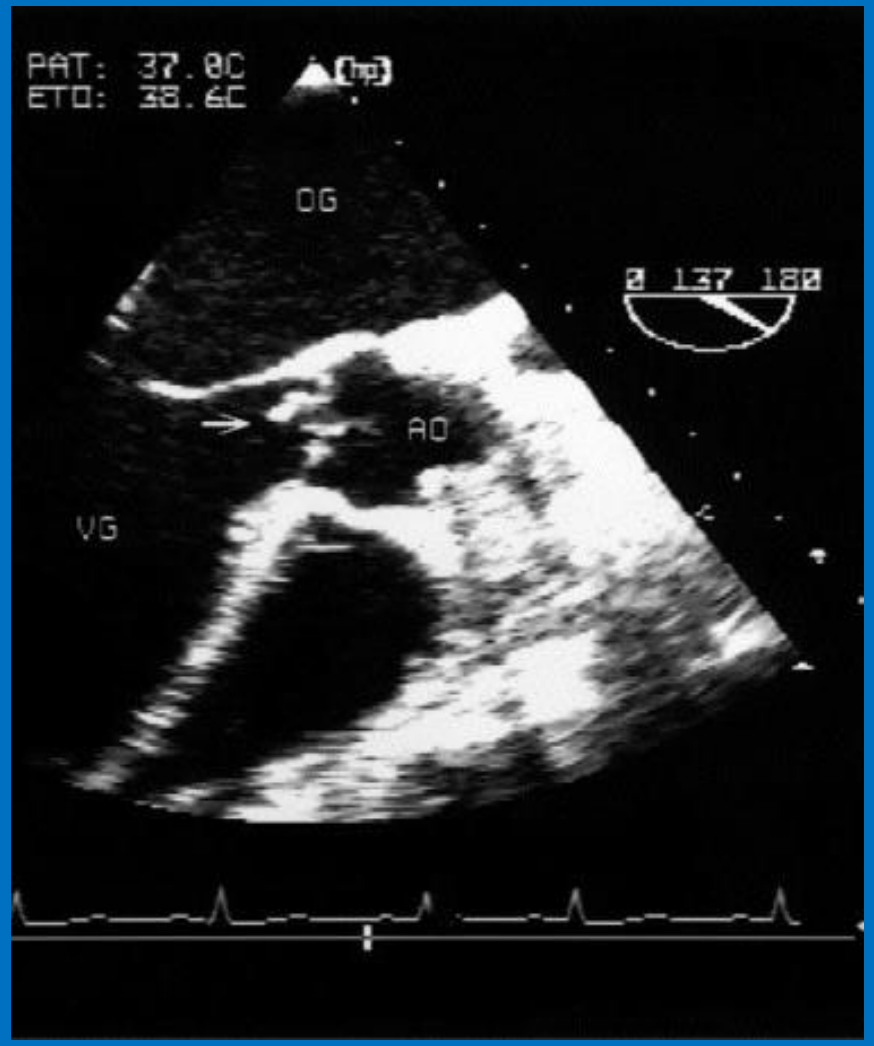
- **Interrogatoire :**
  - Sueurs nocturnes depuis 4 semaines
  - amaigrissement 10 KG

- **Examen clinique extra-oculaire:**
  - Température 37,8°C – TA 150/50 mmHg
  - Fréquence cardiaque 117/min
  - Souffle diastolique 2/6 doux, aspiratif

Hospitalisation en urgence
pour suspicion d'endocardite

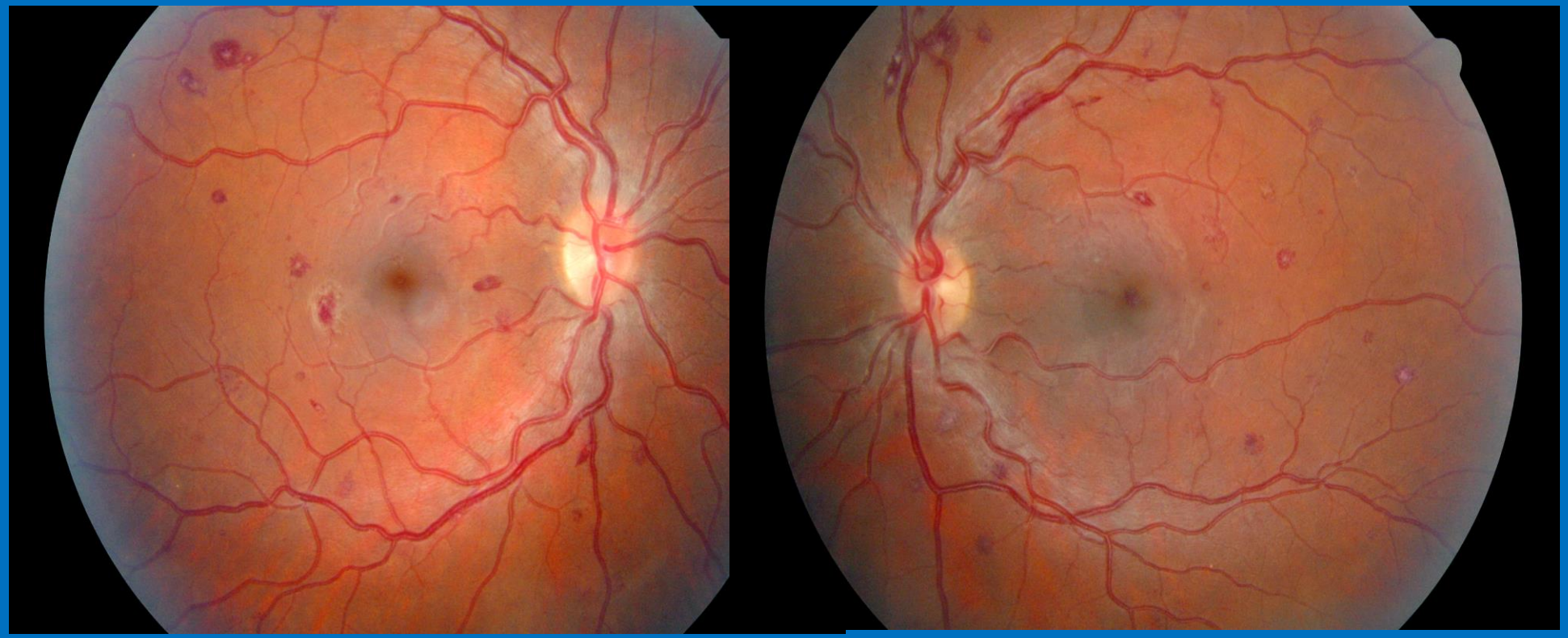
Mr L., 57 ans

- **NFS :** PNN 8 200/mm^3
- **CRP :** 24 mg/L
- **Hémocultures :** positives à S. gallolyticus
- **Echographie cardiaque trans-thoracique et trans-oesophagienne**



Diagnostic d'endocardite aortique compliquée d'emboles septiques oculaires et cérébrelleux

Taches de ROTH : leucémie aiguë



Ce qu'il faut retenir

- Hémorragie(s) rétinienne(s) à centre blanc (1872)
- Composition : fibrine, agrégats plaquettaires, ischémie focale, organismes infectieux, ou de cellules néoplasiques.
- Cause plus fréquente : endocardite (sub-aiguë) bactérienne !
  - Urgence vitale : antibiothérapie urgente voire traitement chirurgical
- Diagnostic différentiel :
  - Leucémie
  - Anémie pernicieuse
  - Rétinopathie hypertensive
  - Rétinopathie VIH
  - Autres : spécificité relativement faible

Ref : Roth's Spots in Leukemic Retinopathy N Engl J Med 1995

- Tsung-Yu Ho, Po-Kang Lin, Cheng-Hsiung Huang. (2008) White-centered Retinal Hemorrhage in Ocular Ischemic Syndrome Resolved After Carotid Artery Stenting. *Journal of the Chinese Medical Association* **71**, 270-272

Taches de ROTH