**Severe intraocular herpes simplex type I after forty-six years of latency**

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A 61-year-old HIV-negative gentleman with longstanding cognitive impairment and previous meningoencephalitis (aged 15years) was brought to the emergency department by his carer. They reported seven days of increasingly severe left-sided eye pain, redness, and loss of vision. Visual acuity testing showed the left eye to be completely blind (no light perception). External ocular examination revealed an inflamed left eye with conjunctival injection, chemosis, subconjunctival haemorrhage, and restriction of eye movements. Slit-lamp examination demonstrated a brisk left uveitis, large areas of necrotic retina, extensive retinal detachment, and deep retinal haemorrhages. In the right eye, there were small dot and blot retinal haemorrhages and two tiny retinal infiltrates, including one just inferior to the fovea.

*<Figure I approximately here>
(Caption = Figure I: Left eye fundus photograph, demonstrating vitreous haze, widespread retinal haemorrhages and infiltrates, and areas of necrotic retina)*

An urgent MRI of the head and orbits showed pathological enhancement of the left optic nerve as well as encephalomalacic changes involving the right temporal and insular lobes, in keeping with previous Herpes simplex virus (HSV) encephalitis.

*<Figure II approximately here>
Figure II: Axial T2 weighted sequence of the brain demonstrating significant Right temporal lobe encephalomalacia (arrowed)*

He was therefore treated for HSV acute retinal necrosis (ARN) with 10mg/kg of intravenous acyclovir three times daily for twelve days, followed by one gram of oral valaciclovir three times daily. Two injections of intravitreal foscarnet (2.4mg/0.1mL) were given to the right (less severely affected) eye, one week apart. Aqueous sampling of the left eye was ultimately positive for HSV type 1 by polymerase chain reaction.

Three months later, his right eye maintains good (20/30) vision, and the blind left eye is comfortable. He will continue antiviral prophylaxis life-long.

ARN is a rare but devastating necrotising viral retinitis caused by HSV or varicella zoster virus. It may sometimes be associated with, or can occur many years after, an episode of HSV encephalitis. Presentation is typically unilateral, but second eye involvement (either simultaneous, or delayed by months to years) occurs in about 30% of cases. Optic neuritis is a recognised complication.A 58-year-old woman presented to the rheumatology clinic with long-standing joint pain and deformities of both hands and feet. Her joint symptoms had begun when she was approximately 18 years of age, after which she had received treatment with ibuprofen and gold thread acupuncture (the insertion of small pieces of sterile gold thread with the use of acupuncture needles). Ten years before the current presentation, she had received a diagnosis of rheumatoid arthritis, which had been confirmed by laboratory test results that showed a rheumatoid factor of 628.7 IU per milliliter (normal value, <14) and an anticitrullinated protein antibody level of 170.8 U per milliliter (normal value, <5). Plain radiographs of both hands that were obtained at the current presentation showed severe joint damage and deformity of the wrists and proximal interphalangeal and metacarpophalangeal joints, with numerous short gold threads surrounding the joints. In East Asia and globally, acupuncture — including gold thread acupuncture — has long been used to treat joint pain. Oral and injectable gold preparations are also sometimes used. After the initial diagnosis of rheumatoid arthritis, the patient had been treated with the combination of methotrexate and leflunomide. When she was referred to our hospital, we changed her treatment regimen to a combination of methotrexate and abatacept, and she underwent surgery for the foot deformities, which led to a substantial reduction in joint pain.