Letter to the Editor

Macular toxoplasmosis and intravitreal clindamycin: An alternative to oral treatment

Toxoplasmosis macular y clindamicina intravitrea: una alternativa al tratamiento oral

Dear Sir:

Toxoplasmosis is the most frequent cause of posterior uveitis in immunocompetent patients.\(^1\) It usually appears as a focal retinitis, generally around a chorioretinal scar, and is accompanied by vitritis. Even though the nature of the lesions is self-limited, treatment is indicated in lesions that threaten the macula or the optic nerve–zone 1, as well as in peripheral lesions associating intense vitritis. In addition to the typical prescription with sulphadiazin, pyrimethamine and folinic acid, which associate well-known risks such as leukopenia and thrombopenia, the simplest and most widely known oral prescription is trimetropim-sulphametoxazole in association with folic acid. Occasionally, this treatment also causes

Fig. 1 – (A) The initial retinography reveals a site of macular yellowish–white retinitis. (B) The initial Optic Coherence Tomography (OCT) evidences a neuroepithelium detachment next to a retinal hyper-reflective lesion. (C) Retinography after 2 intravitral clindamycin and dexamethasone injections reveals an atrophic scar. (D) An OCT of the previous retinography evidences a severe focal reduction of the neurosensory retina thickness with marked underlying indirect hyper-reflectiveness.

adverse reactions such as skin rashes and gastrointestinal and hematological alterations. In our service we treated 2 toxoplasmosis cases in zone one and by means of weekly intravitreal injections of clindamycin (1 mg/0.1 ml) and dexamethasone (0.4 mg/0.1 ml), assisted with aqueous humor paracentesis. In the first case, in a 30-year-old pregnant woman, visual acuity (VA) improved from finger counting at 1 m in the LE to 0.2 after 2 injections in the course of 3 weeks (Fig. 1); in the second case, a 34-year-old male exhibited oral intolerance to sulphamides, VA improved from hand movement in the RE to 0.30 after a single injection in the course of 15 days (Fig. 2). Intravitreal clindamycin is prepared with a clindamycin phosphate vial (Clindamicina Combino Pharm EFG), extracting 0.2 mm from this vial and adding 2.8 ml of 0.9% sodium chloride, injecting 0.1 ml in the vitreous (1 mg/0.1 ml). Intravitreal dexamethasone is prepared on the basis of a dexamethasone vial (Fortecortin), taking directly from this vial 0.1 ml (0.4 mg/0.1 ml).

Various authors have proposed the use of intravitreal clindamycin injections in association with dexamethasone in ocular toxoplasmosis cases. The mean number of intravitreal injections to achieve resolution of chorioretinitis varies between authors, ranging from one injection\(^2\) to 3 injections,\(^3\) with a mean interval between the injections of 2 weeks,\(^2,3\) without differences being found in the results of oral or intravitreal therapy.\(^2\)

To conclude, intravitreal clindamycin injection (1 mg/0.1 ml) associated to dexamethasone (0.4 mg/0.1 ml) is safe and provides good results in a short period of time, thus constituting an alternative to oral treatment in addition to providing greater comfort to the patient and an approved systemic safety profile. It also reduces the follow-up visits and hematological control requirements. This therapeutic alternative should be considered in ocular toxoplasmosis cases in gestating women, sulphamide allergic patients, resistance to oral treatment or those evidencing zone 1 involvement. The most widely used administration pattern is weekly although in our experience it is convenient to monitor the response of each patient on the basis of the visual changes and the tomographic appearance of the infectious site.

REFERENCES
