UVEITIS INFECCIOSAS EN NIÑOS

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VEITIS INFECCIOSAS EN NIÑOS

Couto

- Uveitis menores de 16 a. : 6 – 30 %
- Severa / Complicaciones (alto riesgo)------ Pérdida visual severa
- Asintomática /preverbal/ incapaz de manifestar síntomas
- Dificultad en examen : retardo en el diagnóstico …. AMBLIOPÍA
- Causas de uveitis # adulto .
- Uveitis y Artritis juvenil idiopática: ppal causa no infecciosa
- Toxoplasmosis : ppal causa infecciosa
- Tratamiento : desafío → corticoides y retardo en el crecimiento
  → drogas específicas: dosis y efectos adversos

Br J Ophthalmol. 2009 May;93(5):569-72

VEITIS INFECCIOSAS EN NIÑOS

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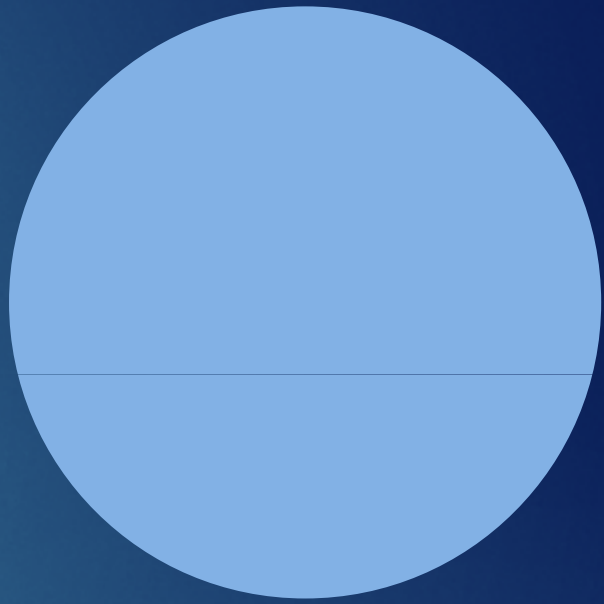
- Retinocoroiditis por toxoplasma
- Retinitis necrotizante herpética
- Toxocariasis
- Neurorretinitis por Bartonella henselae/nematode
- Candidiasis ocular



Infección congénita - TORCH -

- Toxoplasmosis Rubeóla
- Citomegalovirus
- Herpes simplex virus

EITIS INFECCIOSAS EN NIÑOS

Couto

haracteristics of childhood uveitis leading to sual impairment and blindness in the Netherlands

kje M. Hettinga,[1,2,*] Fleurieke H. Verhagen,[1,*] Maria van Genderen[2] and Joke H. de Boer[1]

Acta Ophthalmol. 2014: 92: 798–804

ABSTRACT.

Purpose: **To investigate the clinical characteristics of childhood uveitis leading to visual impairment or blindness.**

Methods: **In this descriptive study, we reviewed data from the medical records of 58 children with visual impairment or blindness due to childhood uveitis, which were seen at an institute for visually impaired patients (Bartiméus) between January 1981 and December 2012, in a retrospective, cross-sectional manner.**

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Table 1. General patient characteristics.

	N (*n* = 58)	Median (IQR*)
Gender		
Male	32 (55%)	
Female	26 (45%)	
Age at diagnosis†		0.9 years (0.2–4.8)
Age at first consult		5.9 years (2.4–9.7)
Time between diagnosis and intake†		2.5 years (0.8–5.5)
Anatomical diagnosis		
Anterior	3 (5%)	
Intermediate	3 (5%)	
Posterior	44 (76%)	
PAN-uveitis	8 (14%)	
Aetiological diagnosis		
Infectious		
Congenital	37 (64%)	
Acquired	6 (10%)	
Non-infectious		
Systemic disease	5 (9%)	
Idiopathic	10 (17%)	
Visual handicap		
Visually impaired	32 (55%)	
Legally blind	26 (45%)	
Medication before intake‡		
No medication	20 (35%)	
Topical only	6 (10%)	
Systemic	7 (12%)	
≥2 systemic medications	18 (31%)	

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Table 2. Diagnoses of children with blindness or visual impairment due to uveitis.

Aetiological group	Aetiological diagnosis	*N*	Percentage of aetiological group (%)	Percentage of total (%)
Infectious	Congenital			
	Toxoplasmosis	20	47	35
	CMV	8	19	14
	Rubella	8	19	14
	HSV	1	3	2
	Acquired			
	CMV	2	5	4
	HSV	1	2	2
	Measles	1	2	2
	Endogenous endophthalmitis	1	2	2
	Candida	1	2	2

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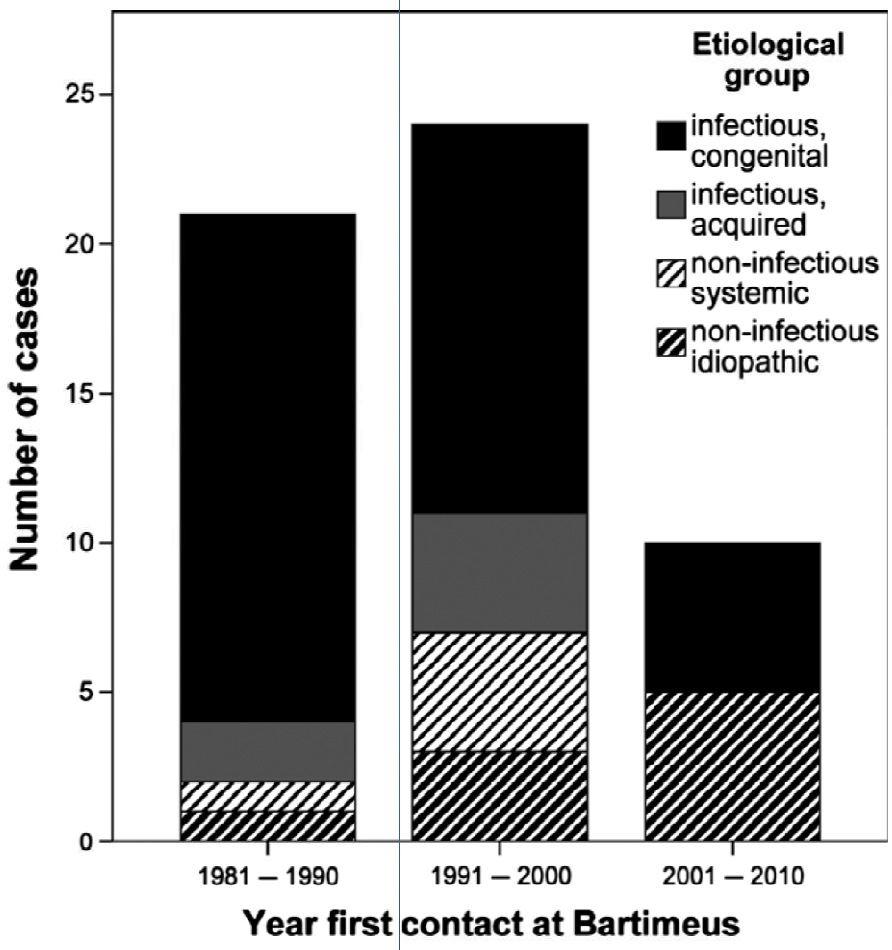

Fig. 1. Distribution of aetiological diagnosis of children with visual impairment and blindness due to uveitis presenting at Bartiméus grouped per 10 years.

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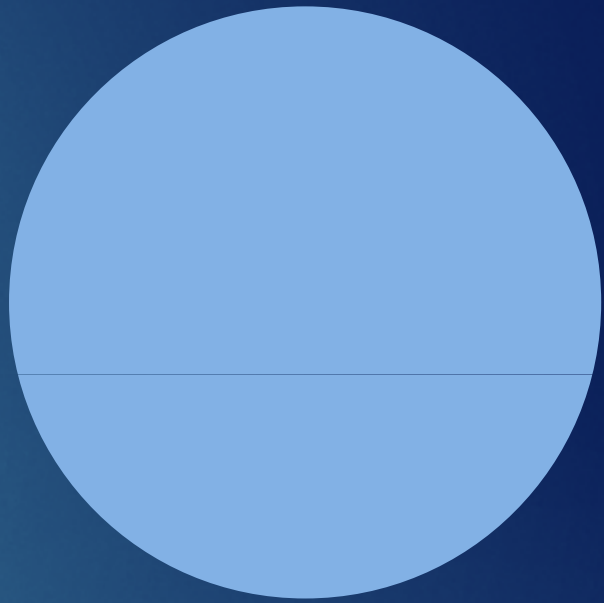
Table 3. Main cause of visual loss in children with uveitis.

	No. of eyes $n = 112$
Macular scar	45 (40%)
Cataract	23 (21%)
Retinopathy/retinal atrophy	12 (11%)
Optic disc atrophy	7 (6%)
Phthisis	6 (5%)
Vitreous opacities	5 (5%)
Glaucoma	3 (3%)
Cystoid macular oedema	3 (3%)
Intracerebral pathology	3 (3%)
Retinal detachment	2 (2%)
Other*	2 (2%)
Miscellaneous	1 (2%)

* Amblyopia not related to uveitis $n = 2$.



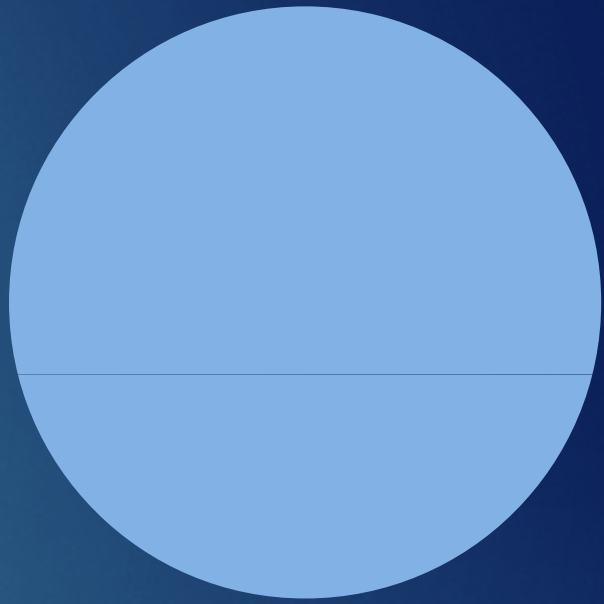
Epidemiology and Outcomes of Pedriatics Uveitis in Argentina

METHODS

Databases from the uveitis clinic at the Hospital de Clínicas José de San Martín and the Hospital de Niños Ricardo Gutierrez both from the city of Buenos Aires, were reviewed between January 1, 2006 and October 1, 2014. All patients with a diagnosis of uveitis and aged 0-16 years were included. *Data was* retrieved retrospectively from the initial and final visit.

Epidemiology and Outcomes of Pedriatics Uveitis in Argentina

Ages	N	(%)
<1 year	42	16,40
1-5 years	48	18,75
6-10 years	80	31,25
11-16 years	86	33,60
Total	256	100

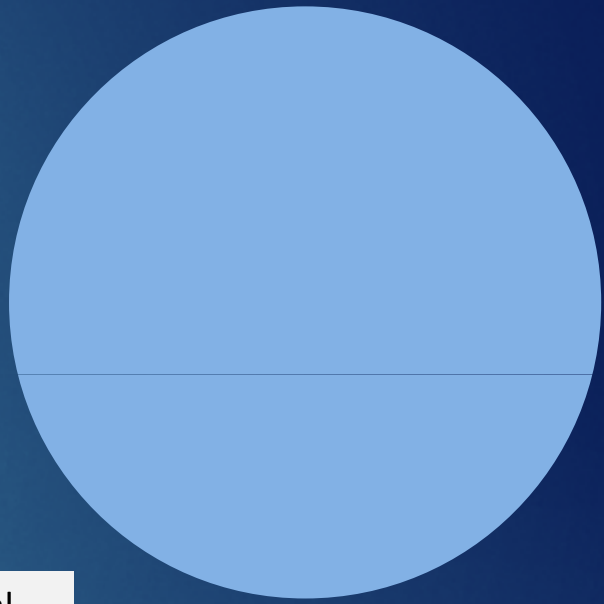


Ages	Hospital Gutierrez	Hospital de Clinicas	Total
<1 year	41	1	42
1-5 years	44	4	48
6-10 years	65	15	80
11-16 years	47	39	86
Total	197	59	256

Epidemiology and Outcomes of Pedriatics Uveitis in Argentina

UNILATERAL (133, 51.9%),
GRANULOMATOUS (144, 56.3%)

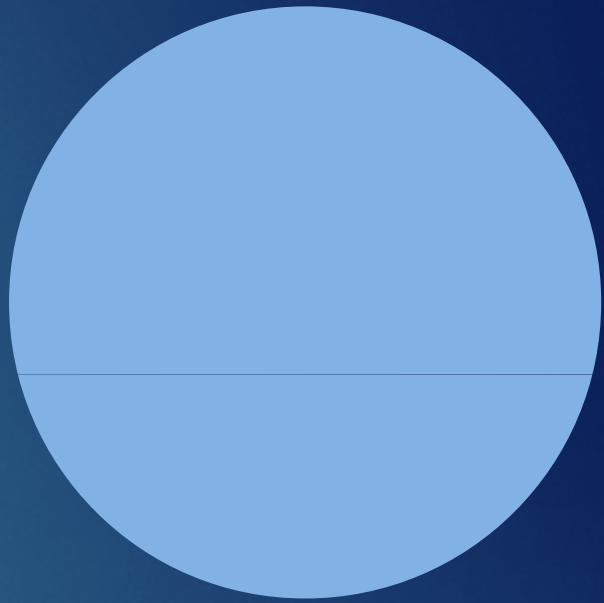
Anatomic location	N	(%)
Anterior	80	31,25
Intermediate	26	10,15
Posterior	119	46,50
Panuveitis	31	12,10
Total	256	100,00



Anatomic location	Hospital Gutierrez	Hospital de Clinicas	Total
Anterior	55	25	80
Intermediate	21	5	26
Posterior	106	13	119
Panuveitis	15	16	31
Total	197	59	256

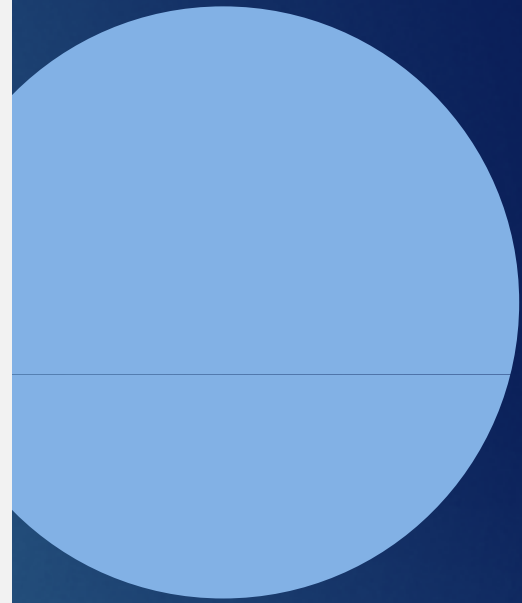
Epidemiology and Outcomes of Pedriatics Uveitis in Argentina

Etiology	Number of Patients (%)
Toxoplasmosis	97 (37.9)
Juvenile idiopathic arthritis	41 (16.0)
Toxocariasis	30 (11.7)
Idiopathic	28 (10.9)
Pars planitis	21 (8.2)
Unknown	13 (5.1)
Vogt-Koynagi-Harada	12 (4.7)
Herpes simplex virus	3 (1.2)
Cytomegalovirus	3 (1.2)
Bacterial endophthalmitis	2 (0.8)
Sarcoidosis	2 (0.8)
HLA-B27	1 (0.4)
Ocular cicatricial pemphigoid	1 (0.4)
Interstitial keratitis	1 (0.4)
Schwartz syndrome	1 (0.4)
Sympathetic ophthalmia	1 (0.4)

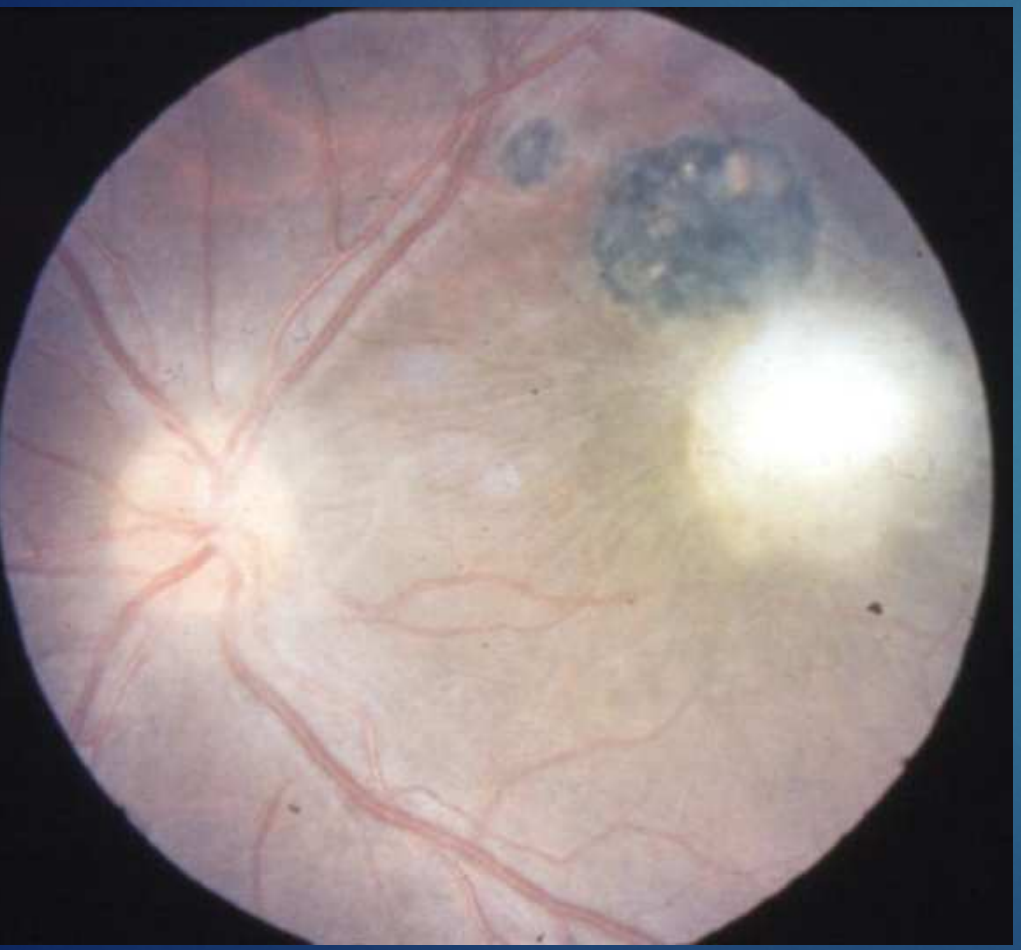


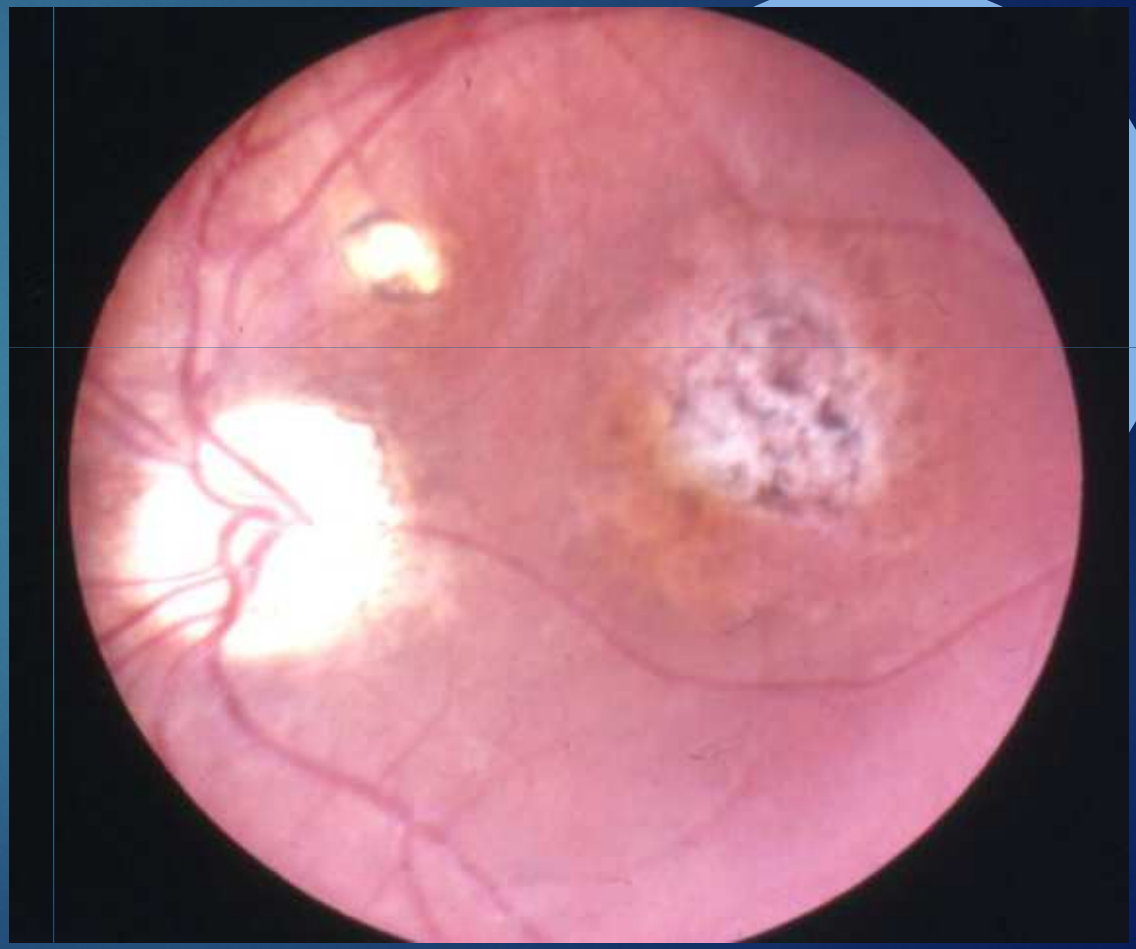
Epidemiology and Outcomes of Pedriatics Uveitis in Argentina

Etiology	Hospital Gutierrez	Hospital de Clinicas	Total
Toxoplasmosis	91	6	97
Juvenile idiopathic arthritis	26	15	41
Toxocariasis	20	10	30
Idiopathic	23	5	28
Pars planitis	16	5	21
Unknown	8	5	13
Vogt-Koynagi-Harada	6	6	12
Herpes simplex virus	1	2	3
Cytomegalovirus	3	0	3
Bacterial endophthalmitis	2	0	2
Sarcoidosis	1	1	2
HLA-B27	0	1	1
Ocular cicatricial pemphigoid	0	1	1
Interstitial keratitis	0	1	1
Schwartz syndrome	0	1	1
Sympathetic ophthalmia	1	0	1
Total	198*	59	257*

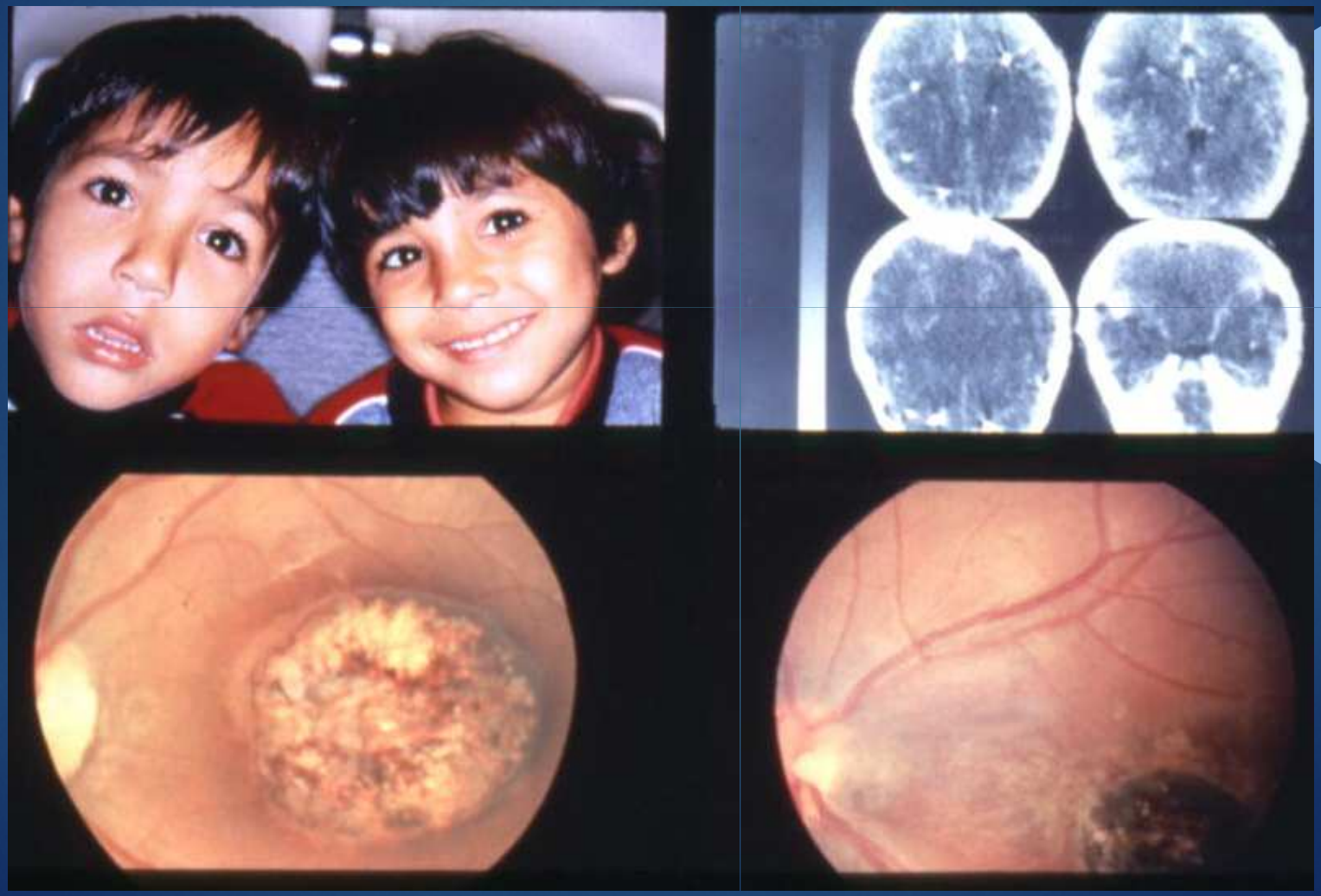


Toxoplasmosis





Toxoplasmosis



EITIS INFECCIOSAS EN NIÑOS

Couto

ngenital Toxoplasmosis in Southeastern zil: Results of Early Ophthalmologic mination of a Large Cohort of Neonates

or Vasconcelos-Santos, MD, PhD,[1,2] Danuza O. Machado Azevedo, MD, PhD,[1] Campos, MD, PhD,[1] Fernando Oréfice, MD, PhD,[1] Gláucia M. Queiroz-Andrade, MD, PhD,[2,3] Machado Carellos, MD, MSc,[2,3] Roberta M. Castro Romanelli, MD, PhD,[2,3] Januário, MD, MSc,[2,4] Luciana Macedo Resende, MSc,[5] Olindo Assis Martins-Filho, MSc, PhD,[6] lina de Aguiar Vasconcelos Carneiro, MSc,[7] Ricardo W. Almeida Vitor, MSc, PhD,[7] Teixeira Caiaffa, MPH, PhD,[8] for the UFMG Congenital Toxoplasmosis Brazilian Group

ive: To report results of early ophthalmologic examinations in a large cohort of newborns with l toxoplasmosis (CT) after neonatal screening.
: Cross-sectional analysis of a cohort.
pants: A total of 178 newborns with confirmed CT from 146,307 screened babies (95% of live births) as Gerais state, southeastern Brazil.
ds: From November 2006 to May 2007, newborns underwent neonatal screening by immunoglobulin ture of dried blood samples. On all positive or suspected cases, confirmative serology was performed and their mothers. Congenital toxoplasmosis was confirmed in newborns who had IgM and/or IgA and gG associated with suggestive ocular lesions (with IgM and IgG in the mother). Ophthalmologic consisted of indirect ophthalmoscopy with a lid speculum. Pediatric examination and radiologic f the central nervous system were also performed. In selected cases, biomicroscopy of the anterior fundus photographs, or ultrasonography (B-scan) was performed.
Outcome Measures: Prevalence of retinochoroidal lesions, either cicatricial or active, and their and associated findings, such as vascular sheathing, hemorrhage, vitreous opacities, and retinal nt, were evaluated. The occurrence of cataract, microphthalmia, microcephaly, intracranial calcifica- hydrocephalus was also recorded.
s: Of 146,307 neonates screened, 190 had CT, yielding a prevalence of 1 in 770 live births, of whom %) underwent standardized ophthalmologic examination at an average age of 55.6±16.6 days. Of these ts, 142 (79.8%) had retinochoroidal lesions consistent with CT in at least 1 eye. Bilateral involvement d in 113 patients (63.5%). Macular involvement was seen in 165 eyes (46.3%) of 111 patients (62.4%). ions were observed in 142 eyes (39.9%) of 85 patients (47.8%). These lesions were located in the f 75 eyes (21.1%) and were associated with retinal vascular sheathing in 44 eyes (12.4%).
usions: A high prevalence of CT was encountered (1/770) with high rates of early retinochoroidal ent (~80%) and many active lesions (in ~50%), indicating a possibly more severe ocular involvement Brazil than in other parts of the world. The hypotheses of higher parasite virulence and increased susceptibility are being currently investigated.

146.307: Recién nacidos (6 meses)

190 : Toxoplasmosis congénita (1/77
178 : Examen oftalmológico (93,7%)
142: Retinocoroiditis (79,8%)
113: Bilateral (63,5%)

tudinal Study of New Eye Lesions in Children with plasmosis Who Were Not Treated During the First Year of Life

PHAN, KRISTEN KASZA, JESSICA JALBRZIKOWSKI, A. GWENDOLYN NOBLE, PAUL LATKANY, D, WILLIAM MIELER, SANFORD MEYERS, PETER RABIAH, KENNETH BOYER, CHARLES SWISHER, N METS, NANCY ROIZEN, SIMONE CEZAR, MARI SAUTTER, JACK REMINGTON, PAUL MEIER, AND RIMA MCLEOD, ON BEHALF OF THE TOXOPLASMOSIS STUDY GROUP

To determine the incidence of new chorio- ns in children with toxoplasmosis diagnosed erefore not treated during, their first year. rospective longitudinal cohort study.

Thirty-eight children were evaluated in ween 1981 and 2005 for new chorioretinal ty-eight children and mothers had serum to *Toxoplasma gondii*.

Twenty-eight of 38 children had one of the agnosis with serum antibody to *T. gondii* chronic infection at age 24 months, central tem calcifications, hydrocephalus, illness ith congenital toxoplasmosis perinatally but d at that time. Twenty-five returned for ring 1981 to 2005. Their mean (range) age was 10.9 ± 5.7 (range, 3.5 to 27.2) years ollow-up was 5.7 ± 2.9 years. Eighteen en developed at least one new lesion. Thir- had new central lesions, 11 (44%) had new sions, and six (24%) had both. Thirteen ew lesions diagnosed at age ≥10 years. New found at more than one visit in four (22%), new lesions developed in seven (39%) of 18 developed new lesions. Of 10 additional eye findings and serologic tests indicative of tion, six returned for follow-up, four (67%) ew lesions at ≥10 years of age.

ONS: More than 70% developed new chorio- s. New lesions were commonly diagnosed after de of life. (Am J Ophthalmol 2008;146: 2008 by Elsevier Inc. All rights reserved.)

CONGENITAL TOXOPLASMOSIS THAT WAS UNTREATED or treated only for one month has been described in small series of patients as a relapsing, recrudescent disease causing significant visual impairment.[1,2] However, the prospective follow-up into adolescence of chorioretinal lesions in children with congenital toxoplasmosis, other than a small group of those with congenital toxoplasmosis diagnosed at birth and treated during the first year of life, has not been rigorously defined. Herein we describe a cohort of 38 children with toxoplasmosis presenting after one year of age, who were followed prospectively in a single center according to a standardized protocol.

METHODS

• DESIGN OF STUDY: The children in this study and their mothers were referred by their physicians and evaluated at the University of Chicago by a group of specialists at the onset of enrollment into the study and later at prespecified times: 1, 3.5, 5, 7.5, 10, 15, 20, 25, 30, 35, 40, and 45 years of age.[3,4] Written informed consent was obtained from all parents or legal guardians of participating minor-age children and/or directly from the patient (if of legal adult age).

• PATIENT COHORT: This cohort consists of 38 persons who were children at the time of diagnosis of their ocular toxoplasmosis, who, with their mothers, had nonacute serologic tests for *Toxoplasma gondii* infection at the time their contact with the Chicago Toxoplasmosis Center was initiated. They were not diagnosed until after their first

Longitudinal Study of New Eye Lesions in Treated Congenital Toxoplasmosis

*Laura Phan, MPH,[1] Kristen Kasza, MS,[2] Jessica Jalbrzikowski, BA,[1] A. Gwendolyn Noble, MD, PhD,[3] Paul Latkany, MD,[1,4] Annie Kuo, BS,[1] William Mieler, MD,[1] Sanford Meyers, MD,[1] Peter Rabiah, MD, Ken Boyer, MD,[5] Charles Swisher, MD,[3] Marilyn Mets, MD,[3] Nancy Roizen, MD,[1,6] Simone Cezar, BS Jack Remington, MD,[7] Paul Meier, PhD,[1,8] Rima McLeod, MD,[1] Toxoplasmosis Study Group**

Objective: To determine the incidence of new chorioretinal lesions in patients with congenital toxop who were treated throughout their first year of life.

Design: Prospective longitudinal observation of a cohort.

Participants: One hundred thirty-two children were studied as part of the longitudinal observatio

Methods: One hundred thirty-two children were treated during their first year of life with pyrime sulfadiazine, and leucovorin. They had eye examinations at prespecified intervals.

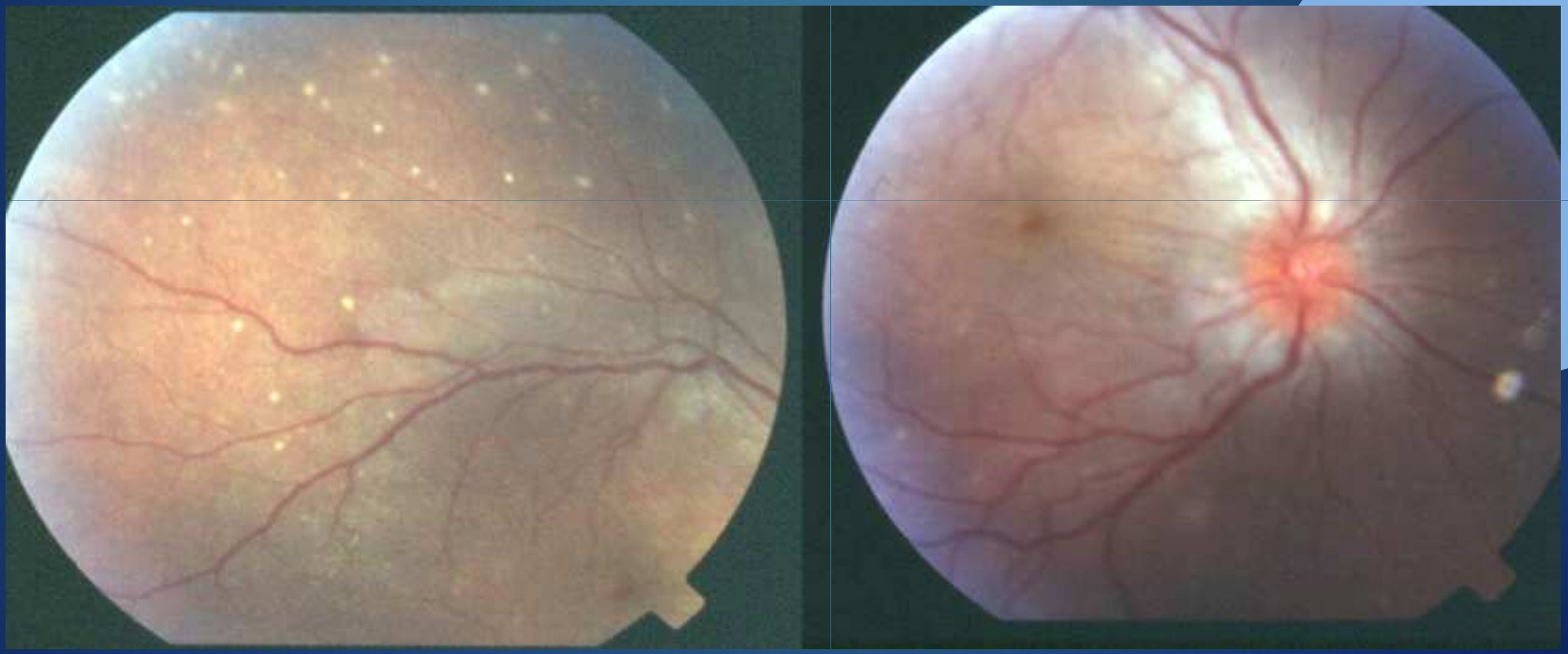
Main Outcome Measures: New chorioretinal lesions on fundus examination and fundus photogr

Results: The mean age (± standard deviation) is 10.8±5.1 years (range, 0.2–23). One hundred eigh have been evaluated for new chorioretinal lesions. Thirty-four (31%; 95% confidence interval, 23%–41 children developed at least one chorioretinal lesion that was previously undetected. These occurred a times during their follow-up course. Fifteen children (14%) developed new central lesions, and 27 (2 newly detected lesions peripherally. Ten (9%) had more than one occurrence of new lesions developin (12%) had new lesions in both eyes. Of those who developed new lesions, 14 children (41%) did so a or later.

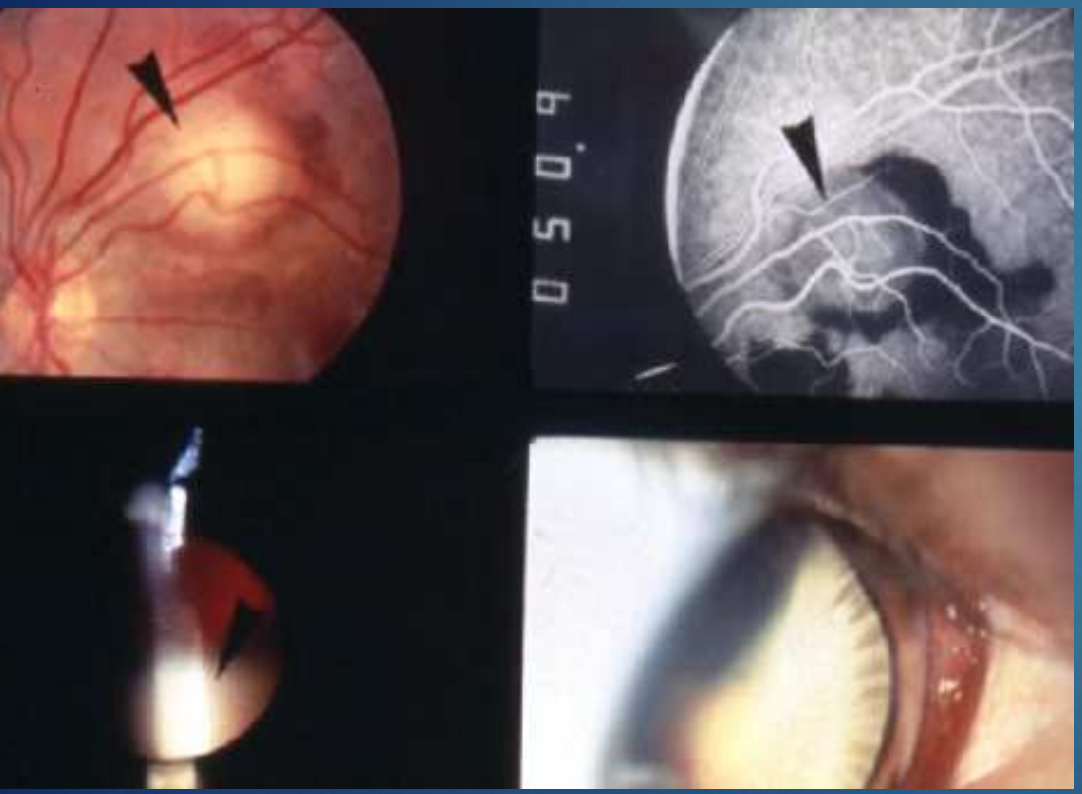
Conclusion: New central chorioretinal lesions are uncommon in children with congenital toxoplasm are treated during their first year of life. This finding contrasts markedly with earlier reports in the lite untreated children or those treated for only 1 month near birth, in whom new lesions were much more (≥82%). Our observation that 14 (41%) of the 34 children with new chorioretinal lesions had occurren they were 10 years or older indicates that long-term follow-up into the second decade of life is imp assessing the efficacy of treating toxoplasmosis during infancy. *Ophthalmology 2008;115:553–559 © the American Academy of Ophthalmology.*

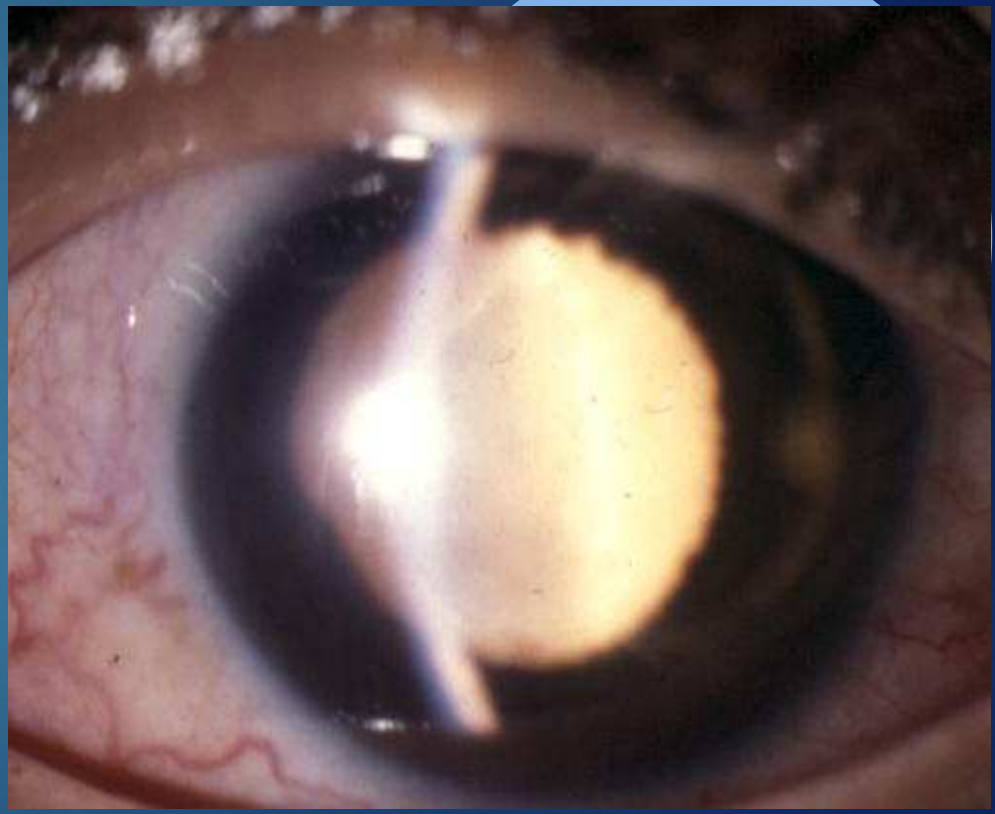
	Non-treated		Treated	
One new lesion	18/38	72(%)	34/108	31(%)
New central lesion	13/38	52(%)	15/108	14(%)
New peripheral lesion	11/38	44(%)	27/108	25(%)

Bartonella henselae : Enfermedad del arañazo del gato



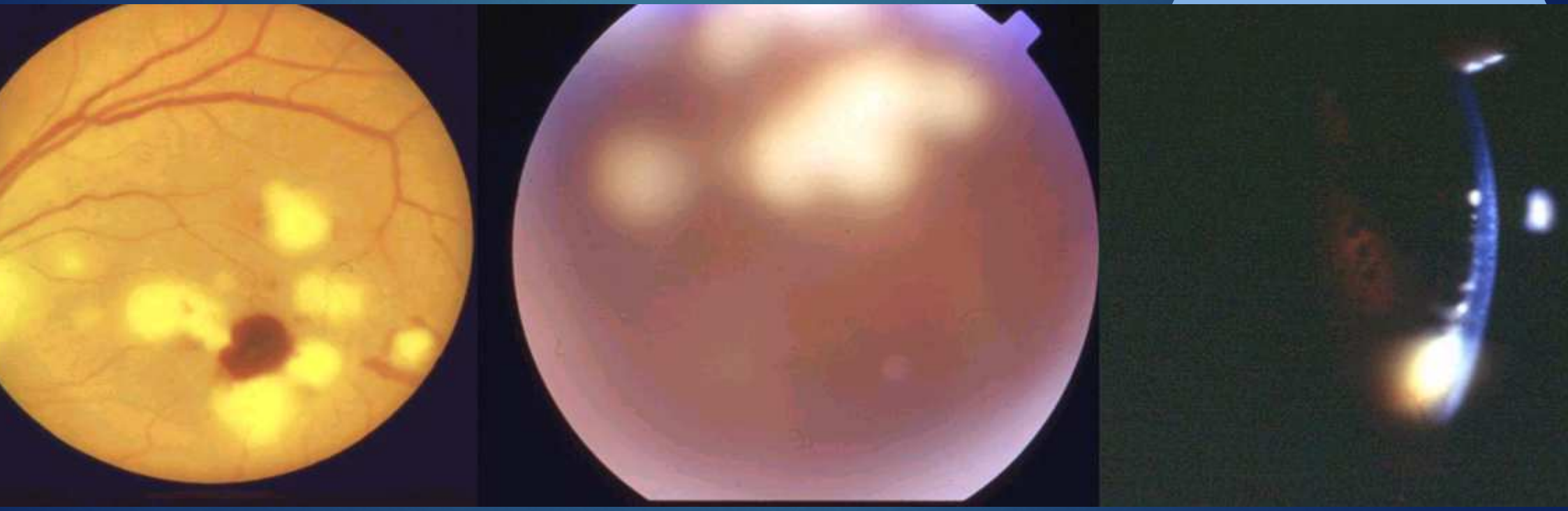
Toxocariasis



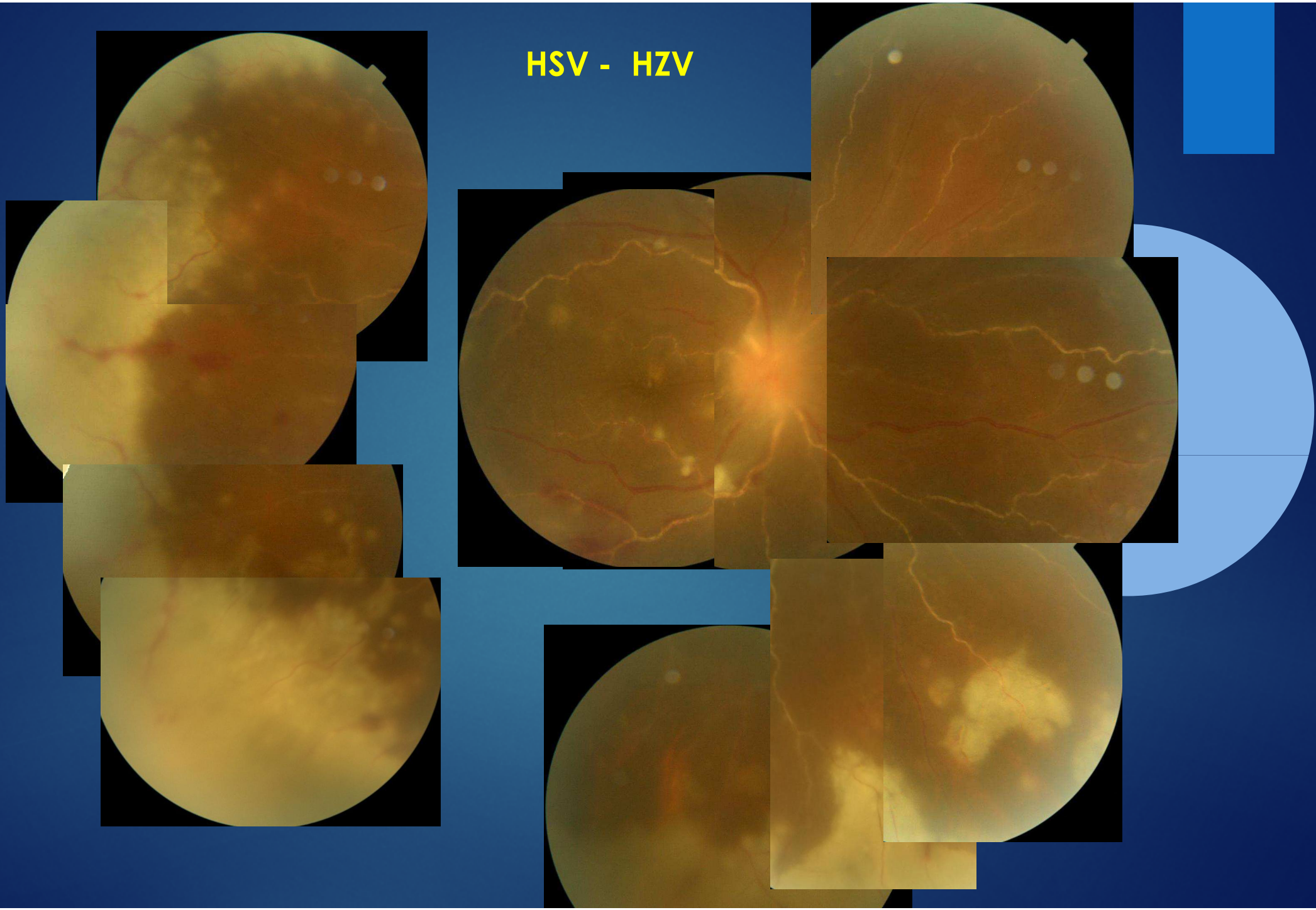


Couto

Candidiasis



HSV - HZV



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Infección	Virus	Forma de contagio	P. incubación	Manifestación sistémica	Manifestación ocular
engue	Flavivirus	Mosquito	3 – 14 d	Fiebre,cefaleas,mialgias, trombocitopenia, sangrado,hipotensión	Hemorragia subconjuntival Maculopatía Edema de papila,vasculitis , Hemorragias retinales
hikunguya	Togaviridae	Mosquito	2 – 5 d	Fiebre,cefaleas,mialgias, Sangrado,poliartritis, meningoencefalitis Oftalmoplegía externa	Uveitis anterior hipertensiva Queratouveitis bilateral Retinitis (mas en polo post) Neuritis óptica Neurorretinitis
NF	Flavivirus	Pajaro-mosquito	3 – 14 d	Encefalitis	Coriorretinitis, uveítis anterior, Vasculitis retinal,neuritis óptica
VF	Bunyaviridae	Ganado mosquito	3 – 7 d	Gripe, encefalitis, fiebre hemorrágica	Retinitis macular o paramacular Hemorragia retinal,edema de papila, vasculitis, uveítis anterior
ckettsiosis	Gram – Intracelular Obligada	Pulgas	8 – 15 d	Fiebre alta, cefaleas, Malasia , rush cutáneo	Retinitis,alt.vascular retinal, edema Macular, alt del nervio óptico, Desprendim seroso de retina

EITIS INFECCIOSAS EN NIÑOS

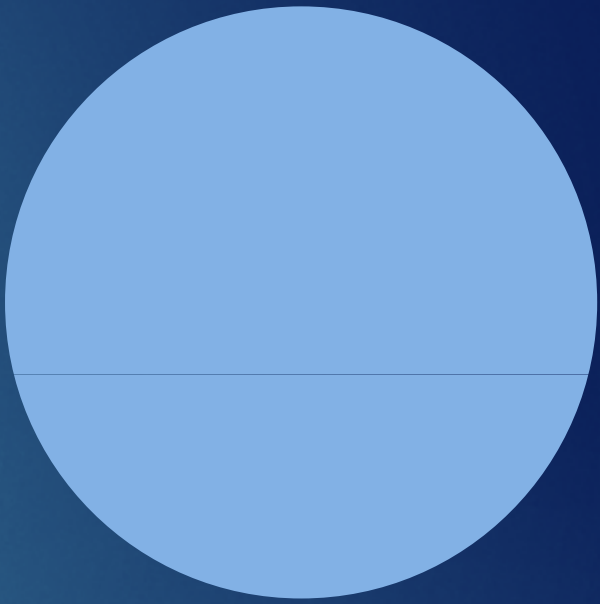
Couto

Dengue

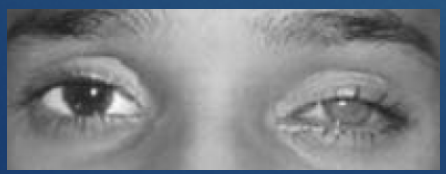
Ophthalmic complications of dengue
Emerg Infect Dis 2006 Feb;12(2):285-9

13 pacientes examinados
9 bilateral / 4 Unilateral : 22 ojos estudiados

Edema macular / hemorragias :10
Vasculitis retinal : 4
Desprendimiento exudativo de retina: 2
Exudados algodonosos: 1
Uveitis anterior :1



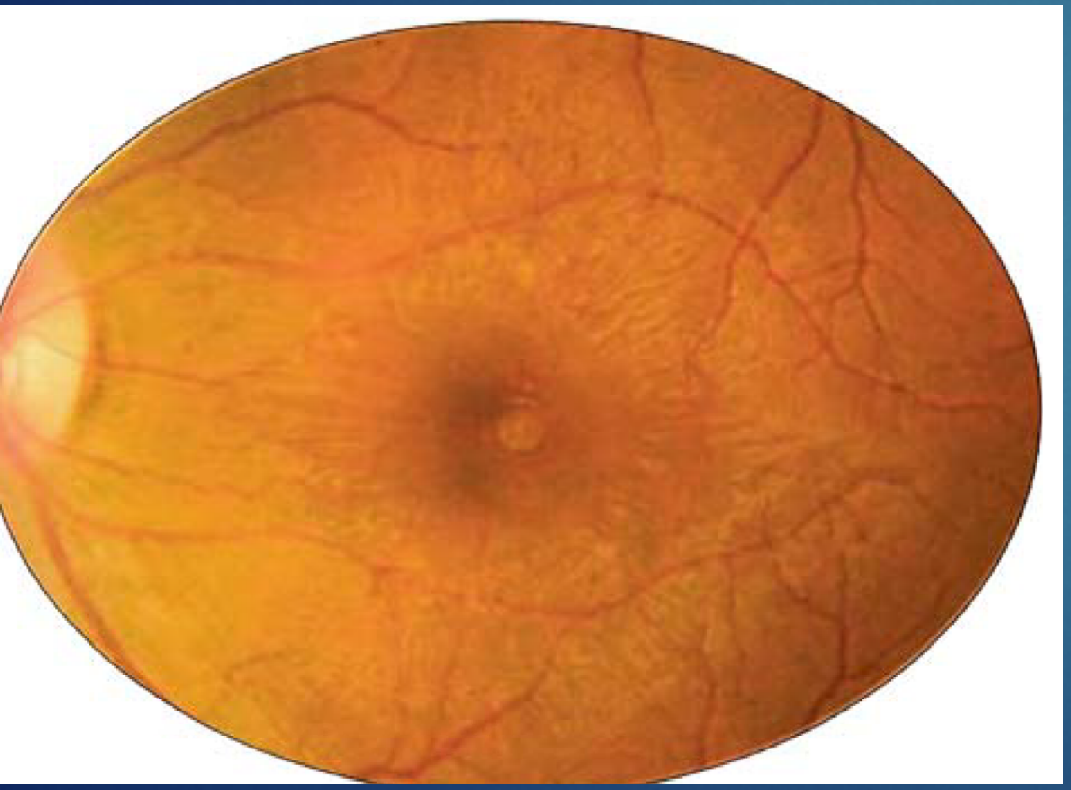
Panophthalmitis in Dengue Fever
Indian Pediatrics.2012 Vol 16:760

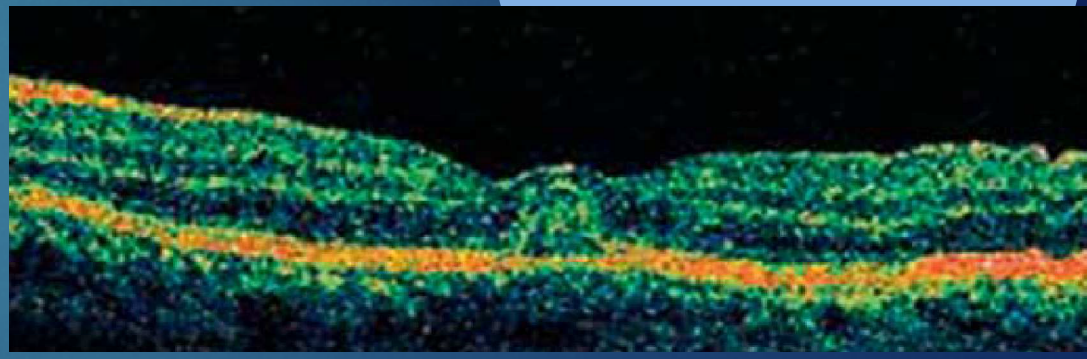


EITIS INFECCIOSAS EN NIÑOS

Couto

Dengue





EITIS INFECCIOSAS EN NIÑOS

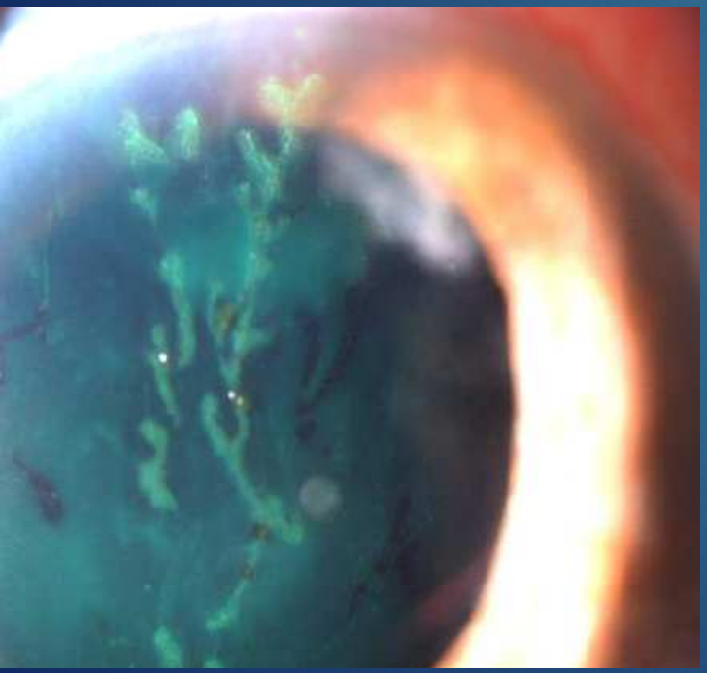
Couto

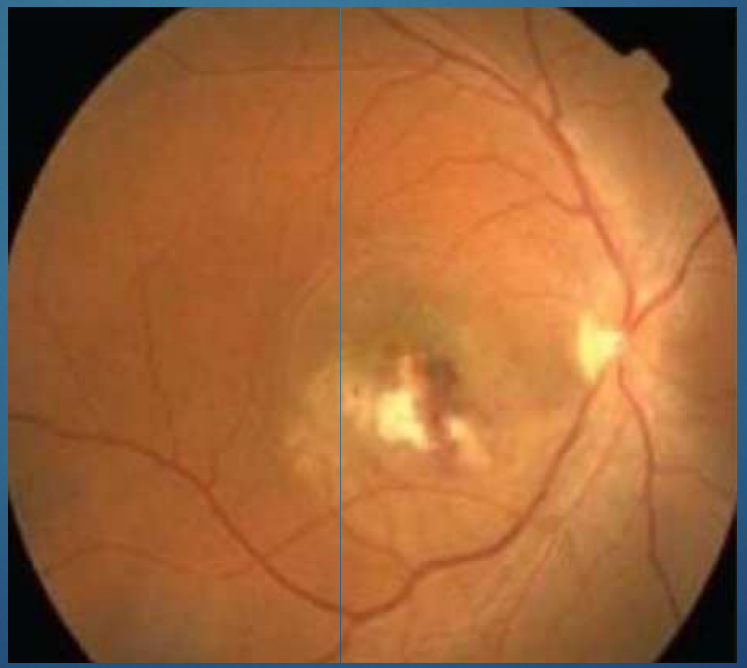
Infección	Virus	Forma de contagio	P. incubación	Manifestación sistémica	Manifestación ocular
engue	Flavivirus	Mosquito	3 – 14 d	Fiebre,cefaleas,mialgias, trombocitopenia, sangrado,hipotensión	Hemorragia subconjuntival Maculopatía Edema de papila,vasculitis , Hemorragias retinales
hikunguya	Togaviridae	Mosquito	2 – 5 d	Fiebre,cefaleas,mialgias, Sangrado,poliartritis, meningoencefalitis Oftalmoplegía externa	Uveitis anterior hipertensiva Queratouveitis bilateral Retinitis (mas en polo post) Neuritis óptica Neurorretinitis
NF	Flavivirus	Pajaro-mosquito	3 – 14 d	Encefalitis	Coriorretinitis, uveítis anterior, Vasculitis retinal,neuritis óptica
VF	Bunyaviridae	Ganado mosquito	3 – 7 d	Gripe, encefalitis, fiebre hemorrágica	Retinitis macular o paramacular Hemorragia retinal,edema de papila, vasculitis, uveítis anterior
ckettsiosis	Gram – Intracelular Obligada	Pulgas	8 – 15 d	Fiebre alta, cefaleas, Malasia , rush cutáneo	Retinitis,alt.vascular retinal, edema Macular, alt del nervio óptico, Desprendim seroso de retina

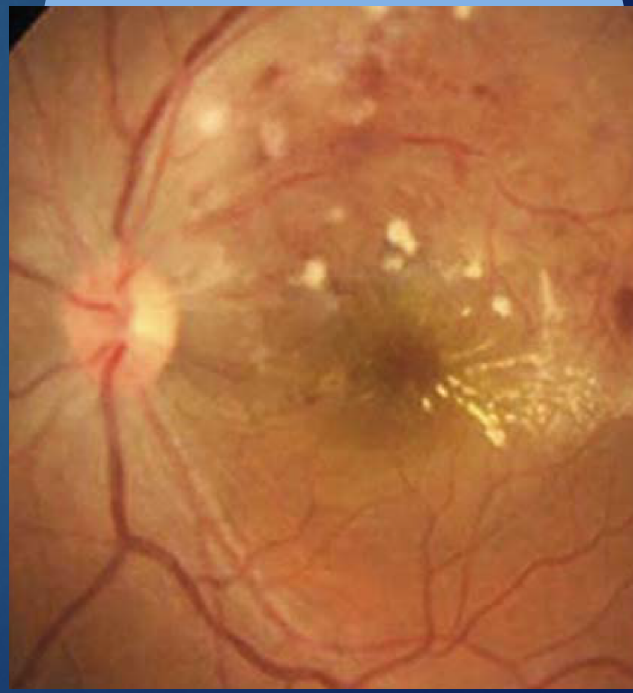
EITIS INFECCIOSAS EN NIÑOS

Couto

Chikunguya







EITIS INFECCIOSAS EN NIÑOS

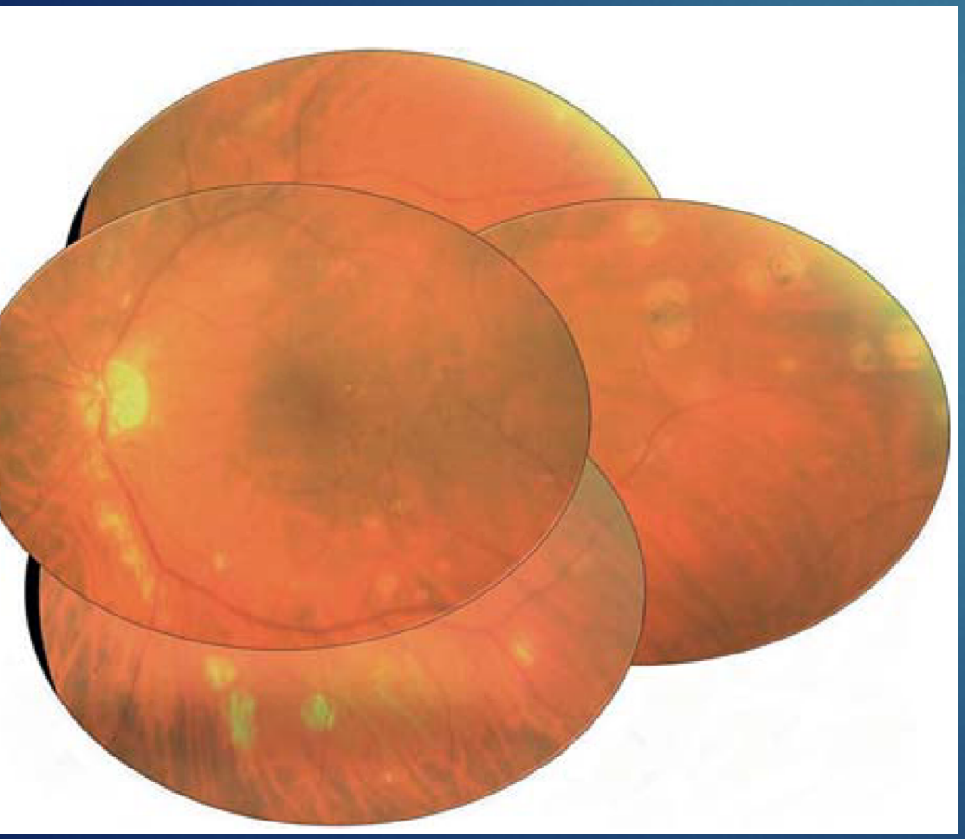
Couto

Infección	Virus	Forma de contagio	P. incubación	Manifestación sistémica	Manifestación ocular
engue	Flavivirus	Mosquito	3 – 14 d	Fiebre,cefaleas,mialgias, trombocitopenia, sangrado,hipotensión	Hemorragia subconjuntival Maculopatía Edema de papila,vasculitis , Hemorragias retinales
hikunguya	Togaviridae	Mosquito	2 – 5 d	Fiebre,cefaleas,mialgias, Sangrado,poliartritis, meningoencefalitis Oftalmoplegía externa	Uveitis anterior hipertensiva Queratouveitis bilateral Retinitis (mas en polo post) Neuritis óptica Neurorretinitis
NF	Flavivirus	Pajaro-mosquito	3 – 14 d	Encefalitis	Coriorretinitis, uveítis anterior, Vasculitis retinal,neuritis óptica
VF	Bunyaviridae	Ganado mosquito	3 – 7 d	Gripe, encefalitis, fiebre hemorrágica	Retinitis macular o paramacular Hemorragia retinal,edema de papila, vasculitis, uveítis anterior
ckettsiosis	Gram – Intracelular Obligada	Pulgas	8 – 15 d	Fiebre alta, cefaleas, Malasia , rush cutáneo	Retinitis,alt.vascular retinal, edema Macular, alt del nervio óptico, Desprendim seroso de retina

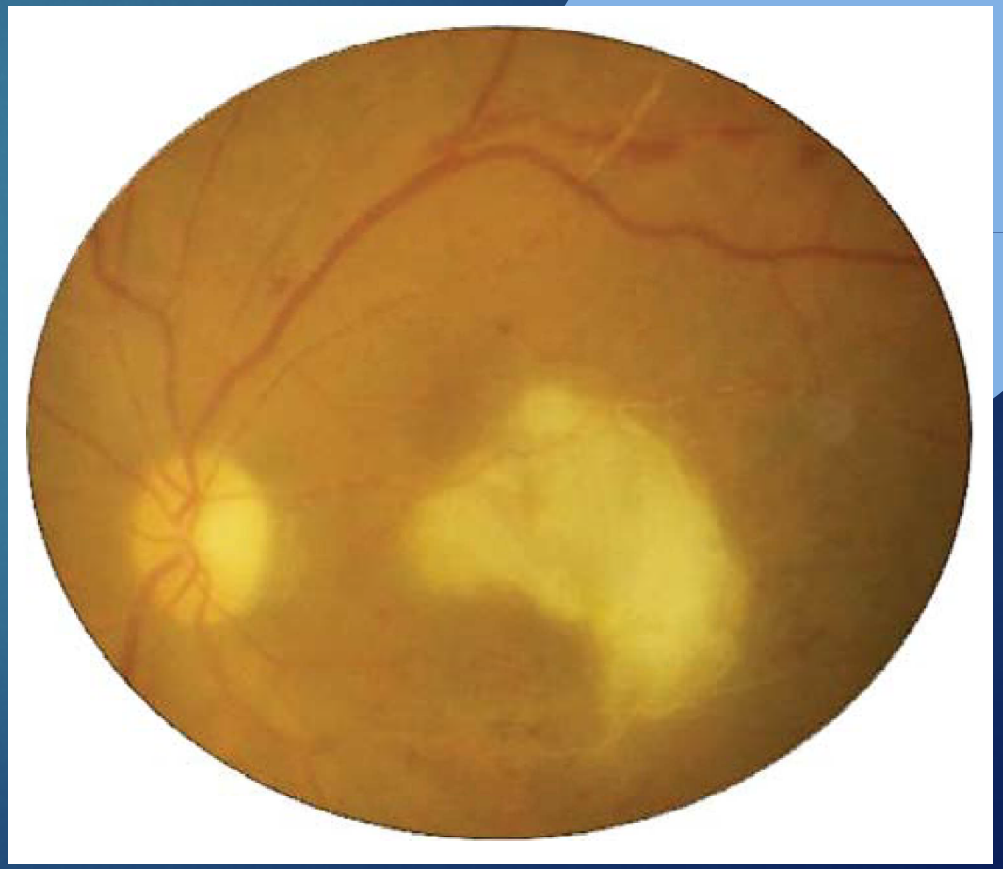
EITIS INFECCIOSAS EN NIÑOS

Couto

West Nile Fever



Rift Valley Fever

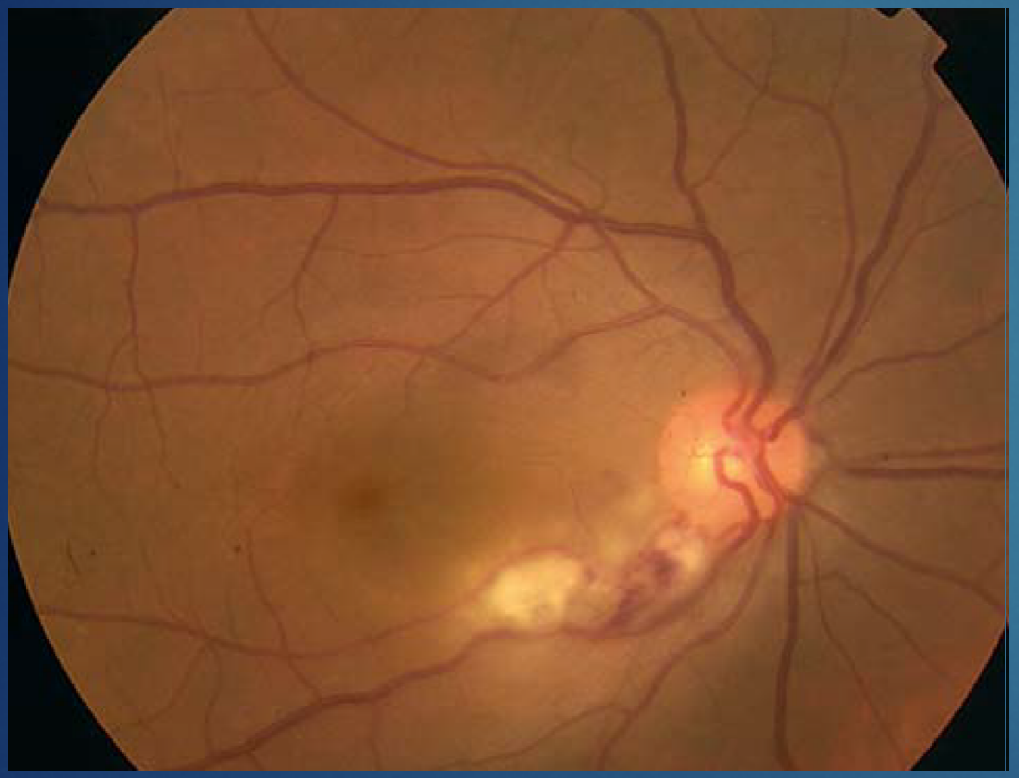


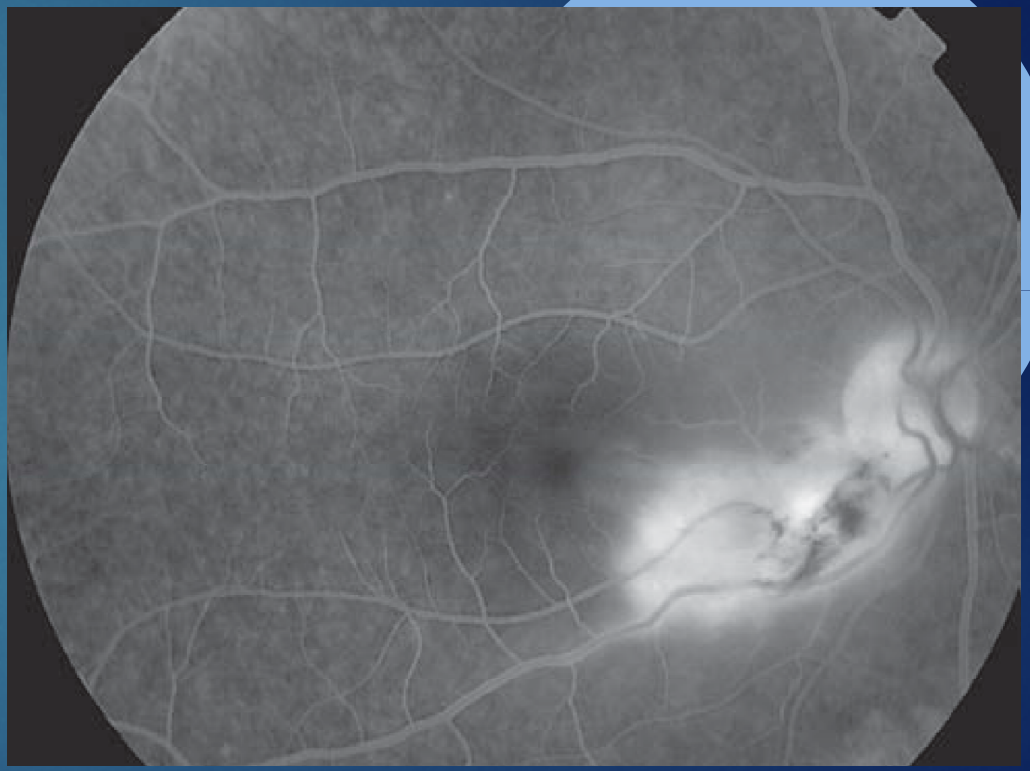
EITIS INFECCIOSAS EN NIÑOS

Couto

Infección	Virus	Forma de contagio	P. incubación	Manifestación sistémica	Manifestación ocular
engue	Flavivirus	Mosquito	3 – 14 d	Fiebre,cefaleas,mialgias, trombocitopenia, sangrado,hipotensión	Hemorragia subconjuntival Maculopatía Edema de papila,vasculitis , Hemorragias retinales
hikunguya	Togaviridae	Mosquito	2 – 5 d	Fiebre,cefaleas,mialgias, Sangrado,poliartritis, meningoencefalitis Oftalmoplegía externa	Uveitis anterior hipertensiva Queratouveitis bilateral Retinitis (mas en polo post) Neuritis óptica Neurorretinitis
NF	Flavivirus	Pajaro-mosquito	3 – 14 d	Encefalitis	Coriorretinitis, uveítis anterior, Vasculitis retinal,neuritis óptica
VF	Bunyaviridae	Ganado mosquito	3 – 7 d	Gripe, encefalitis, fiebre hemorrágica	Retinitis macular o paramacular Hemorragia retinal,edema de papila, vasculitis, uveítis anterior
ckettsiosis	Gram – Intracelular Obligada	Pulgas	8 – 15 d	Fiebre alta, cefaleas, Malasia , rush cutáneo	Retinitis,alt.vascular retinal, edema Macular, alt del nervio óptico, Desprendim seroso de retina

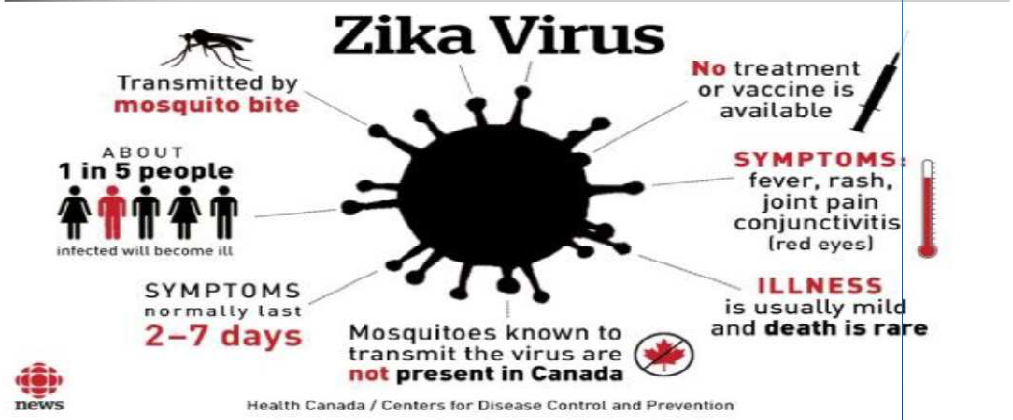
Rickettsiosis





ZIKA


COUNTRIES WITH CONFIRMED ZIKA CASES
UGANDA
NIGERIA
TANZANIA
EGYPT
CENTRAL AFRICAN REPUBLIC
SIERRA LEONE
GABON
INDIA
MALAYSIA
PHILIPPINES
THAILAND
VIETNAM
INDONESIA
MICRONESIA
POLYNESIA
EASTER ISLAND
THE COOK ISLANDS
NEW CALEDONIA
BRAZIL
CHILE
COLOMBIA
EL SALVADOR
GUATEMALA
MEXICO
PARAGUAY
VENEZUELA
SURINAME
CAPE VERDE
FIJI
FRENCH GUIANA
HONDURAS
MARTINIQUE
PUERTO RICO
PANAMA
SAMOA
VANUATU
USA
NETHERLANDS
GERMANY

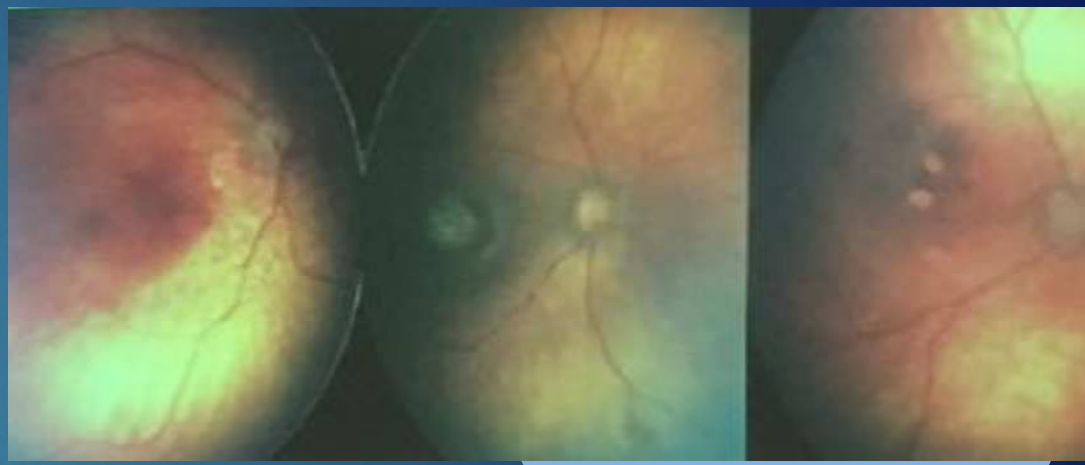

Zika Virus
Transmitted by mosquito bite
ABOUT 1 in 5 people infected will become ill
SYMPTOMS normally last 2–7 days
No treatment or vaccine is available
SYMPTOMS: fever, rash, joint pain conjunctivitis (red eyes)
ILLNESS is usually mild and death is rare
Mosquitoes known to transmit the virus are not present in Canada
news
Health Canada / Centers for Disease Control and Prevention

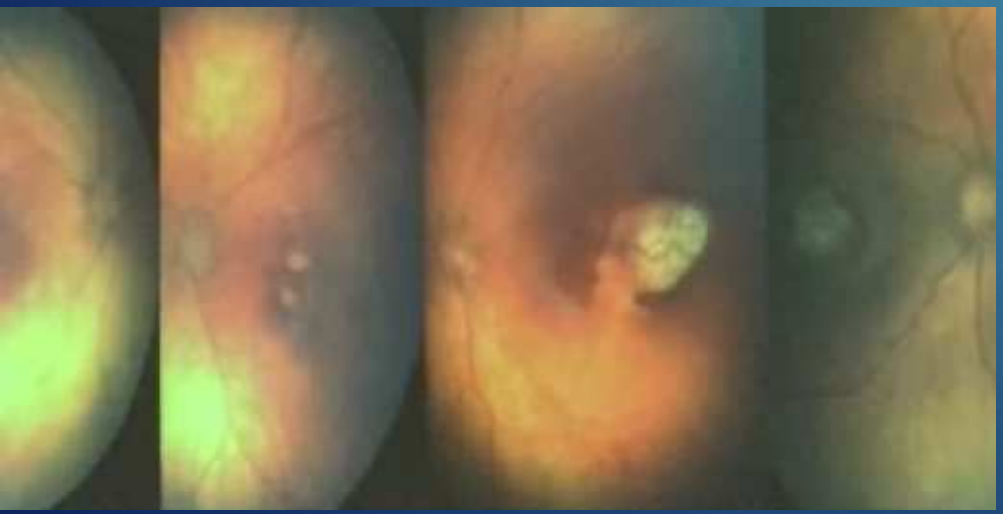
EITIS INFECCIOSAS EN NIÑOS

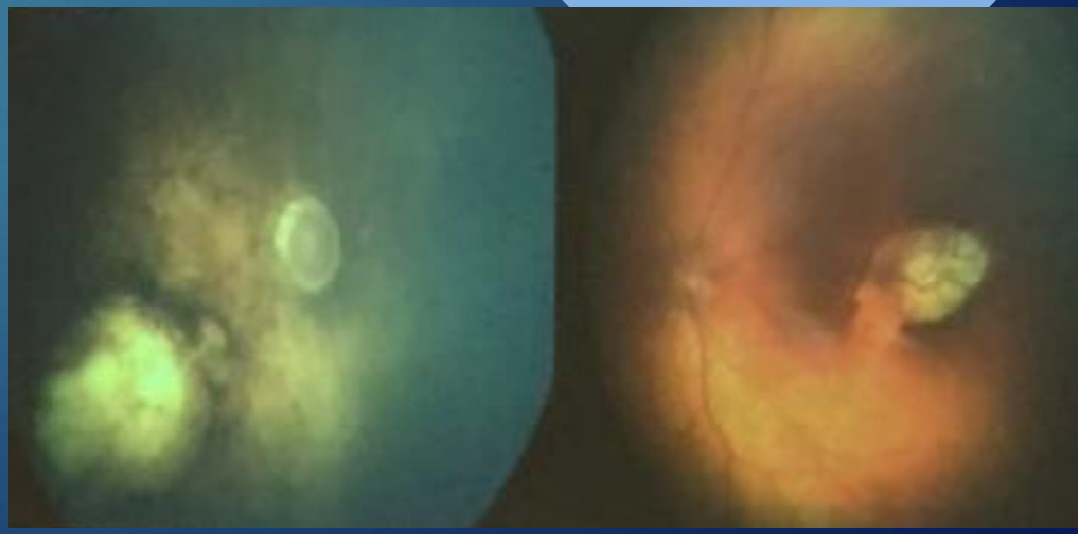
Couto

ZIKA

- Alteraciones retinales
  - Pérdida del reflejo macular
  - Pigmentación macular
  - Atrofia coriorretinal
- Alteraciones del nervio óptico
  - Palidez
  - Aumento de la excavación
  - Hipoplasia







EITIS INFECCIOSAS EN NIÑOS
nclusión

Couto

- Uveitis menos frecuente que adultos
- Si no hay apropiado diagnóstico y tratamiento … complicaciones graves
- Severa pérdida visual.
- Comienzo insidioso y curso crónico
- Diagnóstico específico : > 50%