A 23-year-old man is presented with Central Retinal Vein Occlusion. The retinal haemorrhages worsened and signs of retinal vasculitis appeared later as vision dropped from 6/60 to Counting Fingers. No signs of systemic disease were observed. Routine Mantoux test and chest radiograph were negative for tuberculosis. Fundus flourescein angiogram confirmed presence of retinal vasculitis. Both systemic and topical corticosteroid therapies were ineffective.

Curious to know how Dr. May May Choo and her team dealt this case, we asked her a few questions. She began by saying the most common ocular manifestations of tuberculosis are choroiditis, anterior uveitis which is usually of the chronic granulomatous type (Fig 1), pan-uveitis (Fig 2) and sclerokeratitis. Ocular involvement is seen in 1% of cases of tuberculosis. If the infection is primary, there will be no underlying systemic infection as was seen in our patient. In primary ocular involvement, the common manifestations are in the conjunctiva or cornea either as phlycten, ulcer or interstitial keratitis. Our case shows that retinal vessels can also be the initial site of infective process, inciting intense inflammation that resulted in vein obstruction (Fig 3 & 4). This has not been reported before.

Ocular disease can occur in secondary infection from haematogenous spread through an initial site of primary infection which is usually the lungs. CRVO occurring in a young patient is rare and warrants thorough investigations to rule out connective tissue disorders, vasculitic diseases, anti-phospholipid syndrome, hyperhomocystinaemia. Inherited coagulopathies like deficiencies in anti-thrombin III, protein C, protein S and Factor XII should be ruled out as these may precipitate venous thrombosis. And as this case has shown, infective causes have to be considered as well.

The incidence of ocular involvement in tuberculosis is only 1%. There are very few reports of CRVO as first presenting sign of tuberculosis as mentioned in her case report.

Dr. May May Choo had to use multiple prong approach as this patient was a young, healthy with no previous history of chronic cough or fever and no contact with known tuberculosis patient, the cause for his CRVO was not suspected to be tuberculosis. It was more for non-infective causes like coagulopathies or connective tissue disorders. However, as he developed signs of vasculitis and anterior uveitis, an underlying infective cause had to be ruled out.

![Fig 1: Anterior granulomatous uveitis. Keratic precipitates(kp) can be seen on endothelial surface. Mutton fat kp seen at 6 o’clock and 9 o’clock position on the iris margin.](image-url)