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Bilateral acute iris transillumination syndrome following oral moxifloxacin – a diagnostic challenge and review of the literature

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ABSTRACT

Bilateral Acute Iris Transillumination (BAIT) syndrome is a unique, uncommon, drug-related ocular condition that presents with bilateral pigment dispersion, diffuse iris transillumination, and raised intraocular pressure (IOP), usually triggered by the fluoroquinolone compound moxifloxacin. The patients typically developed severe symptoms, including photophobia, unfocused vision, mid-dilated nonreactive pupils, and ocular pain. Because of its varied similarities among diseases such as viral anterior uveitis and pigment dispersion syndrome, bilateral anterior uveitis and iridocyclitis is often misdiagnosed; thus, patients are treated wrongly with excessive corticosteroid administration. This review explores the geographic distribution, clinical features, underlying risk factors, and potential mechanisms involved in BAIT, with particular emphasis on its strong association with oral moxifloxacin use. BAIT seems more common in 30 to 50-year-old females, with most cases described in Turkey and southern Europe and likely under-diagnosed in other parts of the world. Treatment is symptomatic or control of IOP with topical hypotensive agents, and corticosteroids are contraindicated. BAIT is typically self-limiting but has the potential to cause temporary or permanent vision effects. BAIT is an essential entity to recognize for accurate diagnosis and management, and further research is needed to better elucidate its long-term consequences and pathophysiology.

Keywords: bilateral acute iris transillumination, BAIT syndrome, moxifloxacin, pigment dispersion, differential diagnosis.

1. INTRODUCTION

Bilateral Acute Iris Transillumination (BAIT) syndrome is an uncommon but notable ocular entity that has recently gained attention due to its association with

moxifloxacin therapy (Wefers et al., 2009; Perone et al., 2019). Syndrome with bilateral pigment dispersion, iris transillumination, and elevated IOP, often following oral use of moxifloxacin (a fluoroquinolone antibiotic) (Perone et al., 2019; Knape et al., 2013). The disease was initially described in the early 2000s and it is still underdiagnosed, mostly due to the fact that there is overlap with the clinical presentation of more common ocular diseases, including viral uveitis, pigment dispersion syndrome and Fuchs heterochromic iridocyclitis (Perone et al., 2019; Tugal-Tutkun et al., 2011).

Features of properly manifested BAIT syndrome -photophobia, sensation of sand in the eye, blurring vision, and iridial changes observed upon slit lamp examination (Perone et al., 2019; Tugal-Tutkun et al., 2011). Although the syndrome is rare and its symptoms are not very specific, BAIT is commonly misdiagnosed as a common disease. In addition, the fact that it occurs only after treatment with moxifloxacin makes its diagnosis difficult since association between the drug and the syndrome is not always realized (Perone et al., 2019).

The purpose of this review is to summarize the contemporary knowledge about BAIT syndrome, including pathophysiology, clinical presentation, differential diagnosis and treatment. We hope that by summarizing recent studies, this will help clinicians to recognize the enigmatic disease more appropriately (Perone et al., 2019).

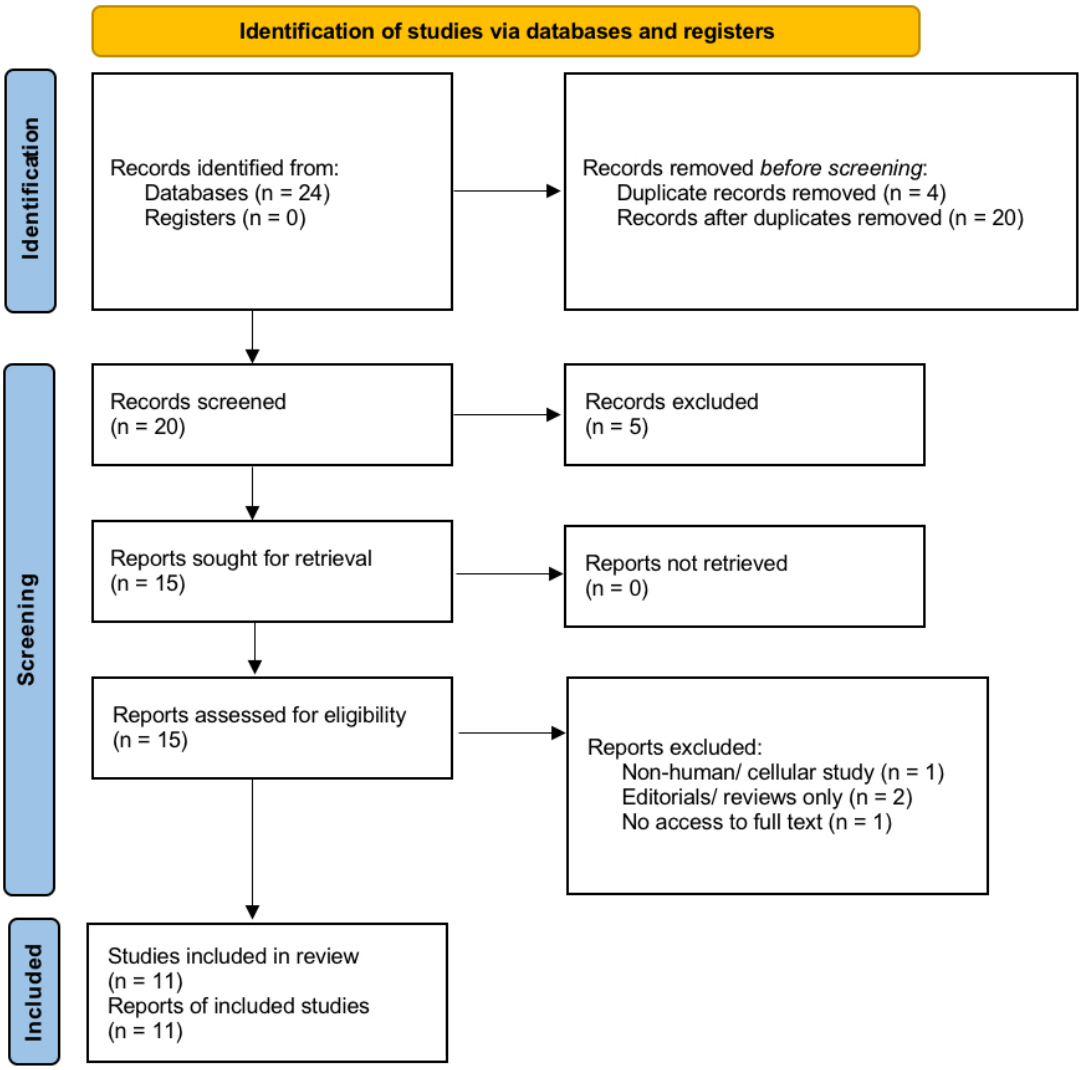

Figure 1. Prisma flow diagram illustrating the study selection process for BAIT syndrome literature review.

2. REVIEW METHODS

A comprehensive literature search was conducted using PubMed, Embase, and Scopus from February to May 2025. The search strategy included terms such as “Bilateral Acute Iris Transillumination,” “BAIT syndrome,” “Moxifloxacin,” “Ocular adverse effects,” “Pigment

dispersion syndrome," and "Increased intraocular pressure." The search was limited to studies published up to May 2025. Eligible publications included case reports, case series, and review articles written in English that addressed BAIT syndrome or closely related ocular conditions. Studies were excluded if they were not directly relevant to BAIT, were not peer-reviewed, or were published in languages other than English. This methodology was designed to ensure a thorough and focused selection of high-quality literature for this review (Figure 1).

3. RESULTS AND DISCUSSION

Studies show a strong link to moxifloxacin, increasing case recognition over time, proposed diagnostic criteria, and geographic underreporting (Table 1). In this paper, we see a time relationship between the onset of moxifloxacin and BAIT syndrome, with most cases concentrated in southern Europe. Patients present with bilateral photophobia and iris transillumination, and increased intraocular pressure, predominantly middle-aged healthy women between thirty and fifty years old. The issue of misdiagnosis prevails and persists elsewhere, especially where the clinicians are not aware of BAIT or with whom BAIT mimics anterior uveitis or pigment dispersion syndrome.

In the studies Perone et al., (2019) and Kalogera et al., (2025), the authors discover a striking incidence of BAIT after systemic moxifloxacin treatment. They stated that the principal slit-lamp findings—diffuse iris transillumination, pigment in the anterior chamber, and mid-dilated pupils—were highly specific diagnostic signs. Pathophysiology: Moxifloxacin crosses blood-aqueous barrier; it causes iris melanocyte destruction, pigment dispersion, and secondary ocular hypertension. Inflammation Inflammation may be present in BAIT, but the lack of anterior chamber cells and keratic precipitates distinguishes BAIT from true uveitis.

This review also points up the requirement to consider BAIT as a self-regressed disorder. Symptoms are typically managed by clinicians lowering intraocular pressure, but they may be called upon to treat anomalies with laser therapy or surgery. By the time the condition is correctly identified by healthcare professionals, long-term corticosteroid use, frequently for an inappropriate diagnosis, has added to the IOP and is seldom appropriate unless definite inflammation is proved. Given both the other potential underreporting from various world regions, there is a need to create awareness among clinicians. By focusing on specific clinical patterns, this article also facilitates clinicians' ability to differentiate BAIT from other pigmentation-triggered conditions of the anterior segment of the eye.

Table 1: Summary of Study Findings on BAIT Syndrome

Study Reference	Year	Number of Cases	Geographic Location	Key Findings
Perone et al.	2019	35	Various	Strong association with moxifloxacin use
Tuğal-Tutkun et al.	2011	20	Turkey	Proposed clinical diagnostic criteria
Kalogera et al.	2025	15	Greece	Documented increase in cases linked to moxifloxacin
Rivera- Valdivia et al.	2021	10	South America	Highlighted underreporting in the region

Geographic Distribution of Documented BAIT Cases

BAIT is a relatively uncommon but an evolving clinical entity. A number of case reports and series are being reported from different geographical locations. The largest aggregation of published cases appears to come from Turkey, where the disease was first described and clinically defined. Turkish ophthalmologists have made significant contributions to the literature on this disorder, including the development of clinical diagnostic criteria and the nosological distinction from related syndromes, such as BADI (Bilateral Acute Depigmentation of the Iris) (Tuğal-Tutkun et al., 2022; Tuğal-Tutkun et al., 2011).

Greece has recently been recognized as a second epicenter with a significant surge in reported patients and systemic exposure to oral moxifloxacin. A case series on a population basis emphasized the temporal and potentially causal link between the use of fluoroquinolones and BAIT progression in the Greek cohort (Kalogera et al., 2025).

In America, doctors encounter BAIT syndrome less commonly; it can be misdiagnosed for the first time, as doctors not infrequently misinterpret it for anterior uveitis or pigment dispersion syndrome on the basis of shared clinical characteristics that both of these entities share (Knape et al., 2013; Jones et al., 2024). On the other hand, reported sporadically only a few cases from South America

(Peru), East Asia, and the Middle East, it is possible that we do not know the real global burden due to underdiagnosis and lack of clinical suspicion in those localities (Rivera-Valdivia et al., 2021).

Overall, the existing epidemiological evidence indicates that local differences in reported BAIT cases may be more related to differences in clinical suspicion, antibiotic prescribing practices, and the ophthalmic diagnostic facilities provided by the community rather than to differences in the actual incidences or prevalence.

Pathophysiology of BAIT Syndrome

Researchers have proposed mechanisms, but they still poorly understand the pathophysiology of BAIT syndrome. One of the main hypotheses suggests that moxifloxacin crosses the blood-aqueous barrier and directly or indirectly affects iris melanocytes, causing iris pigment dispersion. This interaction could release pigment granules into the aqueous humor, leading to their deposition in the anterior chamber and resulting in the observed iris transillumination and pigment dispersion in BAIT (Knape et al., 2013; Jennifer et al., 2013).

Researchers suggest that moxifloxacin, a fluoroquinolone antibiotic, causes these changes by directly interacting with the iris, although the precise cellular mechanisms are still unknown. Studies show that moxifloxacin can induce an inflammatory response in the iris or trabecular meshwork, which in turn may cause pigment dispersion and elevate intraocular pressure. However, further studies are needed to confirm the exact pathophysiological processes (Rivera-Valdivia et al., 2021).

When systemic moxifloxacin is given, it travels through the blood-aqueous barrier, making that barrier more permeable so that the drug can gain access to and interact with the iris melanocyte (the cell that is normally protected by the barrier). This disturbance might be responsible for the abrupt nature of the symptoms on addition of moxifloxacin (Kampougeris et al., 2005).

The pathogenesis of BAIT syndrome is important for establishing diagnostic criteria and treatment. The syndrome eventually spontaneously remits after it has peaked, and it does not have a standard treatment except for the management of increased intraocular pressure (IOP) and symptomatic relief (Hakami et al., 2025; Tuğal-Tutkun et al., 2022).

Risk factors of BAIT syndrome

Moxifloxacin use a Key Risk Factor

The most recognized risk factor of BAIT is moxifloxacin, a fluoroquinolone AB. In one retrospective study of 35 BAIT patients, 74% had a history of antibiotic use and 92% of these were treated with moxifloxacin. In two patients, moxifloxacin was administered prophylactically without an infection at the time of surgical intervention, seemingly indicating a possible causal relationship between the substance and the emergence of BAIT (Gorbea et al., 2024).

Virus and a Triggering Factors

BAIT can also "follow" viral infections, including the flu and COVID-19. 2,3 There are several literature reviews of patients who developed BAIT after upper respiratory tract infection, suggesting that the immune response to infection could injure the iris pigment epithelium (Perone et al., 2019).

Female Sex and Age Between 30–50 Years

Case series have shown that BAIT is more common in women aged 30–50 years. In a study by Perone et al., the majority of BAIT cases involved middle-aged women, suggesting the possibility of hormonal or genetic predispositions to the syndrome (Perone et al., 2019).

Other Fluoroquinolones and Routes of Administration

Researchers primarily blame moxifloxacin for the condition, but they have also also flagged other fluoroquinolones ciprofloxacin as secondary culprits. In addition, BAIT can be prepared by other methods of application including orally, intravenously and topically (e.g., eye drop) (Tuğal-Tutkun et al., 2022).

Absence of Prior Ocular Disease

BAIT often occurs among patients without ocular history. Rivera-Valdivia et al. reported an incident of a patient without preexisting eye diseases who developed BAIT subsequent to moxifloxacin use and emphasized that patients without ocular comorbidities may also share the risk (Rivera-Valdivia et al., 2021).

Clinical Features and Diagnostic Evaluation

Numerous features are associated with the clinical appearance of BAIT syndrome. The patients usually have bilateral photophobia, and it may be the earliest complaint experienced. Photophobia is mediated by light scattering of pigment dispersion in the anterior chamber. Transillumination of the iris is a characteristic slit-lamp finding, in which some areas of the iris appear transparent due to pigment loss (Kalogera et al., 2025).

The process of pigment deposition in the trabecular meshwork that characterizes pigment dispersion causes increased intraocular pressure (IOP). IOP may present with blurring of vision or ocular discomfort. In most instances, patients have mid position fixed dilated pupils that are unresponsive to light. This finding can aid distinction of BAIT syndrome from other diseases, such as viral uveitis or FUS (Perone et al., 2019; Tuğal-Tutkun et al., 2022). Patients may also experience ocular hypertonia, though it is typically not as severe as in acute angle-closure glaucoma. Conjunctival hyperemia can also be observed but is generally mild.

Gonioscopic examination may show pigment accumulation in the trabecular meshwork, serving as a useful diagnostic indicator. While BAIT is typically distinguishable from more severe uveitic conditions, its clinical resemblance to pigment dispersion syndrome or Fuchs heterochromic iridocyclitis can result in diagnostic confusion. This underscores the need to include BAIT syndrome in the differential diagnosis when evaluating patients with similar presentations (Albloushi et al., 2023; Kalogera et al., 2025).

A secure diagnosis may rely on the patient's history of using moxifloxacin and clinical findings such as bilateral iris transillumination and high intraocular pressure (IOP). It is these clinical features, which differentiate BAIT from other diseases which may present in a similar manner (Gorbea et al., 2024; Megalla et al., 2023; Lončarić et al., 2023).

Differential Diagnosis

Many of its clinical presentations are similar to the other ocular diseases, thus representing a diagnostic dilemma. Meanwhile, PDS, which shows same iris changes and increased IOP is the leading diagnosis in the differential diagnosis. However, the iris configuration in PDS is usually concave and the onset is more insidious. Further, PDS generally occurs in younger persons when compared to BAIT (half of BAIT patients are between 30 and 50 years of age) (Perone et al., 2019; Laroche and Sinon, 2021; Rao, 2024; Gurnani and Kaur, 2025; Knape et al., 2013).

Viral uveitis is another condition that can be mistaken for BAIT syndrome. Viral uveitis is usually unilateral and associated with keratin precipitates (KPs), but unlike BAIT, it often presents with significant inflammation. Additionally, viral uveitis may have a history of ocular infection, which clinicians link BAIT syndrome to the systemic use of moxifloxacin (Megalla et al., 2023; Cam and Celiker, 2023).

FUS, also known as Fuchs heterochromic iridocyclitis (FHI), is also an important differential diagnosis. FHI typically presents with unilateral chronic uveitis, iris atrophy, and heterochromia. In contrast, BAIT syndrome is bilateral, acute, and lacks the characteristic signs of chronic inflammation seen in FHI. Gonioscopy in FHI reveals KPs in the anterior chamber angle, which clinicians claim is not visible in BAIT syndrome (Moshirfar et al., 2025; Hakami et al., 2025).

Other conditions, such as pseudoexfoliation syndrome or trauma-induced pigment dispersion, may also mimic the symptoms of BAIT, but these conditions have distinct characteristics. Pseudoexfoliation syndrome, for example, is seen in older individuals and is often associated with pseudoexfoliative material visible on the lens, which is not a feature of BAIT (Perone et al., 2019; Rao et al., 2024; Tomczyk-Socha et al., 2023). Accurate diagnosis requires careful differentiation based on clinical findings and patient history, particularly recent moxifloxacin treatment.

Management and Treatment

The main treatment for BAIT syndrome is relieving the symptoms as well as the elevated intraocular pressure (IOP) by physicians. As BAIT syndrome is self-limiting, treatment of the syndrome itself is not necessary, and most cases will resolve over weeks to months. Pain, photophobia, and elevated IOP, however, may require treatment (Perone et al., 2019; Tuğal-Tutkun et al., 2022).

Control of intraocular pressure is of paramount importance in the treatment of BAIT syndrome. Topical anti-glaucoma drugs, including beta blockers (timolol), carbonic anhydrase inhibitors (dorzolamide), or alpha agonists (apraclonidine), are administered to decrease intraocular pressure (IOP) and avoid complications. Ophthalmologists sometimes prescribe prostaglandin analogs (such as latanoprost), but they warn people to be wary of this therapy, for in rare cases, the problem could become worse (Glaucoma Research Foundation, 2021).

Specialists should avoid corticosteroids unless there is straightforward evidence of inflammation exists, as corticosteroids may exacerbate IOP. If inflammation is present, they may cautiously use topical steroids. But at the same time, IOP should be followed up carefully to avoid steroid induced glaucoma (Albloushi et al., 2023).

For BAIT syndrome, health care professionals should inform patients about the benign nature of the disease and reassure them that the condition would spontaneously resolve in most cases. However, patients with continued symptoms, such as chronic photophobia or a mild elevation in IOP, will need periodic long-term management and follow up (Hakami et al., 2025; Kalogera et al., 2025; Megalla et al., 2023).

Laser treatment or operative surgery may be used in more serious cases and if ophthalmologists are unable to control IOP. But they are seldom required as the disease usually improves on its own (Landim et al., 2024; Den Beste et al., 2017; Megalla et al., 2023).

4. CONCLUSION

Bilateral Acute Iris Transillumination (BAIT) syndrome is a new clinical entity at the crossroad of pharmacology and ophthalmology. While the aetiology of BAIT is not yet completely understood, breakdown of the blood-aqueous barrier by moxifloxacin and direct toxicity to melanocytes are thought to be the causative factors. The fact that only the iris is selectively affected in some patients suggests that there may be a genetic, hormonal, and/or immunological predisposition that needs to be studied further. Ongoing research is necessary to elucidate its pathogenesis, identify high-risk populations, and refine therapeutic approaches.

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Author's Contribution

All authors contributed significantly to the preparation of this manuscript. Julia Krotofil conceived and designed the review topic and supervised the project. Kamil Nieczaj, Julia Sztubińska, Marta Tortyna and Marta Marciniak conducted the literature search and data extraction. Paula Szarek, Olga Samsel and Natalia Sioch performed critical analysis and interpretation of the collected data. Julia Urbańska, Kamil Nieczaj and Maciej Trzciński drafted the manuscript, and Danuta Borowska coordinated final editing and formatting. All authors reviewed and approved the conclusive version of the manuscript and agreed to be accountable for all aspects of the work.

Informed consent

Not applicable.

Ethical approval

Not applicable.

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Conflict of interest

The authors declare that there is no conflict of interest.

Data and materials availability

All data associated with this work are present in the paper.

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