Uveitis Unmaksed

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Disclosure Slide

- Dr Schmidt is an advisor or on the speaker panel for the following companies:
  - Allergan
  - Carl Zeiss
  - Sun Pharmaceuticals
  - Optovue
  - Aerie

Iritis Terminology

- Iritis
- Uveitis
- Iridocyclitis
- Vitritis

Uveitis Fun Facts

- Inflammation of the uveal tract
- May be an autoimmune disorder
- 87.6% are anterior
- 55% are idiopathic
- 21% are traumatic
- *That means that almost ¼ of all uveitises have an underlying cause!*

Uveitis

- To understand the treatment of uveitis one must first understand the pathology
- Generalized term for inflammation of the uveal tract
- Treatment may include systemic workup and/or systemic meds

Goals Of Treatment

- Make patient comfortable
- Improve Visual Acuity
- Decrease inflammation
- Determine any underlying cause
- Minimize side effects of treatment

Uveitis Treatment Questions

- Are NSAIDs effective?
- Which steroid is the most effective?
- What is the correct dosage?
- How quickly should one taper?
- Do systemic steroids have a role?
- What side effects need to be monitored?

Which steroid is the most appropriate to prescribe for treating uveitis?

1. Durezol
2. Lotemax SM
3. Prednisolone acetate
4. Tobradex
5. Inveltys
6. Alrex

What dosage for the drop you chose would you recommend?

1. BID
2. QID
3. Q4H
4. Q2H

All Uveitides Are Created Equal!

- NOT!!!

- Granulomatous vs Non-granulomatous
- Acute vs chronic
- Recurrent vs recalcitrant
- Location – anterior vs posterior vs intermediate

- This differential is critical for proper treatment

The Case Of The "Regular Iritis"

- 48 y/o HM, HBP
- Cc: sore OD x 3 days
- No d/c, was not complaining of redness
- (+) photophobia
- VA OD 20/25, OS 20/20
- IOP – 18OD, 16 OS
- SLE- as shown

Common Iritis Presentation

- Pain
- Sluggish pupil
- AC rxn – Gr 1- 2
  - Cells – WBC
  - Little flare – protein
- Photophobia
- Ciliary flush
- Near normal VA
- No synechiae

Common Clinical Presentation

- Acute iritis
- Affects women 2:1
- Age – 20 -50
- 40% are recurrent

"Regular Case"

- How would you treat this
  1. Prednisolone acetate 1% QID
  2. Pred acetate 1% Q4H
  3. Loteprednol QID
  4. Fluorometholone Q4H
  5. Pred alcohol ½% QID

Would You Add A Cycloplegic Agent?

1. Yes
2. No

When would you next see the patient?

1. 1 day
2. 2 days
3. 3 days
4. 4 days
5. 1 week

"Regular case" – Next visit

- No photophobia or pain
- VA 20/20 OU
- No injection
- Decreasing cells
- IOP 16 OD, 15 OS

"Regular Case"

- What would you do with the drops?
  1. Continue Q4H?
  2. Decrease to QID?
  3. Decrease to BID?
  4. Change to loteprednol QID?
  5. Cycloplegic only?
  6. D/c all meds?

Case #2

- 27 y/o BF
- Sore OS x 1 wk, mild photophobia
- Has had similar "infection" 3 other times
- VA - OD 20/20, OS 20/40
- Med hx: Recurrent colds and flu-like symptoms' ? asthma
- Meds – tylenol
- SLE – as shown
- IOP – 18 OD, 17 OS

What Is Her Most Accurate Diagnosis?

- 1. Iritis
- 2. Uveitis
- 3. Granulomatous Uveitis
- 4. Recurrent Granulomatous Uveitis

How would you treat this?

- 1. Pred forte QID
- 2. PF 6x/day
- 3. PF Q2H
- 4. Durezol QID

Granulomatous Uveitis

- Cell & flare
- Mutton fat KP
- Post. Synechiae
- Hypopyon
- VA decreased
- Iris nodules
- IOP varies
- Post. Uveitis
- Bilateral
- Recurs more

- **More likely to have a systemic etiology**

Complicated Uveitis

- Posterior synechiae
- Increased IOP
- Iris nodules
- Chorioretinal involvement
- KP
- PAS
- Vitritis

Systemic diseases causing uveitis

- Rheumatoid arthritis
- Reiter's syndrome
- Sarcoidosis
- Syphilis
- Ankylosing spondylitis
- PMR
- Lyme's disease
- JRA
- TB
- SLE
- Sjogren's syndrome
- Crohn's disease
- GCA
- Occult blood disorders
- AIDS

When should lab tests be ordered?

- Bilateral cases
- Atypical age group
- Recurrent uveitis
- Recalcitrant cases
- Hyperacute cases
- Worsens with tapering
- VA worsening
- Immunosuppressed px

Lab test specifics

- Sarcoid – ACE, CXR
- TB – PPD, CXR
- RA, JRA – ANA, RF, ESR
- AS – HLA-B27, SIXR
- SLE – ANA
- Syphilis – RPR, VDRL, FTA-Abs
- Lyme's – Lyme titer (ELISA)
- Blood dyscrasias – CBC
- Reiter's – ESR, HLA-B27
- GCA – ESR, CRP

So For This Patient…

What tests would you order?

My patient's labs

- PPD (+)
- ESR – 25mm
- (-) ACE
- RF (-)
- CBC – mostly normal
- Lyme's (-)
- RPR – (-)
- ANA (-)

So What Is Her Diagnosis?

- 1. GCA
- 2. JRA
- 3. Lupus
- 4. RA
- 5.Sarcoid
- 6. Syphilis
- 7. TB
- 8. Lyme's disease

I Bet You Didn't Know

- The more posterior the inflammation, the more likely a cause will be found.
- In granulomatous, bilateral, recurrent or chronic cases of uveitis a cause is found 64.2% of the time.

The Conclusion To This Sordid Tale

- She responded poorly to topical steroids
- At BID the condition continually flared-up
- Underwent systemic therapy for TB
- Uveitis continued to smolder
- What would you do next?

Additional Treatment Options

- Oral prednisone
- Sub-Tenon's injection
- Anything else?

- So tell me Oh Great One, what did you do?

The Smolderer

- 51 y/o BF
- Treated for "eyeritis" for ~ 1 year
- Never completely resolved
- Currently using PF OS QID, Atropine 1% OU BID
- PMH: HBP, Arthritis, chronic cough

Smolderer's symptoms

- Throbbing intermittent pain OS >> OD
- Radiates to temples
- Chronic redness OS
- Photophobia
- Poor near vision

Smolderer's exam

- BCVA: OD 20/20, OS 20/50
- Pupils: 8mm fixed OU
- EOM: no pain on movement
- OD: Normal SLE
- OS: Ciliary flush
  - 2+ cell, 1+ flare
  - No PAS, No post. Synechiae
  - 2+ PSC
- IOP: 14OD, 16 OS

What is the most appropriate diagnosis?

How would you treat her?

1. Politely refer her to Ron Norlund
2. Higher dose PF
3. Durezol Q4H
4. Sub-tenon's injection
5. Continue same meds

What about the Atropine?

Which 4 tests would you order?

1. CBC,ESR, PPD, RF
2. CBC, CXR, VDRL/RPR, ACE
3. Lyme titer,PPD, ACE, ESR
4. CBC, CXR, RF, ACE
5. ACE, ESR, PPD, VDRL/RPR
6. Lyme titer, CBC, ACE, RF
7. RF, ESR,ACE,PPD
8. ANA, ACE, PPD, CBC

1 week later

- Eye feels much better
- She is reading better
- VA OD 20/20, OS 20/50
- AC – tr cell, no flare
- IOP 18OD, 31 OS
- Blood work:
  - ESR – 36mm/hr
  - (+) RF
  - Elevated ACE
- Subsequent CXR – Lung Granuloma

What is the systemic diagnosis?

1. Rheumatoid arthritis
2. Temporal arteritis
3. Sarcoidosis
4. Tuberculosis
5. Lupus
6. Syphilis

What would you do with the steroid?

How would you treat the IOP?

1. Ignore it
2. Get off steroid quickly
3. Betimol ½ OS BI
4. Cosopt OS BID
5. Alphagan OS BID
6. Lumigan OS QHS

Please Tell Me Oh Great One…

- How did she fare?

Case of the traumatic iritis

- 16 y/o male stuck in OS w/ pencil
- Much photophobia, severe pain
- VA; 20/20 OD, 20/20 OS
- SLE:
  - 2+ injection
  - K- 4mm abrasion into anterior stroma, no FB seen
  - AC – 3+ cell, no flare

How would you treat this?

1. Cycloplege only
2. Pressure patch w/ Ciloxan ung and Atropine
3. BCL/cycloplegia/Ofloxacin
4. BCL/ Tobradex
5. BCL/Gentamicin/PF
6. BCL/cycloplegia/PF
7. BCL/Prolensa/Polytrim

When would you next see him?

1. 1 day
2. 2 days
3. 3 days
4. 1 week

Trauma Case- part 2

- 2days later
- Cornea completely re-epithelialized
- 2+ cell
- 2+ bulb injection
- VA 20/20 OU

What would you do now?

1. TD QID
2. BCL/Ofloxscin/ PF
3. Gentamicin QID/PF QID
4. PF QID
5. Lotemax SM QID
6. Prolensa QD