The O.Ds. Guide To Iritis

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Disclosure Slide

- Dr Schmidt is an advisor or on the speaker panel for the following companies:
  - Allergan
  - AMO
  - Sun Pharmaceuticals
  - Bausch & Lomb
  - Optovue
  - Aerie

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Iritis Terminology

- Iritis
- Uveitis
- Iridocyclitis
- Vitritis

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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!*

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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

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Goals Of Treatment

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

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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?

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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

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What dosage for the drop you chose would you recommend?

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

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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

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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

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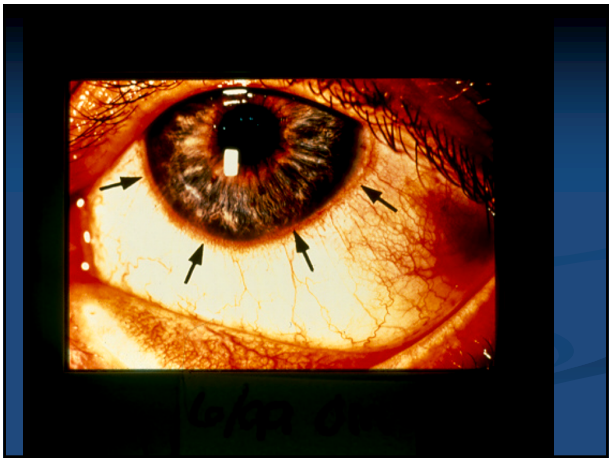

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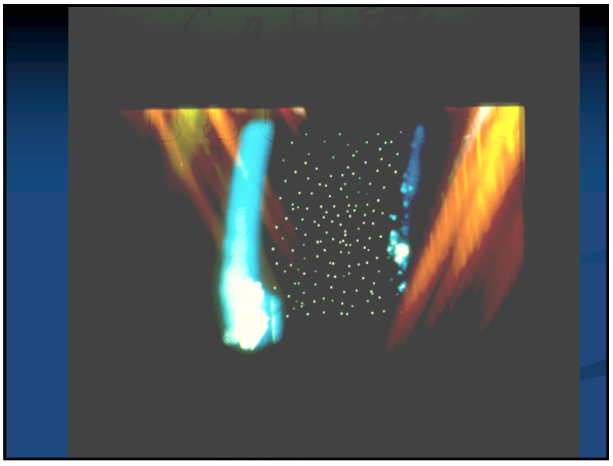

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Common Iritis Presentation

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

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Common Clinical Presentation

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

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"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

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Would You Add A Cycloplegic Agent?

1. Yes
2. No

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When would you next see the patient?

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

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"Regular case" – Next visit

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

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"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?

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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

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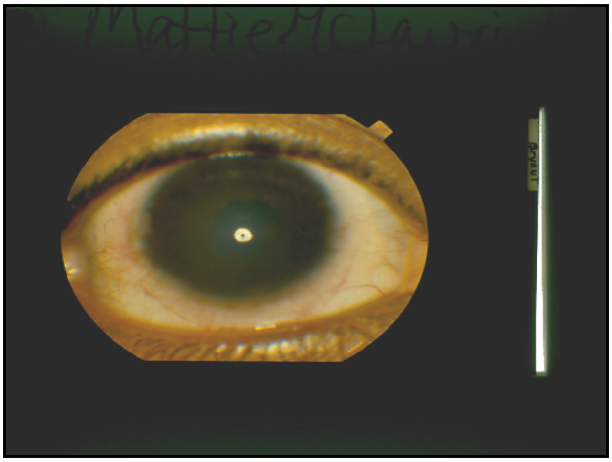

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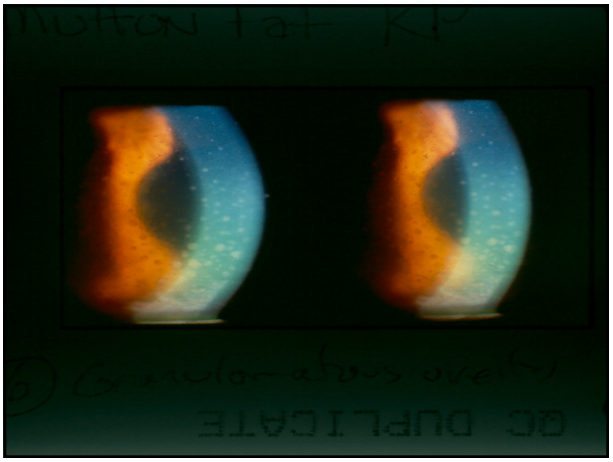

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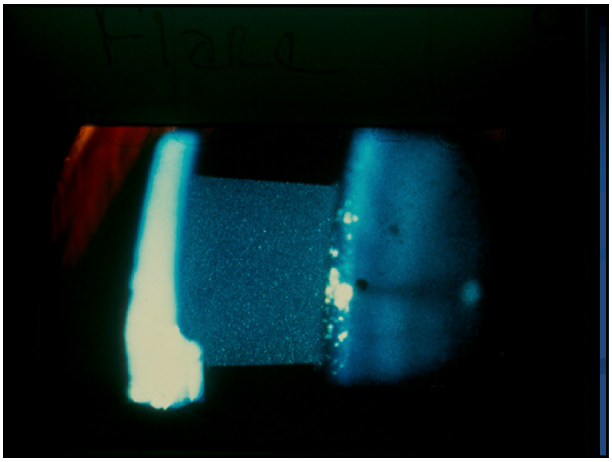

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What Is Her Most Accurate Diagnosis?

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

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How would you treat this?

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

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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**

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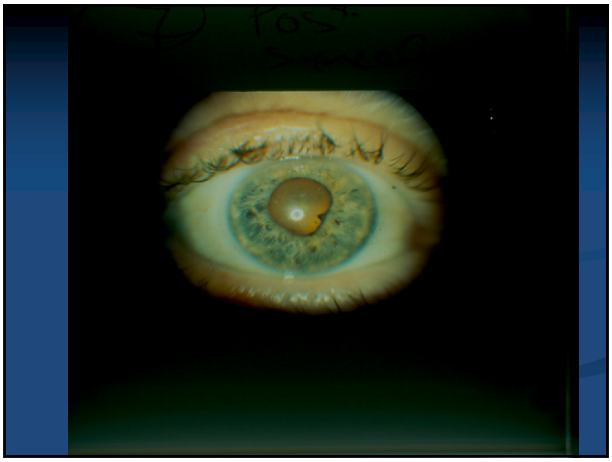

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Complicated Uveitis

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

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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

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When should lab tests be ordered?

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

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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

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So For This Patient…

What tests would you order?

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My patient's labs

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

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So What Is Her Diagnosis?

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

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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.

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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?

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Additional Treatment Options

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

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

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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

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Smolderer's symptoms

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

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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

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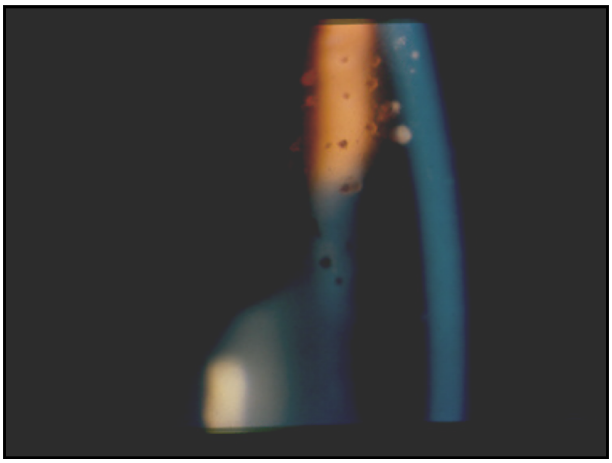

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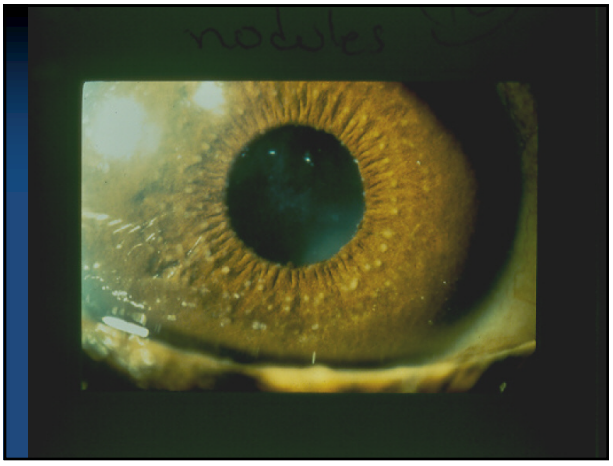

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What is the most appropriate diagnosis?

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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?

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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

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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

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What is the systemic diagnosis?

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

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What would you do with the steroid?

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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

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Please Tell Me Oh Great One…

- How did she fare?

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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

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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

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When would you next see him?

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

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Trauma Case- part 2

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

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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

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"We can measure the health of our country by the health of the game itself."

Ken Burns

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