Iritis, Iritis, Iritis

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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 uveitis 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?
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. Atropine 1% BID
  2. Prednisolone acetate 1% QID
  3. Pred acetate 1% Q4H
  4. Lofepranol QID
  5. Fluorometholone Q4H
  6. Pred alcohol ½% QID
  7. Ketorolac QID
  8. Rimexolone QID

Would You Add A Cycloplegic Agent?
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?

The Case Of Mad Mattis
• 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. PF QID/HA 5% BID
• 5. Voltaren QID/ HA 5% BID
• 6. Lotemax Q4H
Granulomatous Uveitis
- Cell & flare
- Mutton fat KP
- Post. Synechiae
- Hypopyon
- VA decreased

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

Complicated Uveitis
- Iris nodules
- IOP varies
- Post. Uveitis
- Bilateral
- Recurs more

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, SI6R
- 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 Mattie…

What tests would you order?
Mattie’s labs

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

So What Is Mattie’s 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 Mattie’s 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?

Case Of Rosetta

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

Rosetta’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 Rosetta’s diagnosis?

How would you treat Rosetta?
1. Politely refer her out
2. Continue same meds
3. PF QID OS
4. PF Q4H OS
5. PF Q2H OS
6. PF Q4H, Atropine QD OS
7. PF Q2H, Atropine QD OS
8. PF Q4h, Atropine BID OS

Would You Order Blood Work?

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 18 OD, 31 OS
- Blood work:
  - ESR – 36 mm/hr
  - (+) RF
  - Elevated ACE
- Subsequent CXR – Lung Granuloma

What is Rosetta’s systemic diagnosis?
- Rheumatoid arthritis
- Temporal arteritis
- Sarcoidosis
- Tuberculosis
- Lupus
- Syphilis

What would you do with the steroid?
1. Q4H x 1 wk, then QID x 1 wk, slow taper
2. QID x 3 days, tid x 3 days, Bid x 3 days, QD x 3 days (quick taper)
3. QID x 1 mth
4. Change to Lotemax QID
5. Change to Voltaren QID
6. Slow taper and maintain at QD
7. Quick taper and maintain at QD

How would you treat the IOP?
1. Ignore it
2. Get off steroid quickly
3. Betimol ½ OS BID
4. Betimol ¼ OS QAM
5. Cosopt OS BID
6. Xalatan OS QHS
7. Alphagan OS BID
8. Lumigan OS QHS

Please Tell Me Oh Great One...
- How did Rosetta 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- 4 mm 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/Ocuflox
4. BCL/ Tobradex
5. BCL/Ciloxan/PF
6. BCL/cycloplegia/PF
7. BCL/Voltaren/Ciloxan

When would you next see him?
1. 1 day
2. 2 days
3. 3 days
4. 1 week

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

What would you do now?
1. TD QID
2. BCL/Ciloxan/ PF
3. Ciloxan QID/PF QID
4. PFQID
5. Lotemax QID
6. Acular QID

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

Ken Burns