Review Article :

ANTERIOR UVEITIS IN FIVE MINUTES

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A simplified approach to a suspected case of anterior uveitis,based on our experience in Odisha.

IS IT ACTUALLY UVEITIS

- Rule out conjunctivitis/keratoconjunctivitis by type of conjunctival congestion
- True uveitis does not need any topical antibiotic therapy

IS THE LOCATION OF INFLAMMATION PRIMARILY *ANTERIOR*

- Anterior uveitis can have spill-over vitreous cells and vice-versa
- Always dilate pupils to rule out posterior segment inflammation

Once anterior uveitis has been confirmed, we need to rule out FIVE *COMMON* clinical presentations*(excludes trauma/ surgery)*

GRANULOMATOUS ANTERIOR UVEITIS

- Diagnosed by presence of mutton-fat keratic precipitates (k.p.)
- Most commonly TB or sarcoidosis or *acute* VKH or sympathetic ophthalmia (see below)

TB : unilateral or bilateral; posterior synechiae; ± pigmented chorioretinal scars in fundus; positive Mantoux/ Quantiferon/ chest radiography useful, *but not essential*; h/o TB contact often present

· **Sarcoidosis**: not uncommon; bilateral; broad peripheral *anterior*synechie; multiple depigmentedchorioretinal scars in peripheral fundus; negative Mantoux; serum ACE normal if low sarcoid load in body; HRCT – thorax to r/o hilar lymphadenopathy/ interstitial lung disease; check h/o facial palsy, erythema nodosum

CHRONIC OR RECURRENT VKH

- Almost always presents as **anterior uveitis**
- Mostly non-granulomatous with old keratic precipitates; bilateral
- Sunset-glow fundus with multiple chorio-retinal atrophic patches

Needs long term steroid and immunosuppressive therapy (8-12 months

HLA-B27 ANTERIOR UVEITIS

- *Most common* form of uveitis in our clinic
- Unilateral or recurrent in alternating eyes, but almost never bilateral
- **Non-granulomatous**: cells ± f*ibrin* in anterior chamber; occasionally hypopyon
- Fine endothelial dusting may be present but no keratic precipitates; posterior synechiae +, if chronic or recurrent
- Low back (sometimes knee/ ankle) pain, more in morning
- Lab testing for HLA-B27only if*diagnostic confusion*

VIRAL ANTERIOR UVEITIS

- Herpes simplex/ varicella zoster virus
- Mostly unilateral
- Raised IOP; solitary k.p.;sectoral iris atrophy
- May be confused with steroid induced glaucoma
- Needs Tab Valacyclovir 1000 mg tid or Acyclovir 800 mg 5/day and often low

dose maintenance therapy for many months

FUCH'S HETEROCHROMIC IRIDOCYCLITIS

- Quiet eye, mostly unilateral
- Stellate keratic precipitates *all over corneal endothelium*; iris heterochromia not always present
- Posterior subcapsular cataract; secondary glaucoma
- Vitreous floaters often present: needs counseling prior to cataract surgery
- Topical steroids rarely needed

THERAPEUTIC TIPS :

- Topical prednisolone acetate is the mainstay of therapy: aggressive start and slow taper over many weeks
- Atropine is the preferred mydriatic; homatropine/ cyclopentolateare often inadequate
- Posterior sub-tenon's steroids may be required in some cases; systemic steroids are only required for treatment of sarcoidosis or VKH disease