UVEITIS AND OCULAR HYPERTENSION

CAROL SLIGHT
NURSE PRACTITIONER OPTHALMOLOGY
TYPES

- Posner Schlossman
- Fuch’s heterochromic iridocyclitis
- Viral uveitis
- Steroid induced ocular hypertension
POSNER SCHLOSSMAN

- Unilateral, acute secondary open angle
- High IOP with mild anterior uveitis
- IOP rise from Trabeculitis
- Diagnosis of exclusion

- Most common in young people
- More common in men
- Often recurrent
- 1-2% of uveitis cases
  (Kanski, 2003)
<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>SIGNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Blurred vision</td>
<td>• Ciliary Flush</td>
</tr>
<tr>
<td>• Halos around lights</td>
<td>• Corneal Oedema</td>
</tr>
<tr>
<td>• Mild pain</td>
<td>• IOP – over 30 mmHg</td>
</tr>
<tr>
<td>• Redness</td>
<td>• Decreased outflow</td>
</tr>
<tr>
<td></td>
<td>• Open angles</td>
</tr>
<tr>
<td></td>
<td>• Mild A/C reaction</td>
</tr>
<tr>
<td></td>
<td>• +/- KP’s</td>
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TREATMENT

- Intensive steroids initially
- IOP control – Timolol/Brimondine/Brinzolamide
- Slowly taper
- Monitor IOP
- May need ongoing antiocular hypertensives permanently
CASE STUDY

- Ms J
- Presents with episodes of blurred vision and mild headache since 2004
- 13 episodes at ADHB since 2009
- Minimal inflammation +/- cells usually
- IOP usually over 30 mmHg

- All tests –ve
- Never had AC tap
- Glaucoma assessment with HVF
- Now on maintenance dose Prednisolone acetate 1% daily
FUCHS HETERCHROMIC IRIDOCYCLITIS

- Unilateral
- Chronic low grade intraocular inflammation
- Often associated with glaucoma
- Hyper or hypo chromia in comparison to fellow eye
- Do not often require ongoing therapy
CASE STUDY

• Mrs S
• Presented with L eye CF and PSCO 2007
• L Phaco and IOL
• IOP 44 post op
• Ongoing mild inflammation
• Diagnoses FHI
MRS S

- Low grade inflammation but IOP elevated 2008
- On Flucon and timolol and Brimonidine
- 2009 SB uveitis specialist Stop steroids
- Monitored yearly
- Ongoing IOP treatment
- SB glaucoma specialist 2013
- Uncontrolled on maximal medical therapy
- L trabeculectomy 2015
- IOP controlled but still remains on daily Prednisolone acetate 1%
VIRAL UVEITIS

- Varicella zoster virus
  - Shingles
  - Chicken pox
- Cytomegalovirus
- Herpes Simplex
SIGNS

• KP’s
• WBC/Pigmented
• TI defects
• Iris Atrophy
• Presenting IOP high
OCCLUSIVE VASCULITIS RESULTING IN SEGMENTAL IRIS ATROPHY.
TREATMENT

- Topical Prednisolone acetate initially
- Very slow taper
- May taper to alt days then stop and always see after treatment stopped
- Often returns with again KP’s, cells and High IOP
- Consider Oral Acyclovir- 800mg 5 x day 2/52 then 400 mg BD ongoing
CASE STUDY

- Mrs A
- Presented to us first Sept 2016
- Previous AAU in 2008.
- Repeated tests all NAD
- 3+ WBC with 1+ flare
- Iris transillumination noted on first visit
- Medium KP’s
- Iris Atrophy
• Ongoing low grade inflammation
• Unable to stop drops
• Now down to BD daily Prednisolone acetate RE
• Oral Aciclovir 400 mg BD
• Ongoing FU
## CLINICAL FINDINGS IN HYPERTENSIVE ANTERIOR UVEITIS

<table>
<thead>
<tr>
<th>Disorder</th>
<th>KP’s</th>
<th>AC reaction</th>
<th>Angle</th>
<th>Lens</th>
<th>Vitreous</th>
<th>Specific features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posner Schlossman</td>
<td>Few only</td>
<td>Mild</td>
<td>Nil, open</td>
<td>Normal</td>
<td>Nil</td>
<td>Nil specific</td>
</tr>
<tr>
<td>HSV VZV CMV</td>
<td>May have Mutton fat</td>
<td>Mild-severe</td>
<td>Nil to chronic uveitis</td>
<td>Normal</td>
<td>Mild to severe vitritis</td>
<td>Sectoral or diffuse Iris atrophy</td>
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<tr>
<td>Fuchs Heterochromic iridocyclitis</td>
<td>Stellate diffuse</td>
<td>Mild-moderate</td>
<td>Fine vessels open</td>
<td>First PSCO</td>
<td>Mild cellular response</td>
<td>Iris heterochromia</td>
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STEROID INDUCED OHT

- Use of steroids induces raised IOP
- Does not occur always first time using steroids
- Probable breakdown in trabecular meshwork but not completely understood
- Often can’t stop steroids
- Should lessen as frequency reduces
- Should lessen with weaker steroids
  - Prednisolone Acetate
  - Maxidex
  - FML
- Sometimes still require glaucoma surgery
CHALLENGES

- How long do you keep on treatment?
- Does the patient need low dose steroid long term to prevent flare of inflammation and IOP rise?
- Does the patient need ongoing anti ocular hypertensives to keep IOP low?
- Remember any option - long term potential risks of steroids – raised IOP, cataract.