Uveitis Guidelines SWBH

Acute Anterior Uveitis AAU

- Take and document relevant history, e.g. presentation, ophthalmic history, general health, underlying systemic disease
- Document cellular activity (SUN grading) and PS formation
- Unilateral or bilateral: dilate **BOTH** pupils and examine **BOTH** fundi
- Break any fresh posterior synechiae with dilating drops/heat/subconj. mydricaine
- Potent topical corticosteroid (g. prednisolone acetate 1% or g. dexamethasone 0.1%) as per treatment protocol
- Dilating drops g. cyclopentolate 1% or g. atropine 1% (if severe) as per treatment protocol

The SUN working Group Grading for AC cells (1mmx1 mm Slit beam)

Grade	Cells in the field
0	<1
0.5+	1-5
1+	6-15
2+	16-25
3+	26-50
4+	>50

Treatment protocol for 'simple' Anterior uveitis

SUN Grade: ≥ 1 + AC cells

g. prednisolone acetate 1%*	Duration
Hourly	5 days
2 Hourly	1 week
6 x / day	1 week
4 x / day	1 week
3 x / day	1 week
2 x / day	1 week
1 x / day	1 week

SUN Grade: 0.5+ AC cells

g. prednisolone acetate 1%*	Duration
Hourly	2 days
6 x / day	5 days
4 x / day	1 week
3 x / day	1 week
2 x / day	1 week
1 x / day	1 week

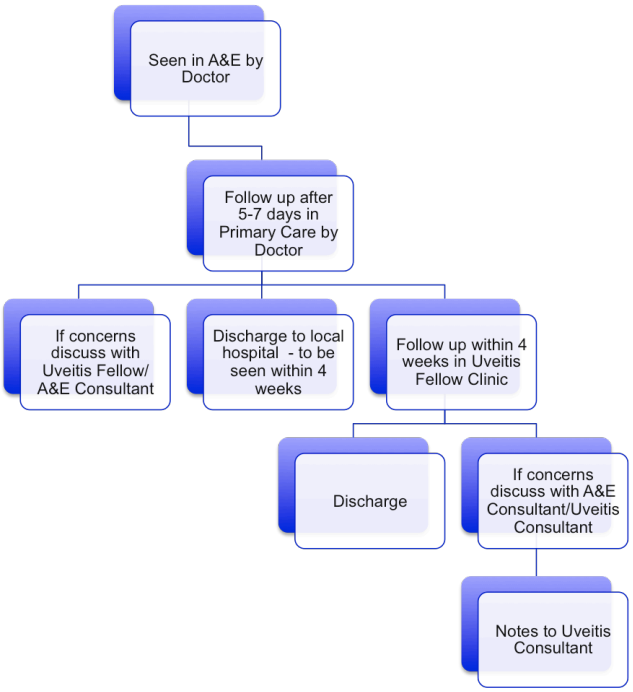
*Instruct the patient to shake the bottle before use.

If a patient has a particular preference for g. dexamethasone 0.1%, this can be used in lieu of g. prednisolone acetate 1%.

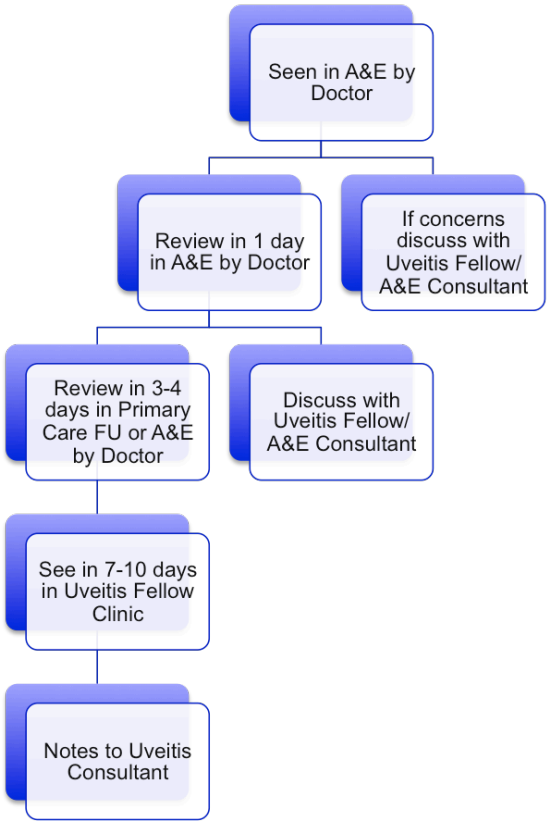
All patients should also receive g. cyclopentolate 1% (or g. atropine 1% if severe) twice daily for 2-4 weeks.

Oc. betamethasone 0.1% nocte (if available) can be given in severe cases.

Management Guidelines: 1st attack mild/moderate AAU



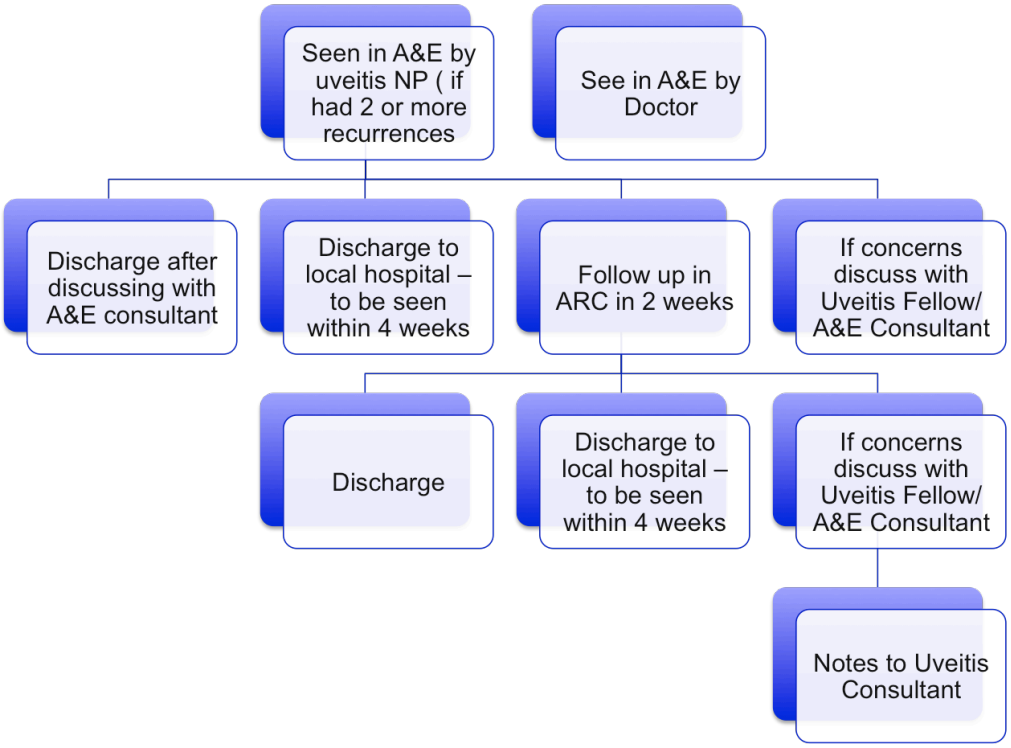
Management Guidelines: severe AAU (≥ 3+ cells, hypopyon, fibrin) 1st attack or recurrence



Management Guidelines: recurrent AAU

- Break any fresh posterior synechiae with dilating drops/heat/sc mydricaine
- Potent topical corticosteroid g. prednisolone acetate 1% (or g. dexamethasone 0.1%) as per treatment protocol
- Dilating drops g. cyclopentolate 1% (or g. atropine 1% if severe) as per treatment protocol

Management Guidelines: mild to moderate recurrent AAU



Unilateral AAU with IOP ≥ 35mmHg Management Guidelines

- Always think that a herpes virus could be a possible cause
- Treat inflammation and IOP appropriately -topical (+/- oral) antihypertensives (PG drops are not contraindicated)
- May need frequent A&E/Primary care review, e.g. in 3/7 or sooner to ensure IOP is controlled
- Do **NOT** stop the topical corticosteroid but can taper to BD if appropriate
- See in Uveitis Fellow Clinic in 2 weeks
- Notes to a Uveitis Consultant **at presentation** to arrange future follow-up

Pan/Posterior/Intermediate Uveitis. New Patient Management Guidelines

- **MUST EXCLUDE AN INFECTIVE PROCESS**
- Dilate **BOTH** pupils and check **BOTH** fundi
- Treat any anterior uveitis with potent topical corticosteroid and dilating drops
- Sight threatening disease: defined as…
  - Significant vitritis/ CMO / retinal vasculitis / optic nerve involvement
  - Contact Uveitis Fellow/Uveitis Consultant for advice
- Non-sight threatening disease:
  - Notes to Uveitis Consultant for further follow-up

Investigations to be Requested for Uveitis Patients in A&E

NEW patients (unless they are known to have a systemic disease that is associated with uveitis, e.g. sarcoidosis) with:

- Panuveitis
- Posterior Uveitis
- Intermediate Uveitis
- Bilateral Anterior Uveitis
- Investigations are required both for determining aetiology and for baseline prior to systemic corticosteroid therapy
- It is **imperative** that the results are available by the time the patient is seen in the Uveitis Clinic

Baseline Ix

- Full blood count
- Erythrocyte sedimentation rate
- C-reactive protein
- Urea and electrolytes
- Liver function tests
- Angiotensin converting enzyme
- Syphilis serology
- Plain chest x-ray
- BP, urinalysis, BM, (temp)
- Other investigations **only** when it is clinically indicated

Other Ix

Imaging

- OCT – **only** where CMO is suspected from history and examination, e.g. typical symptoms, PH of CMO, reduction of vision of 2 or more Snellen lines, vision worse with a pinhole
- B-scan ultrasound – **only** if it is required to make or exclude a diagnosis, e.g. posterior scleritis, RD

AC tap

- e.g. in cases of suspected ARN