106

Uveitis

POSTERIOR SCLERITIS SIMULATING NEURORETINITIS: A CASE REPORT

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Purpose

To report a clinical case of unilateral idiopathic posterior scleritis (PS).

Method

Medical record review.

Results

A 26-year-old woman presented with ocular pain, photophobia and blurred vision in the upper hemifield of left eye (LE) of 2 days duration. Visual acuity (VA) was 6/6 in LE, pupillary reflex and slit-lamp examination were normal, fundoscopy (FU) revealed disc swelling and increased macular thickness. OCT showed cystoid macular edema. At first, neuroretinitis was suspected but associated systemic etiology was rule out.

After 1 month, with a brain magnetic resonance imaging (MRI) reported as normal, VA decreased to 6/9,5 and FE revealed an inferior exudative retinal detachment (RD), OCT revealed macular and peripapillary subretinal fluid. Boluses of methylprednisolone 500 mg/day IV were started for 3 days, followed by prednisone 60 mg/day PO with dose tapering. 3 weeks later, FU of LE showed ischemic peripheral retina mainly in temporal quadrant with intraretinal hemorrhages and a temporal superior hole that was surrounded by laser.

Reviewing MRI, thickening of posterior-inferior sclera was evident in LE; B-ultrasound corroborated this thickening, compatible with PS. Fluorescein angiography showed papillary hyperfluorescence and perivascular staining due to vasculitis at periphery. Partial anatomical response with corticosteroids, therefore methotrexate 25mg/week SC was added, with anatomical but not functional improvement.

Conclusions

PS is a diagnostic challenge due to its ability to mimic other pathologies; a delay in its diagnosis can worsen the visual prognosis. About 60% of cases are idiopathic. Systemic corticosteroids are frequently used, but in refractory cases immunosuppressants can be added.

151

Uveitis

IMPACT OF PREGNANCY ON PUNCTATE INNER CHOROIDOPATHY (PIC) EXACERBATIONS: A COMPARATIVE ANALYSIS

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Purpose: This study aims to elucidate the frequency and pattern of PIC exacerbations during pregnancy, contrasting these findings with a non-pregnant cohort.

Methods: A retrospective single-center analysis was conducted at Hadassah Medical Center, involving female patients with PIC. Patients were categorized into pregnant and non-pregnant groups. Data on exacerbations, best-correct visual acuity (BCVA), age, degree of myopia, and treatment modalities were collected and statistically analyzed.

Results: The study included 5 patients in each group. In the pregnant group, a statistically significant decreasing trend of exacerbations over time was noted (linear regression slope: -0.030, R^2: 0.62, p=0.036). The non-pregnant group showed a similar trend (linear regression slope: -0.082, R^2: 0.58, p=0.047) and significant exacerbation reductions over time ($p \leq -0.02$). Initial and final BCVA values revealed no significant differences between the groups. Age and degree of myopia distribution were similar in both groups, with a very strong negative correlation between age and exacerbations in the pregnant group ($r = -0.948$, $p = 0.014$) along with a strong positive correlation with myopia ($r = 0.880$, $p = 0.049$).

Conclusions: Pregnancy appears to influence the course of PIC, with a notable decrease in exacerbations over time and a strong correlation with age and myopia. These findings underscore the need for tailored management of PIC in pregnant women, considering the unique dynamics of disease progression during pregnancy.

153

Uveitis

OPTIMAL CUT-OFF VALUE OF QUANTIFERON-TB GOLD PLUS TEST FOR DIAGNOSIS OF OCULAR TUBERCULOSIS IN ENDEMIC POPULATION

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Purpose: To evaluate the diagnostic value of QuantiFERON-TB Gold Plus (QFT-Plus) testing for ocular tuberculosis (TB) in an endemic area.

Methods: A retrospective cohort study. The medical records review was performed on patients who underwent QFT-Plus testing between January 2019 and December 2022. The diagnosis of ocular TB was based on criteria from the Collaborative Ocular Tuberculosis study (COTS). QFT-Plus values' distribution was analyzed using a scattered plot, and the optimal cut-off value was determining through Receiver Operating Characteristic curve (ROC) analysis.

Results: Out of 387 patients, 104 (26.9%) tested positive, with 85 diagnosed with ocular TB. Among these, 33 achieved treatment success (38.8%),8 experienced treatment failure (9.4%). The median QFT-Plus values for ocular TB group (TB1-Nil: 1.41 IU/mL, TB2-Nil: 1.51 IU/mL) were significantly higher than non-ocular TB group (TB1-Nil: 0.02 IU/mL, TB2-Nil: 0.01 IU/mL), with P

Conclusion: The cut-off value of 0.35 IU/mL for QFT-Plus resulted in optimal sensitivity and specificity in study's endemic area. However, clinical characteristics indicative of ocular TB plays a crucial role and greatly assists in making timely decisions regarding ATT initiation.

Financial Disclosure: No

161

Uveitis

ACUTE ANTERIOR UVEITIS AS MASQUERADE SYNDROME OF ENDOMETRIAL CARCINOMA-CASE REPORT

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Purpose:
The purpose of this communication is to remind the possible presentation of different pathologies (including malignant tumors) as AAU.

Methods:
We selected a recent case seen at our hospital. A 52-year-old woman came through the emergency service claiming 2 weeks long vision loss in the left eye. She had been diagnosed with AAU in LE in another center and had started topical corticosteroids treatment. Smoker. She also claimed vomits, asthenia, digestive symptoms, and weight loss. A basic ophthalmologic exploration was performed.

Results
Exploration showed VA 0,9/0,7.
Biomicroscopy: Tyndall +++, anterior chamber fibrin ++, posterior sinequiae and anterior capsule pigment.
Funduscopy and macular OCT were normal.

At the weekly check-up, a 2x2mm whitish exophytic lesion was observed in the iris at 11h as tyndall and fibrine improved.
Ocular ecography and anterior ultrasonic biomicroscopy showed a 3.7x2.8x2.6mm solid lesion in the iris and iris-ciliary body of the LE.

The patient was referred to the internal medicine service and endometrial carcinoma with lymph node extension was diagnosed.

Conclusions
Even though anterior uveitis is a quite common finding in the emergency room, we should always consider this as possible manifestation of another disease and pay special attention to the anamnesis.

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169

Uveitis

CMV RETINITIS FOLLOWING INJECTION OF INTRAVITREAL DEXAMETHASONE IMPLANT

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Purpose

To present a case of CMV retinitis in an 87 year-old immunocompetent male patient following intravitreal injection of dexamethasone implant.

Case Report

Patient presented in the Medical Retina Department due to chronic cystic macular edema in his right eye. Ocular history included more than three intravitreal injections in his right eye and cataract surgery bilaterally, two years before. Postoperative OCT assessment revealed the presence of ERM and cystic macular edema in the right eye, which was treated with injection of intravitreal dexamethasone implant. Two months later, patient complained about floaters in his right eye. BCVA was 2/10 and IOP was 22 mmHg. Slit lamp examination showed cells 1+ and flare 1+ in the anterior chamber, endothelial keratic precipitates and vitreous cells 1+. Fundus examination exhibited occlusive vasculitis and a peripheral whitish retinal lesion located upper nasally. After microbiological examination of aqueous humour specimen, CMV infection was diagnosed. Treatment with intravitreal injection of foscarnet was immediately initiated. After two months and four foscarnet injections, there were no signs of vitritis, and retinitis recession was noted. BCVA remained 2/10 and IOP was controlled adequately without any treatment.

Conclusion

In literature, only few cases of CMV retinitis after injection of intravitreal dexamethasone implant have been described. Most of them refer to immunodefficient patients or patients with a history of previous CMV infection. Contrariwise, in the presenting case, patient was immunocompetent with no history of CMV infection. Monotherapy with intravitreal foscarnet injection proved sufficient to control the disease.

200

Uveitis

AN INTERESTING CASE OF U.G.H SYNDROME

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PURPOSE: Presentation of an interesting case with Uveitis-Glaucoma-Hyphema syndrome.

METHODS: A 79-year-old woman, pseudophacic (IOL 3-p sulcus OD, IOL in the bag OS) bilaterally, pseudoexfoliation glaucoma under medication and Sjogren`s syndrome, was examined as an outpatient with reported pain in the right eye and blurred vision. From the clinical examination of the right eye, the patient has a 3p sulcus IOL with mild subluxation, anterior chamber cells (5+), hypertony and hyphema. UBM examination revealed iris-IOL contact. The patient was already receiving anti-inflammatory treatment for three months from a private clinic. Topical anti-inflammatory treatment was enhanced, as was glaucoma topical and systemic medication. In collaboration with the rheumatologist, a full systemic and immunological check was done again and the systemic treatment with p.o. cortisone was amplified.

RESULTS: Despite modifications to the local and systemic medical therapy, the uveitis, intraocular pressure, and hyphema failed to improve to a satisfactory degree. The immunological test results provided no additional informative data. In light of the ultrasound findings, a diagnosis of uveitis-glaucoma-hyphema (UGH) syndrome was established. We subsequently performed removal of the intraocular lens along with vitrectomy.A vitreous specimen was obtained for culture and PCR (HSV, CMV, VZV), with no pathogenic microorganism found.

CONCLUSIONS: Recurrent chronic uveitis accompanied by hyphema and ocular hypertension in pseudophakic patients should prompt consideration of Uveitis-Glaucoma-Hyphema (UGH) syndrome in the differential diagnosis. UGH syndrome constitutes a rare late postoperative complication that, if unresponsive to conservative medical management, necessitates surgical intervention.

219

Uveitis

ARE WE MANAGING BACTERIAL CONJUNCTIVITIS IN PRIMARY CARE ACCORDING TO NICE GUIDELINES?

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Acute infective conjunctivitis accounts for approximately 1% of all GP consultations in the UK. In this audit, we will focus on patients managed as a bacterial conjunctivitis in a GP practice in the UK, to assess if they have been managed according to NICE guidelines.

Methods

EPRs were accessed, and patients coded as a conjunctivitis within Q3 of 2023 were initially included, and patients with non-bacterial conjunctivitis were excluded. They were then divided into paediatric and adult patients to see if the different age groups were managed differently.

Results

18 adults were initially included for data collection. After excluding the irrelevant patients, 6 adult patients were finally included in the audit. Only two of the six adult patients (33%) were managed according to the NICE guidelines. 66% of the adult patients were not managed according to NICE guidelines.

Paediatric patients

7 children were initially included in the audit. 1 was excluded and 6 children were finally included in the audit. Similarly to the adult cohort, only 2 of the 6 patients (33%) were managed in compliance with NICE guidelines.

Conclusion

Only 33% of patients with bacterial conjunctivitis were managed according to NICE guidelines. The commonest error was seen when prescribing chloramphenicol eye drops with incorrect frequency. The results were presented at the practice quality improvement meeting to alert doctors of the guidelines and prescribing errors when managing bacterial conjunctivitis.

235

Uveitis

FROM ANTERIOR UVEITIS TO CHRONIC VOGT-KOYANAGI-HARADA SYNDROME: A CLINICAL JOURNEY THROUGH INFLAMMATORY RELAPSES AND POLIOSIS

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Purpose

VKH syndrome is a multisystemic autoimmune disorder affecting tissues with high melanocyte concentration. Recent data suggest a distinction between initial-onset VKH with prodromal neurological symptoms and subclinical choroiditis, and chronic VKH with recurrent inflammation and cutaneous depigmentation. We report a severe chronic VKH case with atypical poliosis presentation following a single episode of anterior uveitis

Methods

An 18-year-old man consulted for bilateral decreased vision, ocular redness, and significant depigmentation of his hair and eyelashes. No neurological or auditory-problem were observed, a first anterior uveitis episode happened several weeks prior, treated by topical steroids. Visual acuity was 0.8/0.6, and IOPs were normal. Examinations revealed granulomatous bilateral panuveitis with vitritis, Dalen-Fuchs lesions, papillitis, macular edema, and serous retinal detachment. ICGA revealed numerous hypofluorescent dark dots, over the entire fundus. Complementary tests showed positive results for HLA DRB01*04, confirming the diagnosis of VKH syndrome.

Results

This case illustrates as a chronic form of VKH, without prodromal symptoms, but with poliosis and severe ocular inflammation following a single episode of anterior uveitis several weeks earlier. Topical and systemic steroids failed to control vitritis and posterior uveitis. Subsequent immunosuppressors were introduced sequentially, but the patient experienced multiple inflammatory relapses. A six-month follow-up showed decreased persistent poliosis and satisfactory control of inflammation with the combination of methotrexate, occasional ozurdex injections and adalimumab.

Conclusion

Performing choroidal assessment (ICGA, EDI-OCT) to detect initial-onset VKH is crucial. Early introduction of appropriate combined immunosuppressive treatment could prevent progression to the chronic phase, characterized by recurrent inflammatory relapses and a comparatively poor visual prognosis.

236

Uveitis

WHEN EYES AND KIDNEYS COLLIDE: A PEDIATRIC TINU SYNDROME STORY

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Purpose

TINU (Tubulointerstitial Nephritis and Uveitis) is a rare syndrome, comprising less than 2% of uveitis cases. Typical presentation involves bilateral anterior uveitis, with posterior lesions occurring less frequently. We report the case of a young girl presenting with bilateral papillitis and vasculitis, in addition with anterior activity.

Method

An 11-year-old girl of Moroccan descent was referred for bilateral ocular redness, with asthenia and abdominal pain. Upon slit lamp examination, bilateral anterior inflammation was observed, while fundus examination revealed slight vitritis and hyperemic, blurred papillae. Fluorescein angiography revealed significant papillitis and vasculitis, whereas ICGA demonstrated the presence of several granulomas.

Laboratory work-up disclosed an inflammatory syndrome characterized by anemia, elevated blood creatinine, and heightened levels of urinary beta2 microglobulin. Treatment was initiated with local and systemic corticosteroids to address both ocular and renal inflammation. Methotrexate and adalimumab were added to the treatment regimen to manage the uveitis component.

Discussion

While renal biopsy remains the gold standard for diagnosing TINU, it is not necessary for definitively diagnosing the syndrome if key clinical findings are present, including typical uveitis and interstitial nephritis (manifested as abnormal renal function, abnormal urinalysis, and systemic illness lasting ≥ 2 weeks). Although renal biopsy wasn't performed in this case, the diagnostic criteria for TINU syndrome were fulfilled.

Conclusion

TINU syndrome is underrecognized due to misdiagnosis. Our case presented atypically with ocular posterior lesions in addition to classic anterior inflammation. Renal biopsy is not mandatory for diagnosing definite TINU syndrome, as long as key clinical findings are present.