Dr. Kanwal Sajid Abbasi

MCPS, FCPS, FRCS (Glasgow)
Senior Registrar ophthalmology
BBH
UVEAL TRACT
ANATOMY

1. Iris

2. Ciliary body
   a. Pars plicata
   b. Pars plana

3. Choroid
- Internal limiting membrane
- Nonpigmented ciliary epithelium
- Pigmented ciliary epithelium
- Stroma of ciliary process
- Arteriole
- Venules
VASCULAR SUPPLY

Ophthalmic artery
Short posterior artery
Long posterior artery
Anterior ciliary artery
Vortex veins
NERVE SUPPLY (SENSORY)

Long and short ciliary nerves
DEFINITION

INFLAMMATION OF UVEAL TRACT
CLASSIFICATION

1. Anterior
   - Iritis
   - Iridocyclitis

2. Intermediate
   (pars plana, peripheral retina, vitreous)
3. Posterior retinitis, choroiditis, vasculitis
4. Panuveitis
5. Endophthalmitis
6. Panophthalmitis
RETINITIS
CHOROIDITIS
VASCULITIS
CLASSIFICATION

- Acute
- Chronic
- Recurrent
ACUTE ANTERIOR UVEITIS

- Most common form
- Sudden onset and duration 3 months or less
CHRONIC UVEITIS

- Less common than acute
- Characterized by persistent inflammation that promptly relapses, in less than 3 months, after discontinuation of treatment
- Granulomatous or non-granulomatous
RECURRENT
Repeated episodes of uveitis separated by periods of inactivity without treatment lasting at least 3 months
ACUTE ANTERIOR UVEITIS

How to diagnose?

- **History**
  - Redness, Pain, photophobia

- **Examination**
  a. Visual acuity (acc to grade of inflammation)
  b. Cicumcorneal injection
  c. Miosis (sphincter spasm, posterior synechiae)
  d. Endothelial dusting
  e. Keratic precipitates
  f. Aqueous cells
  g. Aqueous flare
Aqueous cells

<table>
<thead>
<tr>
<th>Cells in field</th>
<th>Grade</th>
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<tbody>
<tr>
<td>&lt;1</td>
<td>0</td>
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<tr>
<td>1-5</td>
<td>±</td>
</tr>
<tr>
<td>6-15</td>
<td>+1</td>
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<tr>
<td>16-25</td>
<td>+2</td>
</tr>
<tr>
<td>26-50</td>
<td>+3</td>
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<tr>
<td>&gt;50</td>
<td>+4</td>
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## Aqueous flare

<table>
<thead>
<tr>
<th>Description</th>
<th>Grade</th>
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<tbody>
<tr>
<td>Nil</td>
<td>0</td>
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<tr>
<td>Just detectable</td>
<td>+1</td>
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<tr>
<td>Moderate</td>
<td>+2</td>
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<tr>
<td>Marked</td>
<td>+3</td>
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<tr>
<td>Intense</td>
<td>+4</td>
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h. Hypopyon
  - HLA B27 associated AAU
  - Behcet
i. Posterior synechia
j. IOP - Low or increase
k. Fundus examination
l. Duration
m. Prognosis - GOOD
CILIARY INJECTION
MIOSIS
ENDOTHELIAL DUSTING BY CELLS
AQUEOUS FALRE AND CELLS
FIBRINOUS EXUDATE
HYPOPHYON
CHRONIC UVEITIS

HISTORY
May remain asymptomatic till the complications develop like cataract or raised IOP

EXAMINATION
a) White eye
b) Aqueous cells
c) Aqueous flare
d) Kps (epitheliod cells, lymphocytes, polymorphs)
   • Mutton fat
   • Resolved mutton fat (ghost)
   • Pigmented
e) Dilated iris vessels
f) Iris nodules
g) Iris atrophy
h) Duration
i) Prognosis
Early synechiae formation in active AAU
Extensive synechiae and pigment on lens
LARGE MUTTON
FAT KPS
GHOST CELL KPS
OLD PIGMENTED
KPS
KOEPPE NODULES
BUSACCA NODULES
COMPLICATIONS

- Cataract
- Glaucoma (Open angle/ closed angle)
- Band keratopathy
- Hypotony
SYSTEMIC ASSOCIATIONS

- Ankylosing spondylitis
- Rieters syndrome
- Psoriatic arthritis
- Juvenile idiopathic arthritis
- Ulcerative colitis
- Crohns disease
INVESTIGATIONS

ESR
RA factor
ANA
X-ray chest
X-ray sacroiliac joint
HLA Tissue typing
Montaux test
TREATMENT

- **TOPICAL**
  - STEROIDS (anti-inflammatory, frequency)
    - Prednisolone, dexamethasone
  - MYDRIATICS
    - Cycloplegic, atropine, tropicamide
Role of mydriatics:
- To prevent posterior synechiae formation
- To break posterior synechiae
- To relieve sphincter spasm, pain relief
• PERIOcular STEROIDS

• SYSTEMIC STEROIDS
- **NSAIDS**
- **ANTIMETABOLITES**
  Methotrexate, azathioprine
- **CALCINEURIN INHIBITORS**
  Ciclosporin, tacrolimus
- **BIOLOGICAL BLOCKERS**
  daclizumab, anakinra
THANK YOU