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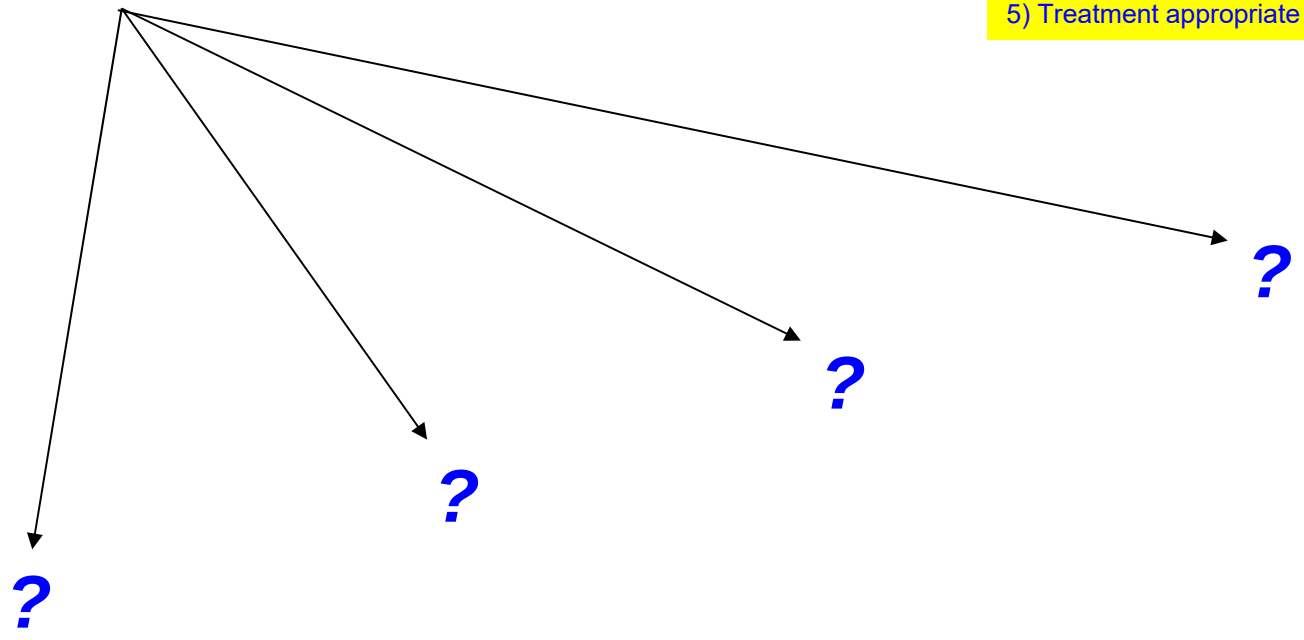

What are the four basic anatomic locations for uveitis?

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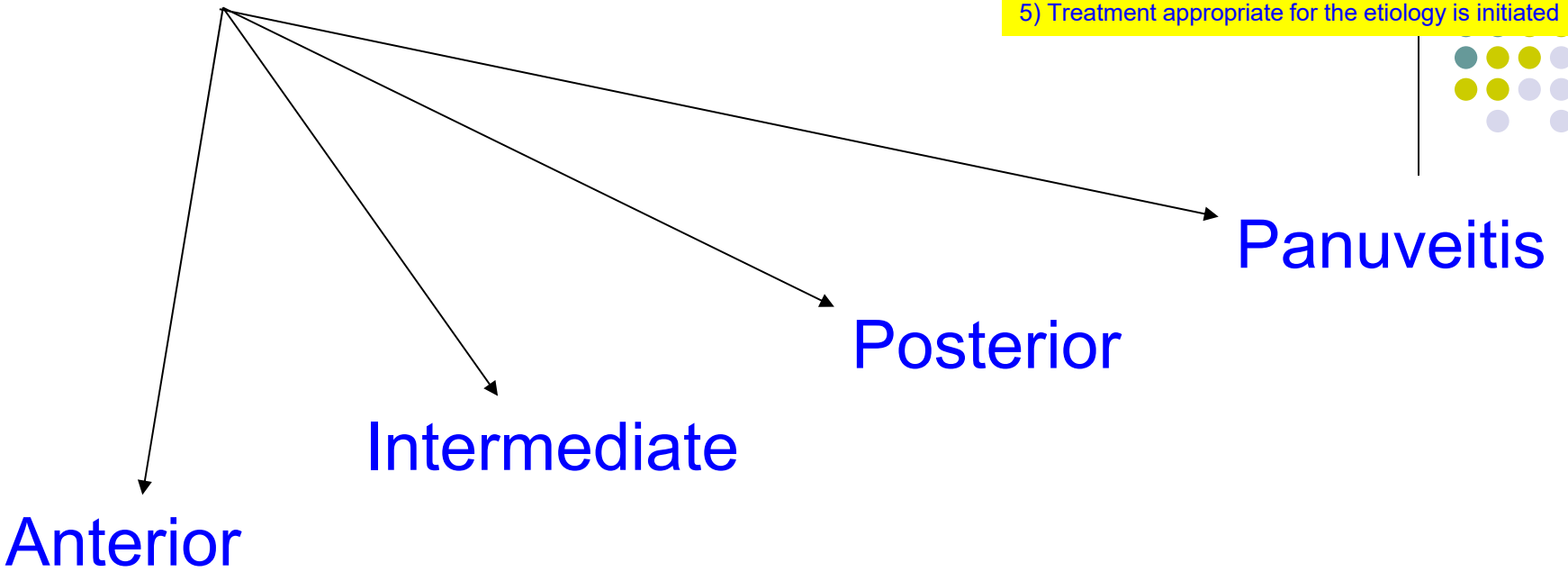

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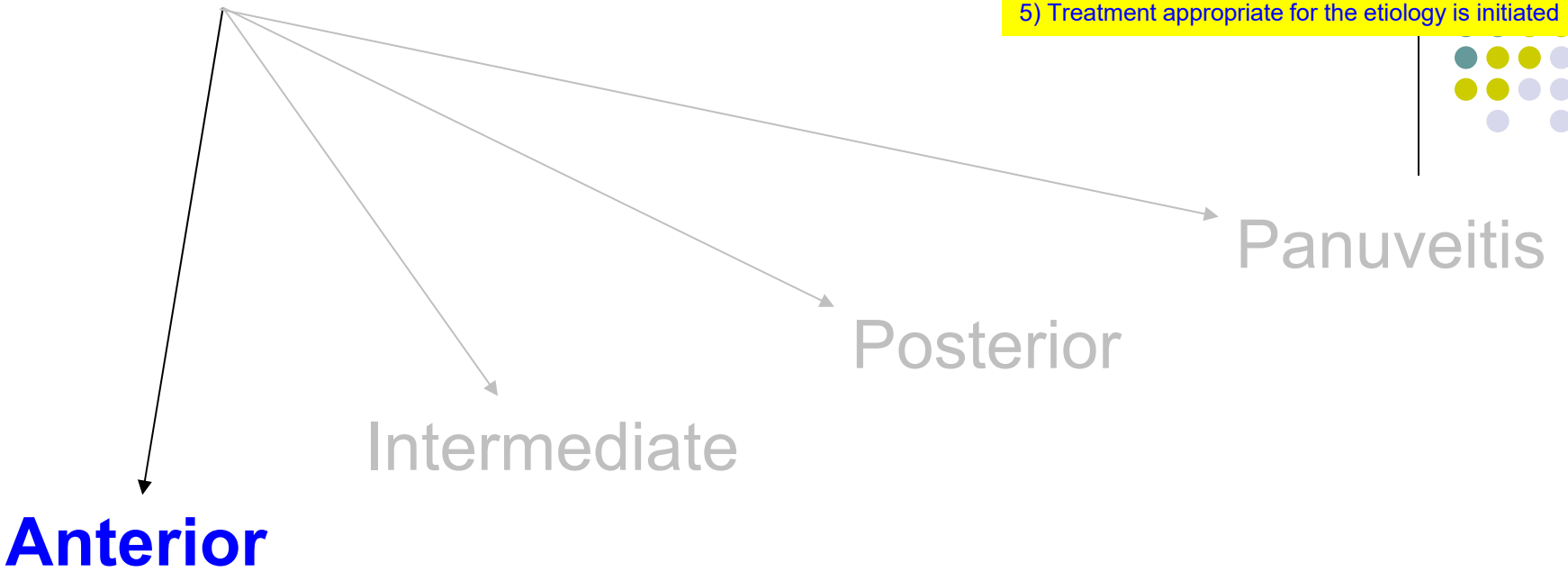
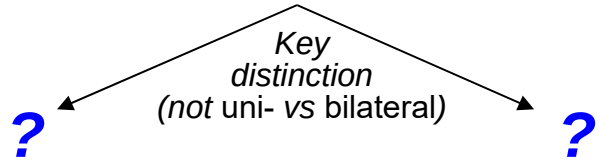


In this slide-set, we will drill down on **anterior uveitis**

Uveitis: ***Anterior***



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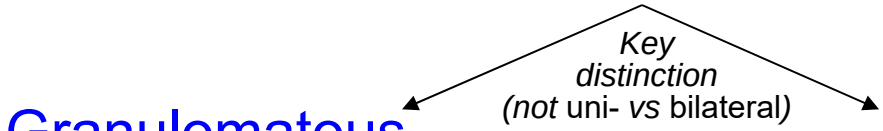

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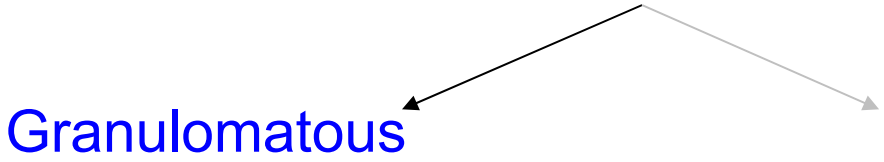

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Granulomatous

Nongranulomatous

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The presence of **epithelioid** and **giant** cells

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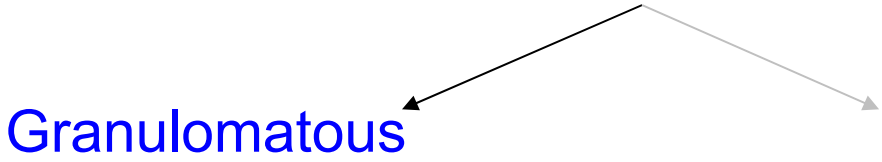

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In clinical ophtho-speak, to what does the term granulomatous *refer?*

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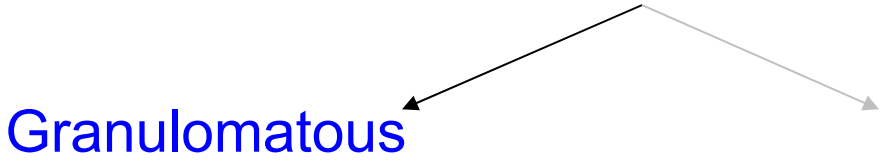

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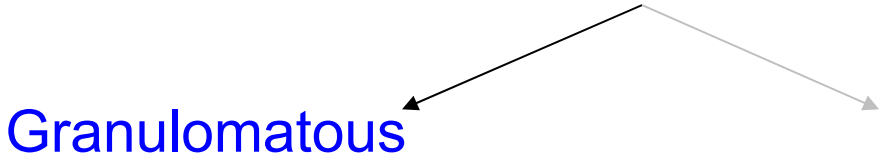

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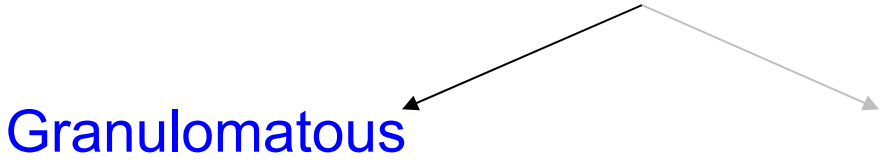

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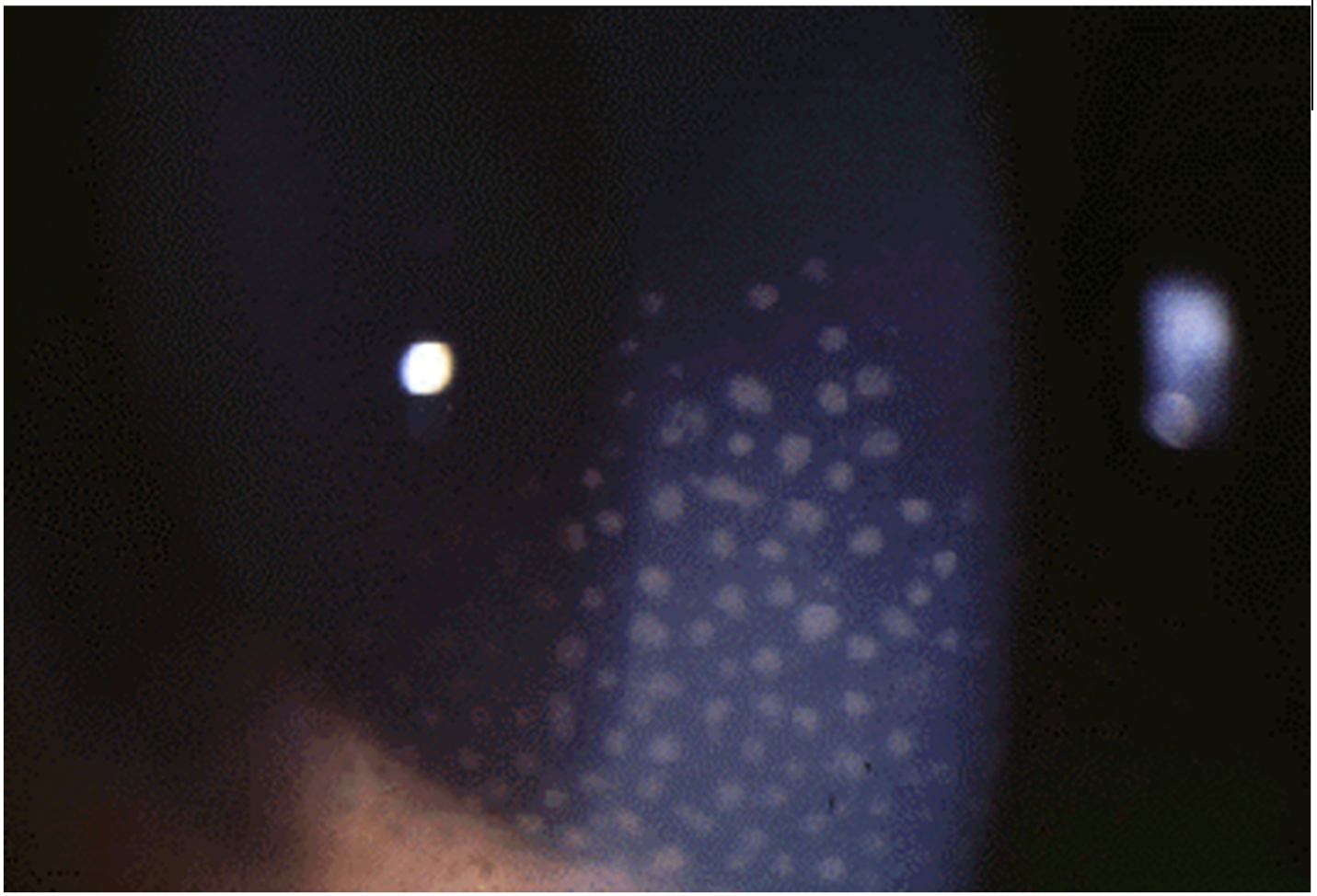
What do granulomatous KP look like?
They are large, grayish, and look 'greasy'



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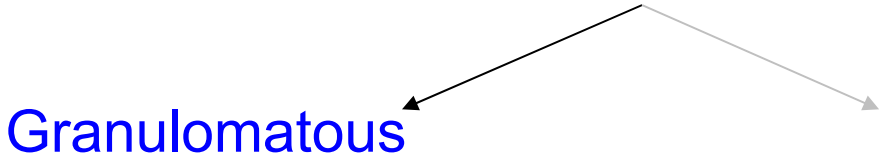

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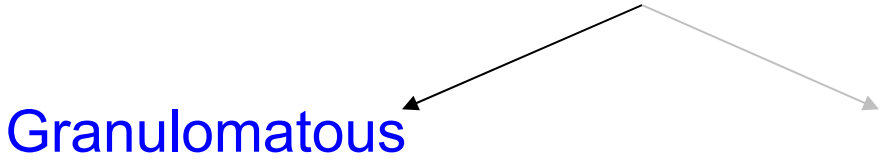

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Not necessarily. While significant overlap exists between the two, it is **not** the case that 'clinically granulomatous dz' is always histologically granulomatous

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Throughout the *anterior uveitis* slides, the term *granulomatous* refers to the slit-lamp appearance of the KP, not to the histology of the condition

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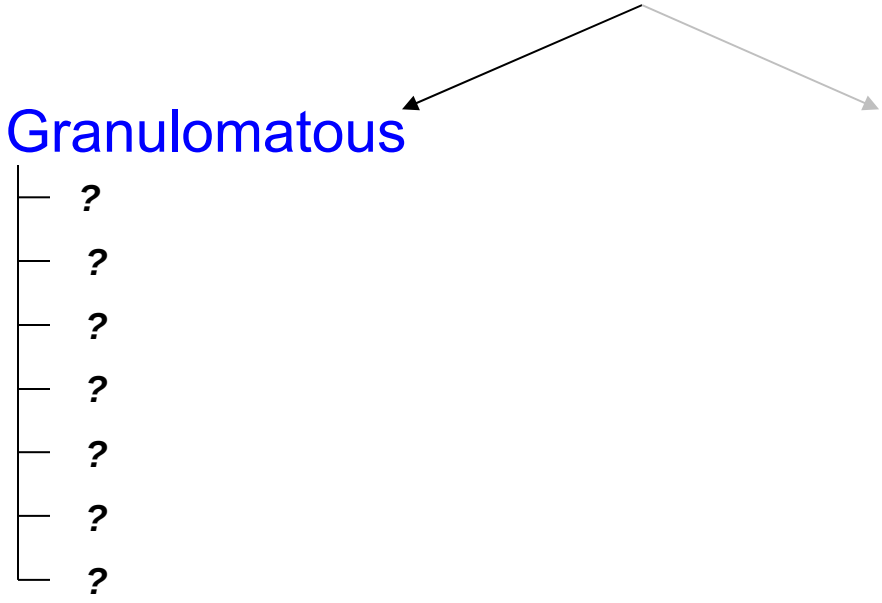

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- TB
- Sarcoid
- Syphilis
- HSV
- VKH
- Toxoplasmosis
- Lyme

Nongranulomatous

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- **VKH** ***?***
- **Toxoplasmosis** ***?***
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Nongranulomatous

While these condition can present as an anterior uveitis, to do so would be distinctly unusual. Instead, what would be the typical manner in which each of these would present?

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Granulomatous

- TB
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- **VKH** — *Panuveitis (with one exception)*
- **Toxoplasmosis** — *Posterior uveitis*
- **Lyme** — *Intermediate uveitis*

Each of these conditions will be covered in detail elsewhere

Nongranulomatous

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Nongranulomatous

What is the one exception? In what situation is VKH likely to present as a granulomatous anterior uveitis?
The natural course of VKH is to pass through four stages, the fourth of which (the *chronic recurrent* stage) may present in this fashion

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- **HSV**
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- Toxoplasmosis
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Nongranulomatous

To anticipate: We will have more to say about each of *these* conditions in later sections as well

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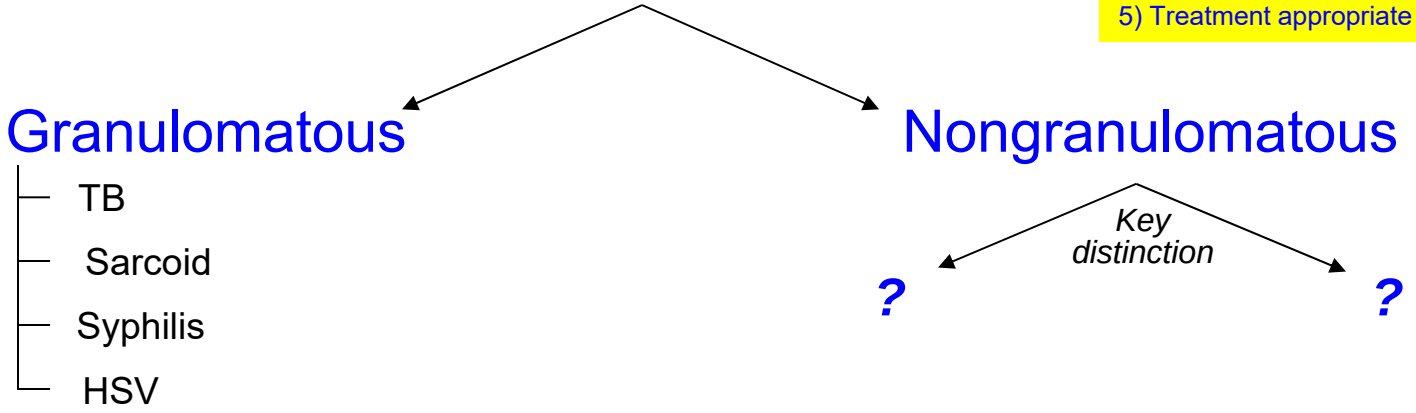

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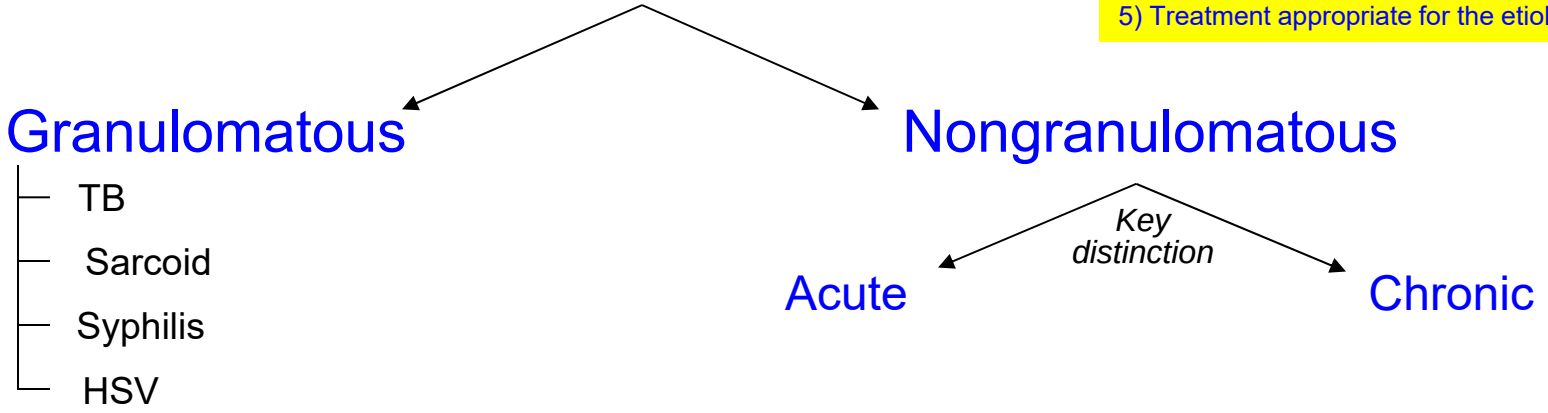

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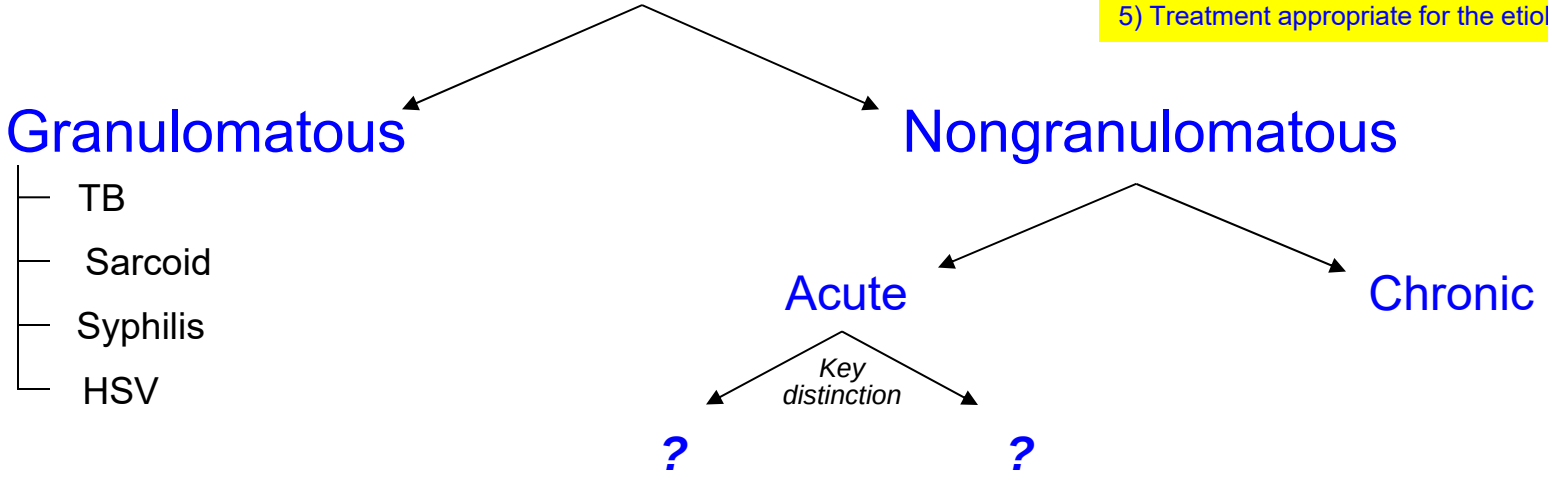

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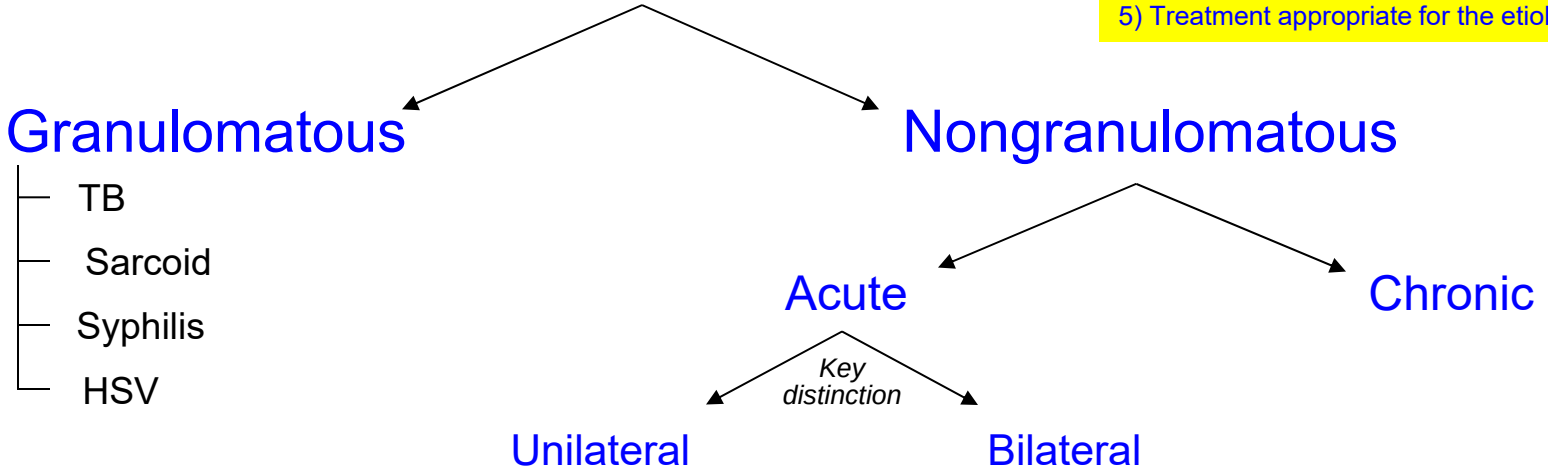

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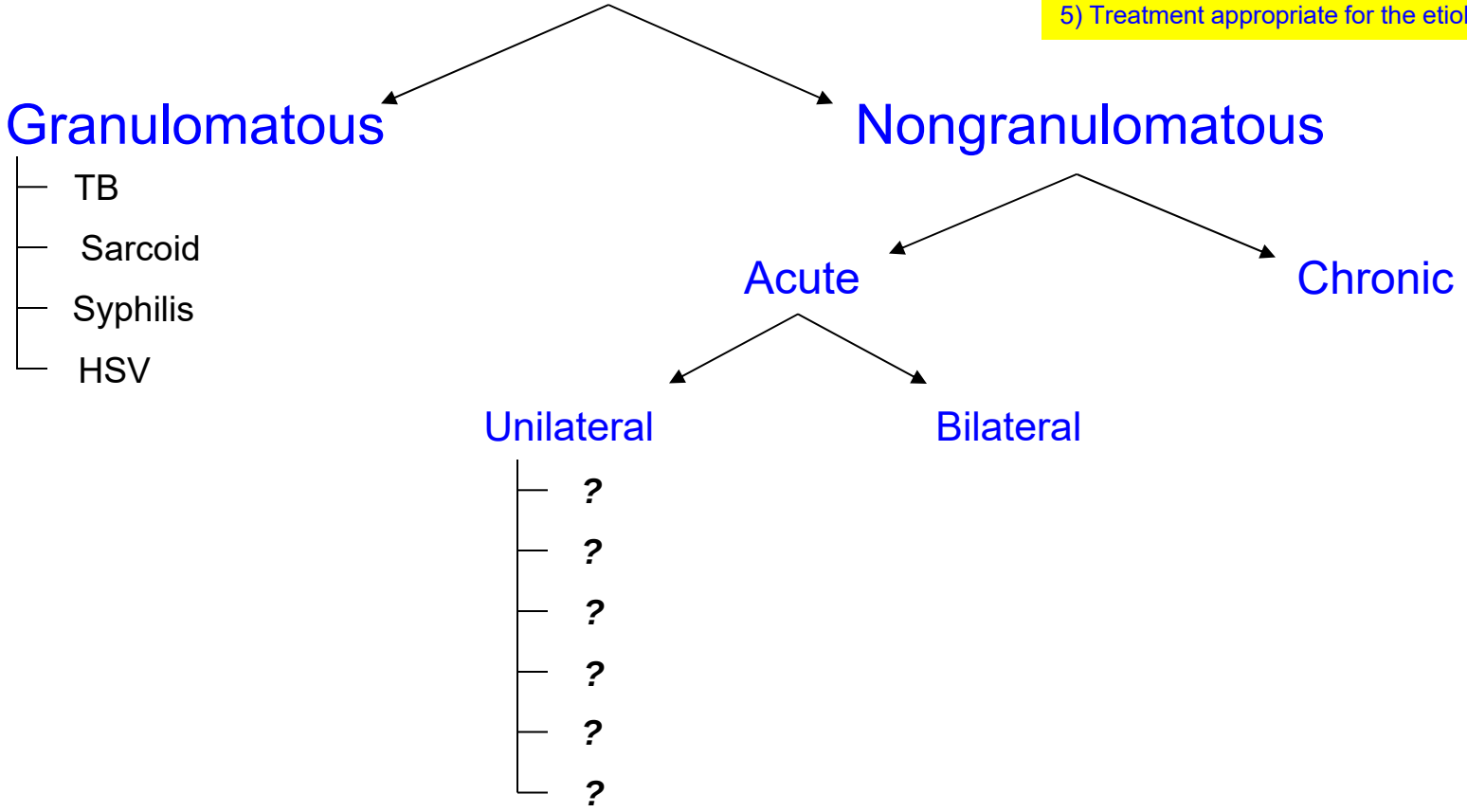

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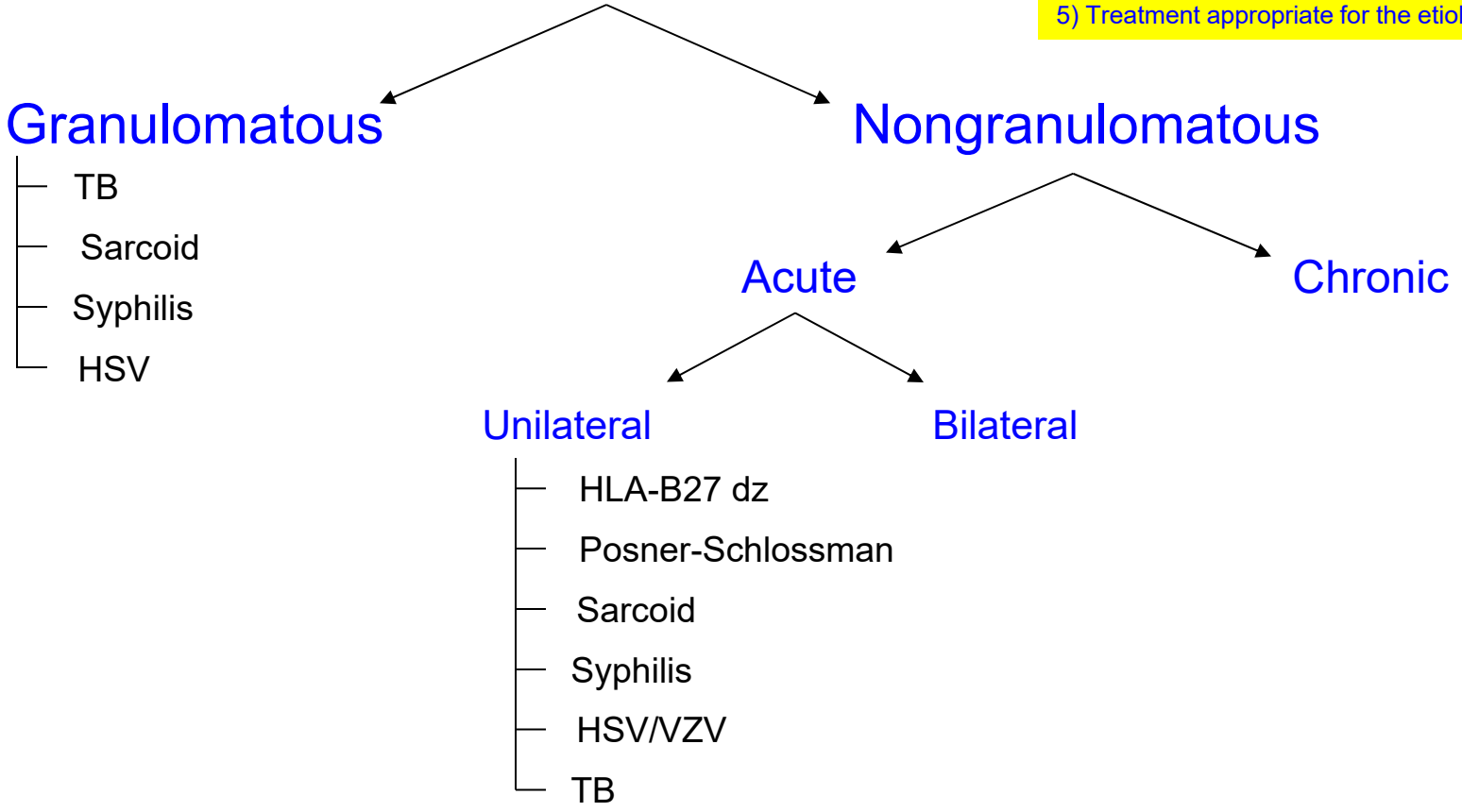

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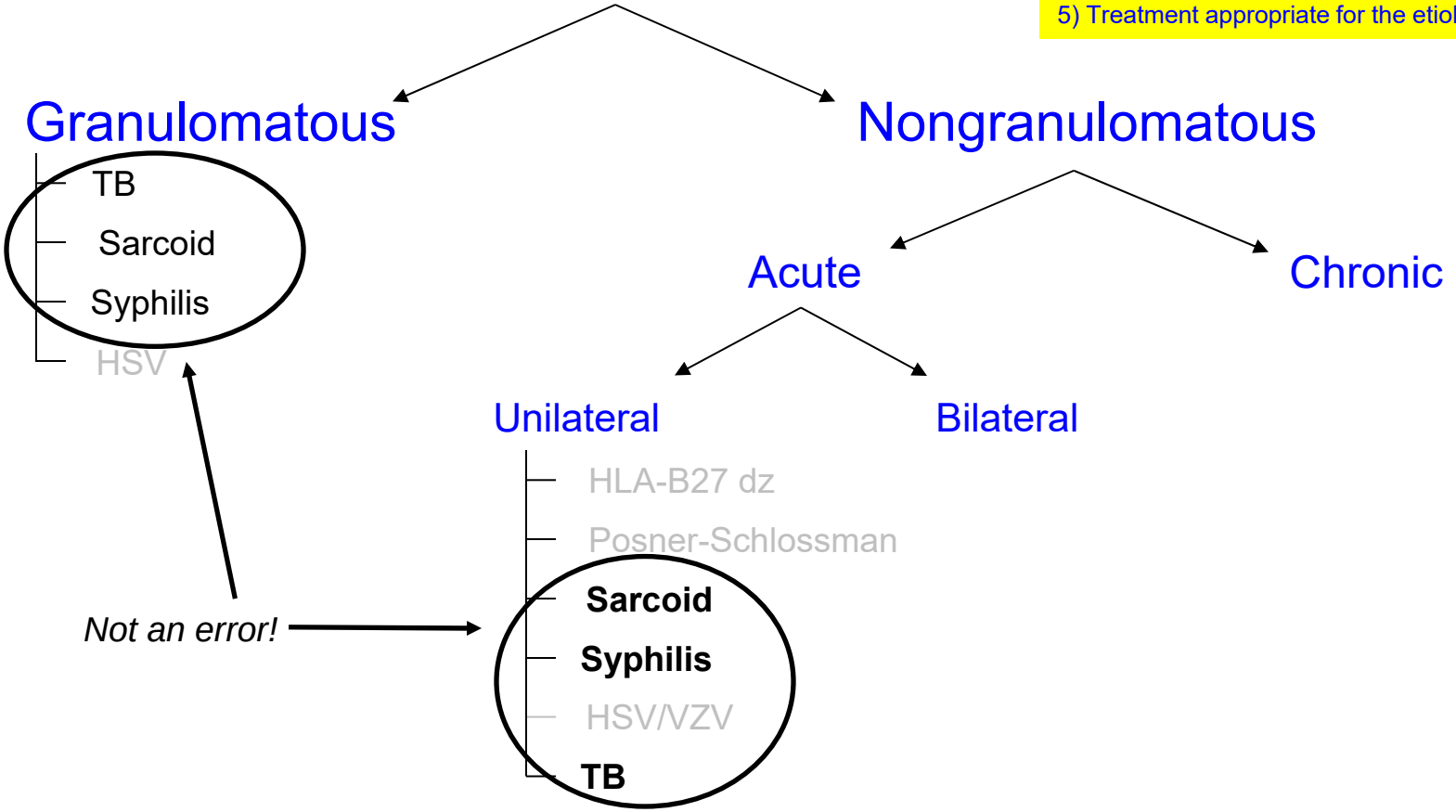

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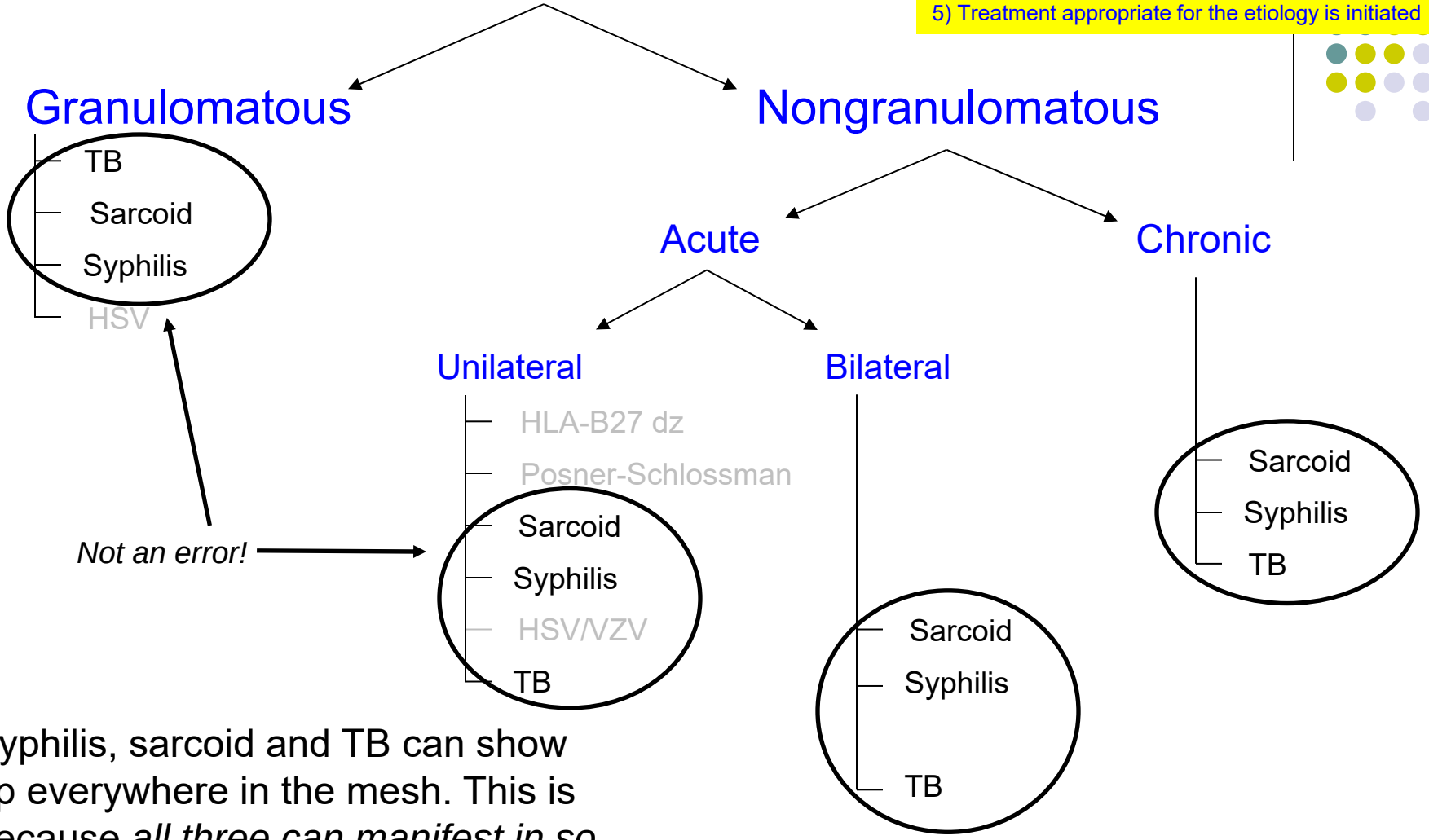

Syphilis, sarcoid and TB can show up everywhere in the mesh. This is because *all three can manifest in so many different ways*.

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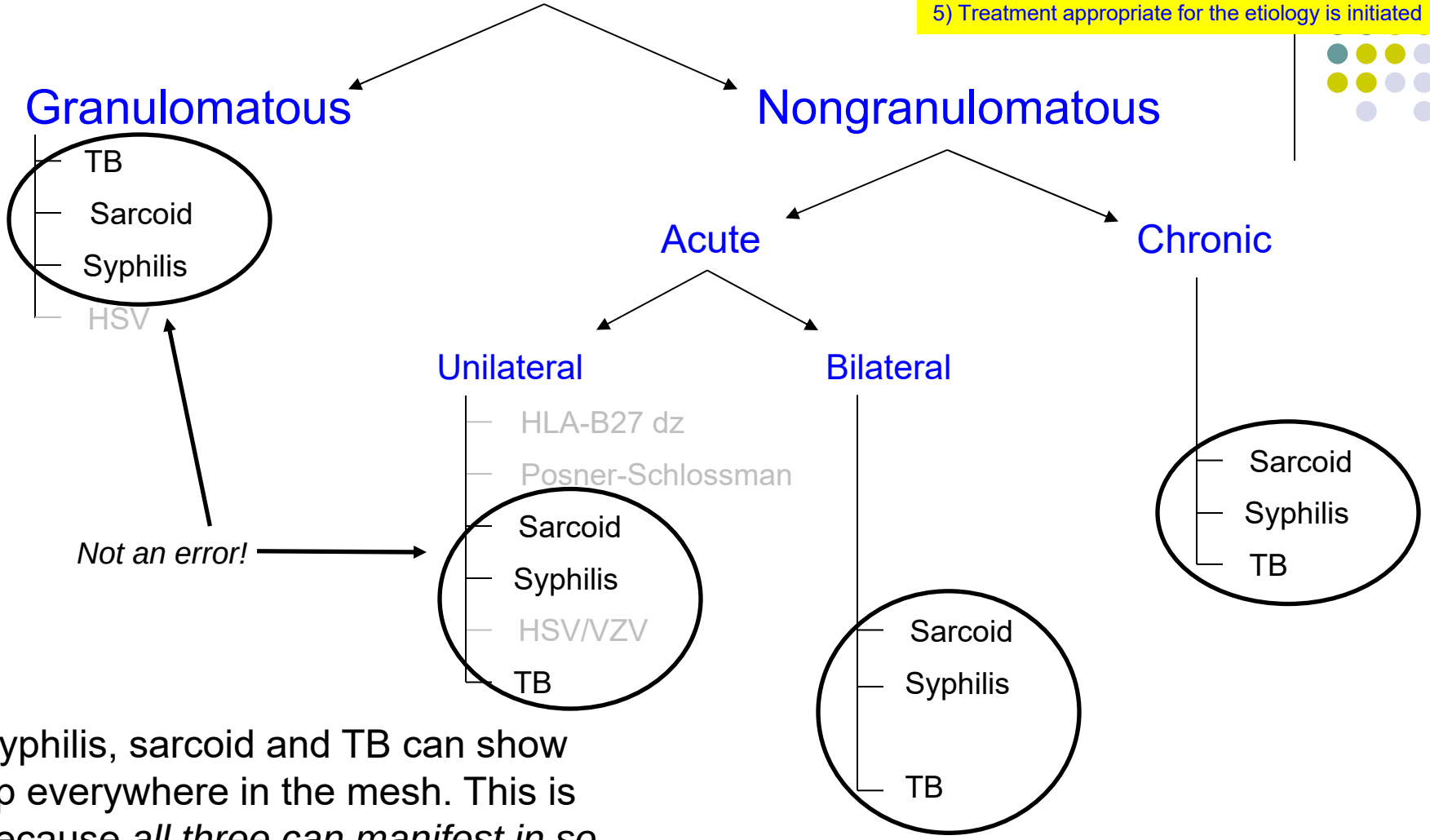

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Rule of thumb:

Syphilis, sarcoid and TB are on the DDx for **every** pt with **any** form of uveitis!

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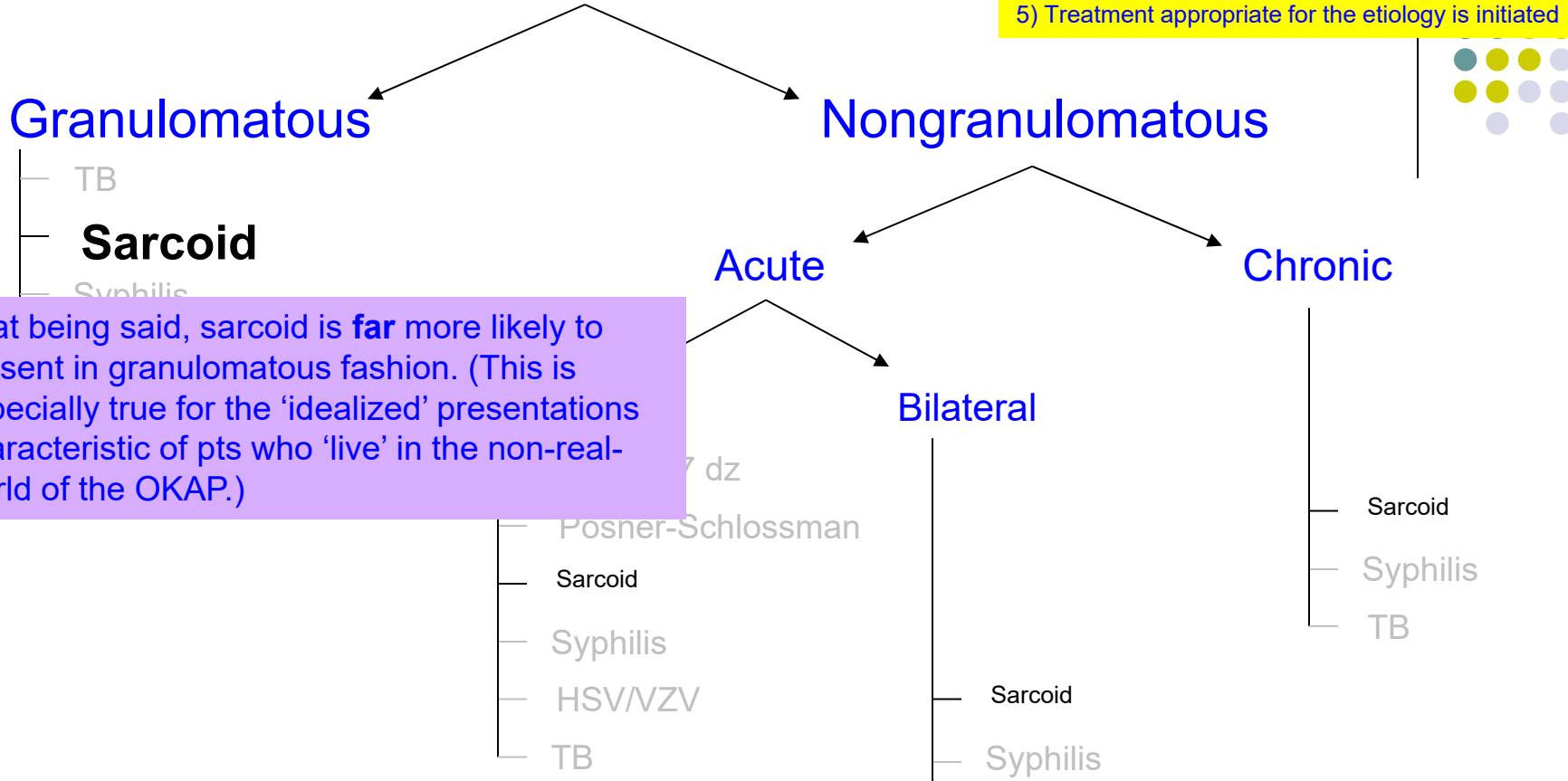

That being said, sarcoid is **far** more likely to present in granulomatous fashion. (This is especially true for the 'idealized' presentations characteristic of pts who 'live' in the non-real-world of the OKAP.)

As we will see, syphilis, sarcoid and TB will show up everywhere in the mesh. This is because *all three can manifest in so many different ways*.

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Syphilis, sarcoid and TB are on the DDx for **every** pt with **any** form of uveitis!

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      - **HLA-B27 dz** aka...
        - Posner-Schlossman
        - Sarcoid
        - Syphilis
        - HSV/VZV
        - TB
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What is the other umbrella term for the HLA-B27 diseases?

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What are the four HLA-B27 conditions?
--Ankylosing spondylitis (AS)
--Reactive arthritis (ReA)
--Psoriatic arthritis (PA)
--Inflammatory bowel disease (IBD)

Uveitis: ***Anterior***

1) The uveitis is profiled
2) The profiled case is meshed
3) A differential diagnosis list is generated
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- Granulomatous
  - TB
  - Sarcoid
- Nongranulomatous
  - Acute
    - ateral
      - **HLA-B27 dz** aka...the SNSAs
      - Posner-Schlossman
      - Sarcoid
      - Syphilis
      - HSV/VZV
      - TB
    - Bilateral
      - ?
  - Chronic
    - ?

What is the other umbrella term for the HLA-B27 diseases?
The **SNSAs**

What are the four HLA-B27 conditions?
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Of the four HLA-B27 dz, two are much more likely to cause a **bilateral** *and/or* **chronic** *anterior uveitis, in contrast to the acute unilateral anterior uveitis of the other two. Not coincidentally, the strength-of-association between these two and HLA-B27 is much weaker. Which two are these?*

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IBD and **PA**. You need to remember that IBD and PA are HLA-B27 dz, and that they can present with an acute unilateral anterior uveitis. However, for OKAP/Board purposes, the preferred response on a question concerning an HLA-B27 uveitis presentation is likely to be AS or ReA. For this reason, we will focus on AS and ReA in this portion of the slide-set.

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Note that, while we will consider each entity separately, it is important to recognize that in clinical practice, considerable overlap exists among them, and thus differentiating among them is not always possible.

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Syphilis
- HSV/VZV
- TB

For example:
--Which can present with back pain?

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--Which can present with back pain? **All of them**

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For example:
--Which can present with back pain? **All of them**
--Which can present with peripheral arthropathies?

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For example:
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--Which can present with peripheral arthropathies? **All of them**
--Which can present with skin changes?

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Bearing this caveat in mind, we will now address AS and ReA in detail

For example:
--Which can present with back pain? **All of them**
--Which can present with peripheral arthropathies? **All of them**
--Which can present with skin changes? **All of them**

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HLA-B27 dz (not IBD/PA)
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Who is the typical AS pt?

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Who is the typical AS pt?
A white male age 16-40

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Does this mean African-Americans, Asian-Americans, etc, don't get AS?

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Does this mean African-Americans, Asian-Americans, etc, don't get AS?
No, they do--just at significantly lower rates

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Who is the typical AS pt?
A white **male** age 16-40

What is the male:female ratio for AS?

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A white **male** age 16-40

What is the male:female ratio for AS?
This is a tricky question. The prevalence is probably fairly similar between men and women, but **AS tends to be much more severe in men**, and thus males are more likely to present in clinic.

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What is the classic nonocular complaint in AS?

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What is the classic nonocular complaint in AS?
bodypart **pain/stiffness**

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What is the classic nonocular complaint in AS?
Low back pain/stiffness

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Who is the typical AS pt?
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What is the classic nonocular complaint in AS?
Low back pain/stiffness that is 1) worse in the [time of day] and 2) [improves v worsens] with exertion/movement

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Low back pain/stiffness that is 1) worse in the morning, and 2) improves with exertion/movement

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What is the classic nonocular complaint in AS?
Low back pain/stiffness that is 1) worse in the morning, and 2) improves with exertion/movement

What is the classic uveitis presentation in an AS pt?
The sudden onset of a painful vs painless unilateral nongranulomatous iritis , often with a exam finding

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The sudden onset of a painful unilateral nongranulomatous iritis , often with a hypopyon

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The sudden onset of a painful unilateral nongranulomatous iritis , often **with a hypopyon**

Absent a hx of trauma and/or intraocular surgery, if you see a unilateral hypopyon, think AS first!

Uveitis: ***Anterior***

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- Granulomatous
  - TB
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- Nongranulomatous
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What is the other umbrella term for the HLA-B27 diseases?
The **SNSAs**

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~~--Psoriatic arthritis (PA)~~
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HLA-B27 dz (not IBD/PA)
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What is the classic finding on sacroiliac plain films?
'Bamboo spine'

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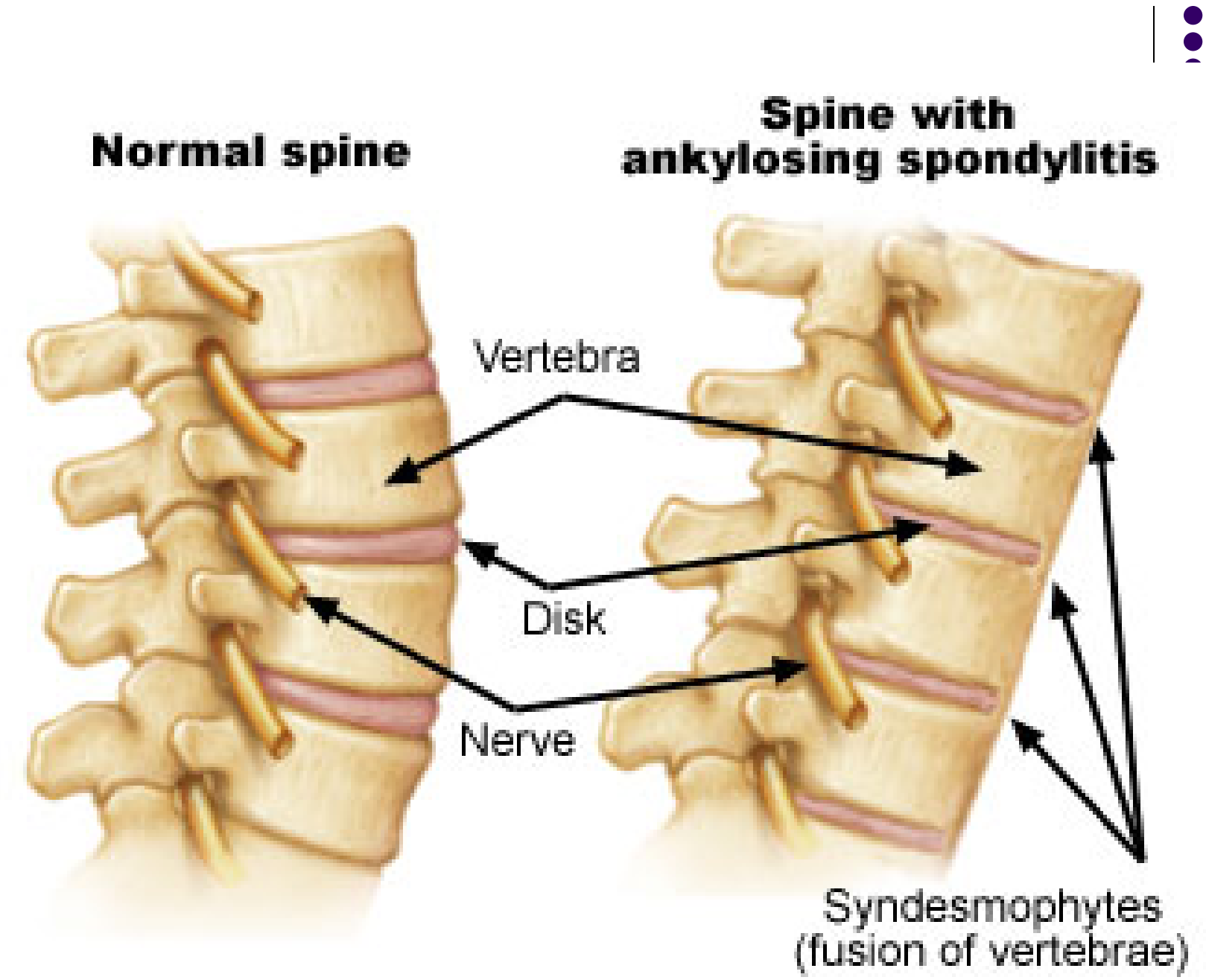
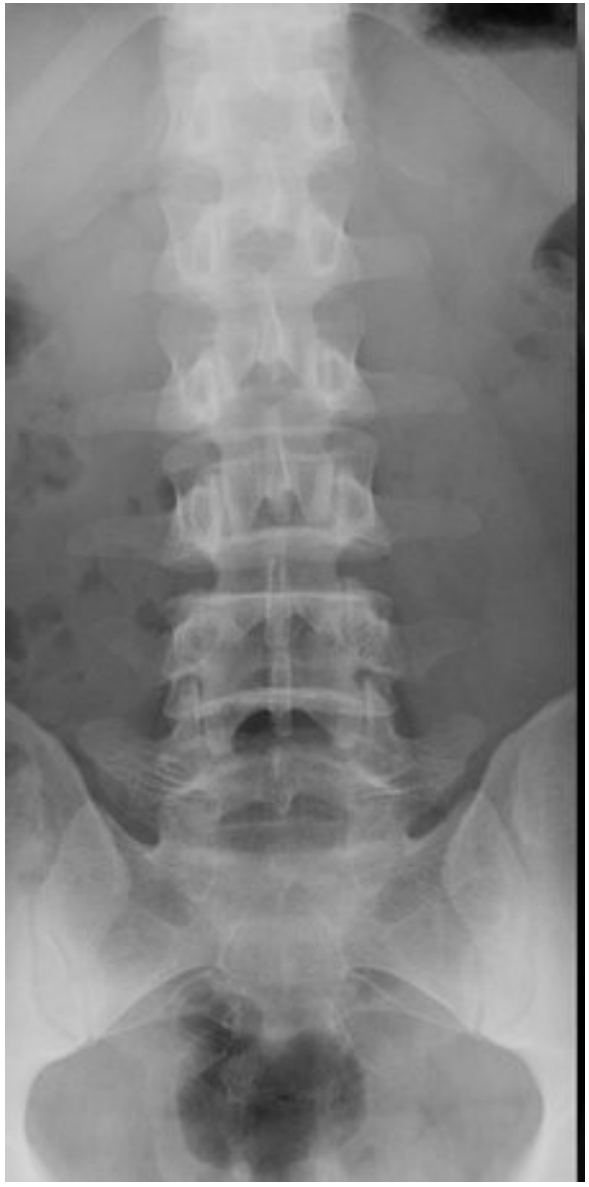
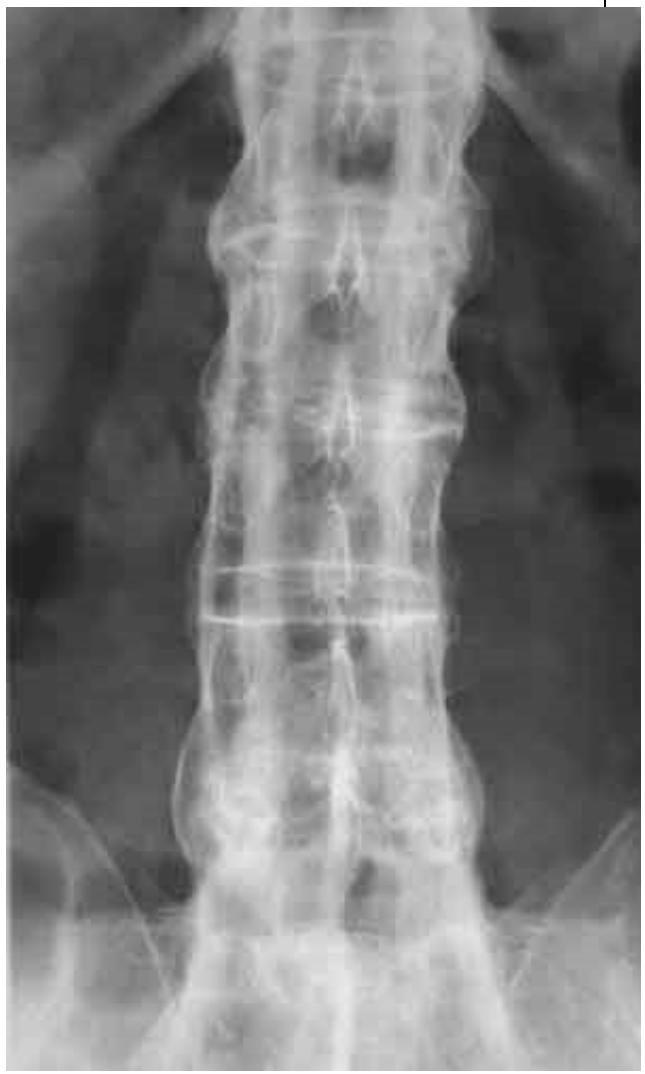
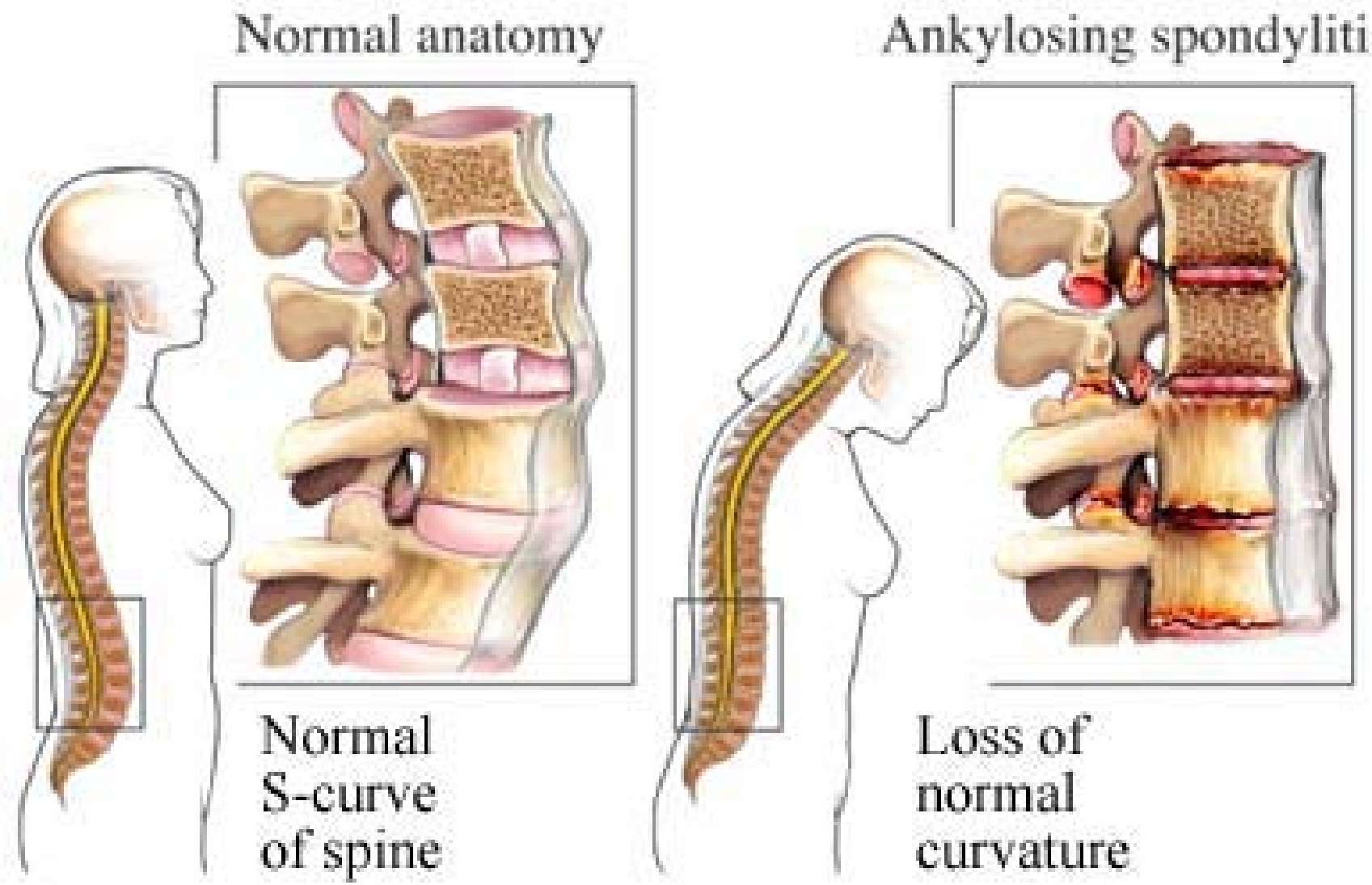

Normal spine
Spine with ankylosing spondylitis
Vertebra
Disk
Nerve
Syndesmophytes (fusion of vertebrae)

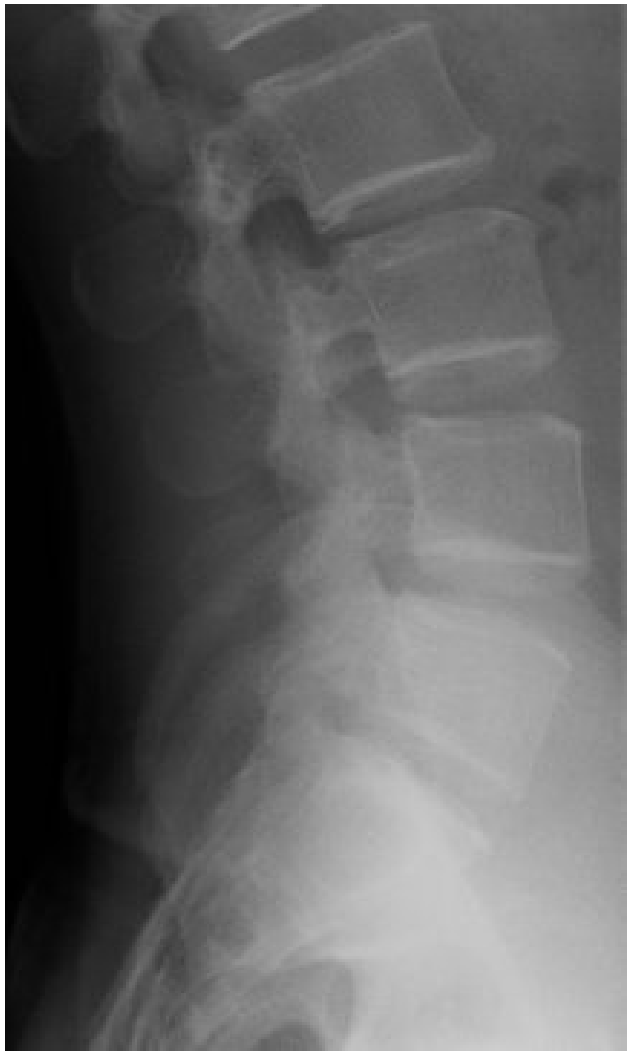


Normal

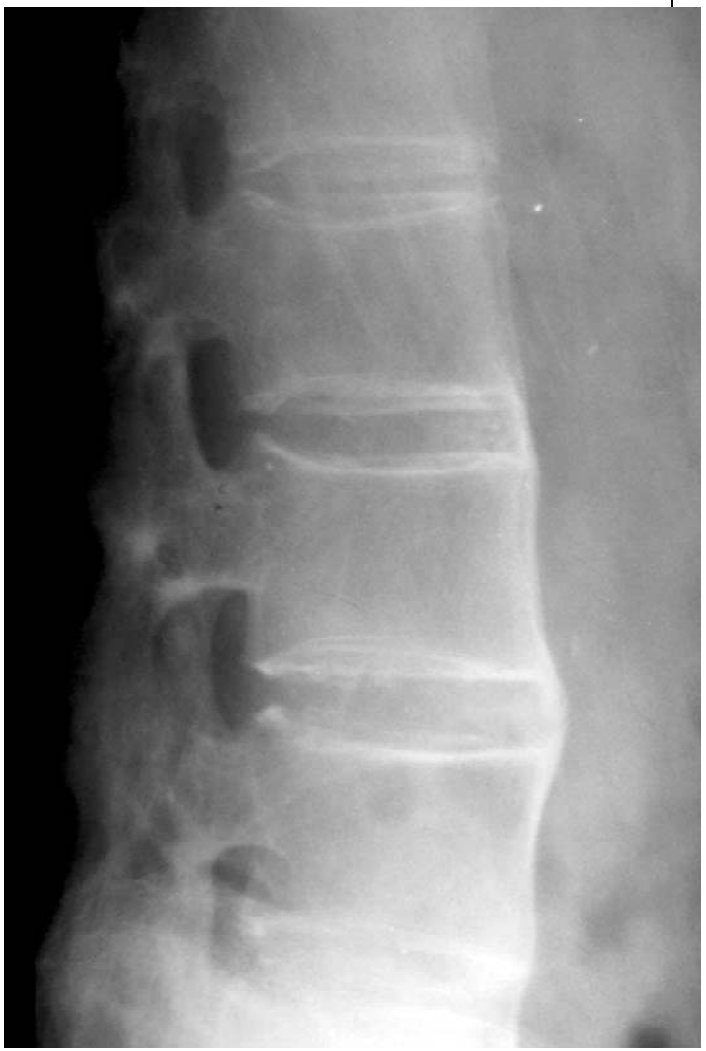


Ankylosing spondylitis. Note the fusion of the vertebrae


Normal anatomy
Ankylosing spondylitis
Normal
S-curve
of spine
Loss of
normal
curvature



Normal. Note the S-curve



AS. Note the loss of normal curvature

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Sacroiliac plain films or check for HLA-B27?

Why not check for HLA-B27?

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Sacroiliac plain films *or check for HLA-B27?* **No!**

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Why not check for HLA-B27?
Because being HLA-B27+ is not diagnostic of anything other than of being HLA-B27+. Consider: While over 95% of AS pts are HLA-B27+, only about 1% of HLA-B27+ individuals have AS. Diagnostic criteria for AS include clinical criteria (eg, low back pain), along with radiographic changes consistent with sacroiliitis. HLA-B27 status, while contributory when working up a uveitis pt, is too nonspecific to be diagnostic.

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The **SNSAs**

What are the four HLA-B27 conditions?
--Ankylosing spondylitis (AS)
--Reactive arthritis (ReA)
~~--Psoriatic~~
~~--Inflammat~~

How is AS uveitis managed?
The ophthalmologist must do two things:
1) Address the uveitis in the typical manner (ie, with topical steroids and cycloplegia),

Who
A whi

What
Low

What is the classic uveitis presentation in an AS pt?
The sudden onset of a painful unilateral nongranulomatous iritis , often with a hypopyon

How long do the uveitic episodes last?
2 - 6 weeks

What class of medicine is usually first-line treatment for the systemic manifestations of AS, and may also help reduce the risk of uveitis recurrence?
NSAIDs

Is more aggressive immunomodulation/suppression sometimes needed?
Yes

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2) The profiled case is meshed
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  - TB
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A white male age 16-40

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Does this mean African-Americans, Asian-Americans, etc, don't get ReA?

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No, they do--just at significantly lower rates

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What is the male:female ratio for ReA?

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The triad of [redacted] (note: **not** uveitis)

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Can't see, can't pee, can't climb a tree'

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Only about 10

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--And of course, the [redacted] joint

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Note the predilection for lower-extremity joints-- an important clue that you're dealing with ReA!

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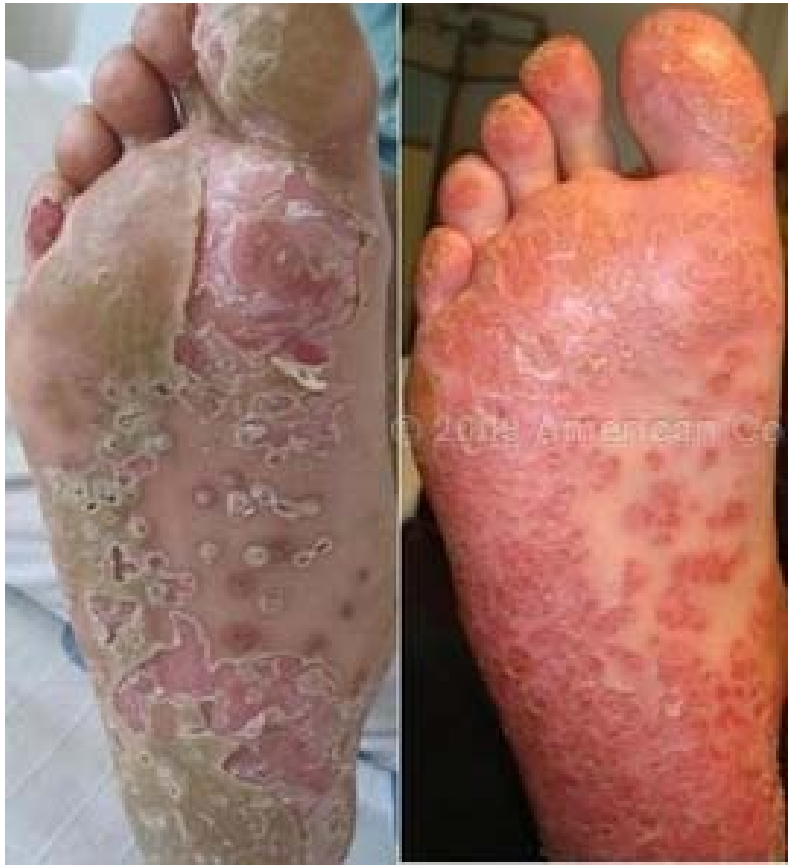

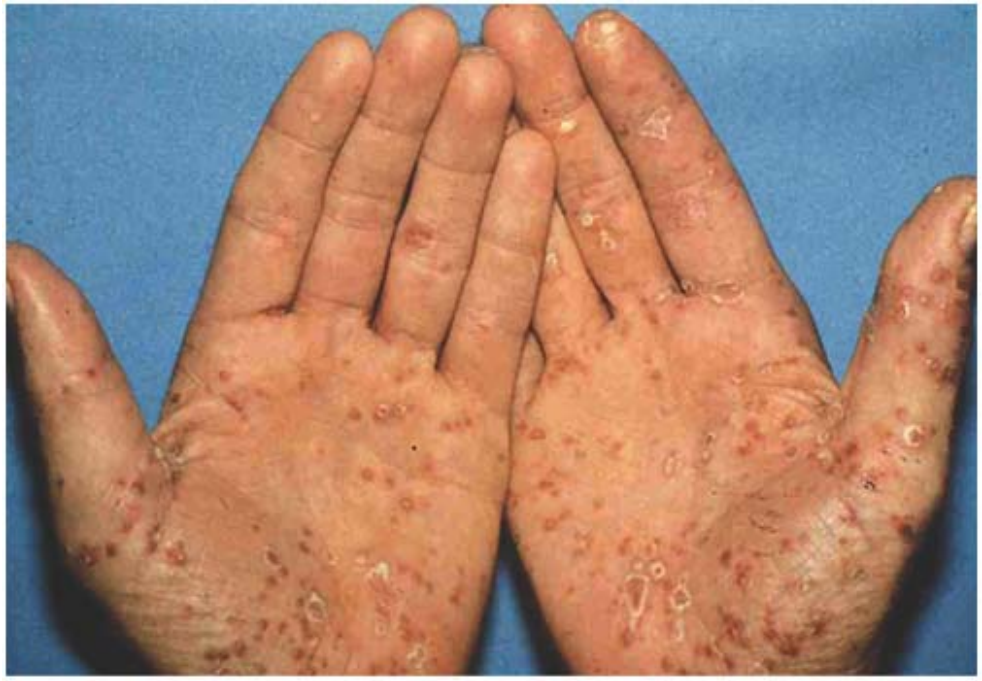

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Posner-Schlossman
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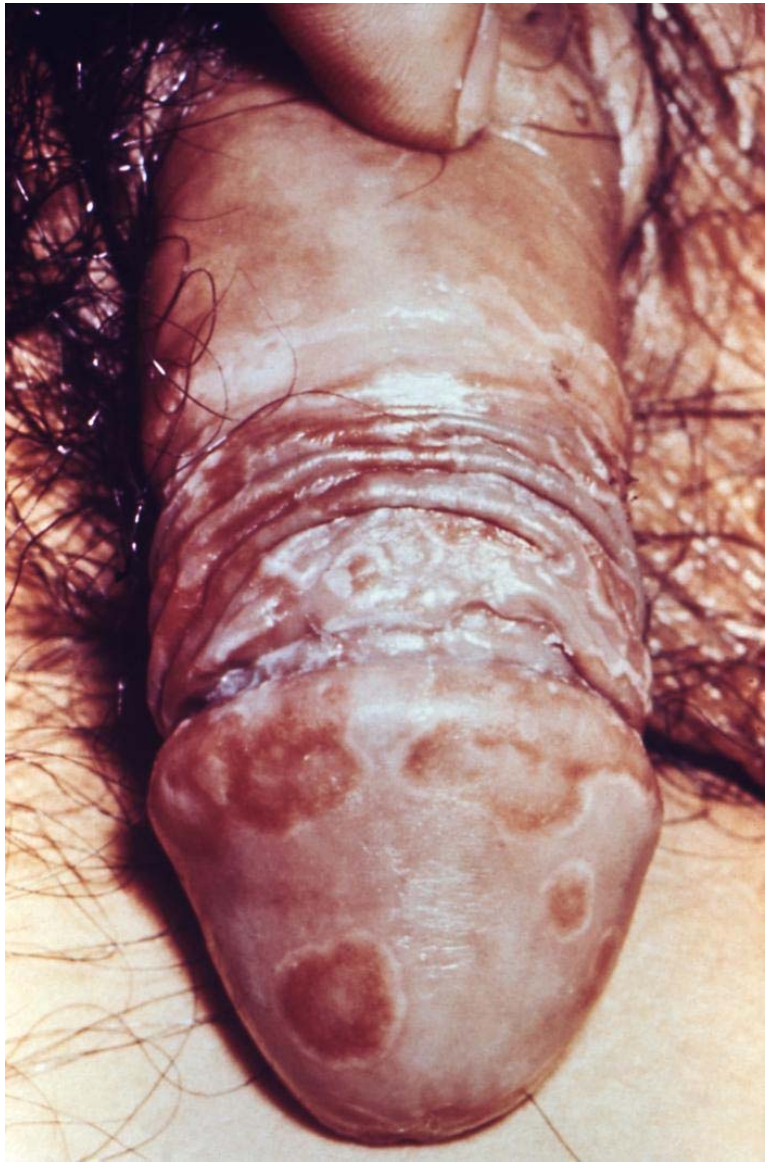

Reactive arthritis: Circinate balanitis

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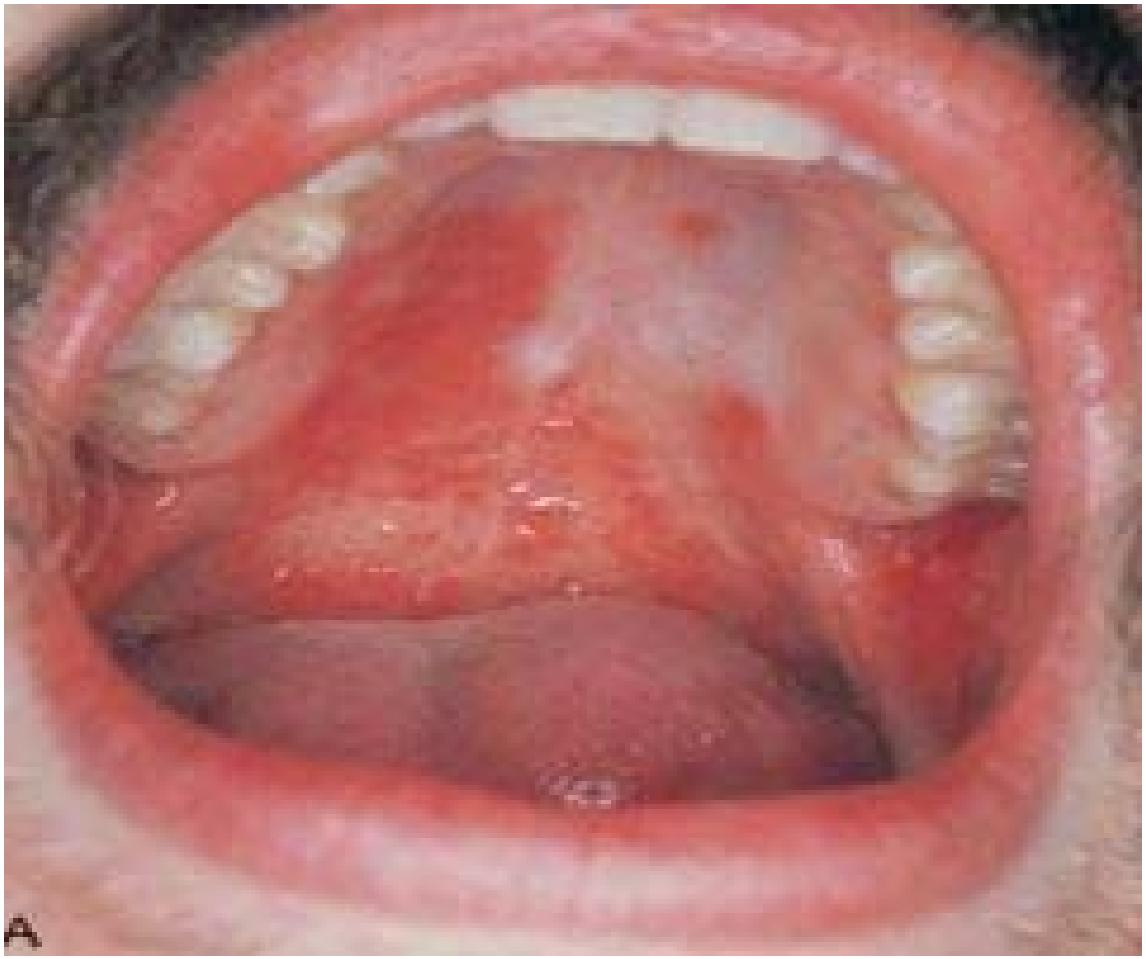

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Yersinia pestis, *the causative organism in plague?*

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No, *Yersinia enterocolitica*, the causative organism in a diarrheal condition called *yersiniosis*

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In the vast majority of cases, **within one month**

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ReA is a clinical diagnosis. An HLA-B27 would be reasonable, but positivity would not make the diagnosis.

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What is the other umbrella term for the HLA-B27 diseases?
The **SNSAs**

What are the four HLA-B27 conditions?
--Ankylosing spondylitis (AS)
--Reactive arthritis (ReA)
~~--Psoriatic arthritis (PA)~~
~~--Inflammatory bowel disease (IBD)~~

HLA-B27 dz (not IBD/PA)
Posner-Schlossman
Sarcoid

Who is the typical ReA pt?
A w

Wh
Th

Wh
A b

How is ReA uveitis managed?
In the typical manner (ie, with topical steroids and cycloplegia). PO NSAIDs may reduce the risk of recurrence, and will suppress the systemic manifestations.

Uveitis: ***Anterior***

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  - TB
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Is Rheumatology referral required?

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Should antibiotics be given to treat the triggering infection?
Probably only in the case of *Chlamydia*-induced disease

Is Rheumatology referral required?
Generally no. However, it is important to recognize that a subset of pts are at risk for debilitating sequelae similar to those of AS, and would benefit from Rheum input.

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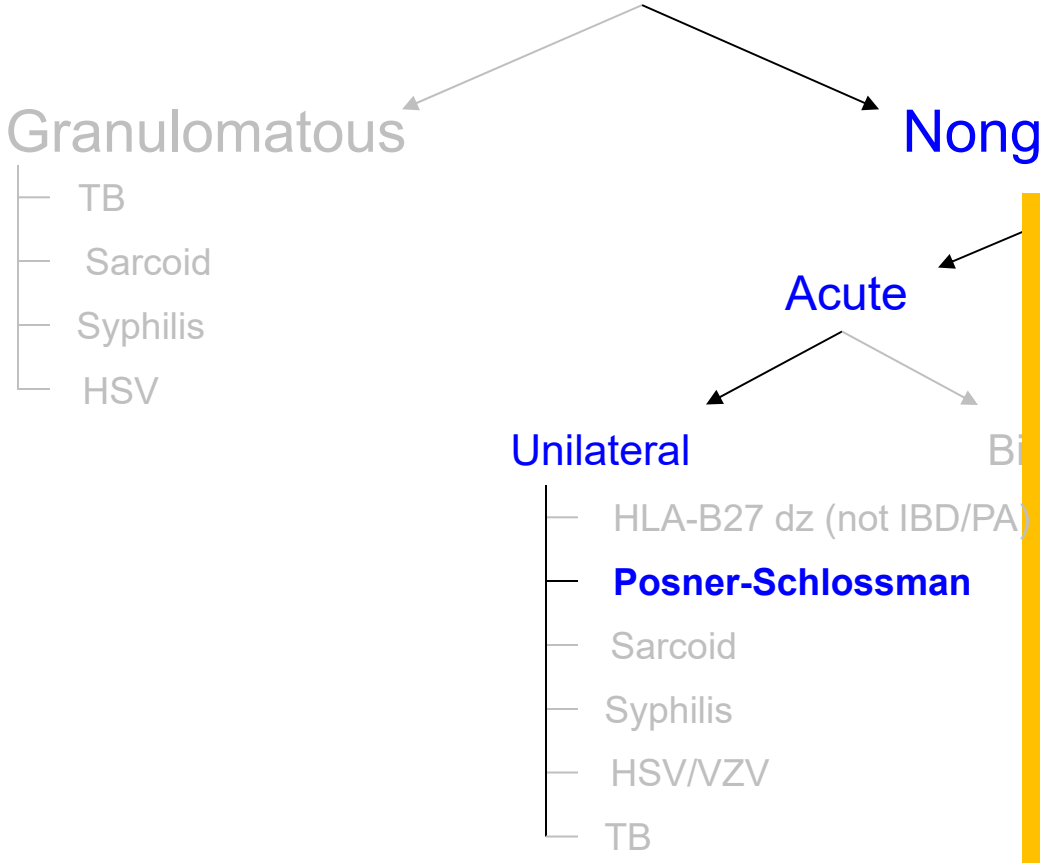

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Glaucomatocyclitic crisis

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Who is the typical pt?
An adult age 20-50

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Who is the typical pt?
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Does the inflammatory component tend to be mild, or severe?

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Glaucomatocyclitic crisis

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How severe?

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How severe?
IOP in the 40-60 range is typical

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Does the IOP elevation tend to be mild, or severe?
Severe

Is the angle open, or closed?

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How long do the crises last?

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How long do the crises last?
Hours to days

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How long do the crises last?
Hours to days

Do they recur?

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What are the presenting complaints in Posner-Schlossman?
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What are the presenting complaints in Posner-Schlossman?
--Unilateral discomfort
--Blurred vision
--Haloes around lights

-What is the noneponymous name for Posner-Schlossman?
Glaucomatocyclitic crisis

Who is the typical pt?
An adult age 20-50

Does the inflammatory component tend to be mild, or severe?
Mild

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Hours to days

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What is the cause of the blurred vision/haloes?

What are the presenting complaints in Posner-Schlossman?
--Unilateral discomfort
--Blurred vision
--Haloes around lights

-What is the noneponymous name for Posner-Schlossman?
Glaucomatocyclitic crisis

Who is the typical pt?
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What is the cause of the blurred vision/haloes?
Corneal edema secondary to the high IOP

What are the presenting complaints in Posner-Schlossman?
--Unilateral discomfort
--Blurred vision
--Haloes around lights

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Who is the typical pt?
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*Does the eye tend to be **red and angry**?*

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Glaucomatocyclitic crisis

Who is the typical pt?
An adult age 20-50

Does the inflammatory component tend to be mild, or severe?
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How long do the crises last?
Hours to days

Do they recur?
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*Does the eye tend to be **red and angry**?*
No, it is usually **white and quiet**

-What is the noneponymous name for Posner-Schlossman?
Glaucomatocyclitic crisis

Who is the typical pt?
An adult age 20-50

Does the inflammatory component tend to be mild, or severe?
Mild

Does the IOP elevation tend to be mild, or severe?
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What is the etiology of Posner-Schlossman?

Yes

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Is the angle open, or closed?
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How long do the crises last?
Hours to days

What is the etiology of Posner-Schlossman?
Uncertain; however, there is some evidence it is secondary to infection with [virus (abb.)]
Yes

Uveitis: ***Anterior***

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    - Unilateral
      - HLA-B27 dz (not IBD/PA)
      - **Posner-Schlossman**
      - Sarcoid
      - Syphilis
      - HSV/VZV
    - Bi

-What is the noneponymous name for Posner-Schlossman?
Glaucomatocyclitic crisis

Who is the typical pt?
An adult age 20-50

Does the inflammatory component tend to be mild, or severe?
Mild

Does the IOP elevation tend to be mild, or severe?
Severe

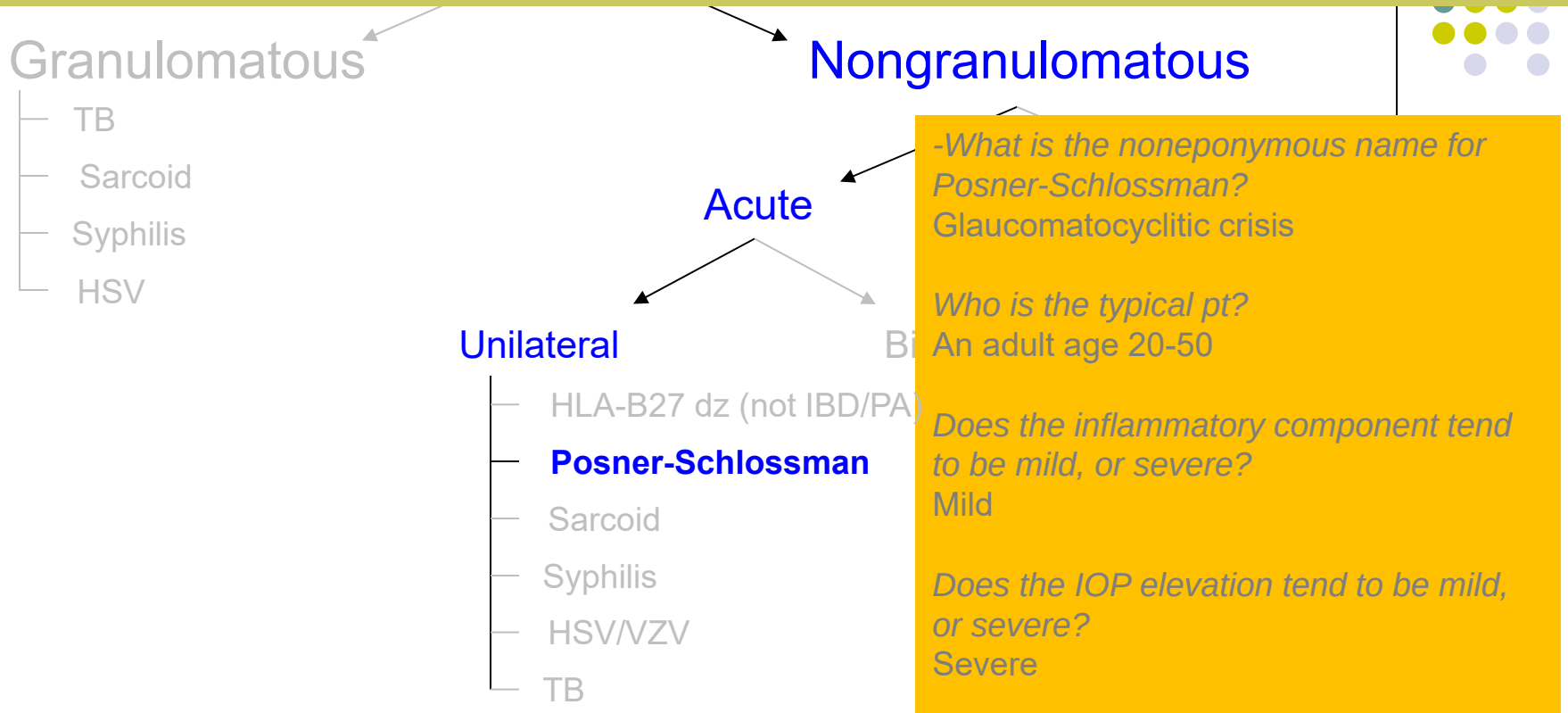
Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

What is the etiology of Posner-Schlossman?
Uncertain; however, there is some evidence it is secondary to infection with **CMV**

Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?



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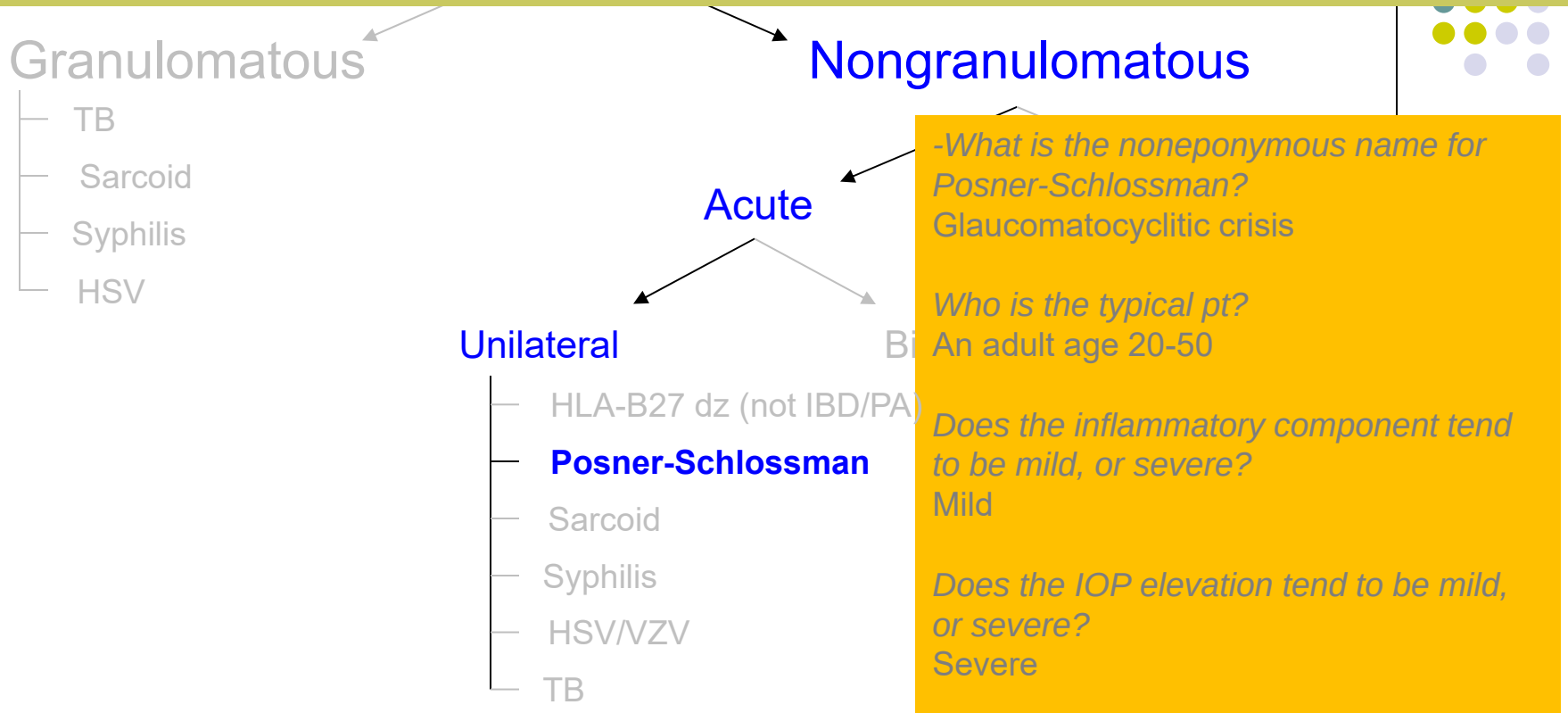
Does the IOP elevation tend to be mild, or severe?
Severe

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome



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An adult age 20-50

Does the inflammatory component tend to be mild, or severe?
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Does the IOP elevation tend to be mild, or severe?
Severe

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Gender predilection		

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Gender predilection	None	Male

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Gender predilection	None	Male
Refractive status		

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Gender predilection	None	Male
Refractive status	No tendency	Myopic

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Gender predilection	None	Male
Refractive status	No tendency	**Myopic**

Do they tend to be low myopes, or high myopes?

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Gender predilection	None	Male
Refractive status	No tendency	**Myopic**

Do they tend to be low myopes, or high myopes?
High myopes

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Gender predilection	None	Male
Refractive status	No tendency	Myopic
Precipitating factors		

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Gender predilection	None	Male
Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Gender predilection	None	Male
Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event
Endothelial findings		

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Gender predilection	None	Male
Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	Krukenberg spindle

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

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Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	**Krukenberg spindle**

What is a Krukenberg spindle?

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

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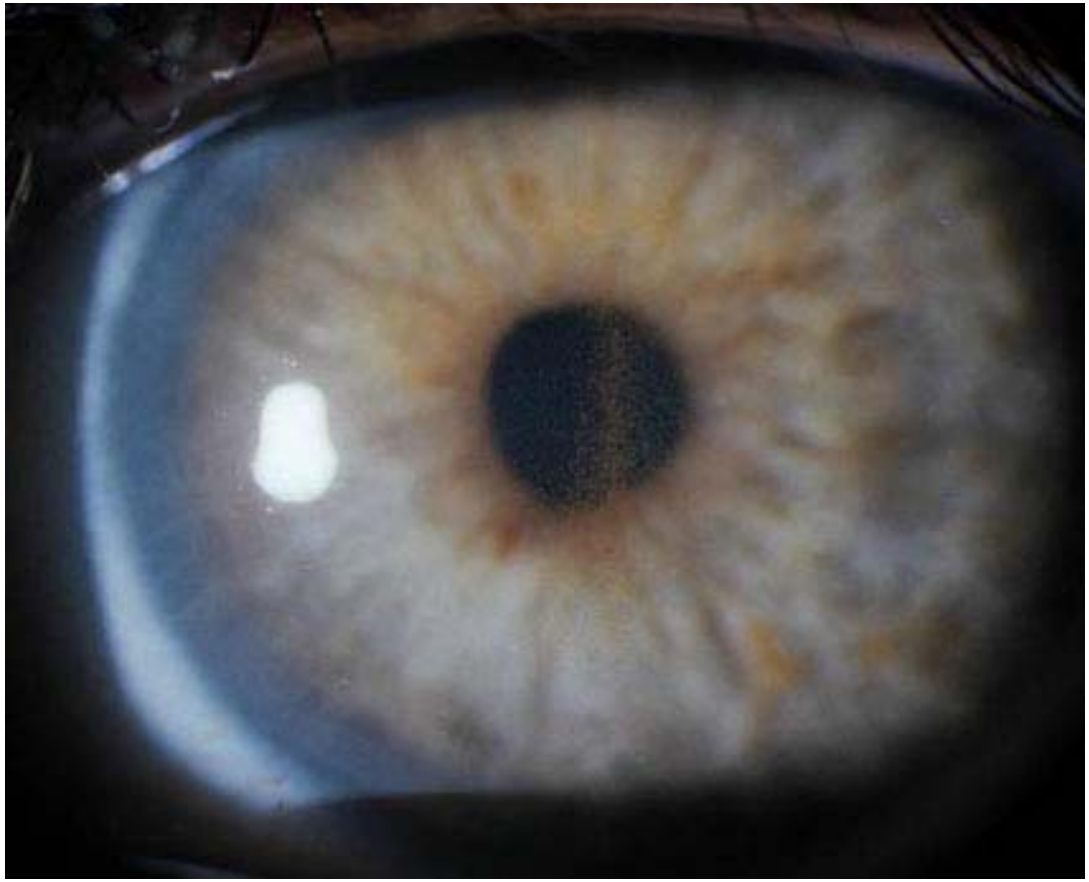
Gender predilection	None	Male
Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	**Krukenberg spindle**

What is a Krukenberg spindle?
A vertical distribution of pigment on the endothelial surface of the cornea.

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes



PDS: Krukenberg spindle

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Gender predilection	None	Male
Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	**Krukenberg spindle**

What is a Krukenberg spindle?
A vertical distribution of pigment on the endothelial surface of the cornea.

What is the source of this pigment?

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
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Gender predilection	None	Male
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Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	**Krukenberg spindle**

What is a Krukenberg spindle?
A vertical distribution of pigment on the endothelial surface of the cornea.

What is the source of this pigment?
It is liberated from the posterior aspect of the iris by the rubbing of the zonules.

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
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Endothelial findings	KP	**Krukenberg spindle**

What is a Krukenberg spindle?
A vertical distribution of pigment on the endothelial surface of the cornea.

What is the source of this pigment?
It is liberated from the posterior aspect of the iris by the rubbing of the zonules.

What factors account for the location and shape of the K spindle?

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
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What is a Krukenberg spindle?
A vertical distribution of pigment on the endothelial surface of the cornea.

What is the source of this pigment?
It is liberated from the posterior aspect of the iris by the rubbing of the zonules.

What factors account for the location and shape of the K spindle?
Convection currents within the anterior chamber funnel pigment into this area

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

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Gender predilection	None	Male
Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	Krukenberg spindle
AC findings		

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

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Gender predilection	None	Male
Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	Krukenberg spindle
AC findings	Cell	Pigment

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

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AC findings	Cell	Pigment
Gonioscopic findings		

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Hours to days

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Endothelial findings	KP	Krukenberg spindle
AC findings	Cell	Pigment
Gonioscopic findings	May have 'KP'	Heavy TM pigment; +/- Sampaolesi line

Is the angle open, or closed?
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How long do the crises last?
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Do they recur?
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Endothelial findings	KP	Krukenberg spindle
AC findings	Cell	Pigment
Gonioscopic findings	May have 'KP'	Heavy TM pigment; +/- **Sampaolesi line**

What is a Sampaolesi line*?*

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

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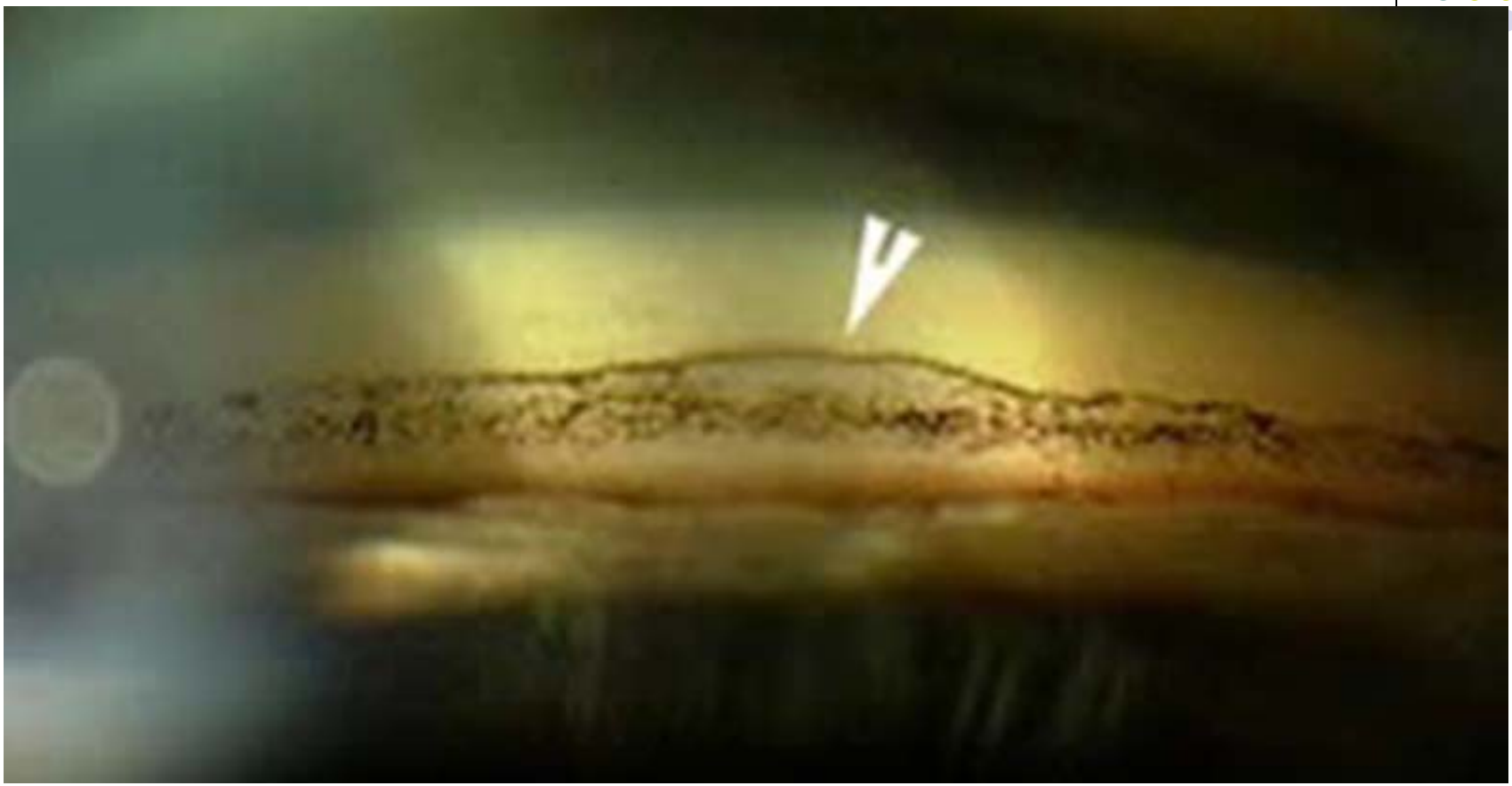
Endothelial findings	KP	Krukenberg spindle
AC findings	Cell	Pigment
Gonioscopic findings	May have 'KP'	Heavy TM pigment; +/- **Sampaolesi line**

What is a Sampaolesi line*?*
A scalloped line of pigment present anterior (ie, 'above' on gonioscopy) to Schwalbe's line in the angle

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes



PDS: Sampaolesi line

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Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	Krukenberg spindle
AC findings	Cell	Pigment
Gonioscopic findings	May have 'KP'	Heavy TM pigment; +/- Sampaolesi line
Iris findings		

Is the angle open, or closed?
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How long do the crises last?
Hours to days

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Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	Krukenberg spindle
AC findings	Cell	Pigment
Gonioscopic findings	May have 'KP'	Heavy TM pigment; +/- Sampaolesi line
Iris findings	None	Radial TID; concave bowing

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
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Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	Krukenberg spindle
AC findings	Cell	Pigment
Gonioscopic findings		
Iris findings	None	**Radial TID**; concave bowing

What mechanism is responsible for the radial iris TID in PDS?

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
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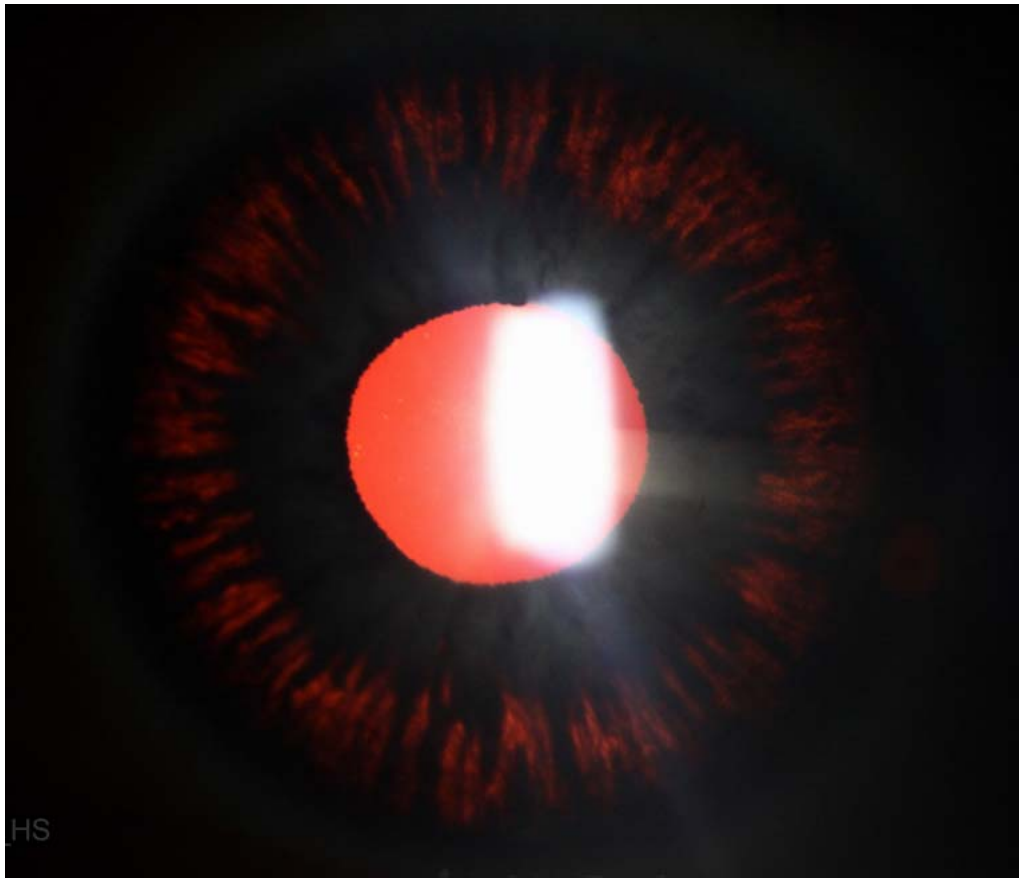
Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	Krukenberg spindle
AC findings	Cell	Pigment
Gonioscopic findings		
Iris findings	None	**Radial TID**; concave bowing

What mechanism is responsible for the radial iris TID in PDS?
Mechanical rubbing of zonules against the posterior aspect of the iris (note how this is facilitated by the posterior bowing of the iris)

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes



PDS: Radial TID

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	Posner-Schlossman	Pigment Dispersion
Gender predilection	None	Male
Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	Krukenberg spindle
AC findings	Cell	Pigment
Gonioscopic findings	May have 'KP'	Heavy TM pigment; +/- Sampaolesi line
Iris findings	None	Radial TID; concave bowing
Lens findings		

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
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Refractive status	No tendency	Myopic
Precipitating factors	None	Exercise; emotional event
Endothelial findings	KP	Krukenberg spindle
AC findings	Cell	Pigment
Gonioscopic findings	May have 'KP'	Heavy TM pigment; +/- Sampaolesi line
Iris findings	None	Radial TID; concave bowing
Lens findings	None	Scheie stripe

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
G		
Pr		nt
Er		
Go		
		ing
Lens findings	None	**Scheie stripe**

What is a Scheie stripe?

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

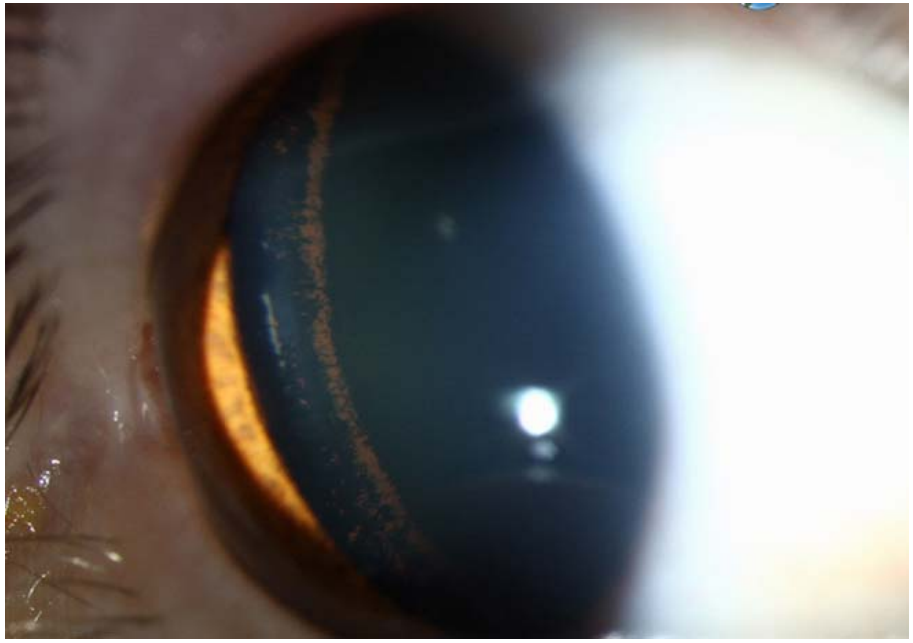
Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
G		
Pr		nt
Er		
Go		
		ing
Lens findings	None	**Scheie stripe**

What is a Scheie stripe?
A linear accumulation of pigment on the lens capsule

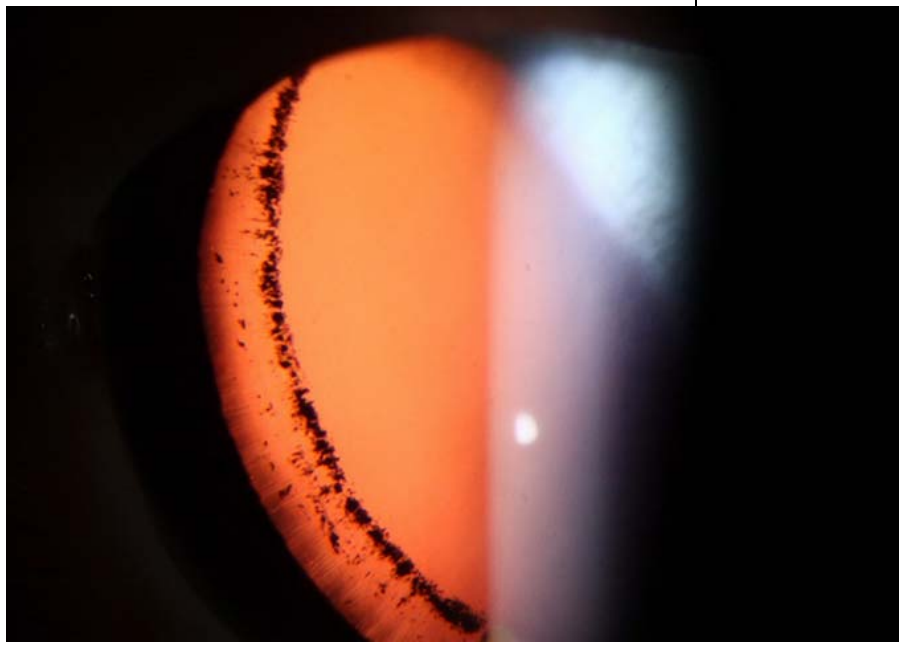
Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes



Direct illumination



Retroillumination

PDS: Scheie stripe

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
G		
Pr		nt
Er		
Go		
		ing
Lens findings	None	**Scheie stripe**

What is a Scheie stripe?
A linear accumulation of pigment on the lens capsule

Where on the capsule is a Scheie stripe found?

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	Posner-Schlossman	Pigment Dispersion
Lens findings	None	**Scheie stripe**

What is a Scheie stripe?
A linear accumulation of pigment on the lens capsule

Where on the capsule is a Scheie stripe found?
On the posterior capsule, where the zonular fibers attach

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	Posner-Schlossman	Pigment Dispersion
G		
I		
Pr		nt
Er		
Go		
		ing
Lens findings	None	**Scheie stripe**

What is a Scheie stripe?
A linear accumulation of pigment on the lens capsule

Where on the capsule is a Scheie stripe found?
On the posterior capsule, where the zonular fibers attach

Is this finding pathognomonic for PDS?

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Lens findings	None	**Scheie stripe**

What is a Scheie stripe?
A linear accumulation of pigment on the lens capsule

Where on the capsule is a Scheie stripe found?
On the posterior capsule, where the zonular fibers attach

Is this finding pathognomonic for PDS?
Yes

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
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Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Lens findings	None	**Scheie stripe**

What is a Scheie stripe?
A linear accumulation of pigment on the lens capsule

Where on the capsule is a Scheie stripe found?
On the posterior capsule, where the zonular fibers attach

Is this finding pathognomonic for PDS?
Yes

What is the other, less-well-known eponymous name for this finding (worth mentioning mainly because the BCSC Glaucoma *book uses it instead of the more common* Scheie's stripe*)?*

Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

The scenario of a young adult with episodic unilateral pain, blurred vision and haloes, and significantly elevated IOP should bring to mind another condition--what is it?
Pigment dispersion syndrome. So let's compare/contrast them:

Characteristics	**Posner-Schlossman**	**Pigment Dispersion**
Lens findings	None	**Scheie stripe**

What is a Scheie stripe?
A linear accumulation of pigment on the lens capsule

Where on the capsule is a Scheie stripe found?
On the posterior capsule, where the zonular fibers attach

Is this finding pathognomonic for PDS?
Yes

What is the other, less-well-known eponymous name for this finding (worth mentioning mainly because the BCSC Glaucoma *book uses it instead of the more common* Scheie's stripe*)?*
Zentmayer line

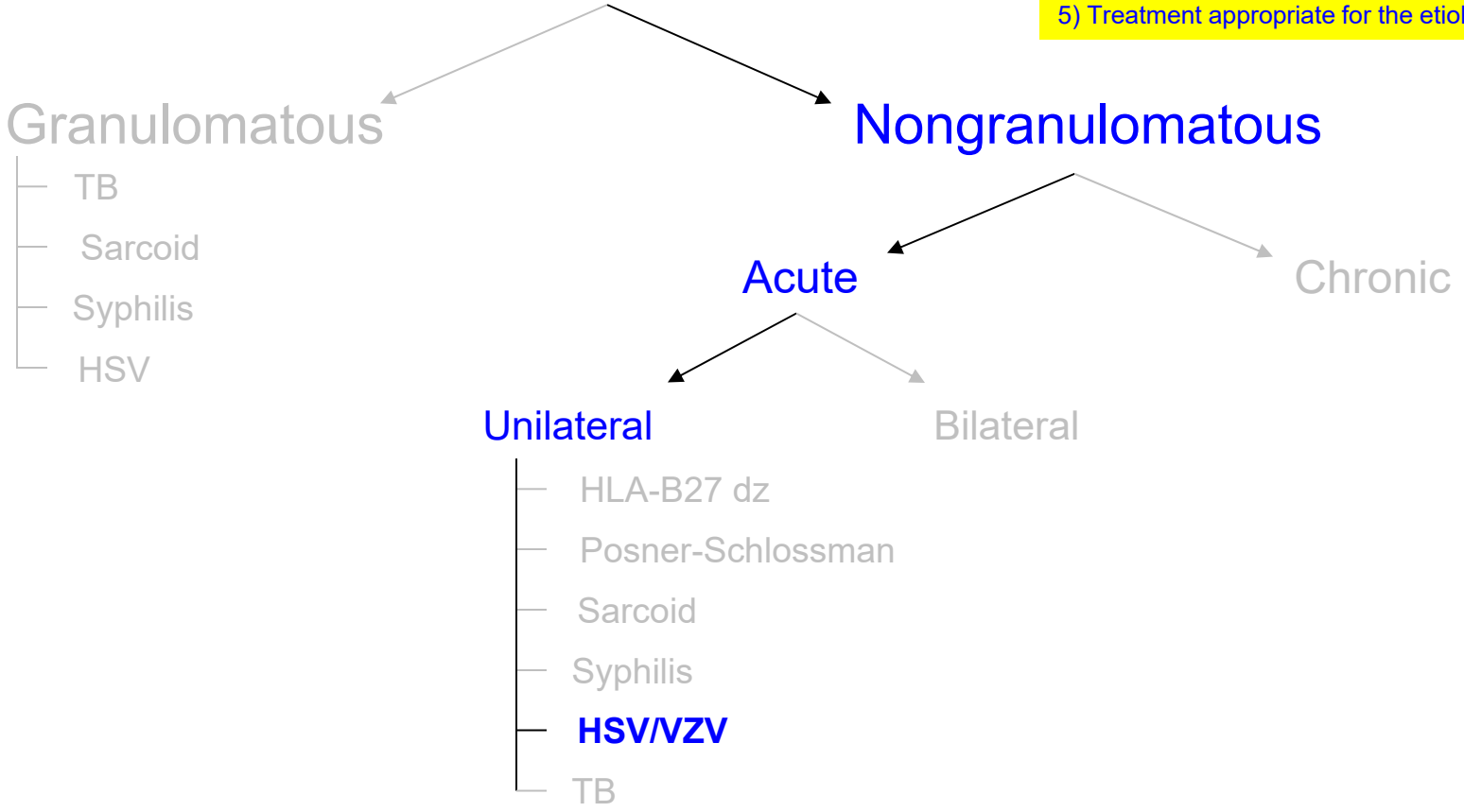
Is the angle open, or closed?
Open

How long do the crises last?
Hours to days

Do they recur?
Yes

Uveitis: ***Anterior***

1) The uveitis is profiled
2) The profiled case is meshed
3) A differential diagnosis list is generated
4) Studies are obtained to identify the etiology
5) Treatment appropriate for the etiology is initiated



Four aspects of the presentation provide clues that a uveitis is HSV/VZV. What are they?

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Uveitis: ***Anterior***

1) The uveitis is profiled
2) The profiled case is meshed
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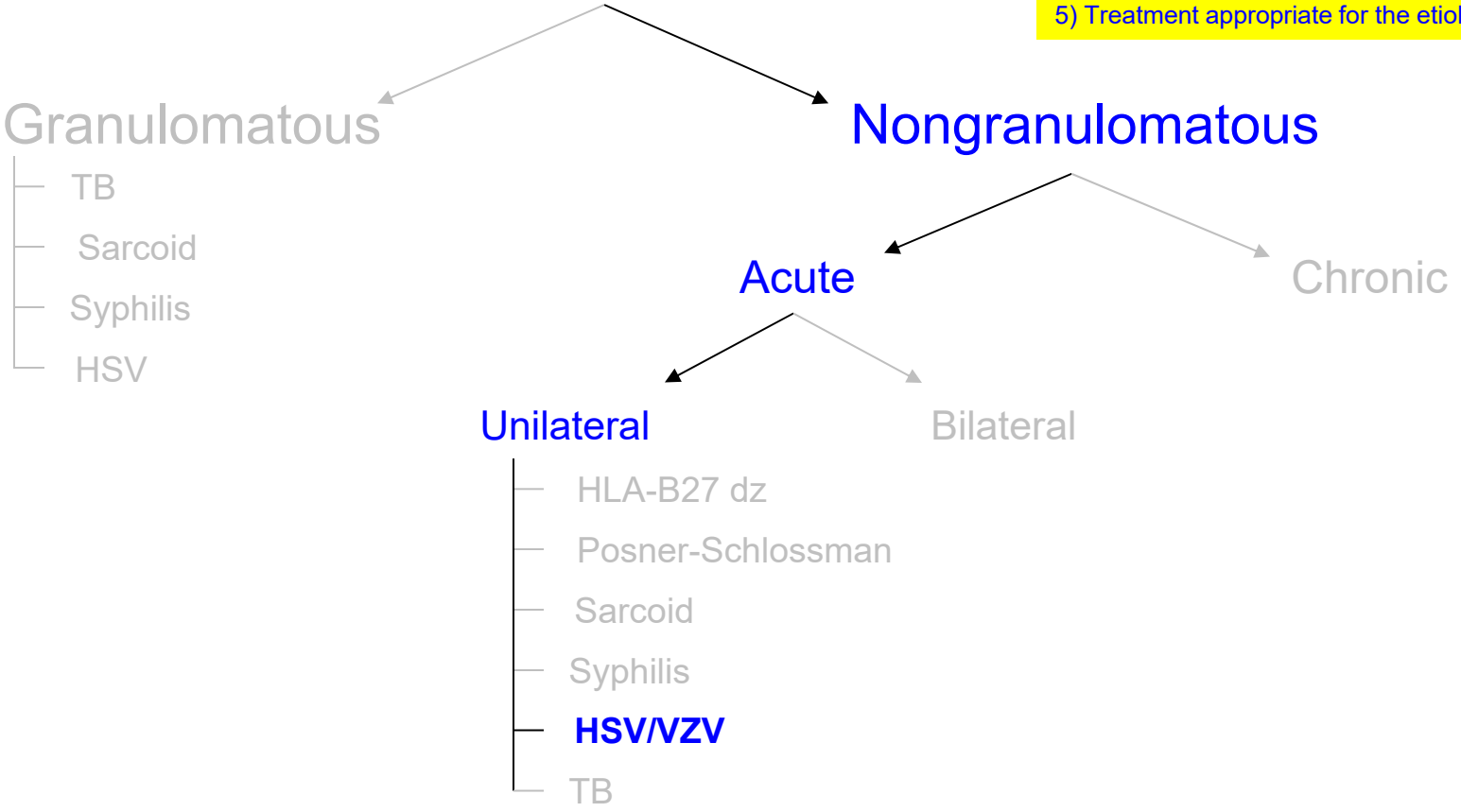

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--A hx of [two words] (HSV), or [three words] (VZV)
--
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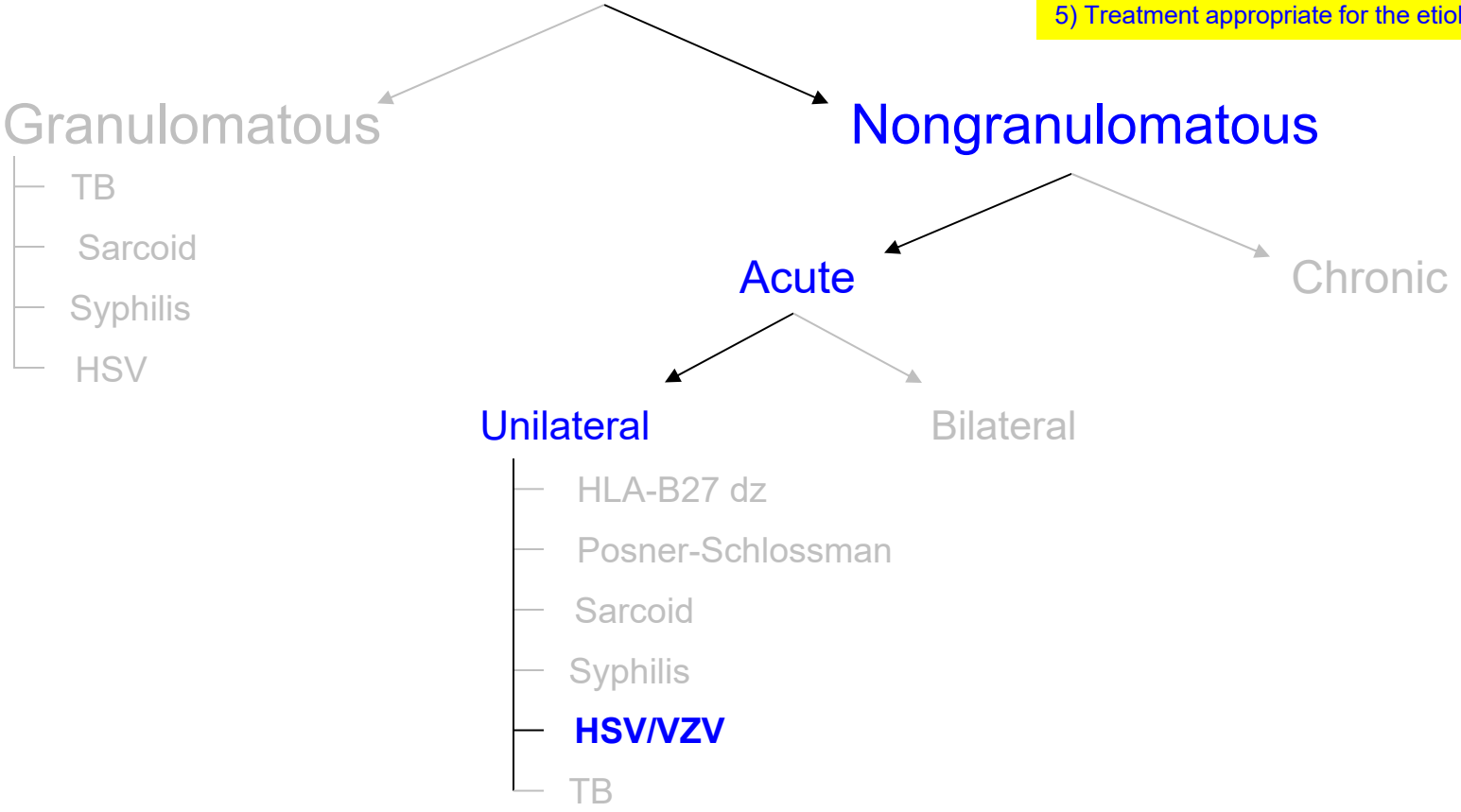

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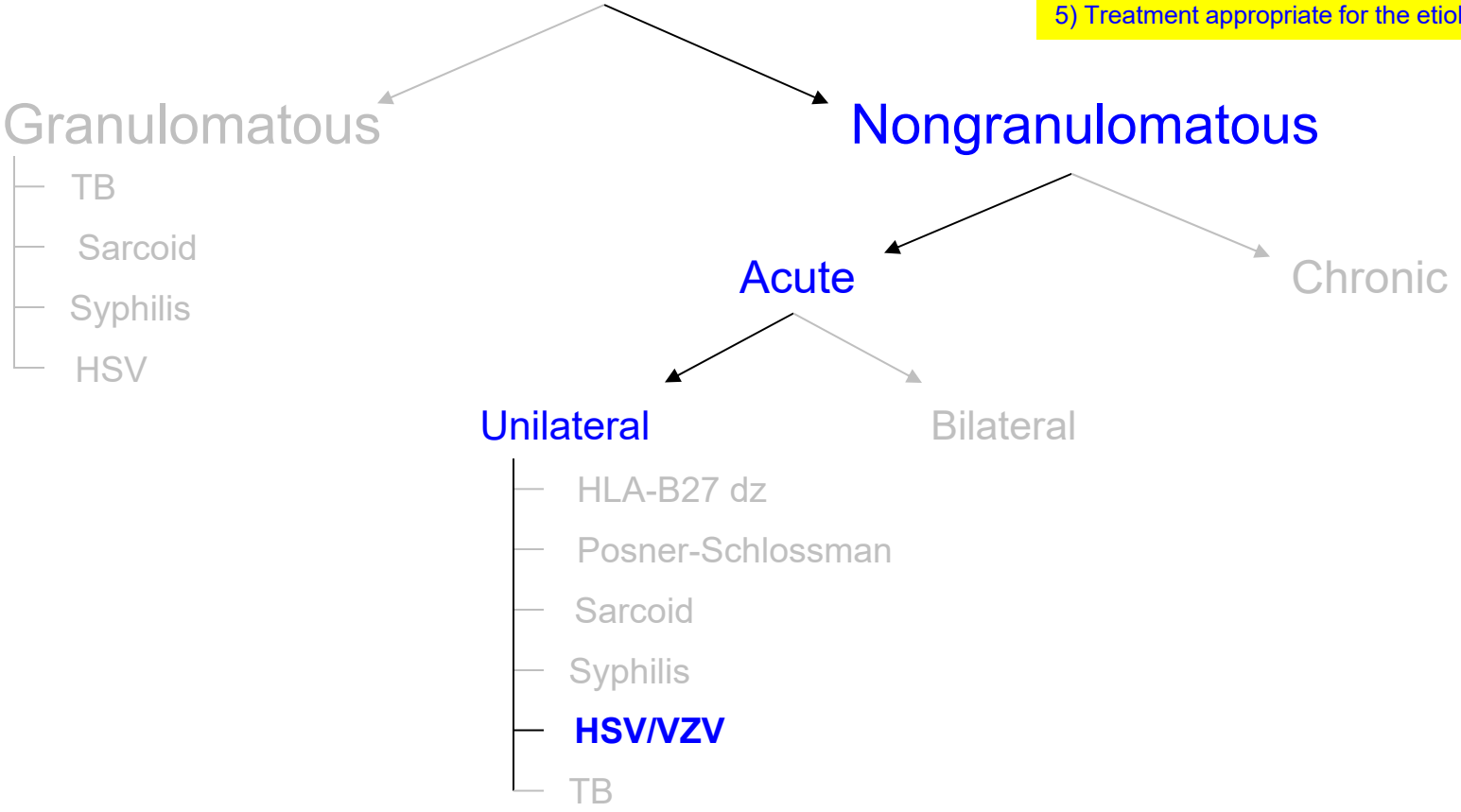

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--The nature of the exam finding (abb.)
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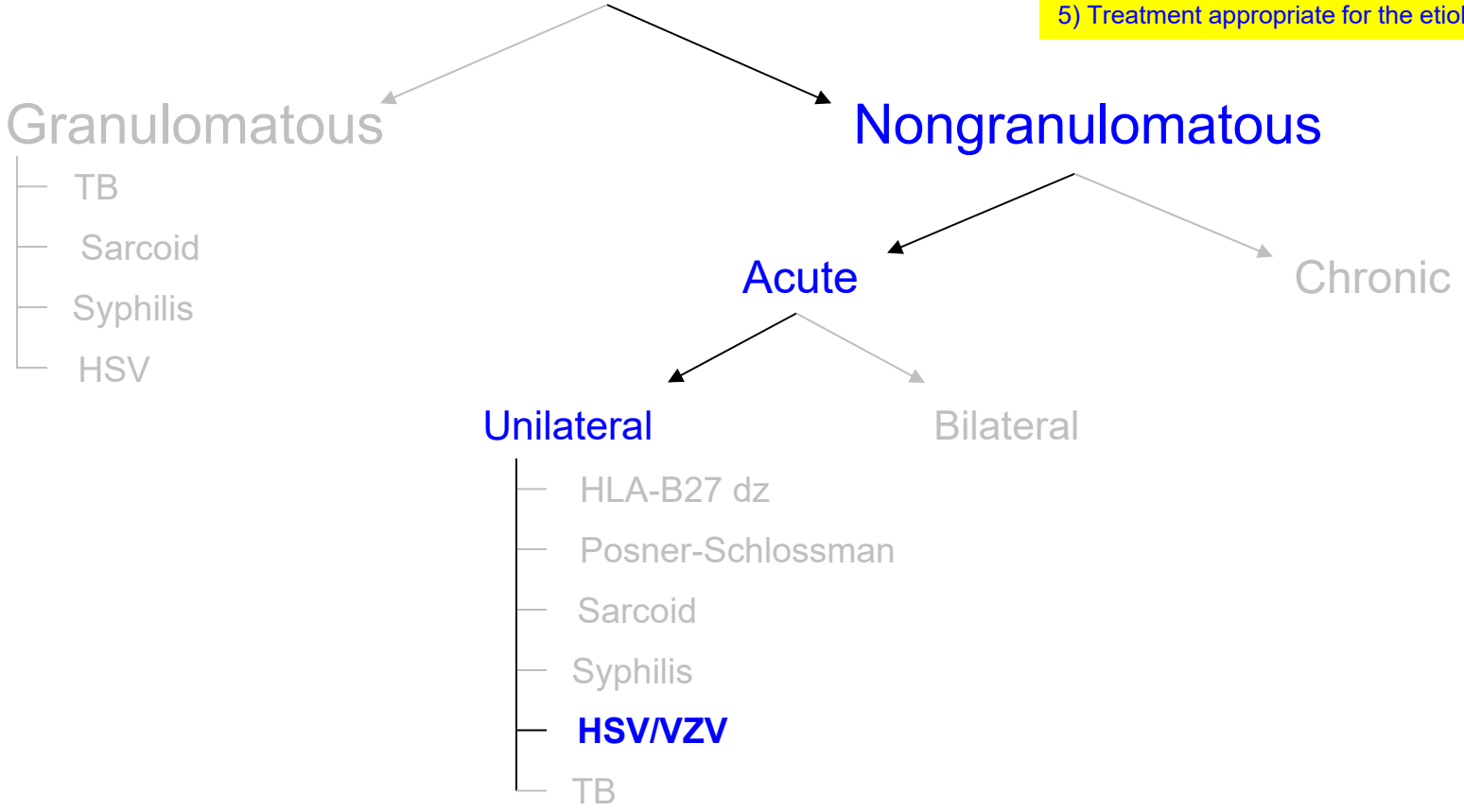

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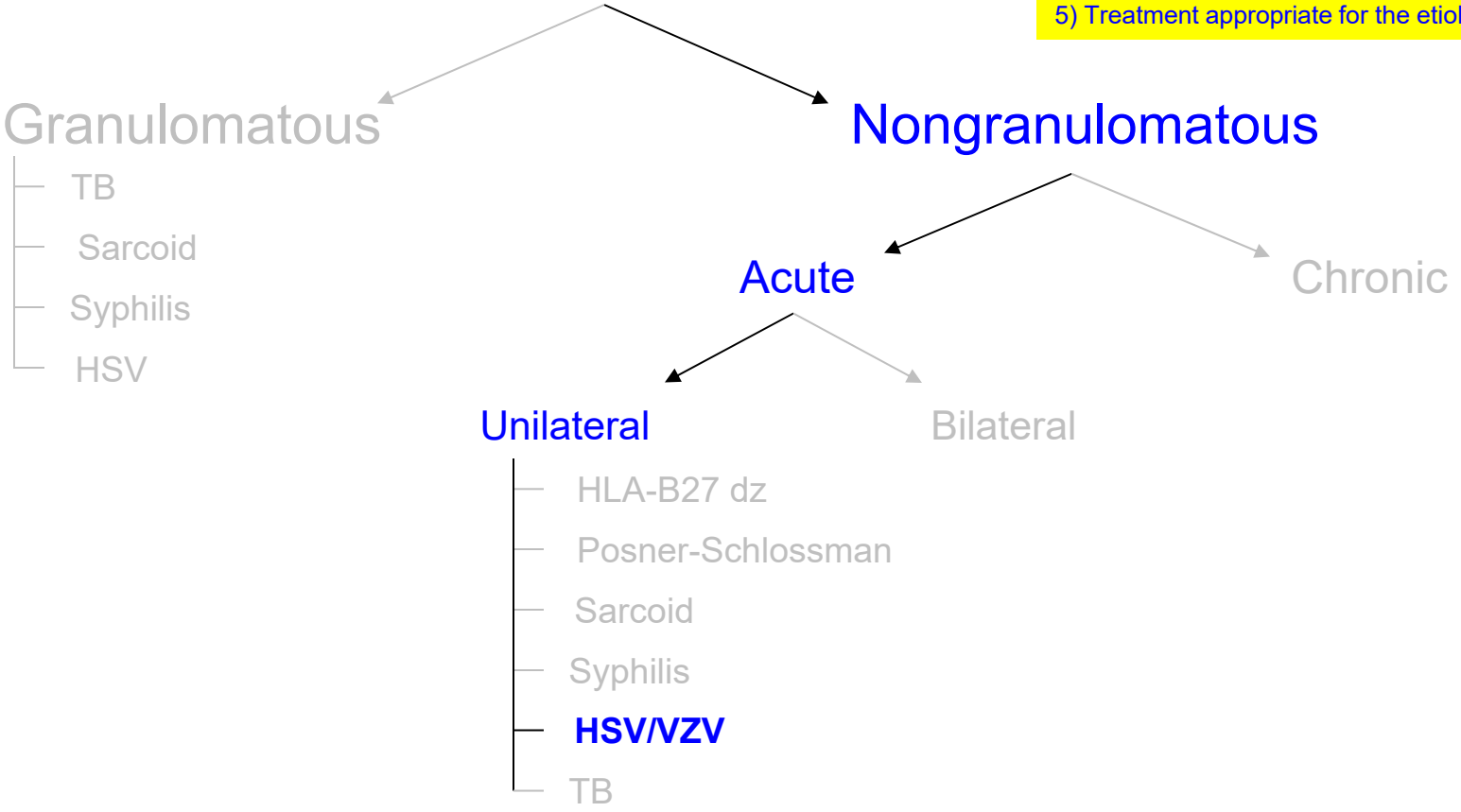

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--Significantly elevated vs depressed IOP
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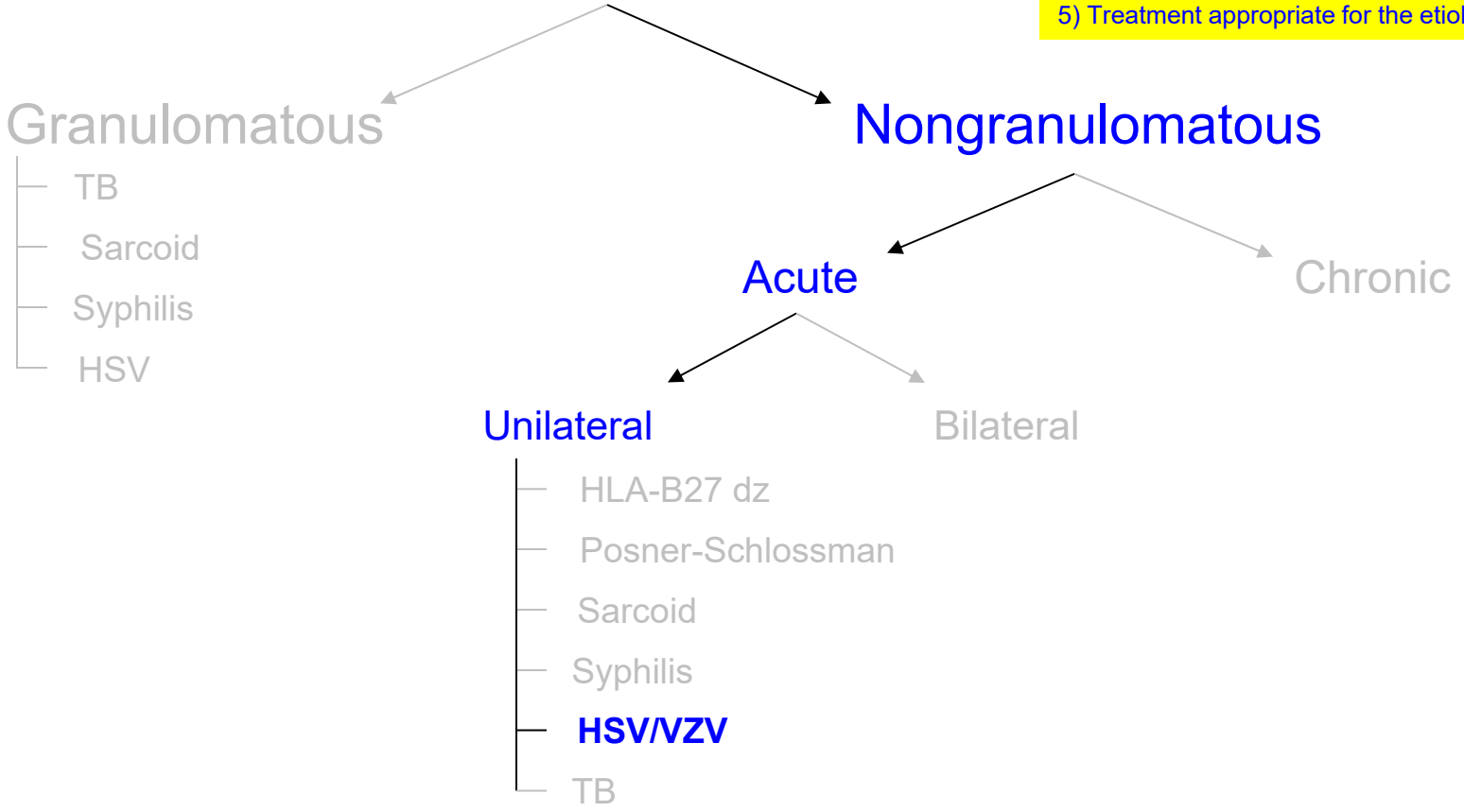

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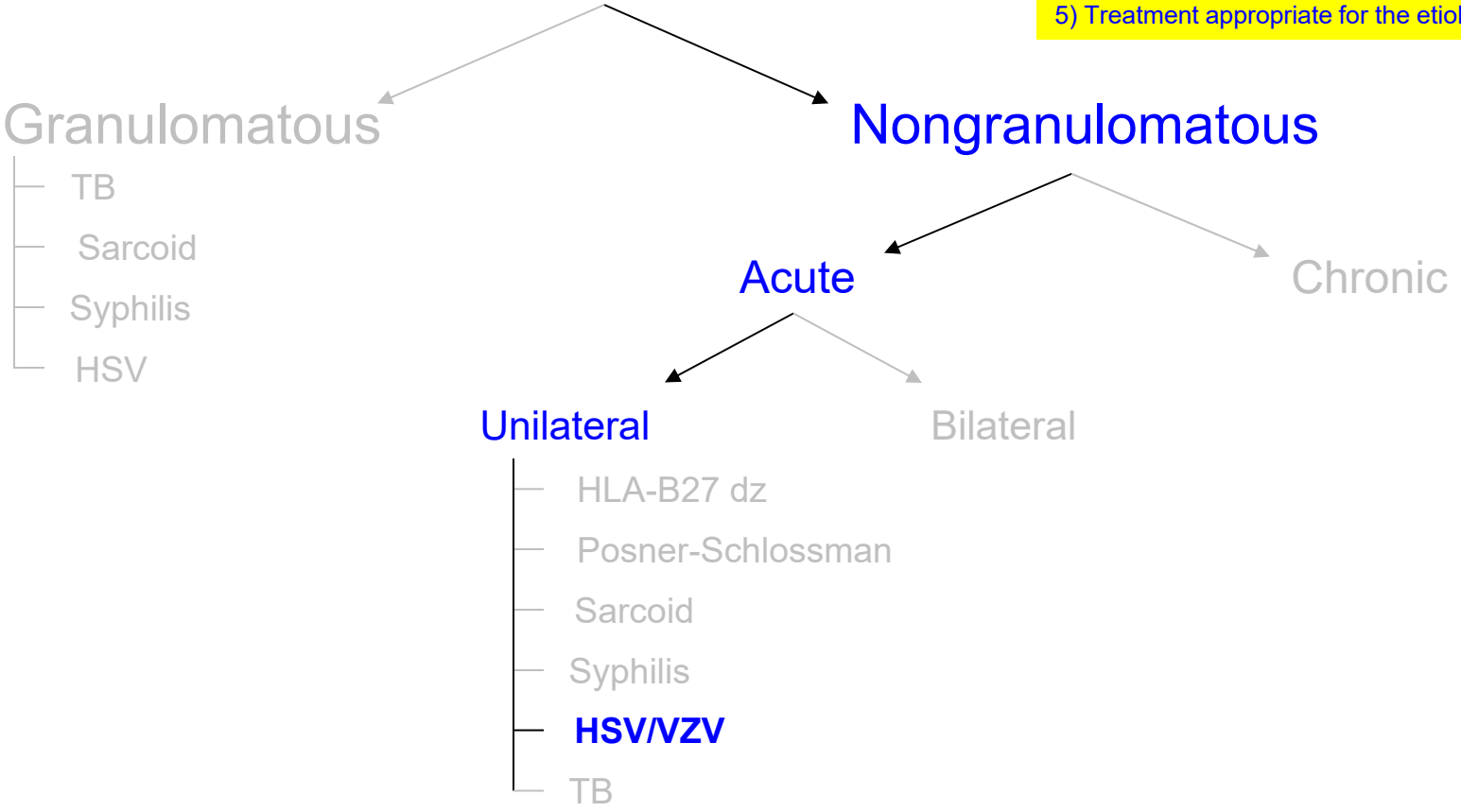

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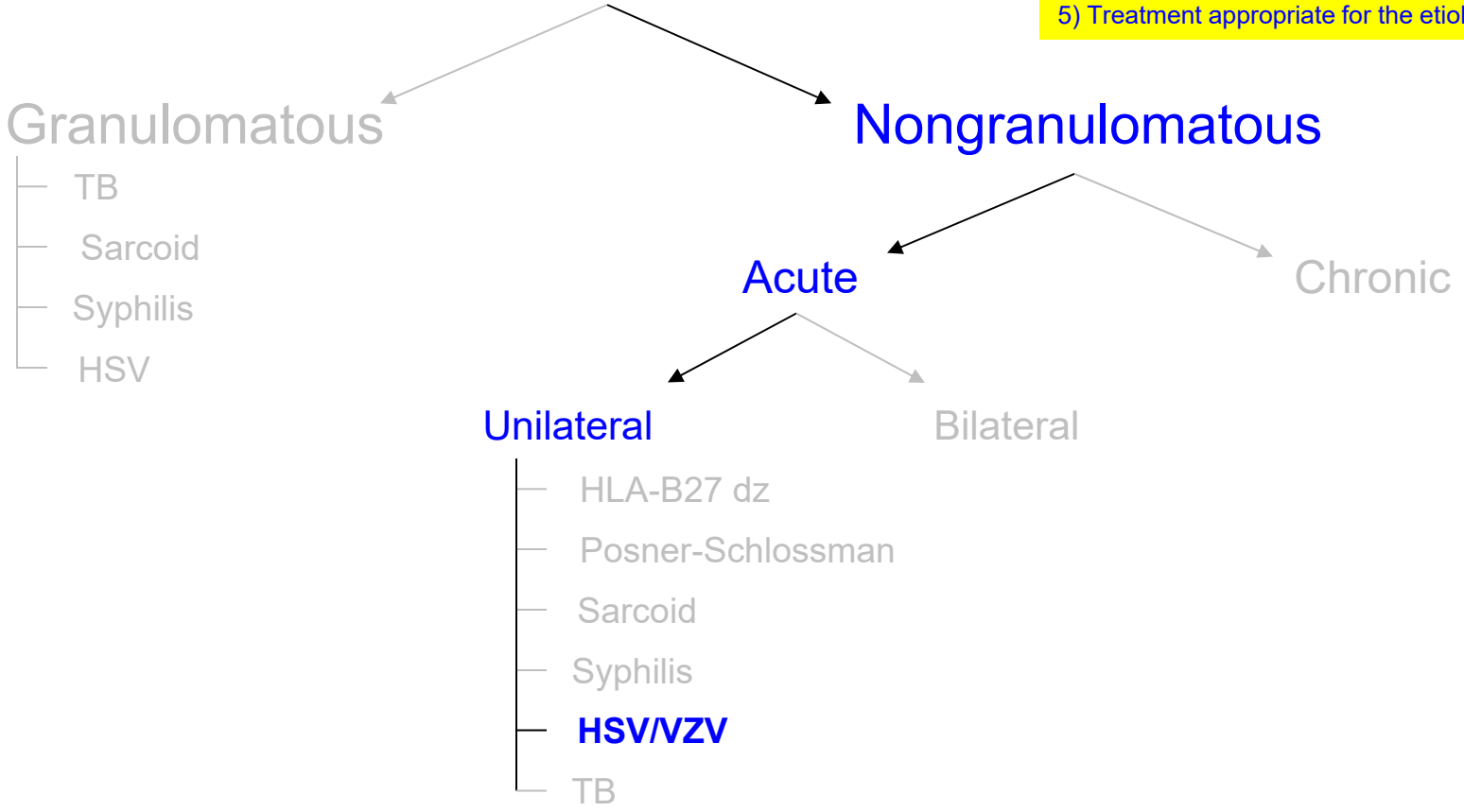

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--The presence of iris atrophy

1) The uveitis is profiled

gy
nitiated

Once acquired, VZV takes up residency in nerve-cell bodies. What sort of nerve does it 'prefer'?

- Syphilis
- **HSV/VZV**
- TB

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The **nasociliary**, **frontal** and **lacrimal** nerves

Ophthalmic division branches: ***NFL***:
***N**asociliary*
***F**rontal*
***L**acrimal*

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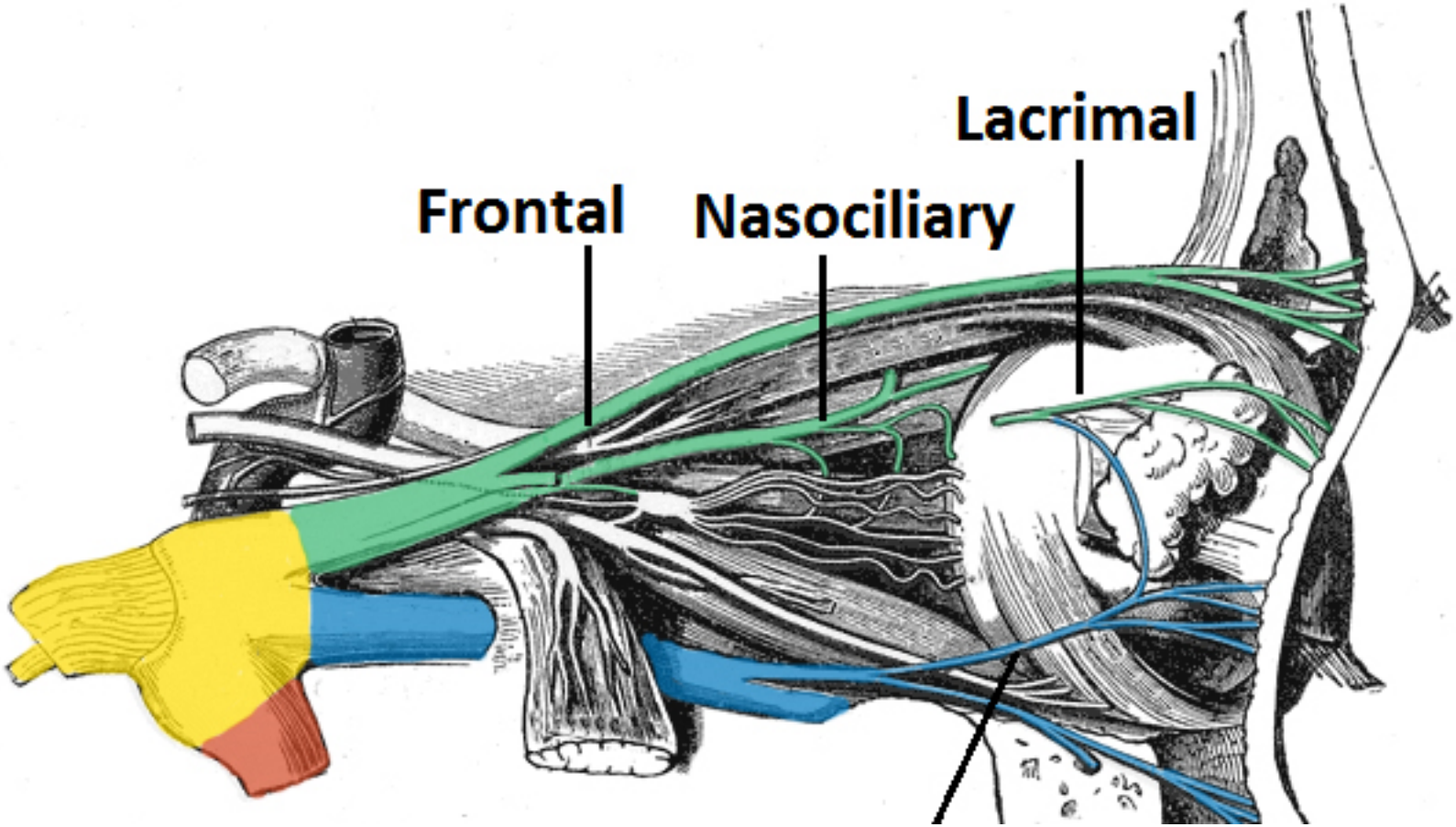

Ophthalmic nerve (V_1) and its three branches

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The long v short ciliary nerve

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The fact that there is a **long** *ciliary nerve implies that there is/are* **short** *ciliary nerves. What do the short ciliary nerves carry?*

Syphilis

HSV/VZV

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Portions of the sinuses; the nasal cavity; the conj; part of the upper lid; and the skin of the nose

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In this context, what is Hutchinson's sign?

clues that a uveitis is HSV/VZV. What are they?
or **vesicular skin eruption (VZV)**

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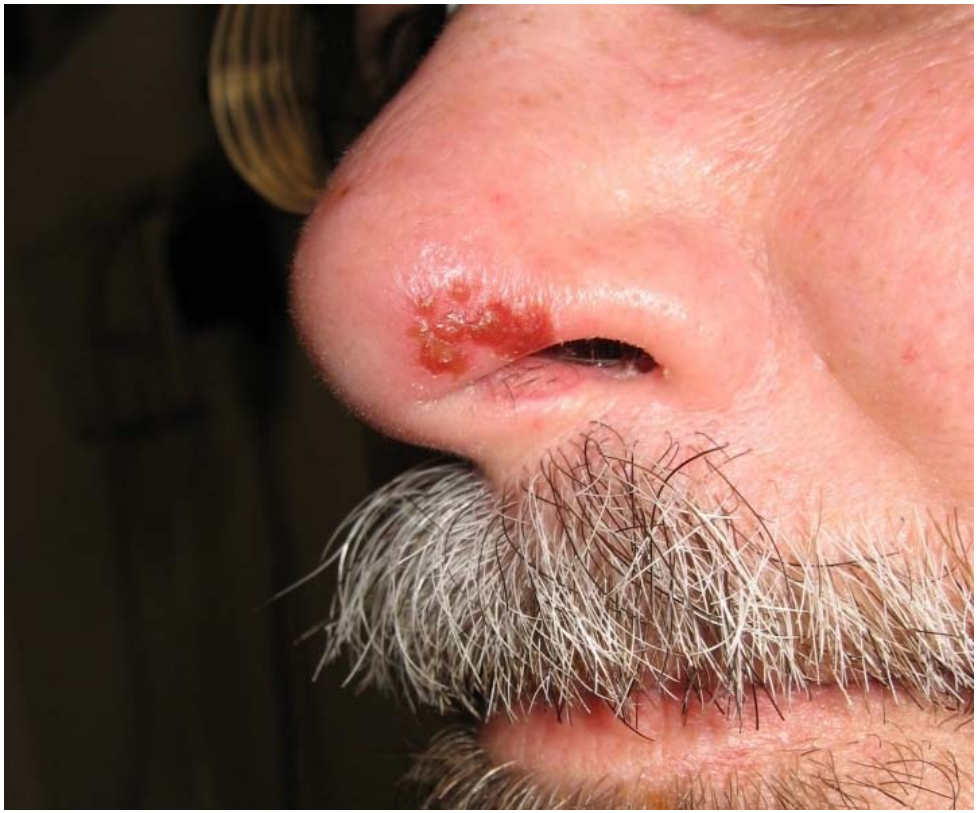

Hutchinson's sign

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In this context, what is Hutchinson's sign?
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What is the significance of Hutchinson's sign with regard to anterior uveitis?

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- Syphilis
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In this context, what is Hutchinson's sign?
A vesicular lesion located at the lateral aspect of the tip of the nose

What is the significance of Hutchinson's sign with regard to anterior uveitis?
It indicates the 'naso-' portion of the nasociliary nerve is involved in a VZV eruption, which raises the strong possibility the '-ciliary' portion (and therefore the eye) is as well

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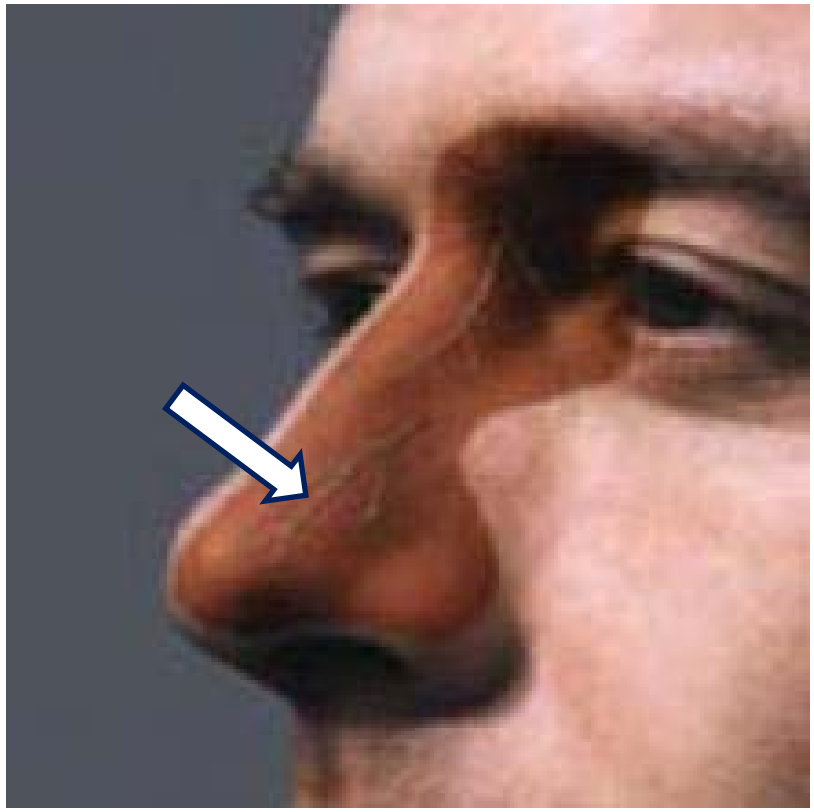
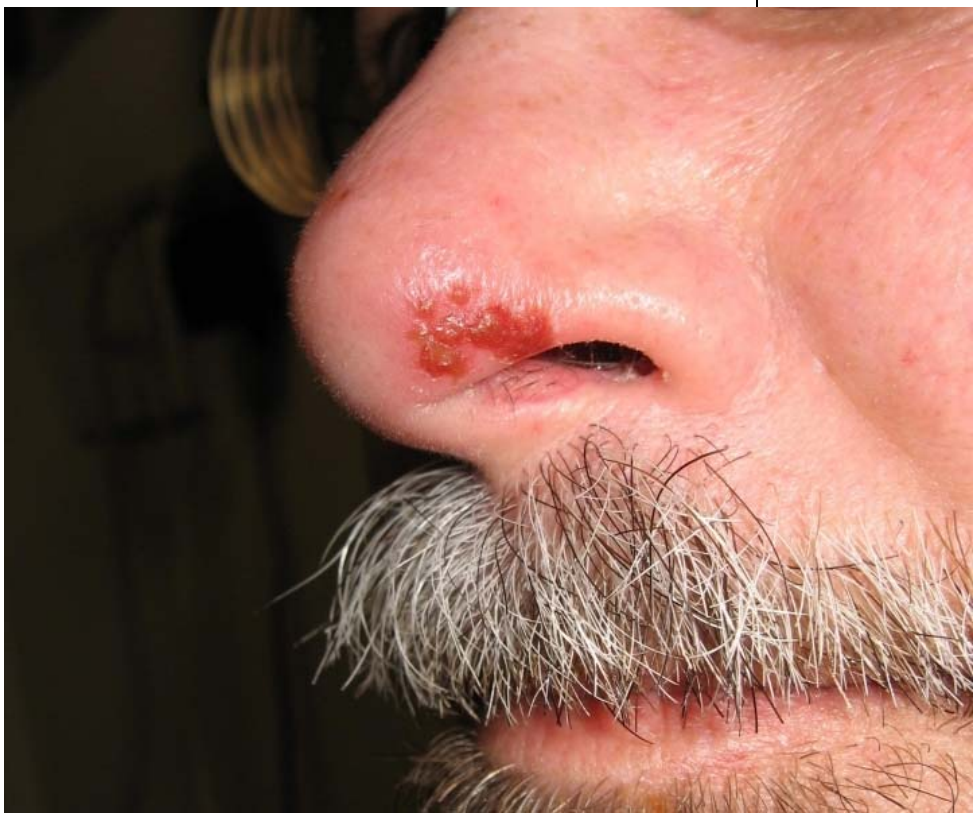


The ‘naso-’ portion of the nasociliary nerve



Hutchinson's sign

Uveitis: ***Anterior***

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2) The profiled case is meshed
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5) Treatment appropriate for the etiology is initiated

- Granulomatous
  - TB
  - Sarcoid
  - Syphilis
  - HSV
- Nongranulomatous
  - Acute
    - Unilateral
      - HLA-B27 dz
      - Posner-Schlossman
      - Sarcoid
      - Syphilis
      - **HSV/VZV**
      - TB
    - Bilateral
  - Chronic

Four aspects of the presentation provide clues that a uveitis is HSV/VZV. What are they?

--**A hx of dendritic epitheliopathy (HSV)**, or vesicular skin eruption (VZV)

--The nature of the KPs

--Significantly elevated IOP

--The

Rule of thumb: In a pt with a hx of herpetic epitheliopathy, anterior uveitis is herpetic until proven otherwise!

Uveitis: ***Anterior***

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Four aspects of the presentatio
--A hx of dendritic epitheliopath
--The nature of the KPs
--Significantly elevated IOP
--The presence of iris atrophy

How do KP typically present in HSV/VZV anterior uveitis?
--Size:
--Distribution:
--Shape:

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--Size: **Small**
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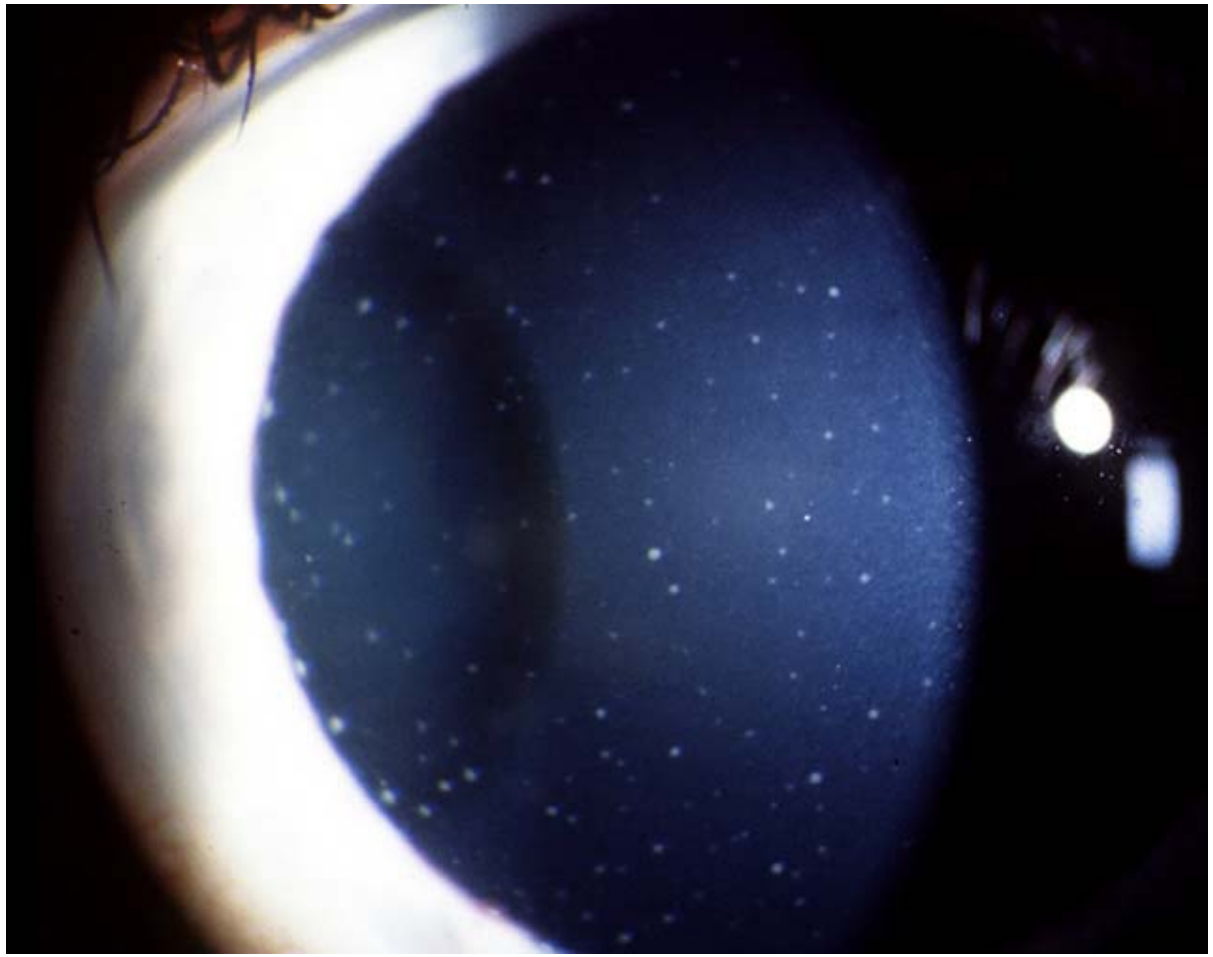

Herpetic uveitis. Note the small, diffuse, stellate KP

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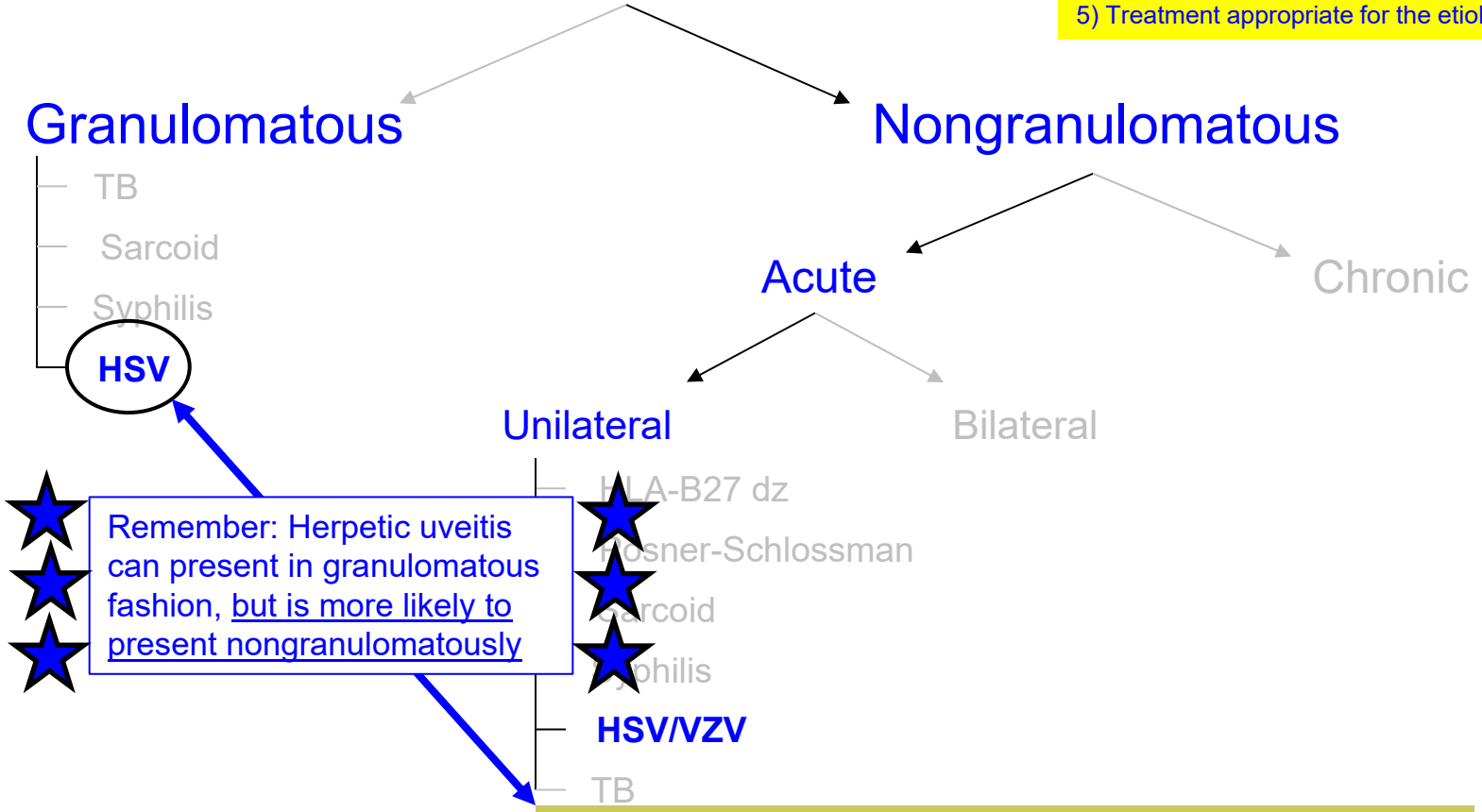

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Fuch's heterochromic iridocyclitis (very likely) and toxoplasmosis (much less likely)

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What pattern of iris atrophy is typically seen in…
--HSV iritis?
--VZV iritis?

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--HSV iritis? 'Diffuse'
--VZV iritis? 'Sectoral'

Iris atrophy

Sectoral

Diffuse