**SUMMARY OF UVEITIS CME - Uveitis Simplified**

An US(I)-MOS-POS initiative

Sunday, DATE: April 9th, 2023

Venue: 5th Floor, Dr. R.S Wadia Auditorium, Cancer Building, Ruby Hall Clinic, Sassoon Road, Pune - 411001

Summary editor: Dr Pranav Radkar, MC member, POS

Total attendance: 113

**Session 1 – Panelist (Dr Santosh Bhide, Dr Salil Mehta, Dr Anagha Heroor, Dr Mayur Morekar, Dr Udayan Dixit)**

1. **SUN criteria & step by step evaluation of Anterior Uveitis – Dr Rohit Modi**

* Classification and diagnosis of anterior uveitis is crucial for treatment.
* SUN classification is used to classify uveitis into anterior, intermediate, posterior and panuveitis.
* Acute, Recurrent and chronic depends on course and limited & persistent depends on the duration of anterior uveitis.
* Cells, flare vitreous haze are graded by examination.
* A step by step approach is needed for uveitis.

1. **Learning Case - Acute Anterior Uveitis – Dr Mayur Morekar**

* Important point to note is that not every anterior uveitis needs evaluation.
* Pattern recognition is key in the diagnosis of the cause of uveitis.

1. **Diagnostics in uveitis - what to order, when to order? – Dr Aartee Palsule**

* Different uveitic entities require different treatment.
* Systemic associations need consideration.
* Pattern recognition and mesh naming are methods to make a diagnosis.
* Making a diagnosis is crucial before ordering tests

1. **What exactly is “intermediate uveitis” - learn with an example – Dr Devendra Venkatramani**

* Uveitis involving vitreous and peripheral retina.
* Infective and Non-infectious causes need to be considered.
* Spills over anterior uveitis have KPs, flare and few cells.
* Post. Synechiae are common in Intermediate uveitis with systemic associations.
* Tuberculosis and Syphilis are important causes to be considered in India.

**SESSION 2 – Panelist (Dr Nitin Prabhudesai, Dr Rohit Modi,** **Dr Mandar Paranjpe, Dr Samyak Mulkutkar)**

1. C**horoidal granulomas - a differential diagnosis- Dr Nitin Prabhudesai**

* Involves infectious or non-infectious causes.
* Infective- Tuberculosis and syphilis.
* Non-Infective – sarcoidosis, VKH.
* Laboratory investigations , Radiology need sound history.
* Treatment depends on etiology.

1. **Retinal vasculitis - The Basics – Dr Rohit Modi**

* Systemic vasculitis mainly involves arterioles whereas retinal vasculitis involves veins.
* Can be infectious as well non infective. Clinically can be distinguished into arteriolar and venous predominant.
* Arteriolar predominant can have perivascular sheathing or at times no sheathing.
* Venous predominants have retinitis, chorio-retinitis and vitritis.

1. **Tuberculous Uveitis – Dr Nikhil Beke And Non-Tuberculosis Uveitis- Dr Samyak Mulkutkar**

* Difference between retinitis and choroiditis is the key as retinitis is mostly infective and choroiditis is infective.
* Systemic steroids and AKT remains the mainstay of treatment.
* A high degree of suspicion is required for Non Tuberculosis Uveitis.
* Clinical Patterns often point towards diagnosis.

**SESSION 3 – PANELIST (Dr Soumyava Basu, Dr Anand Subramaniyum, Dr Mukesh Pariyani, Dr Aditi Patwardhan )**

1. **Keynote presentation : What to test - how much to believe – Dr Soumyava Basu**

* Clinical pattern is mostly enough to diagnose uveitis etiologies and types.
* Investigations are done either to rule in/out infections , systemic diseases or to know immune status ,fitness for therapy and to monitor treatment.
* Positive predictive value of a test has to be considered before ordering for any test.
* Pre-test probability has been considered and includes history, clinical signs and prevalence for any disease.
* A positive RA factor and a positive ANA has little diagnostic value
* Today’s era work-up /screening has limited value and should be avoided.

9. **Basics of episcleritis & scleritis – examples – Dr Samyak Mulkutkar**

* Anatomical positions of vessels are helpful in understanding the differences in episcleritis and scleritis.
* Blanching and mobility are the key clinical signs used to differentiate both.
* Systemic associations are present in scleritis.
* Steroids and NSAIDS are the mainstay of treatment.

10. **Cataract surgery in uveitis - pearls of wisdom – Dr Hitesh Sharma**

* Control of inflammation before surgery and timing of surgery is crucial in outcomes.
* Counseling about recurrences is important.
* Small pupil, synechiae , shallow AC, friable iris vessels , IOP and weak zonules are possible challenges in surgery.
* Post Op inflammation control and frequent follow ups are advisable.
* CME has to be looked for during this time.

11. **Learning Case – Panuveitis in Behcet’s Disease - Dr Anand Subramaniyam**

* Rare presentation in Behcet’s disease.
* Systemic symptoms and signs are key in diagnosis.
* Oral steroids and immunosuppressant therapy are used for treatment.

12. **Basics of Immunomodulation for uveitis - Dr Mayur Morekar**

* Immunotherapy has extended the treatment spectrum in uveitis.
* They provide durable corticosteroid free remission.
* A Step-Ladder approach is the way to go involving steroids (Short term) and NSAIDS, Immunomodulator drugs, peripheral retinal cryopexy, lasers biologics , cytotoxic drugs and vitrectomy.
* Typically it takes weeks for the onset of action.
* Our aim in uveitis should be tailored investigations to tailored care.

13. **Free paper Presentation**

* Presenters – Dr Sayali Shah, Dr Varun Doshi / Dr Tarun , Dr Shreya , Dr Shivani K, Dr Nikhil T, Dr Abhinav G, Dr Apurva P, Dr M Silva and Dr Ajinnkya R.

14. **Grand Quiz- Dr Mukesh Paryani.**