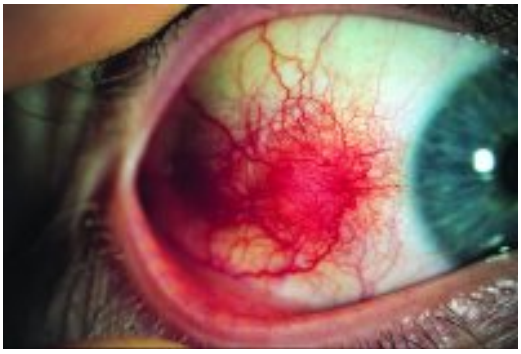
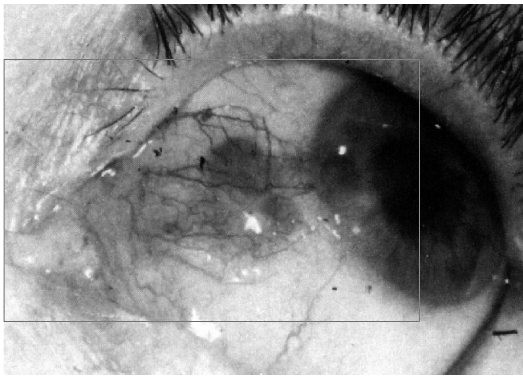
Nodular Scleritis

Clinical Features



This is inflammation of the outer coat of the eye. It forms in a specific area resulting in a nodule formation. Pain and redness are the key features. Lacrimation (Watery eye) and photophobia are more common in scleritis than in episcleritis. However, they are not always clearly related to the severity of the scleritis or to the keratitis and uveitis that may accompany it.
The pain of scleritis is its most dominant feature and is the symptom that causes the patient to seek medical advice. Pain, when it occurs, may be localized to the eye, but in 66% of patients it is much more diffuse, radiating to the temple, the jaw, and the sinuses. The pain is probably caused by distention of sensory nerve endings as a result of edema.



Although patients with nodular anterior scleritis resemble those with nodular episcleritis on cursory examination, detailed examination reveals marked differences. The nodule or nodules (they may be multiple) consist of scleral (Skin of the eye) tissue that is immovable episclera(Outer skin of the eye) is tightly adherent to the nodule, which is tender to the touch. Although the sclera sometimes becomes transparent below the nodule, it does not become necrotic, nor does the condition extend beyond the site of the nodule, as occurs in necrotizing scleral disease

Cause

This is often unknown. Occasionally infections can cause this. Other inflammatory connective tissue diseases such as Rheumatoid Arthritis, SLE, Relapsing polychrondritis, Ankylosing spondylitis, and Wegners.
Often some screening blood tests may be done to look for an immunological or other causes.

Treatment

Local Corticosteroids

Local steroid therapy increases the patient's comfort, but it is not effective in suppressing scleral inflammation. It is occasionally justified to use local steroid therapy alone when the inflammation is mild, the pain is slight, and corneal involvement is present, or very occasionally between attacks in the more severe forms of the disease to prevent remission. However, local steroids should be used only sparingly. g. Acular (Ketorolac Trometamol 0.5%) tds (three Times Per Day) can also be tried in mild cases.

Systemic Therapy

NONSTEROIDAL ANTI-INFLAMMATORY AGENTS.

Nonsteroidal anti-inflammatory agents are effective in suppressing the inflammatory response in the majority of patients with diffuse and nodular scleritis, especially if they exhibit a high flow pattern on fluorescein angiography. Dosage levels need to be high initially and, as a consequence, care must be taken to monitor the patients to ensure that no toxic side effects occur. Treatment must be continued until the inflammation subsides, after which it can be stopped abruptly.

In assessing the effect of treatment, pain, tenderness, episcleral and scleral injection, and corneal and intraocular involvement should be used as parameters of activity of the disease. In a series of double-blind controlled trials, the effects of different anti-inflammatory and immunosuppressive agents have been compared. The suggested routines of treatment are based on the results of these trials. Unfortunately, not all of the nonsteroidal anti-inflammatory agents are effective in controlling scleral inflammation. The current practice is to use flurbiprofen (Froben), 100 mg three times daily, for at least 1 week in all patients who present with scleritis of whatever type, provided there is no evidence of vascular closure or scleral destruction on slit lamp examination. The response, if it is going to occur, is immediate, with the pain disappearing within 48 hours. If there is a poor response to, the drug is changed to another nonsteroidal anti-inflammatory agent, because there is an individual susceptibility among the patients. Only if there is no response in the progression of the disease or if there is evidence of vascular closure are systemic steroids or other immunosuppressive drugs used.

SYSTEMIC STEROID THERAPY.

If the scleritis is severe or necrotizing or if areas of vascular closure are detected with slit lamp examination or fluorescein angiography, then the use of systemic steroids is mandatory Prednisone and prednisolone are most commonly used.

Extracts from Duanes Ophthalmology