Scleritis

PROTOCOL FOR MANAGEMENT OF SCLERITIS

History: Past infection, Trauma, Ocular surgery, Present illness, Medications
Review of Systems: Skin, Ear, nose and sinuses,Cardiovascular,Respiratory,Hands and joints

Systemic associations include:
Rheumatoid arthritis, Wegener's granulomatosis, Systemic lupus, Relapsing polychondritis, Hyperuricaemia, Crohns and Ulcerative Colitis, Varicella Zoster, HLA-B27 (+uveitis)
Others: lymphoma and metastatic malignancy, drug induced-bisphosphonates
There is an association with Rosacea and eyelid colonisation- Staph Aureus

Tuberculosis is a rare cause in the UK.

Symptoms
Pain, (severe and wakes patient up during the night),
Redness, watering, proptosis, reduced or double vision
Signs
Eyelid disease/blepharitis/rosacea
Localised or diffuse scleral congestion, oedema- bluish or violate hue (examine in room light)
Scleral thinning- yellow or grey patch, look also for avascular patches
Restriction or pain on ocular movement
Associated corneal melt or uveitis
Proptosis
Fundus examination- signs of vasculitis/disc swelling/choroidal folds
Tests
- Phenylephrine 2.5% - no blanching of redness implies deep scleral vessels
- B scan ultrasound- thickening of sclera and or the T sign

Management of Scleritis
1. Investigations: FBC, CRP, Plasma viscosity, U&E,LFTs, ANA,ANCA,Rheumatoid Factor, CXR,Urinalysis,Eyelid and nose swabs if blepharitis, Blood pressure and Weight

Other tests based on history, physical exam and results:
Uric Acid
TPHA test for syphilis
QuantiFERON-TB- blood test for TB

2.Anterior segment / Fundus photography as soon as possible.

3. Seek senior opinion immediately or phone Consultant to discuss. Do not manage in URC!

Treatment
Topical steroids alone have a high failure rate but may be a helpful adjunctive.

Anterior scleritis Non-necrotising (Diffuse or nodular)
First Line:Oral NSAID: Flurbiprofen 50mg tds-qds

Second Line (first line if severe): Commence steroid if not settling after one week:
Oral prednisolone Dose: 1mg per Kg
Must have weight, BP, urinalysis, Bloods and as required a CXR before commencing.
Check (relative) contraindications. E.g. Peptic Ulcer disease, renal failure
See osteoporosis and gastritis prevention below.

Necrotising Scleritis- An emergency!
First Line: Intravenous steroid/ immunosuppressive
Discuss with Rheumatology team for same day admission.

Posterior Scleritis
First Line:Oral NSAID
Second line (first line if severe):Oral steroid.

When to Refer to Rheumatologist
If patient has rheumatic disease

- Necrotising scleritis
- ANCA positive
- Any positive signs or blood results suggesting a systemic vasculitis.
- Unresponsive to oral steroids
- If no improvement in symptoms or signs within 1 week of starting steroids – discuss with Rheumatology team. May need admission for review and pulsed steroid or different agent. Patients may also require pulsed steroid for uncontrolled pain with active disease.
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Osteoporosis Prevention
1. DEXA Scan: All patients likely to require long-term high dose steroid require a DEXA scan to assess their risk of long bone fracture. Please arrange this on the system.
2. The current protocol for prevention osteoporosis is Alendronate 70mg once weekly and Calcichew D3 Forte 1 tablets daily.
Bisphosphonates can cause or exacerbate scleritis and should be used with caution.
Prevention of Gastric Ulceration: Lansoprazole 30mg od for as long as patient is on NSAID or steroids.