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Letter to Editor

Ophthalmology Section

Unexplained Anterior Uveitis: Viral Causes

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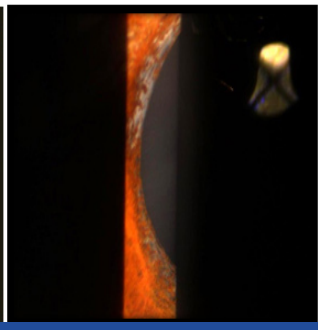
Sir,

Idiopathic anterior uveitis is increasingly being associated with a viral aetiology. Herpes simplex and Herpes zoster virus (HSV/HZV) are known causes of anterior uveitis but other viruses including Cytomegalovirus (CMV) and Rubella are now being recognized [1].

Viral anterior uveitis has characteristic clinical features, an understanding of which assists the examining ophthalmologist in making an appropriate diagnosis and in initiation of a timely management which varies with the viral strain. The diagnosis may be relatively straight forward in the presence of concomitant skin lesions, active keratitis, and/or corneal anaesthesia. However, in the absence of such clues, the diagnosis requires a high index of clinical suspicion and astute observations, especially as access to intraocular fluid analysis is not available to most clinicians [2].

Herpetic anterior uveitis is characterised by diffusely distributed keratic precipitates (KP), moderate inflammation, posterior synechiae and sectoral or diffuse iris atrophy [Table/Fig-1]. HSV uveitis is suggested by patchy atrophy around the pupillary sphincter [Table/Fig-2] [3]. The intraocular pressure (IOP) is usually raised. HSV usually affects a younger age group whereas HZV is more commonly seen in elderly and immunocompromised patients [4].

Cytomegalovirus (CMV) anterior uveitis has few KPs, mild inflammation with raised intraocular pressure (IOP) and no posterior synechiae. The iris has a moth eaten appearance. CMV uveitis can simulate Posner-Schlossman Syndrome, Fuchs' uveitis and herpetic uveitis [5].



[Table/Fig-1]: Diffuse iris atrophic changes **[Table/Fig-2]:** Pupillary pigment atrophy

Rubella is characterised by posterior subscapular cataract, mild inflammation, diffuse iris atrophy, lack of posterior synechiae and mildly raised IOP. Fuch's uveitis is now considered to be usually due to Rubella virus. Presence of cataract on presentation is highly suggestive in cases of mild anterior uveitis with raised IOP in a younger age group. In most instances the condition is benign and does not require any anti-inflammatory therapy. An appropriate diagnosis avoids unnecessary work-up and ineffective therapy. Steroids do not have much effect and should be avoided. Follow-up should be regular to monitor lens opacities and intraocular pressure [2].

In summary, in cases of unexplained anterior uveitis, a high index of suspicion regarding possible viral cause should be maintained and antiviral therapy should be considered in eyes with recalcitrant uveitis. As access to intraocular fluid analysis is not available to most clinicians, all attempts should be made to reasonably diagnose the causative virus on the basis of clinical features as a virus specific therapeutic approach is necessary along with standard anti-inflammatory, cycloplegic and antiglaucoma medications.

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