CATARACT SURGERY IN CASES OF UVEITIS

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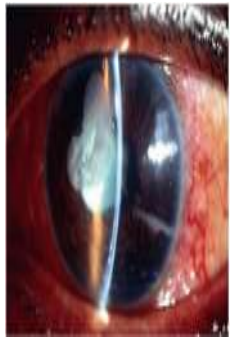
- Cataract is one of the most common complications in patients with chronic uveitis.
- Its incidence varies from 57% in pars planitis to 78% in Fuchs heterochromic iridocyclitis.
- The most common type of cataract in uveitic patients is posterior sub capsular cataract.

PATHOPHYSIOLOGY

- It is thought to be the result of prolonged breakdown of the blood ocular barriers caused by intraocular inflammation.

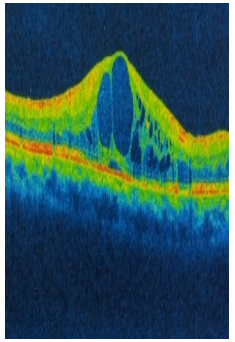
- The entry of plasma phospholipids or its precursors into the eye is thought to increase lens epithelial permeability that develop PSC.

INDICATIONS FOR SURGERY



Phacoantegenic uveitis (absolute indication)

Visually significant cataract in an eye with good expected visual potential & controlled inflammation



Cataract that impairs fundus assessment in patients with posterior segment pathology

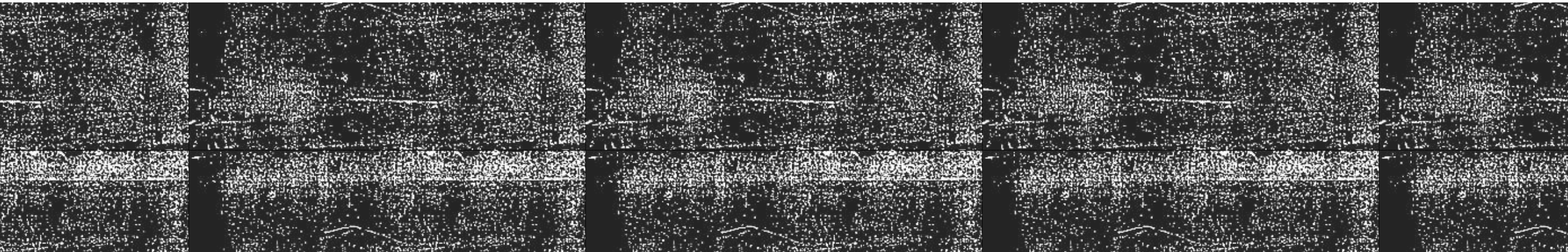
TIMING OF SURGERY

Eye quiescent for at least 3 months before surgery

Paediatric patients carry risk of amblyopia

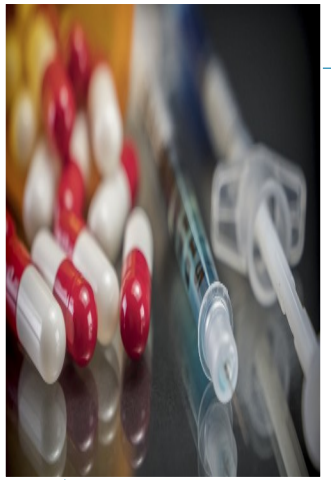
Posterior segment pathology

PRE-OPERATIVE WORKUP




Identify cause of uveitis
Treat the cause
Control inflammatio n

PROPHYLAXIS



Steroid

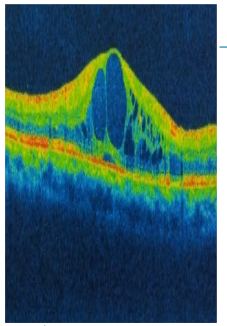
- Oral : 1mg / kg / day
- IV : for urgent surgery
- Local: topical, periocular, Ozurdex

Anti infectious

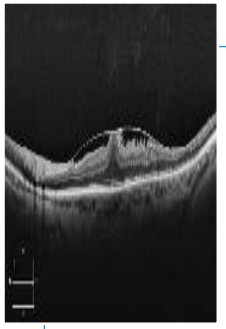
- Toxoplasmosis
- Herpetic uveitis

CONCOMITANT PATHOLOGIES

Corneal opacities (band shaped keratopathy)



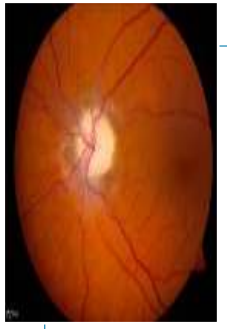
CME



ERM

RD

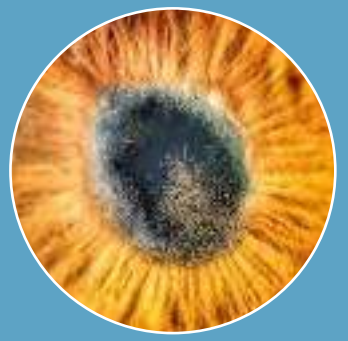
Glaucoma



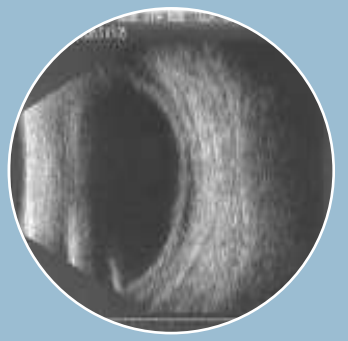
Optic atrophy

POOR PROGNOSTIC SIGNS

Low IOP < 6 mmHg even when quiescent

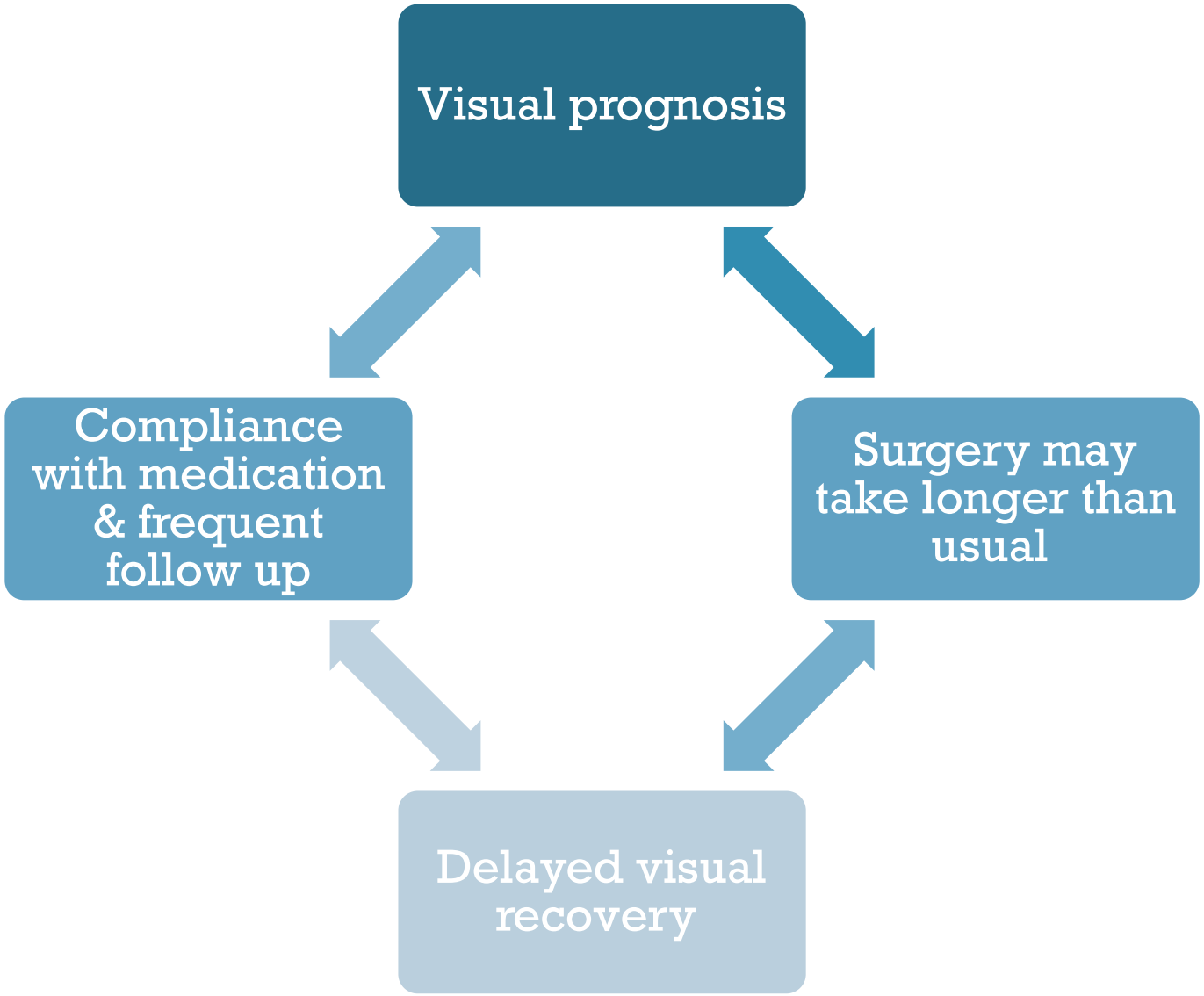


Seclusio pupillae with normal IOP



Diffusely thickened choroid or choroidal effusion

COUNSELLING



CHOICE OF SURGERY

Cataract only

- Phacoemulsification (less inflammation)

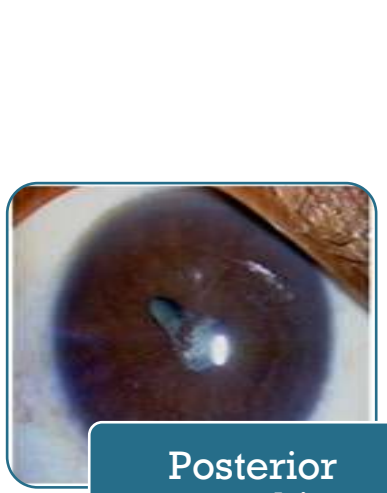
Cataract & glaucoma

- Cataract done first

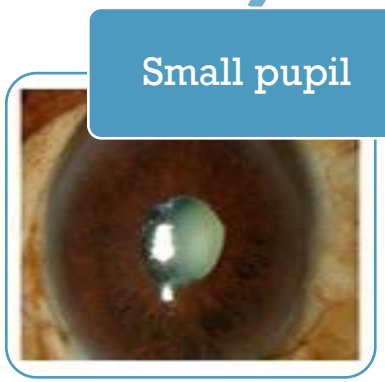
Cataract & retinal problems

- Combined surgery

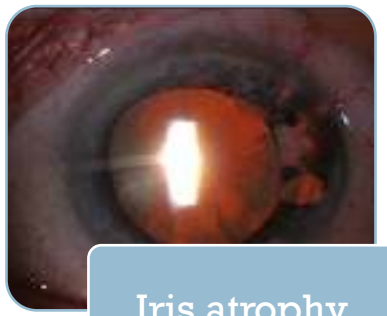
INTRA-OPERATIVE DIFFICULTIES



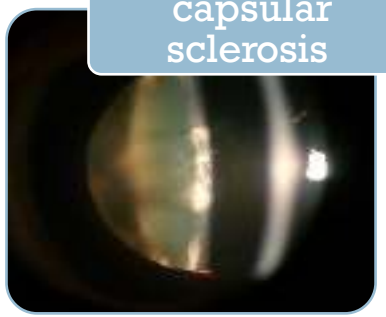
Posterior synechia



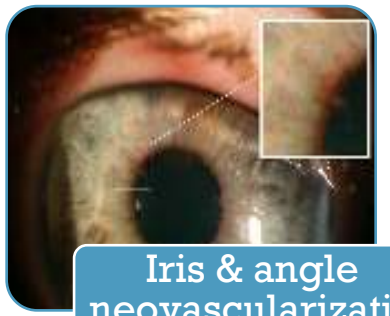
Small pupil



Iris atrophy



Anterior capsular sclerosis



Iris & angle neovascularization

IOL IMPLANTATION ??!

In e
with
co ll
ed
uveitis,
IOL
implant
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should
be
deferre
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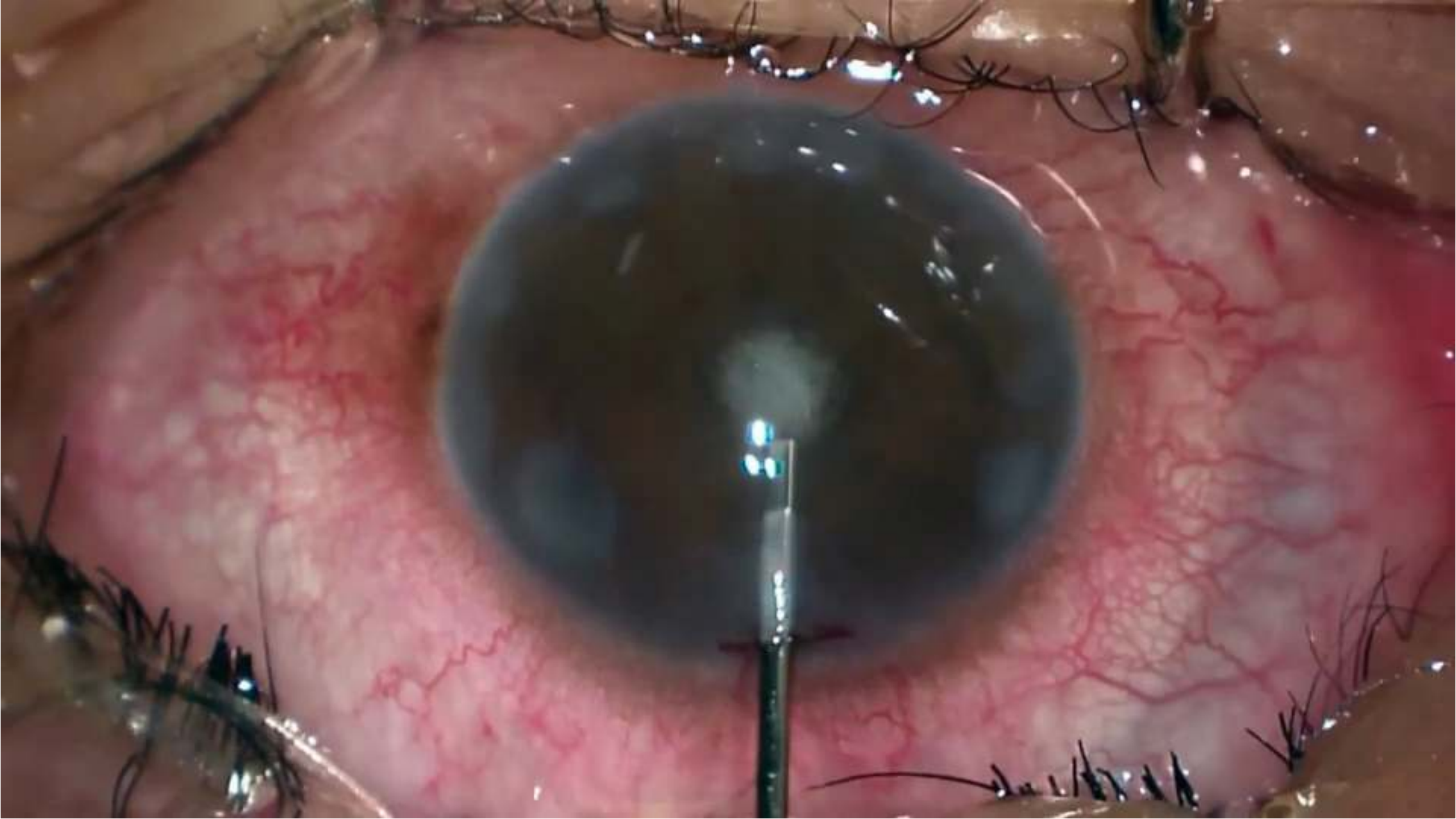
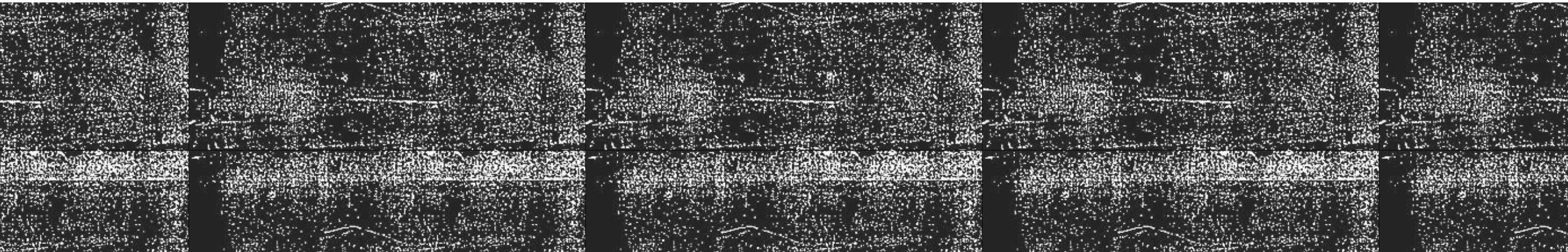
- Position :
  - In the bag
  - Avoid sulcus & AC IOLs
- design
  - Single piece, hydrophobic IOLs
  - Heparin coated
  - Avoid silicon IOLs



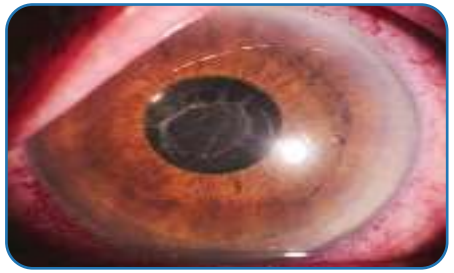
POST-OPERATIVE MANAGEMENT



Over-treat and relax

Don’t undertreat and then try to catch up !!

COMPLICATIONS

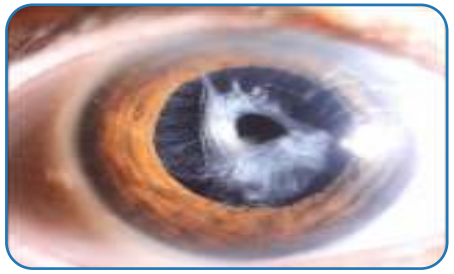


Post-operative inflammation

- Systemic & topical steroids
- Keep the pupil mobile

Hypotony

- Oral & topical anti-inflammatory
- Severe cases: PPV, trimming of CB traction membranes & SOI



Post capsular opacification & capsular phimosis

- Circular, large & well centered rhexis
- Acrylic IOL with square edge optic design
- Meticulous removal of VES.
- Control of post-operative inflammation

Take home message

- Complete systemic & ocular examination is a must in patients with uveitic cataract
- The disease should be quiescent for at least 3 months before surgery
- Adequate pre-operative prophylactic anti-inflammatory therapy is necessary
- Proper surgical technique, choice of IOL & post-operative control of inflammation can lead to satisfactory visual outcomes after surgery


Thank
you