THE ROYAL VICTORIA EYE AND EAR HOSPITAL DUBLIN

LOOKING AFTER THE NATION'S EYES AND EARS SINCE 1897

Clinical Guideline for the treatment of

SCLERITIS AND EPISCLERITIS

DESCRIPTION

- Scleritis - inflammation of the deep vascular plexus of episclera and underlying sclera
- Episcleritis – inflammation of the superficial episcleral vascular plexus and conjunctiva
- Typically presents in middle age, F>M
- 30% with underlying inflammatory disorder (RA, GPA and PAN most common)

RED FLAGS

- Can be first presentation of serious systemic illness – NB systems review and Hx
- Beware necrotising scleritis – presents as an area of blanched/avascular sclera
- Scleromalacia perforans (necrotising scleritis without inflammation) is painless/asymptomatic, RA associated, chronic occlusive vasculitis

HOW TO ASSESS

HISTORY

- Red, painful eye
- Possible vision loss
- Gradual onset
- Prior history of ocular inflammation/infection
- Prior history of associated medical conditions
- Episcleritis typically painless or mild discomfort, scleritis moderate to severe pain, can wake patient from sleep
- Assess relevant risk factors for atypical scleritis – infectious, masquerade (e.g. MM) and post-surgery/trauma

EXAMINATION

- Examine at first in brightly lit room, without slit lamp
- Dilated episcleral and scleral vessels
- Episcleral vessels blanch readily with phenylephrine, can help differentiate scleritis and episcleritis
- Scleritis can be nodular, diffuse or necrotising
- Blanched or avascular areas indicate necrotising scleritis
- Assess for thinning of sclera – appears grey/blue, best noted with diffuse light
- Assess remaining eye for inflammation – cornea, anterior chamber, and posterior chamber
- IOP
- Posterior scleritis may have serous RD, macular oedema, disc oedema, choroidal thickening/folds, B Scan may show T-Sign, can occur with a white eye.

INVESTIGATIONS

- Detailed history NB
- If first presentation, systems review to assess risk of underlying systemic disease
- OCT, B-Scan if indicated
- Swabs/scrapings if infectious cause suspected
- BP
- Systemic evaluation with bloods, urinalysis, and imaging in subspecialty clinic.

TREATMENT

- First line treatment for episcleritis/mild scleritis is oral NSAID +/- FML or PF/Maxidex.
- Consider cover with topical antibiotic if associated keratitis.
- Moderate to severe scleritis should be discussed with the registrar on-call.
- Infectious cause must be treated first if suspected.
- Oral steroid starting at 60mg (with PPI +/- calcichew).
- Admission for intravenous methylprednisolone with severe cases.

FOLLOW-UP

- Mild/moderate episcleritis – often self-limiting, discharge with treatment and advice.
- Severe episcleritis/mild scleritis – follow up once in EED within 1 week, if not resolving refer to subspecialty clinic.
- Moderate/severe scleritis – discuss with senior ophthalmologist or registrar on call and book subspecialty clinic within 1-2 weeks.
- Systemic immunosuppression associated with reduced mortality in scleritis
- Consider need for GP letter or referral re underlying conditions.