Systemic diseases associated with intermediate uveitis

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BACKGROUND Intermediate uveitis is characterized by vitreal inflammation with associated inflammation of the vitreous base and peripheral anterior retina and choroid. It may be found as an isolated and idiopathic condition or in association with systemic disorders such as multiple sclerosis and sarcoidosis.

OBJECTIVE To identify the clinical features of intermediate uveitis and assess its association with systemic diseases.


RESULTS Evidence of systemic disorders was found in 26 of 83 patients (31.3%). Of these 26 patients, 10 had presumed sarcoidosis, 6 had multiple sclerosis, 2 had isolated optic neuritis, 2 had inflammatory bowel disease, 4 had isolated thyroid abnormalities, and 2 had histories suggestive of Epstein-Barr virus infection. Associated ocular findings included cystoid macular edema, peripheral retinal perivascular sheathing, cataracts, posterior vitreous detachment, fine keratic precipitates, preretinal macular fibrosis, retinal tears, retinal detachment, and optic disc edema.

CONCLUSIONS Patients with intermediate uveitis may have associated systemic diseases and should have careful follow-up with regular systemic evaluation.

INDEX TERMS: UVEITIS, INTERMEDIATE; SARCOIDOSIS; MULTIPLE SCLEROSIS; OPTIC NEURITIS; INFLAMMATORY BOWEL DISEASES; THYROID DISEASES; EPSTEIN-BARR VIRUS • CLEVE CLIN J MED 1993; 60:460-465

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document intermediate uveitis as a heralding inflammatory event for underlying diseases, and describe the clinical features of this condition.

**PATIENTS AND METHODS**

We reviewed the records of 83 patients (42 women and 41 men) at The Cleveland Clinic Foundation who were found to have intermediate uveitis between 1970 and 1991. All patients presented with ocular symptoms or were referred with ocular inflammation. Intermediate uveitis was defined as the presence of vitreal inflammation in one or both eyes with associated inflammatory deposits in the vitreous base or on the pars plana in at least one eye and minimal anterior chamber inflammation. Patients with unilateral and bilateral inflammation were included. Patients were excluded if they had a predominantly posterior uveitis, if they had more than mild anterior chamber reaction, or if the anterior chamber inflammation was granulomatous in appearance on presentation. The average age at which intermediate uveitis was first observed was 23.3 years (range 4 to 54 years). The mean follow-up period after the diagnosis of intermediate uveitis was 5.7 years (ranging up to 21 years).

Associated systemic disorders were identified from the patient history and the laboratory evaluation. The diagnosis of sarcoidosis is usually established by systemic findings with histopathologic and radiologic abnormalities. In the absence of systemic findings, the diagnosis of ocular sarcoidosis is presumptive. The diagnosis of presumed sarcoidosis was based on clinical suspicion and on the findings of anergy and abnormal serum lysozyme or angiotensin-converting enzyme levels; no patients had biopsies to confirm the diagnosis. The diagnosis of multiple sclerosis was based on Poser's classification.

Inflammatory bowel disease was documented by colonoscopy. Thyroid dysfunction was documented by history and need for thyroid replacement therapy. Lyme disease antibody titers were measured in two patients. The most commonly obtained studies in all patients included chest roentgenograms, serologic tests for syphilis, complete blood counts, serum electrolyte levels, liver function tests, the erythrocyte sedimentation rate, and serum angiotensin-converting enzyme and lysozyme levels.

The chronologic order in which the diagnoses of intermediate uveitis and the associated systemic disorders were made was noted. Associated ocular findings in patients with intermediate uveitis were documented.

**RESULTS**

Systemic disease associations were noted in 26 of 83 patients (31.3%) with intermediate uveitis (Table 1). In these 10 men and 16 women, the mean age at presentation with intermediate uveitis was 24.7 years.

Evidence for presumed sarcoidosis was found in 10 patients (12%). One had sarcoidosis for 2 years before developing intermediate uveitis. In 4 patients, presumed sarcoidosis was diagnosed during the evaluation of the initial episode of intermediate uveitis. The remaining 5 patients were found to have laboratory evidence of presumed sarcoidosis beginning 2.5 to 20 years after intermediate uveitis was first observed. Seven of the 10 patients with presumed sarcoidosis presented with exudation predominantly from the pars plana, 2 presented with vitreous “snowball” opacities without pars plana exudates, and one presented with both. Only 2 of the 10 had peripheral retinal perivascular sheathing noted on initial evaluation, but half eventually demonstrated this on follow-up. Cystoid macular edema developed during the course of evaluation in 5 of the 10 patients.

Multiple sclerosis was associated with intermediate uveitis in six patients (7.2%). Three had clini-
TABLE 2
ASSOCIATED OCULAR FINDINGS IN INTERMEDIATE UVEITIS

<table>
<thead>
<tr>
<th>Ocular Finding</th>
<th>Idiopathic pars planitis (N=57)</th>
<th>Intermediate uveitis with associations (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cystoid macular edema</td>
<td>34 (60%)*</td>
<td>12 (46%)*</td>
</tr>
<tr>
<td>Peripheral retinal perivascular sheathing</td>
<td>16 (28%)</td>
<td>14 (54%)*</td>
</tr>
<tr>
<td>Cataract</td>
<td>15 (26%)</td>
<td>6 (23%)</td>
</tr>
<tr>
<td>Posterior vitreous detachment</td>
<td>12 (21%)</td>
<td>7 (27%)</td>
</tr>
<tr>
<td>Fine keratic precipitates</td>
<td>10 (18%)</td>
<td>5 (19%)</td>
</tr>
<tr>
<td>Preretinal macular fibrosis</td>
<td>8 (14%)</td>
<td>5 (19%)</td>
</tr>
<tr>
<td>Retinal tears</td>
<td>4 (7%)</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>Retinal detachment or traction</td>
<td>4 (7%)</td>
<td>6 (23%)</td>
</tr>
<tr>
<td>Optic disc edema</td>
<td>3 (5%)</td>
<td>5 (19%)</td>
</tr>
</tbody>
</table>

*Total >100% because multiple findings in individual patients are listed separately.

DISCUSSION

This review of a large series of patients presenting with intermediate uveitis reveals the association of systemic conditions in 26 of 83 patients (31.3%). The most common associated disorder in our pa-
The finding of thyroid disease in patients with intermediate uveitis is of unknown significance. Our three patients with long-standing hypothyroidism may have had Hashimoto's thyroiditis. These patients displayed pars plana exudates and cystoid macular edema. Thyroid microsomal autoantibody titers, which were not obtained, would have helped to confirm this diagnosis. Both of our patients with Graves' disease had pars plana exudates, cystoid macular edema, and vitreoretinal tractional abnormalities as well.

Pars planitis has previously been described in two patients with inflammatory bowel disease, specifically ulcerative colitis. In contrast, one of our two patients with inflammatory bowel disease had Crohn's disease, and the other had an unspecified inflammatory bowel disease. Both of our patients displayed pars plana exudates, cystoid macular edema, vitreous traction, and retinal tears. One of these patients also displayed peripheral retinal perivascular sheathing.

The association between Epstein-Barr virus infection and intermediate uveitis has been described. Two of our patients described a history suggestive of Epstein-Barr virus infection before the onset of their uveitis. Neither of these patients had confirmatory Epstein-Barr virus titers measured by us. However, serologic studies to prove causality in past or chronic Epstein-Barr virus infections are sometimes difficult to interpret.

No significant systemic disease association could be identified in 57 of the 83 patients. It is possible that idiopathic pars planitis may stand alone as a diagnostic entity. However, it is also possible that in some patients with intermediate uveitis, an underlying systemic disease may not be obvious. The underlying disorder could be subclinical and already exist. For example, oligoclonal bands have been described in a patient with pars planitis without clinical evidence for multiple sclerosis. Possibly, intermediate uveitis may be the harbinger for underlying systemic disease, that is, a systemic disorder may not surface clinically or laboratory test results may not become abnormal until after intermediate uveitis is first observed. In some patients with pars planitis, other signs of associated underlying systemic conditions may never surface clinically. Further, distinguishing between diseases associated with intermediate uveitis may be difficult. For example, central nervous system sarcoidosis may mimic multiple sclerosis by clinical and laboratory evaluation.
Many of the well-recognized diseases associated with intermediate uveitis, such as sarcoidosis and multiple sclerosis, are thought to have an autoimmune basis. This is also true of the other systemic disease associations found in this study. For example, primary thyroid gland failure is most commonly caused by autoimmune thyroiditis, and Graves’ disease is thought to result from a defective stimulated overproduction of thyroid autoantibodies. Ulcerative colitis is sometimes considered a hypersensitivity reaction associated with circulating antibodies. Despite the possibility that pars planitis may not be pure in etiology and that patients with pars planitis may eventually manifest one of many systemic disorders, investigators have explored a common immunopathogenesis for this group of patients. Evidence for this includes a suggestion of abnormalities in cellular immunity: these patients have increased numbers of CD4 T cells found in the pars planitis “snowbanks” and abnormal ratios of helper T cells to suppressor T cells in aqueous and serum. Further, although most investigators have been unable to document an HLA association with pars planitis, one recent study found an increased incidence of the HLA-DR2/DQw1 haplotype in these patients. Interestingly, the DR2 antigen is also found with increased incidence in patients with multiple sclerosis.

This retrospective study is limited by the extent of historical and physical data recorded and laboratory testing information available at the time the patients were evaluated. Possibly, an underlying systemic disease was overlooked because we were unaware of a specific disease association, or confirmatory laboratory studies were not available at that time. For example, Lyme disease has only recently been shown to give rise to clinical findings similar to that found in pars planitis. Further, other diseases not apparent to us now may become apparent with increasing clinical knowledge and laboratory advances in the future. However, our study suggests that patients with intermediate uveitis may have associated systemic disorders and suggests possible avenues of systemic evaluation. Since intermediate uveitis may herald underlying systemic disease, a careful systemic evaluation should be done prior to assigning the diagnosis of pars planitis to a patient with intermediate uveitis. Further, patients with pars planitis should be evaluated periodically for underlying associated systemic conditions.

REFERENCES


