

Practical Management of Uveitic CME

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Thomas Albini, MD, moderator of the Uveitis Resource Center, recently spoke with Nisha Acharya, MD, of the University of California, San Francisco, and The Proctor Foundation, about uveitic cystoid macular edema (CME) and practical approaches to its management. Their conversation follows:

Thomas Albini, MD: How big of a problem is CME for patients with uveitis?

Nisha Acharya, MD: About 40% of patients with uveitis affecting the posterior segment have ME.

TA: When you approach a patient with uveitic CME, do you address modifiable behaviors that might influence its progression?

NA: Smoking is a major risk factor for uveitic CME, so I let all of my patients know that quitting smoking can absolutely help.

THERAPEUTIC APPROACHES

TA: CME is one of the more common causes of vision loss in patients with acute anterior uveitis. What's your approach in these cases?

NA: By treating the inflammation with topical agents to start, you often can achieve resolution of the ME. I generally start with prednisolone acetate for milder cases. For more severe cases, I use Difluprednate or durezol.

TA: What dosing regimen do you use?

NA: The approved dosage of durezol for the treatment of inflammation is four times a day, but we often go to six or eight times a day, and that dosage tends to achieve good results in 50% to 60% of our patients within a couple of weeks.

TA: How long do you give a topical approach before you move on to a more aggressive option?

NA: The longer ME is present the more harmful it is and the less likely you are to recover vision. If I don't see a response in two weeks with aggressive topicals dosed at six or eight times a day, I move on.

TA: How do you decide whether to use a sub-Tenons or intravitreal injection vs oral steroids?

NA: If both eyes have to be treated, then I go with systemic therapy. If the patient would rather not get injections, they receive a course of oral therapy. Other patients have diabetes or osteoporosis or have mood changes with systemic steroids, and in those cases I go with regional steroids

TA: For oral steroids, do you start your patients on a 1-mg-per-kg dose and then taper over two months down to 10 mgs or less?

NA: Yes, I keep up the 1-mg-per-kg dose for at least a few weeks in an effort to get a response because if you taper too quickly you are unlikely to treat ME effectively.

TA: When you decide between a sub-Tenon's injection vs an intravitreal injection, what guidelines do you follow?

NA: We start with a periocular sub-Tenon's and try one or two of those before we move on to an intravitreal injection. Even though we don't have good comparative studies, I think that intravitreal is probably more effective – but with a higher rate of complications. Occasionally, there are patients who have very severe edema, and in those cases I start with an intravitreal injection.

TA: What is your agent of choice for intravitreal injections, and what do you think about the available options: Kenalog, Trience, Ozurdex?

NA: We previously used Kenalog a lot, but because of issues with preservatives and endophthalmitis I have

switched primarily to Trience. I have also been using Ozurdex because it has a longer duration of action and may have a lower side effect profile. We think there is less pressure rise associated with Ozurdex than with Trience, so for patients who might need longer control or have pressure issues, I am moving toward Ozurdex.

TA: In addition to its duration of action, another benefit of Ozurdex is its pharmacodynamics – it clears very quickly in eyes that have been vitrectomized. Another reason that I prefer Ozurdex is because of the anterior migration that sometimes results with triamcinolone. Even though there is the potential for Ozurdex to migrate to the front in some eyes, it can be a very safe option in eyes with an intact capsule or phakic eyes.

NA: I agree, and in my experience, patients who have had both Ozurdex and triamcinolone often comment that their quality of vision and quality of life is a lot better with Ozurdex because they don't have a blob floating around in their eye. However, we remain willing to use both because we do not have evidence showing that one is superior. They're both really good options for ME.

TA: One of the concerns physicians have about Ozurdex is the 22-gauge injector – although there is a newer version that is easier to use because it is better lubricated. Do patients who have had both Ozurdex and triamcinolone mention a difference?

NA: Typically patients have no complaints and say they are fine with the Ozurdex injection, which in my practice is generally accompanied by a local anesthetic. With the triamcinolone we usually administer the shot without the benefit of local anesthesia. These patients have often been through so much in their lives having

had uveitis that getting an injection is not nearly as troubling to them as some might imagine.

TA: Is the Retisert implant a good option for uveitic CME?

NA: Despite varying outcomes from the ongoing Multi-center Uveitis Steroid Treatment Study (MUST),¹ I believe it has so far shown that ME can be reasonably treated with a Retisert implant—which isn't surprising because we've been using steroids for ME for ages.

CHRONIC SITUATION

TA: If you have a patient on a steroid-sparing agent, such as mycophenolate, for two to three months, and their uveitis has not resolved, do you increase the dosage or add a second agent?

NA: If they have signs of other active inflammation, such as choroidal lesions, vitreous haze or active vasculitis, I escalate the systemic therapy to the maximum dose. In the case of mycophenolate, that is 1.5 g twice a day. We do not want to keep patients on systemic steroid doses of 7.5 mg for longer than two to three months because of the side effects. I sometimes consider adding a biologic agent such as a TFNL inhibitor because we often find that increasing amino suppression results in ME reduction.

If ME persists despite all of those efforts, adjunctive therapy with local steroid injections such as Ozurdex or Trience works well. Anecdotal evidence suggests that 80% of patients respond to one intravitreal injection. ■

1. <http://www.bu.edu/eye/evidence-based-medicine/vitreo-retinal-studies/multi-center-uveitis-steroid-treatment-study-must/>