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CLINICAL FEATURES, SYSTEMIC ASSOCIATIONS, AND MANAGEMENT OF PEDIATRIC UVEITIS IN NORTH INDIAN COHORT

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Pediatric Uveitis accounts for only 5-10% of all uveitis cases with etiological differences and challenges in therapy especially with long-term corticosteroid usage. Uveitis in children is commonly associated with infectious and rheumatological disorders. However, a large subset may be idiopathic. Management in these patients is by the use of corticosteroids in systemic or topical formulations. Long term side effects of corticosteroids in children necessitates the need for alternative therapy such as immunomodulators. Immunomodulator therapy (IMT) is added in patients with steroid dependence (recurrence on tapering of corticosteroids), unbearable side effect profile of corticosteroids or in patients resistant to oral steroid therapy. However, the onset of action of IMT differs along with their own side effect profile. This mandates a good coordination between different disciplines. The multidisciplinary team may comprise of a paediatrician, rheumatologist, infectious disease specialist and an ophthalmologist at the very least. Keeping this in mind, a conjoint clinic was initiated by the institute where pediatric ophthalmologists and pediatric rheumatologist coordinate the management of pediatric uveitis. Through the following study we plan to evaluate the pattern of uveitis in children presenting to the conjoint clinic and describe the systemic associations and management outcomes.

In this observational study, all pediatric patients (age<16 years) presenting or being followed up in the conjoint clinic of the institute were recruited from January 2024 till Dec 2024. These patients were either referred with complains of uveitis or referred by the pediatric rheumatologist with a known systemic rheumatological disease to rule out uveitis. Data collected included age of onset of uveitis, anatomic location of uveitis, clinical features, systemic associations, complications and their subsequent management including topical therapy, systemic corticosteroids and immunomodulator therapy was noted at each follow-up.

A total of 93 children ranging from 3-18 years were recruited. No gender predilection was noted. Amongst these 93 children, unilateral uveitis was seen in 16 (17.2%), bilateral uveitis in 53(57%) and no uveitis was seen in 24 children (25.8%). Mean age of the cohort was 9.4 years. The most common clinical presentation was anterior uveitis. The most common systemic association was juvenile rheumatoid arthritis seen in 20 patients all of which presented with anterior uveitis. Idiopathic uveitis was seen in 36 patients while uncommon diagnosis like blau syndrome was seen in 6 patients with uveitis. Management was using immunomodulatory therapy for 57 patients. Amongst these 57 patients, 50 patients were on methotrexate which was the most common immunomodulator used in our practice with additionally 32 patients requiring biological therapy in the form of injection adalimumab and 1 patient requiring infliximab. Uveitis related blindness was seen in 8.6% of the cohort.

Anterior uveitis is the most common form of uveitis in children. Pediatric Uveitis is more commonly associated with systemic manifestations as compared to its adult counterpart with 35% of our cohort having systemic manifestations. Unlike the previously published literature, cause of infectious uveitis in our cohort was negligible. This could be due bias in the patients being referred to our tertiary eye care centre. Previous studies such as the fundamentals of care for uveitis (FOCUS) has provided a

recommendation for involvement of more than one medical specialty for the benefit of patients with uveitis which is why the concept of conjoint clinics are important especially in the setting of uveitis.