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Network Eye Diseases (ERN-EYE)

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These recommendations originate from the French Society for Ophthalmology

Recommendations for patients with uveitis during the COVID-19 Pandemic

Uveitis affects a heterogeneous population of varying ages with a significant risk of developing serious morbidity from COVID-19. In particular the use of steroids or immunosuppressants in uveitis patients warrants extra precaution and a consideration of the risk-benefit trade off.

Uveitis Managed In the Outpatient Setting

In the event of the first episode of anterior uveitis or acute recurrence:

- Be cautious of 'red eye' referrals as COVID-19 may present with conjunctivitis.
- Local guidelines on personal protective equipment should be strictly followed with gloves recommended if touching the lids.
- Establish sufficient history & examination to eliminate a sight-threatening infectious uveitis cause.
- Follow-up after the initial consultation should be performed after 2-3 days and then remotely whenever possible (telephone or video).
- Corticosteroids delivered topically are not contraindicated, however one should consider a slower taper than normal to prevent relapse and return visits during the height of the pandemic.

In cases of chronic anterior uveitis on corticosteroid eye drops only:

- **If stable and controlled at last visit**: No follow-up consultation should be arranged at present. Taper topical steroid therapy down slowly. If the intraocular pressure (IOP) was >20mmHg at last visit, with concerns a steroid IOP response is going unchecked, prescribe prophylactic IOP lowering drops.
- **If uncontrolled uveitis**: Arrange face-to-face consultation follow-up.

In cases of uveitis or scleritis on systemic corticosteroids, immunosuppressants and/or biological agents:

- **If stable and controlled at last visit**: No face-to face follow-up should be arranged consultation at present. Teleconsultations whenever possible to check patients' status. Maintain the current doses that have achieved quiescence (when <10mg per day of prednisone equivalent). Higher steroid doses should be tapered off slowly. In the absence of intercurrent COVID-19 disease, steroid-sparing immunosuppressants and/ or biologics should be maintained.

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- Blood tests for monitoring, if normal for the last 2 months, should be done at an extended interval to avoid unnecessary healthcare facility visits for the patient.

- **If uncontrolled uveitis/scleritis with sight threatening inflammation**: Arrange face-to-face consultation follow-up. If the risk of sight loss is severe (monocular patients, macular or papillary involvement) and the patient does not have COVID-19 symptoms, then the benefit/risk trade-off is in favour of hospitalisation for intravenous methylprednisolone or anti-infective treatments when deemed necessary.
- If there are COVID-19 symptoms then the patients should receive local steroid therapies to allow systemic treatment to be postponed.

In cases of herpetic kerato-uveitis or toxoplasmic retinochoroiditis:

- Start antivirals or antibiotics respectively with follow-up intervals extended on a case by case basis – if visually threatening then short interval follow-up consultations may be required.
- Hospitalisation might be necessary in sight threatening situations.
- Avoid starting concurrent systemic corticosteroids if at all possible
- Consider remote consultation by phone or video for follow-up and modulation of the drug regimen.

Intravitreal injections (IVT):

- Macular oedema from uveitis and vitritis are not immediately sight threatening complications and pre-planned intravitreal corticosteroids for these conditions can be deferred at the peak of the pandemic.
- However, as discussed above, local or intravitreal corticosteroids provides a safe local anti-inflammatory route for patients with COVID-19 symptoms who are contraindicated (transiently) systemic steroids.
- Intravitreal injection is favoured over sub-Tenon's due to relatively reduced systemic absorption and risk of immunosuppression.
- Inflammatory choroidal neovascularization (CNV) is potentially sight threatening so anti-VEGF injections should continue for this but, as with myopic CNV, should be given PRN if possible.
- If the local policy is to reduce staff-patient contact time in your injection facility by omitting pre-injection examination and imaging (to limit the risk of contracting COVID-19), a regimen of fixed monthly injections (for 3 months maximum) can be chosen when each injection provides subjective improvement for the patient.

Uveitis Managed In the Hospital Setting

The following cases are examples of sight threatening uveitis that may still warrant inpatient care:

- Herpetic endothelitis or ophthalmic zoster of the immunocompromised requiring intravenous anti-viral treatment.
- Acute viral retinitis or retinal necrosis requiring intravitreal injections and intravenous antivirals.
- Severe bacterial uveitis.
- Endophthalmitis requiring intravitreal and intravenous injections of antibiotics/antifungals.
- Posterior uveitis or panuveitis with severe vision loss, no fundal view or a macular or papillary threat that cannot receive local treatment.

General Uveitis Management Notes

- Only perform imaging investigations if deemed indispensable.
- If a uveitis patient on established therapy with corticosteroid and/or immunosuppressants (including biologics) remains well during the pandemic they are not advised to stop treatments as this may lead to a severe inflammatory rebound necessitating higher doses of steroids and more visits to a healthcare facility.
- In case of suggestive symptoms, the uveitis specialist needs to be immediately informed in order to arrange testing for COVID-19. In case of positivity or high suspicion of COVID-19, it is advised to discontinue transiently the immunosuppressive and/or biological therapy. However, on an individual basis, it might be possible to maintain a low dose of systemic corticosteroid therapy.
- If increased anti-inflammatory therapy is required in patients with COVID-19 symptoms a local route of corticosteroid will be preferred.

Reminder to patients:

- Follow national guidelines for social distancing and infection control (regular handwashing etc).

- If you develop a fever > 38°C take paracetamol (maximum 3g / day) but avoid NSAIDs.

- If you develop other possible symptoms of COVID-19 (malaise, cough, loss of sense of smell/taste, muscle aches, diarrhoea, headache, and / or fever> 38 °) follow national guidelines but seek medical advice.

- If chest tightness and/or severe shortness of breath associated with infectious signs: call national medical emergency numbers.

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