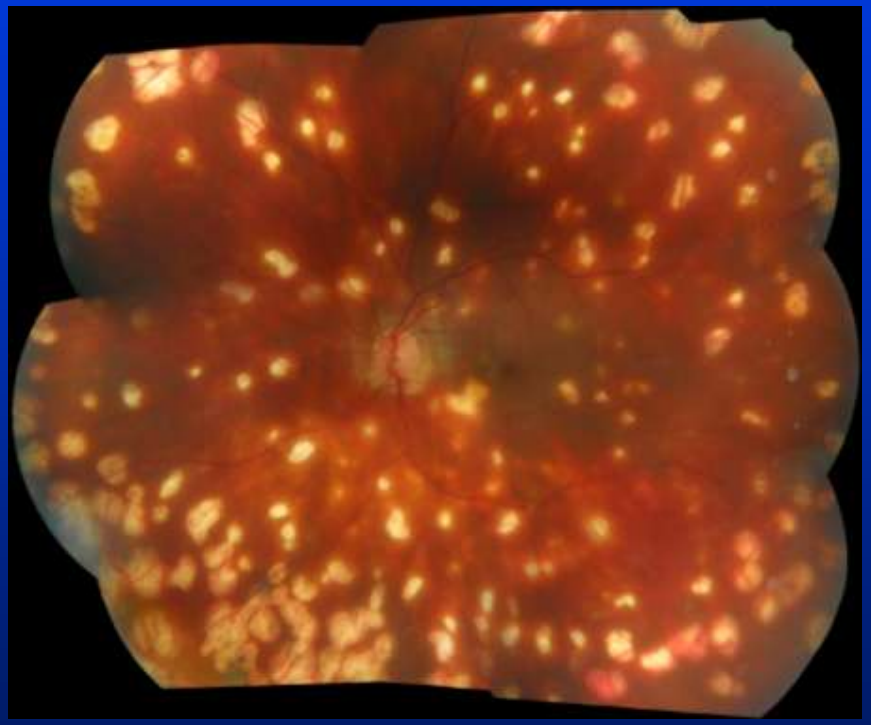
Uvéites



Antoine BRÉZIN

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Étiologie des uvéites

Étiologies inconnues
≈ 25%

Étiologies systémiques présumées
≈ 25%

Étiologies oculaires isolées
≈ 25%

Étiologies systémiques prouvées
≈ 25%

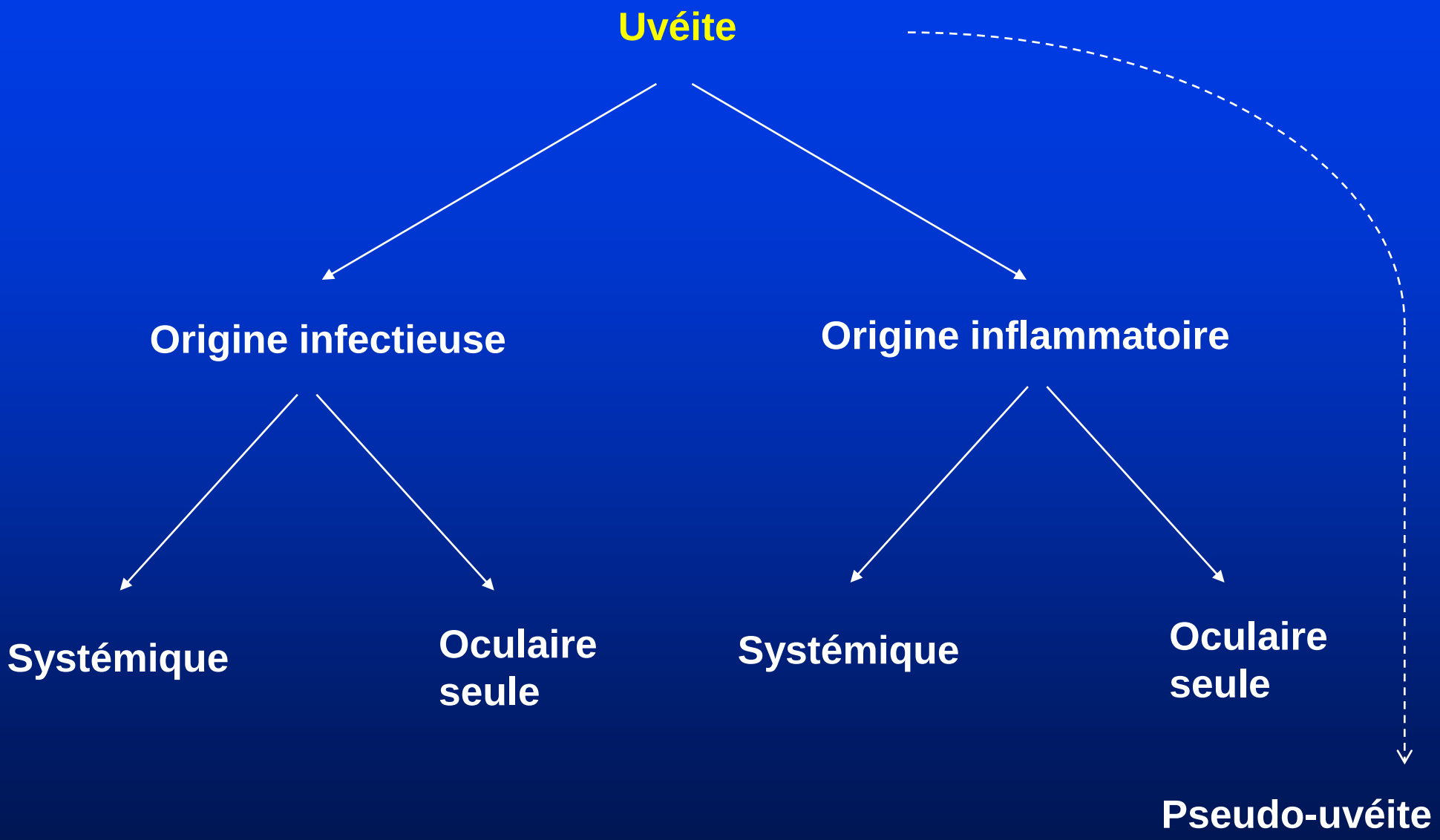

Uvéite
Origine infectieuse
Origine inflammatoire
Systémique
Oculaire seule
Systémique
Oculaire seule
Pseudo-uvéite

TABLE 1. The SUN* Working Group Anatomic Classification of Uveitis

Type	Primary Site of Inflammation†	Includes
Anterior uveitis	Anterior chamber	Iritis
		Iridocyclitis
		Anterior cyclitis
Intermediate uveitis	Vitreous	Pars planitis
		Posterior cyclitis
		Hyalitis
Posterior uveitis	Retina or choroid	Focal, multifocal, or diffuse choroiditis
		Chorioretinitis
		Retinochoroiditis
		Retinitis
		Neuroretinitis
Panuveitis	Anterior chamber, vitreous, and retina or choroid	

*SUN = Standardization of uveitis nomenclature.

†As determined clinically. Adapted from the International Uveitis Study Group anatomic classification in reference 1.

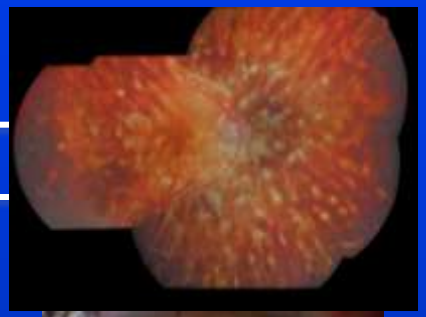
TABLE 2. The SUN* Working Group Descriptors of Uveitis

Category	Descriptor	Comment
Onset	Sudden	
	Insidious	
Duration	Limited	≤3 months duration
	Persistent	>3 months duration
Course	Acute	Episode characterized by sudden onset and limited duration
	Recurrent	Repeated episodes separated by periods of inactivity without treatment ≥3 months in duration
	Chronic	Persistent uveitis with relapse in <3 months after discontinuing treatment

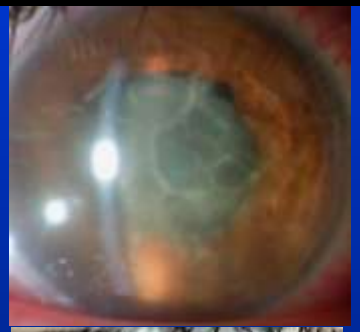
*SUN = Standardization of uveitis nomenclature.

Démarche diagnostique raisonnée

Atteinte concomitante bilatérale

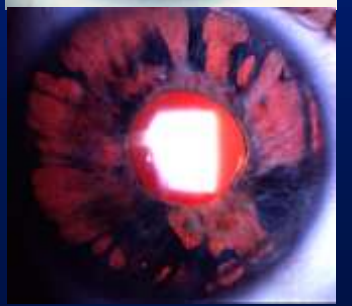


Atteinte bilatérale à bascule



Atteinte unilatérale chronique

Atteinte unilatérale récidivante



Recherche de l'étiologie

~~Check-list systématique~~

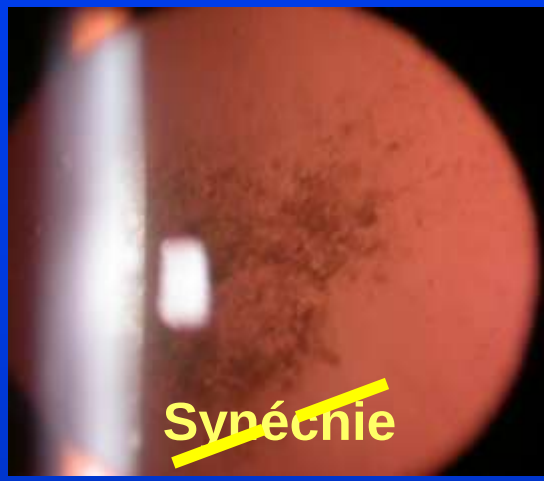
Examens selon :

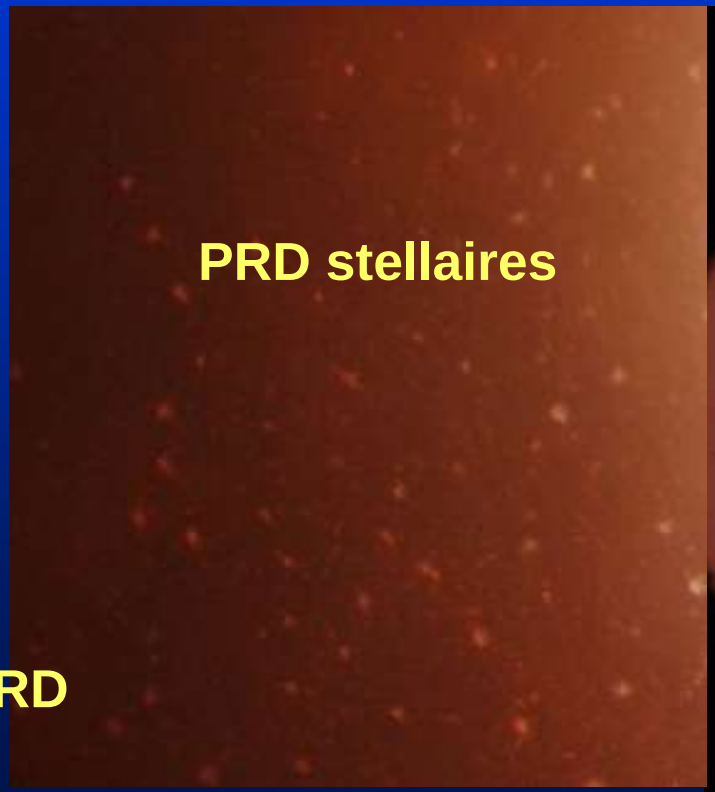
- Manifestations extraoculaires
- Sémiologie ophtalmologique
- Intensité de l'uvéite

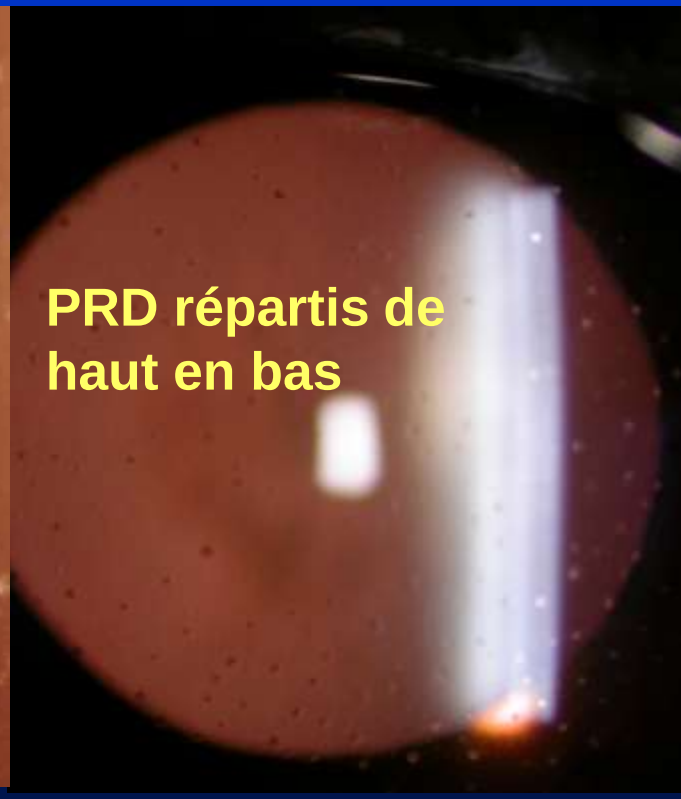
Exemples d'uvéites ne nécessitant PAS d'examens complémentaires pour leur diagnostic

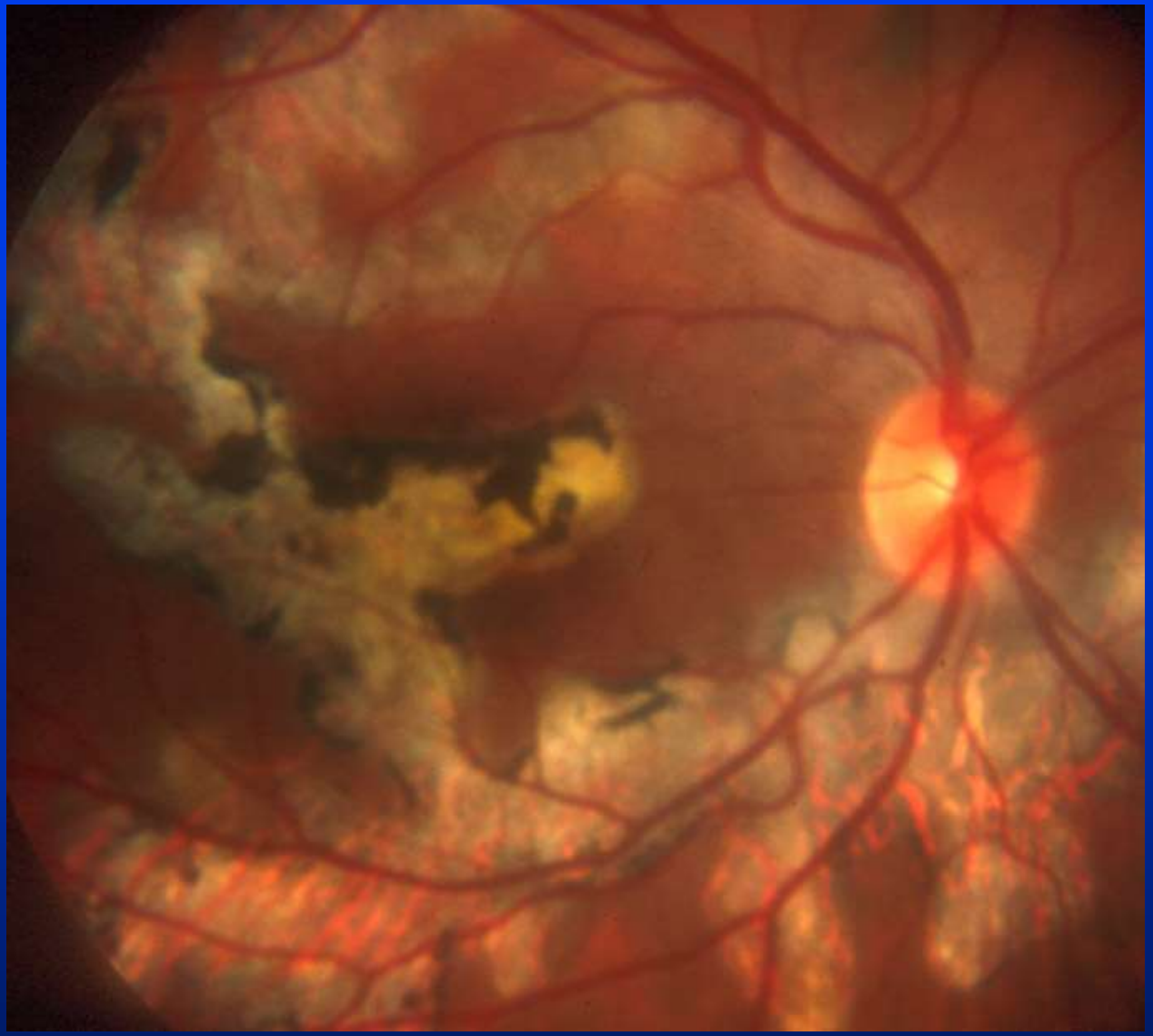
- Cyclite hétérochromique de Fuchs
- Epithéliopathie en plaques
- Maladie de Behçet
- Choroïdite serpigineuse

Cyclite hétérochromique de Fuchs



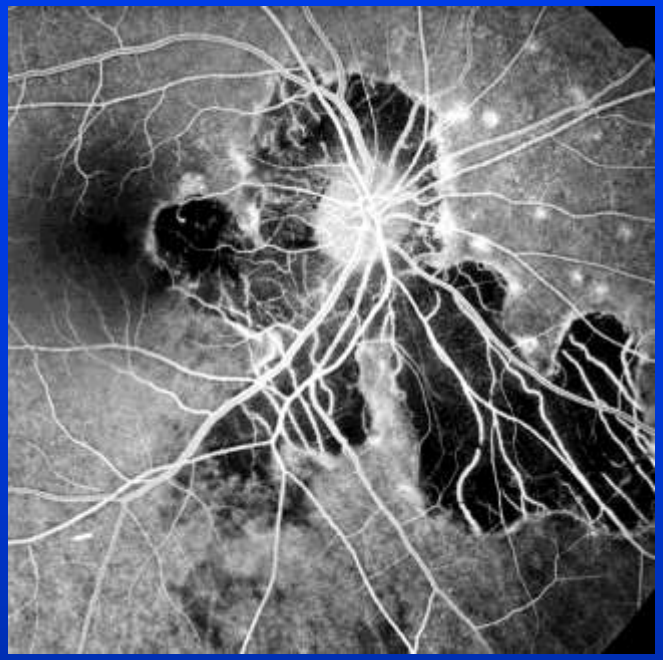


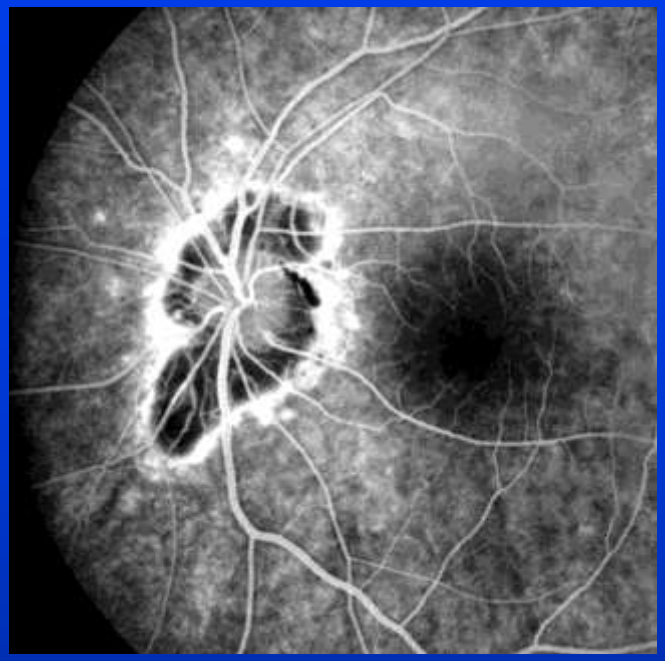


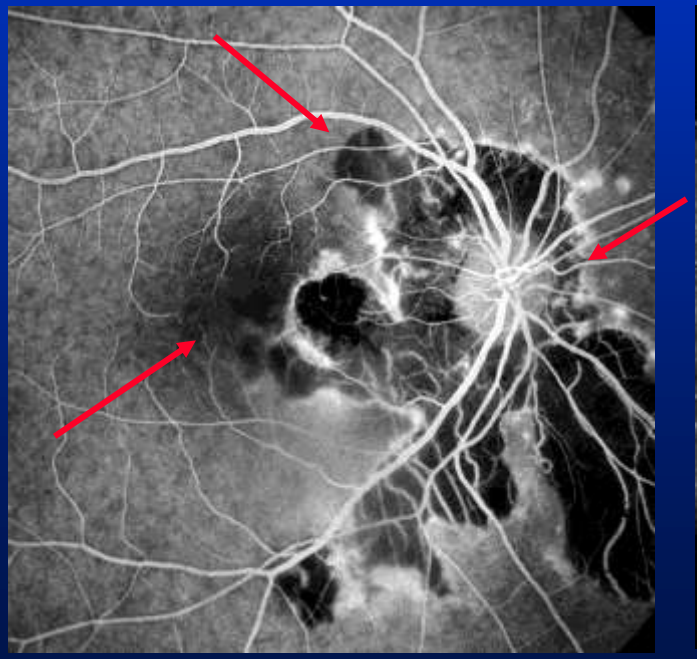


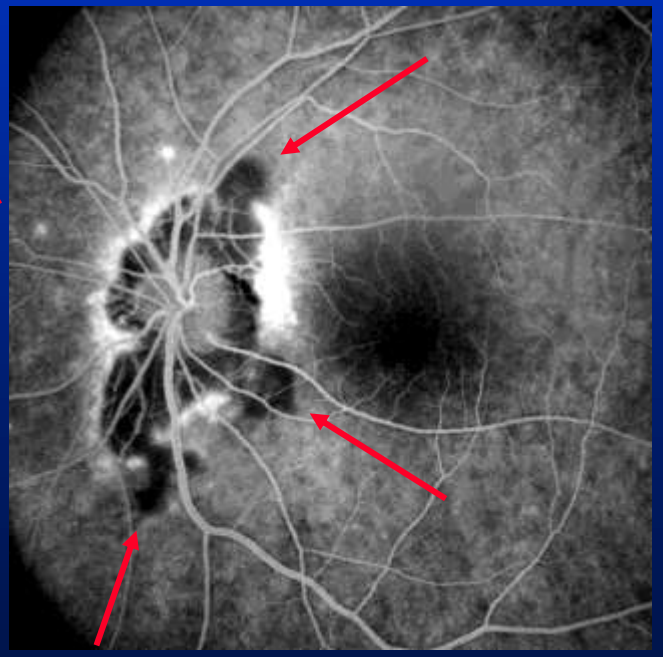
Choroïdite serpigineuse

+ 6 mois

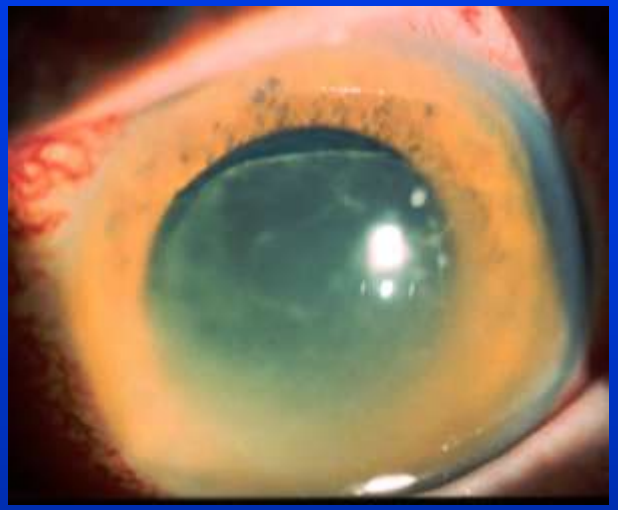
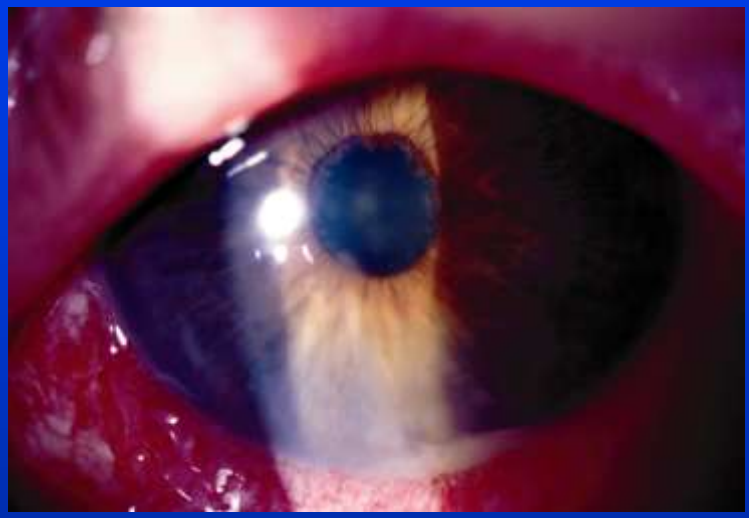








Uvéites antérieures aiguës

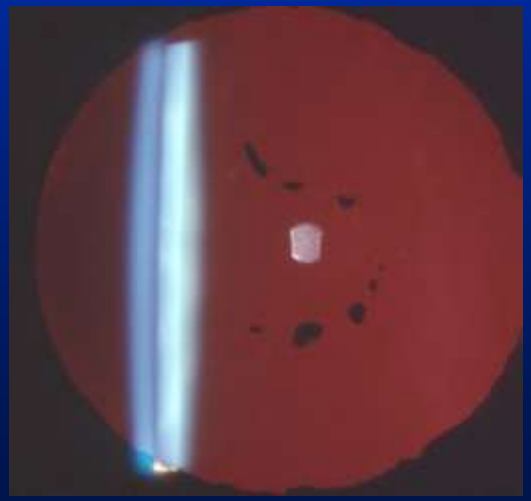
UN examen complémentaire, avant autres investigations

HLA B27

- **Positif**
- **Négatif**

Traitement des uvéites aiguës

Succès



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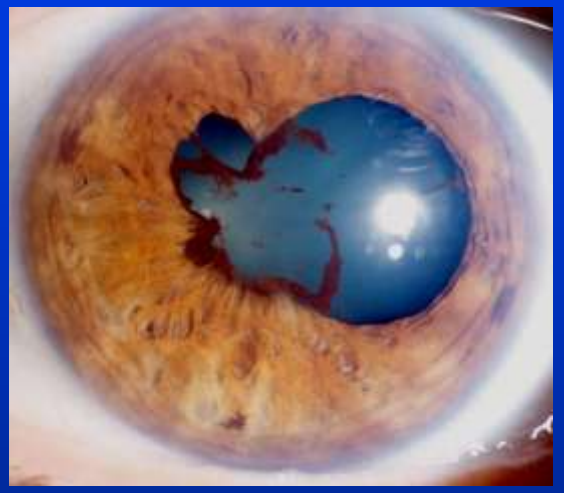
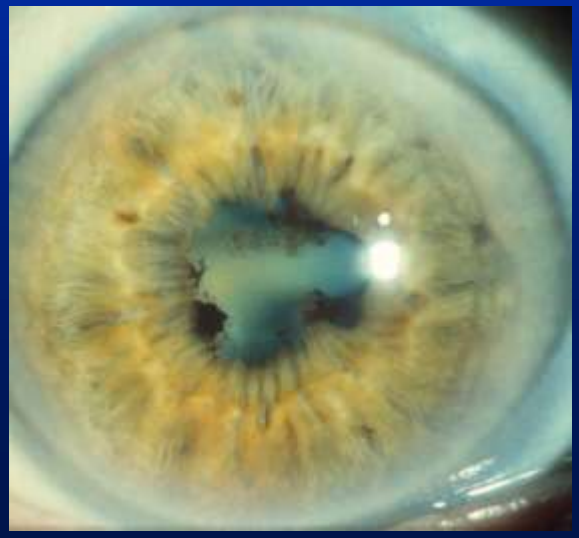
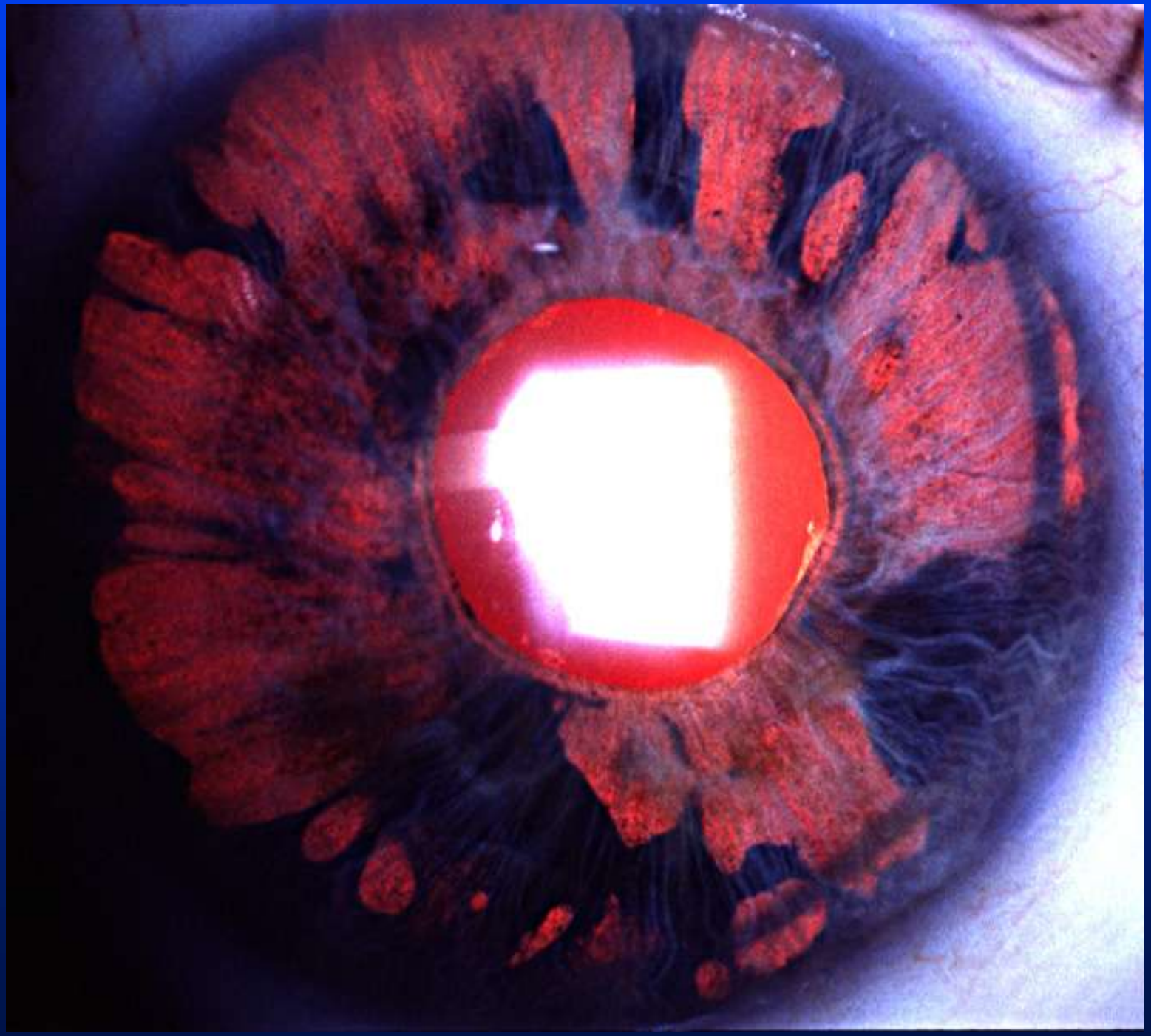
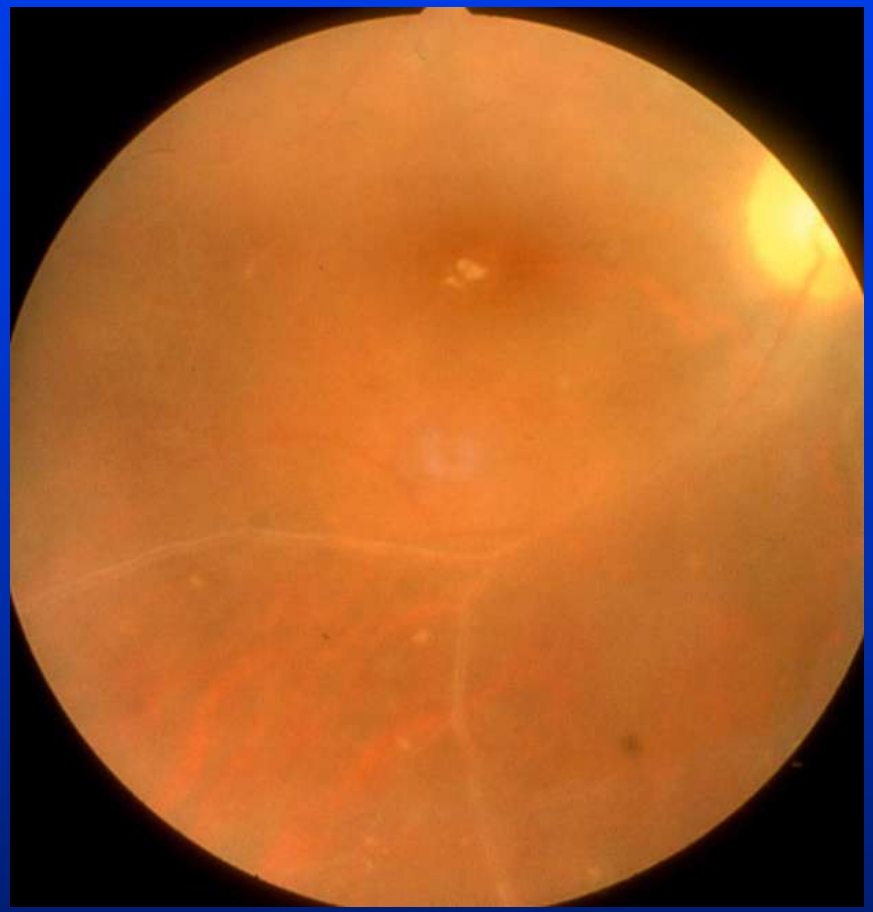






Segmentite herpétique

Diagnostic clinique :
- unilatéralité
- atrophie irienne
- évolution par poussées
- antécédents d ’herpès labial ou cornéen
- hypertonie



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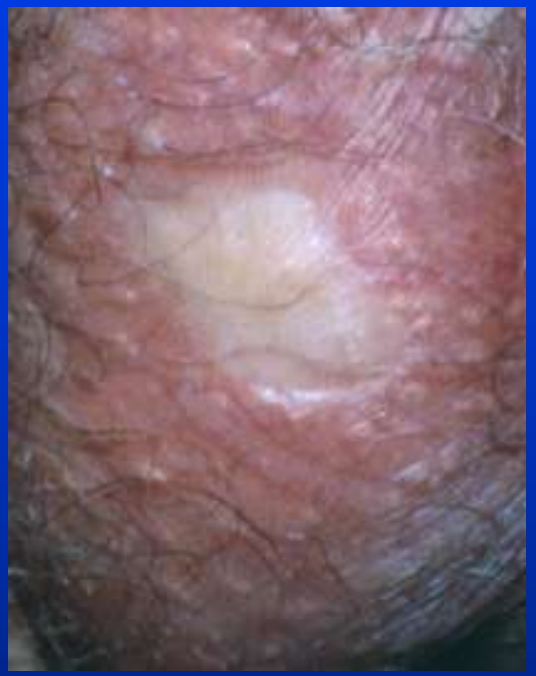
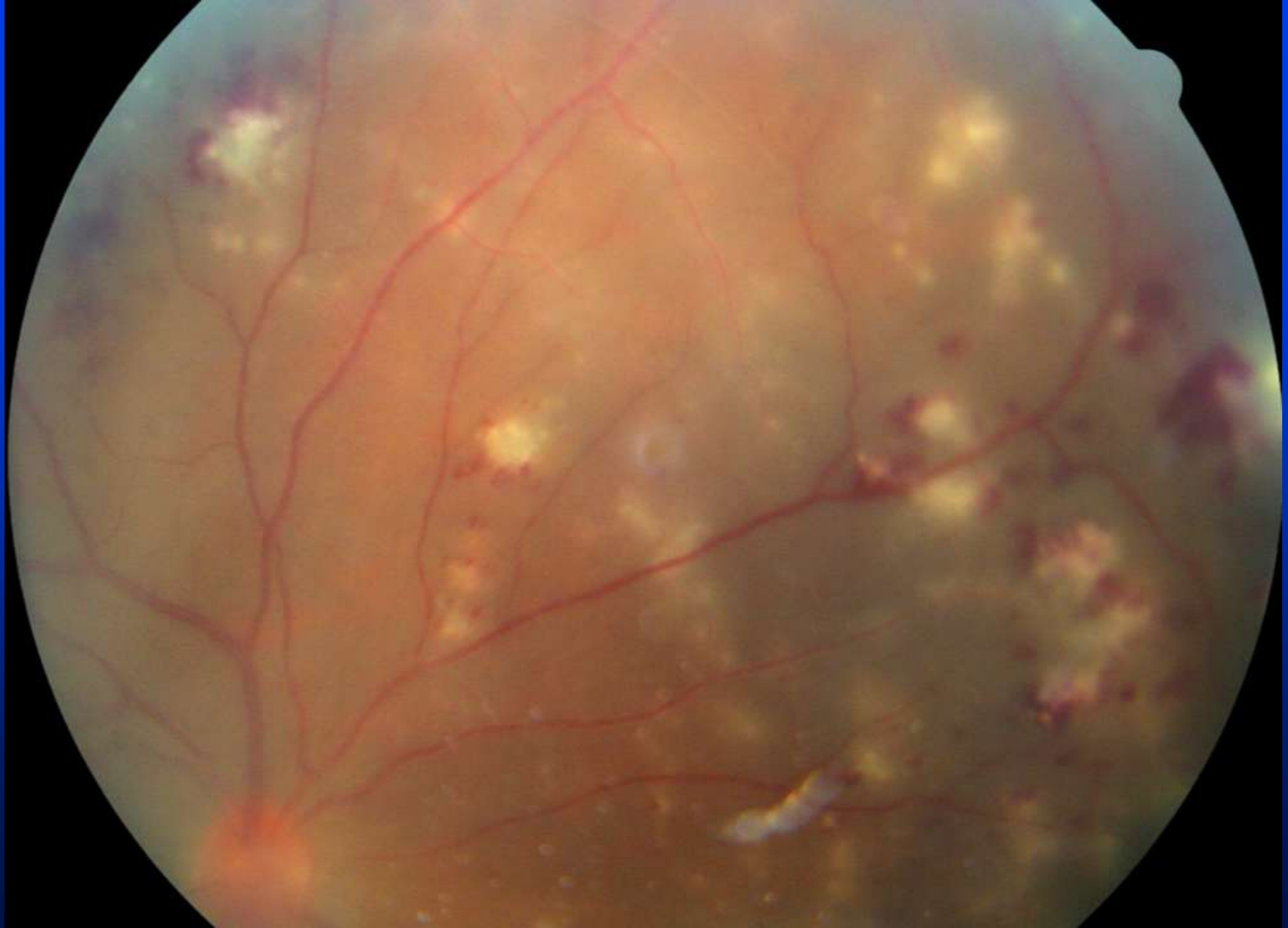
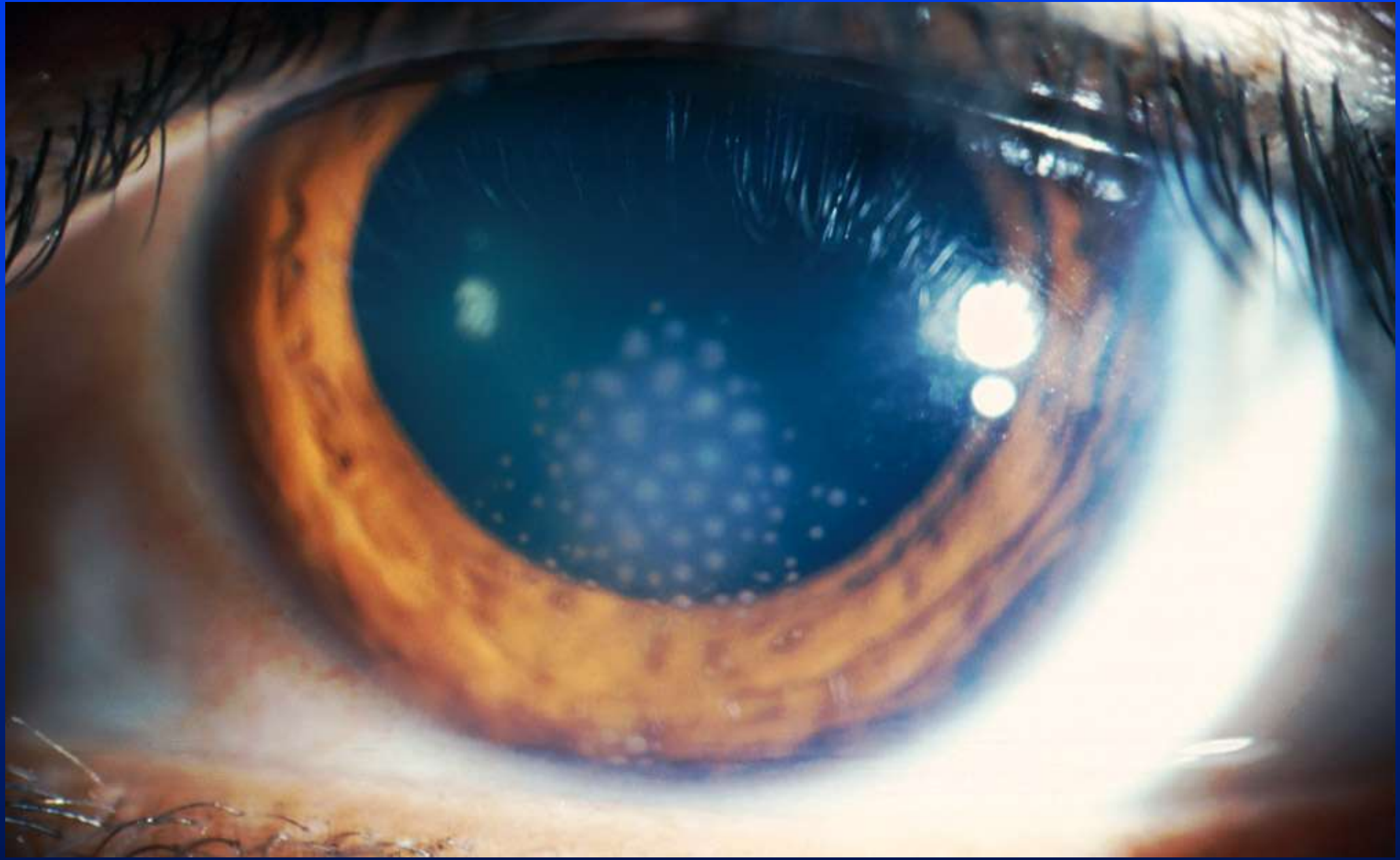


Maladie de Behçet

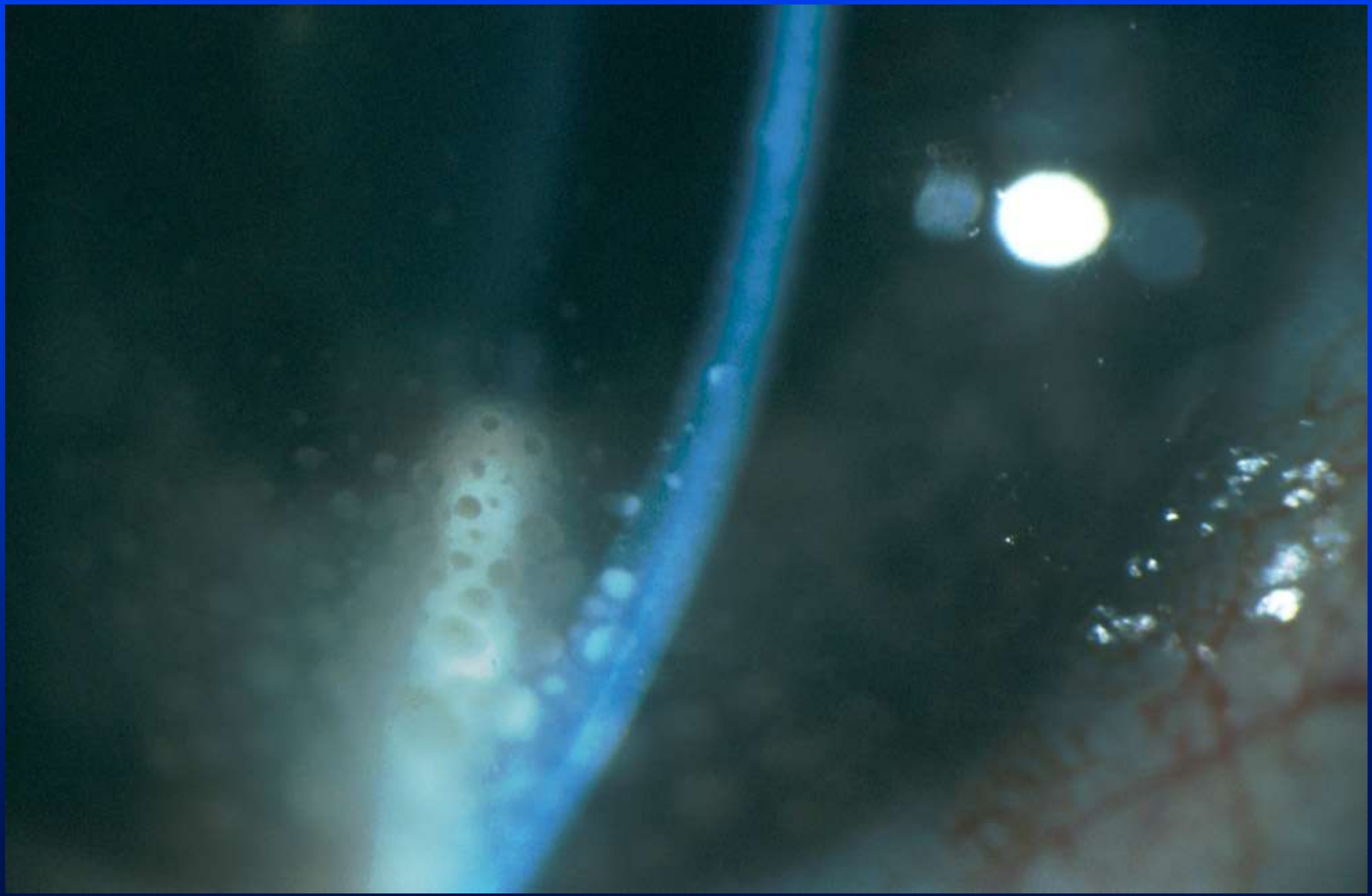


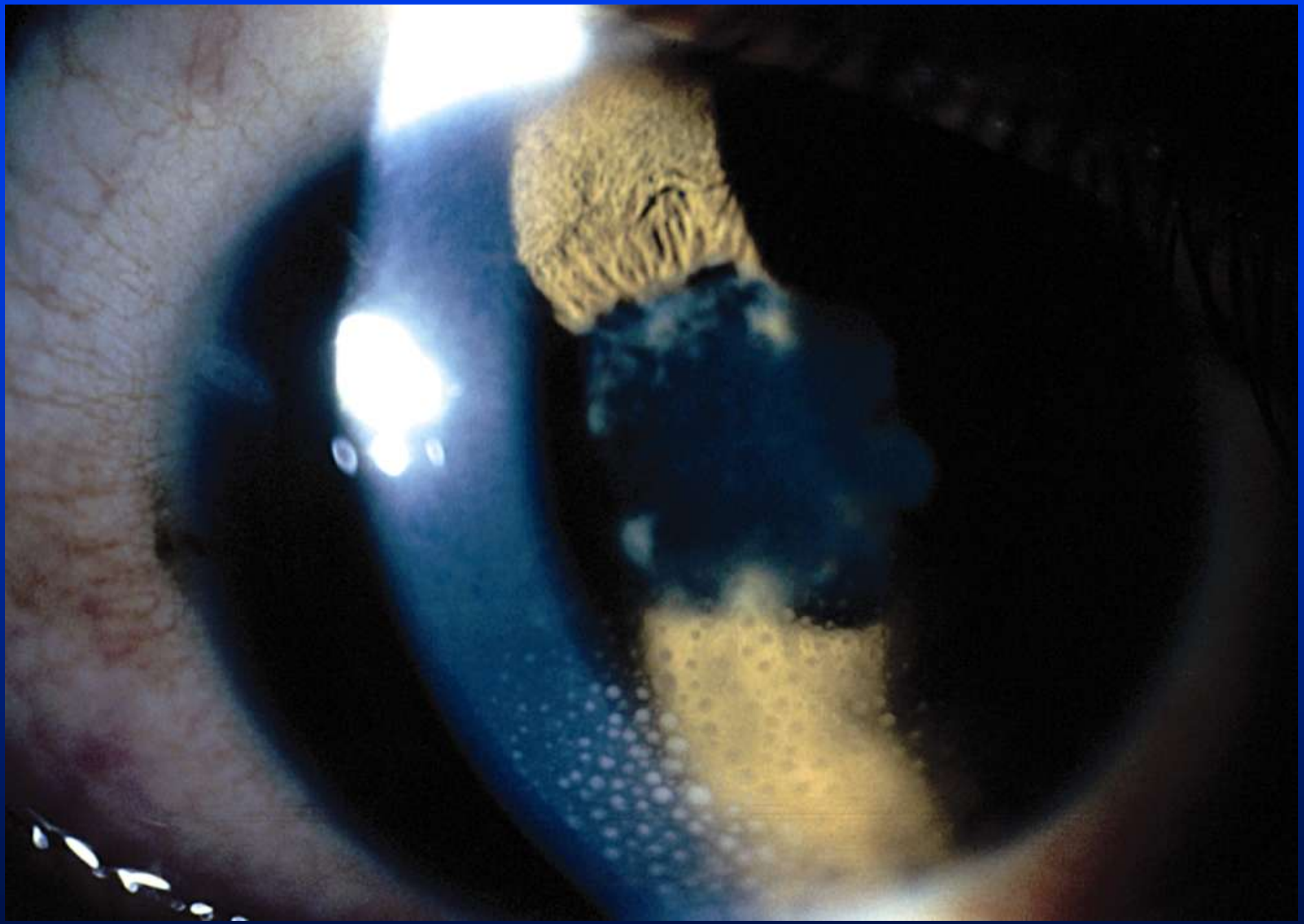


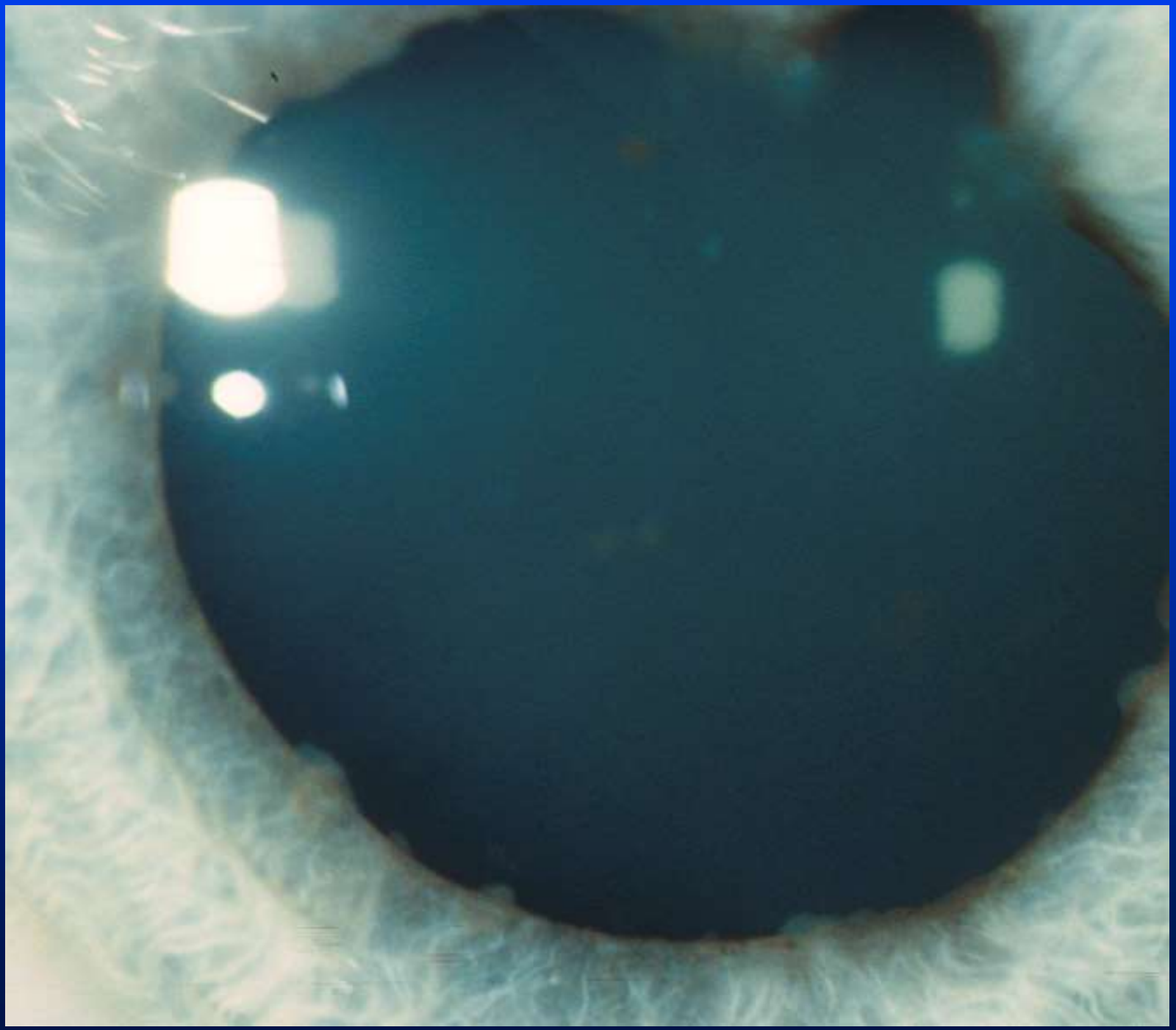
Uvéite granulomateuse ➔ **Diagnostic simple… ou complexe !**

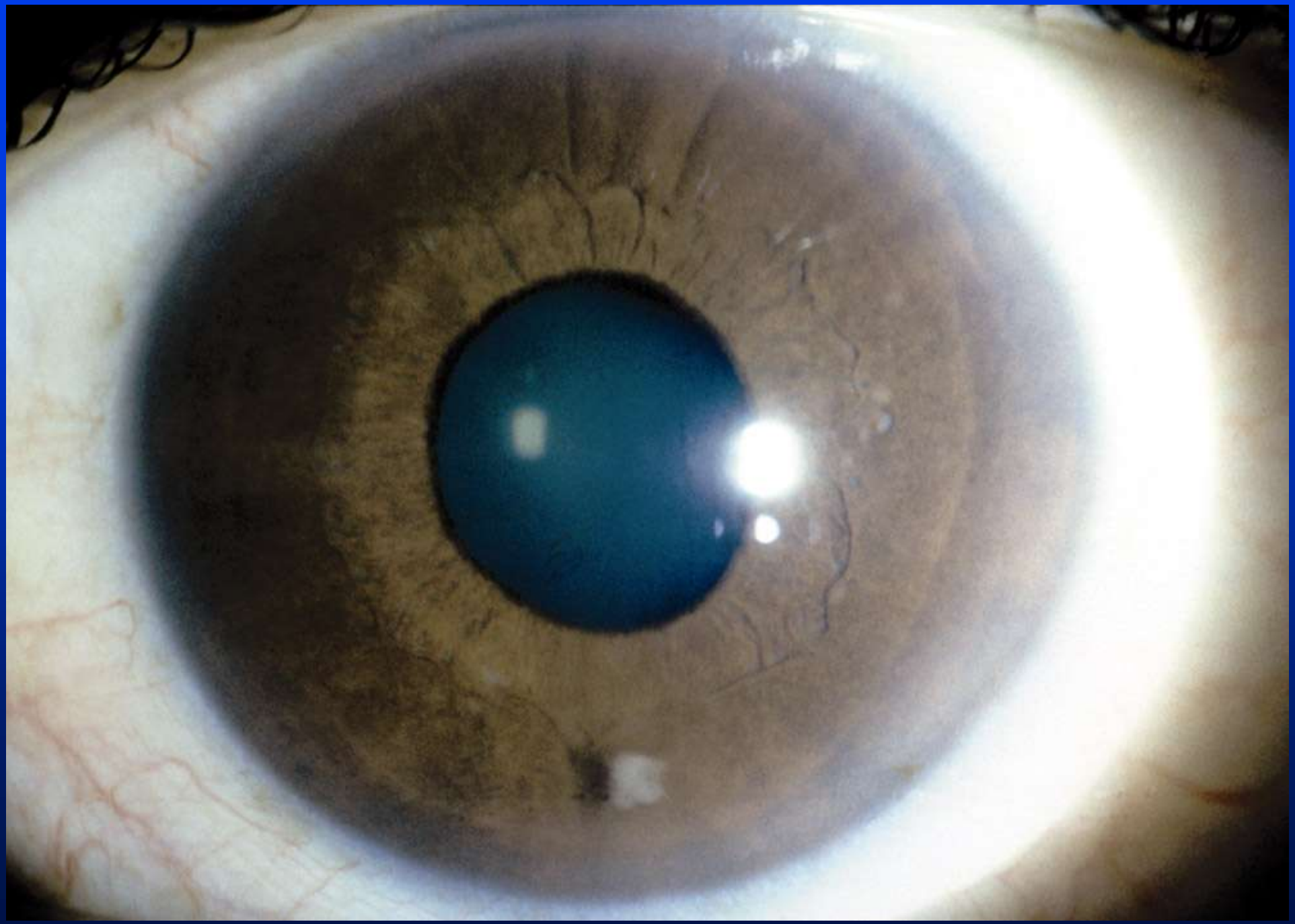
Uvéites susceptibles d'avoir une présentation antérieure granulomateuse

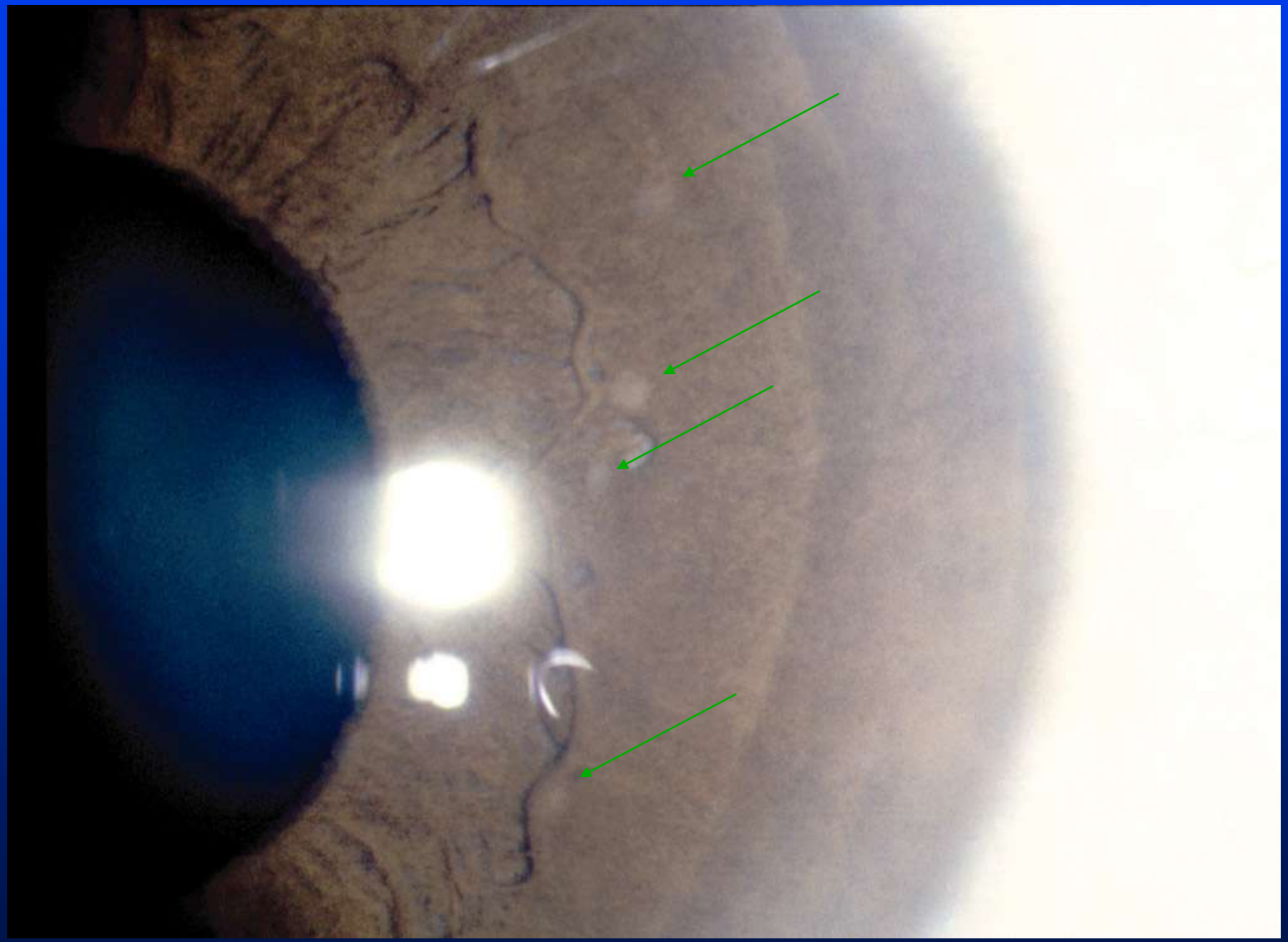
Sarcoïdose
Sclérose en plaques
Maladie de Vogt-Koyanagi-Harada
Rectocolite hémorragique
Ophtalmie sympathique
Uvéites phacoantigéniques
Toxoplasmose, toxocarose
Syphilis, maladie de Lyme, tuberculose, lèpre, brucellose
Uvéites associées à HTLV-1
Uvéites médicamenteuses

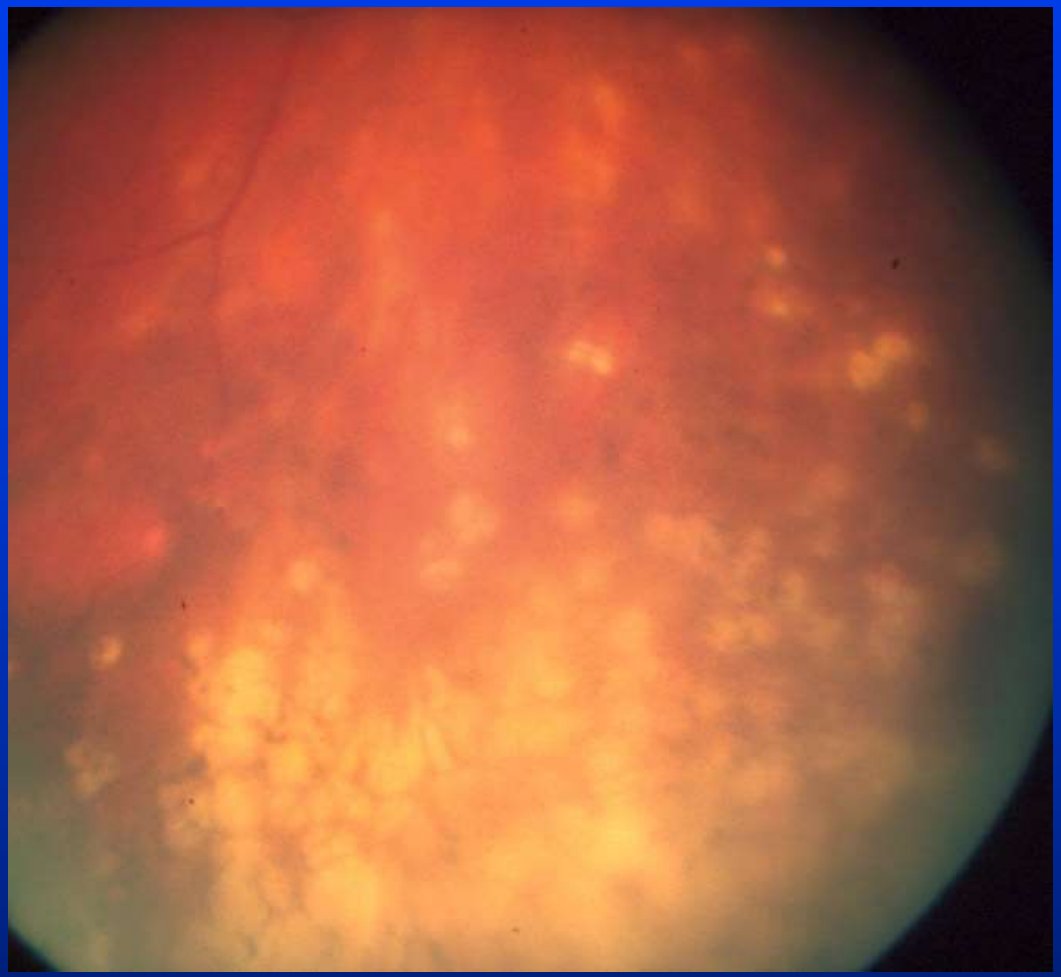






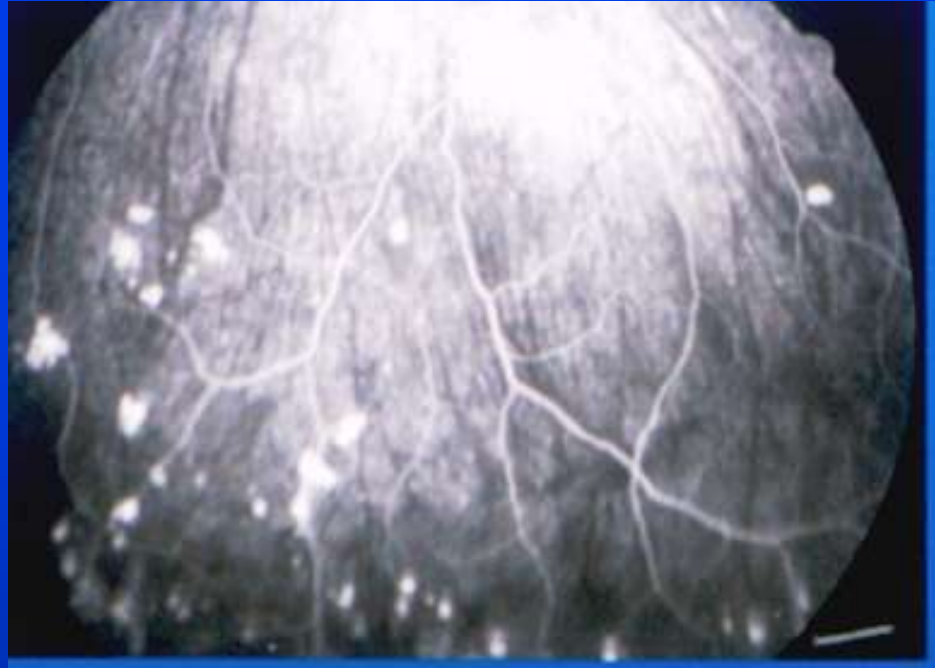


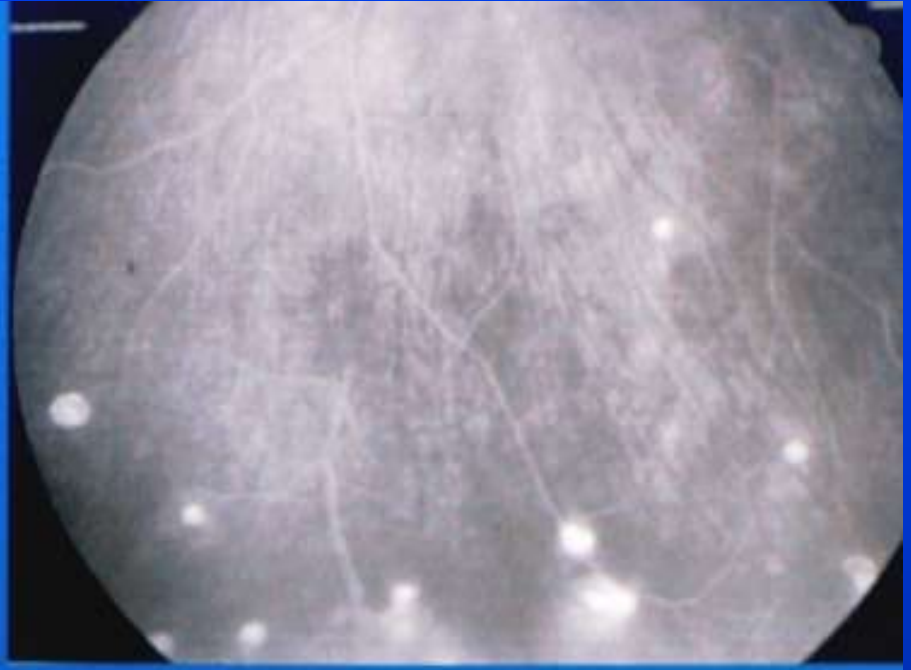


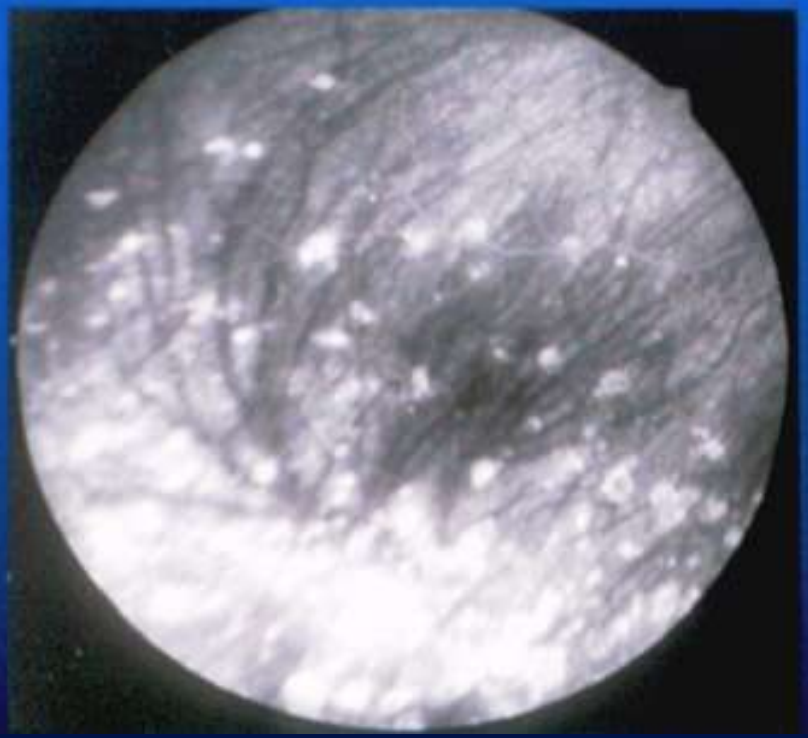


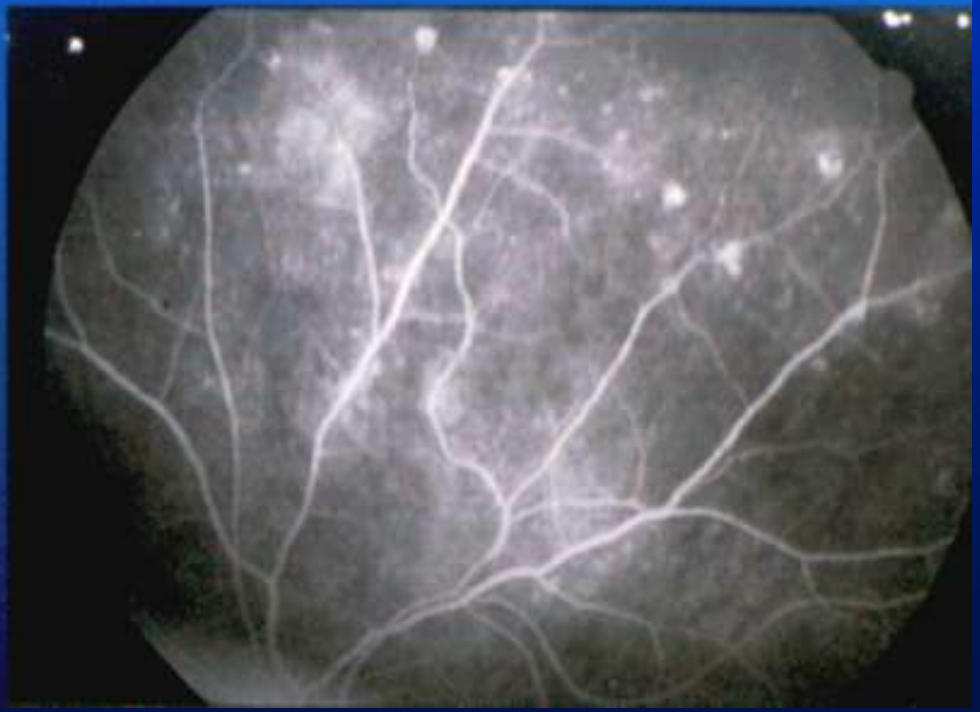
Choroïdite multifocale périphérique ou « taches de bougies »

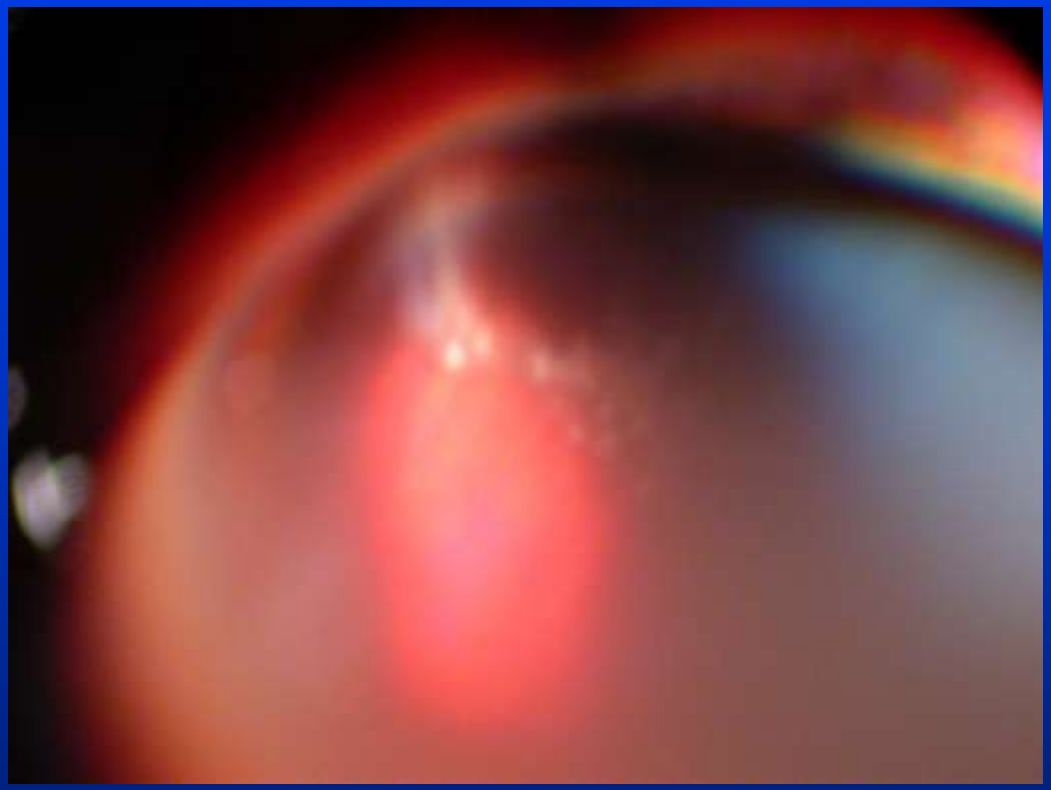
Sarcoïdose





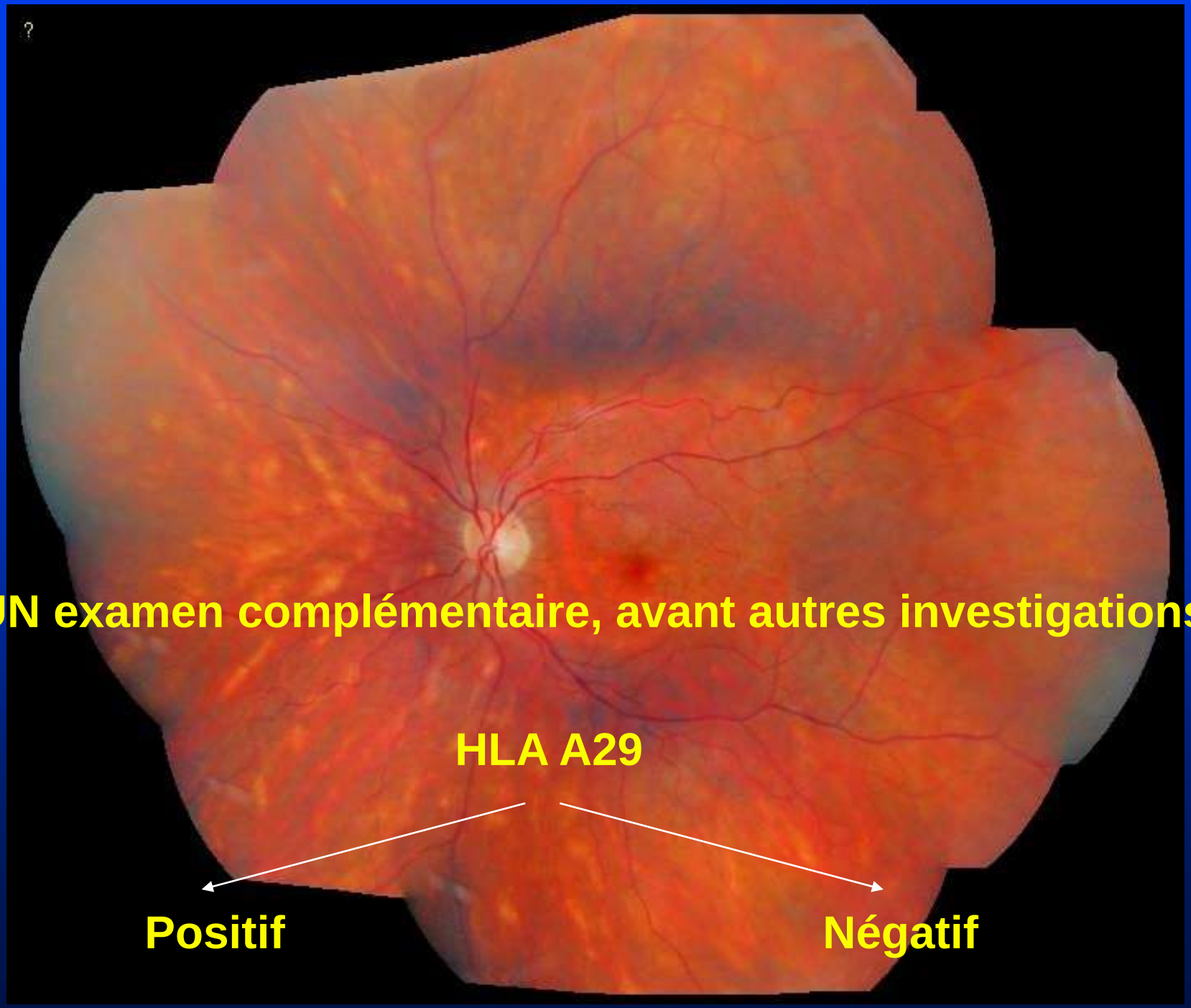


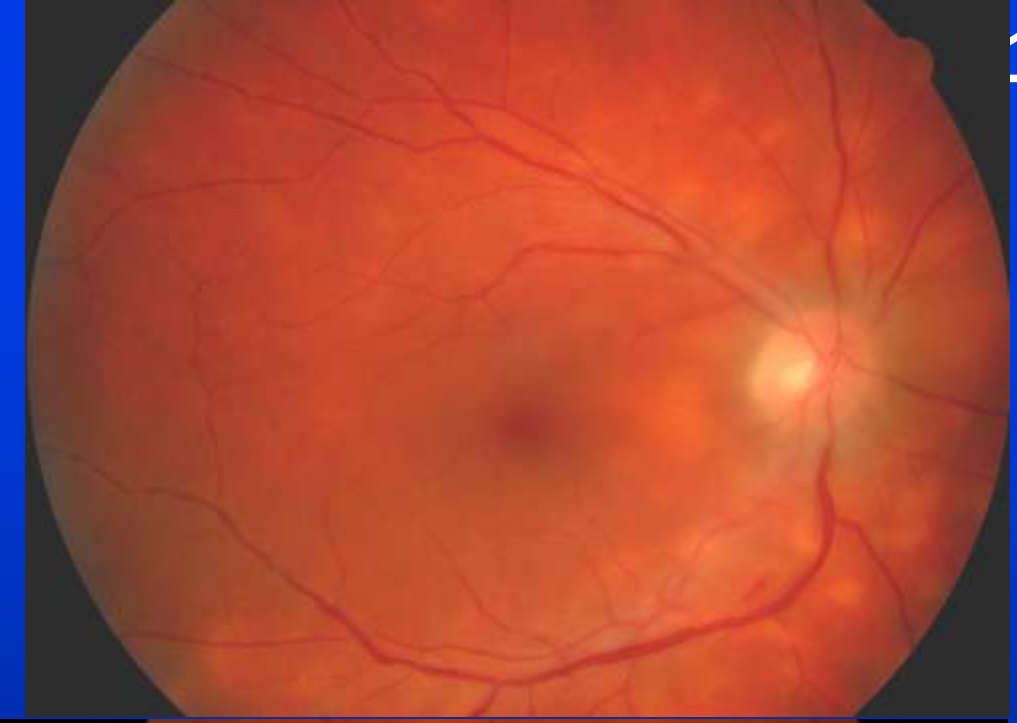




Uvéite intermédiaire

Faible taux d’élucidation diagnostique


UN examen complémentaire, avant autres investigations
HLA A29
Positif
Négatif



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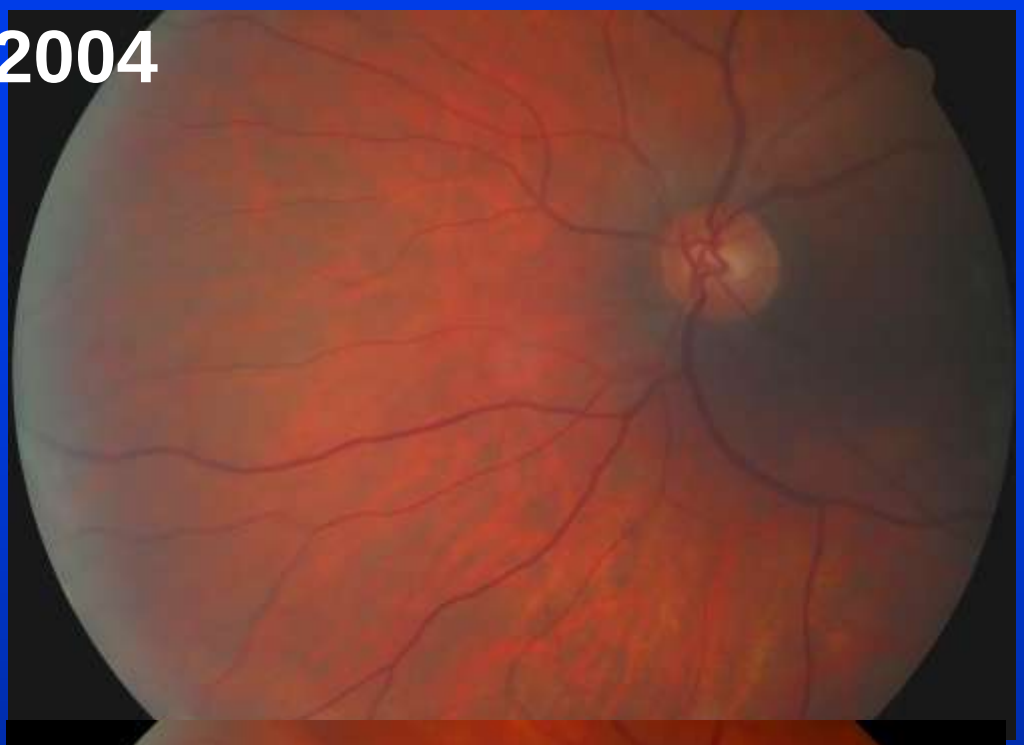

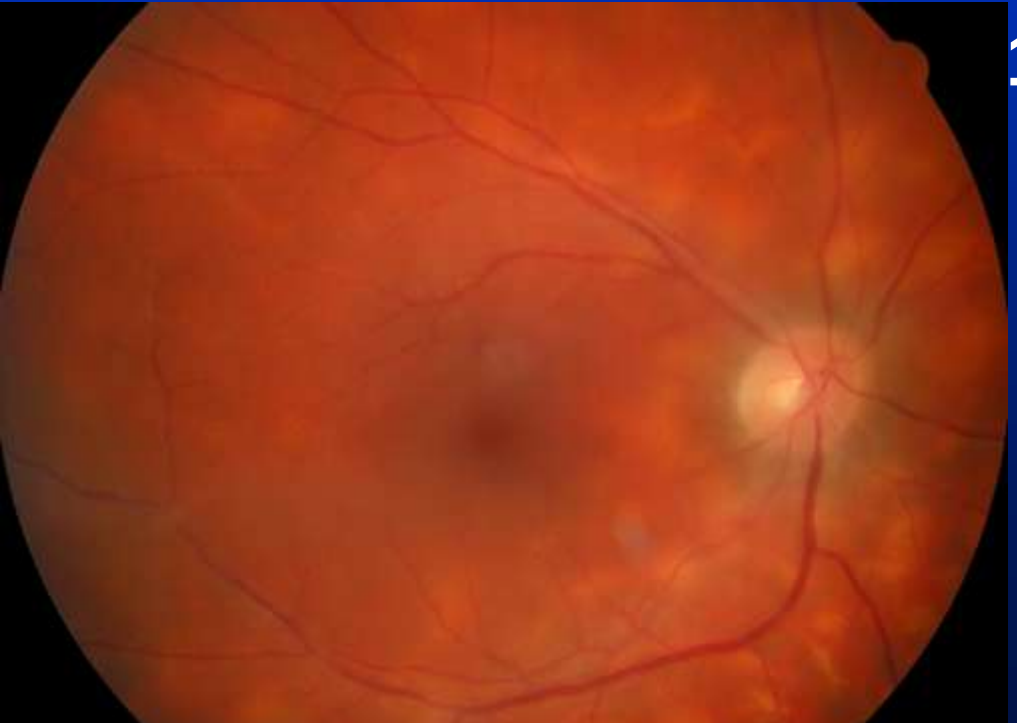

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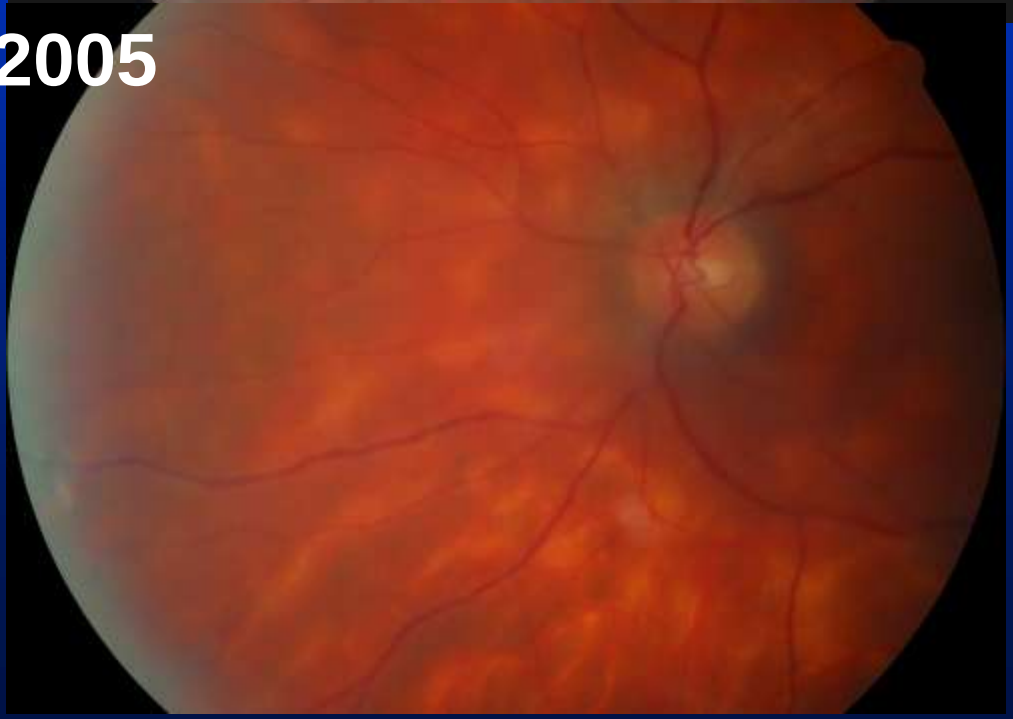

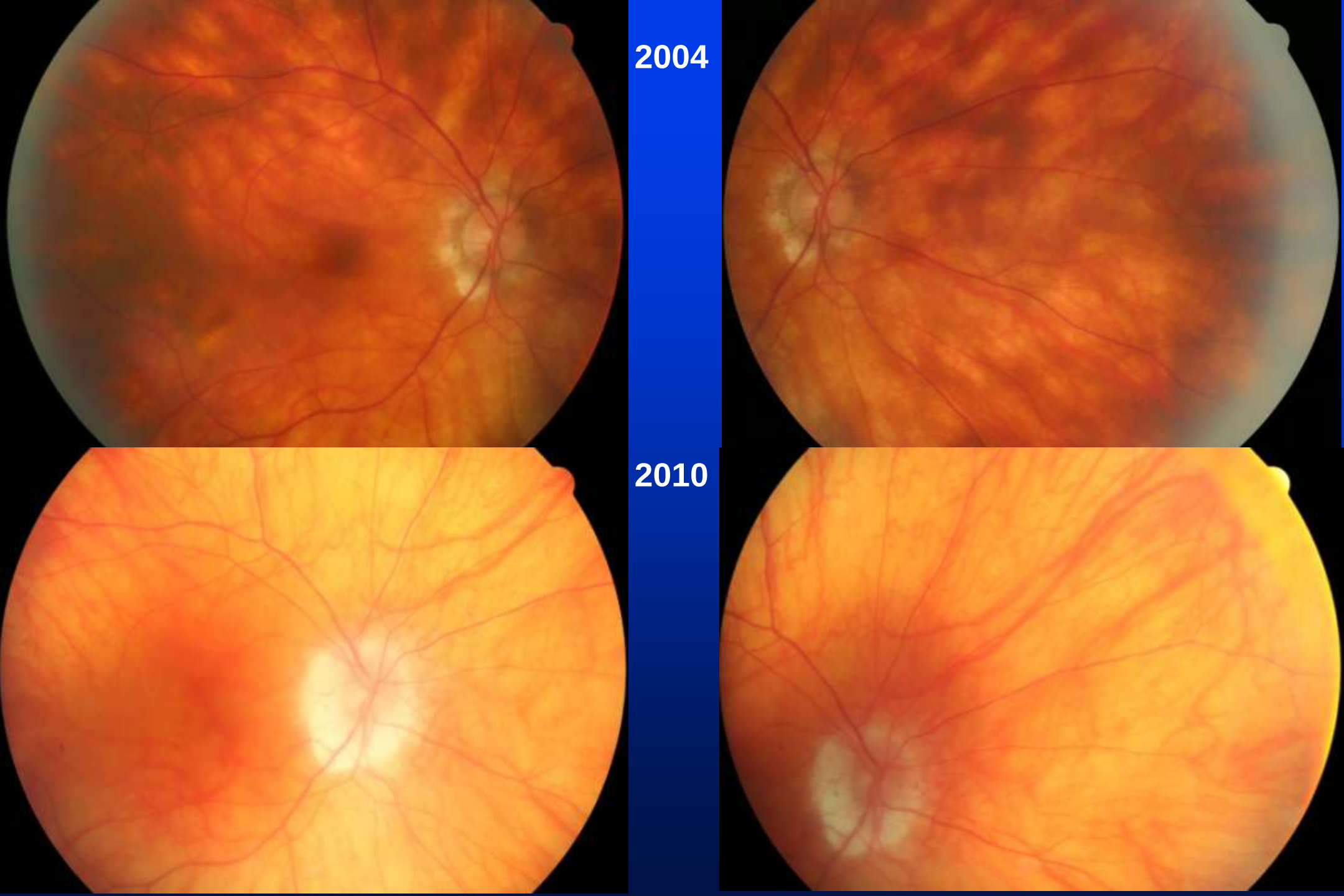
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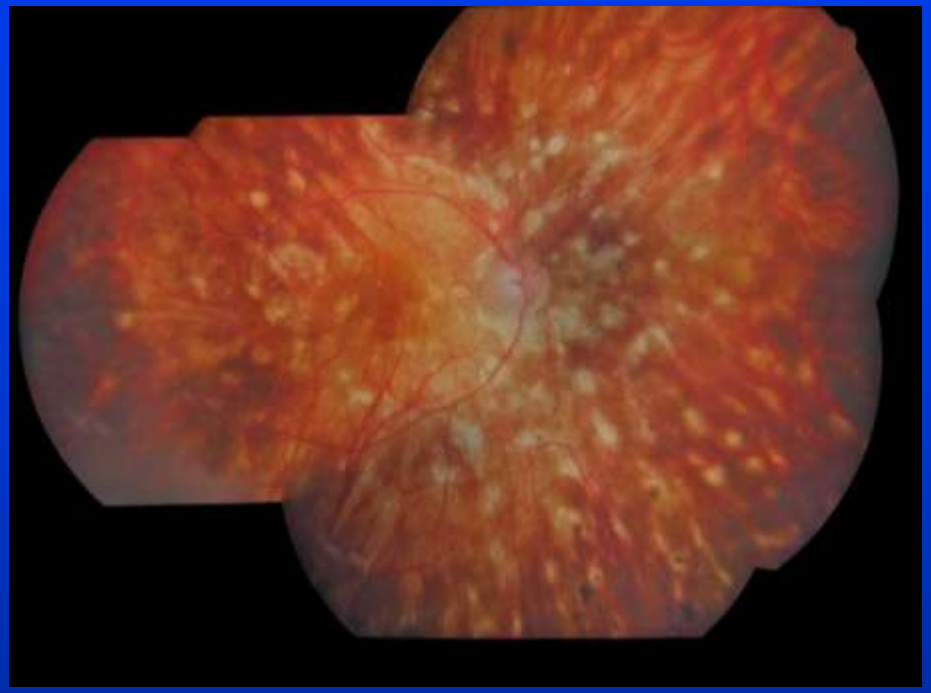
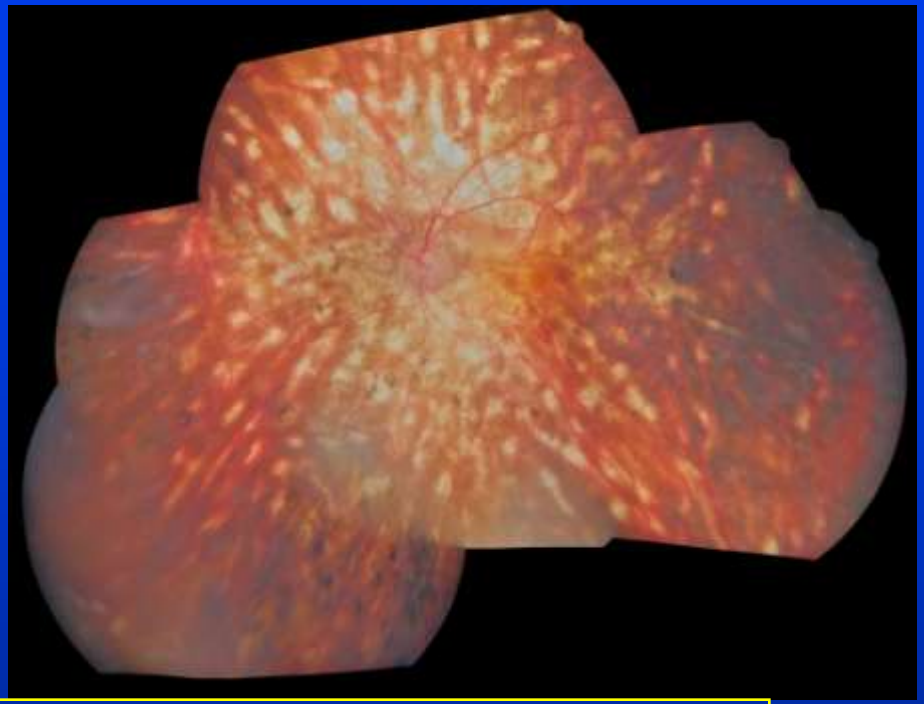
2010





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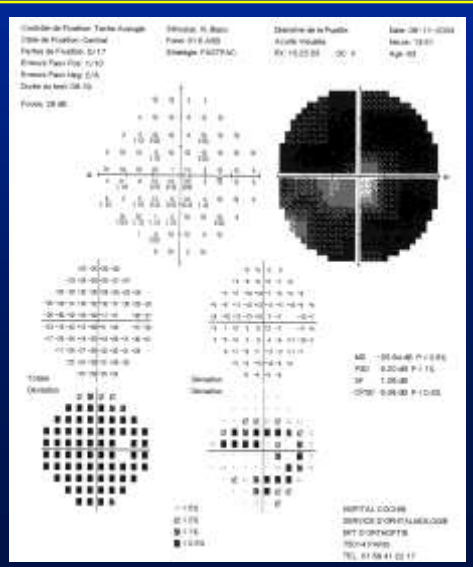

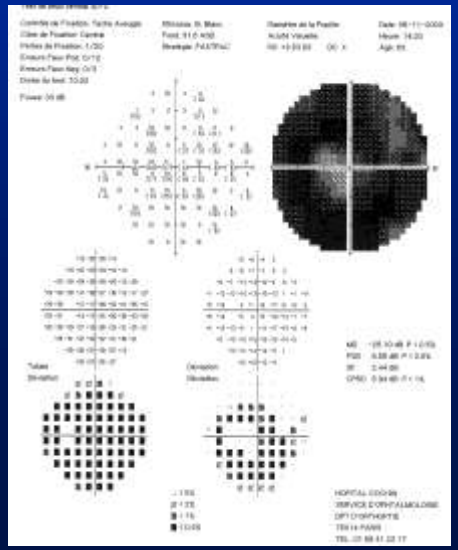

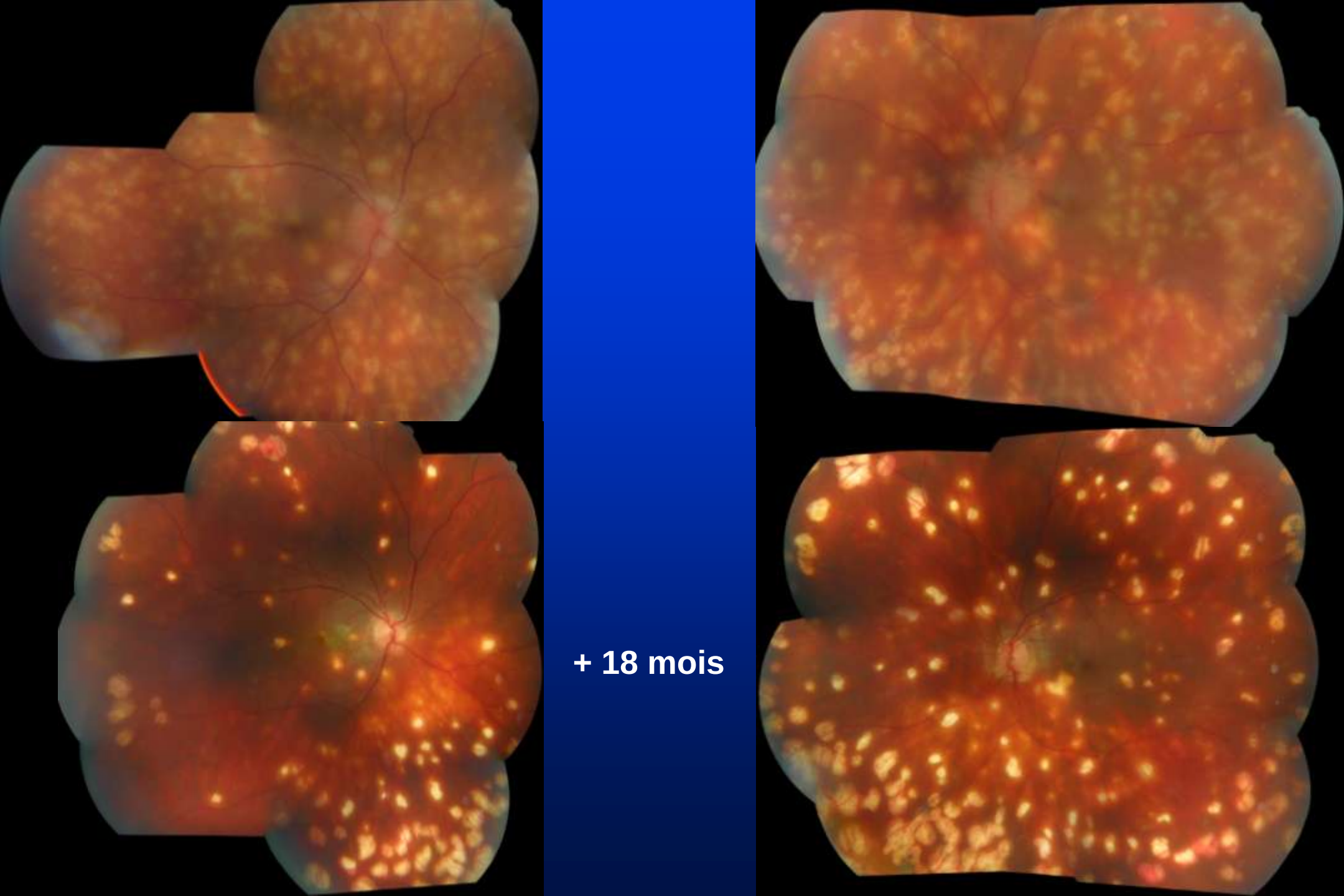
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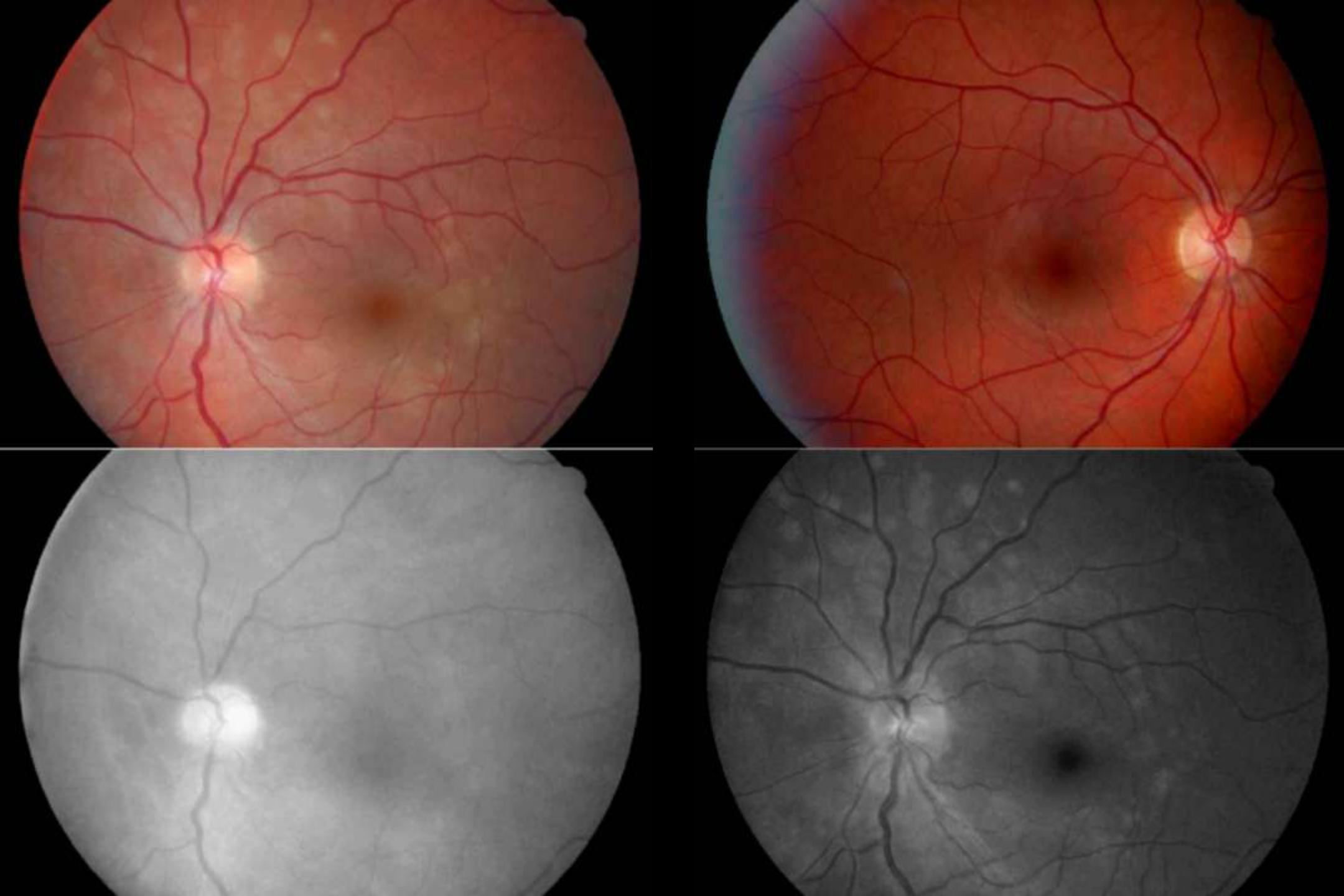

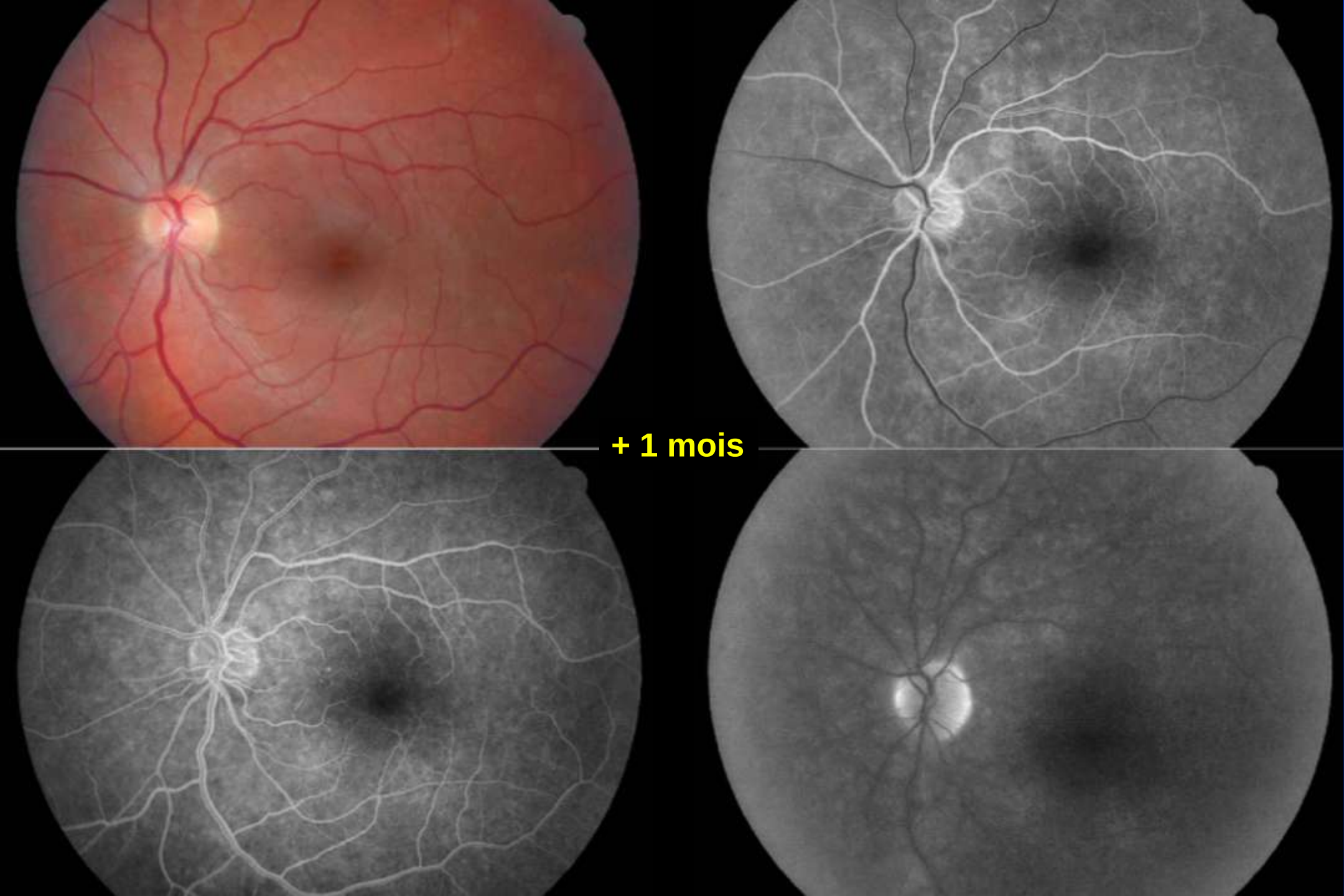
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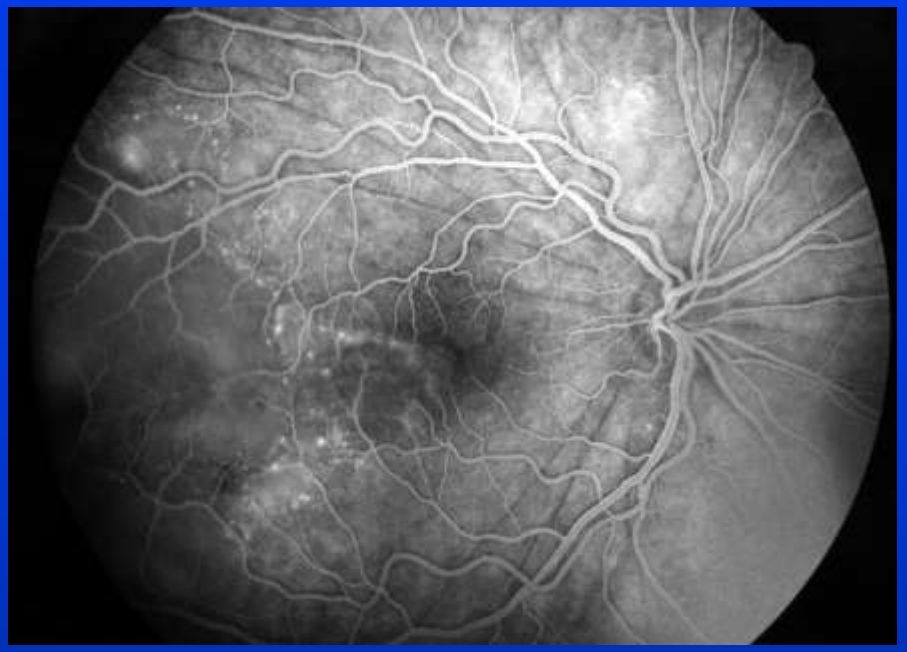

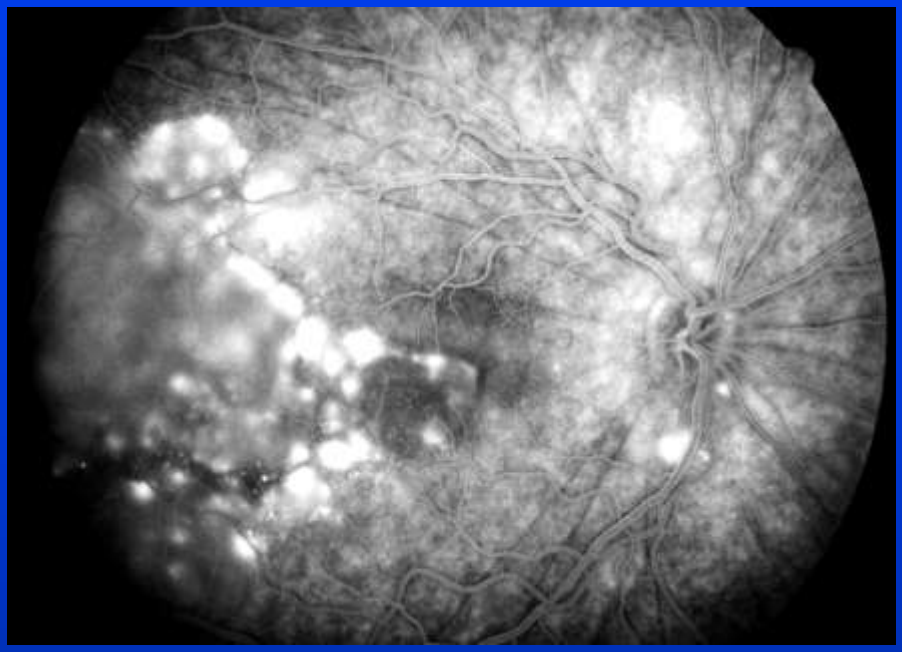

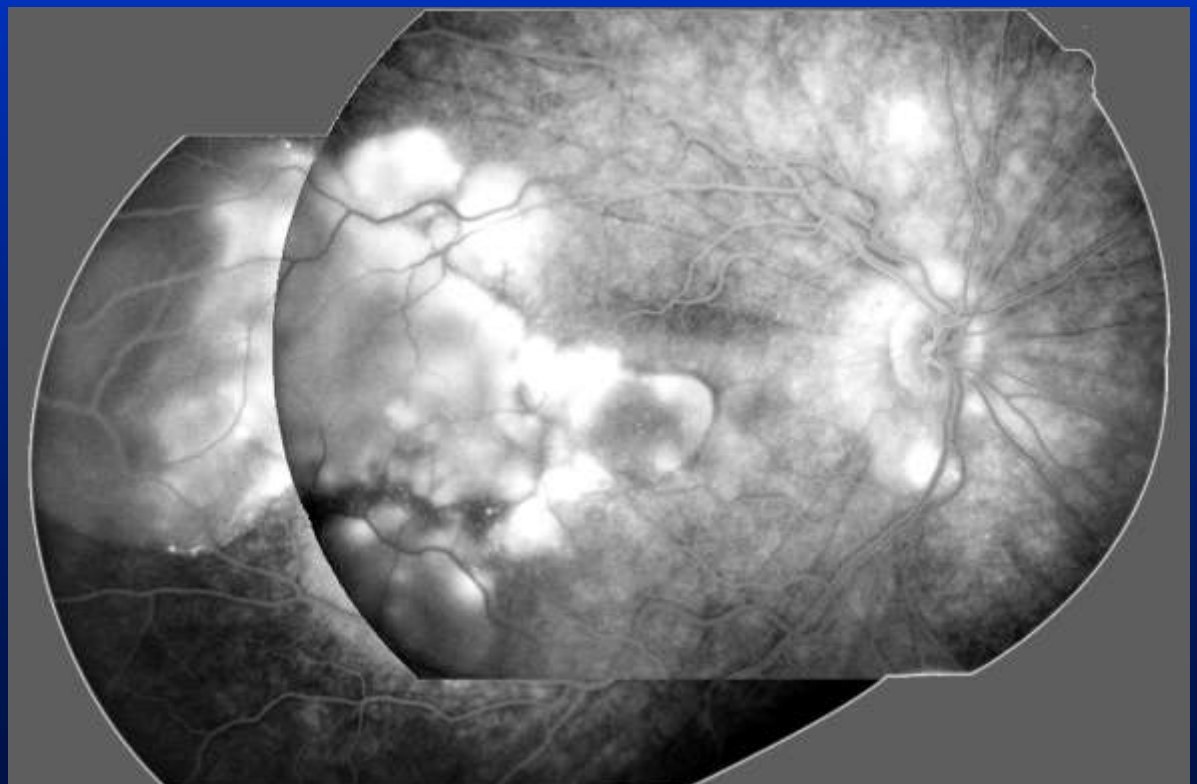

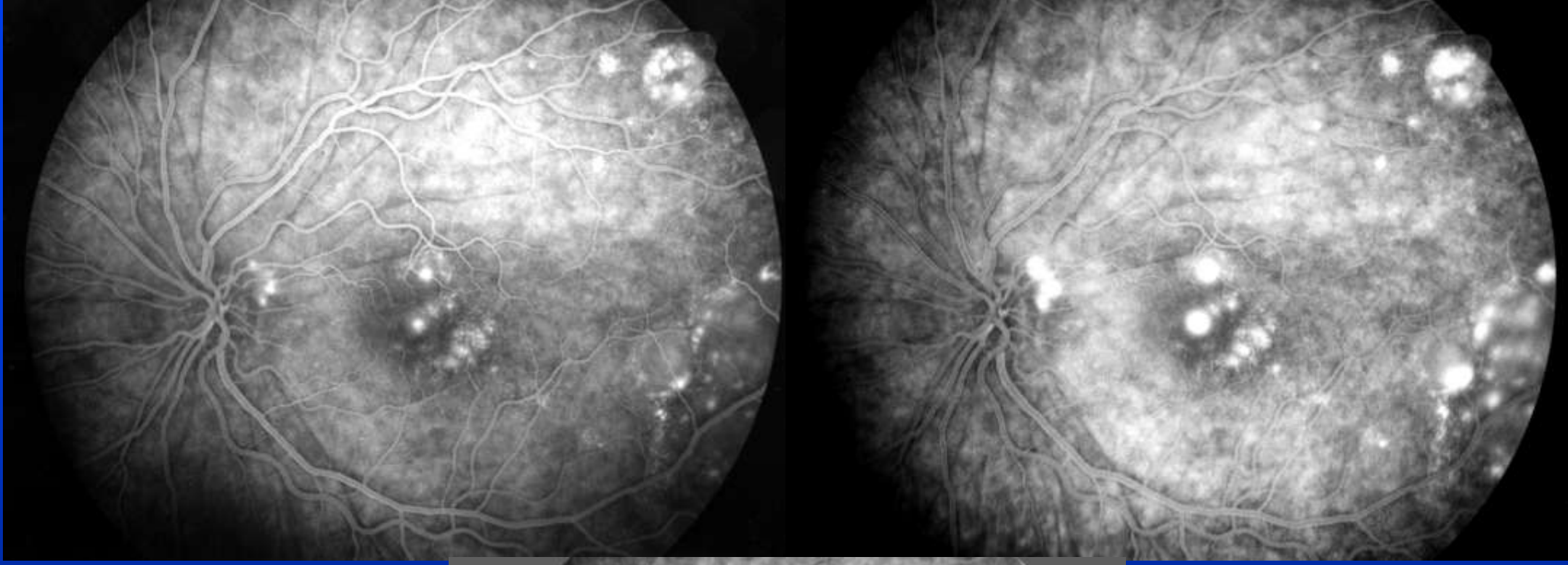

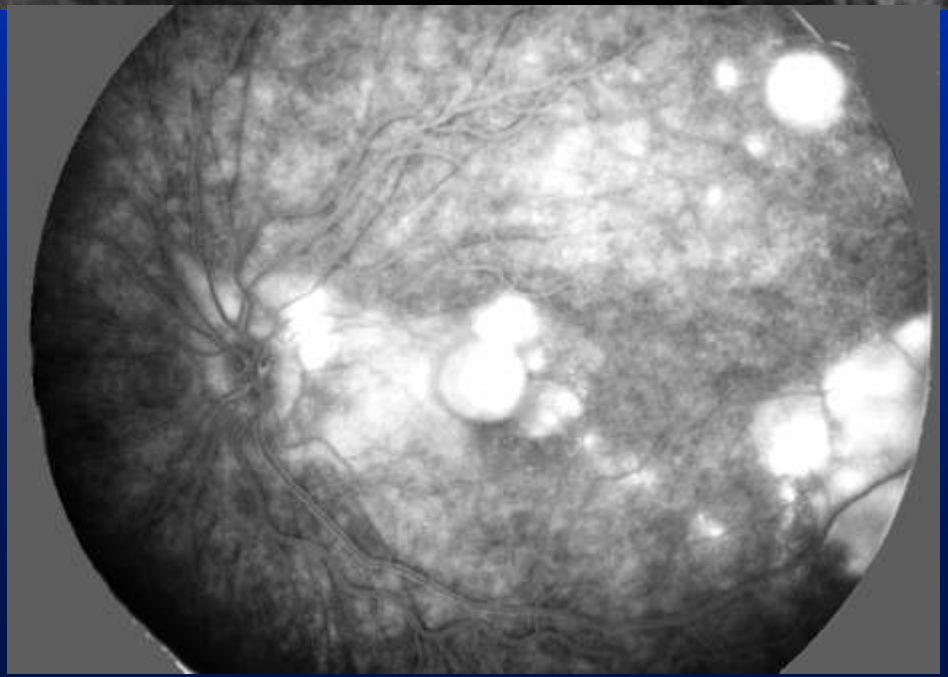

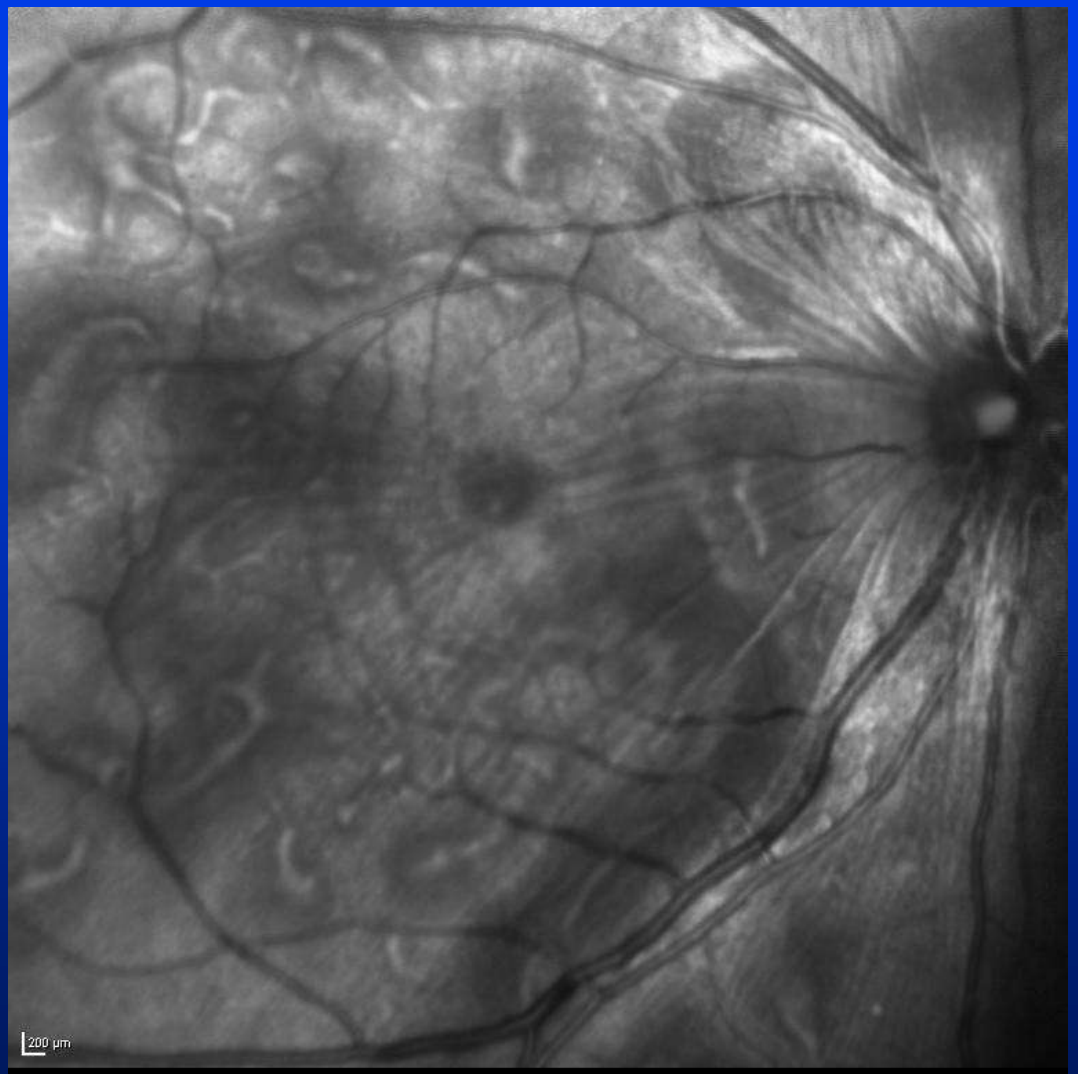
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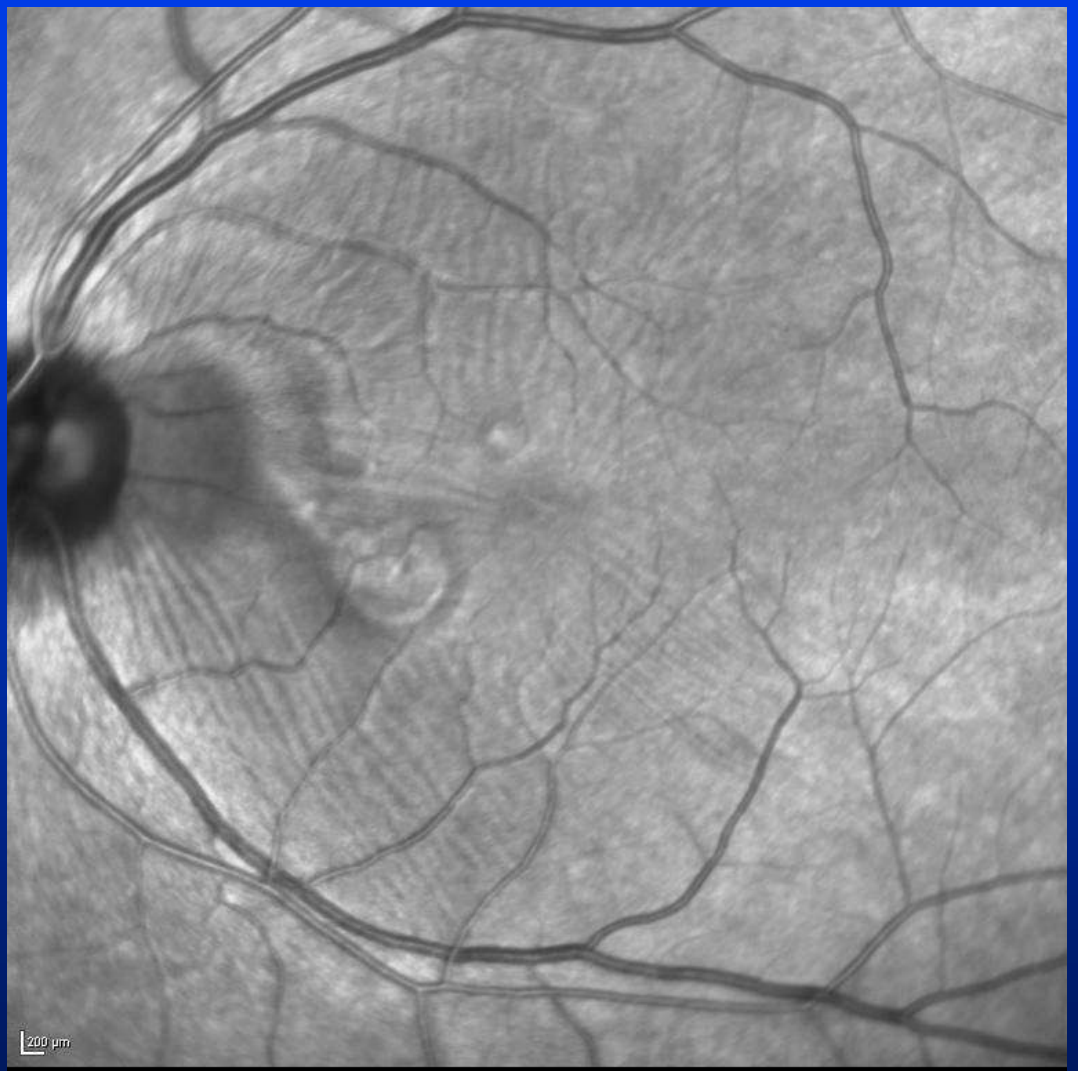
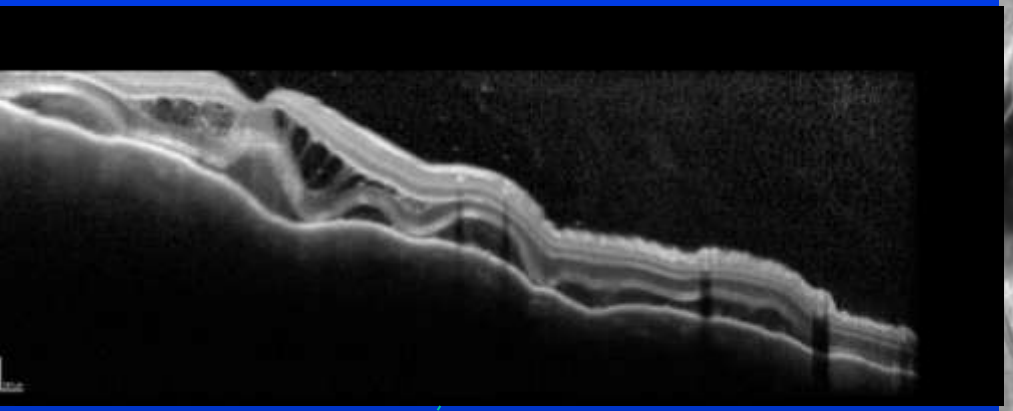
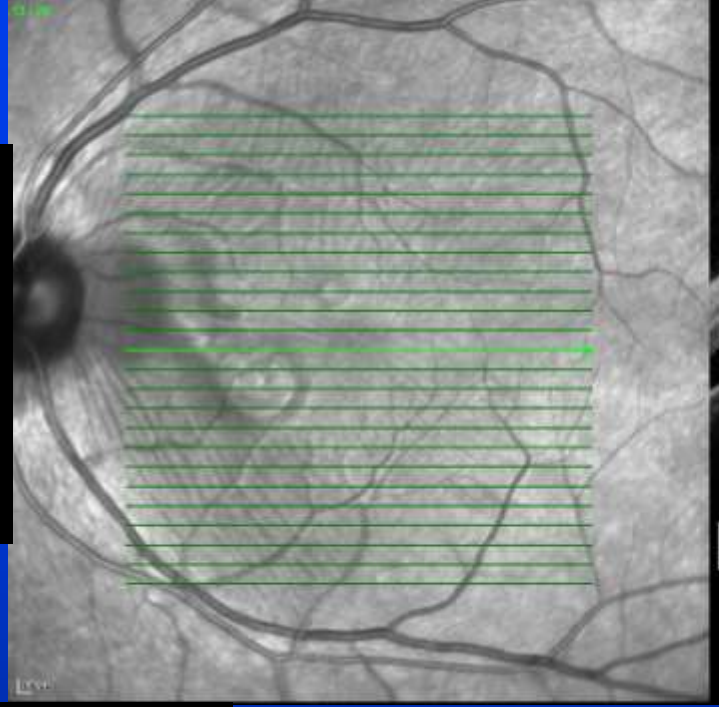
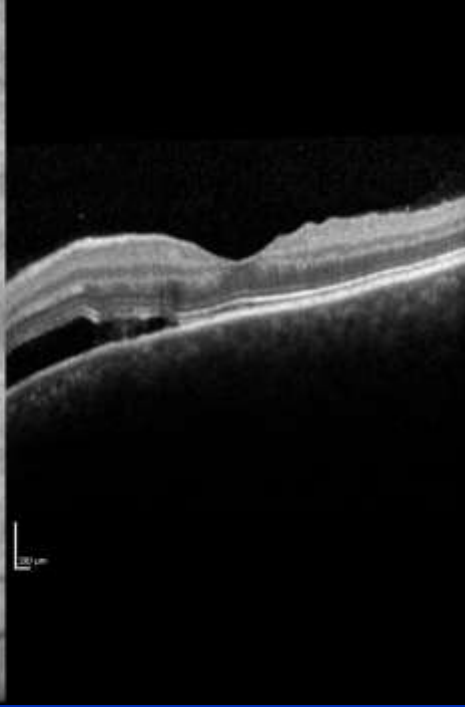
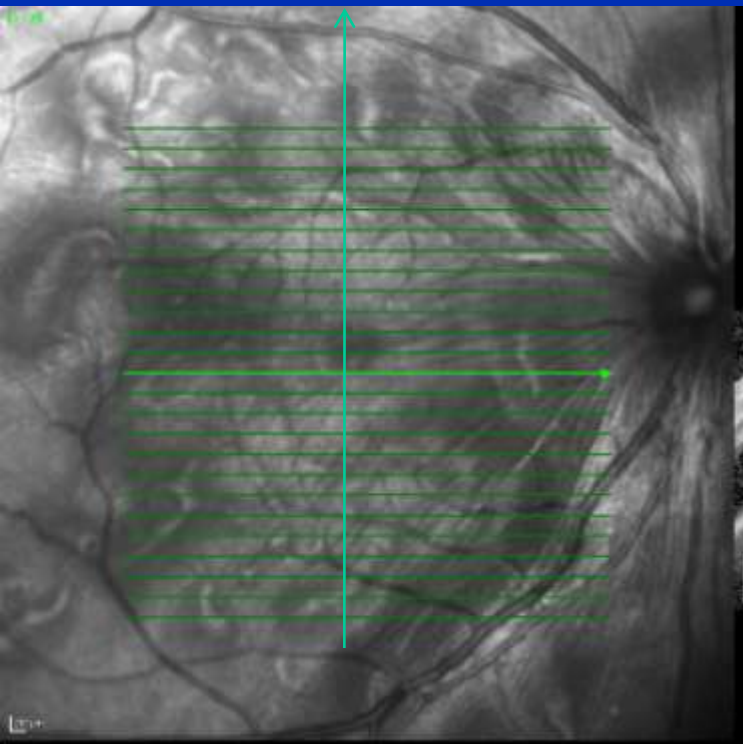
IR 30° ART(46)
HEIDELBERG ENGINEERING

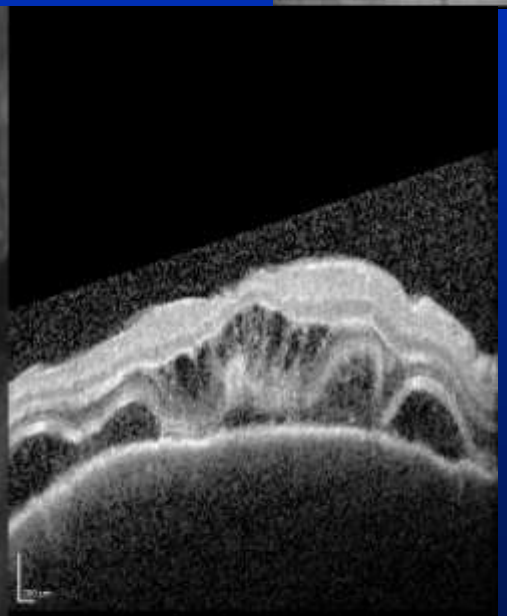

200 µm
12/10/2011, OS
IR 30° ART(49)
HEIDELBERG ENGINEERING

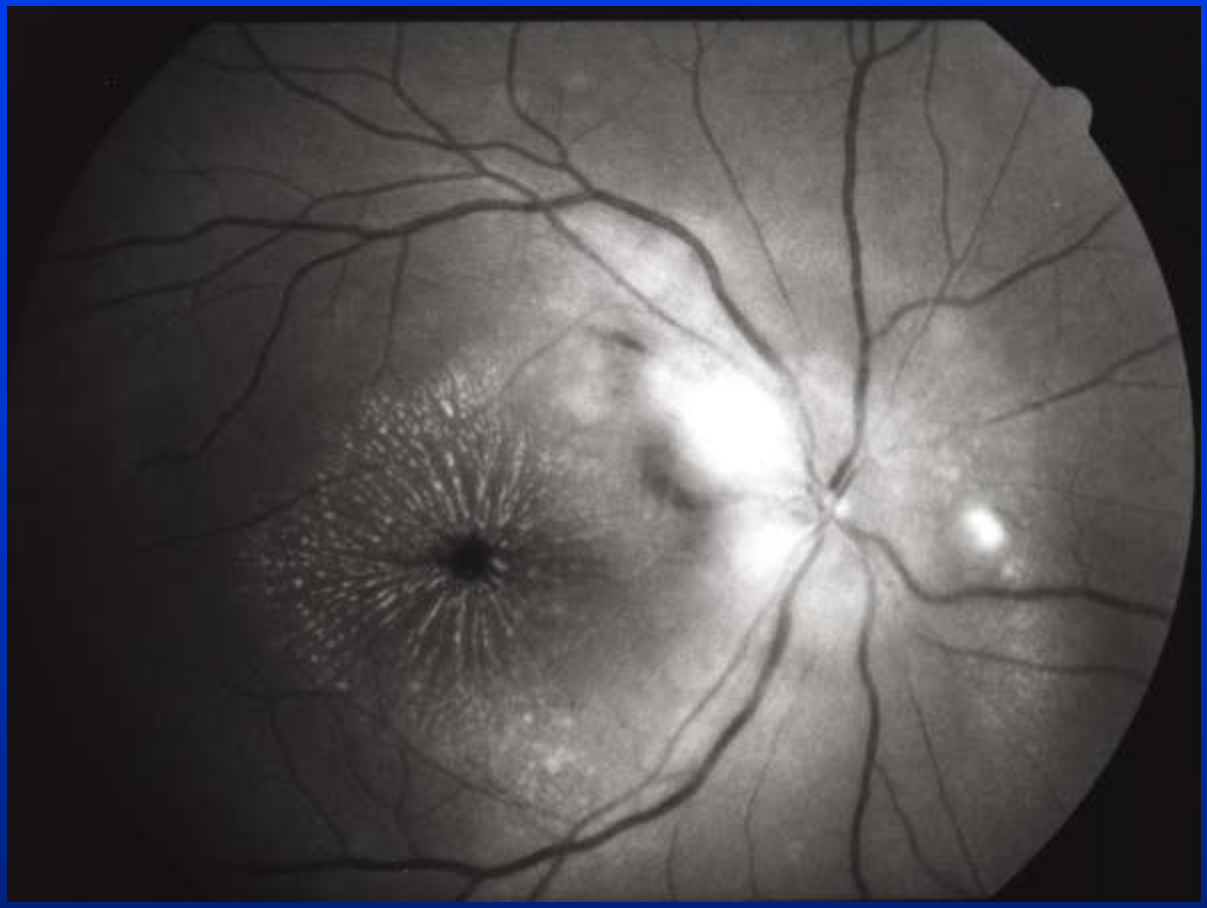






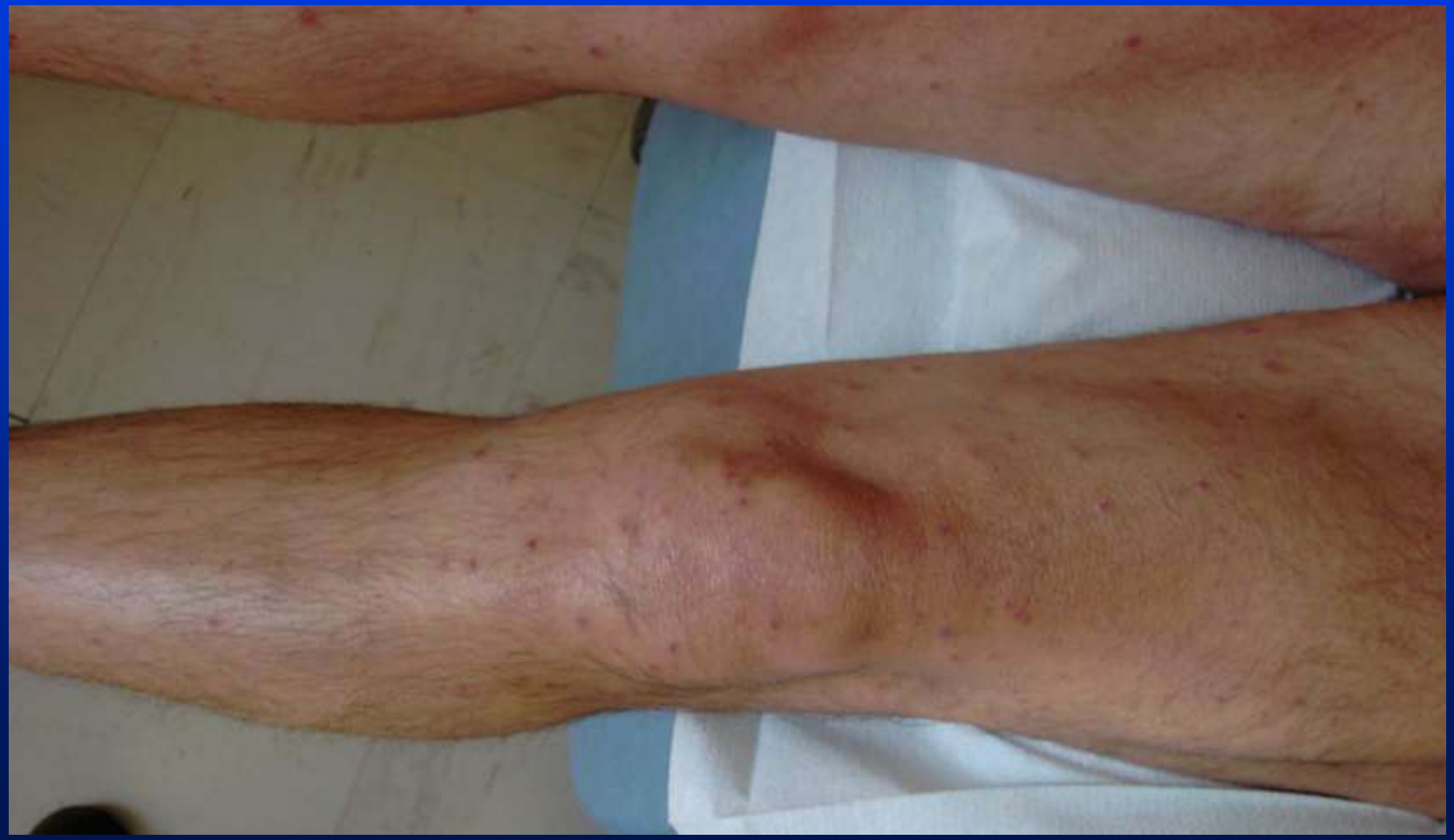


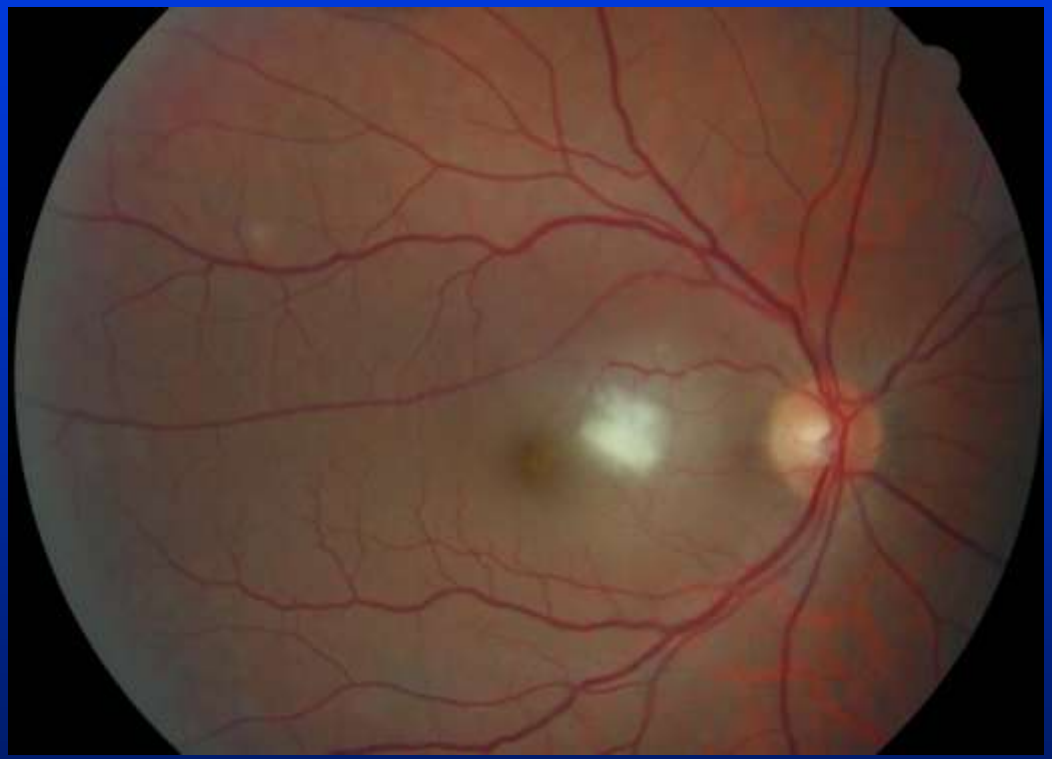


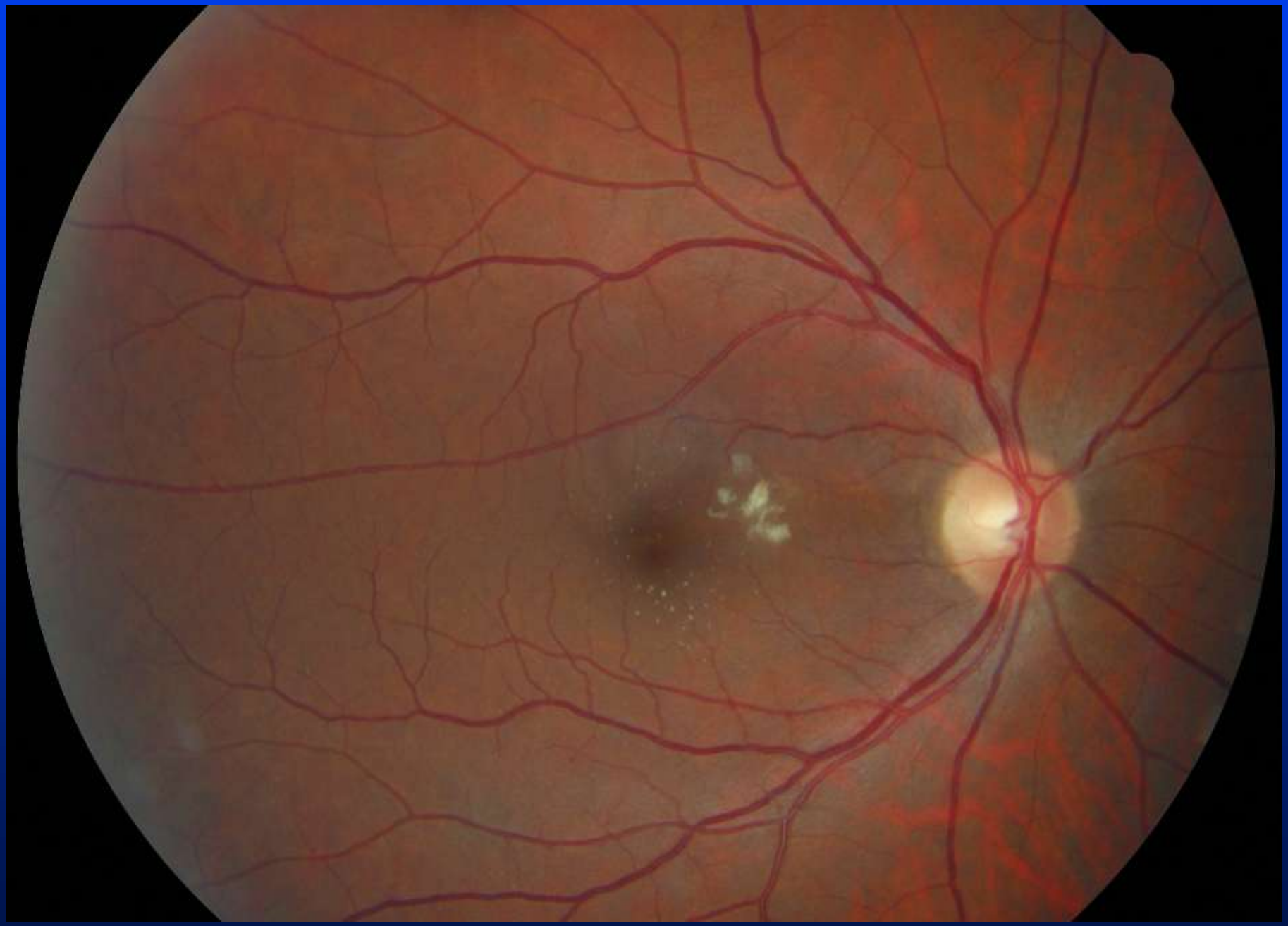


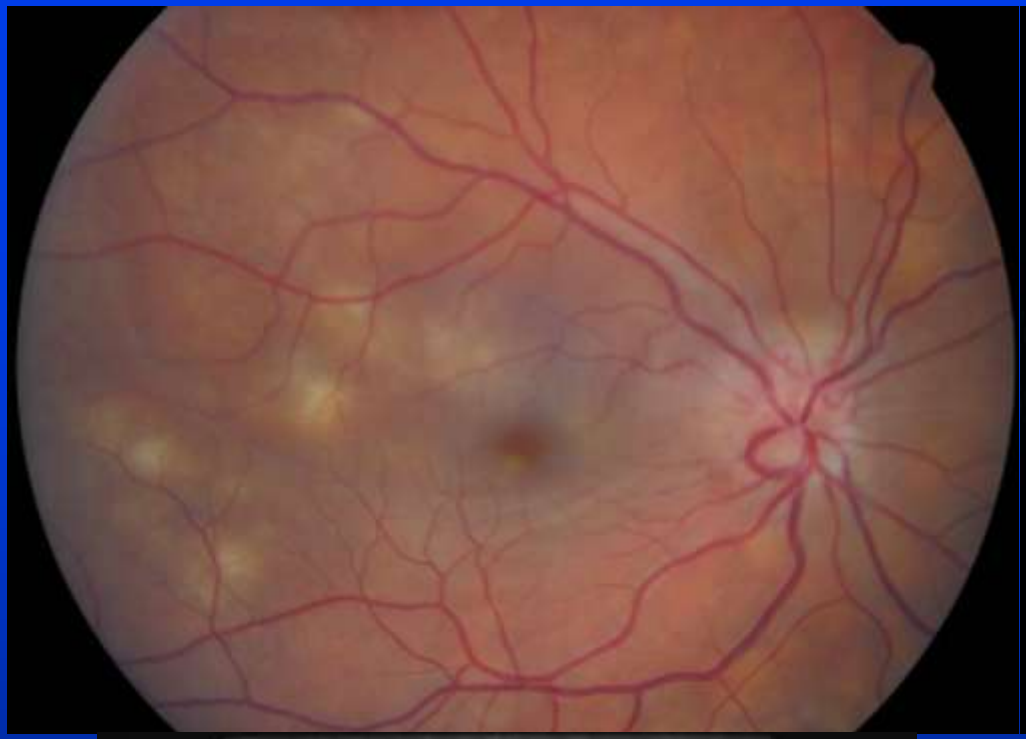
Maladie des griffes du chat

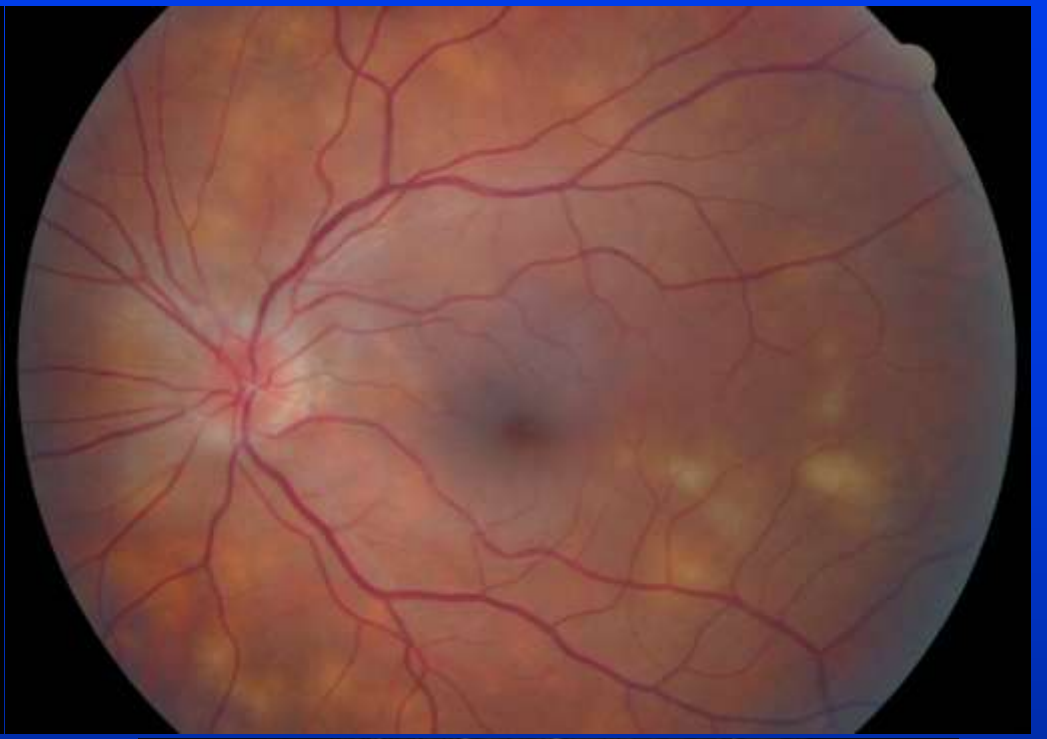
Monsieur L., 45 ans, baisse d'acuité visuelle du côté droit (1/10^{e}) dans un contexte d'éruption papuleuse généralisée avec fébricule et asthénie.

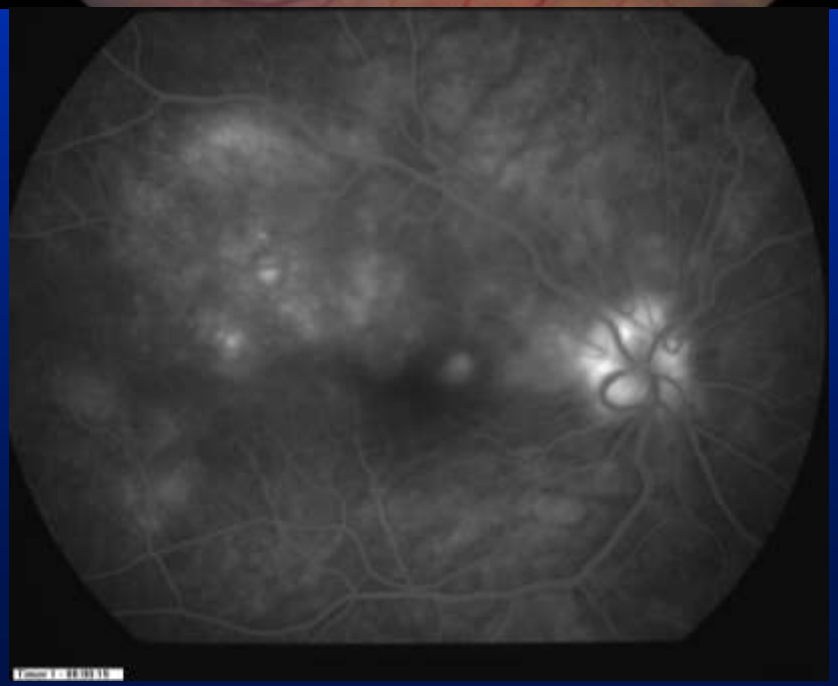


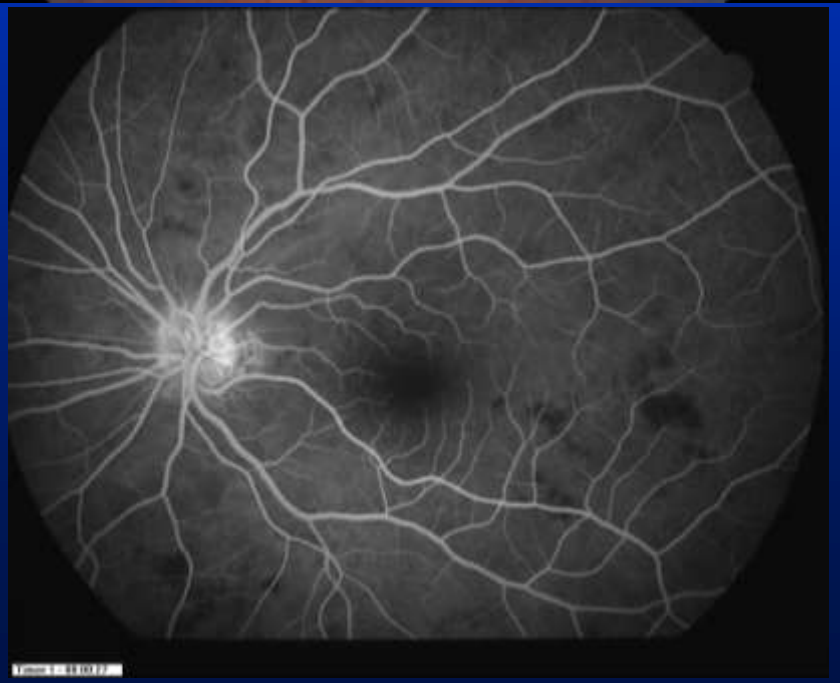


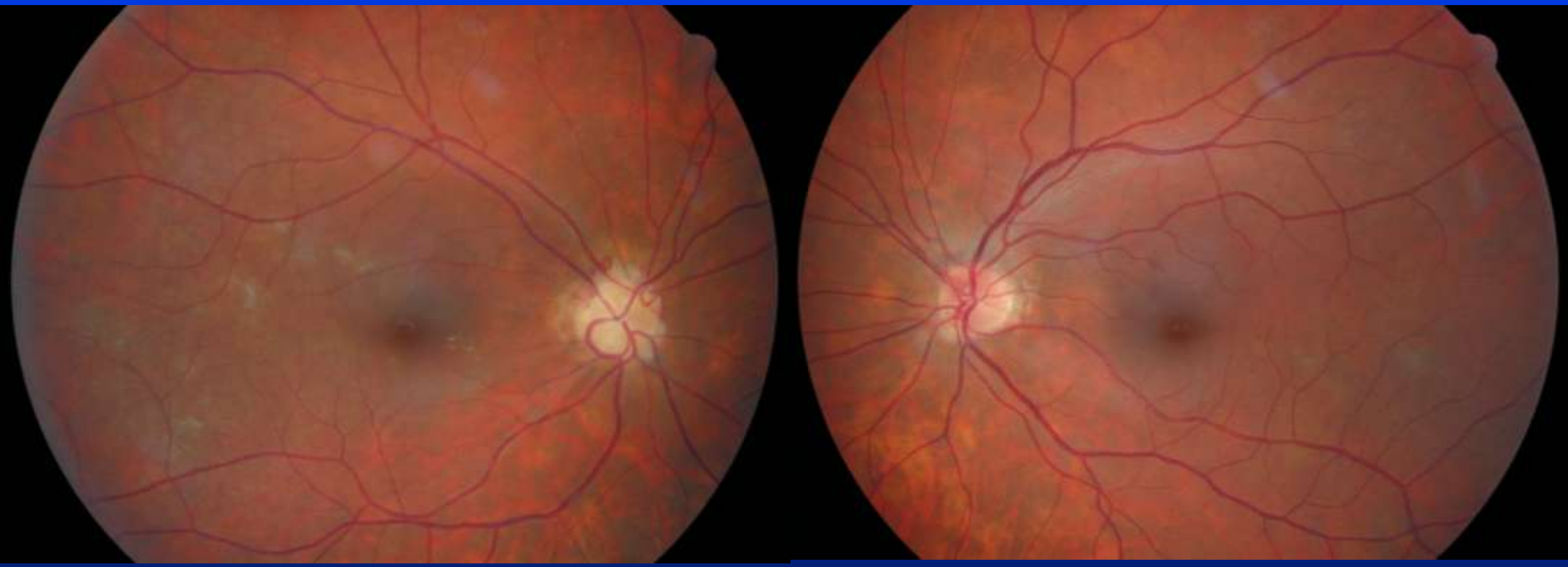




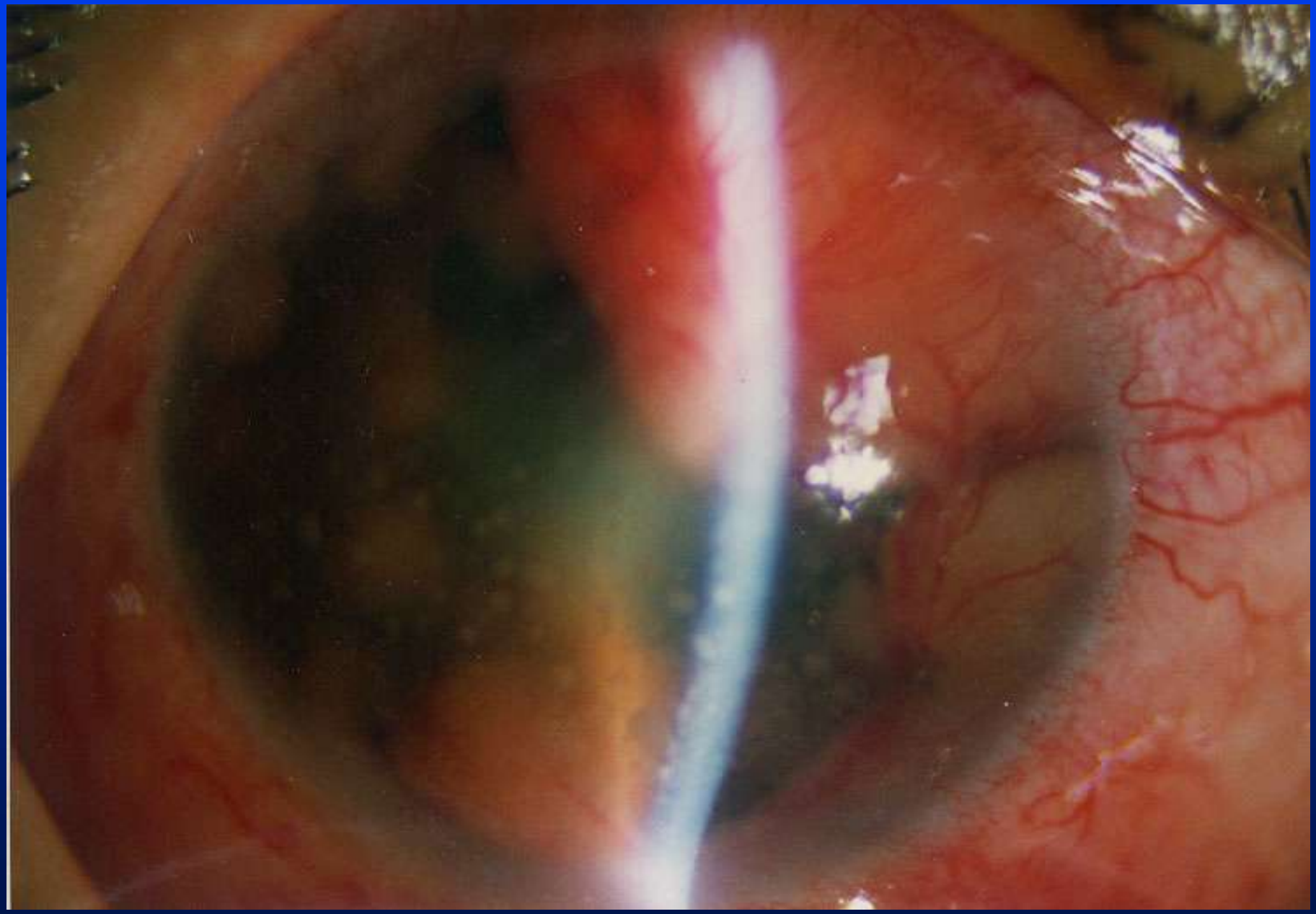


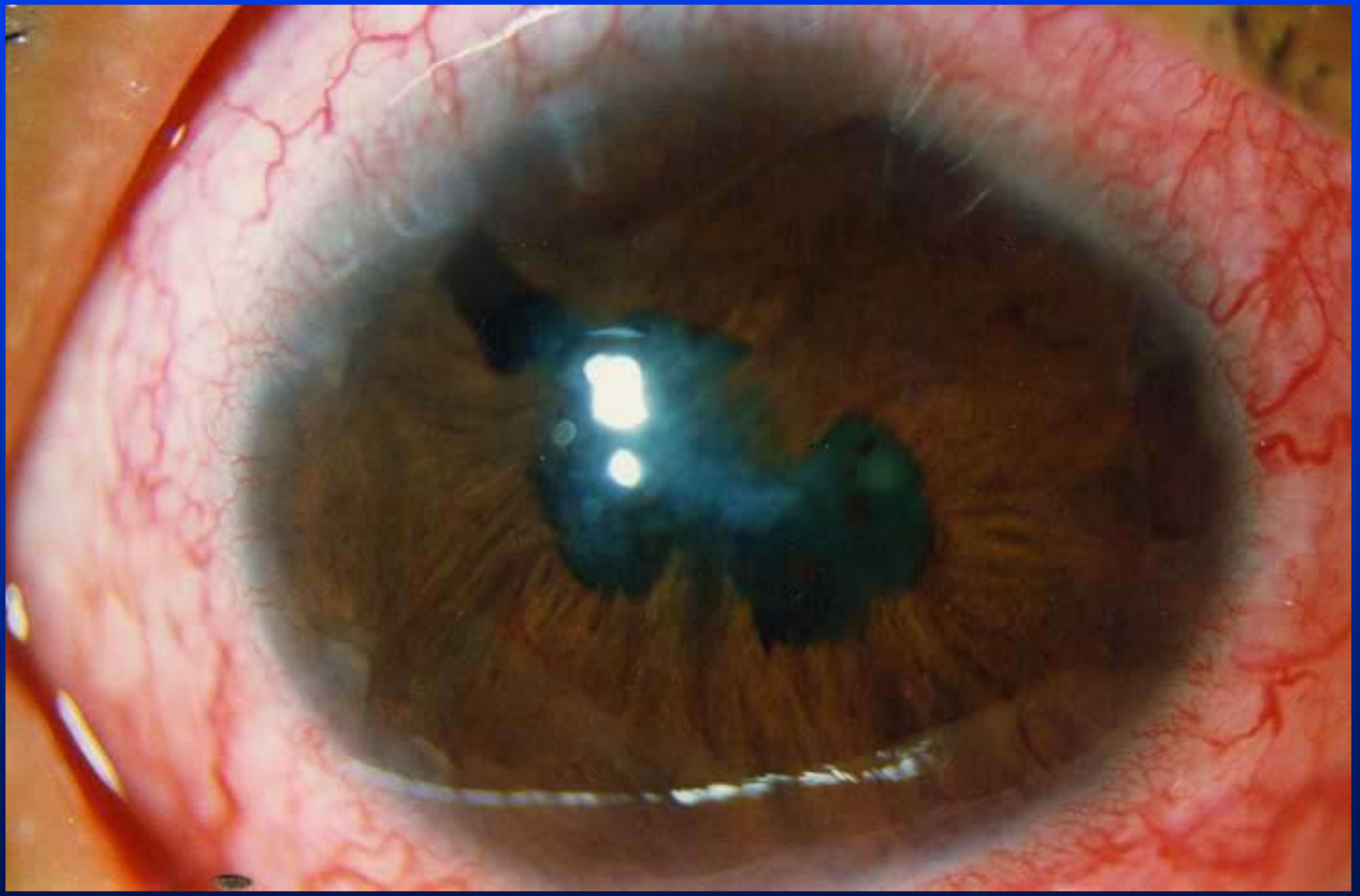


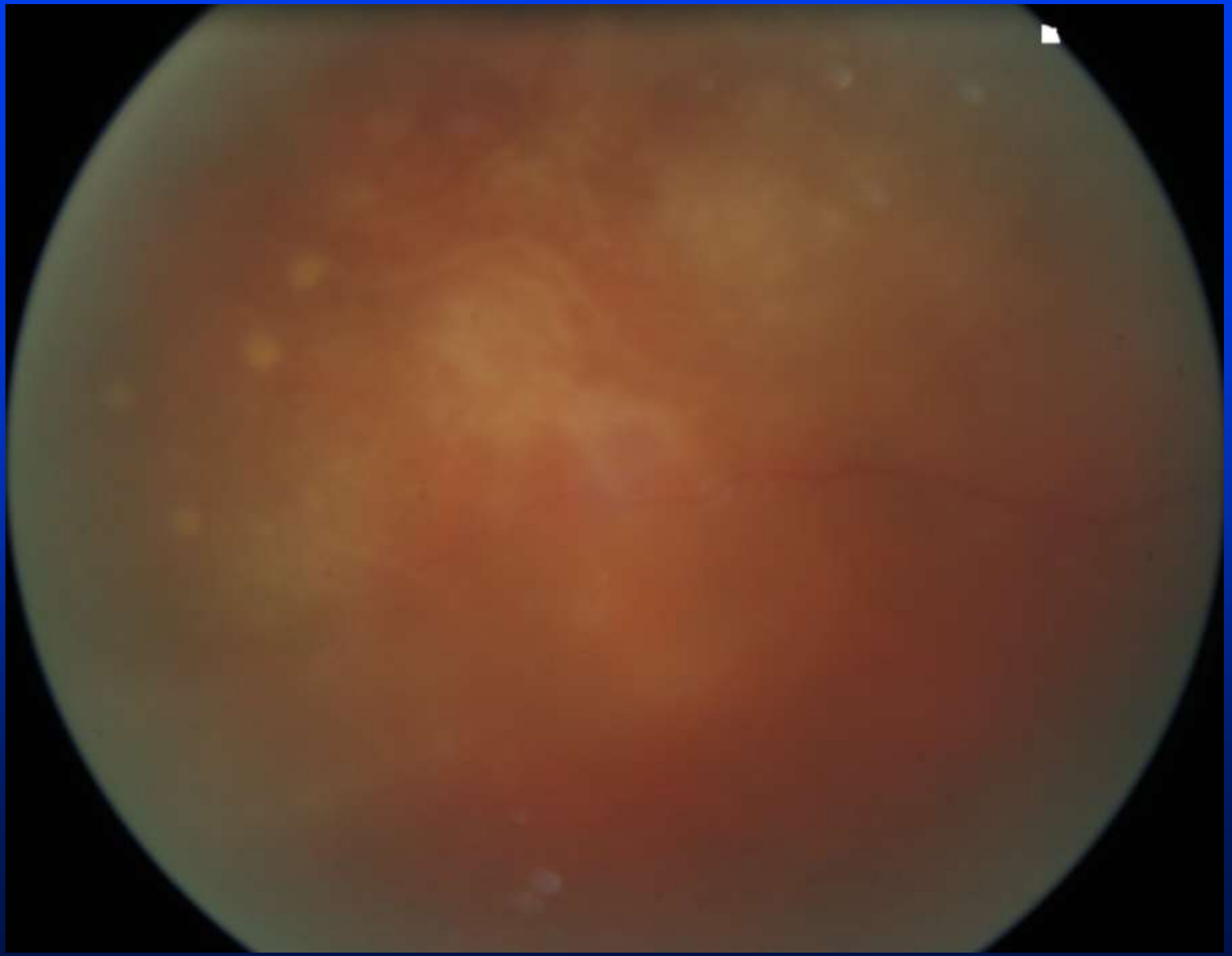




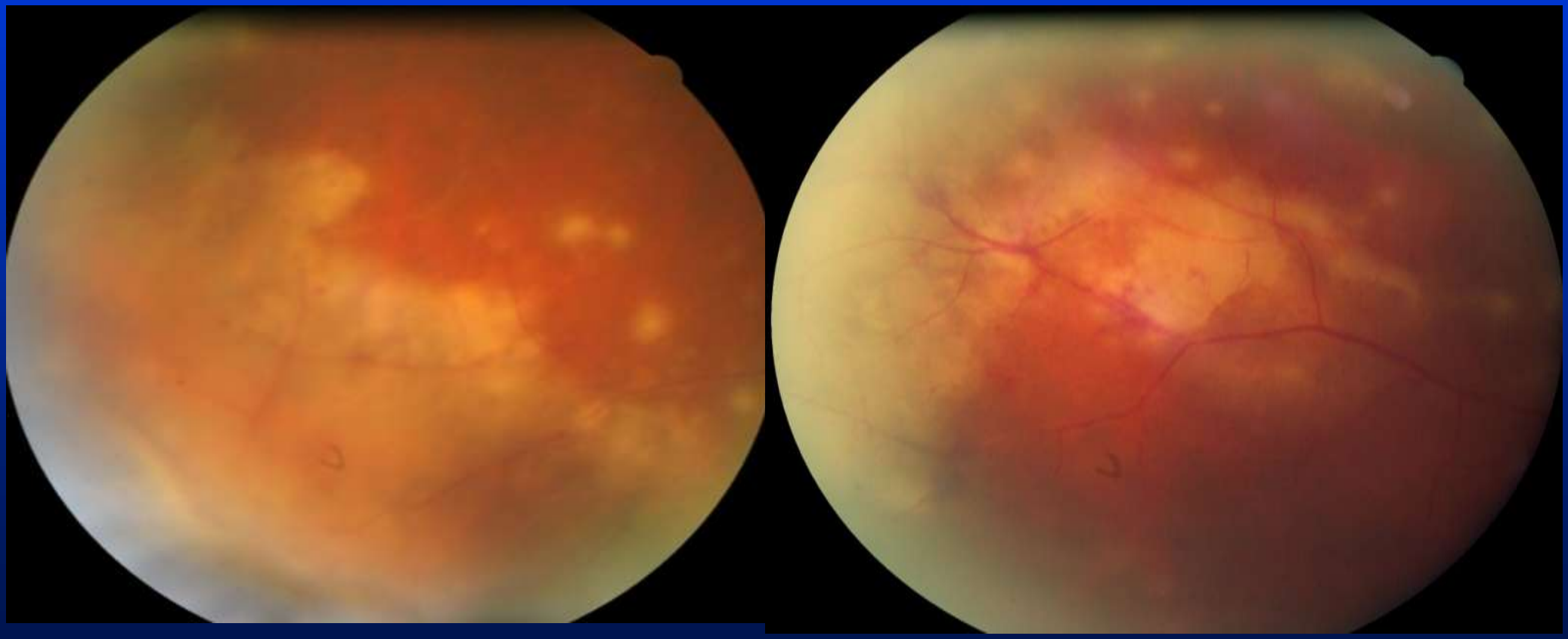
Après traitement

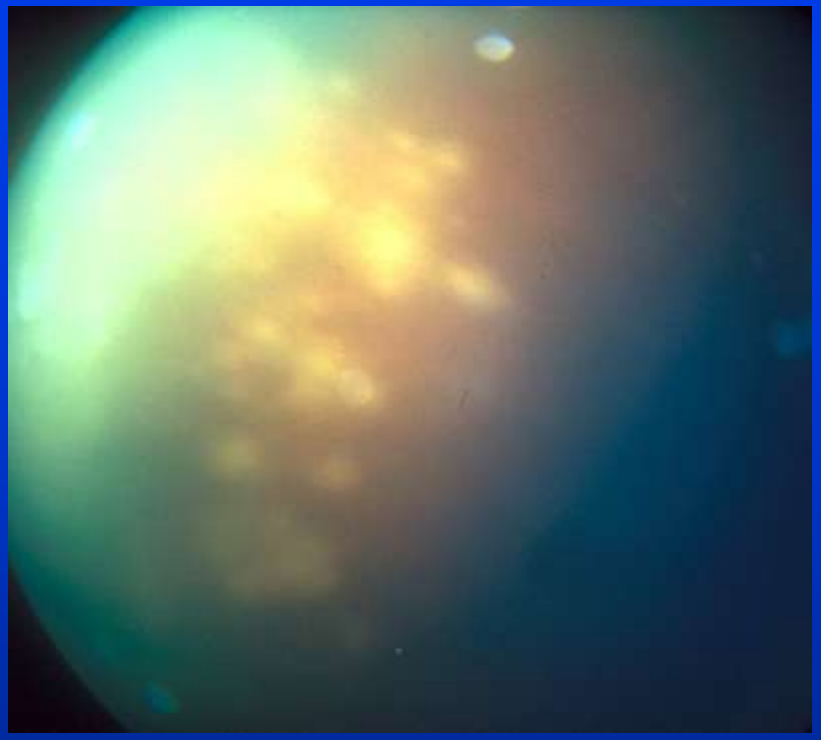


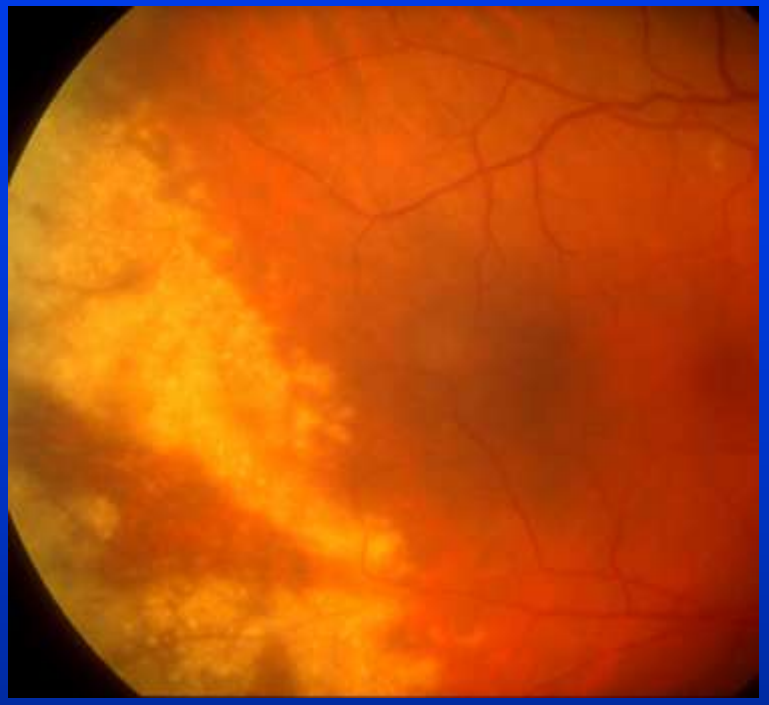




Monsieur B., 30 ans , consulte pour une baisse d'acuité visuelle sévère unilatérale installée en quelques jours à 1/10^{e}.





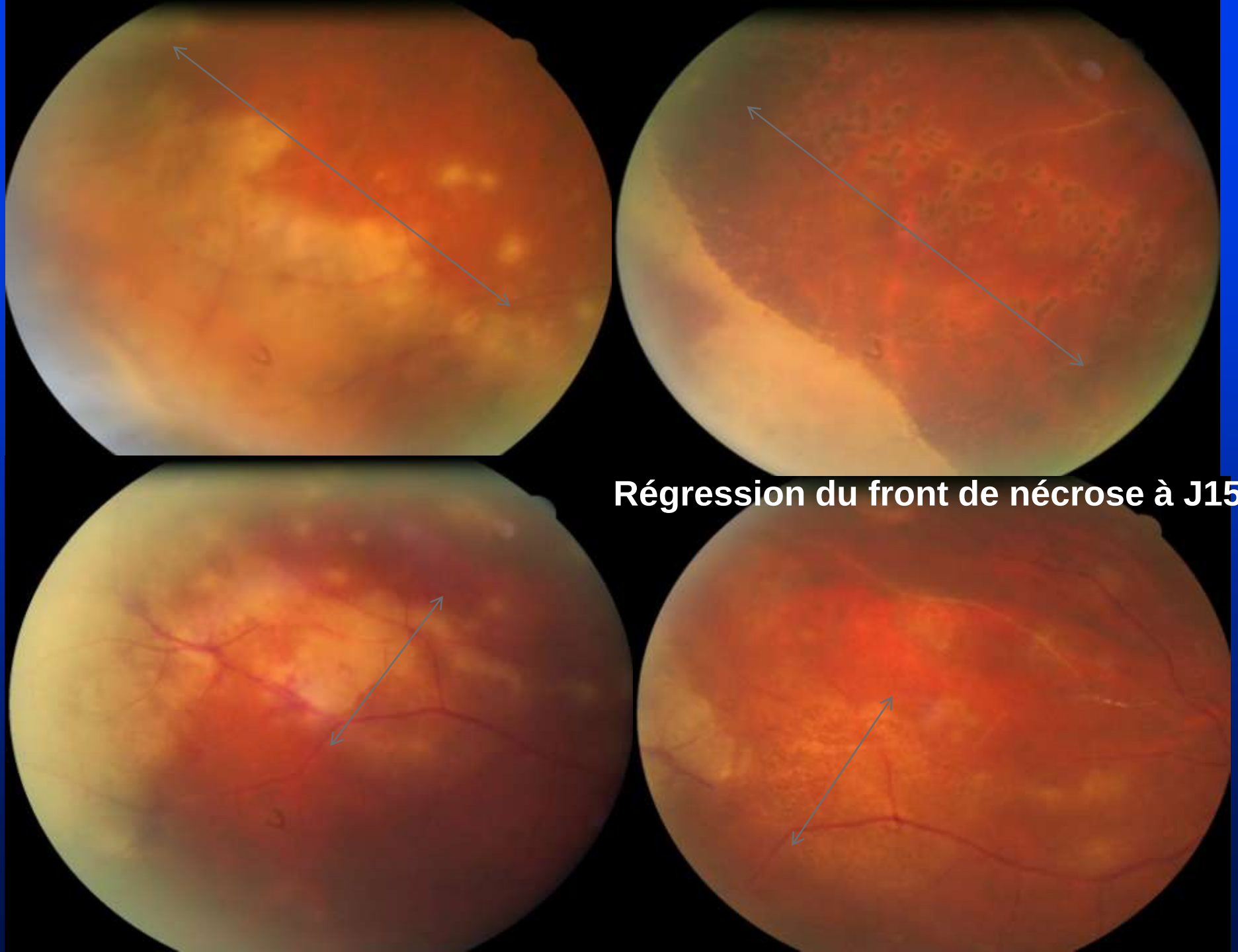


Nécrose rétinienne aiguë (ARN)

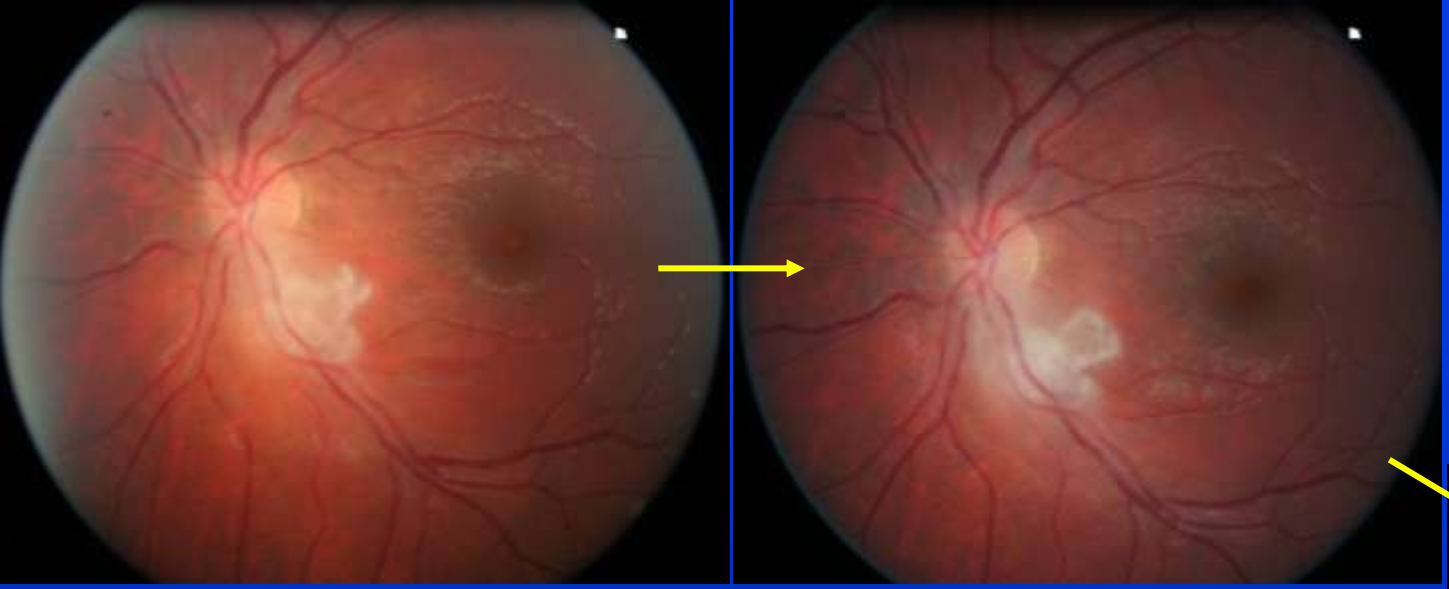
Suspicion clinique

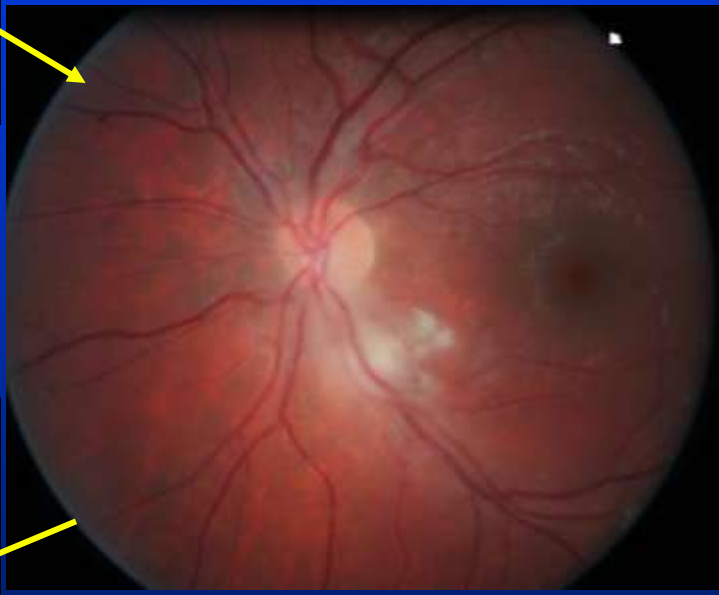
→

Traitement en urgence & PCA pour PCR à la recherche ADN HSV1-2 & VZV

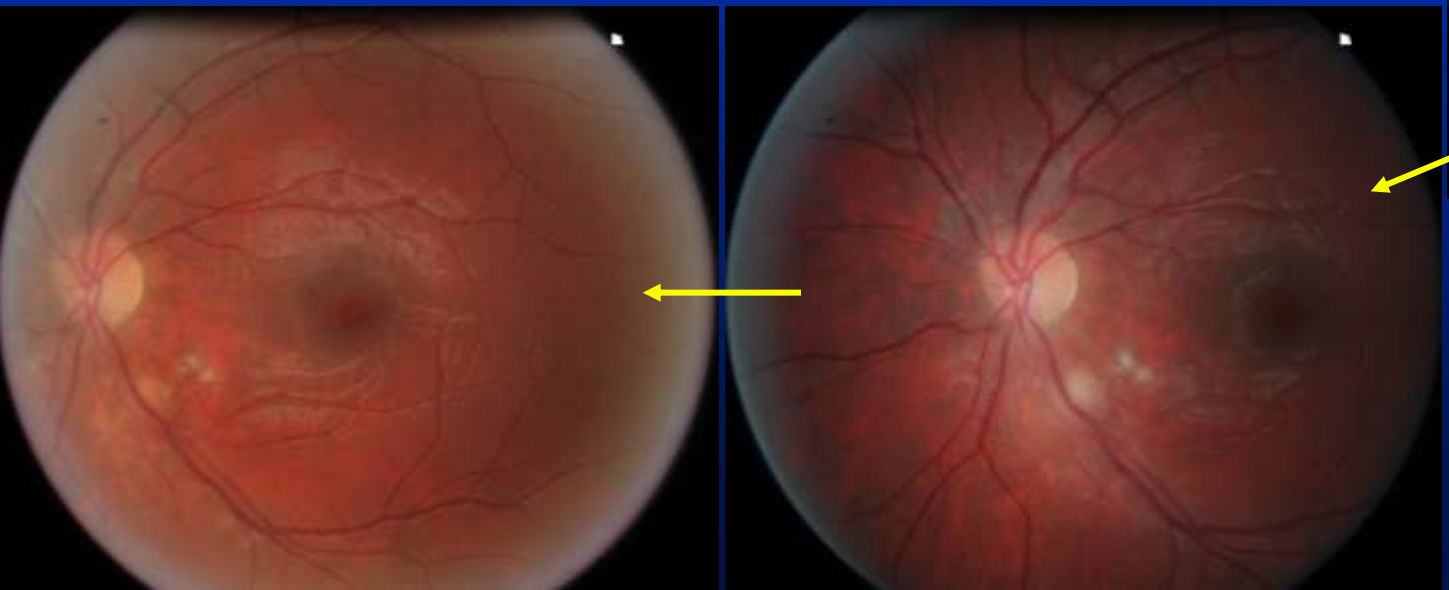


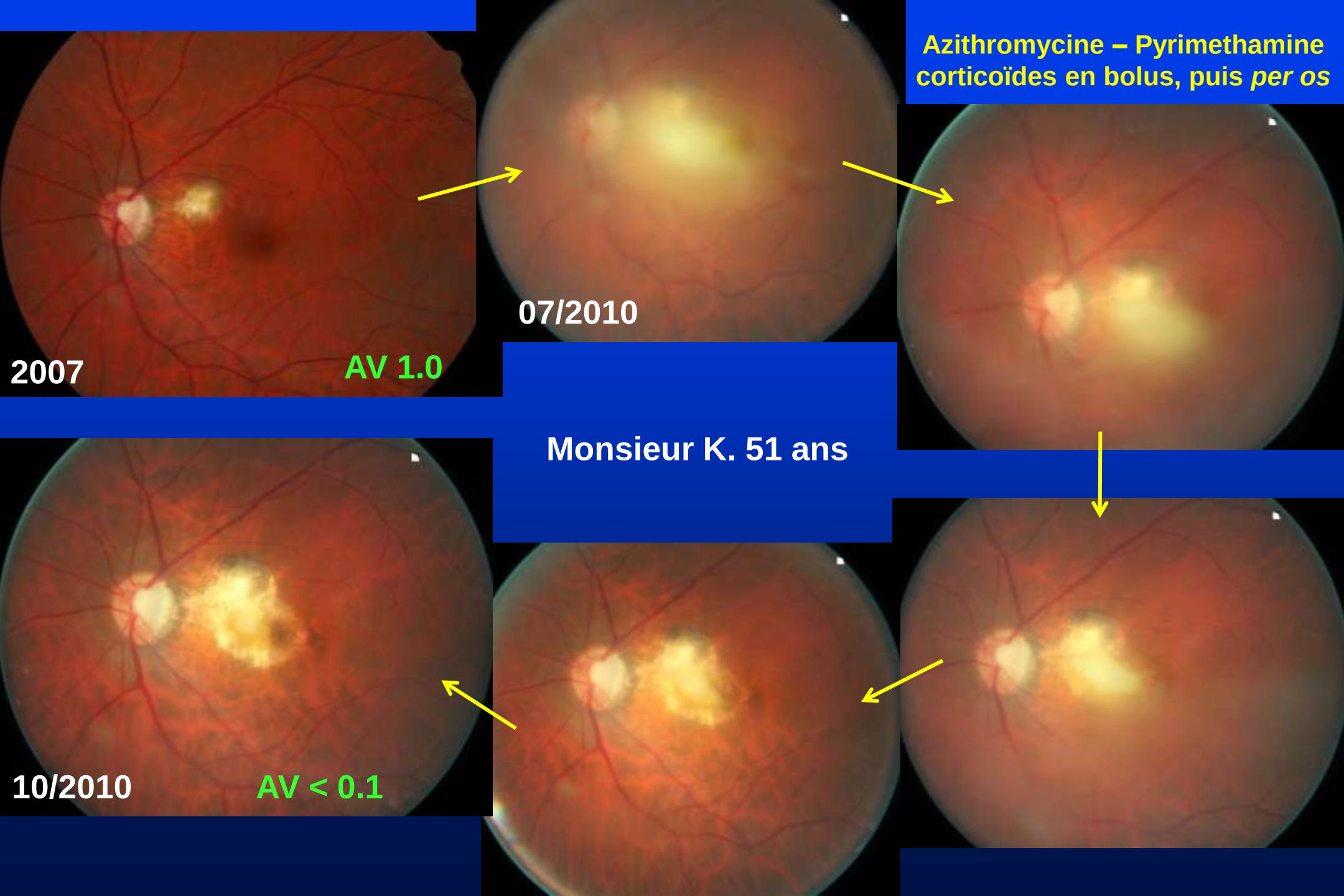
Régression du front de nécrose à J15

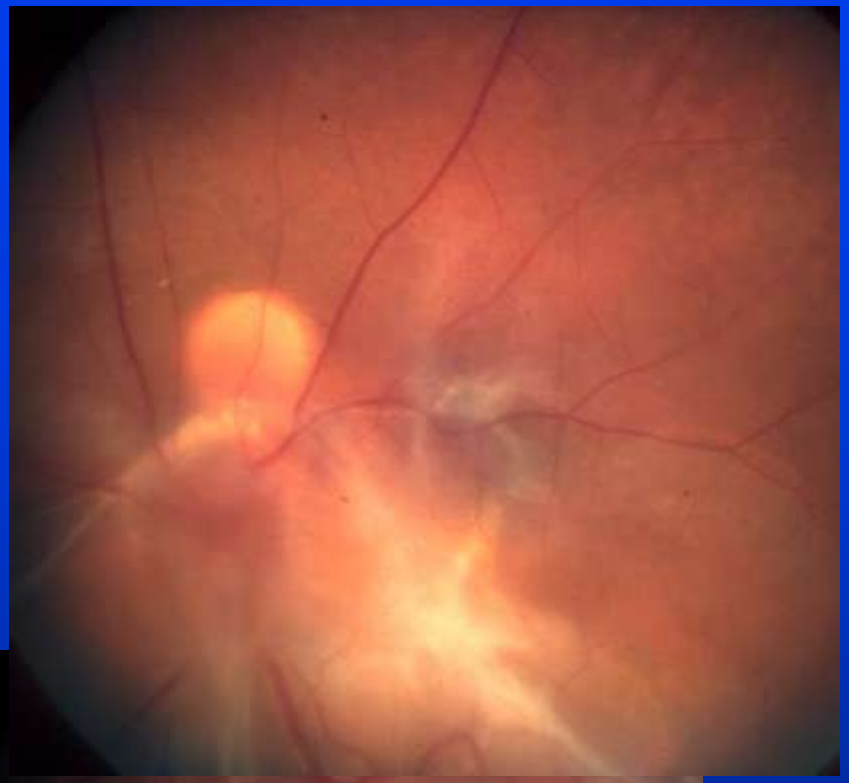


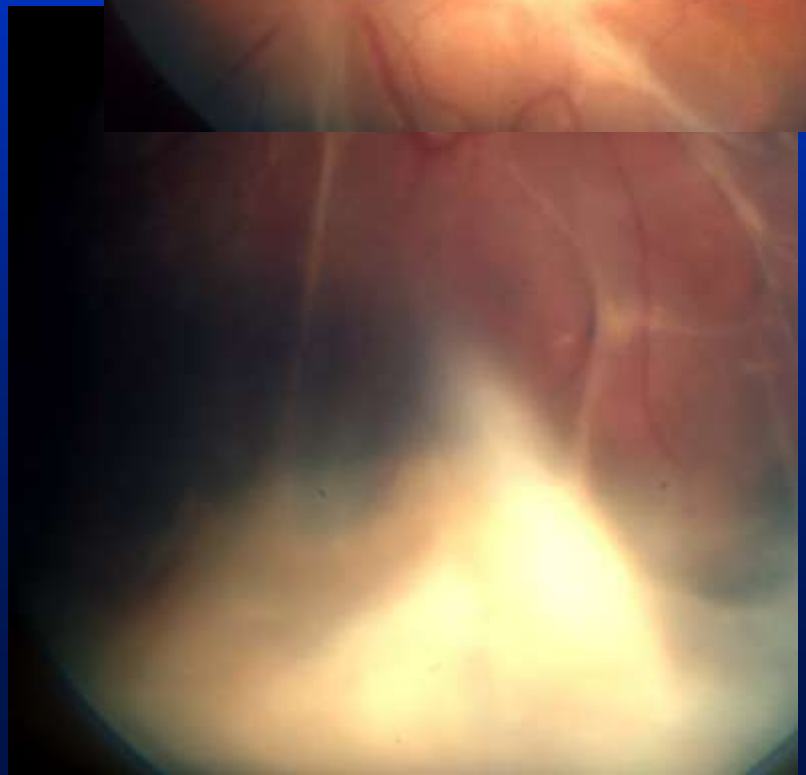


Toxoplasmose




Azithromycine – Pyrimethamine
corticoïdes en bolus, puis *per os*
2007
AV 1.0
07/2010
Monsieur K. 51 ans
10/2010
AV < 0.1

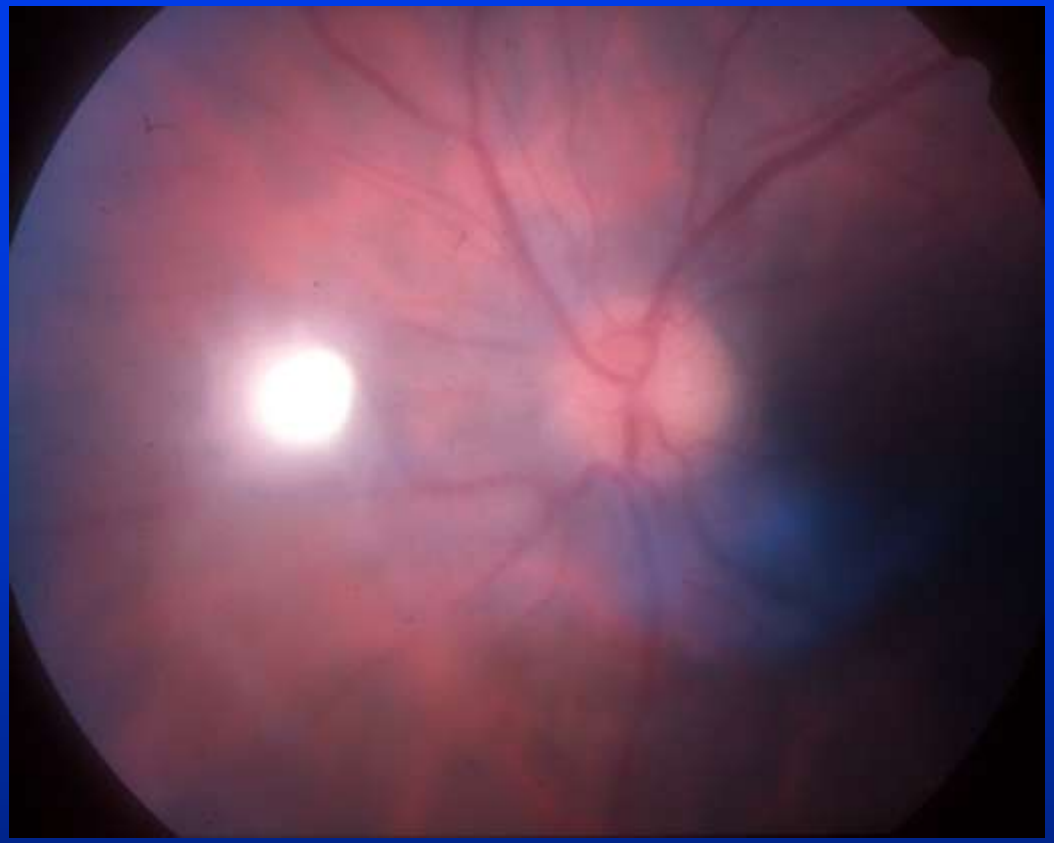


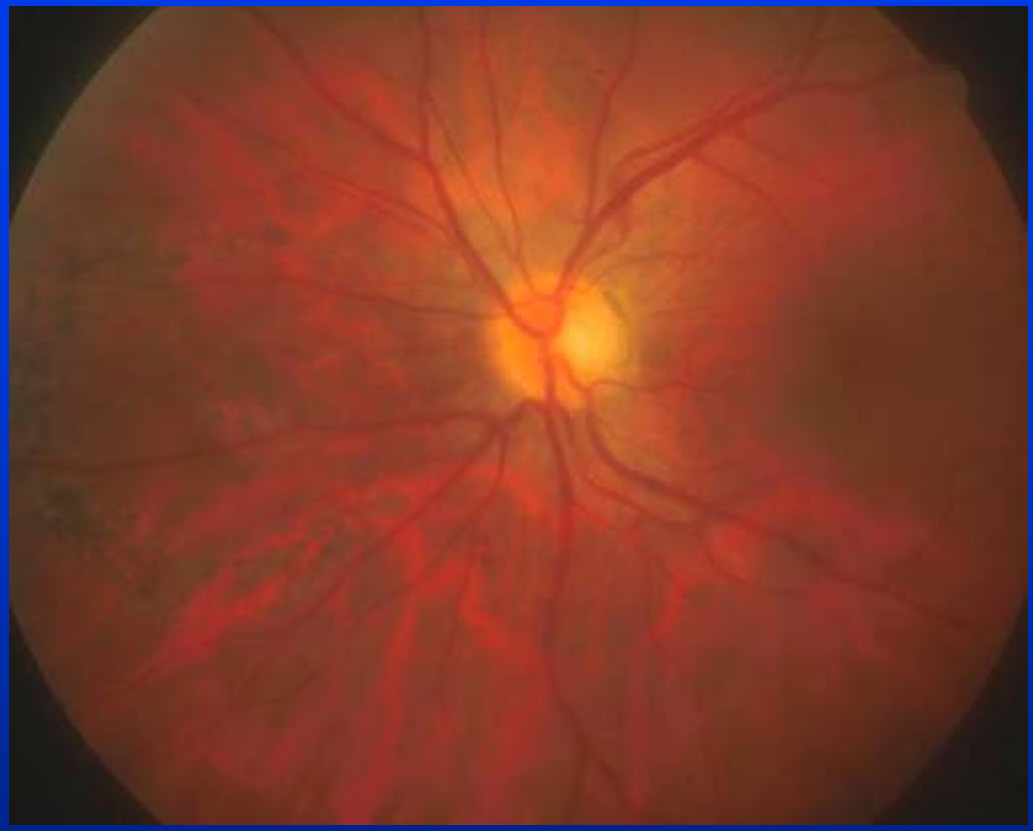


Toxocarose

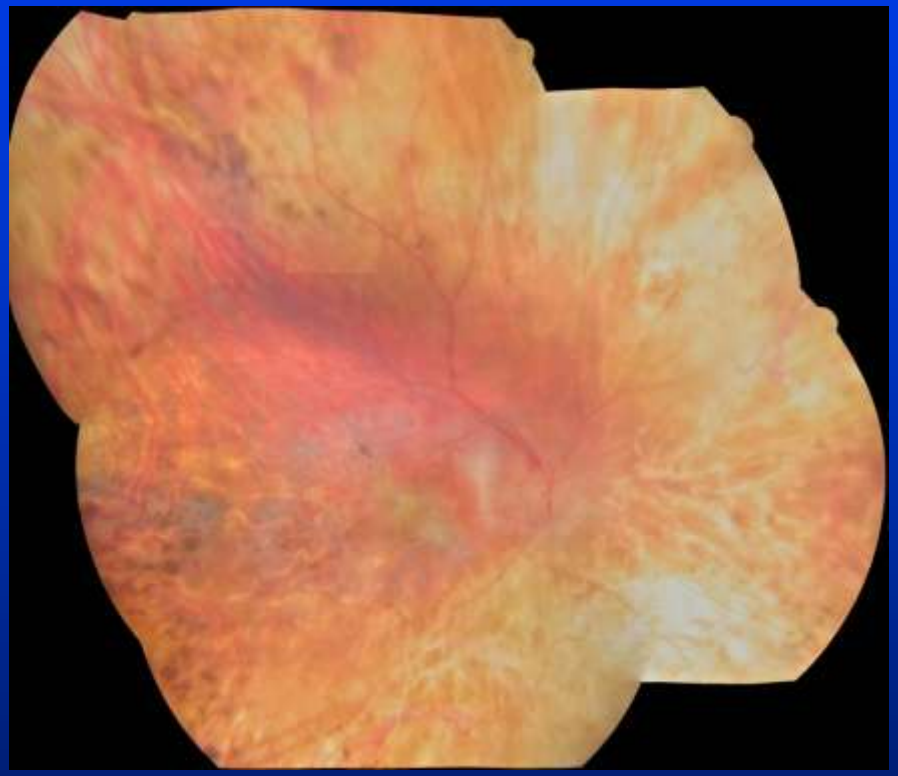
Faire le diagnostic !

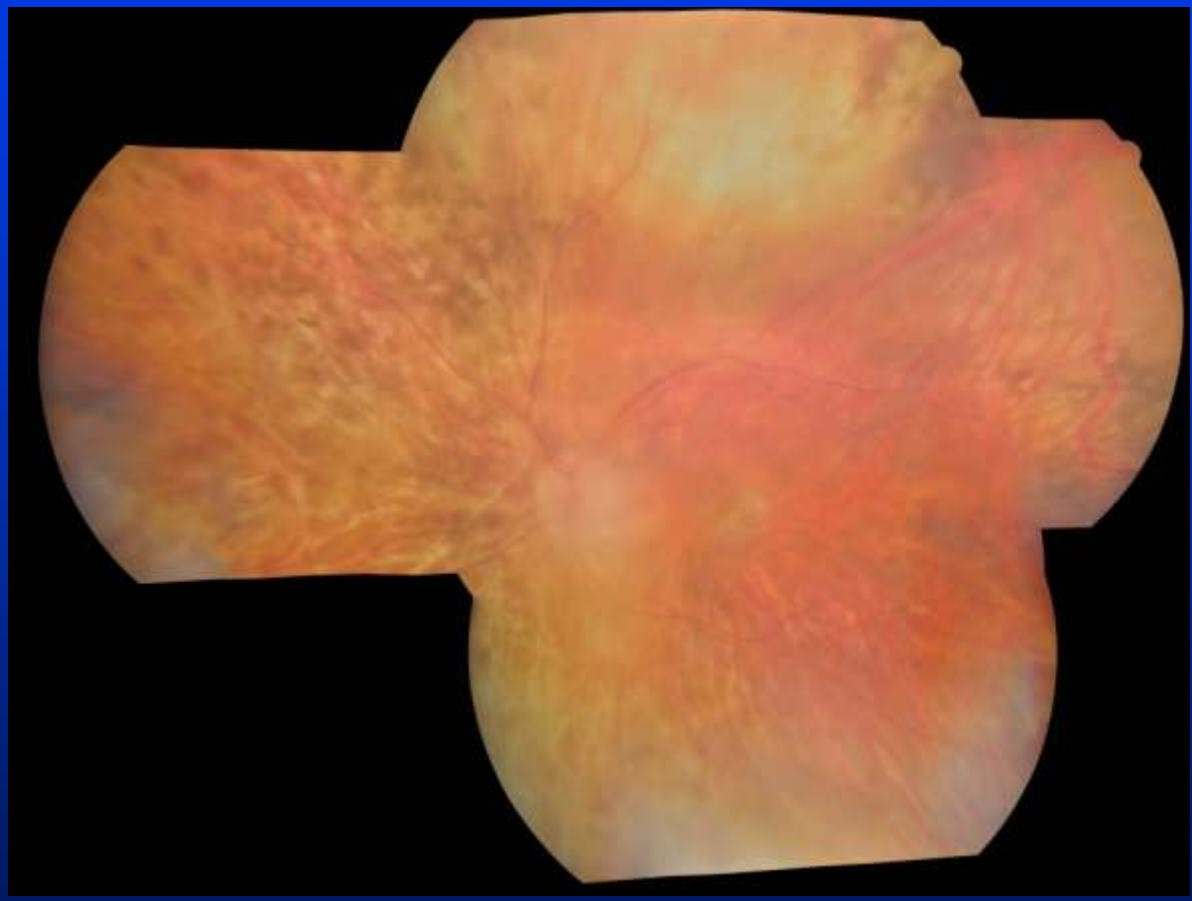
Réussir le traitement !



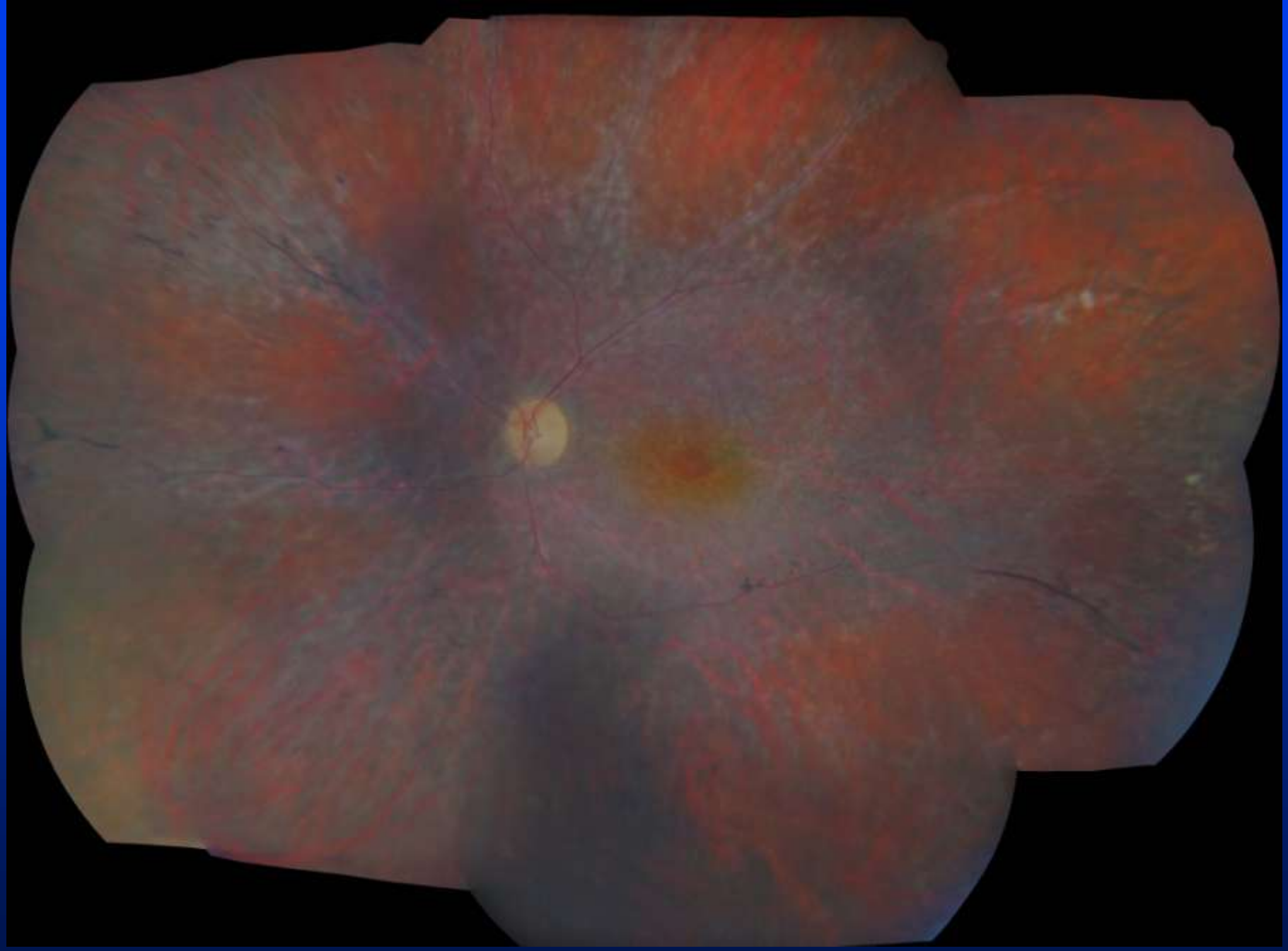


Uvéite ? Syndrome paranéoplasique ? ou Pseudouvéite ?





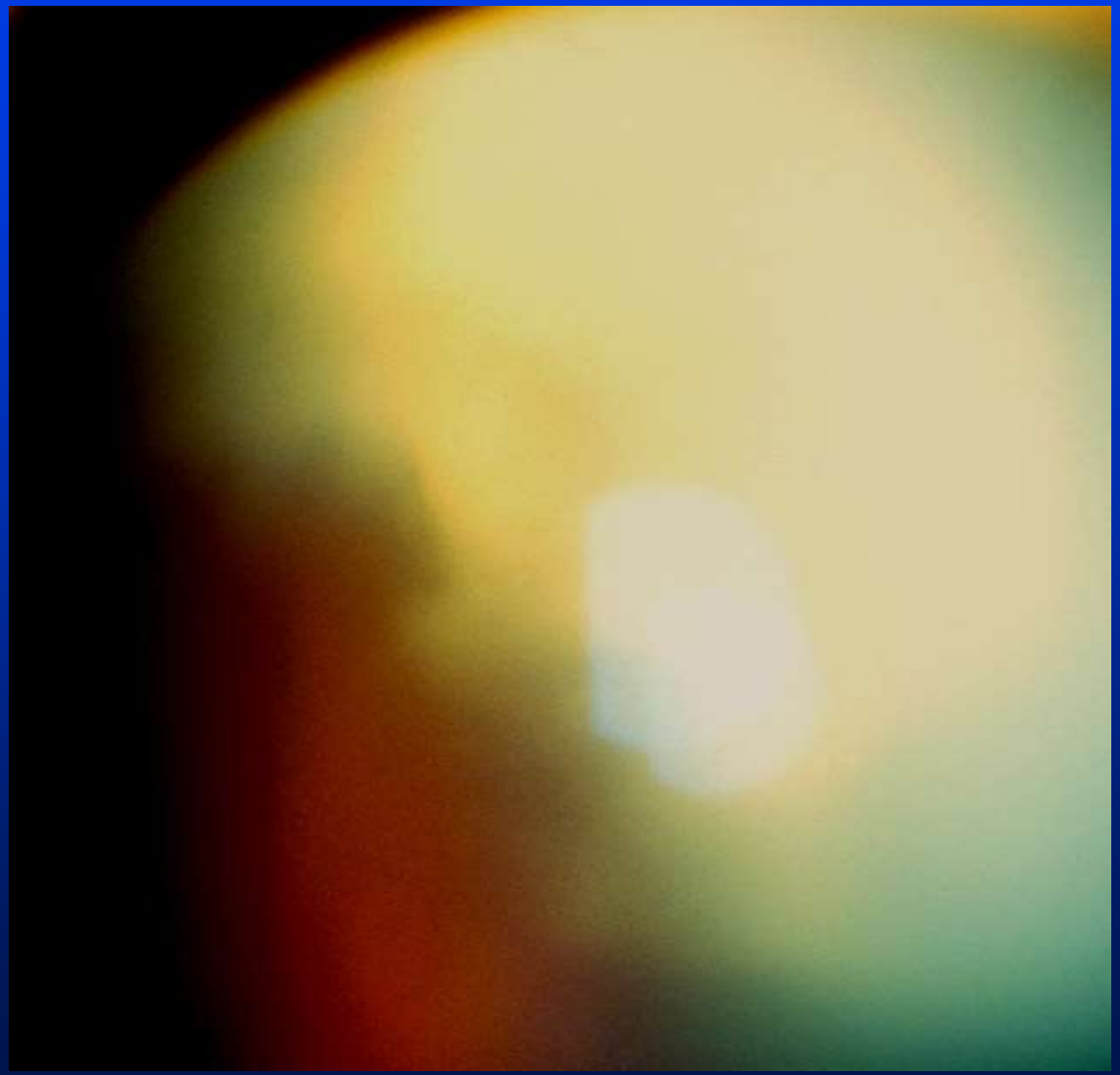
Melanoma Associated Retinopathy (M.A.R.)

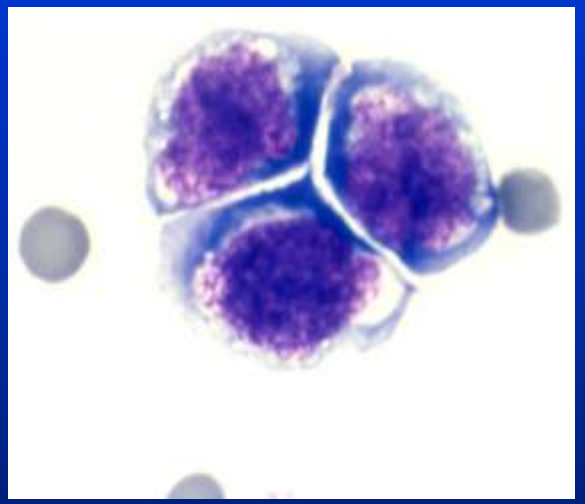


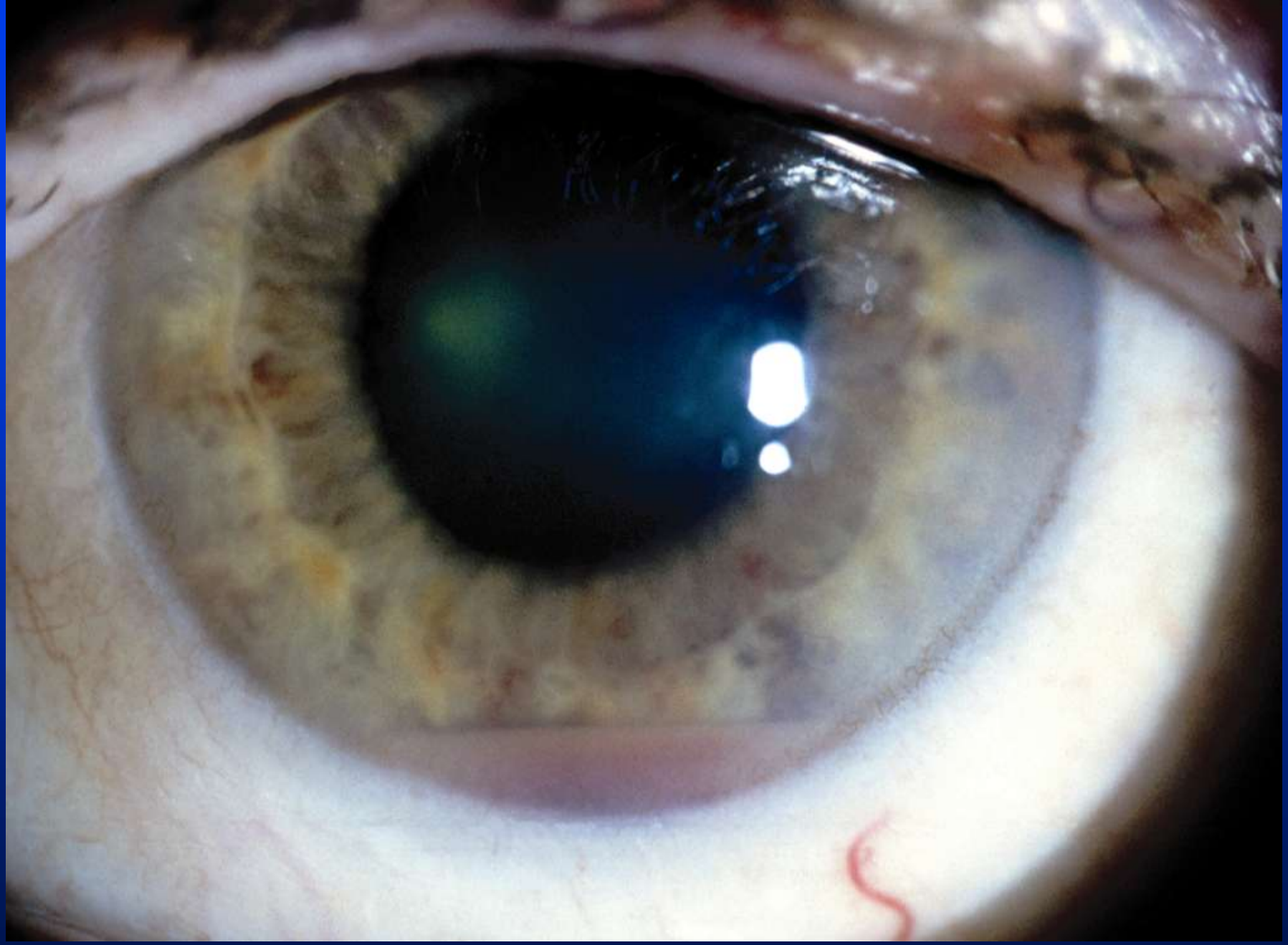
C.A.R. (Cancer Associated Retinopathy)


83 ans - “Panuvéite” bilatérale ….

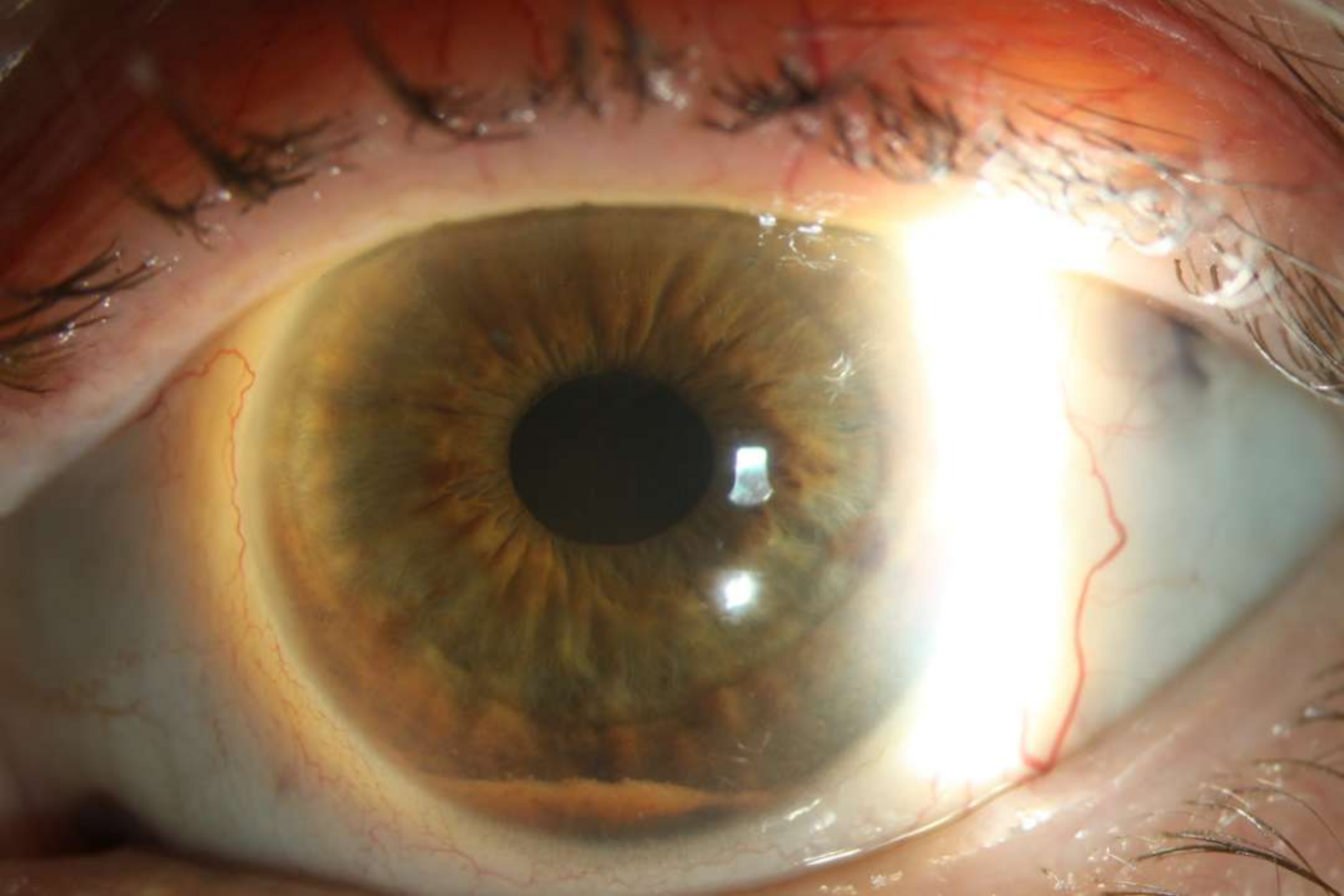
Lymphome intra-oculaire

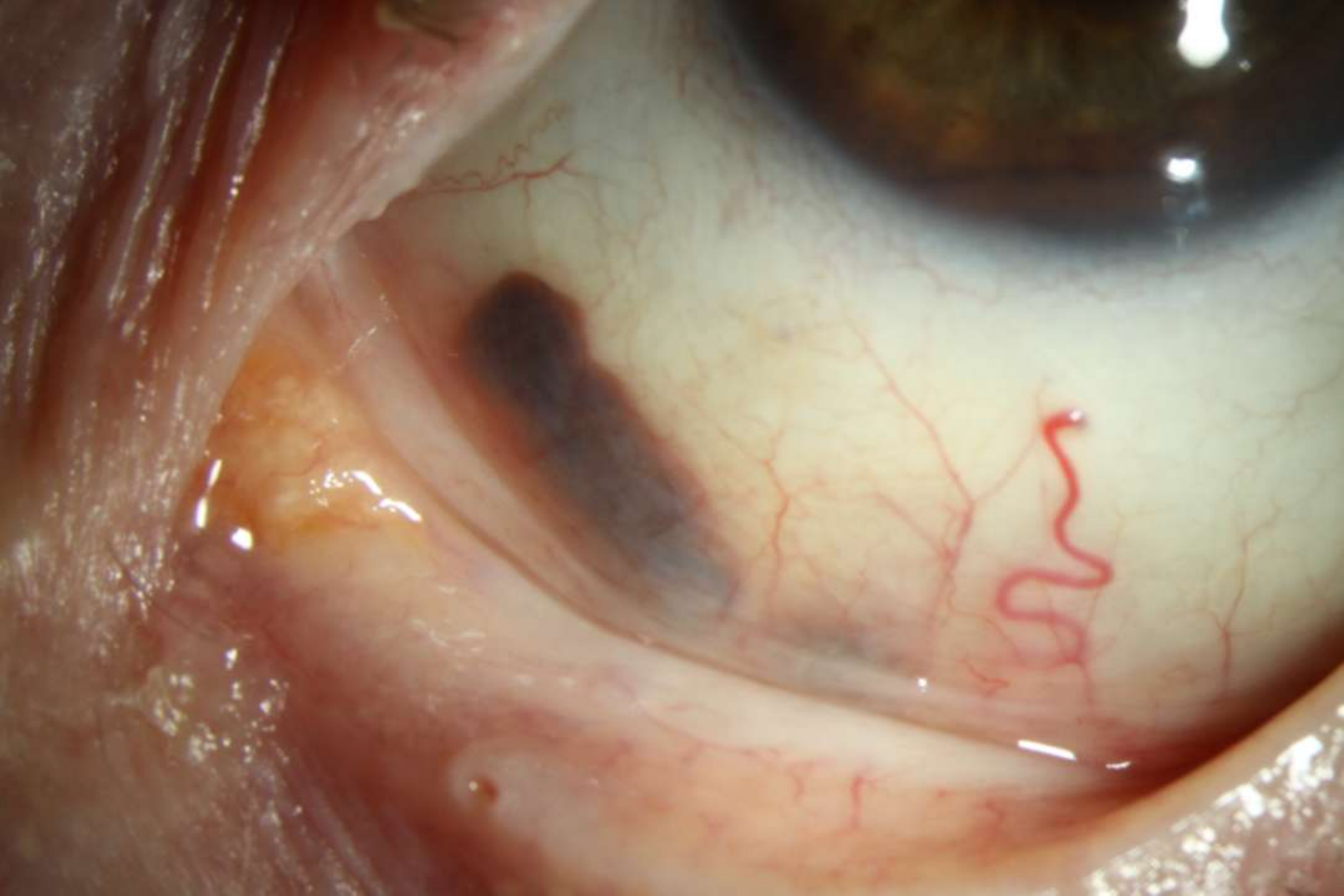


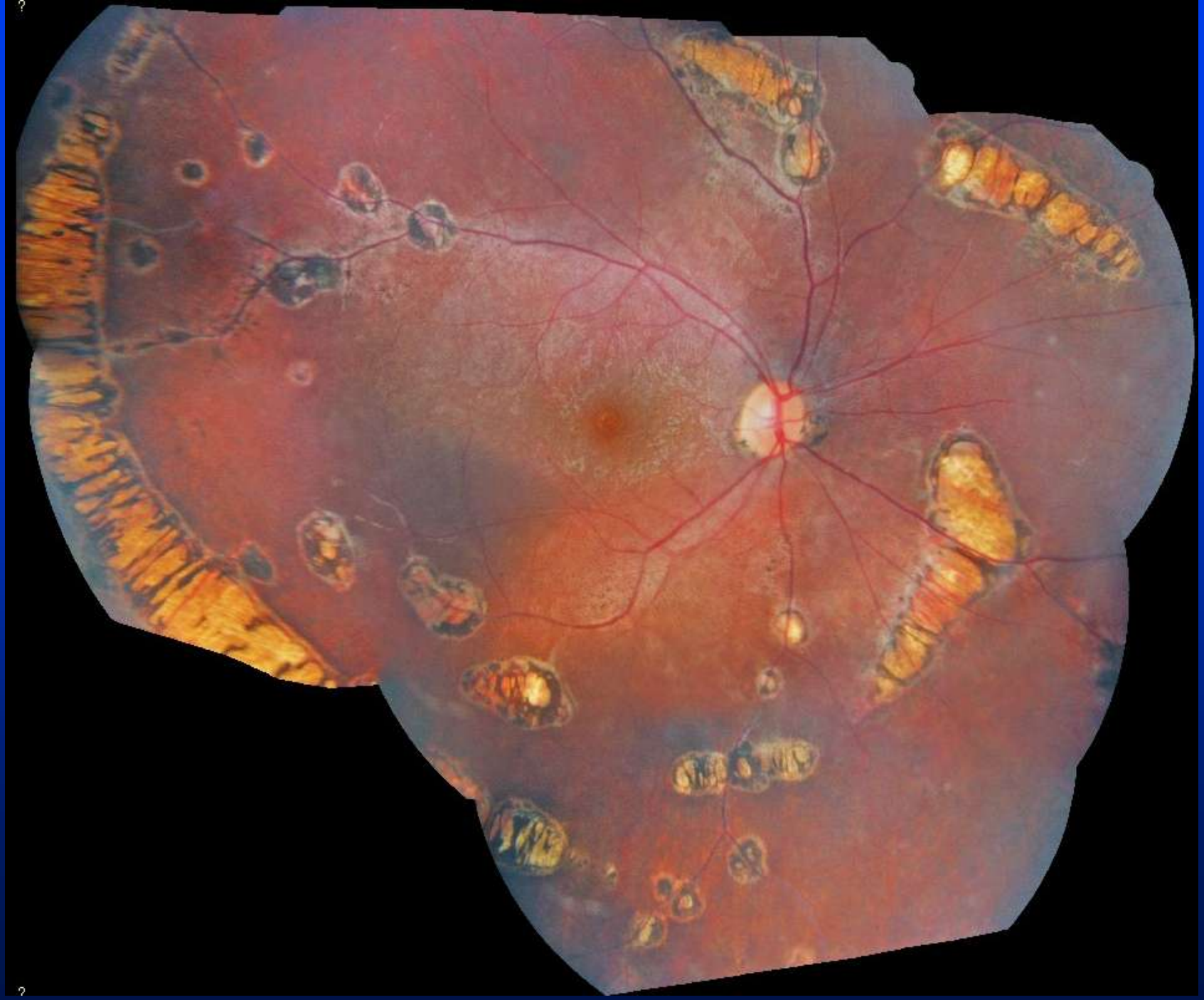




Acutisation d’une leucémie myéloïde chronique







Chorioretinal lesions as the unique feature of complete chronic granulomatous disease in an 8-year-old girl

Martin Chalumeau · Dominique Monnet · Antoine P. Brézin · Dominique Gendrel · Jean-Laurent Casanova · Bénédicte Gérard · Sylvie Chollet-Martin

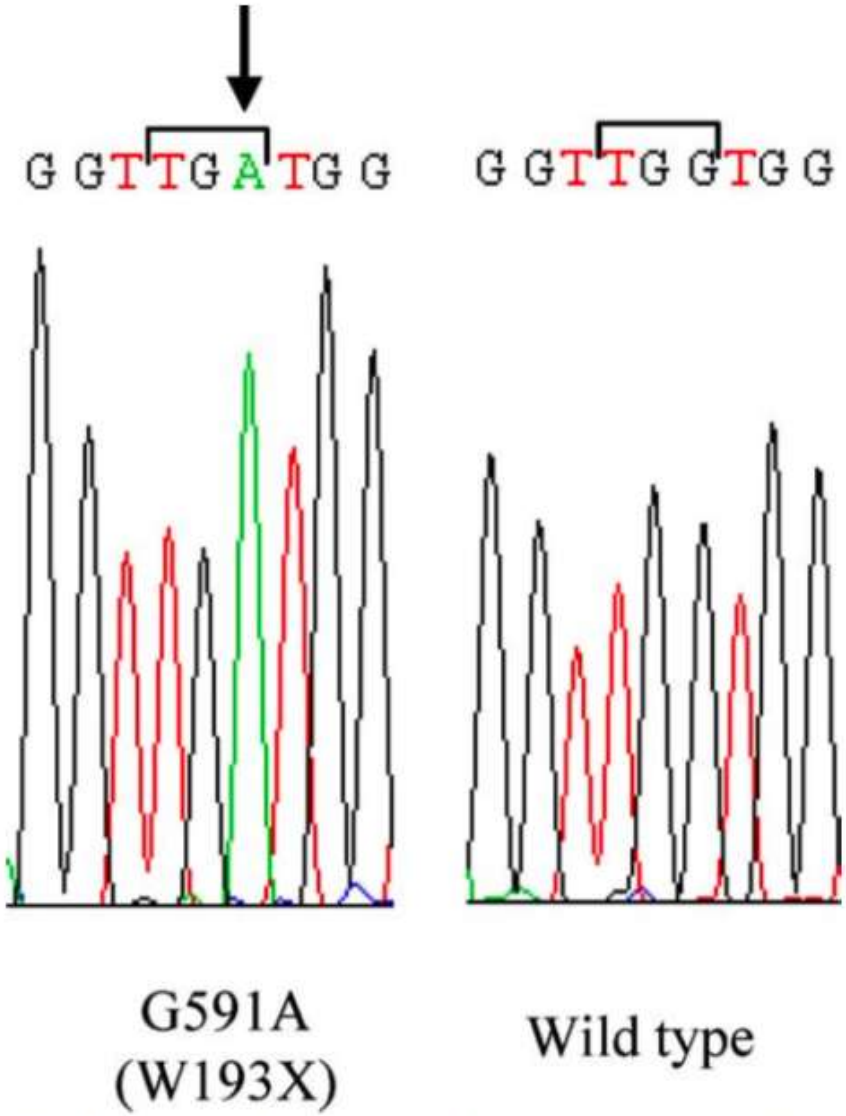
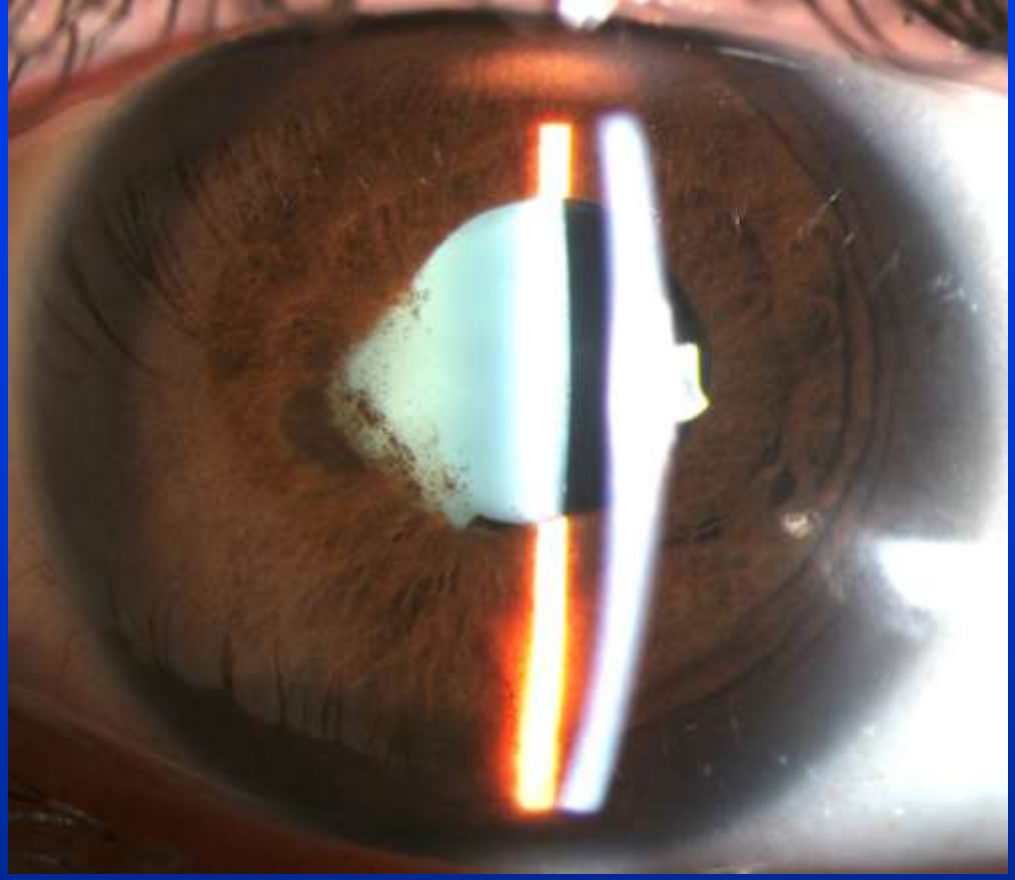
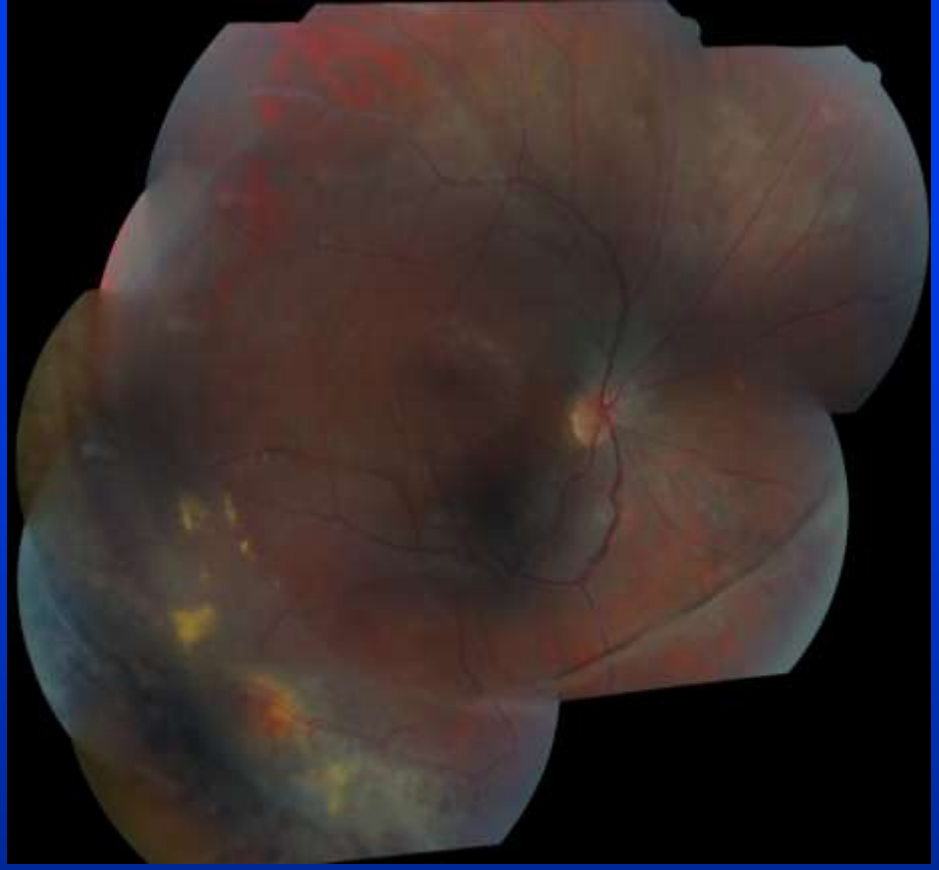
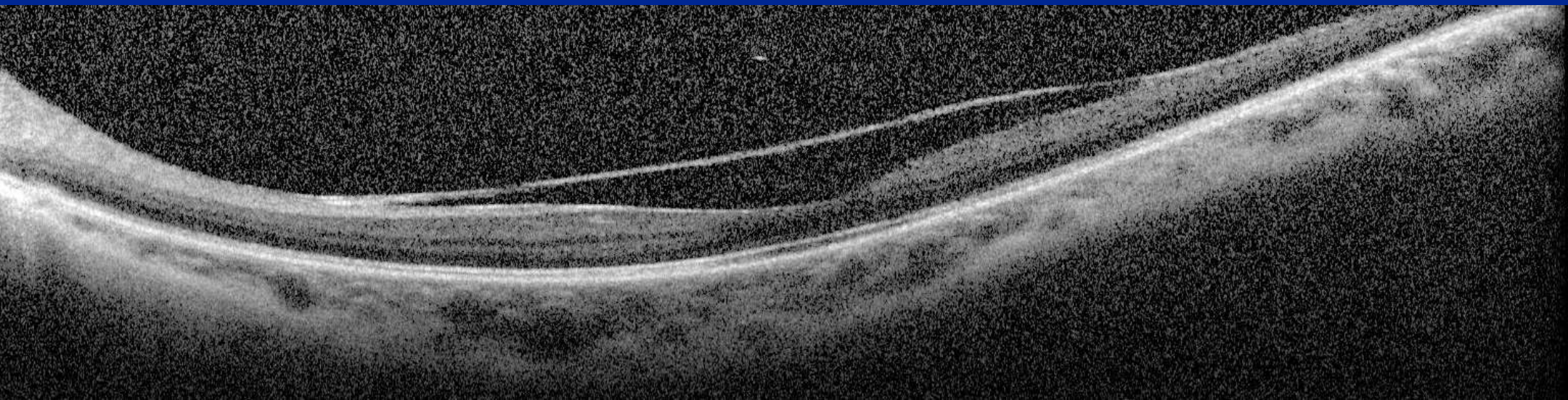


Fig. 2 The G591A mutation in the *NCF1* gene changed the tryptophan at position 193 into the TGA stop codon

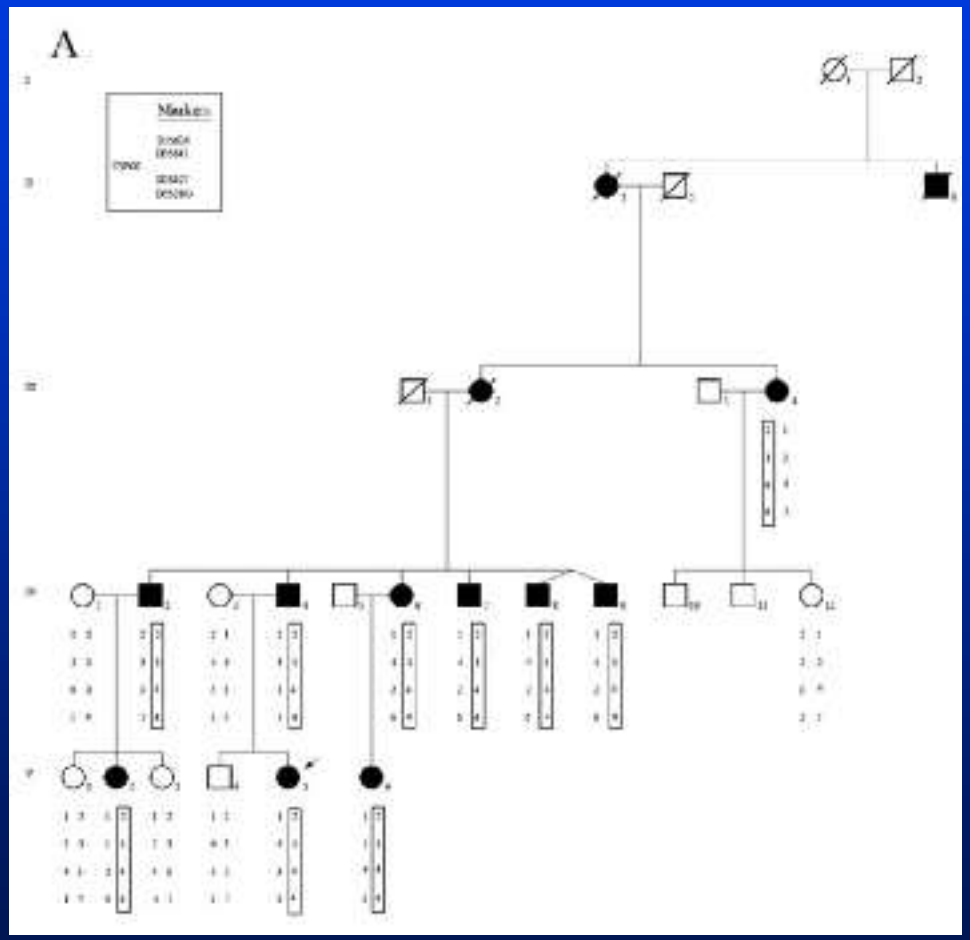


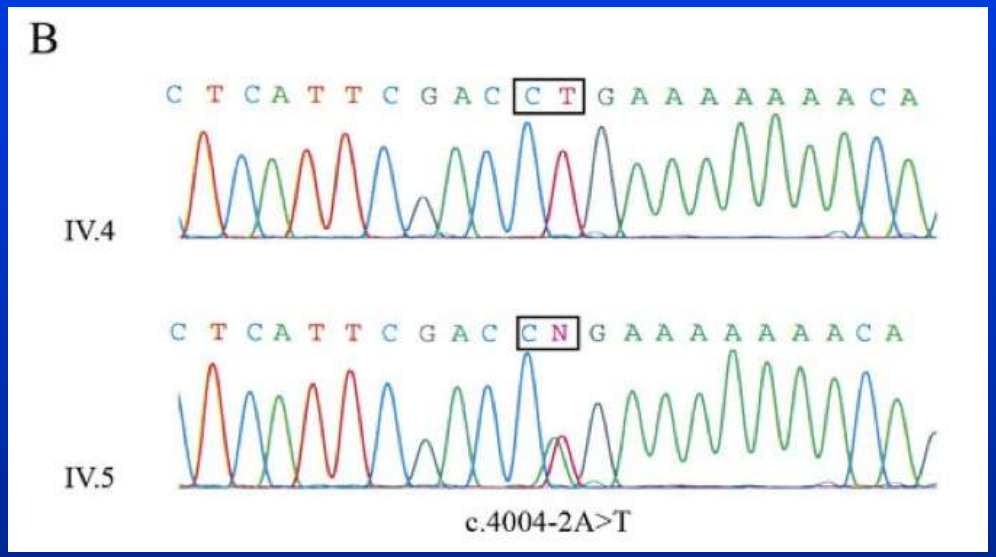




A new *VCAN*/versican splice acceptor site mutation in a French Wagner family associated with vascular and inflammatory ocular features

Antoine P. Brézin,[1] Brigitte Nedelec,[2] Amandine Barjol,[1] Pierre-Raphael Rothschild,[2] Marc Delpech,[2,3] Sophie Valleix[2,3]





Uvéites : quand il ne faut pas traiter

- **Traitement notoirement inefficace**

ou/et

- **Évolution spontanée favorable**

ou/et

- **Rapport [effets secondaires / bénéfices] défavorable**

ou/et

- **Masquage de la cause**

ou/et

- **Stade « dépassé »**

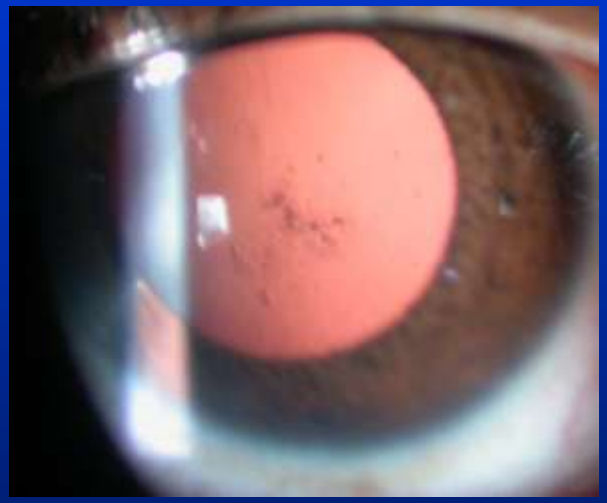
ou/et

- **Maladie rare, données insuffisantes**

Quand ne pas traiter (1) ?

- **Entités pour lesquelles aucun traitement n'a fait la preuve de son efficacité :**

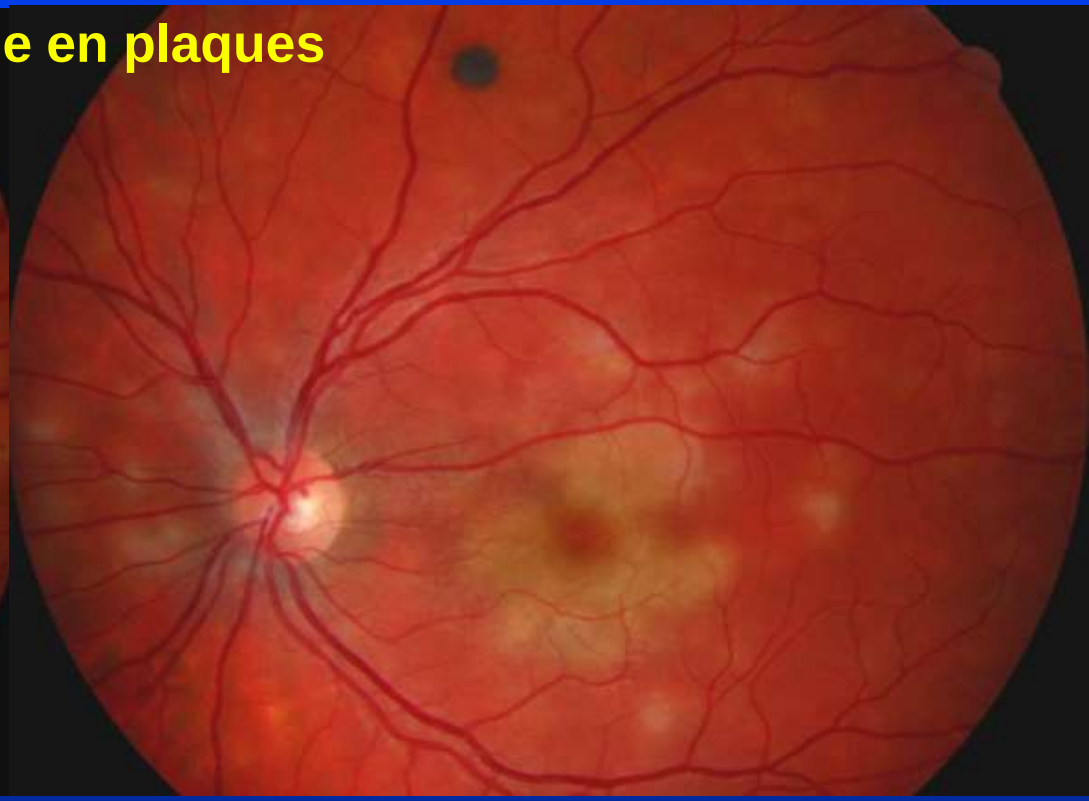
Ex . cyclite hétérochromique de Fuchs

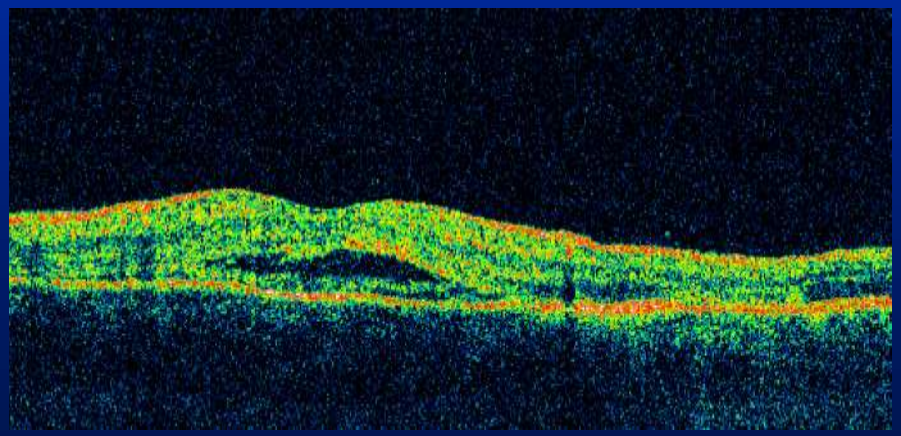


- **Entités d'évolution spontanée généralement favorable**

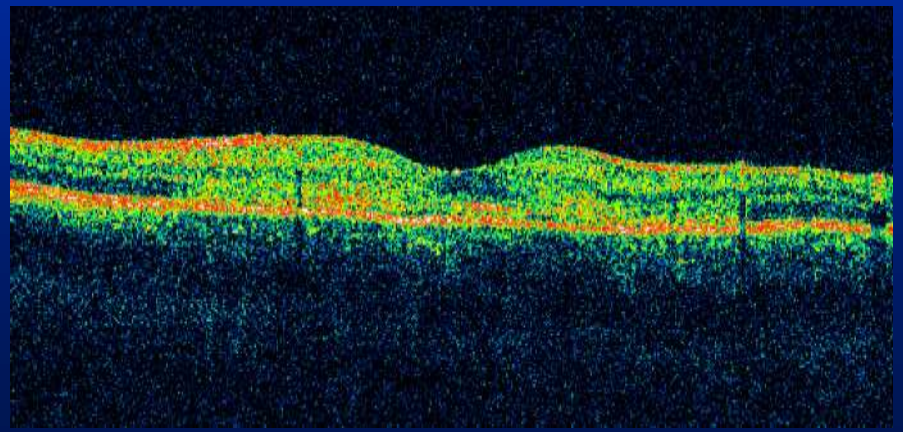
Ex . épithéliopathie en plaques

Epithéliopathie en plaques

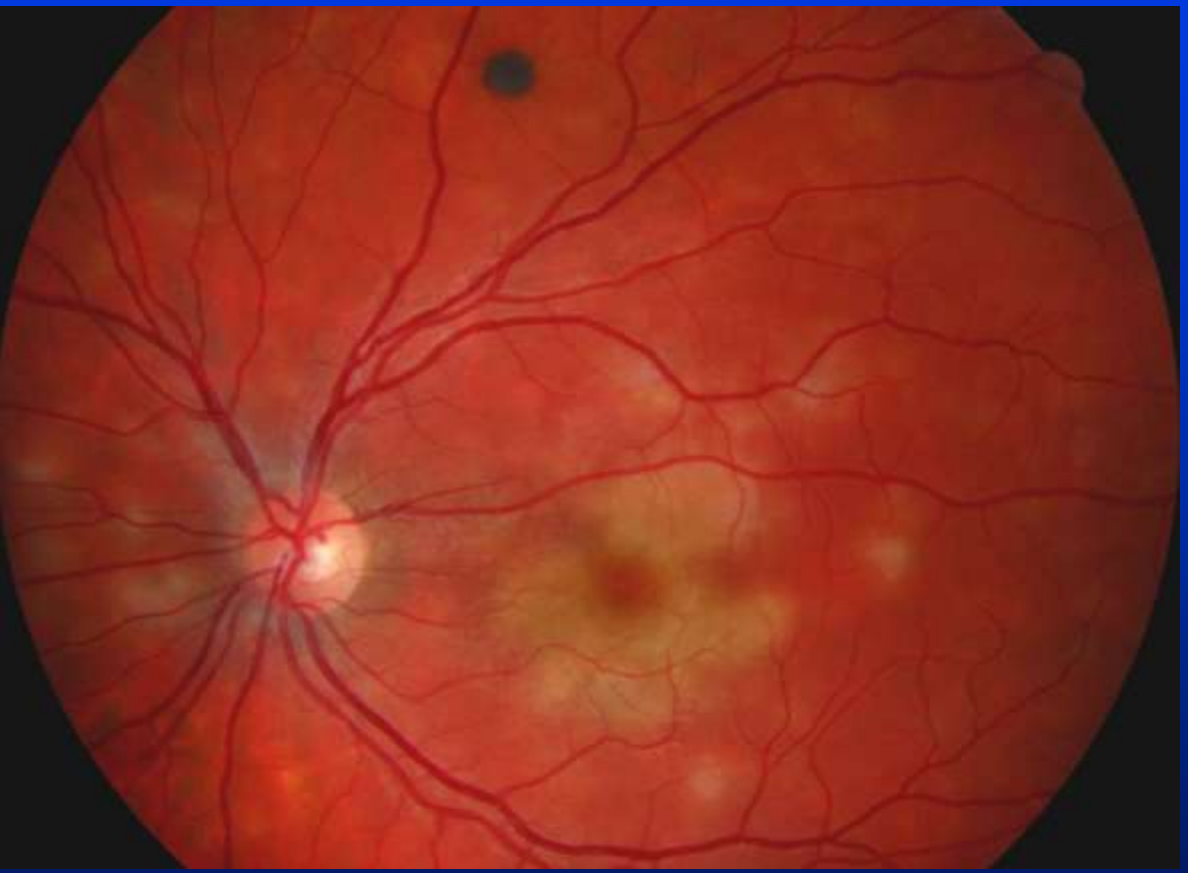


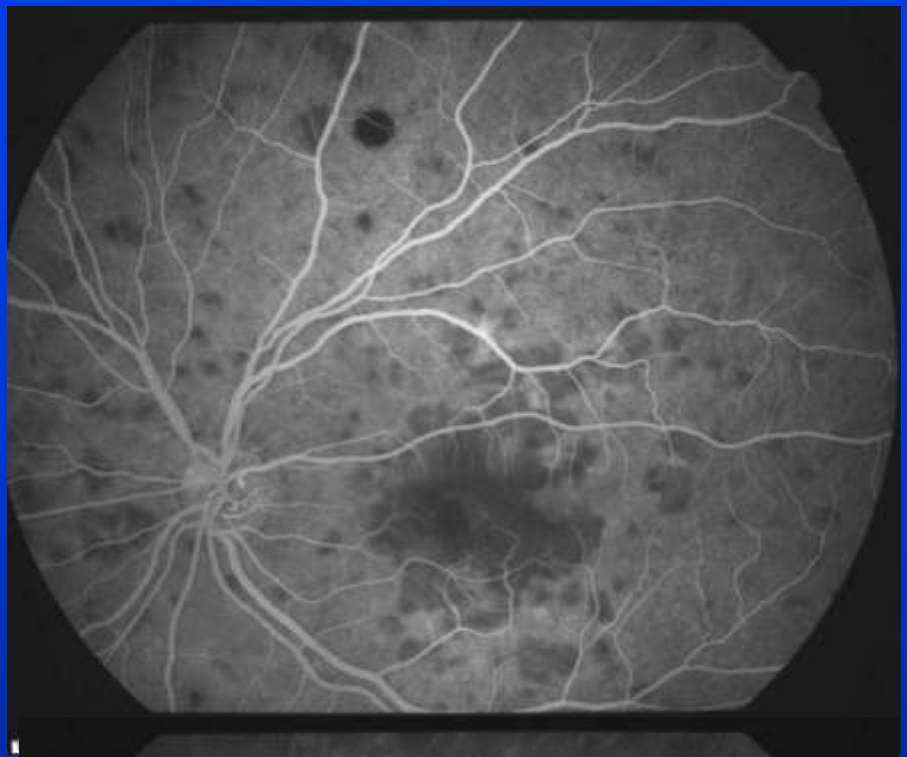


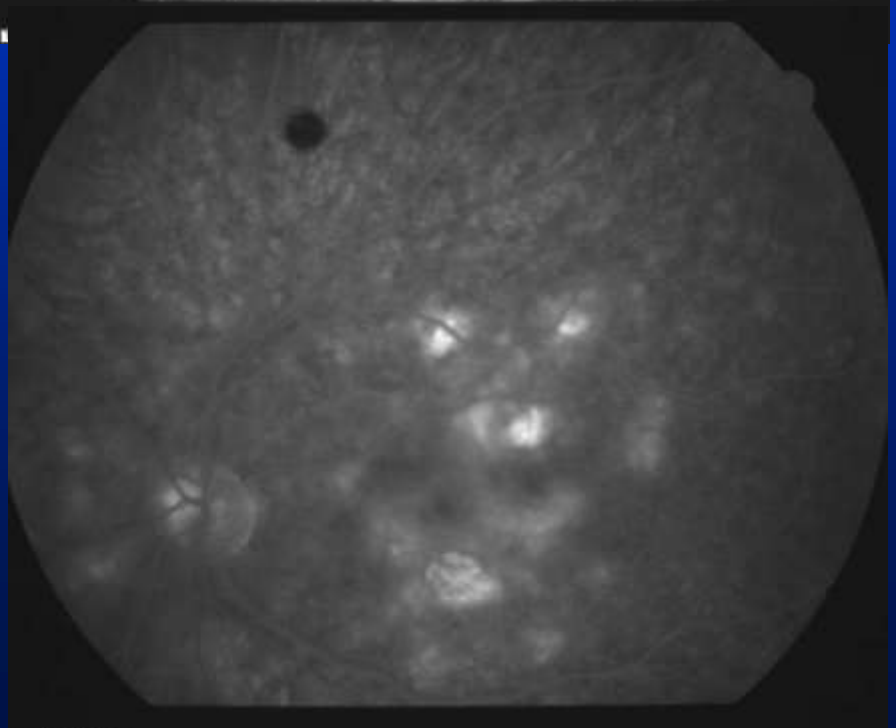
AV 1/20

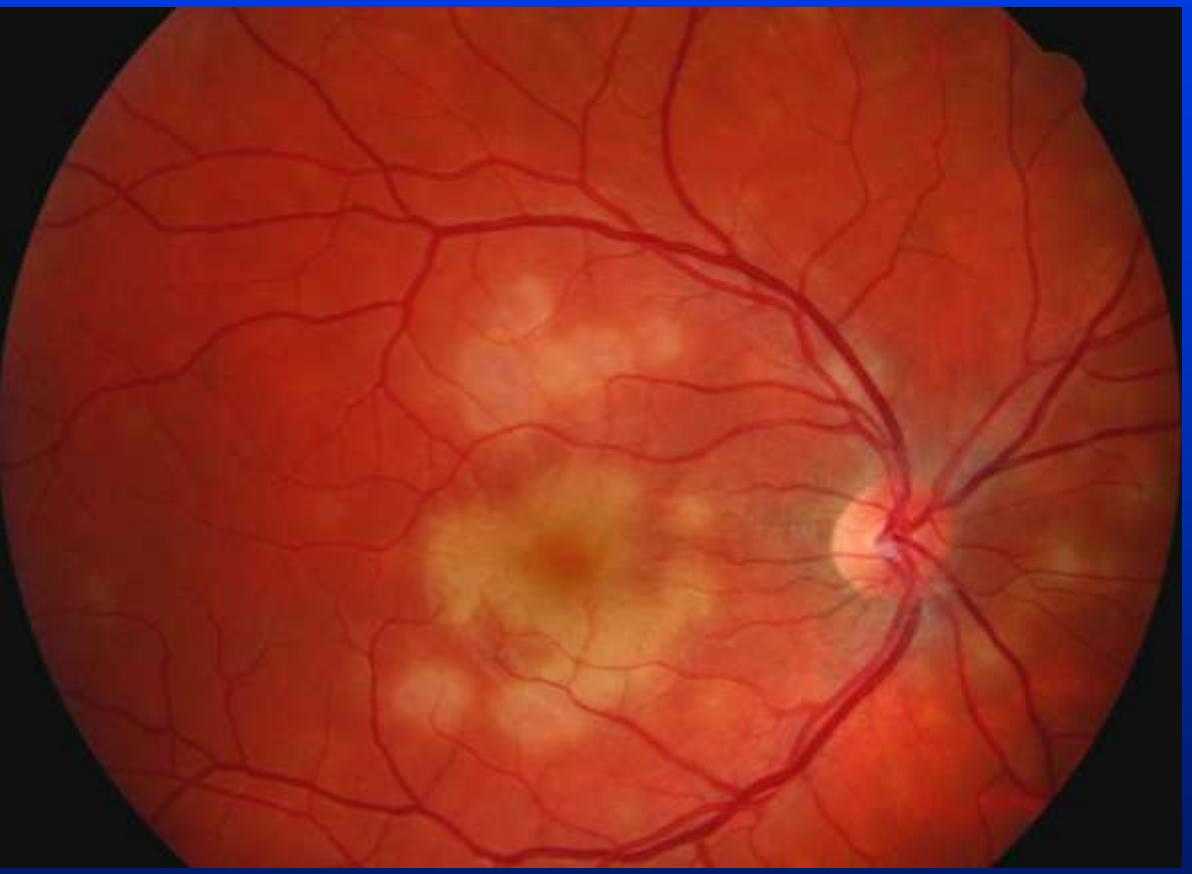


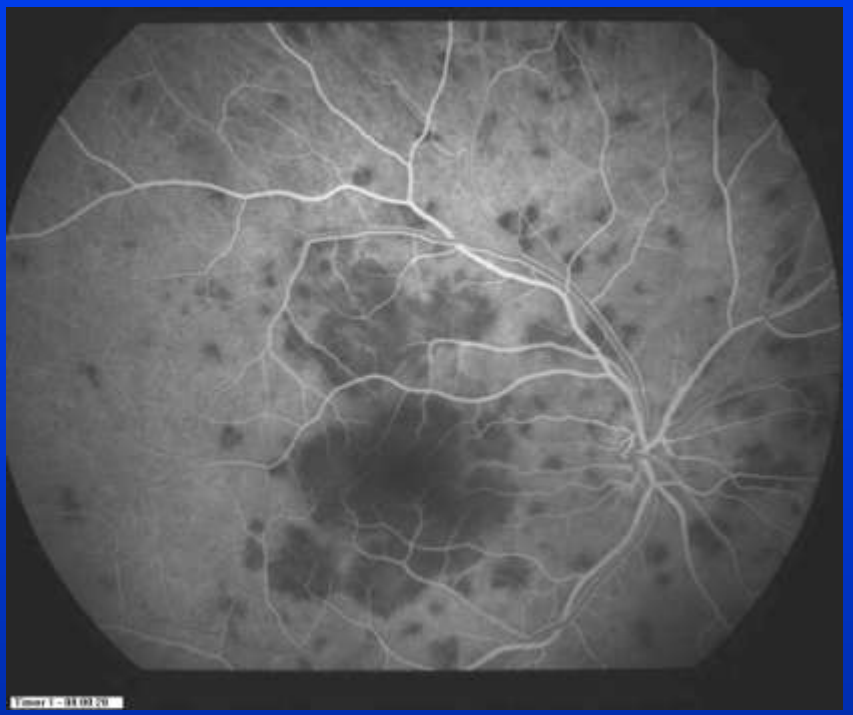
AV 4/10

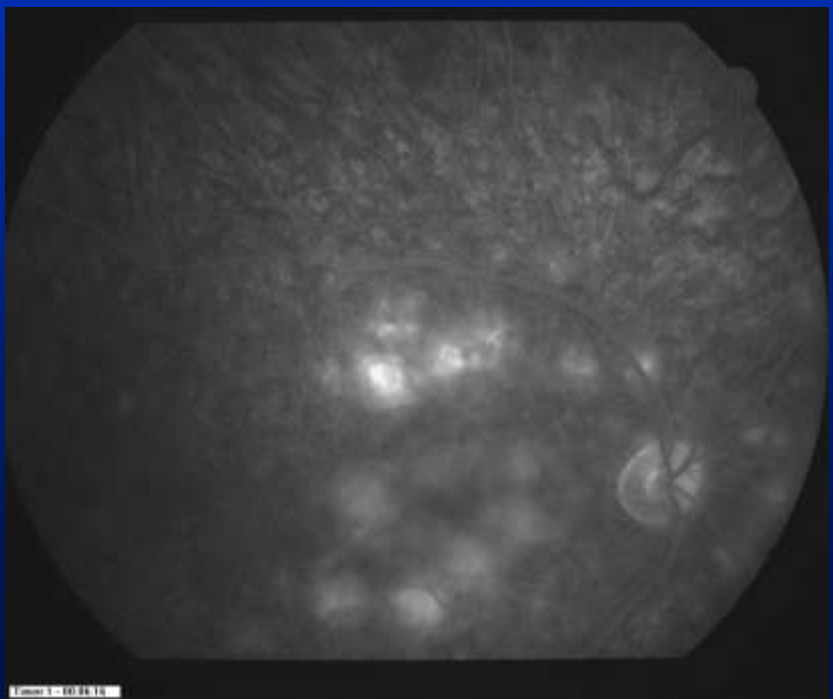


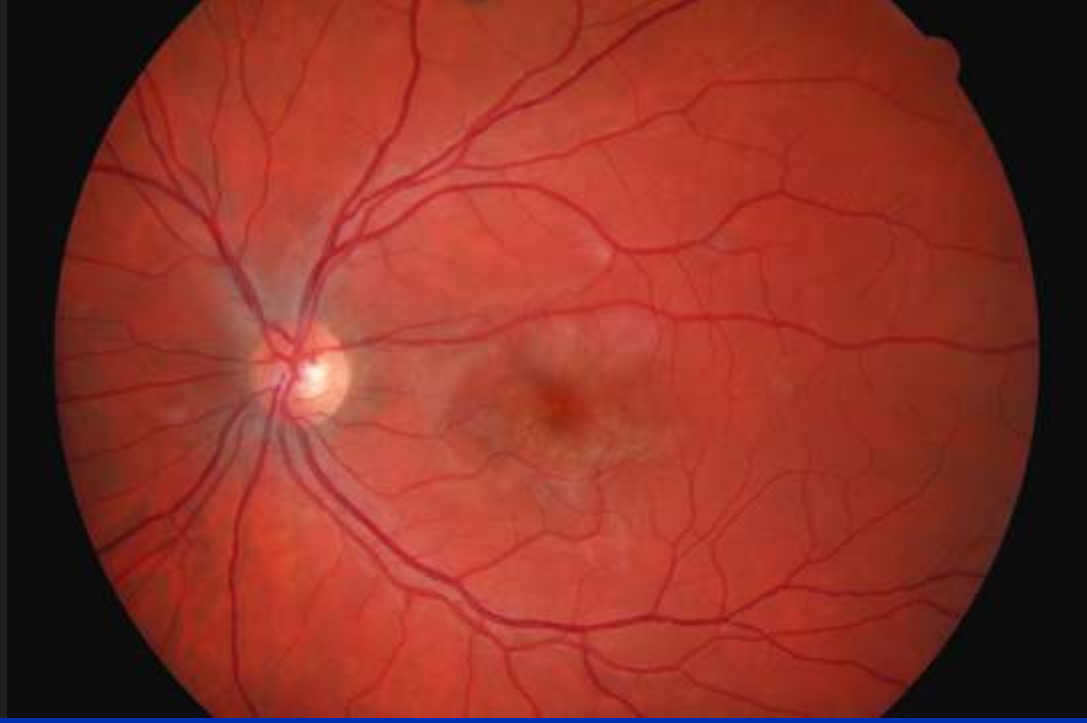


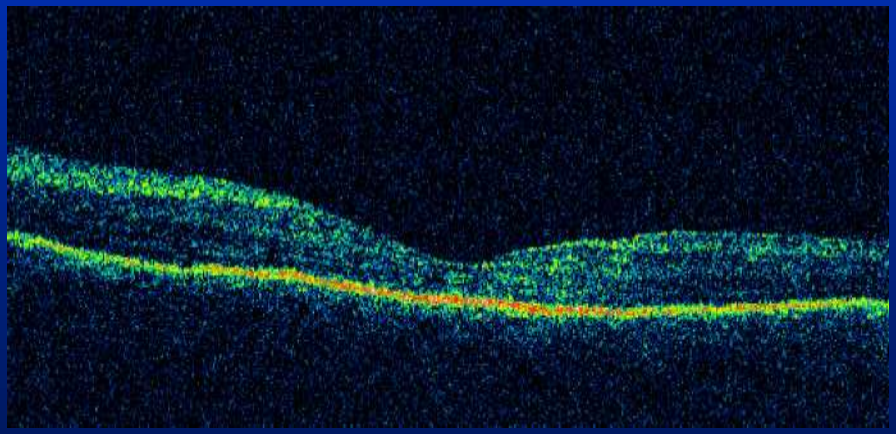


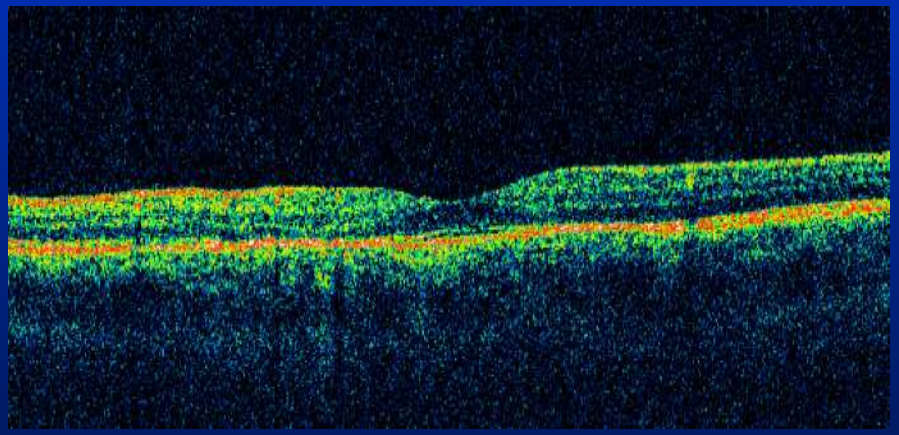












AV 10/10

AV 10/10

Quand ne pas traiter (2) ?

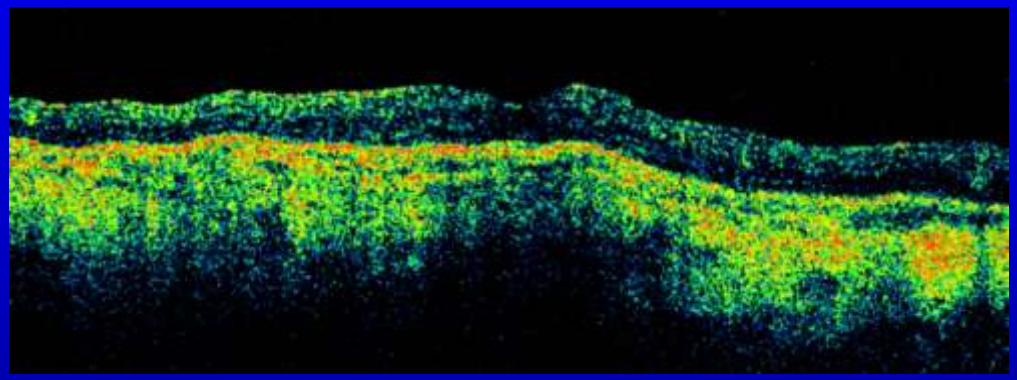
- **Rapport effets secondaires/bénéfice attendu susceptible d'être défavorable**

Ex. Uvéite intermédiaire idiopathique de l'enfant ou de l'adolescent : cas avec opacités vitréennes responsables de myodésopsies, mais conservation de l'acuité visuelle et absence d'œdème maculaire.

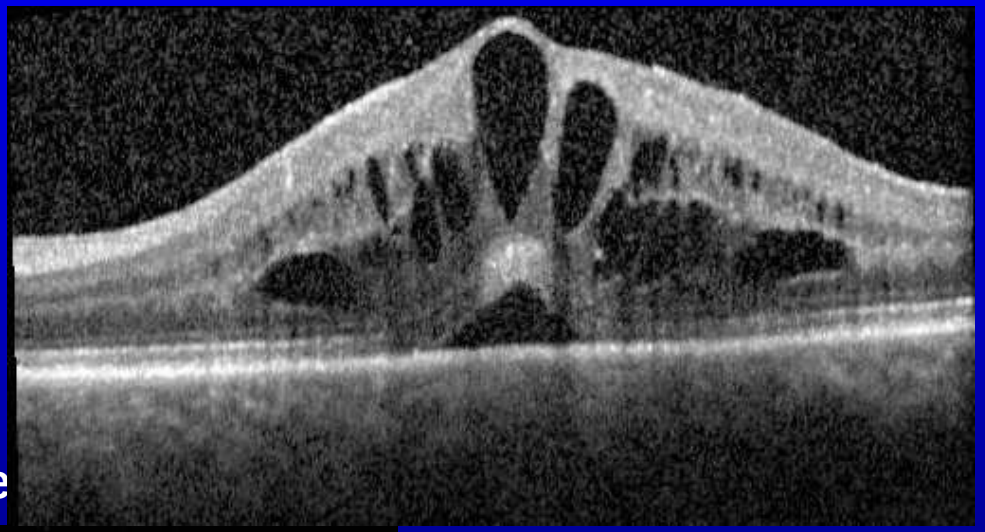
Ex. Choriorétinopathie de type birdshot : cas avec taches caractéristiques de la maladie, mais sans œdème maculaire ou vascularites actives.

Analyse maculaire et uvéites postérieures

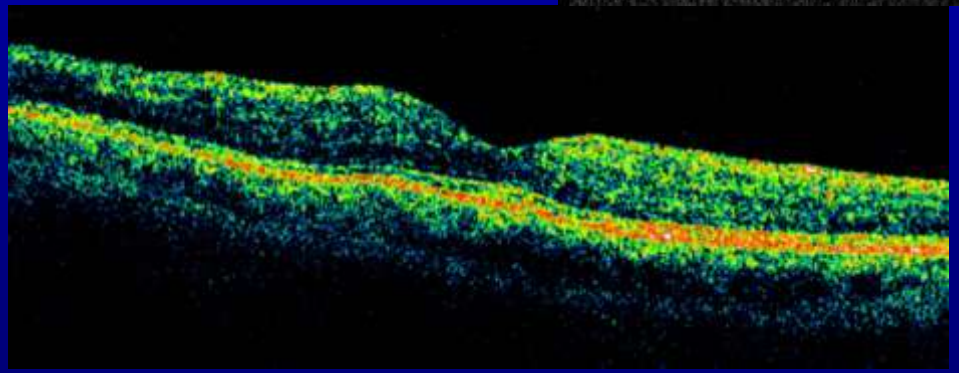
Atrophique



Oedème maculaire



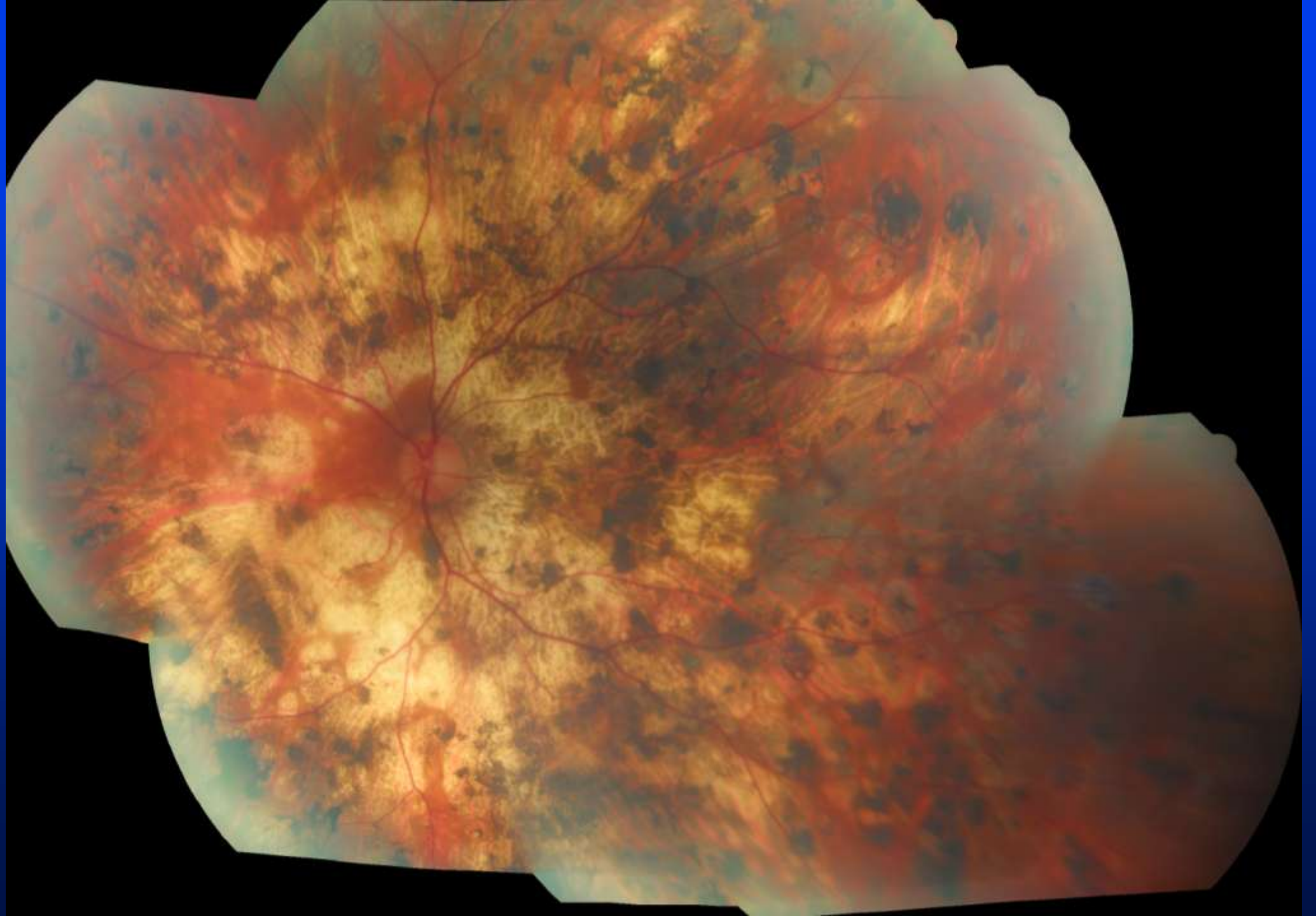
Normale



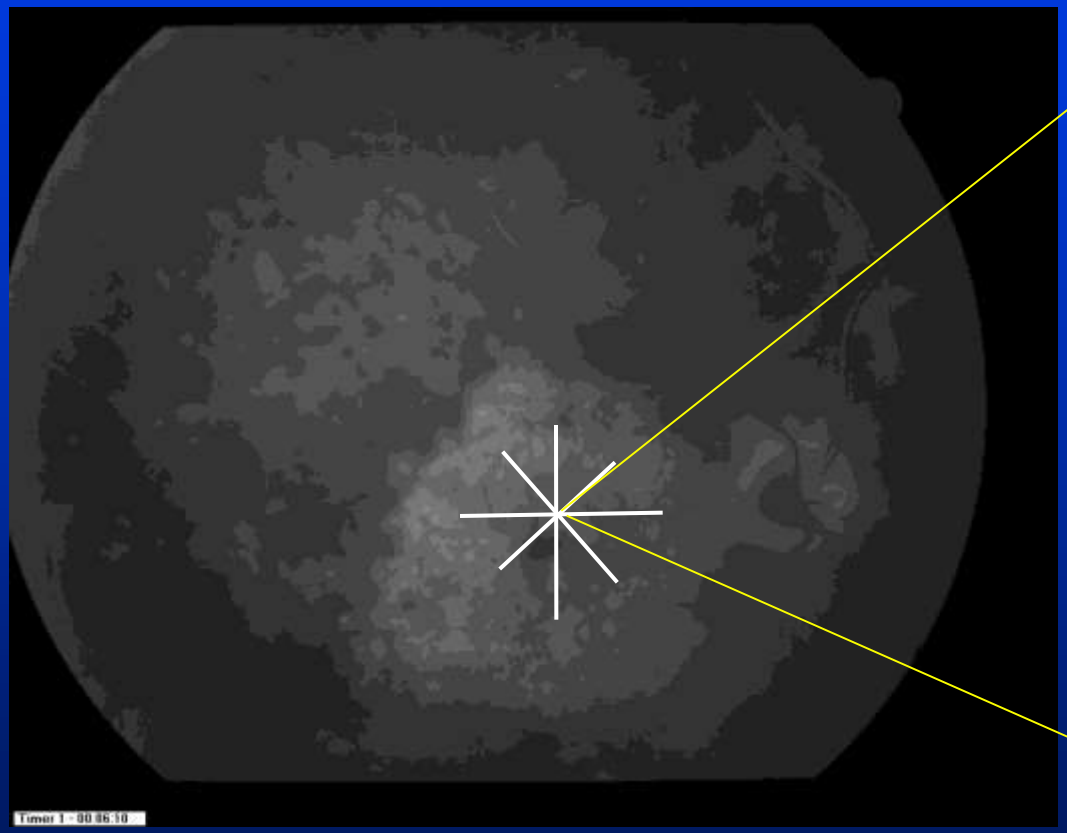
Quand ne pas traiter (3) ?

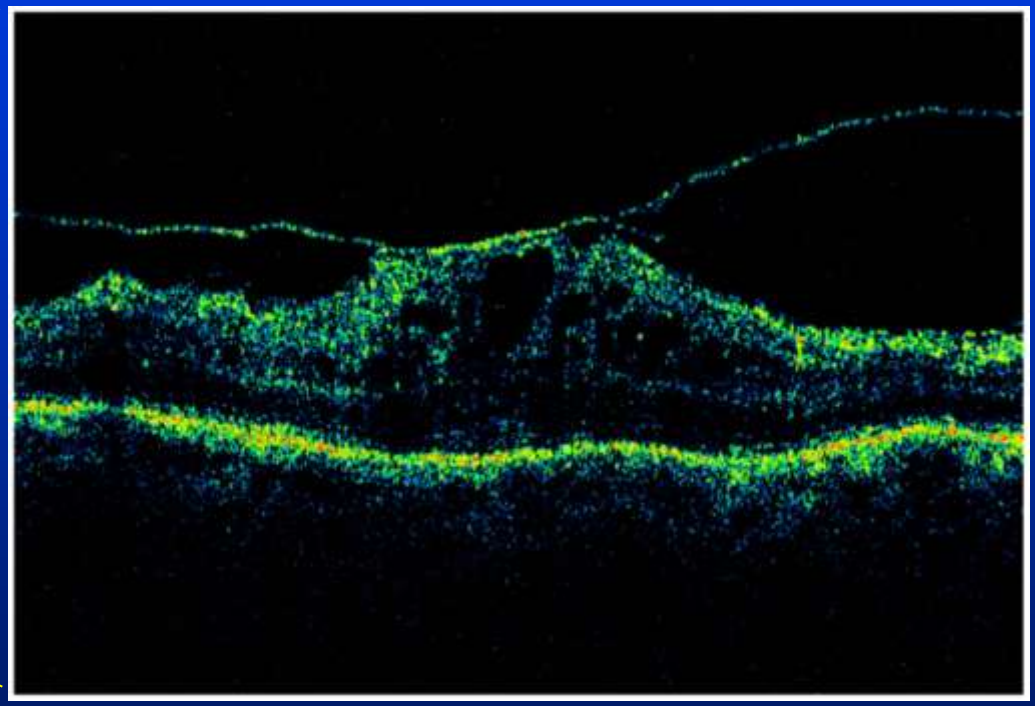
- **Dégâts structuraux rendant irréversibles les déficits fonctionnels**

Ex. Phase terminale « *burned-out* » ou « pseudo-rétinopathie pigmentaire » d'une choriorétinopathie de type birdshot ou d'une choroïdite serpigineuse.

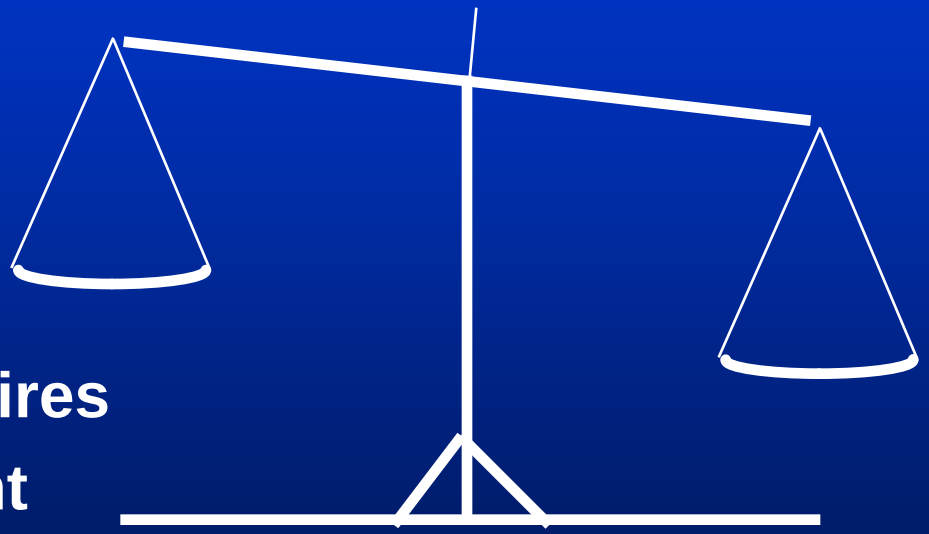


Ne pas traiter par une corticothérapie une complication « structurelle »





Décision thérapeutique

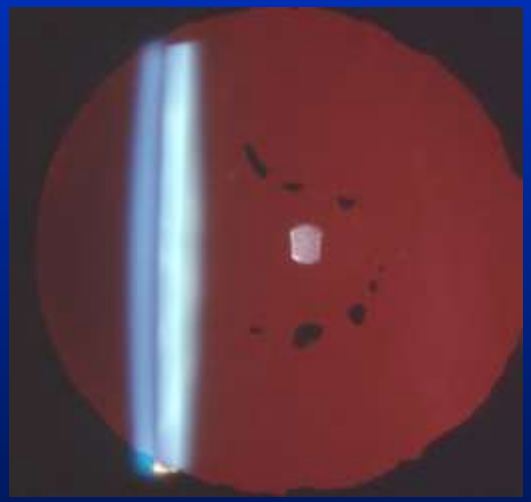


Effets secondaires du traitement

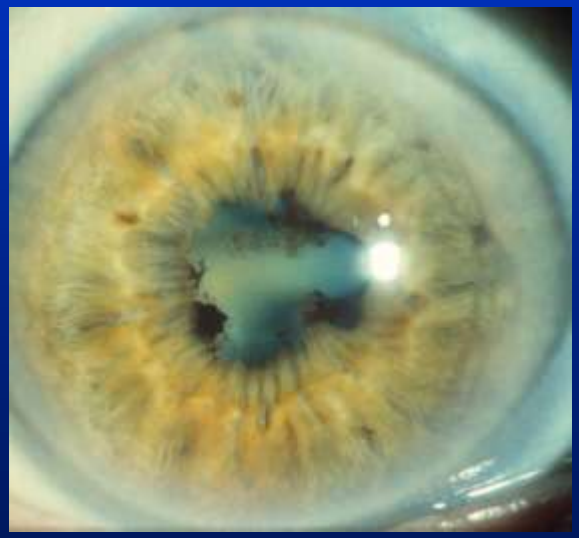
Bénéfices thérapeutiques

⇒ **Réfléchir avant d'agir !**

Succès



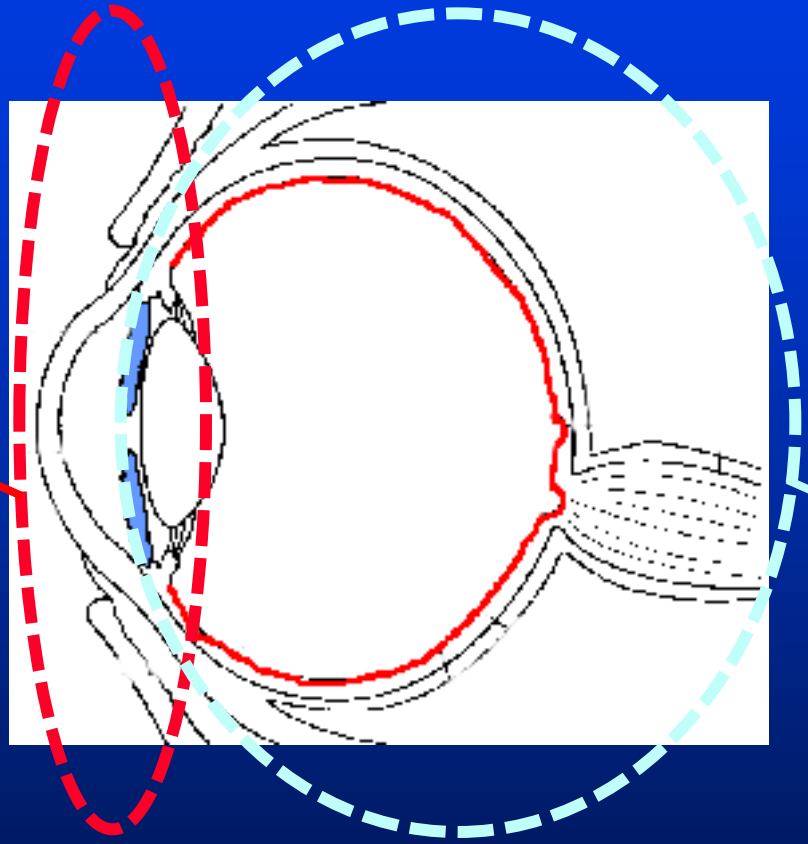
Échec



La réflexion ne doit pas faire retarder le traitement
Prévention des synéchies : traiter précocément et intensément !

Type de traitement selon le site de l'inflammation

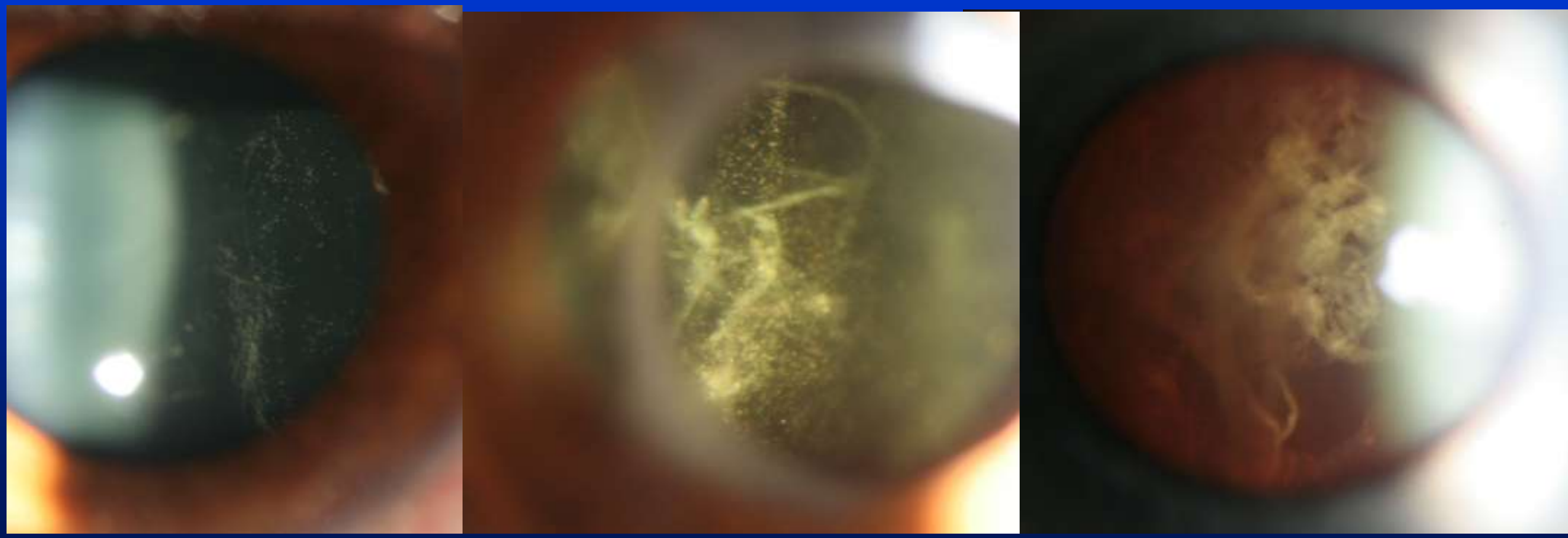
Uvéite antérieure : traitement topique

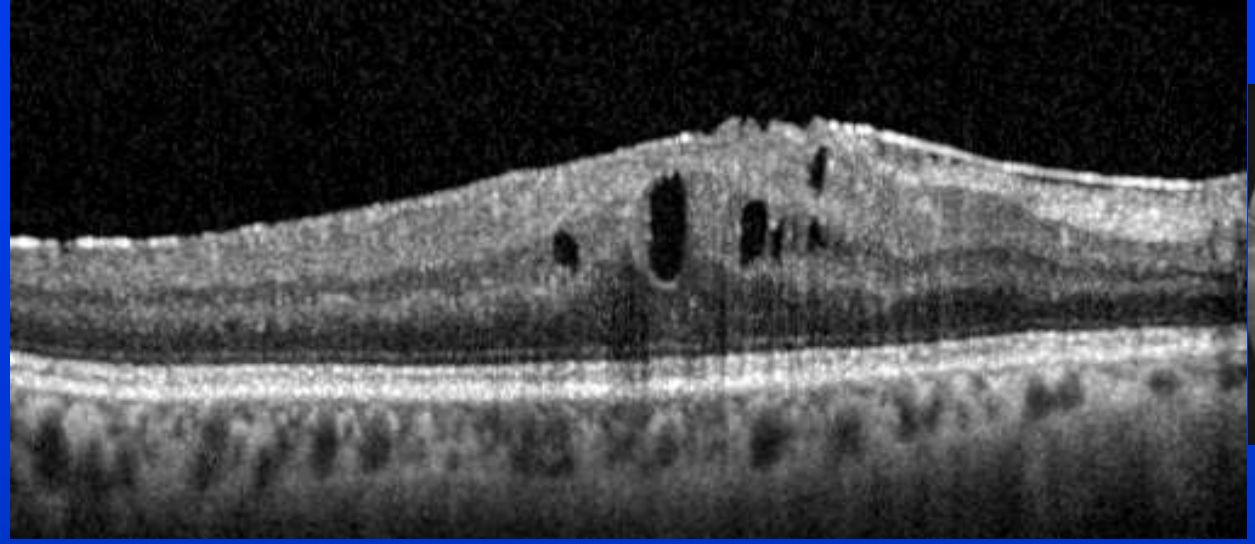


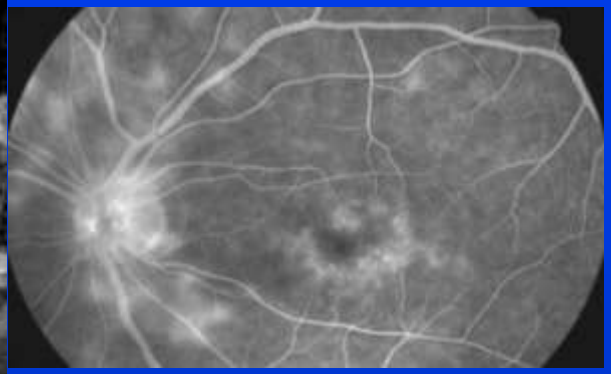
Uvéites intermédiaires et postérieures : traitement systémique, intra- ou périoculaire

Pas de traitement	Traitement intra- ou péri-oculaire	Traitement par voie générale dans certains cas	Traitement par voie générale indispensable
Exemples :	*Exemples* :	*Exemples :*	*Exemples :*
Fuchs	Uvéite antérieure compliquée par contiguïté d'OM	Birdshot	Behçet
EEP	Uvéite intermédiaire idiopathique du sujet jeune avec OM	Sarcoïdose	VKH
Uvéite intermédiaire idiopathique du sujet jeune sans OM			Ophtalmie sympathique

Uvéites intermédiaires : traitement plutôt péri- ou intraoculaire







Facteurs en faveur d'un traitement intra- ou

- Unilatéralité
- Idiopathique
- Phase initiale de traitement

Facteurs en faveur d'un traitement systémique:

- Bilatéralité
- Manifestations extraoculaires
- Echec ou plus de 2 injections/an
- Hypertonie

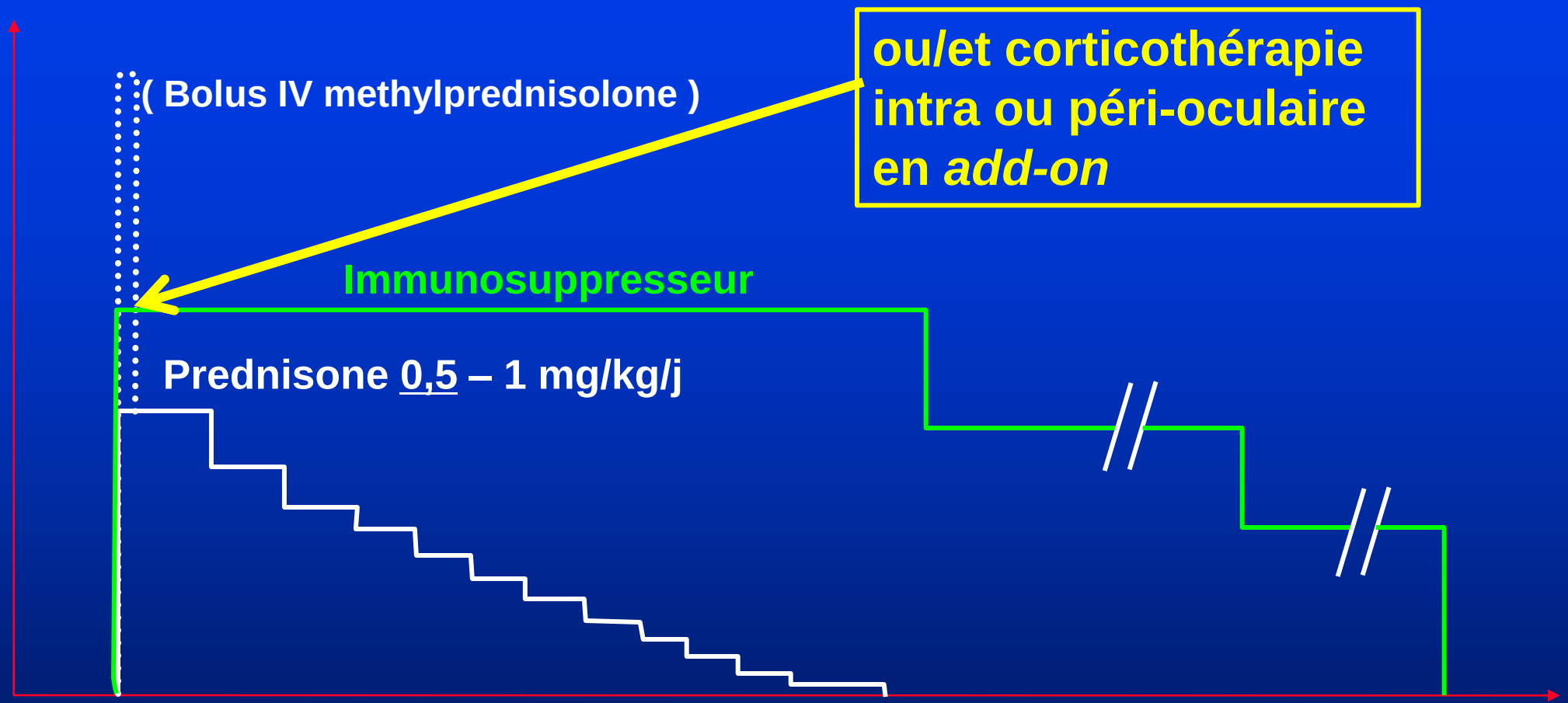
Facteurs de traitement péri-oculaire (injection sous-ténonienne triamcinolone) ou intraoculaire (Ozurdex®)

injection sous ténonienne (triamcinolone) :
Sujet jeune,
phake,
œdème maculaire uvéitique modéré et récent

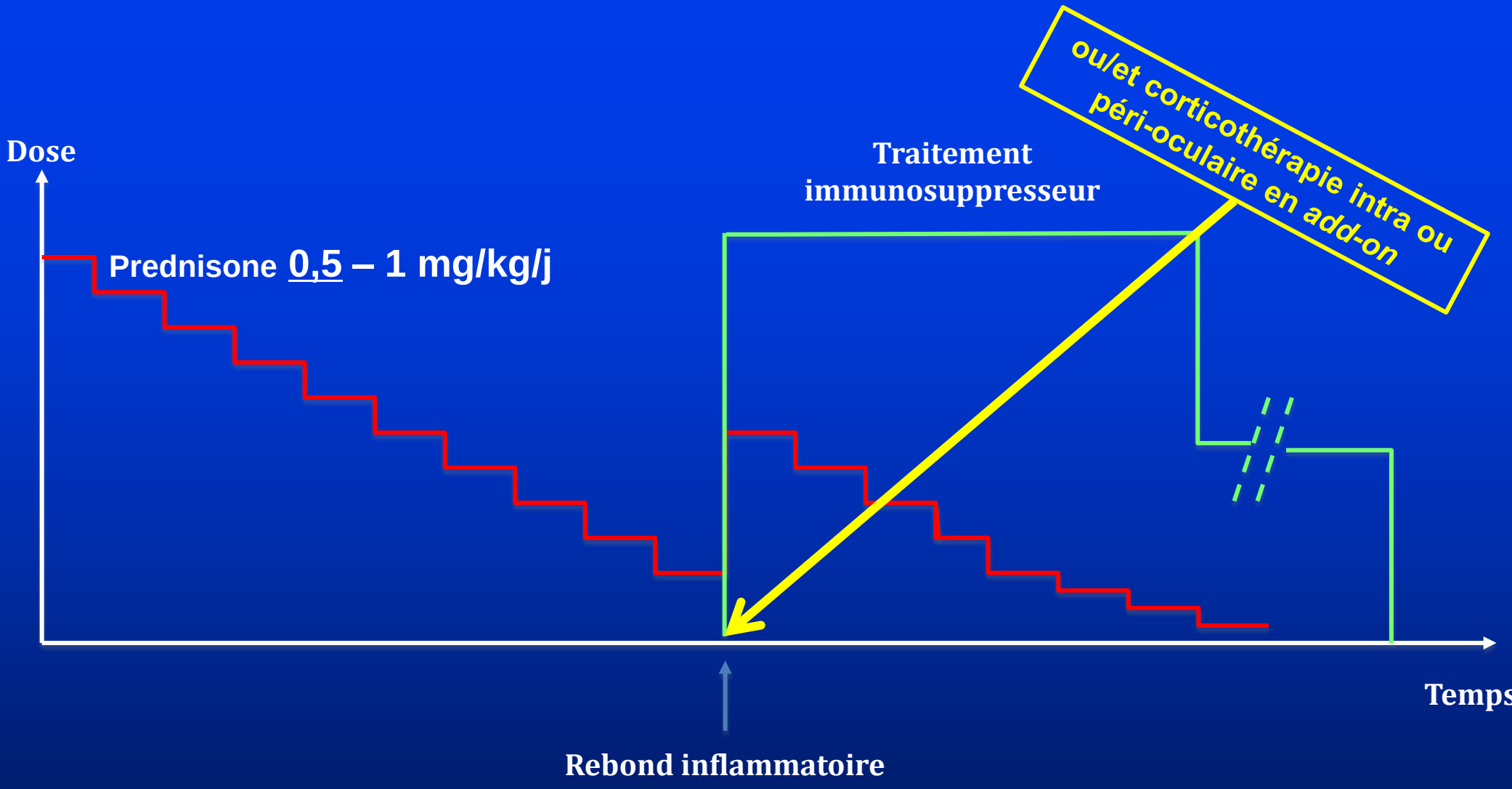
Ozurdex®
Sujet âgé,
pseudophake,
œdème maculaire uvéitique sévère

Epargne cortisonée systémique

- **Corticothérapie topique** → **Curative**
  → **Préventive (long cours)**
- **Corticothérapie péri-oculaire**
- **Corticothérapie intraoculaire**



Uvéites sévères : Schéma thérapeutique « classique »



Uvéites sévères : Schéma thérapeutique « de secours »


Merci