

Pars Planitis

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The average pars planitis patient is a child or young adult who experiences a gradual onset of blurred vision or floaters in one or both eyes. The anterior chamber reaction is usually mild. Cells are found in the vitreous and a snow bank inferiorly over the pars plana. With intravenous fluorescein there is leakage of green dye into the anterior inferior vitreous apparently from a retinal phlebitis and/or neovascularization in the region of the pars plana. Cystic macula edema is a major feature of severe cases of pars planitis and is the major reason for treating these patients. Remember that macular edema can be due to many other conditions, including iridocyclitis and cyclitis. In my experience pars planitis has been over diagnosed by the referring ophthalmologist when he uses the term erroneously for patients with cystic maculopathy but no snow banks. One should not make the diagnosis without a snow bank over the pars plana or at least a few snow balls in that region. Since January of 1961 we have had evidence that one of the major features of pars planitis is a retinal phlebitis. The soft snow banks which are seen over the pars plana in the earlier stages apparently turn into a hard crusted snow that on histopathology are seen to be composed of collagen. Most of the histopathology available supports the concept that there is little uveal inflammation. I believe that pars planitis is a definite clinical entity with an as yet "unknown" etiology. For pars planitis patients, no diagnostic work up is necessary because it will show nothing except decreased skin test reactions.

About 80% of the eyes do well without any treatment. One should not treat for the nuisance of vitreous cells alone. One should treat only if there is severe exudation into the vitreous which might result in opacification of the vitreous or massive vitreous retraction or if there is cystic maculopathy by decreased vision, positive photostress test, cysts in the macula on fluorescein angiography or by slit-lamp microscopy. This cystic maculopathy can result in permanently decreased vision if not treated.

The major treatment consist of adequate corticosteroids to the back of the eye.

Depending on the course and reponse to steroid therapy we divided the 67 eyes of

our pars planitis patients into four groups: 1) The vision was 6/12 or better and remained essentially the same; 2) Initial vision less than 6/12 but with treatment improved 2 or more lines; 3) Vision remained worse than 6/12; 4) Vision declined.

1) This group in which the vision remained 6/12 or better with treatment included two-thirds of the eyes studied. There were two types of response: a) steady-in which the vision remained the same; b) vacillating-in which vision varied, but in both groups an adequate vision of 6/12 or better was preserved.

2) When we considered eyes in which the vision improved 2 lines or more, we noticed two types of improvement: **rapid** (an improvement of two lines or more taking less than two months) and **slow** improvement (two lines or more) taking more than two months, and often more than one year and often requiring both prednisone tablets and periocular injections.)

We have decided that it is unwise to tell the patient that they will not respond to corticosteroid without the experience of an intensive trial for at least 4 months. By intensive trial we mean at least 100 mg of prednisone every other breakfast and periocular injections of 40mg every two weeks.

3) In 5 eyes the vision remained around the 6/20 to 6/30 region.

4) Only five of the 67 eyes had a deteriorating vision and in 4 of these 5 the deterioration was considered to be due to the development of posterior subcapsular cataract. So in actuality only one of 67 eyes failed to respond some to medication.

If the disease fails to respond adequately to corticosteroids or if corticosteroids cannot safely be used or if one considers that the dangers of immunosuppressive agent are worth taking to avoid producing more cataracts, immunosuppressive agents are given and have been found to be of value. The use of cryotherapy is still controversial, although more people are claiming to get good results. The reason for the controversy may be because of differences in technique, so if cryotherapy is used one should follow carefully Aaberg's directions for proper technique. (Treatment of pars planitis. Survey Ophthalmol. 22:120, 1977).

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