

EPISCLERITIS AND SCLERITIS—II

Sclero-keratitis

Nearly half the patients with scleritis, but very few with episcleritis, show some corneal involvement.

Classification

Characteristic corneal changes are seen in each type of anterior scleritis.

Nodular	(i) Localized stromal keratitis (ii) Localized sclerosing keratitis
Diffuse	(i) Acute stromal keratitis (ii) Sclerosing keratitis (iii) Limbal guttering
Necrotizing	(i) Sclerosing keratitis (ii) Keratolysis

Stromal Keratitis (Figs 1 and 2)

Onset usually insidious but may be acute. A midstromal opacity, "waxy" in appearance, appears in the same quadrant as the nodule (Fig. 1). Some vessels may follow the development of the opacity. As the scleral nodule resolves, the keratitis may resolve incompletely. In the acute form (Fig. 2), there is localized corneal oedema accompanied by active vascularization.

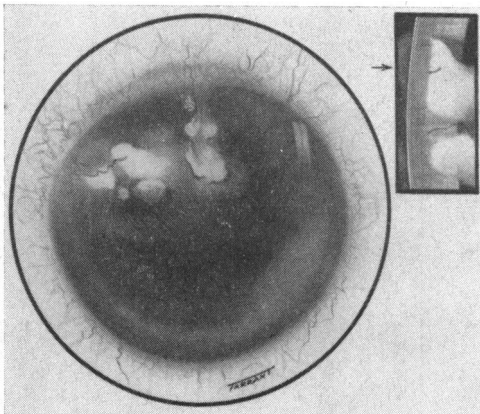


FIG. 1.—Stromal keratitis.

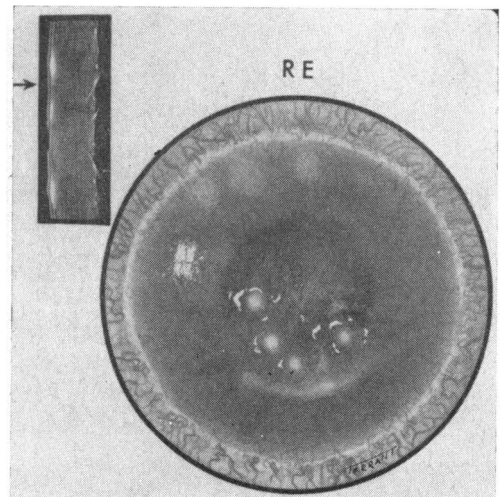


FIG. 2.—Acute form of stromal keratitis.

Sclerosing Keratitis (Fig. 3)

The commonest corneal complication of scleritis. A yellow or white "crystalline" opacity appears insidiously in the mid-stroma ("Candy Floss Opacity"), and progresses in the presence or absence of active scleritis. Vascularization is minimal. Resolution does not occur.

Limbal Guttering (Fig. 4)

A progressive gutter appears in the paralimbal area but does not extend more than 2 mm. into the cornea. Deep vascularization is passive. There may be a "waxy" deposit on the corneal side of the lesion. The gutter fills in following treatment although an opacity remains.

Keratolysis (Fig. 5)

There is a sudden melting away of tissue, several millimetres in diameter, at some point in the cornea. As the cornea thins it becomes ectatic, ruptures, and the eye may be lost. The condition may become static at the stage of descemetocoele.

More than one type of corneal involvement may occur in the same patient.

Treatment

The treatment of *sclero-keratitis* is that of *scleritis*. Initially, unless the attack is very severe, local steroids. If no response to local therapy within 3 to 4 days, either oxyphenbutazone (600 mg. daily for 1 week then 300 mg. daily until suppressed) or indomethazine (100 mg. daily until suppressed). If not responding, stop local and systemic therapy and substitute systemic steroids (prednisolone, at least 60 mg. daily for 4 days. As soon as inflammation is suppressed, reduce to 10–15 mg. daily and withdraw slowly over 2 months).

Episcleritis usually resolves on local steroid therapy (gutt. prednisolone 2-hrly). Very occasionally it is necessary to give systemic therapy as for scleritis.

Illustrations:

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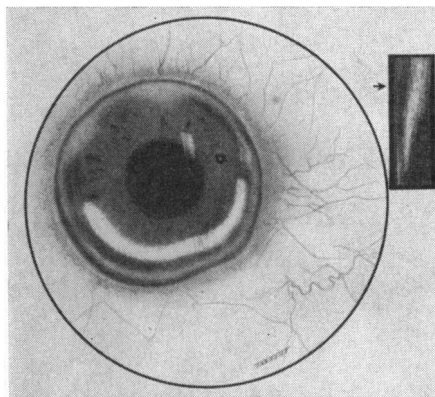


FIG. 3.—Sclerosing keratitis.

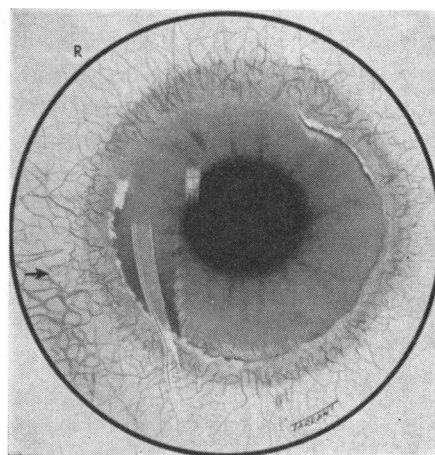


FIG. 4.—Limbal guttering.

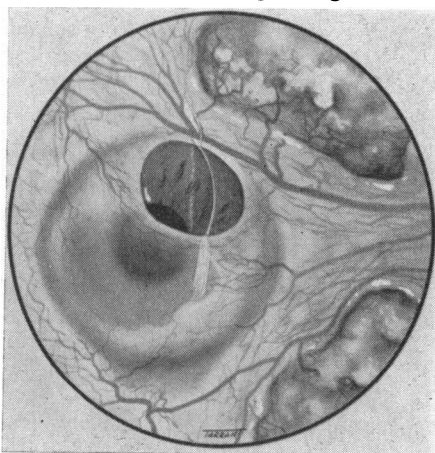


FIG. 5.—Keratolysis.

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