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RHEUMATOID ARTHRITIS ASSOCIATED NECROTISING SCLERITIS-A CASE SCENARIO

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ABSTRACT We report a case of rheumatoid arthritis associated necrotising scleritis without inflammation. The patient was successfully treated with scleral patch graft under immunosupressive agent cover, the patient is doing well with good scleral integrity with BCVA 6/6.

KEYWORDS : Necrotising Scleritis, Scleral patch graft, Rheumatoid Arthritis

INTRODUCTION:

In patients of Rheumatoid arthritis, necrotising scleritis, an ocular manifestation of a systemic vasculitic process, is associated with significant ocular morbidity.[1] Necrotising scleritis is commonly associated with collagen vascular disorders and other autoimmune diseases.

Necrotising Scleritis has also been reported after various ocular surgeries including pterygium excsions,[2] cataract surgeries,[3] retinal detachment surgeries, trabeculectomies, strabismus surgeries, and various implants as well.

Case

We report a 53 year old female patient who presented with scleral thinning with uveal show at the superomedial part of the globe. She was a known case of rheumatoid arthritis undergoing treatment with a rheumatologist. She was on Methotrexate(25mg/week) and Azathioprine (50mg/day) from the last 2 years when she noticed one day, a large patch measuring 12x8mm in the superomedial compartment of her eye. On examination, it was a 12x 8 mm large 0.5 mm depth scleral area of thinning with uveal show at one end with no vitreous prolapse.

Under peribulbar anaesthesia, the wound site is exposed using traction suture inferiorly at 6 o' clock followed by removal of the necrotising tissue at the site and a thorough saline wash was done. Then, the measurement was taken using callipers and the same sized glycerol scleral tissue was dissected to fit in the defect.

Further, interrrupted anchoring sutures using 10-0 nylon were placed. Since it was a large graft, so suturing with good force vectors was needed to be done for this graft.

The plan was to use interrupted sutures at the four ends starting with the diagonal edges followed by their mid-points making its number to be raised to eight suture technique for anchorage from anterior to posterior borders. Overriding of edges at the limbus was not to be done else efforts would have gone in vain leading to exposure of graft and dessication thereof.

The peroperative decision for any horizontal mattress suture is a matter of surgeons choice for providing more anchorage at the centre if the need arises. In this case, we were much satisfied with 8 suture interrupted technique. The scleral graft was then well covered with conjunctiva, and 6-0 vicryl was used for conjunctival repostion.

The patient is doing well at the end of 6 weeks, with good ocular intregrity and is managed on topical steroids 1% Prednisolone Acetate 6 times per day and immuno-supressants as advised from time to time from a rheumatologist.

DISCUSSION

Rheumatoid associated necrotising scleritis is a major cause for scleral thinning and further ocular morbidity.

In 2006, Ismael et al [1] case illustrated that biologic agents may be considered in refractory cases of sight- and life-threatening scleritis as they used infliximab and the patient responded rapidly. So, when patients are refractory to systemic corticosteroids and/or immunosuppressants, infliximab is yet another weapon in the armamentarium.

In 2012, Rishi R Doshi et al demonstrated the spectrum of post-operative scleral necrosis occuring most commonly following pterygium (71.4%) and scleral buckling (97.2%) surgery. Hypopyon is uncommon (10.0%) in patients with postoperative scleral necrosis, but when present is a strong predictor of infection (odds ratio, 21.2; 95% confidence interval, 2.9-157.5). Rates of underlying autoimmune disease are generally low (0.0-12.5%) except following cataract and lens procedures. [2]

CONCLUSION

Aggressive approach both medical, surgical is needed in all cases of rheumatoid associated ocular manifestations. As an examiner, we tend to forget examination sclera to the extent that which we should all do in autoimmune cases, to rule out episcleritis, scleritis with or without inflammation. Early diagnosis will defer complications therof and will save the integrity of the eyeball.

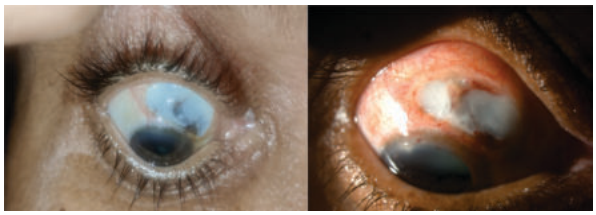

Fig 1 : Shows a large 12x8 mm scleral defect

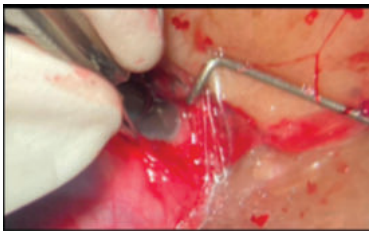

Fig 2: shows fully covered scleral patch graft

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