GIVING A NOD TO NODULAR EPISCLERITIS

Systemic workup may be warranted to rule out a more serious condition.

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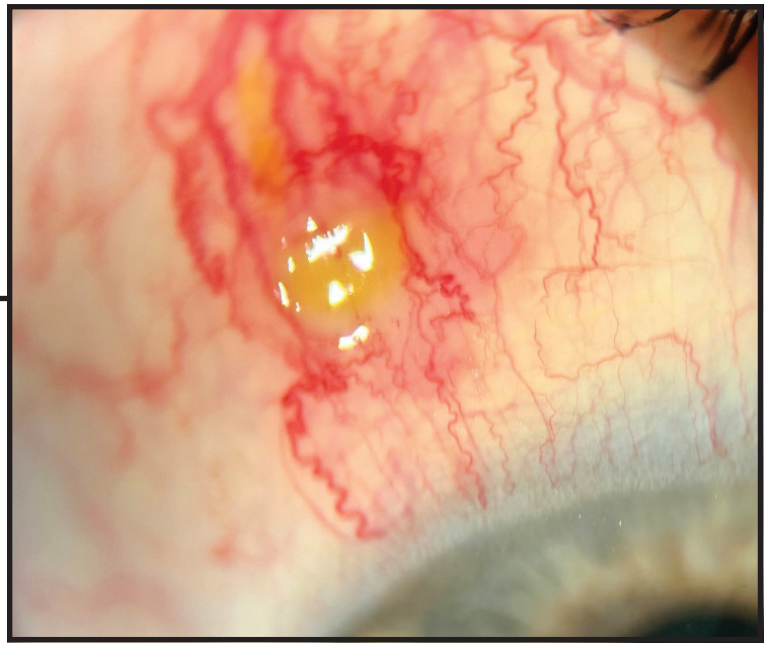

Figure. Nodular episcleritis in a 44-year-old White female. Late uptake of sodium fluorescein is noted with the bright red nodule and radially engorged vessels of the superficial episcleral plexus.

Episcleritis is typically a benign inflammatory disorder of the thin and highly vascular connective tissue between Tenon capsule and the sclera.[1] The most anterior structure is the conjunctiva, followed by the conjunctival plexus, Tenon capsule, superficial episcleral plexus, episclera, scleral plexus, and sclera. The conjunctival plexus contains hair-like vessels that freely move over the underlying structures and appear bright red when engorged and inflamed.[2] Similarly, the episcleral plexus contains straight and radially arranged vessels that also move freely (but not as easily) over underlying structures and, when inflamed, appear a salmon pink in color.

Episcleritis is classified as simple or nodular. In either case, patients may present with complaints of sudden discomfort, photophobia, or tearing.[1] Patients with episcleritis present with congested vessels that appear salmon pink or bright red in color and typically occur within a single quadrant (Figure). In addition, the blood vessels in episcleritis are radially engorged and mobile over the sclera, including the nodule in nodular episcleritis.[2] To differentiate between episcleritis and scleritis, phenylephrine 2.5% may be instilled into the conjunctival sac, leading to constriction of the conjunctival and superficial episcleral plexus to a greater degree than the scleral plexus.[1,2]

TREATMENT AND SYSTEMIC CONCERNS

Management of episcleritis varies depending on symptomatology and presentation. Complete resolution may occur without intervention or require topical corticosteroids and/or NSAIDs.[1-3] Watson et al showed resolution of episcleritis at day 10 with no significant difference between placebo versus treatment with a topical corticosteroid.[2] Rare cases may require administration of oral NSAIDs or corticosteroids.

The majority of episcleritis cases are idiopathic and self-limiting, but between 26% and 36% of cases may be associated with systemic conditions.[2,4] A retrospective study by Akpek et al found episcleritis systemic associations with atopy, vasculitic-autoimmune disease (ie, rheumatoid arthritis, systemic lupus erythematosus, relapsing polychondritis, Wegener granulomatosis), and sero-negative arthritic conditions (ie, inflammatory bowel disease and psoriasis).[4] There was no significant correlation between systemic disease and number of recurrences, type of episcleritis, or laterality. Although episcleritis is mainly a benign condition, it is important to consider systemic workup for any positive review of systems. ■

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