24

AMERICAN UVEITIS SOCIETY

24th Annual

Winter Symposium

January 18-20, 2020 • Canyons Grand Summit Hotel, Park City, Utah

2020

PROGRAM CO-CHAIRS:

ALAN G. PALESTINE, MD and ALBERT T. VITALE, MD

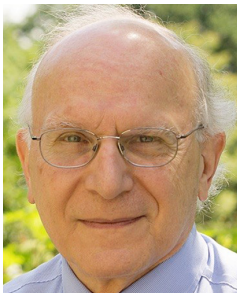
AUS 24th Annual Winter Symposium

Guest Speakers

Douglas A. Jabs, MD, MBA
Professor of Epidemiology and Director of the Center for Clinical Trials and Evidence Synthesis
Professor of Ophthalmology
Wilmer Eye Institute
Baltimore, MD

Glenn J. Jaffe, MD
Robert Machemer Professor of Ophthalmology
Chief of the Vitreoretinal Division
Duke Eye Center
Durham, NC

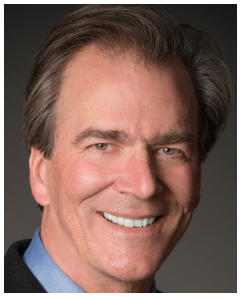
Kathryn L. Pepple, MD, PhD
Assistant Professor of Ophthalmology
University of Washington
Seattle, WA



James T. Rosenbaum, MD
Chair of the Division of Arthritis and Rheumatic Diseases at the Oregon Health & Science University
Emeritus Chair of Ophthalmology at Legacy Devers Eye Institute
Portland, OR

Program Co-Chairs

Alan G. Palestine, MD
Professor of Ophthalmology and Rheumatology
University of Colorado
Anschutz Medical Campus
Aurora, CO



Albert T. Vitale, MD
Professor, Ophthalmology and Visual Sciences
John A. Moran Eye Center
University of Utah
Salt Lake City, UT

Saturday Morning, January 18

7:00 – 8:00 AM
Registration/Breakfast

7:00 – 9:35 AM
Exhibits

8:00 – 8:05 AM
Opening Remarks
ALBERT T. VITALE, MD

8:05 – 9:32 AM
CASE PRESENTATIONS, FREE PAPERS AND DISCUSSIONS

8:05 – 8:14 AM
Prospective Evaluation of the Use of Imaging Quantification of Inflammation to Monitor Patients with Uveitis (IQI Study)
JORDAN D. DEANER, MD

8:14 – 8:18 AM
Discussion

8:18 – 8:27 AM
Long-term Cerebral and Retinal Outcomes of Immunosuppression in Active Susac Disease
SRUTHI AREPALLI, MD
Travel Grant Awardee

Purpose: The rare nature of Susac syndrome, combined with its variable systemic manifestations creates a therapeutic challenge for clinicians. The report analyzes the outcomes of 18 patients with active disease, either with complete (cerebral, retina and cochlear involvement) or incomplete (cerebral and retinal involvement) and their response to therapy.

Methods: A retrospective chart review was performed of all Susac patients presenting to the Cleveland Clinic in Cleveland, Ohio, USA (June 1st, 2012 to October 17th, 2019). A rheumatologist, ophthalmologist and an audiologist determined the extent of disease burden in all patients. Patients were classified as active if cerebral and/ or retinal disease was present. Cerebral involvement was confirmed with MRI revealing corpus callosum lesions or T2 hyperintense lesions, or in cases of a normal MRI, symptoms consistent with typical Susac encephalopathy and cognitive dysfunction symptoms. Retinal disease was established with a dilated fundus examination and fluorescein angiography (FA). Fundus evidence of active or past disease included branch retinal artery occlusion (BRAO), vascular sheathing, sclerosis, neovascularization or vitreous hemorrhage. FA also documented the presence of BRAO, as well as revealed segmental hyperflourescence, vascular leakage, non-perfusion, vascular remodeling and neovascularization. Relapse of disease during follow up was determined by new lesions on MRI, typical Susac encephalopathy, or new retinal or FA findings as described above.

Results: Of the 18 patients, 13 (72%) initially presented with complete and 5 (28%) presented with incomplete disease. The mean age of presentation was 37.3 years (range: 23 years to 45 years) and 14 (78%) were female. The average period of follow up was 27.4 months (range, 5 months to 65 months). A brain MRI was performed in every patient, revealing corpus callosum lesions in 12 (67%) and T2 weighted hyperintense lesions in 4 (22%). Four patients (22%) had a normal MRI at the time of presentation but had convincing evidence of cerebral involvement, including encephalopathy and cognitive dysfunction. On baseline ophthalmic examination, visual acuity ranged from 20/20 to 20/30. Fundus examination revealed a BRAO in 5 patients (28%), vascular sheathing in 3 (17%), sclerosis in 3 (17%), neovascularization in 2 (11%), and vitreous hemorrhage in 1 patient (6%). Fluorescein angiography confirmed the presence of BRAO in 5 patients (28%), segmental hyperflourescence in 4 (22%), leakage in 6 (33%), non-perfusion in 10 (56%), vascular remodeling in 2 (11%), and neovascularization in 2 (11%).

Every patient was started on some form of immunosuppression at presentation. Generally, patients with milder manifestations (n=9, 50%) were treated with a regimen of intravenous immunoglobulin (IVIG), an antimetabolite, and corticosteroids. More severe disease burden (n=9, 50%) warranted a combination of IVIG, an antimetabolite or cyclophosphamide, rituximab and corticosteroids. Overall, 17 patients (94%) were started on IVIG, 14 (78%) on mycophenolate, 1 (6%) on azathioprine, 2 (11%) on cyclophosphamide, 5 (28%) on rituximab and all 18 received corticosteroids.

Of the 9 patients with mild disease, 6 (67%) continued to flare with cerebral and/or retinal involvement requiring re-initiation of immunotherapy. The remaining 3 patients (33%) were successfully tapered off their regimen without reactivation. Similarly, of the 9 patients with more severe disease, 6 (67%) required continued treatment due to poorly controlled disease or recurrence with tapering of their medications. 3 patients (33%) were successfully monitored off treatment without evidence of relapse.

Conclusions: Susac disease can present a diagnostic and therapeutic dilemma requiring long-term immunosuppression. The paucity of literature surrounding initiation of treatment cessation further adds to the challenge of these patients. This large case series demonstrates that the majority of patients require sustained immunotherapy to prevent cerebral and retinal consequences of the disease.

8:27 – 8:31 AM
Discussion

8:31 – 8:35 AM
Susac or Not?
HELEN K. LI, MD

8:35 – 8:38 AM
Discussion

8:38 – 8:47 AM
Choroidal Thickness as a Marker for Response to Treatment in Panuveitis
CHRISTIAN A. MEHREGAN, MD

8:47 – 8:51 AM
Discussion

8:51 – 8:55 AM
Rapidly Progressive Bilateral Maculopathy
JEFFREY G. GROSS, MD

8:55 – 8:58 AM
Discussion

8:58 – 9:02 AM
Clumps and Dumps
JANE M. WELLS, BMBS, BSc(Optom), FRANZCO

9:02 – 9:05 AM
Discussion

9:05 – 9:14 AM
Ophthalmic Manifestations of Lyme Disease in Lyme-endemic Connecticut
MAREZ MEGALLA, MD

9:14 – 9:18 AM
Discussion

9:18 – 9:22 AM
An Unusual Case of Bilateral Retinal Detachments
KEVIN K. MA, MD

9:22 – 9:25 AM
Discussion

9:25 – 9:29 AM
Unilateral Retinitis Pigmentosa
JULIA SHULMAN, MD

9:29 – 9:32 AM
Discussion

9:32 – 9:35 AM
Wrap Up
ALBERT T. VITALE, MD

9:35 AM
End of Morning Session

Saturday Afternoon
January 18

3:30 – 4:00 PM
Break

3:30 – 7:35 PM
Exhibits

4:00 – 4:05 PM
Introduction
ALAN G. PALESTINE, MD

4:05 – 6:05 PM
SCIENTIFIC SESSION 1 – OCULAR IMMUNOLOGY AND BIOLOGIC AGENTS: PAST, PRESENT AND FUTURE

4:05 – 4:50 PM
Ocular Immunology: Mechanisms of Homeostasis and Disease
KATHRYN L. PEPPLE, MD, PhD

The eye is a unique and complex organ that has multiple strategies in place to protect against unnecessary and damaging inflammation. This state of immune privilege was initially attributed to structural factors such as the blood–ocular barrier and the absence of an ocular lymphatic system. We now know that establishing and maintaining ocular homeostasis is an active process requiring the integration of multiple cellular and soluble mediators. In the case that these homeostatic mechanisms fail, or are overwhelmed by infection, the resulting inflammation manifests clinically as uveitis. The goal of this lecture is to provide uveitis specialists with a review of ocular immunology as it applies to the pathogenic mechanisms of intraocular inflammation. Topics to be covered include an update on basic immunology, a summary of the mechanisms regulating ocular immune privilege, and an introduction to key inflammatory pathways that become dysregulated in disease.

4:50 – 5:05 PM
Discussion

5:05 – 5:50 PM
Emerging Biologics in Rheumatology
JAMES T. ROSENBAUM, MD

Although the tumor necrosis factor inhibitor, adalimumab, is the only FDA or EMA-approved biologic to treat uveitis, several other biologics such as secukinumab (target interleukin (IL)-17A) or gevokizumab (target IL-1b) have been tested for uveitis in large randomized clinical trials, and additional biologics (e.g. other TNF inhibitors, anti-IL-6 receptor, type I interferons, B cell depletion, CTLA soluble receptor, and anti-IL-12/23) have been studied, usually without randomization or masking. Additional targets for biologics include type I interferon receptor, GM-CSF, IL-17 receptor, Complement factor 5, adhesion molecules, IL-23, CD3, insulin-like growth factor receptor-1, CD22, IL-5, and IL-17A and IL-17F (in the form of a single bispecific antibody). This list is not exhaustive and excludes biologics which have been principally marketed to oncologists. The lecture will primarily discuss those biologics which have been designed to treat immune or inflammatory diseases but not yet been tested for relevance to uveitis or scleritis.

5:50 – 6:05 PM
Discussion

6:05 – 6:25 PM
Break

6:25 – 7:18 PM
CASE PRESENTATIONS, FREE PAPERS AND DISCUSSIONS

6:25 – 6:34 PM
Weekly Adalimumab for Non-Infectious Ocular Inflammatory Diseases
JENNIFER LEE, MD
Travel Grant Awardee

Purpose: To investigate the efficacy of weekly adalimumab (ADA) in patients with non-infectious ocular inflammation who failed ADA every two weeks.

Methods: A single-center, retrospective analysis of patients with refractory ocular inflammation on ADA every 2 weeks who were switched to weekly dosing, seen from January 2012 to April 2019. The main outcome measure was disease control versus treatment failure within 6 months of weekly therapy. Treatment failure was defined by: persistent anterior chamber cell, new or persistent angiographic inflammation, new or persistent tomographic intraretinal or subretinal fluid, active retinal/choroidal lesions, orbital pain, and scleral injection.

Results: Twenty-five patients (18 females, 7 males, median age 14 years, range 2-68 years) were evaluated. The types of uveitis include juvenile idiopathic arthritis (n =6), idiopathic chronic anterior/intermediate uveitis (n=3), scleritis (n=4), sarcoidosis (n= 2), tubulointerstitial nephritis panuveitis (n=1), Vogt Koyanagi Harada syndrome (n=1), birdshot chorioretinopathy (n=2), and HLA-B27 associated chronic anterior uveitis (n=2). Fourteen patients (56%) achieved disease control on weekly therapy with 6 months of follow up. In the treatment success cohort, six were receiving concomitant antimetabolite therapy, five were able to stop topical corticosteroids, and 2 were able to reduce topical corticosteroids. Weekly dosing appeared more likely to succeed in cases of juvenile idiopathic arthritis (5 out of 6).

Conclusion: In this series of patients with refractory ocular inflammation, increasing the dose of ADA from every two weeks to once a week conferred a beneficial reduction in ocular inflammation and disease control in more than half the patients.

6:34 – 6:38 PM
Discussion

6:38 – 6:47 PM
Reduction of Anterior Uveitis Flares in Patients with Axial Spondyloarthritis Following 1 Year of Treatment with Certolizumab Pegol: 48-Week Interim Results from a 96-Week Open-Label Study
LARS BAUER, MD

6:47 – 6:51 PM
Discussion

6:51 – 6:55 PM
Multiple Evanescent White Dot Syndrome Following Inactivated Influenza Vaccination
CALEB C. NG, MD

6:55 – 6:58 PM
Discussion

6:58 – 7:07 PM
AAV Mediated Expression of Immunosuppressive Transgenes Prevents Experimental Autoimmune Uveitis
BRIAN C. GILGER, DVM, MS

7:07 – 7:11 PM
Discussion

7:11 – 7:15 PM
Relapsing Thrombotic Thrombocytopenic Purpura in a Patient on Long-term Infliximab Treatment for Chronic Uveitis
RENUKA MOPURU, MD

7:15 – 7:18 PM
Discussion

7:18 – 7:32 PM
INDUSTRY PARTNER PRESENTATIONS

7:18 – 7:23 PM
Allergan, Inc.

7:23 – 7:26 PM
EyePoint Pharmaceuticals

7:26 – 7:29 PM
UCB

7:29 – 7:32 PM
Gilead Sciences, Inc.

7:32 – 7:35 PM
Wrap Up
ALAN G. PALESTINE, MD

7:35 PM
End of Evening Session

7:45 – 10:00 PM
Dinner at The Canyons Grand Summit Hotel

Sunday Morning
January 19

7:00 – 8:00 AM
Breakfast

7:00 – 9:30 AM
Exhibits

8:00 – 8:04 AM
Introduction
ALAN G. PALESTINE, MD

8:04 – 9:30 AM
CASE PRESENTATIONS, FREE PAPERS AND DISCUSSIONS

8:04 – 8:13 AM
Spectrum of Ocular Inflammation Associated with Checkpoint Inhibition
JASMINE H. FRANCIS, MD, FACS

8:13 – 8:17 AM
Discussion

8:17 – 8:21 AM
Let It Snow
AMY E. YUAN, MD

8:21 – 8:24 AM
Discussion

8:24 – 8:33 AM
Incidence and Risk of Cataract Formation in Intermediate Uveitis
CAROLINE MINKUS, MD
Travel Grant Awardee

Purpose: To determine the incidence of cataract formation in patients with intermediate uveitis, and evaluate associated risk factors.

Methods: Patients were identified from the Systemic Immunosuppressive Therapy for Eye Diseases Cohort Study. Medical records were reviewed to determine patients' demographic information and clinical data. Patient demographic characteristics, as well as inflammatory exam findings, were compared using statistical models. The primary outcome was development of visually significant cataract as defined by a decrease in visual acuity to 20/40 or less, or requiring cataract surgery.

Results: A total of 2190 eyes from 1302 patients with intermediate uveitis treated at teritiary care uveitis centers were included. The absolute risk of cataract formation was 35.5% at ten years. This was increased in patients with concurrent anterior uveitis causing posterior synechiae (HR=2.68, 95% CI = 2.00-3.59, p<0.001), and in those with epiretinal membrane formation (HR=1.54, 95% CI = 1.15-2.07, p = 0.004). Low dose corticosteroid medications (oral prednisone 7.5mg daily or less, or topical corticosteroid drops less than two times daily) suggested a slightly decreased risk of cataract formation, though this was not statistically significant. Higher doses of corticosteroids significantly increased the incidence of cataract. Patient demographics including age at presentation, race, sex, and smoking status, were not statistically significantly associated with a difference in risk. Similarly, use of several common medications including aspirin, angiotensin converting enzyme inhibitors, nonsteroidal anti-inflammatory medications, and statins, did not confer a difference in risk.

Conclusions: Our study found that the absolute risk of cataract formation in intermediate uveitis is moderate. The risk increases with the presence of concurrent anterior uveitis causing posterior synechiae, and with higher doses of corticosteroid medications.

8:33 – 8:37 AM
Discussion

8:37 – 8:46 AM
Diagnostic and Clinical Utility of Vitreous Biopsies
WEN F. HU, MD, PhD

8:46 – 8:50 AM
Discussion

8:50 – 8:54 AM
Immunotherapy Uveitis in a Primary Angle Closure Suspect Patient
JONATHAN C. TSUI, MD

8:54 – 8:57 AM
Discussion

8:57 – 9:06 AM
Ocular Inflammatory Side Effects of Checkpoint Inhibitors
YING QIAN, MD

9:06 – 9:10 AM
Discussion

9:10 – 9:14 AM
Hidden in the Eyes: Recurrence of Systemic Hemopathies Reportedly in Remission: Four Cases
MARIE-HELENE ERRERA, PHARMD, MD, PhD

9:14 – 9:17 AM
Discussion

9:17 – 9:26 AM
Health Disparities in Chronic Non-Infectious Uveitis
THIRAN JAYASUNDERA, MD

9:26 – 9:30 AM
Discussion

9:30 AM
End of Morning Session

Sunday Afternoon
January 19

3:30 – 4:00 PM
Break

3:30 – 7:30 PM
Exhibits

4:00 – 6:05 PM
SCIENTIFIC SESSION 2 – LOCAL AND SYSTEMATIC TREATMENT OPTIONS FOR UVEITIS

4:00 – 4:05 PM
Introduction
ALBERT T. VITALE, MD

4:05 – 4:50 PM
Local Uveitis Therapy
GLENN J. JAFFE, MD

There are several methods to deliver drugs locally to treat uveitis. Current local delivery methods include topical drops, trans-scleral delivery, periocular or intravitreal injection, and suprachoroidal or intravitreal sustained drug delivery systems. The indication and chosen method may depend on patient preference, response to systemic medications, and the uveitis cause, laterality location, severity. Topical treatment is given primarily to treat anterior uveitis, or to manage uveitic cystoid macular edema. The FDA has approved specific intravitreal Implants. The approved biodegradable implant is an injectable dexamethasone delivery system approved to treat macular edema and uveitis, and comprises a polymeric matrix that incorporates the drug. Drug is released as the matrix erodes. The advantage is that it can be placed in the office and there is no remaining implant once matrix erodes but drug delivery duration is limited to 6 wks-3 months. Approved non-biodegradable implants that release drug over 2.5-3 years include the surgically implanted fluocinolone acetonide implant and an injectable fluocinolone acetonide implant approved to treat intermediate, posterior and panuveitis. Drug is released across a semipermeable membrane with zero order release kinetics. The advantages of these implants include linear drug delivery from a non-toxic implant that is suitable for very sustained delivery over years. The disadvantage is that the implant retained in eye after drug is depleted. Additional investigational implants are currently under investigation, and include electrophoretic trans-scleral gene delivery, and suprachoroidal delivery systems.

4:50 – 5:05 PM
Discussion

5:05 – 5:50 PM
The Role of Systemic Therapy in the Treatment of the Uveitides
DOUGLAS A. JABS, MD, MBA

Treatment of non-infectious uveitides is guided by the uveitic anatomic class. Anterior uveitides are treated with topical corticosteroids. For chronic uveitides requiring chronic suppression, topical corticosteroids < 3 times daily have limited ocular side effects. If higher doses are required, systemic medications are added, methotrexate in children and low-dose oral corticosteroids in adults. The majority of patients with intermediate, posterior, and pan-uveitides are treated with systemic medications. For multiple diseases, time-updated modeling of longitudinal data demonstrated that immunosuppression produced superior. The Multicenter Uveitis Steroid Treatment (MUST) Trial and Follow-up Study demonstrated that systemic therapy with oral corticosteroids and immunosuppression produced superior long-term visual results to those of a long-lasting (3-year) regional therapy, the fluocinolone acetonide implant. There was a near doubling of the rate of blindness with regional therapy, largely due to relapse-related chorioretinal damage, highlighting the problem with the relapse-driven reimplantation/reinsertion approach. Other than a greater use of antibiotics for infection, the rate of systemic side effects was no greater with the systemic than with regional therapy. Regional therapy had greater rates of ocular side effects, including cataract and glaucoma. The implication is that the systemic approach is the preferred initial approach for non-infectious intermediate, posterior, and panuveitides.

5:50 – 6:05 PM
Discussion

6:05 – 6:25 PM
Break

6:25 – 7:18 PM
CASE PRESENTATIONS, FREE PAPERS AND DISCUSSIONS

6:25 – 6:34 PM
Long-term Outcomes of Treatment with Biologics in Eyes with Refractory NIPPU Uveitis
SUE LIGHTMAN, MD, PhD, FRCOphth

6:34 – 6:38 PM
Discussion

6:38 – 6:47 PM
Suprachoroidal CLS-TA Improves Patient Outcomes in Uveitis of All Anatomic Subtypes: Subgroup Analysis of the Phase 3 PEACHTREE Study
CHRISTOPHER R. HENRY, MD

6:47 – 6:51 PM
Discussion

6:51 – 6:55 PM
Multifocal Mystery
MARK W. JOHNSON, MD

6:55 – 6:58 PM
Discussion

6:58 – 7:07 PM
Fluocinolone Acetonide Intravitreal Insert for NIU-PS: Significant IOP Elevations Through 36 Months
MICHAEL A. SINGER, MD

7:07 – 7:11 PM
Discussion

7:11 – 7:15 PM
Unilateral Retinal Vasculitis with Central Retinal Vein Occlusion as the Presenting Manifestation in a Sjogren's Syndrome Patient
DANIEL BRILL, MD

7:15 – 7:18 PM
Discussion

7:18 – 7:27 PM
INDUSTRY PARTNER PRESENTATIONS

7:18 – 7:21 PM
Bausch + Lomb

7:21 – 7:24 PM
Clearside Biomedical

7:24 – 7:27 PM
Mallinckrodt Pharmaceuticals

7:27 - 7:30 PM
Wrap Up
ALBERT T. VITALE, MD

7:30 PM
End of Evening Session

8:00 – 10:00 PM
Dinner

Monday Morning
January 20

7:00 – 8:00 AM
Breakfast

7:00 – 10:00 AM
Exhibits

8:00 – 8:05 AM
Introduction
ALAN G. PALESTINE, MD

8:05 – 10:00 AM
CASE PRESENTATIONS, FREE PAPERS AND DISCUSSIONS

8:05 – 8:14 AM
Intraocular Pressure Following Administration of Suprachoroidal Triamcinolone Acetonide Suspension (CLS-TA): Post-Hoc Analysis from the Phase 3 PEACHTREE Clinical Trial for Uveitis
PAULINE T. MERRILL, MD

8:14 – 8:18 AM
Discussion

8:18 – 8:22 AM
Dot Within a Dot
AKSHAY S. THOMAS, MD, MS

8:22 – 8:25 AM
Discussion

8:25 – 8:34 AM
Optimizing the Patient Pathway for Idiopathic Acute Anterior Uveitis from Accident and Emergency
NICOLE K. SCRIPSEMA, MD

8:34 – 8:38 AM
Discussion

8:38 – 8:42 AM
Macular Ischemia Associated with Retinal Vasculitis and Oral Ulcers
TAYLOR FIELDS, MD

8:42 – 8:45 AM
Discussion

8:45 – 8:54 AM
Clinical Utility of Anti-infliximab Antibodies and Serum Infliximab Levels in Noninfectious Uveitis and Scleritis Patients Treated with Infliximab
LIANNA VALDES, MD

8:54 – 8:58 AM
Discussion

8:58 – 9:02 AM
The Double-edged Sword
RACHEL PATEL, MD

9:02 – 9:05 AM
Discussion

9:05 – 9:09 AM
Refractory Sclerouveitis in Pregnancy - A Diagnostic and Therapeutic Dilemma
HAYLEY R. JAMES, MD

9:09 – 9:12 AM
Discussion

9:12 – 9:16 AM
Anterior Uveitis In Reverse - A New Syndrome For An Old Pathogen?
K. MATTHEW MCKAY, MD

9:16 – 9:19 AM
Discussion

9:19 – 9:23 AM
A Thorny Case
RENE CHOI, MD, PhD

9:23 – 9:26 AM
Discussion

9:26 – 9:30 AM
When All Else Fails...What Now?
LAUREN BIERMAN, MD

9:30 – 9:33 AM
Discussion

9:33 – 9:42 AM
Efficacy of Targeted Janus Kinase (JAK) Inhibition by Tofacitinib in Birdshot Chorioretinitis.
LYNN M. HASSMAN, MD, PhD

9:42 – 9:46 AM
Discussion

9:46-9:50 AM
A Case of Relentlessly Blinding Scleritis...For Real?!
DAVID LIU, MD

9:50 – 9:53 AM
Discussion

9:53 – 10:00 AM
Closing Remarks
ALAN G. PALESTINE, MD AND ALBERT T. VITALE, MD

10:00 AM
Meeting Adjourned

Save The Date

AUS 25th Annual Winter Symposium
Canyons Grand Summit Hotel, Park City, Utah
January 16-18, 2021

INDUSTRY PARTNERS

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