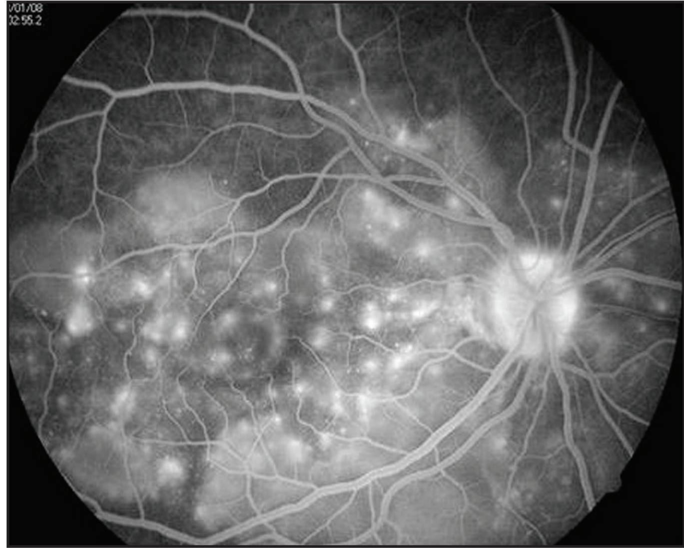

Figure 8-1. Fluorescein angiogram of a patient showing the acute phase of VKH syndrome who was hospitalized and treated with intravenous methyl-prednisolone (1 g/day for 3 days) and continued on oral prednisone at 1 mg/kg/day for the following 3 weeks before tapering to less than 10 mg/day with excellent therapeutic response.

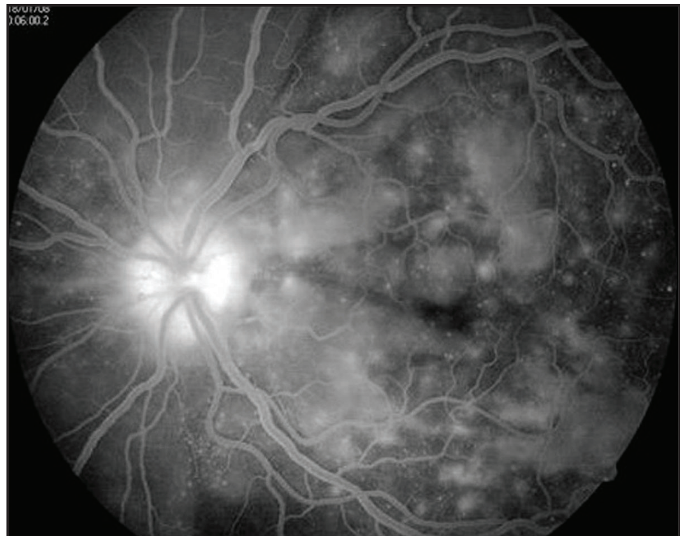

Figure 8-2. Late phase fluorescein angiogram of the left eye with acute VKH syndrome, showing extensive dye leakage from the serous retinal detachment on the posterior pole (same patient as in Figure 8-1) .

Oral corticosteroids are also frequently administered as prophylaxis for patients with uveitis at the time of cataract surgery.[4] In this respect, I advise patients to start or readjust oral prednisone 3 days before surgery to a dose of 40 to 60 mg/day and to continue so for 1 week after cataract removal and then taper it slowly according to the inflammatory status.

In some forms of infectious uveitis like severe ocular toxoplasmosis, herpetic uveitis, and neuro-syphilis, among others, systemic prednisone also plays a very important role as adjunctive therapy to control severe inflammation once the patient is on antibiotics for at least 3 days prior to corticosteroid administration (Figure 8-3).[5]

Patients in whom systemic corticosteroids should be avoided are those already overweight and patients with diabetes mellitus, hypercholesterolemia, arterial hypertension, coronary insufficiency, peptic ulcer, pregnancy, and also children under 16 years of age.