

Pars Planitis: A Syndrome of Unknown Etiology or a Clinical Picture of Multiple Etiologies?

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The term "pars planitis" (PP) was first used by Welch in 1960 to describe a syndrome characterized by peripheral posterior segment inflammation, vitreous opacities and edema of the posterior pole. Ten years earlier Schepens described the same condition, calling it "peripheral uveitis". The major clinical feature in the described disease is the accumulation of yellow-gray inflammatory exudates at the pars plana and ora serrata. Others have used terms such as "chronic cyclitis", "vitritis", and "peripheral uveoretinitis" to describe this syndrome. Although there are some differences in the description of the findings, complications, and prognosis among these reports, the common feature is inflammation in a zone which includes ciliary body, the choroid and peripheral retina: the intermediate zone of the eye.

In 1987 the International Uveitis Study Group introduced the term intermediate uveitis (IU) to denote inflammation in this anatomic area, in an attempt to bring order out of the naming chaos. The term IU is used to identify any inflammation which is primarily in the region of pars plicata, pars plana and peripheral retina. The term pars planitis (PP) is reserved to define a specific clinical entity in which the fundamental lesion is the presence of inflammatory exudates at the pars plana.

The cause of PP has not been identified, although an immune mediated process has been suggested. The inciting agent, whether endogenous or exogenous, remains unknown, and histopathologic studies have been performed in only a few cases of PP; a relevant animal model of PP has not been developed.

Pars planitis exists as an isolated ocular syndrome, although a number of diseases have been found to be associated with it. Multiple sclerosis (MS), sarcoidosis (SC), Adamantiades-Behcet Disease (ABD), Lyme disease, seronegative spondyloarthropathies associated with HLA-B27, as well as tuberculosis and brucellosis may produce uveitis restricted to the pars plana which is clinically identical to PP. MS, SC, or ABD have been reported to both precede and follow the clinical diagnosis of PP. And we have recently reported that PP may be part of cat scratch uveitis.

Results: Thirty-three patients had idiopathic pars planitis (group 1). Eighteen patients had or were suspect for sarcoidosis, seven had multiple sclerosis and five had miscellaneous immunologic disease (group 2). Patients with a systemic disease usually presented with granulomatous uveitis; patients with idiopathic pars planitis usually presented with non-granulomatous uveitis, ($p=0.003$). Posterior synechiae formation was the only other finding with a statistically significant difference between the two groups ($p=0.024$). The course of pars planitis and the final outcome were comparable.

Conclusion: The similarities in clinical findings, course of pars planitis and outcome between the patients with no evidence of underlying systemic disease and the patients with proven or suspected underlying systemic disease of immunologic origin may represent indirect evidence for the existence of a common pathogenetic mechanism and common treatment needs.