

## RECURRENT ANTERIOR UVEITIS. CLINICAL CASE

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**Abstract:** Focal disease as a pathological condition is characterized by functional disorders and organic tissue alterations due to chronic outbreaks of infection, after which, microbes, toxins, toxic products of tissue septic disintegration, endo- and exogenous allergens disseminate in the body through blood, neural, or digestive pathways, microbes with the potential to trigger lesional events. In cases with ocular inoculation, this will bring about episodes of uveitis.

### INTRODUCTION

Uveitis, as the inflammation of the structures that are part of the uveal tract, can be localized to the anterior or posterior side of the uvea, determined by the distinct anatomical structures involved in vascularisation. The demarcation of both vascular areas, iridociliary (above), choroidal (posterior) (1), determines the location of the inflammation in the two separate areas, although there are cases where the inflammatory process includes both territories simultaneously or sequentially.(2)

### CASE REPORT

The patient, B.G., aged 42 years old was admitted to the Department of Ophthalmology within Sibiu Clinical County Emergency Hospital with a diagnosis of recurrent anterior uveitis in the right eye.

In order to establish the etiology, there were made complementary and interdisciplinary examinations.

After dental examination, the following issues were found:

*Exobucal examination:*

a). Inspection - symmetrical face, right face profile, normal skin colour, normal ratio between the three floors of the face, normal mouth opening, normal chin opening.

b). Palpation – normal local temperature, palpable and painless nodes, temporomandibular joint (TMJ) without changes, painless sinus points (frontal, maxillary).

*The endobucal examination* revealed: normal lip appearance in colour and volume; integral and normally coloured labio-jugal mucosa; supple and painless buccal and maxillary vestibule with normally coloured mucosa, without the presence of lesions, fistulae, inflammation; painless buccal flour without pathological formations; normal shape of the arches.

*Odontal examination:*

	G	√	Cd	Oni	CM	Co									
X	1.7	X	1.5	1.4	1.3	1.2	1.1	2.1	2.2	2.3	X	2.5	2.6	2.7	X
X	4.7	4.6	4.5	4.4	4.3	4.2	4.1	3.1	3.2	3.3	3.4	3.5	3.6	3.7	X

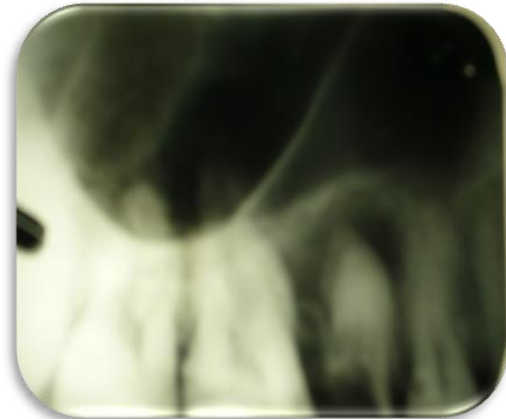
*Legend:* G = gangrene, CO = occlusal carries, OO = occlusal obturation X = extraction, CM = mesial carries OM = mesial obturation CD = distal carries OD = distal obturation CMOD = distal mesial-occlusal caries, √ = distal root, c = correct, i = incorrect

At the periodontal examination, there was revealed the presence of supragingival tartar in the cervical third part, at the level of the teeth 3.2., 3.1., 4.1., 4.2.

### Complementary examinations:

- a). Radiologically: in view of diagnosis:
- at retroalveolar level: there was revealed the presence of the remaining root of tooth 1.5 (figure no. 1). The patient history reveals that the remaining root is old, which is confirmed by radiological image, on which periapical granuloma could be noticed. At the level of 3.6 (figure no. 2), there is an incomplete root canal, which is a potential endodontic outbreak. At the level of 4.5 (figure no. 3), there is an increased radiotransparency, proving the presence of a periapical process.
  - Orthopantomogram was not performed.
- b). Tests: verifying pulp vitality with ice.

Figure no. 1. 1.5 Remaining root with periapical granuloma



The patient was treated in the Department of Ophthalmology, after previously accomplishing mouth remediation as follows:

### Treatment:

- Remaining root extraction at the level of 1.5. tooth after plexus anesthesia with Septanest 1/200000, followed by apical curettage.
- Apical resection at the level of 4.5.

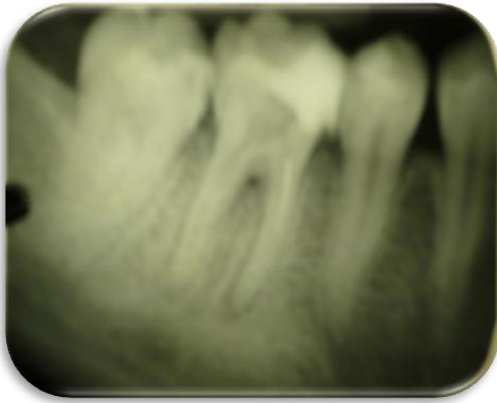
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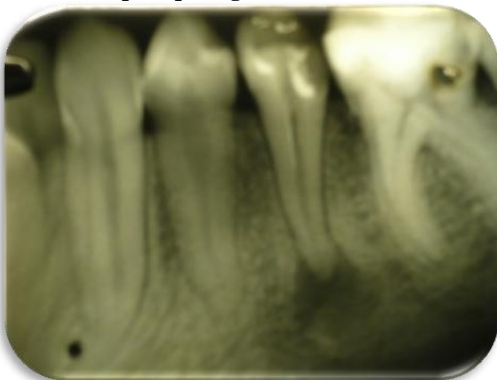
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## CLINICAL ASPECTS

**Figure no. 2. 3.6 - incomplete root canal**



**Figure no. 3. 4.5 - periapical granuloma**



- dezobturation of canals at the level of 3.6., mechanical-chemical treatment with hydrogen peroxide, chlorine-based antiseptics, canals drying with tows of paper, endodontic application of calcium hydroxide based-paste over a period of 3 weeks, then accomplishing the final obturation.
- oral hygiene by brushing and professional dental cleaning.
- treatment of caries, filling the incorrect obturations.

Upon inspection, one could notice the healing of the ophthalmological condition and the persistence of some sequelae.

In the right eye, there were irido-crystalline synechiae in the lower half (figure no. 4).

**Figure no. 4. Irido-crystalline synechiae**



The patient was under observation, came to regular check-ups and presented no recurrences of iridocyclitis.

This patient confirmed the data obtained statistically, regarding the frequency of dental etiology focal diseases in anterior uveitis, most of them being periapical focal diseases (remaining root at the level of 1.5. tooth and periapical granuloma at the level of 4.5.).

### DISCUSSIONS

The detection of the etiology of uveitis is difficult under the current conditions. However, in those in which the cause could be determined, dental focal diseases played an important part. The confirmation of the involvement of the dental focal diseases was also accomplished by the therapeutic trial, after removing the focal disease, a favourable outcome could be reported.(3)

In order to find out which were the most common focal diseases within anterior uveitis, there was performed in each patient a thorough dental examination, thus establishing the degree of pathogenicity of each focal disease in the etiology of uveitis.(4)

For the therapeutic success to be as long as possible, it is imperative that, in addition to the symptomatic treatment, immediately (5) to perform the dental examination, removing any possible dental focal disease which could have been possible to trigger anterior uveitis.(6)

### CONCLUSIONS

1. To establish the etiology of anterior uveitis, it is indicated to perform a dental examination.
2. The most active dental focal diseases are the encapsulated periapical ones (old root remnants and apical periodontitis).
3. Removal of dental focal disease leads to a favourable evolution.
4. The cleaning of dental focal disease is mandatory to prevent relapses.

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