European Glaucoma Society
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UGH syndrome should be considered in every pseudophakic patient, with active unilateral inflammation and elevated intraocular pressure

The Science behind the Tip

Uveitis-Glaucoma-Hyphaema (UGH) Syndrome is a rare syndrome characterized by iris transillumination defects, microhyphaemas and pigmentary dispersion, concomitant with elevated intraocular pressure (IOP)[1]. The syndrome is caused by repetitive mechanical trauma of a malpositioned intraocular lens with adjacent structures (iris, ciliary body, iridocorneal angle)[1,2]. It is important to remember that even though the syndrome was initially described in cases with anterior chamber intraocular lenses, recent literature describes UGH with any type of intraocular lens, whether placed in the sulcus or in the bag[3].

Single piece acrylic intraocular lenses placed in the sulcus carry a high risk of subsequent UGH. Careful clinical examination and a high index of suspicion is crucial for making the diagnosis. Anterior segment imaging such as ultrasound biomicroscopy (UBM) or ocular coherence tomography (OCT), are extremely useful in confirming the diagnosis[1,3]. When the diagnosis is established, initial medical management should include topical steroids, anti-glaucoma medication and cycloplegics, while IOL exchange should not be delayed if vision is reduced, the IOP and inflammation remain uncontrolled or progressive glaucoma is detected[4].

References

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