Is granuloma annulare related to intermediate uveitis with retinal vasculitis?

B van Kooij, M Canninga van Dijk, J de Boer, V Sigurdsson, A Rothova

Correspondence to: Bram van Kooij, FC Donders Institute, Department of Ophthalmology, University Hospital Utrecht, PO Box 85500, 3508 GA Utrecht, Netherlands; b.vankooij@ooogh.azu.nl

Aim: To report on eight patients with severe idiopathic intermediate uveitis (IU) and granuloma annulare (GA), a self limiting cutaneous condition of unknown aetiology.

Methods: Retrospective case series. Clinical ophthalmic and dermatological data were studied and fluorescein angiography and skin biopsies were reviewed.

Results: All patients with idiopathic IU had similar ocular features (eight with vitritis, seven with retinal vasculitis) and developed complications such as cystoid macular oedema (n=5), cataract (n=4), and glaucoma (n=3). Systemic diseases were not found, but a localised type of GA was observed in all.

Conclusion: Seven out of eight patients with IU and GA developed severe retinal vasculitis. Further studies are needed for a better understanding of this association, a common pathogenesis, and its eventual clinical consequences.

Intermediate uveitis (IU) is a chronic intraocular inflammation of the vitreous and the peripheral retina. This uveitis is usually a bilateral disease with the onset mostly in the teenage or young adult years. Complications include cystoid macular oedema (CMO), peripheral retinal vasculitis, and cataract. The aetiology is of unknown origin in the majority of cases, although an occasional association with systemic diseases such as sarcoidosis, multiple sclerosis, and inflammatory bowel disease is described.2–5

Granuloma annulare (GA) is a self limiting cutaneous condition of unknown aetiology. GA is characterised by smooth, skin coloured annular plaques and papules and affects mainly children and young adults. Associations of generalised GA with sarcoidosis and diabetes mellitus are reported.2–9

We describe eight patients with IU who also suffered from GA.

PATIENTS AND METHODS

Diagnosis of IU was based on the IUSG criteria.10 All patients underwent complete clinical examination, fluorescein angiography, and the standard screening protocol for intermediate uveitis, which included erythrocyte sedimentation rate, red and white blood cell counts, glucose levels, determination of serum angiotensin converting enzyme levels and serological tests for syphilis, bartonellosis, and chest radiography. HLA typing was performed in three cases. The presence of systemic diseases was assessed according to current diagnostic criteria. All patients were examined by dermatologists and skin biopsies of all patients were consistent with the diagnosis of GA and were, in addition, revised by an independent dermatopathologist.

RESULTS

The clinical features of our patients are given in Table 1. Our series included five female and three male patients. Mean age at onset of IU was 28 years with a range of 8–60 years. Mean follow up was 7.1 years with a range of 1–17 years. The results of uveitis screening were within normal limits for all (except one case with high erythrocyte sedimentation rate (ESR)). Detailed examinations by an internist or paediatrician revealed no indications suggestive of sarcoidosis, multiple sclerosis, or diabetes mellitus. The patient with elevated ESR disclosed monoclonal paraproteinaemia, but progression did not occur during follow up. During the follow up, none of the remaining patients developed associated systemic disease. HLA typing disclosed positivity for HLA B8 in two of four patients examined.

Eight patients presented with similar manifestations of ocular disease, which consisted of bilateral, chronic IU. Seven out of eight exhibited severe retinal vasculitis (periphlebitis; Figs 1 and 2). The only patient without retinal vasculitis was a 8 year old child. Ocular complications developed in 7/8 patients and included CMO, cataract, and glaucoma. Visual acuity at onset ranged from 0.02–0.8 and final visual acuity ranged from 0.1–1.25. Patients were initially treated topically, but the severity of the inflammation required periocular triamcinolone injections in three patients and systemic corticosteroids in three. One patient was treated with laser because of peripheral ischaemic retinopathy. Of seven patients with retinal phlebitis four developed CMO. The causes of definitive visual loss included CMO in four patients (six eyes) and vasculitis in one patient (two eyes; in two eyes a temporary visual loss was attributed to cataract).

GA manifested at mean age of 30 years with a range of 5–62 in four before and four after the onset of IU (Table 1, Fig 3). Histological examination of skin biopsies showed abnormalities typical for GA in all patients. The epidermis was normal. In the underlying dermis there were one or more areas of necrobiosis, surrounded by histiocytes (Fig 4). In most biopsies some lymphocytes and eosinophils were also present in the infiltrate. One patient was treated with hydroxychloroquine, two patients with topical corticosteroids, and one patient with cryotherapy and four received no treatment. All skin lesions recovered within 1 year.

Patient 1

An 8 year old boy presented with bilateral IU. Visual acuity was 0.02 in the right eye and 1.25 in the left eye. Both eyes had cells in the vitreous and snowbanking. On funduscopic CMO was noted in the right eye, which was confirmed by fluorescein angiography. The patient was treated with periocular steroid injection in the right eye. The activity of inflammation slowly subsided however the final visual acuity remained 0.1 due to CMO. Visual acuity in the left eye was 1.25.
during the follow up of 7 years. Repeated evaluations for systemic diseases were negative. Three years before the onset of IU, he developed skin lesions, which were clinically consistent with GA. Skin biopsy confirmed the suspected diagnosis. The lesions recovered spontaneously within 1 year.

**Patient 2**

A 50 year old woman presented to our clinic with bilateral IU. Visual acuity was 0.6 in the right eye and 0.2 in the left eye. Both eyes had occasional cells in the anterior chamber and cells in the vitreous. On funduscopy severe CMO was noted. Fluorescein angiography demonstrated active vasculitis and CMO in both eyes. She was treated with periocular steroid injections; however, the CMO persisted and acetazolamide was added. In response to corticosteroids a high intraocular pressure developed and the depot was removed with good effect. However, she developed a severe recurrence and the patient required systemic corticosteroid medication (initial dose 40 mg, slowly tapered to 5 mg a day). Repeated evaluation for systemic disease was negative. After 3 years of treatment she underwent cataract surgery in both eyes. At 8

---

**Table 1**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Sex</th>
<th>Age at onset of IU (years)</th>
<th>Age at onset of GA (years)</th>
<th>Followup (years)</th>
<th>CMO</th>
<th>Vasculitis</th>
<th>Cataract</th>
<th>Glaucoma</th>
<th>Intraocular surgery (No of procedures)</th>
<th>Visual acuity at onset</th>
<th>Worst visual acuity</th>
<th>Optimal visual acuity</th>
<th>Cause of permanent visual loss</th>
<th>Treatment of IU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>8</td>
<td>5</td>
<td>7</td>
<td>+</td>
<td>+</td>
<td>–</td>
<td>–</td>
<td>+</td>
<td>1.25</td>
<td>0.6</td>
<td>0.02</td>
<td>R</td>
<td>CS, topical NSAID</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>50</td>
<td>55</td>
<td>8</td>
<td>+</td>
<td>+</td>
<td>–</td>
<td>–</td>
<td>+</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>R</td>
<td>CS, topical NSAID, acetazolamide</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>+</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>CS topical NSAID, topical CSM</td>
<td>CS topical NSAID, topical CSM</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>36</td>
<td>38</td>
<td>7</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>CS topical NSAID</td>
<td>CS topical NSAID, topical CSM</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>60</td>
<td>42</td>
<td>2</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>CS topical NSAID, topical CSM</td>
<td>CS topical NSAID, topical CSM</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>42</td>
<td>25</td>
<td>8</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>CS topical NSAID</td>
<td>CS topical NSAID, topical CSM</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>9</td>
<td>25</td>
<td>17</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>CS topical NSAID</td>
<td>CS topical NSAID, topical CSM</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>9</td>
<td>25</td>
<td>17</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>CS topical NSAID</td>
<td>CS topical NSAID, topical CSM</td>
</tr>
</tbody>
</table>

CS = corticosteroids; NSAID = non-steroidal anti-inflammatory drug.

---

**Figure 1**

Segmental vasculitis (periphlebitis) in a patient with granuloma annulare (see Table 1, patient no 5).

**Figure 2**

Peripheral retina with extended leakage of inflamed vessels (same patient as in Fig 1, Table 1, patient no 5).

**Figure 3**

Localised form of granuloma annulare. Note the erythematous papules arranged in a ring.
A 36 year old female patient with bilateral IU presented to our clinic. Visual acuity was 1.0 in the right eye and 0.8 in the left eye. One year before the onset of IU he developed localised vitritis and snowbanking. On funduscropy CMO was seen in the left eye which was confirmed by fluorescein angiography. The patient was treated with periocular steroid injections; however, systemic corticosteroids were required 1 year later (initial dose 20 mg, slowly tapered off to 10 mg a day, but complete withdrawal of systemic corticosteroids was not feasible). After 3 years of treatment she developed secondary cataract in both eyes. Snow banking and peripheral ischaemic retinopathy of the left eye manifested after 6 years of follow up and required laser treatment. At the 7 year follow up, visual acuity was 0.4 in the right eye (caused by cataract) and 1.0 in the left eye, despite persistent vitreous inflammation. Repeated evaluations for systemic diseases were negative. Two years after the onset of IU she developed skin lesions, which were clinically consistent with GA. The diagnosis was confirmed by skin biopsy. The lesions recovered spontaneously within 1 year.

Patient 6
A 36 year old woman was referred to our department with a history of IU in both eyes for 8 years treated with corticosteroid drops. On examination, her visual acuity was 0.6 and 0.8; clear anterior chambers and old synchiae in right eye were noted. On funduscopy, she exhibited periphlebitis in the periphery of both eyes. The patient was treated with topical corticosteroids and developed cataract during her follow up of 8 years, which caused a compromised visual acuity. Three years before the onset of uveitis she developed granuloma annulare on her forearms and later on her feet.

Patient 7
A 62 year old man was referred to our department with a history of vitritis in both eyes for 2 years, treated with corticosteroid drops. On examination clear anterior chambers were noted, but slight vitritis was present. His visual acuity was 0.8 and 0.6. On funduscopy, he exhibited periphlebitis of the right eye and small punched out lesions in the periphery of both eyes. On fluorescein angiography leakage of both discs was found, but no CMO. The patient was treated with topical corticosteroids. On systemic examination elevated ESR and monoclonal paraproteinaemia were found. Two years after the onset of uveitis he was diagnosed with granuloma annulare on his back, which was treated with topical corticosteroids and diminished within 1 year.

Patient 8
A 21 year old woman was referred to our department with a history of IU in both eyes for 12 years, treated with systemic corticosteroids. On examination clear anterior chambers were noted, but slight vitritis in both eyes. On funduscopy, both eyes exhibited peripheral snowbanking. Initialy normal fluorescein angiography demonstrated CMO and extensive retinal vasculitis 14 years after the onset of the disease. The patient was treated with periocular steroid injections, acetazolamide, and systemic NSAIDs. Repeated evaluations for systemic diseases were negative. Seventeen years after the onset of IU she developed skin lesions, which were clinically consistent with GA. The diagnosis was confirmed by skin biopsy. The lesions were treated with topical corticosteroids and disappeared within 1 year.

DISCUSSION
This series reveals an association of IU and localised form of GA in eight cases. Seven of these patients had severe retinal vasculitis. These clinical features are strongly similar to variant of IU described by Park et al.1 IU is responsible for about 10% of all uveitis patients; however, in teenagers and young adults this percentage increases up to 15–39%.10 IU may remain active for 5–30 years. So far,
our patients exhibited long term ocular activity and only one patient had remission (Table 1). CMO, vasculitis, and cataract are well known complications of IU and all our patients developed at least one of these complications.\(^7\) Seven of our patients had vasculitis (88%), in contrast with 11–55% observed in those with IU.\(^6\)\(^,\(^1\) Since GA is common in children, and one patient of our series (child with IU) did not have vasculitis, it is feasible that the combination of localised GA and IU in this child might be a coincidence.

GA is a skin abnormality with an unknown cause, which mainly affects children and young adults. Localised GA is the most common form and resolves spontaneously after 1–2 years. Generalised GA shows a more chronic course, a later age of onset, a rare spontaneous recovery, and poorer response to therapy. Other GA variations include subcutaneous, erythematous, and perforating types.\(^,\(^7\) In our series, all patients had localised GA (one patient had the subcutaneous type). GA was occasionally described following insect bites, trauma, and PUVA therapy.\(^7\) None of our patients had a history of such a precedent event.

An association between uveitis and GA has to our knowledge never been described. The known relation between granuloma annulare and diabetes mellitus and sarcoidosis has been reported previously.\(^\text{8}\)\(^,\(^9\)\) In our patients, despite repeated analyses, these diseases were not observed. The association of IU and GA might a coincidence; however, this seems improbable. All IU and GA patients presented with uniform clinical features and GA was not reported in patients with other types of uveitis. Secondly, sarcoid associated uveitis and GA share common pathological features. Recent reports have clearly demonstrated GA occurring in association with sarcoidosis.\(^\text{9}\)\(^,\(^\text{10}\)\) In one report it is proposed that GA may act as a precursor lesion to cutaneous sarcoidosis.\(^\text{9}\) Since ocular sarcoidosis, including in those with IU, may precede systemic involvement by many years, it is still feasible that our patients may still develop sarcoidosis in the future. Thirdly, the association of HLA-B8 with pars planitis and also with granuloma annulare with insulin dependent diabetes mellitus has been described.\(^\text{11}\)\(^,\(^\text{12}\)\) These findings suggest that there might exist an immunogenic predisposition to both diseases. HLA-B8 was found in two of four typed cases in this study; however, the lack of HLA typing in this study prevents us from drawing the conclusion. Furthermore, several reports have described a correlation of increased matrix metalloproteinase (MMP) 2, 9, and 12 in uveitis and GA with disease activity.\(^\text{13}\)\(^,\(^\text{14}\)\) MMPs are a family of enzymes that are capable of degrading extracellular matrix proteins. These findings suggest that there might be a common basal defect, which finally leads to both diseases.

The course of IU is variable, ranging from low grade activity and a self limited process to chronic disease with remissions and exacerbations.\(^\text{15}\) Long term visual prognosis is usually favourable and depends on the development and severity of associated CMO. Visual prognosis in our patients and in a similar type of IU (phakic patients with chronic vasculitis) was excellent.\(^\text{16}\) Although five of our patients developed CMO, visual acuity of more than 0.5 was retained in all.

In conclusion, we report seven patients with a combination of IU associated with retinal vasculitis and GA. Further studies are needed for a better understanding of this association and its eventual clinical consequences.

**REFERENCES**

Is granuloma annulare related to intermediate uveitis with retinal vasculitis?

B van Kooij, M Canninga van Dijk, J de Boer, V Sigurdsson and A Rothova

Br J Ophthalmol 2003 87: 763-766
doi: 10.1136/bjo.87.6.763

Updated information and services can be found at:
http://bjo.bmj.com/content/87/6/763

These include:

References
This article cites 18 articles, 2 of which you can access for free at:
http://bjo.bmj.com/content/87/6/763#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections
Articles on similar topics can be found in the following collections
- Ciliary body (31)
- Angle (1006)
- Glaucoma (988)
- Intraocular pressure (1002)
- Lens and zonules (807)
- Retina (1608)

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/