Supplementary Table

Recommended eye interventions for Uveitis and strength of recommendation and quality of evidence

Description of Intervention	Relevant Guidelines*	Strength of recommendation (strong, intermediate, weak)	Quality of evidence (RCT, systematic review, meta-analysis, clinical studies, expert opinion)
Adalimumab for treating non-infectious uveitis in the posterior segment of the eye in adults with inadequate response to corticosteroid	1	Strong	RCT
Stop adalimumab for non-infectious uveitis in the posterior segment of the eye in adults with inadequate response to corticosteroids if there is 1 of the following: new active inflammatory chorioretinal or inflammatory retinal vascular lesions, or both, or a 2-step increase in vitreous haze or anterior chamber cell grade or worsening of best corrected visual acuity by 3 or more lines or 15 letters.	1	Strong	Expert Opinion
Dexamethasone intravitreal implant is recommended as an option for treating non-infectious uveitis in the posterior segment of the eye in adults, only if there is: active disease (that is, current inflammation in the eye) and worsening vision with a risk of blindness.	1	Strong	RCT
In children and adolescents with JIA at high risk of developing uveitis, ophthalmic screening every 3 months is conditionally recommended over screening at a different frequency.	2	Weak	Clinical Studies
In children and adolescents with JIA and controlled uveitis who are tapering or discontinuing topical glucocorticoids, ophthalmic monitoring within 1 month after each change of topical glucocorticoids is strongly recommended over monitoring less frequently.	2	Strong	Expert Opinion

In children and adolescents with JIA and controlled uveitis on stable therapy, ophthalmic monitoring no less frequently than every 3 months is strongly recommended over monitoring less frequently.	2	Strong	Clinical Studies
In children and adolescents with JIA and controlled uveitis who are tapering or discontinuing systemic therapy, ophthalmic monitoring within 2 months of changing systemic therapy is strongly recommended over monitoring less frequently.	2	Strong	Clinical Studies
In children and adolescents with JIA and active CAU, using prednisolone acetate 1% topical drops is conditionally recommended over difluprednate topical drops.	2	Weak	Expert Opinion
In children and adolescents with JIA and active CAU, adding or increasing topical glucocorticoids for short-term control is conditionally recommended over adding systemic glucocorticoids	2	Weak	Clinical Studies
In children and adolescents with JIA who develop new CAU activity despite stable systemic therapy, topical glucocorticoids prior to changing/escalating systemic therapy is conditionally recommended over changing/escalating systemic therapy immediately.	2	Weak	Expert Opinion
In children and adolescents with JIA and CAU still requiring 1–2 drops/day of prednisolone acetate 1% (or equivalent) for uveitis control, and not on systemic therapy, adding systemic therapy in order to taper topical glucocorticoids is conditionally recommended over not adding systemic therapy and maintaining on topical glucocorticoids only.	2	Weak	Clinical Studies
In children and adolescents with JIA and CAU still requiring 1–2	2	Weak	Clinical Studies

drops/day of prednisolone acetate 1% (or equivalent) for at least 3 months and on systemic therapy for uveitis control, changing or escalating systemic therapy is conditionally recommended over maintaining current systemic therapy.			
In children and adolescents with JIA and CAU who are starting systemic treatment for uveitis, using subcutaneous methotrexate is conditionally recommended over oral methotrexate.	2	Weak	Expert Opinion
In children and adolescents with JIA with severe active CAU and sight-threating complications, starting methotrexate and a monoclonal antibody TNFi immediately is conditionally recommended over ethotrexate as monotherapy.	2	Weak	Expert Opinion
In children and adolescents with JIA and active CAU starting a TNFi, starting a monoclonal antibody TNFi is conditionally recommended over etanercept.	2	Weak	RCT
In children and adolescents with JIA and active CAU who have an inadequate response to 1 monoclonal antibody TNFi at standard JIA dose, escalating the dose and/or frequency to above standard is conditionally recommended over switching to another monoclonal antibody TNFi.	2	Weak	Expert Opinion
In children and adolescents with JIA and active CAU who have failed a first monoclonal antibody TNFi at above-standard dose and/or frequency, changing to another monoclonal antibody TNFi is conditionally recommended over a biologic in another category.	2	Weak	Expert Opinion
In children and adolescents with JIA and active CAU who have failed methotrexate and 2 monoclonal antibody TNFi at	2	Weak	Clinical Studies

above-standard dose and/or frequency, the use of abatacept or tocilizumab as biologic DMARD options, and mycophenolate, leflunomide, or cyclosporine as alternative nonbiologic DMARD options is conditionally recommended.			
In children and adolescents with spondyloarthritis, strongly recommend education regarding the warning signs of AAU for the purpose of decreasing delay in treatment, duration of symptoms, or complications of iritis.	2	Strong	Expert Opinion
In children and adolescents with spondyloarthritis otherwise well controlled with systemic immunosuppressive therapy (DMARDs, biologics) who develop AAU, conditionally recommend against switching systemic immunosuppressive therapy immediately in favor of treating with topical glucocorticoids first.	2	Weak	Expert Opinion
In children and adolescents with JIA and CAU that is controlled on systemic therapy but who remain on 1–2 drops/day of prednisolone acetate 1% (or equivalent), tapering topical glucocorticoids first is strongly recommended over systemic therapy.	2	Strong	Clinical Studies
In children and adolescents with uveitis that is well controlled on DMARD and biologic systemic therapy only, conditionally recommend that there be at least 2 years of well-controlled disease before tapering therapy.	2	Weak	Expert Opinion
Assessing a patient with possible uveitis • Take a medical history, and ask: About the signs and symptoms, including the onset and duration. • If symptoms are unilateral or bilateral.	3	Strong	Expert Opinion

• If vision is affected, or there is an increase in floaters. • If there is any pain – the type of pain (for example, dull, or throbbing), the intensity, and the location (ophthalmic, or non-ophthalmic eye pain). • About a foreign body sensation • If eyes are watering more than normal, or if there is any discharge • If there is photophobia. • Previous illnesses, including previous eye problems. • Medication • Whether the person wears contact lenses — if they do, ask about the hygiene routine. • If there is any history of chemical exposure, trauma or surgery. • Family history Conduct a physical examination: • If perforation of the globe is suspected (for instance in ocular trauma or as a complication of scleritis), do not palpate the eye — arrange for urgent ophthalmology assessment. • Assess for evidence of facial trauma. • Examine the eyelids for inflammation and erythema, or any abnormalities (for example, trichiasis, entropion or ectropion). • Examine the eyelids and surrounding area for rashes and vesicles. • Examine the conjunctiva, including the tarsal surface.			

• If foreign body is a possibility, invert the upper lid to check for a sub-tarsal foreign body. • Check the pattern of redness (if present) • Perform fluorescein examination • Check for any discharge from the eye(s). • Check the person's visual acuity using a Snellen chart.			
Refer people with severe eye pain and a significant reduction in vision immediately for same-day assessment by an ophthalmologist.	3	Strong	Expert Opinion
Refer people with suspected uveitis (new presentations, and recurrent) for assessment within 24 hours by an ophthalmologist.	3	Strong	Expert Opinion
Uveitis should be managed by an ophthalmologist	3	Strong	Expert Opinion
Do not initiate treatment for uveitis in primary care, unless asked to do so by an ophthalmologist	3	Strong	Expert Opinion

*1: NICE – Adalimumab, 2: ACR – JIA Uveitis, 3: NICE – Uveitis CKS

AAU: Acute Anterior Uveitis, CAU: Chronic Anterior Uveitis, DMARD: Disease Modifying Anti-Rheumatic Drug, TNFi: Tumour Necrosis Factor Inhibitor