



Optimizing Perioperative Management Strategies in Uveitic Cataract Surgery: A Survey of Expert Practices

✉ Berru Yargı Özkoçak, ✉ Çiğdem Altan

University of Health Sciences Türkiye, Beyoğlu Eye Training and Research Hospital, Clinic of Ophthalmology, İstanbul, Türkiye

Abstract

Objectives: To evaluate the current practices in uveitic cataract surgery based on expert opinions and identify areas of agreement and divergence.

Materials and Methods: A descriptive, cross-sectional expert survey was conducted among tertiary referral centers and university hospitals in Türkiye. A structured 10-item questionnaire was electronically distributed to uveitis specialists who had at least 5 years of experience in uveitis, were in active clinical practice, and managed at least 50 uveitic cataract cases per year. The questionnaire addressed preoperative preparation, intraoperative approach, and postoperative management. Multiple answers were permitted. Descriptive statistics were used for analysis. The terms “strong consensus”, “consensus”, and “divergence” were used to categorize levels of agreement.

Results: Strong consensus was observed for a 3-month inflammation-free period before surgery (85%, 17/20), continuation of conventional immunosuppressants without dose adjustment (95%, 19/20), and preference for hydrophobic acrylic intraocular lenses in uveitis associated with juvenile idiopathic arthritis (80%, 16/20). In postoperative management, 80% (16/20) tapered topical steroids within 4-6 weeks. For biologic therapies, 75% (15/20) adjusted surgical timing based on pharmacodynamic half-life. Preoperative topical steroid strategies showed divergence, with no dominant protocol. Steroid coverage strategies were practiced differentially; 65% (13/20) relied on topical steroids alone in anterior uveitis, while 60% (12/20) used intravenous steroids for posterior/panuveitis. Non-steroidal anti-inflammatory drug use for macular edema

prophylaxis varied widely, and recurrence management involved systemic steroids (70%, 14/20), periocular injections (55%, 11/20), or intravitreal therapy (40%, 8/20).

Conclusion: Expert consensus highlights standardized perioperative strategies in uveitic cataract care. However, considerable variation persists in several key areas, emphasizing the need for further research. Personalized approaches remain crucial.

Keywords: Expert survey, inflammation-free period, macular edema prophylaxis, perioperative management, uveitic cataract surgery

Introduction

Cataract is a frequent and vision-threatening complication of uveitis, resulting from chronic/recurrent intraocular inflammation and prolonged corticosteroid exposure.^{1,2} In uveitic patients, cataract impairs visual acuity and limits the clinician's ability to evaluate the posterior segment, thereby complicating imaging and therapeutic monitoring.³

Technological advancements in cataract surgery and improved perioperative control of inflammation have made uveitic cataract surgery increasingly safe and successful. Nevertheless, perioperative management poses a series of unique challenges due to the need for aggressive control of inflammation while minimizing treatment-related complications. Especially in patients receiving systemic immunosuppressants or biological agents, surgical timing and perioperative immunomodulatory strategies require a careful balance, with adequate suppression to prevent intraocular inflammation but awareness of the increased risks of infection and delayed tissue healing.^{1,4} The attainment of a favorable outcome is based on thorough preoperative management, individualized approaches tailored to the patient, a precise and uncomplicated surgery, and postoperative control of complications.^{4,5}

Cataract surgery in uveitis requires an individualized approach. The heterogeneity of uveitic entities and ongoing medical treatments and the varying severity of inflammation and

Cite this article as: Yargı Özkoçak B, Altan Ç. Optimizing Perioperative Management Strategies in Uveitic Cataract Surgery: A Survey of Expert Practices. *Türk J Ophthalmol.* 2025;55:249-255

Address for Correspondence: Berru Yargı Özkoçak, University of Health Sciences Türkiye, Beyoğlu Eye Training and Research Hospital, Clinic of Ophthalmology, İstanbul, Türkiye

E-mail: byargi@hotmail.com **ORCID-ID:** orcid.org/0000-0002-6801-6178

Received: 29.06.2025 **Accepted:** 06.08.2025

DOI: 10.4274/tjo.galenos.2025.27917

other associated ocular and systemic factors make it difficult to establish a universal strategy. While general recommendations exist, there is no globally accepted guideline for perioperative management. In daily practice, management depends on individual patient characteristics and clinician experience.^{1,4,5,6} Given the relatively small number of ophthalmologists specializing in uveitis, expert opinion is particularly valuable in defining best practices for this patient group.

This study aimed to evaluate the real-world clinical decision-making process regarding perioperative management strategies for uveitic cataract surgery in Türkiye, focusing on preoperative, intraoperative, and postoperative practices. Identifying areas of consensus and divergence is expected to contribute to a deeper understanding of the factors influencing surgical planning and postoperative management.

Materials and Methods

This descriptive, cross-sectional study was conducted with experienced ophthalmologists managing uveitic patients in Türkiye to evaluate real-life perioperative management practices in uveitic cataract surgery. Ethical approval was not required and the study complied with the tenets of the Declaration of Helsinki.

The questionnaire was administered in Turkish to ensure clarity and accessibility and consisted of 10 multiple-choice questions carefully designed to assess different aspects of perioperative management. Questions 1-6 addressed preoperative management, question 7 focused on intraocular lens (IOL) preferences, and questions 8-10 covered postoperative strategies. The complete questionnaire is available as [Supplementary Material 1](#). The questionnaire was reviewed and validated by two uvea specialists (C.A. and B.Y.O.) to ensure content relevance and clarity.

Participants were selected based on the criteria of having at least 5 years of experience in uveitis management, being actively engaged in clinical practice in Türkiye, and performing at least 50 uveitic cataract surgeries per year. All respondents were certified specialists, predominantly working in tertiary referral hospitals or university clinics.

The survey was administered electronically via the SurveyMonkey electronic platform and distributed through electronic communication channels, including professional networks and targeted email invitations. To reflect the diversity of real-world practices, participants were allowed to select multiple answers for each question.

Responses were collected anonymously over a defined period (February 1-28, 2025). No personal or institutional identifiers were obtained, and participation was voluntary.

Statistical Analysis

The survey responses were compiled and analyzed using Microsoft Excel and SPSS for Mac version 23.0 (IBM Corp., Armonk, NY, USA). Descriptive statistics were used to summarize response frequencies and percentages for each question. Based on response rates, areas of consensus and divergence were identified

to highlight patterns of practice in perioperative management ([Table 1](#)).

Results

The study questionnaire was distributed to 25 uveitis specialists meeting the selection criteria and was completed by 20 of them (80% return rate).

The distribution of responses to questions 1-6 regarding preoperative management along with their respective percentages are presented in [Table 2](#).

Table 1. Consensus definitions used in the study

Classification	Definition
Strong consensus	≥75% of participants selected the same response AND ≥20% difference from the next best option
Consensus	60-74% of participants selected the same response AND ≥15% between the two most selected answers
Divergence	Either 50-59% selected the same response OR <15% difference between the two most selected answers

Table 2. Preoperative strategies and response distribution

Question	Option	% (n)
Q1. Preoperative inflammation-free period	3 months	85% (17)
	6 months	15% (3)
	Patient-dependent	15% (3)
Q2. Preoperative topical steroids	1-3 days before, 3-5 drops/day	35% (7)
	1-3 weeks before, 3-5 drops/day	30% (6)
	Not used	35% (7)
	1-3 days before, hourly	20% (4)
	1-3 weeks before, hourly	30% (6)
Q3. Steroid coverage (anterior uveitis)	Topical only	65% (13)
	IV steroid on surgery day	10% (2)
	Increase preop systemic dose	20% (4)
	Add systemic postop	10% (2)
	Not applied	30% (6)
Q4. Steroid coverage (posterior/panuveitis)	IV steroid on surgery day	60% (12)
	Increase preop systemic dose	40% (8)
	Add systemic postop	25% (5)
	Topical only	10% (2)
	Not applied	15% (3)
Q5. Conventional IST before surgery	Continue without change	95% (19)
	Increase dose	5% (1)
Q6. Biologic agent management	Time surgery to half-life	75% (15)
	Do not interrupt	45% (9)
	Skip one dose	15% (3)

IST: Immunosuppressive therapy, IV: Intravenous, Q: Question, n: Number of responses of participants. The option with the highest rate of selection is marked in bold

The survey included only a single question concerning intraoperative management. This question focused on IOL selection in patients with juvenile idiopathic arthritis (JIA)-associated uveitis. The respondents preferred the implantation of a hydrophobic acrylic IOL (80%, 16/20). A smaller proportion of specialists preferred deferring IOL implantation to a second session (20%, 4/20), while only 10% (2/20) reported using hydrophilic lenses.

The distribution of the responses to questions 8-10, which focused on postoperative anti-inflammatory strategies, are shown in [Table 3](#).

[Table 4](#) summarizes the survey results based on the predefined classification criteria for consensus and divergence.

Discussion

Uveitic cataract surgery represents a highly complex intersection of cataract and inflammatory disease management, challenging even the most experienced surgeons. Unlike senile

cataracts, the perioperative management of uveitic cataracts is highly individualized. The management is dependent on the underlying etiology of uveitis, anatomical complications, and the systemic immunosuppressive therapy (IST) received by the patient.⁷ The current guidelines provide limited specific recommendations, leaving the majority of decisions to the discretion of the managing clinician. In this context, the present survey-based study provides valuable insight into real-world clinical preferences and highlights areas of consensus among ophthalmologists experienced in uveitic cataract. These findings aimed to provide a basis for future controlled studies on areas of divergence.

Question 1 focused on the inflammation-free period before surgery. According to the survey results, 85% of the experts recommended a 3-month quiescent period. This finding is broadly consistent with the common view in the literature. Numerous studies have emphasized the importance of quiescence of inflammation for a period of at least 3 months prior to cataract surgery.^{5,7,8,9,10} It is hypothesized that this period is conducive to a reduction in postoperative complications, particularly cystoid macular edema (CME).^{9,11} In an expert survey conducted by International Uveitis Study Group (IUSG), 70% of respondents preferred 3 months, while 11% indicated a tendency to wait longer (e.g., 6 months).¹² In a study conducted on pediatric uveitis patients, the shortest inflammation-free period was reported to be 6 months, and this was found to be safe.¹³ However, some studies suggest that surgery may be considered in patients with recurrent or chronic uveitis during a “window of opportunity” when inflammation is better controlled.¹⁴ The etiology of uveitis is also a significant factor in this decision-making process. Patients diagnosed with Fuchs uveitic syndrome were reported to have a favorable prognosis following cataract surgery, even when the anterior chamber reaction is not fully controlled.¹⁵ A study on the outcomes of cataract surgery in patients diagnosed with Vogt-Koyanagi-Harada disease found no significant difference in postoperative outcomes between a 1-month or 3-month inflammation-free period before surgery.¹⁶ Although the literature on this subject is based primarily on expert opinion, a recent study showed that longer quiescence periods, such as 30, 60 or 90 days, significantly reduced the risk of recurrence within the first 90 days.¹⁰

Question	Option	% (n)
Q8. Tapering topical steroids	4-6 weeks	80% (16)
	3 months	35% (7)
	6 months	5% (1)
Q9. NSAID for CME prophylaxis	Postop only (1 month)	45% (9)
	Not used	35% (7)
	1 week preop	20% (4)
	1-3 days preop	5% (1)
Q10. Postop recurrence management	Add systemic steroid	70% (14)
	Periocular steroid	55% (11)
	Intravitreal steroid	40% (8)
	Increase topical + add systemic	35% (7)
	Increase IS dose	20% (4)
	Add new IS agent	15% (3)
	Increase topical only	5% (1)

CME: Cystoid macular edema, NSAID: Non-steroidal anti-inflammatory drug, Preop: Preoperative, Postop: Postoperative, IS: Immunosuppressive, Q: Question, n: number of responses from participants. The option with the highest rate of selection is marked in bold

Strong consensus	Consensus	Divergence
Q1: 3-month inflammation-free period preoperatively (85%)	Q3: Topical-only for anterior uveitis (65%)	Q2: Preoperative topical steroid regimens (mixed)
Q5: Continue conventional IST unchanged (95%)	Q4: IV steroid on surgery day for posterior/panuveitis (60%)	Q9: NSAID use for CME prophylaxis (varied approaches)
Q7: Hydrophobic acrylic IOL for JIA (80%)	Q6: Time surgery with biologic half-life (75%)	Q10: Postop recurrence strategies (no dominant choice)
Q8: Taper topical steroids in 4-6 weeks (80%)		

*Strong consensus was defined as ≥75% agreement with at least a 20% margin from the next response, consensus was defined as 60-74% agreement with a 15% margin, and responses without a clear majority or with <15% margin were considered divergent
CME: Cystoid macular edema, IOL: Intraocular lens, IST: Immunosuppressive therapy, IV: Intravenous, JIA: Juvenile idiopathic arthritis, NSAID: Non-steroidal anti-inflammatory drug, Q: Question

Question 2 focused on preoperative topical steroid regimen preferences. The responses demonstrated significant variability, with no dominant protocol emerging. This finding aligns with recent observations in the literature.^{8,17} While the administration of topical steroids prior to surgery is common practice, there is no standardized protocol concerning dosage, frequency, or duration.¹⁴ Different regimens have been described in previous studies, including every hour on the day before, 8 to 12 times a day for 2 days before, 4 times daily for 72 hours before, and 3, 4, 5, or 6 times a day for 1 week before surgery.^{1,4,5,18,19,20,21,22,23} This diversity is reflected in the distribution of survey results and the variation in practice. The current literature lacks clear, high-level evidence-based guidance on this topic.¹²

Question 3 addressed the use of steroid coverage strategies for the management of anterior uveitis. A moderate consensus emerged, with 65% of experts preferring management with topical steroids alone in patients with anterior uveitis. This finding aligns with the established principle that preoperative regimens should be adapted according to the anatomical classification of uveitis and the severity of disease.⁸ Some reports suggest that topical steroid use alone may be sufficient in patients with inactive isolated anterior uveitis or where inflammation is controlled with topical treatment alone, as stated above.^{1,8,17} Conversely, in more complex or severe cases (posterior/panuveitis, persistent inflammation, high-risk patients), the necessity of systemic steroids or other immunosuppressives is emphasized.^{5,8} The 30% of participants who reported not using a preoperative steroid coverage strategy may be indicative of the view that in very mild or single-episode cases, no additional steroid protection is required.

Question 4 addressed steroid coverage strategies in cases of posterior/panuveitis. The survey results indicated that 60% of the experts favored the administration of intravenous (IV) steroids on the day of surgery, 40% preferred preoperative systemic dose escalation, 25% preferred postoperative systemic supplementation, 10% preferred topical treatment alone, and 15% used no additional treatment. As stated in the discussion of question 3, the type and severity of uveitis are crucial factors, and more intensive preoperative steroid prophylaxis may be necessary in high-risk uveitis cases with severe inflammation, such as panuveitis, or those prone to aggressive postoperative inflammation.^{5,8} Various protocols have been proposed in the literature: 1 g IV methylprednisolone daily for 3 days prior to surgery, a single dose of IV methylprednisolone (15 mg/kg) half an hour before surgery, or oral prednisolone (0.5-1 mg/kg/day) started up to 2 weeks prior to surgery and then tapered.^{5,8,9,18,22,24} In one study, a 2-week preoperative course of oral prednisolone was found to be more efficacious in recovering blood aqueous barrier function than a single dose of IV methylprednisolone.²⁵ The IUSG expert survey similarly demonstrated that preoperative systemic corticosteroid escalation is common (76%), but there is variation in dosage and timing.¹² Considering this variation, the 60% consensus in the present study suggests that the indicated IV regimen is a common preference, though there are

alternative approaches in the literature that are considered valid or equivalent.

Question 5 assessed views on adjusting conventional IST preoperatively. The survey revealed a strong consensus among experts, with 95% expressing their agreement that conventional IST should be maintained without any alteration in dosage. This result is consistent with the literature, which states that uveitic patients who are scheduled to undergo cataract surgery, particularly those exhibiting no inflammatory activity, should continue their current maintenance immunosuppressive regimen.^{5,8}

Question 6 addressed the management of perioperative biologic agents. The majority of experts (75%) preferred to adjust the timing of surgery according to half-life, with 45% stating they did not interrupt treatment and 15% preferring to skip a dose. Biological agents are used in cases of severe or refractory uveitis.^{5,24} The most critical prerequisite for cataract surgery is the quiescence of inflammation, and biological agents are a part of this suppression.^{9,22} There is an absence of detailed protocols in the literature regarding the adjustment of surgical timing according to the specific half-life of biological agents. Nonetheless, expert opinion suggests that pharmacokinetic profiles are considered during surgical planning. The objective is presumably to identify the window in which the biological agent's efficacy is at its zenith, during which the probability of surgical stress-induced inflammation is lower. The 45% preference for not interrupting treatment is consistent with the general principle of maintaining systemic immunomodulation to reduce the risk of flare.^{5,8} Our findings point to the increasing role of biological agents in uveitis management and a more sophisticated surgical decision-making process based on their properties.

Question 7 addressed IOL preferences in JIA-associated uveitis, a subgroup with a high risk of postoperative complications.² In the present survey, 80% of respondents reported a preference for hydrophobic acrylic IOLs, while 20% opted to defer IOL implantation and 10% preferred hydrophilic IOLs. IOL implantation in JIA cases has historically been the subject of controversy, with aphakia frequently being favoured.^{1,5,21} Nevertheless, contemporary approaches indicate that IOL implantation in this group can be both feasible and successful when perioperative inflammation is stringently controlled.^{13,21,26} In a study focusing on JIA-associated uveitic cataract, favorable visual outcomes were reported in patients who were quiescent for a period of at least 6 months preoperatively.¹³ Comparative studies on IOL materials have generally focused on uveitic eyes as a whole rather than specifically on JIA. The existing literature consistently demonstrates that acrylic lenses are associated with lower rates of inflammation, posterior capsular opacification, and CME compared to materials such as silicone or poly(methyl methacrylate), thus supporting their superior biocompatibility.^{18,27} Direct comparisons have been made between hydrophobic and hydrophilic acrylic lenses, with hydrophilic IOLs demonstrating slightly higher flare and CME rates.

However, other studies have indicated that modern hydrophilic acrylic lenses possess satisfactory uveal biocompatibility.^{23,28} These findings help explain the predominant preference for hydrophobic acrylic IOLs in the current survey. Our results are consistent with those of the IUSG survey, in which 71% of responders preferred hydrophobic acrylic IOLs.¹² The authors emphasized that IOL selection in such complex cases is largely guided by individual clinical experience, reflecting the perceived absence of high-level evidence.¹² In brief, the current survey data indicate that when inflammation is adequately controlled, IOL implantation is widely favored in JIA-associated uveitis, with hydrophobic acrylic lenses being the dominant choice among experienced clinicians.

Question 8 asked about approaches to tapering topical corticosteroids in the postoperative period of uncomplicated cataract surgery. A strong consensus was observed, with 80% of participants favoring a 4-6 week tapering period. The literature highlights the significance of regulating postoperative inflammation following cataract surgery in uveitic eyes. The severity of postoperative inflammation determines the frequency of topical steroid use.^{4,5,19,20,21} The taper times of topical steroids may vary in the literature.^{19,29} In this context, the 4-6 week period in this survey may be consistent with shorter or intermediate taper regimens. However, in severe or persistent cases, the use of topical steroids over a longer period (3-4 months or 6 months) may also be indicated.^{6,19,28}

Question 9 assessed the use of non-steroidal anti-inflammatory drug (NSAID) drops for CME prophylaxis in the postoperative period. Topical NSAID drops were utilized by 60% (12/20) of the participants, with considerable variability in timing and duration. Topical NSAID drops play a pivotal role in the prevention of CME.³⁰ According to the literature, combination therapy (topical steroids + NSAIDs) appears more effective than steroids alone in reducing CME risk in severe uveitis.^{31,32,33} A study focusing on postoperative NSAID use in Behçet's uveitis reported reduced inflammation, although CME outcomes were not specifically assessed.³⁴ In alignment with current reviews, our results confirm that NSAIDs are frequently incorporated as adjunctive agents rather than replacements for steroids. However, the lack of uniformity in practice patterns suggests a need for further evidence-based guidance, particularly regarding timing, duration, and indications tailored to disease severity.

The responses to question 10, regarding the preferred treatment approaches in immunosuppressed patients with posterior/panuveitis recurrence in the postoperative period, demonstrate a high level of agreement with extant literature. The majority of the experts preferred systemic steroid administration (70%) as first-line treatment, followed by periocular (55%) and intravitreal (40%) steroid administration. High-dose oral or IV corticosteroids remain the cornerstone for managing severe flare-ups.^{1,5,6,7,8,11,21,24,25} In severe exacerbations, IV methylprednisolone or high-dose oral corticosteroids have been recommended.^{9,25} In several studies, periocular steroid administration has been emphasized as a potential alternative to systemic steroids.³⁵ Intravitreal triamcinolone and dexamethasone implants

were also shown to be effective in controlling postoperative inflammation and providing targeted therapy with reduced systemic side effects.^{5,24} It has been hypothesized that intravitreal triamcinolone may be more efficacious than orbital floor triamcinolone with regard to CME and early inflammation.²⁰ A comparative study conducted between systemic steroids and intravitreal administration revealed comparable outcomes in terms of postoperative inflammation control and visual recovery. However, intravitreal use was associated with an increase in intraocular pressure, while systemic administration was linked to the development of CME.¹⁹ An alternative approach, which was less frequently favored in our study but has a place in the literature, involves increasing the dose of existing IST (20%) or adding a new agent (15%). It has been documented that these options are being considered in cases resistant to steroid treatment or those with frequent recurrences.^{4,21} In light of these data, the survey results suggest that multiple routes of steroid administration are commonly used in practice for the management of recurrence after uveitic cataract surgery, but patient-specific and individualized approaches are also an integral part of the treatment process.

Study Limitations

This expert-based survey provides valuable insights into real-world perioperative strategies in uveitic cataract surgery. Nevertheless, this study has limitations. Firstly, the survey allowed participants to select multiple response options but did not include open-ended questions. While this design facilitates the identification of general trends, it limits the ability to determine the order of preference, frequency of use, or primary strategy employed by each clinician. Furthermore, it potentially restricted the reporting of non-conventional or varied approaches beyond the scope of the predefined answer choices. Secondly, the modest sample size (n=20) may limit the generalizability of the findings. This limitation reflects the inherent challenge of conducting surveys in highly specialized fields such as uveitis, where the pool of qualified respondents is limited. Finally, the institutional context (e.g., university hospitals, public referral centers, private clinics) was not evaluated as a variable in this study. The influence of perioperative decision-making may be attributed to variations in institutional resources, local treatment protocols, and patient demographics. The absence of stratification based on practice setting may have resulted in unmeasured confounders, complicating interpretation of treatment preferences and observed patterns.

Conclusion

This survey highlights prevailing trends and variations in the perioperative management of uveitic cataract surgery, offering a structured overview of current practices among experienced uveitis specialists. A strong consensus was observed in key areas, including the recommended preoperative quiescent period, the continuation of conventional IST, and IOL preferences in JIA-associated uveitis, reflecting shared principles in core decision-making domains. Conversely, notable divergence was identified

in preoperative topical steroid use, NSAID prophylaxis for CME, and strategies for managing postoperative recurrences. These domains, which are characterized by variability and an absence of standardized protocols, may serve as valuable focal points for future prospective studies aiming to establish more definitive guidelines. While personalized care remains paramount, in the absence of universally accepted guidelines, expert consensus continues to serve as a critical reference point, supporting the refinement of perioperative strategies in this complex and nuanced field.

Ethics

Ethics Committee Approval: The ethical approval was not required in this instance, as the expert survey did not involve the use of patient data and guaranteed the anonymity of the participants.

Informed Consent: Not necessary.

Acknowledgements

The authors would like to thank all the uveitis specialists who generously shared their time and expertise by participating in this survey. Their valuable contributions were essential to the completion of this study.

Declarations

Authorship Contributions

Concept: B.Y.O., Design: B.Y.O., Data Collection or Processing: B.Y.O., Analysis or Interpretation: B.Y.O., Ç.A., Literature Search: B.Y.O., Writing: B.Y.O., Ç.A.

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study received no financial support.

References

- Meier FM, Tuft SJ, Pavésio CE. Cataract surgery in uveitis. *Ophthalmol Clin North Am.* 2002;15:365-373.
- Thorne JE, Woreta FA, Dunn JP, Jabs DA. Risk of cataract development among children with juvenile idiopathic arthritis-related uveitis treated with topical corticosteroids. *Ophthalmology.* 2020;127(Suppl 4):21-26.
- Durrani OM, Tehrani NN, Marr JE, Moradi P, Stavrou P, Murray PI. Degree, duration, and causes of visual loss in uveitis. *Br J Ophthalmol.* 2004;88:1159-1162.
- Foster CS, Rashid S. Management of coincident cataract and uveitis. *Curr Opin Ophthalmol.* 2003;14:1-6.
- Al-Essa RS, Alfawaz AM. New insights into cataract surgery in patients with uveitis: a detailed review of the current literature. *Saudi J Ophthalmol.* 2022;36:133-141.
- Van Gelder RN, Leveque TK. Cataract surgery in the setting of uveitis. *Curr Opin Ophthalmol.* 2009;20:42-45.
- Mehta S, Linton MM, Kempen JH. Outcomes of cataract surgery in patients with uveitis: a systematic review and meta-analysis. *Am J Ophthalmol.* 2014;158:676-692.
- Chan NS, Ti SE, Chee SP. Decision-making and management of uveitic cataract. *Indian J Ophthalmol.* 2017;65:1329-1339.
- Chen JL, Bhat P, Lobo-Chan AM. Perioperative management of uveitic cataracts. *Adv Ophthalmol Optom.* 2019;4:325-339.
- Rohl A, Patnaik JL, Claire Miller D, Lynch AM, Palestine AG. Timing of quiescence and uveitis recurrences after cataract surgery in patients with a history of uveitis. *Ophthalmol Ther.* 2021;10:619-628.
- Bélair ML, Kim SJ, Thorne JE, Dunn JP, Kedhar SR, Brown DM, Jabs DA. Incidence of cystoid macular edema after cataract surgery in patients with and without uveitis using optical coherence tomography. *Am J Ophthalmol.* 2009;148:128-135.
- Sreekantam S, Denniston AK, Murray PI. Survey of expert practice and perceptions of the supporting clinical evidence for the management of uveitis-related cataract and cystoid macular oedema. *Ocul Immunol Inflamm.* 2011;19:353-357.
- O'Rourke M, McCreery K, Kilmartin D, Brosnahan D. Paediatric cataract in the uveitis setting. *Eur J Ophthalmol.* 2021;31:2651-2658.
- Llop SM, Papaliodis GN. Cataract surgery complications in uveitis patients: a review article. *Semin Ophthalmol.* 2018;33:64-69.
- Tejwani S, Murthy S, Sangwan VS. Cataract extraction outcomes in patients with Fuchs' heterochromic cyclitis. *J Cataract Refract Surg.* 2006;32:1678-1682.
- Ji Y, Hu K, Li C, Li P, Kijlstra A, Eghrari AO, Lei B, Du L, Wan W, Yang P. Outcome and prognostic factors of phacoemulsification cataract surgery in Vogt-Koyanagi-Harada uveitis. *Am J Ophthalmol.* 2018;196:121-128.
- Mora P, Gonzales S, Ghirardini S, Rubino P, Orsoni JG, Gandolfi SA, Majo E, Guex-Crosier Y. Perioperative prophylaxis to prevent recurrence following cataract surgery in uveitic patients: a two-centre, prospective, randomized trial. *Acta Ophthalmol.* 2016;94:e390-394.
- Alió JL, Chipont E, BenEzra D, Fakhry MA; International Ocular Inflammation Society, Study Group of Uveitic Cataract Surgery. Comparative performance of intraocular lenses in eyes with cataract and uveitis. *J Cataract Refract Surg.* 2002;28:2096-2108.
- Dada T, Dhawan M, Garg S, Nair S, Mandal S. Safety and efficacy of intraoperative intravitreal injection of triamcinolone acetonide injection after phacoemulsification in cases of uveitic cataract. *J Cataract Refract Surg.* 2007;33:1613-1618.
- Roesel M, Tappeiner C, Heinz C, Koch JM, Heiligenhaus A. Comparison between intravitreal and orbital floor triamcinolone acetonide after phacoemulsification in patients with endogenous uveitis. *Am J Ophthalmol.* 2009;147:406-412.
- Lobo AM, Papaliodis GN. Perioperative evaluation and management of cataract surgery in uveitis patients. *Int Ophthalmol Clin.* 2010;50:129-137.
- Bajraktari G, Jukić T, Kalauz M, Oroz M, Radolović Bertetić A, Vukojević N. Early and late complications after cataract surgery in patients with uveitis. *Medicina (Kaunas).* 2023;59:1877.
- Pålsson S, Schuborg C, Sterner B, Andersson Grönlund M, Zetterberg M. Hydrophobic and Hydrophilic IOLs in patients with uveitis - a randomised clinical trial. *Clin Ophthalmol.* 2025;19:373-383.
- Moshirfar M, Somani AN, Motlagh MN, Ronquillo YC. Management of cataract in the setting of uveitis: a review of the current literature. *Curr Opin Ophthalmol.* 2020;31:3-9.
- Meacock WR, Spalton DJ, Bender L, Antcliff R, Heatley C, Stanford MR, Graham EM. Steroid prophylaxis in eyes with uveitis undergoing phacoemulsification. *Br J Ophthalmol.* 2004;88:1122-1124.
- Schmidt DC, Al-Bakri M, Rasul A, Bangsgaard R, Subhi Y, Bach-Holm D, Kessel L. Cataract surgery with or without intraocular lens implantation in pediatric uveitis: a systematic review with meta-analyses. *J Ophthalmol.* 2021;2021:5481609.
- Abela-Formanek C, Amon M, Kahraman G, Schauersberger J, Dunavoelgyi R. Biocompatibility of hydrophilic acrylic, hydrophobic acrylic, and silicone intraocular lenses in eyes with uveitis having cataract surgery: Long-term follow-up. *J Cataract Refract Surg.* 2011;37:104-112.
- Tomlins PJ, Sivaraj RR, Rauz S, Denniston AK, Murray PI. Long-term biocompatibility and visual outcomes of a hydrophilic acrylic intraocular lens in patients with uveitis. *J Cataract Refract Surg.* 2014;40:618-625.
- Ren Y, Du S, Zheng D, Shi Y, Pan L, Yan H. Intraoperative intravitreal triamcinolone acetonide injection for prevention of postoperative inflammation and complications after phacoemulsification in patients with uveitic cataract. *BMC Ophthalmol.* 2021;21:245.

30. Russo A, Costagliola C, Delcassi L, Parmeggiani F, Romano MR, Dell'Omo R, Semeraro F. Topical nonsteroidal anti-inflammatory drugs for macular edema. *Mediators Inflamm.* 2013;2013:476525.
31. El Gharbawy SA, Darwish EA, Abu Eleinen KG, Osman MH. Efficacy of addition of nepafenac 0.1% to steroid eye drops in prevention of post-phaco macular edema in high-risk eyes. *Eur J Ophthalmol.* 2019;29:453-457.
32. Heier JS, Topping TM, Baumann W, Dirks MS, Chern S. Ketorolac versus prednisolone versus combination therapy in the treatment of acute pseudophakic cystoid macular edema. *Ophthalmology.* 2000;107:2034-2038;discussion 2039.
33. Wittpenn JR, Silverstein S, Heier J, Kenyon KR, Hunkeler JD, Earl M; Acular LS for Cystoid Macular Edema (ACME) Study Group. A randomized, masked comparison of topical ketorolac 0.4% plus steroid vs steroid alone in low-risk cataract surgery patients. *Am J Ophthalmol.* 2008;146:554-560.
34. Işık MU, Yalçındağ NE. Comparison of the efficacy of nepafenac 0.1% in quiescent Behçet's uveitis and non-uveitic healthy patients after phacoemulsification surgery. *Int Ophthalmol.* 2020;40:2345-2351.
35. Roesel M, Heinz C, Koch JM, Heiligenhaus A. Comparison of orbital floor triamcinolone acetonide and oral prednisolone for cataract surgery management in patients with non-infectious uveitis. *Graefes Arch Clin Exp Ophthalmol.* 2010;248:715-720.