Supplementary Setting Description

Most patients are referred for diagnostic evaluation and/or treatment recommendations by ophthalmologists in the community or by ophthalmology or pediatric outpatient clinics at our hospital. In the first visit, a detailed medical history and complete ophthalmic examination is performed and when an specific etiology is suspected, several laboratory test (including complete blood counts, erythrocyte sedimentation rate, C-reactive protein, and liver and renal function tests), radiographic tests (including chest and sacroiliacal X-rays), serological assays (including herpes viruses, syphilis, and toxoplasmosis), and other determinations (including HLA typing, autoantibodies determination, or Purified Protein Derivative skin test) are performed. Clinical and ophthalmological examinations, including measure of corrected visual acuity (CVA) using the Snellen scale, are repeated in each visit. The periodicity of such visits is not standardized, meaning that the frequency with which patients attend our clinic is based on their clinical manifestations, the progression of CVA, and the presence of ocular manifestations with visual risk (such as ocular hypertension).

Children and adolescents with intermediate uveitis (IU) are treated based on the laterality of the disease, and the presence of inflammatory activity. In unilateral or asymmetric cases, we use sequential periocular corticosteroids injections, and in case of macular edema, low dose of systemic carbonic anhydrase inhibitors, topical corticosteroids, and new generation topical non-steroids anti-inflammatory drugs, such as bromphenac or nepafenac.

In bilateral cases we use a stepwise protocol including systemic, periocular, and topical corticosteroids. Systemic corticosteroids are used at anti-inflammatory dosage (0.5 mg/kg/day) during the shortest possible time, in order to avoid the adverse drug

reactions associated with these drugs in this age group. In case of persistent inflammation or severe cases, immunosuppressive drugs (ISDs; mainly methotrexate or azathyoprine) are introduced early during follow-up, in order to allow both a rapid control of inflammation and to taper the systemic corticosteroids. Combine therapy with other synthetic (azathyoprine or methotrexate) or biologic ISDs (mainly adalimumab) is reserved in case of intolerance or insufficient inflammatory control.

In our center, pars plana vitrectomy (PPV) is not used as a surgical option to control the inflammatory activity. This procedure is reserve for the treatment of sequels such us macular epiretinal membranes or dense and organized vitreous opacities. Although PPV has been associated with good clinical response, improvement of visual acuity, and sustained control of vitreous inflammation in several studies(1–3), it is necessary to consider that this procedure has several surgical risks when performed in an inflamed eye, such as regmatogenous retinal detachment, persistent hypotony and specially cataract development. This last complication has an important impact in this age group, considering the lost of accommodation and the risk of implanting an intraocular lens in an eye that might suffer chronic or recurrent inflammation.