The importance of tuberculous infection in the aetiology of uveitis is, it is agreed, difficult to assess, because the clinical appearances of the condition are not always characteristic and histological confirmation is only possible in a small minority of cases. The common occurrence of active tuberculosis or of healed tuberculous lesions among the general population and the improvement of many cases of uveitis following the administration of tuberculin preparations has led, in the past, to a very widespread diagnosis of tuberculous uveitis, and the incidence amongst all cases of uveitis has varied in several series from two per cent. to forty-eight per cent.

It has been suggested that the uveitis may be due to the presence of *Mycobacterium tuberculosis* in the eye following a transient bacillaemia or that the uveal tract becomes sensitized to products produced by the *Mycobacterium* and that it subsequently reacts to this sensitivity. Professor Alan Woods (1954), while acknowledging the occurrence of sensitivity of the uveal tract to tuberculous products, states that uveitis does not occur unless the *Mycobacterium* is present in the uveal tract. The intensity of the reaction only is influenced by the sensitivity. Most ophthalmologists agree that, at the present time, tuberculosis can be regarded as a less important aetiological factor in uveitis than in the past, but the diagnosis of these cases remains a matter of great difficulty.

The records of the Eye Sanatorium of Moorfields Eye Hospital have been reviewed with the object of clarifying the diagnosis of cases of tuberculous uveitis. 225 cases of chronic or recurrent uveitis were admitted between 1952 and 1958, and all were investigated and treated. The age of these patients is shown in the graph.

The uveitis was binocular in 170 patients and uni-ocular in 55: that is to say that the ratio of binocular cases to uni-ocular was more than three to one.

Tuberculous uveitis was diagnosed in those patients who had uveitis of such a characteristic tuberculous type as tuberculomata, and in those who
had non-characteristic uveitis but who either had a history of systemic tuberculous infection, or who had been in close contact with the disease as when it occurred in near relatives or when they were nursing patients suffering from it. The diagnosis was not made also unless the skin sensitivity was positive in 1/10,000 or greater dilution of old tuberculin. The view might be taken that a positive skin sensitivity is in itself evidence of a systemic infection, but this may be in a very small and sensitizing dose and not in sufficient concentration to cause a tuberculous lesion.

Tuberculous uveitis was diagnosed in thirty-three patients (14.6%). The age incidence is shown in the graph and this indicates clearly that the maximum age incidence of patients with tuberculous uveitis is earlier than that of patients with non-specific uveitis and that a second peak occurs in the fifty to sixty age group (see graph). The condition was bilateral in twenty cases and unilateral in thirteen, the ratio of bilateral cases to unilateral cases being only 1.5 to one.

Analysis of these cases shows:

**Clinical features**

a. Granulomatous uveitis  
   (with or without macroscopic iris nodules) 23 cases.

b. Tuberculoma of choroid 3 cases.

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