

## Psoriasis Revealed by Posterior Scleritis

S. Hida<sup>1\*</sup>, N. Ousman<sup>1</sup>, W. Berramdane<sup>1</sup>, FZ. Mebrouki<sup>1</sup>, A. Maadane<sup>1</sup>, R. Sekhsoukh<sup>1</sup>

<sup>1</sup>Mohammed VI University Hospital, Oujda; Mohammed Premier University, Oujda; Faculty of Medicine and Pharmacy, Oujda

DOI: <https://doi.org/10.36348/sjmps.2026.v12i05.011>

| Received: 21.03.2026 | Accepted: 13.05.2026 | Published: 23.05.2026

\*Corresponding author: S. Hida

Mohammed VI University Hospital, Oujda; Mohammed Premier University, Oujda; Faculty of Medicine and Pharmacy, Oujda

### Abstract

Posterior scleritis is a rare and potentially sight-threatening inflammatory condition involving the sclera posterior to the ora serrata. Its diagnosis is often challenging due to nonspecific clinical features and limited accessibility to direct examination. It is commonly associated with systemic autoimmune diseases, while its association with psoriasis remains rare. A 58-year-old woman presented with severe right ocular and periorbital pain exacerbated by eye movements, associated with persistent headaches. Symptoms had been evolving for two months with an initial diagnosis of anterior scleritis. Ophthalmologic examination revealed reduced visual acuity (3/10), diffuse conjunctival hyperemia, and inferonasal retinal folds. B-scan ultrasonography and optical coherence tomography confirmed posterior scleritis by demonstrating scleral thickening and retinal folds. Systemic evaluation identified erythematous lesions consistent with psoriasis and a biological inflammatory syndrome, while autoimmune and infectious workups were unremarkable. Orbital MRI confirmed scleral thickening. Intravenous corticosteroid therapy led to rapid symptom relief, recovery of visual acuity to 10/10, and resolution of retinal abnormalities within 10 days. Methotrexate therapy resulted in sustained improvement. Posterior scleritis may reveal underlying systemic disease. Psoriasis, although rare, should be considered. Early diagnosis and prompt treatment are essential to prevent visual complications.

**Keywords:** Posterior scleritis, psoriasis, ocular inflammation, corticosteroids, methotrexate.

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### INTRODUCTION

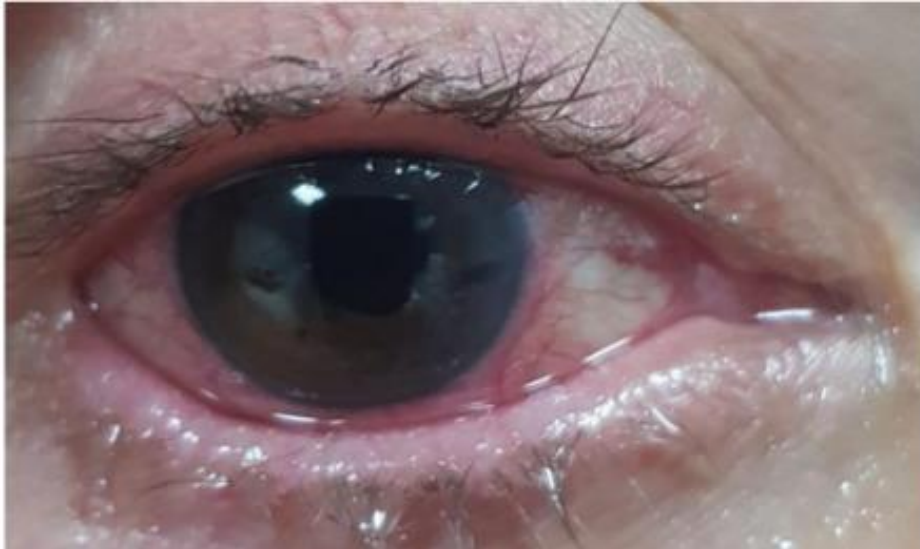
Posterior scleritis is a rare but severe inflammation affecting the sclera posterior to the ora serrata, which can impact the deep structures of the eyeball such as the choroid, the retina, and the optic nerve. The inaccessibility of the posterior sclera to direct examination poses a diagnostic challenge, along with clinical and etiological polymorphism [1]. In the following manuscript, we describe the case of psoriasis revealed by posterior scleritis.

### OBSERVATION

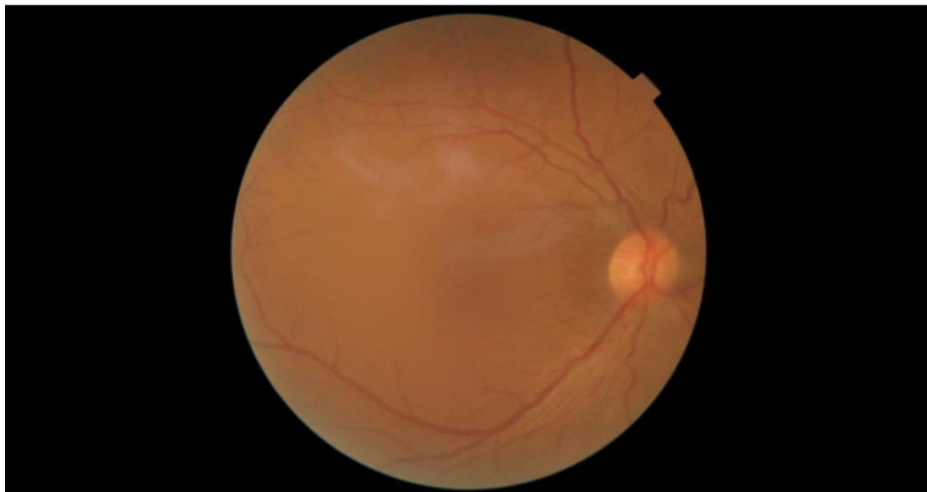
A 58-year-old female patient presented to the emergency department with right ocular and periorbital pain exacerbated by eye movements, causing insomnia. She also reported highly debilitating headaches that did not respond to symptomatic treatment. The medical history revealed that the patient had already presented

with the same symptomatology for 2 months. The ophthalmological examination had, however, proven non-contributory, and the diagnosis of anterior scleritis had been made. With better clinical improvement under topical non-steroidal anti-inflammatory drugs. Furthermore, the patient reported a history of chronic arthralgia re-lieved by analgesics.

The ophthalmological examination revealed a best-corrected visual acuity of 3/10 in the right eye. Examination of the anterior segment showed the presence of 360° conjunctival hyperemia (Figure 1). Examination of the posterior segment revealed the presence of inferonasal retinal folds without associated papilledema or macular edema. (Figure 2) A B-scan ultrasonography revealed a significant hyperechoic scleral thickening, confirming the diagnosis of posterior scleritis (Figure 3). Macular OCT objectified retinal folds corresponding to the scleral thickening (Figure 4).



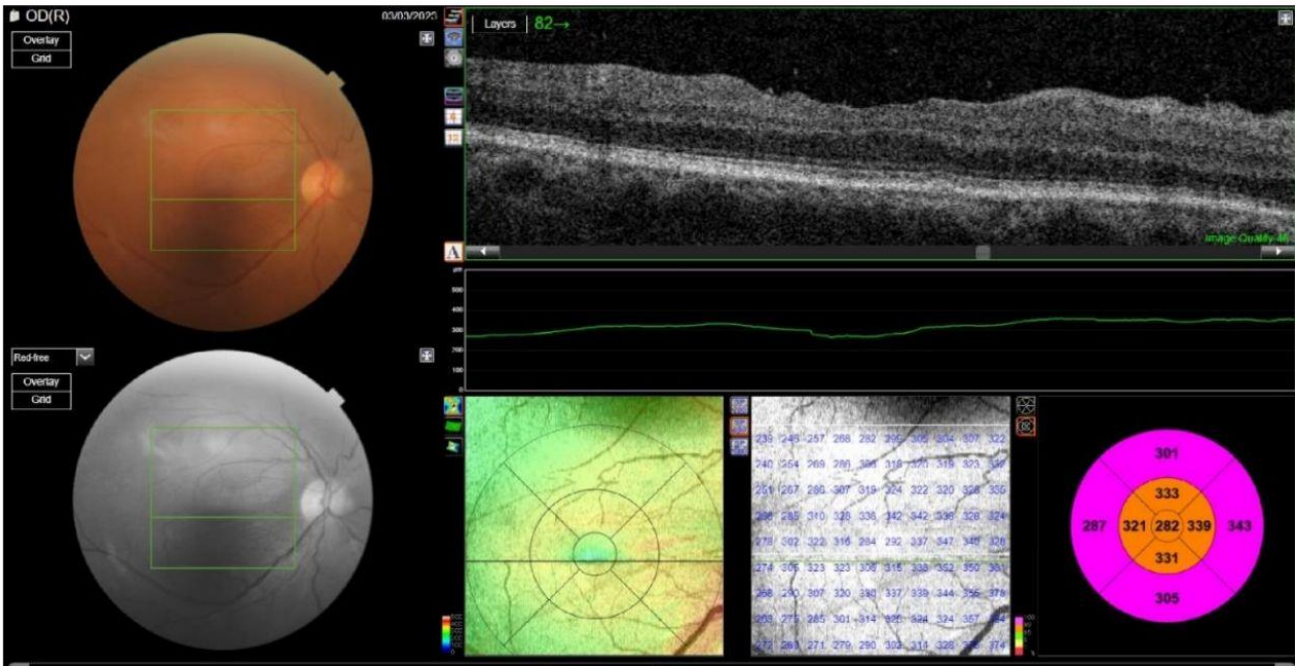
**Figure 1: Photograph showing diffuse conjunctival hyperemia**



**Figure 2: Fundus photograph showing inferonasal retinal folds**



**Figure 3: Scleral thickening on an ultrasound scan**



**Figure 4: Optical coherence tomography scan showing the retinal folds**

The general clinical examination revealed pruritic erythemasquamous lesions on the scalp, elbows, upper buttocks, and knees, suggestive of psoriasis; accordingly, an etiological assessment was requested, consisting of blood tests and an orbital MRI. Blood tests revealed an inflammatory syndrome (CRP = 96 mg/L, accelerated ESR), which was confirmed by SPEP showing a moderate increase in beta-2 globulins.

The autoimmune workup found a positive rheumatoid factor at 30 IU/mL, with the rest of the panel (ANA, Anti-DNA, ANCA, anti-CCP, anti-SCL70, C4, ACE, IgG4) being unremarkable. Serological tests for herpes, syphilis, Lyme disease, HLA-B27, HIV, and toxoplasmosis were also negative. The orbital MRI confirmed a scleral thickening (Figure 5).



**Figure 5: T1-weighted MRI sequence showing a scleral hypersignal related to thickening**

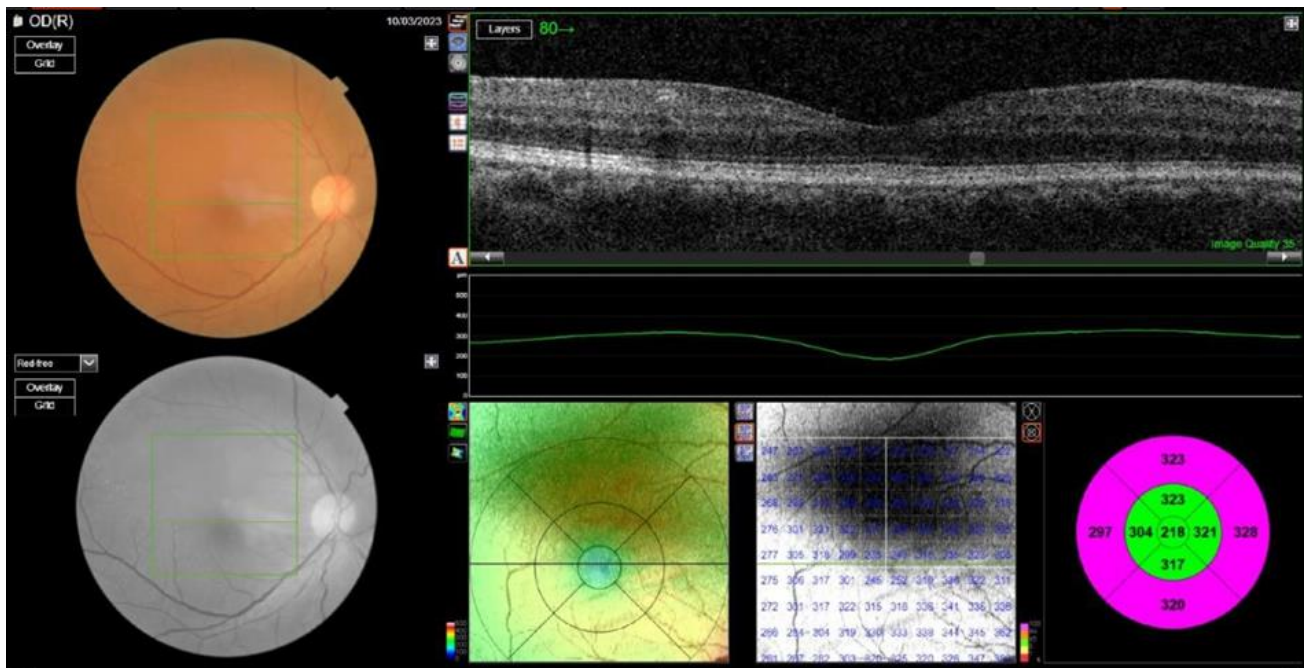
The patient initially received non-steroidal anti-inflammatory drugs, and due to a lack of clinical improvement, intravenous corticosteroid boluses were

administered for 3 days at a dose of 10 mg/kg/day, which resulted in a rapid decrease in pain, an improvement in visual acuity to 10/10, and a regression of the scleral

thickening with the disappearance of the retinal folds by day 10. (Figure 6)

The patient was referred to the dermatology department for the management of her psoriasis to

control the disease on both the cutaneous and articular levels. Immunosuppressive therapy with methotrexate (25 mg/week) was initiated, combined with topical corticosteroid therapy, resulting in improvement at the ocular, cutaneous, and articular levels.



**Figure 6: Optical coherence tomography scan showing the disappearance of the retinal folds on day 10 of treatment**

## DISCUSSION

Posterior scleritis is a rare disease that represents approximately 2 to 12% of all documented scleritis cases [2], which is itself an infrequent condition estimated to have an incidence of approximately 6 cases per 100,000 individuals in the general population and accounts for 5% of all ocular inflammations. According to previous studies, posterior scleritis frequently affects women with a mean age of 46 years [3].

Autoimmune etiologies predominate, with already known systemic associations, notably rheumatoid arthritis, systemic lupus erythematosus, and ANCA-positive vasculitides. A single study has shown that an idiopathic etiology is reported in 62.3% of the posterior scleritis cases studied [4].

Clinically, posterior scleritis manifests as intense ocular pain exacerbated by eye movements, sometimes accompanied by an early decrease in visual acuity. On fundus examination, the diagnosis is made based on the presence of non-specific signs (choroidal folds and serous retinal detachments, papilledema/macular edema). B-scan ultrasonography is the examination of choice, allowing confirmation of the diagnosis based on a scleral thickening of more than 2 mm and/or the pathognomonic ultrasound "T-sign". Orbital MRI is useful in cases of diagnostic doubt and shows a hypersignal on T1-weighted sequences confirming the scleral thickening.

Psoriasis is an erythematous squamous dermatosis linked to keratinocyte hyperproliferation that affects 1 to 3% of the population, characterized by multiple extracutaneous [5] manifestations. Although ocular manifestations are commonly encountered clinically, their exact rate remains poorly defined. Posterior scleritis is one of the ocular involvements described in rare studies in association with psoriatic arthritis; a study conducted including 31 patients between April 2005 and April 2010 by Gonzalez-Gonzalez *et al* [6] showed that 20% of posterior scleritis cases are linked to a systemic disease, 6.5% of which were psoriatic arthritis. Another study conducted in Turkey on 114 patients treated for scleritis found that only a single patient was diagnosed with psoriatic arthritis [7].

Our interest in this reported case is to provide an approach to the etiologies of posterior scleritis and to consider psoriasis and psoriatic arthritis as associated systemic causes despite their low incidence in the various studies conducted.

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