Table 2: Consensus statements for the management of HSV and VZV AU

Unilaterality, increased IOP, decreased corneal sensation and diffuse or sectoral iris atrophy are quite specific for HSV or VZV AU. Sectorial iris atrophy is critical to diagnosing HSV AU.
Initiation of treatment for HSV/VZV AU (anti-inflammatory or antiviral therapy) can be administered when PCR/GWC is pending or unavailable.
Repeat PCR/GWC is not necessary; clinical follow-up is sufficient.
Resolution of inflammation (KPs, cells, flare) and IOP normalization are considered clinical endpoints for both HSV and VZV AU.
Topical corticosteroids will be given in HSV and VZV AU only if systemic/topical antiviral coverage is also initiated.
Corticosteroid, not NSAID, is the preferred first-line topical anti-inflammatory agent in HSV/VZV AU.
Neither periocular nor systemic corticosteroid is considered a role in HSV and VZV AU.
A beta-blocker is the IOP-lowering agent of first choice in HSV/VZV AU.
Largely because of its simpler dosing regimen, oral valacyclovir is the most common systemic antiviral used by the respondents in both HSV and VZV AU.
If the patient stops treatment, restarting treatment is necessary only if disease activity is noted again.
If there is active corneal involvement, oral antiviral therapy is indicated. Adding topical antiviral treatment can be considered (its preferred dosage and duration is unclear). Titrating topical corticosteroid dosage to the presence of viral keratitis (i.e. decrease if there is epithelial keratitis but increase if there is stromal keratitis) is indicated.

IOP = intraocular pressure, PCR = polymerase-chain-reaction, GWC = Goldmann-Witmer coefficient, KPs = keratic precipitates, NSAID = non-steroid anti-inflammatory drugs