Supplementary Table 5. Important patient care principles with moderate and high variations among experts with regional differences

Patient care principles	Cumulative N= 68	Asia N = 33	Europe N = 20	America (USA) N = 9	Other regions N = 6
Performing quantitative PCR for suspected HSV/VZV AU					
Not available yet. If it is available, I will order it as quantitative results are relevant to my management	25 (36.8%)	12 (36.4%)	7 (35.0%)	3 (33.3%)	3 (50.0%)
Not useful for HSV/VZV AU management	24 (35.3%)	12 (36.4%)	7 (35.0%)	3 (33.3%)	2 (33.3%)
Routinely perform both qualitative and quantitative multiplex PCR for suspected HSV/VZV AU	16 (23.5%)	7 (21.2%)	6 (30.0%)	3 (33.3%)	0
Decline to answer	3 (4.4%)	2 (6.1%)	-	-	1 (16.7%)
Resolution of corneal edema is required as a clinical treatment endpoint					
If significant corneal edema persists despite no intraocular inflammation and normal IOP, treatment will be continued	38 (55.9%)	17 (51.5%)	13 (65.5%)	5 (55.6%)	3 (50.0%)
Corneal edema sometimes may persist because of cornea decompensation (despite it being the first episode)	17 (25.0%)	10 (30.3%)	5 (25.0%)	2 (22.2%)	0
Corneal edema sometimes may lag behind the other clinical signs such as IOP, cells, KPs, flare which are more sensitive	10 (14.7%)	5 (15.2%)	0	2 (22.2%)	3 (50.0%)
Decline to answer	3 (4.4%)	1 (3.0)	2 (10.0%)	-	-
Maintenance treatment for an HSV/VZV related viral AU that recurs as SEPARATE EPISODIC BOUTS OF HYPERTENSIVE UVEITIS - (Up to 4 separate episodes per year based on SUN criteria for recurrence) is required					
Starting long term maintenance therapy (PO antivirals +/- topical steroids and IOP lowering drops) if there are 2 or more episodes of hypertensive uveitis per year	35 (51.5%)	18 (54.5%)	10 (50.0%)	4 (44.4%)	3 (50.0%)
Starting long term maintenance therapy (PO antivirals +/- topical steroids and IOP lowering drops) if there are 3 or more episodes of hypertensive uveitis per year	24 (35.3%)	10 (30.3%)	7 (35.0%)	5 (55.6%)	2 (33.3%)
Starting long term maintenance therapy (PO antivirals +/- topical steroids and IOP lowering drops) if there are 4 episodes of hypertensive uveitis per year	5 (7.4%)	2 (6.1%)	2 (10.0%)	0	1 (16.7%)
Disagree and will still aggressively attempt to treat to quiescent and taper off for each episode of hypertensive uveitis	4 (5.9%)	3 (9.1%)	1 (5.0%)	0	0
The most common dosage and duration for INITIAL SYSTEMIC antiviral therapy for HSV viral AU if used: PO valacyclovir 1g BD to TDS for 10-14 days OR PO acyclovir 400-800mg 5x per day for 10-14 days					
Agree with valacyclovir dosage and duration	15 (22.1%)	10 (30.3%)	2 (10.0%)	3 (33.3%)	0
Agree with acyclovir dosage and duration	1 (1.5%)	0	1 (5.0%)	0	0
Agree with both valacyclovir and acyclovir dosage and duration	46 (67.6%)*	20 (60.6%)	14 (70.0%)*	6 (66.7%)*	6 (100%)**
Disagree with both	5 (7.4%)	2 (6.1%)	3 (15.0%)	0	0
Decline to answer	1 (1.5%)	1 (3.0%)	-	-	-
The most common dosage and duration for INITIAL SYSTEMIC antiviral therapy for VZV viral AU if used:					

PO valacyclovir 1g TDS for 10-14 days OR PO acyclovir 800mg 5x per day for 10-14 days					
Agree with valacyclovir dosage and duration	15 (22.1%)	9 (27.3%)	3 (15.0%)	3 (33.3%)	0
Agree with acyclovir dosage and duration	1 (1.5%)	0	1 (5.0%)	0	0
Agree with both valacyclovir and acyclovir dosage and duration	48 (70.6%)*	22 (66.7%)*	14 (70.0%)*	6 (66.7%)*	6 (100%)**
Disagree with both	4 (5.9%)	2 (6.1%)	2 (10.0%)	0	0
Decline to answer	0	-	-	-	-
The most common dosage and duration for INITIAL TOPICAL antiviral therapy for HSV viral AU if used is acyclovir ointment (3%) 5 times a day for 1 month					
Agree with both topical dosage and duration	18 (26.5%)	13 (39.4%)	4 (20.0%)	1 (11.1%)	0
Agree with only the topical dosage but prefer a shorter duration	14 (20.6%)	4 (12.1%)	6 (30.0%)	1 (11.1%)	3 (50.0%)
Agree with only the topical duration but prefer a tapering dosage (i.e. fewer number of times per day)	6 (8.8%)	3 (9.1%)	1 (5.0%)	0	2 (33.3%)
Disagree with both	21 (30.9%)	12 (36.4%)	6 (30.0%)	3 (33.3%)	0
Decline to answer	9 (13.2%)	1 (3.0%)	3 (15.0%)	4 (44.4%)	1 (16.7%)
The most common dosage and duration for INITIAL TOPICAL antiviral therapy for VZV viral AU if used is acyclovir ointment (3%) 5 times a day for 1 month					
Agree with both topical dosage and duration	19 (27.9%)	14 (42.4%)	4 (20.0%)	1 (11.1%)	0
Agree with only the topical dosage but prefer a shorter duration	13 (19.1%)	4 (12.1%)	5 (25.0%)	1 (11.1%)	3 (50.0%)
Agree with only the topical duration but prefer a tapering dosage (i.e. fewer number of times per day)	5 (7.4%)	3 (9.1%)	0	0	2 (33.3%)
Disagree with both	20 (29.4%)	10 (30.3%)	7 (35.0%)	3 (33.3%)	0
Decline to answer	11 (16.2%)	2 (6.1%)	4 (20.0%)	4 (44.4%)	1 (16.7%)
The most common dosage and duration for MAINTENANCE antiviral therapy for HSV viral AU if used is PO valacyclovir 500mg BD to TDS for 3-12 months OR PO acyclovir 200-400mg BD for 3-12 months					
Agree with valacyclovir dosage and duration	13 (19.1%)	9 (27.3%)	2 (10.0%)	2 (22.2%)	0
Agree with acyclovir dosage and duration	9 (13.2%)	4 (12.1%)	3 (15.0%)	0	2 (33.3%)
Agree with both valacyclovir and acyclovir dosage and duration	34 (50.0%)	15 (45.5%)	12 (60.0%)	4 (44.4%)	3 (50.0%)
Disagree with both	11 (16.2%)	5 (15.2%)	2 (10.0%)	3 (33.3%)	1 (16.7%)
Decline to answer	1 (1.5%)	0	1 (5.0%)	0	0
The most common dosage and duration for MAINTENANCE antiviral therapy for VZV viral AU if used is PO valacyclovir 500mg BD to TDS for 3-12 months OR PO acyclovir 400mg BD for 3-12 months					
Agree with valacyclovir dosage and duration	17 (25.0%)	11 (33.3%)	2 (10.0%)	3 (33.3%)	1 (16.7%)
Agree with acyclovir dosage and duration	7 (10.3%)	2 (6.1%)	3 (15.0%)	1 (11.1%)	1 (16.7%)
Agree with both valacyclovir and acyclovir dosage and duration	34 (50.0%)	15 (45.5%)	13 (65.0%)	3 (33.3%)	3 (50.0%)
Disagree with both	7 (10.3%)	3 (9.1%)	1 (5.0%)	2 (22.2%)	1 (16.7%)
Decline to answer	3 (4.4%)	2 (6.1%)	1 (5.0%)	0	0
The use of cycloplegics and mydriatics in HSV/VZV viral AU					
Comfortable with routine use of cycloplegics/mydriatics in cases of HSV/VZV viral AU	28 (41.2%)	17 (51.5%)	6 (30.0%)	4 (44.4%)	1 (16.7%)

Will consider using cycloplegics/mydriatics in cases of HSV/VZV viral AU if necessary (patient has significant AC inflammation, pain etc, although this might be rare)	35 (51.5%)	14 (42.4%)	12 (60.0%)	4 (44.4%)	5 (83.3%)**
Will not use cycloplegics/mydriatics as there is a possibility of permanent mydriasis	5 (7.4%)	2 (6.1%)	2 (10.0%)	1 (11.1%)	0
Decline to answer	0	-	-	-	-

PCR = polymerase chain reaction, HSV = Herpes Simplex Virus, VZV = Varicella-zoster virus, AU = anterior uveitis, USA = United States of America, IOP = intraocular pressure, KPs (Keratic Precipitates), BD = twice a day, TDS = three times a day, PO = per oral

*moderate variation, ** minimal variation

Suppl Table. 2. Global current practice pattern of HSV and VZV AU diagnosis and investigation aspect

Round 1 (n=76)						
No	**Question**	**Sub-questions/answers**	**HSV, commonest response (n,%)**	**Median (IQR)**	**VZV, commonest response (n,%)**	**Median (IQR)**
1	What are the clinical signs that make you suspect a viral AU in the first presentation?*	Unilaterality	Quite specific (n=43, 56%)	3 (1)	Quite specific (n=42, 54%)	3 (1)
		Raised IOP	Quite specific (n=49, 64%)	3 (0)	Quite specific (n=45, 58%)	3 (0)
		Decreased corneal sensation	Quite specific (n=28, 36%)	3 (2)	Quite specific (n=32, 42%)	3 (1)
		Corneal edema	Slightly specific (n=32, 42%)	2 (1)	Slightly specific (n=34, 44%)	2 (1)
		Diffuse KPs	Not specific at all (n=29, 38%)	2 (2)	Not specific at all (n=31, 40%)	2 (2)
		Stellate KPs	Not specific at all (n=36, 47%)	2 (1)	Not specific at all (n=37, 48%)	2 (1)
		Granulomatous KPs	Quite specific (n=25, 32%)	2 (2)	Quite specific (n=27, 35%)	2 (2)
		Anterior synechiae	Not specific at all (n=81, 47%)	1 (0)	Not specific at all (n=81, 47%)	1 (0)
		Posterior synechiae	Not specific at all (n=46, 60%)	1 (1)	Not specific at all (n=44, 57%)	1 (1)
		Absence of synechiae	Not specific at all (n=47, 61%)	1 (1)	Not specific at all (n=51, 66%)	1 (1)
		Iris heterochromia	Not specific at all (n=47, 61%)	1 (1)	Not specific at all (n=48, 62%)	1 (1)
		Iridoplegia	Slightly specific (n=27, 35%)	2 (1)	Quite specific (n=31, 40%)	3 (1)
		Diffuse iris atrophy	Slightly specific (n=32, 42%)	2 (2)	Slightly specific (n=28, 36%)	2 (2)
		Sectoral iris atrophy	Very specific (n=32, 42%)	3 (2)	Very specific (n=34, 44%)	3 (1)
		Engorged iris vessels	Not specific at all (n=38, 49%)	2 (1)	Not specific at all (n=40, 52%)	1 (1)
		Anterior chamber cells	Not specific at all (n=37, 48%)	2 (1)	Not specific at all (n=37, 48%)	2 (1)
		Anterior chamber flare	Not specific at all (n=45, 58%)	1 (1)	Not specific at all (n=45, 58%)	1 (1)
2	Do you think it is important to perform the following when a viral AU is suspected?**	Aqueous tap	Sometimes (n=28, 36%)	3 (1)	Sometimes (n=26, 36%)	3 (1)
		Serology i.e. IgM and IgG	Rarely (n=31, 40%)	2 (2)	Rarely (n=30, 40%)	2 (2)
		Confocal microscopy	Not available at my center (23, 30%)	2 (3)	Not available at my center (23, 30%)	2 (3)
3	Do you perform additional investigations i.e. aqueous tap, serology or confocal microscopy in the presence of classical skin lesions to confirm your diagnosis of a viral AU?	No	49 (64%)	[redacted]	57 (74%)	[redacted]
		Aqueous tap (routine)	17 (22%)		10 (13%)	
		Aqueous tap if atypical features (corneal involvement, lack of iris atrophy)	4 (5%)		3 (4%)	
		Aqueous tap if poor response to treatment	2 (2.5%)		3 (4%)	
		Serology i.e. IgM and IgG	3 (4%)		2 (2.5%)	
		PCR of vesicles or cold sore	1 (1%)		1 (1%)	
		Confocal microscopy	1 (1%)		1 (1%)	
4	What will you send the aqueous tap for?	Multiplex qualitative PCR for various infective causes	56 (73%)	[redacted]	56 (73%)	[redacted]
		Multiplex quantitative PCR for various infective causes	37 (48%)		35 (45%)	

		GWC for intraocular antibodies concurrent with PCR	16 (21%)		16 (21%)	
		GWC for intraocular antibodies if PCR negative	6 (8%)		6 (8%)	
		Microscopy and culture	3 (4%)		2 (2.5%)	
		Drug resistance testing assuming you have a positive initial result	4 (5%)		2 (2.5%)	
5	If you perform qualitative multiplex PCR for various infective causes, is this followed by quantitative PCR where available?	It is not available	27 (35%)		29 (38%)	
		No, I do not use quantitative PCR for my management	21 (27%)		20 (26%)	
		Yes, I send for quantitative PCR	29 (37%)		28 (36%)	
6	In your practice currently, how is the diagnosis of a viral AU clinched – What proportion of your patients (expressed in %) are diagnosed based on:**	Clinical features only (%)		70 (IQR 40 – 90) %		80 (IQR 45 – 90) %
		Clinical features and negative lab test (%)		5 (IQR 0 – 20) %		5 (IQR 0-20) %
		Clinical features and positive lab test (%)		30 (IQR 10 – 50) %		20 (IQR 10-50) %
7	What and how often do you perform blood investigations for your patients maintained on systemic antiviral therapy?	Who takes responsibility for ordering and reviewing these tests[#]	Ophthalmologist (n=70, 91%)		Ophthalmologist (n=70, 91%)[#]	
		How often do you order Complete blood count[##]	Once a year (n=19, 25%)		Once a year (n=18, 23%)[##]	
		How often do you order urea, creatinine and electrolytes[##]	Twice a year (n=23, 30%)		Twice a year (n=23, 30%)[##]	
		How often do you order liver function tests[##]	Ophthalmologist (n=70, 91%)		Twice a year (n=23, 30%)[##]	
8	Do you use endothelial cell count as a surrogate marker for control of infection?	Yes	7 (9%)		5 (6.5%)	
	a. Are other imaging modalities of importance in your follow-up of patients?	Clinical (slit lamp) photo	4 (5%)		5 (6.5%)	
		ASOCT	3 (4%)		3 (4%)	
		Specular	1 (1%)		1 (1%)	
		Confocal microscopy	2 (2.5%)		2 (2.5%)	
		Macular OCT	2 (2.5%)		2 (2.5%)	
		OCT – RNFL ± Visual fields (if glaucoma)	2 (2.5%)		2 (2.5%)	

Round 2 (n=68)

No	Question	Sub-questions/answers	HSV, response (n,%)	VZV, response (n,%)
1	What ADDITIONAL clinical signs will you consider CRITICAL to assist you in	Corneal sensation	Yes (41; 60%) No (24; 35%) Decline to answer (3; 5%)	Yes (41; 60%) No (26; 38%) Decline to answer (1; 2%)

	making a better diagnosis of HSV/VZV-related viral AU at the first presentation of the patient - focus on how SPECIFIC these signs are with respect to the condition?	Corneal oedema	Yes (33; 48%) No (34; 50%) Decline to answer (1; 2%)	Yes (30; 44%) No (35; 51%) Decline to answer (3; 5%)
		Stellate KPs	Yes (28; 41%) No (38; 56%) Decline to answer (2; 3%)	Yes (28; 41%) No (39; 57%) Decline to answer (1; 2%)
		Iridoplegia	Yes (40; 59%) No (28; 41%) Decline to answer (0; 0%)	Yes (-) No (-) Decline to answer (-)
		Sectorial iris atrophy	Yes (52; 76%) No (16; 24%) Decline to answer (0; 0%)	Yes (-) No (-) Decline to answer (-)
		Engorged iris vessels	Yes (7; 10%) No (54; 80%) Decline to answer (7; 10%)	Yes (-) No (-) Decline to answer (-)
		Anterior chamber cells	Yes (34; 50%) No (33; 48%) Decline to answer (1; 2%)	Yes (38; 56%) No (28; 41%) Decline to answer (2; 3%)
2	Will you consider QUANTITATIVE multiplex PCR as an important adjunct, and under what circumstances?	I routinely perform both qualitative and quantitative multiplex PCR for suspected HSV/VZV viral AU cases		16 (23%)
		I do not perform quantitative multiplex PCR because it is not available. If it is available, I will order it as quantitative results are relevant to my management		25 (37%)
		I do not perform quantitative multiplex PCR because it is not useful for my management		24 (35%)
		Decline to answer		3 (5%)

*Coded as 1:Not specific at all, 2:Slightly specific, 3:Quite specific, 4:Very specific
** Coded as: 0"Not available in my center", 1"Never", 2"rarely", 3"Sometimes", 4"Often", 5"All the time",
# Coded as: 1"Myself, the ophthalmologist" 2"Internal medicine specialist" 3"Infectious disease specialist"
Coded as: 0"Never" 1"Once a year" 2"Twice a year" 3"Thrice a year" 4"Four or more times a year"

Suppl Table 3. Global current practice pattern of HSV and VZV AU treatment aspect

Round 1 (n=76)				
No	**Question**	**Sub-questions/answers**	**HSV, commonest response (n,%)**	**VZV, commonest response (n,%)**
1	Do you initiate treatment (nonspecific i.e. anti-inflammatory therapy or specific i.e. antiviral therapy) in the following instances?	PCR/GWC pending or unavailable	Both anti-inflammatory and antiviral treatment (n=66, 87%)	Both anti-inflammatory and antiviral treatment (n=66, 87%)
		PCR/GWC negative	Both anti-inflammatory and antiviral treatment (n=40, 53%)	Both anti-inflammatory and antiviral treatment (n=42, 55%)
2	How do the results from an aqueous tap help you to modify or end treatment? Please select any/all of the following:	I alter my treatment dosages/frequency/duration based on the results of repeated PCR/GWC	18 (23%)	19 (25%)
		I stop treatment only if repeated PCR/GWC is negative	6 (8%)	5 (6%)
		I do not repeat PCR/GWC. I follow up the patient clinically	62 (82%)	61 (80%)
3	What are the clinical endpoints in the treatment of viral AU? Please select any/all of the following:	Resolution of inflammation clinically i.e. cells, flare, KPs	75 (99%)	75 (99%)
		Resolution of raised IOP	59 (78%)	58 (76%)
		Resolution of cornea oedema	52 (68%)	53 (70%)
		Negative results on repeated aqueous tap	6 (8%)	4 (5%)
4	Do you alter your treatment strategy based on clinical presentation?			
	a. Chronic anterior uveitis[#]	No	11 (14%)	9 (12%)
		Yes (not given specifics)	19 (25%)	20 (26%)
		Yes – long term maintenance with oral antivirals ± topical steroids	39 (51%)	34 (44%)
	b. Episodic hypertensive anterior uveitis?[#]	No	7 (9%)	8 (10%)
		Yes (not given specifics)	14 (18%)	14 (18%)
		Yes – maintenance with antivirals	15 (19%)	14 (18%)
		Yes – aggressive topical steroids and IOP lowering agents	14 (18%)	14 (18%)
		Depends upon the frequency: If frequent episodes, then consider maintenance.	11 (14%)	11 (14%)
5	Antiviral related questions	Do you start on antiviral therapy?	Only systemic (n=44, 58%)	Only systemic (46, 60%)
		First-line systemic antiviral	Oral Valacyclovir (n=51, 67%)	Oral Valacyclovir (n=56, 73%)
		First-line topical antiviral	Acyclovir (n=32, 42%)	Acyclovir (n=33, 43%)
		Second-line antiviral therapy assuming no contraindications?	Oral Valcyclovir (n=17, 22%) Oral Acyclovir (n=10, 13%) Famicyclovir (n=8, 9%)	Oral Valcyclovir (n=15, 19%) Oral Acyclovir (n=10, 13%) Famicyclovir (n=9, 12%)
	a. What is your typical dosage and duration of initial topical and/or systemic antiviral therapy?[#]	Oral Acyclovir [10-14 days]	800 mg 5 times a day (n=17, 22%)	800 mg 5 times a day (n=15, 20%)
		Oral Valacyclovir [10-14 days]	1 g BD or TDS (n=38, 49%)	1g TDS (n=52, 68%)

		Topical Acyclovir (3%) [1 month]	5 times a day (n=5, 6.5%)	5 times a day (n=5, 6%)
		Topical gancyclovir (0.15% gel) [1 month]	3 to 4 times a day (n=2, 2.5%)	3 to 4 times a day (n=2, 3%)
	b. What is your typical dosage and duration of maintenance topical and/or systemic antiviral therapy?[#]	Oral acyclovir [3-12 months]	200 to 400 mg 2 times a day (n=1, 30%)	400 mg 2 times a day (n=24, 31%)
		Oral Valacyclovir [3-12 months]	500 mg BD or TDS (n=33, 43%)	500 mg BD of TDS (n=34, 45%)
		Depends upon severity and duration of acute phase	n=5 (6%)	n=5 (6%)
6.	Will you start the following medications in case of a viral AU?			
	a. Topical corticosteroids without antiviral coverage	No	61 (79%)	58 (76%)
		Yes	15 (19%)	18 (23%)
	b. Topical NSAIDs without antiviral coverage (n=73)	No	53 (69%)	53 (69%)
		Yes	20 (26%)	20 (26%)
	c. Cycloplegics/mydriatics	No, it is not required	21 (27%)	20 (26%)
		No, I worry about permanent mydriasis	5 (6.5%)	8 (10%)
		Yes	50 (65%)	48 (63%)
7.	What is your first-line drug for topical anti-inflammatory therapy, assuming no contraindications?			
	a. First line drug:	Steroid	74 (96%)	75 (99%)
		NSAID	2 (4%)	1 (2%)
	b. Name of first line drug:		Prednisolone acetate 1% (n=53, 69%)	Prednisolone acetate 1% (n=52, 69%)
	c. Route of steroid administration (periocular vs. systemic)		No role (n=62, 80%)	No role (n=59, 77%)
	d. IOP lowering agent of choice		Beta blockers (n=61, 79%)	Beta blockers (n=61, 79%)
8	What is your typical dosage and duration of initial topical and/or systemic steroid therapy?[##]	Topical steroid (with antiviral coverage)	Varies from 2-3 hourly to 4 times a day [1-2 weeks]	
9	What is your typical dosage and duration of maintenance topical and/or systemic steroid therapy?[##]	Topical steroid (with antiviral coverage)	Very slow taper till no activity [3-12 months]	
		Oral Steroid	Nil	

Round 2 (n=68)

No	Question	Sub-questions/answers	HSV, response (n,%)	VZV, response (n,%)
1	From the first round of the survey, a significant proportion of experts (68 and	Yes, if significant corneal oedema persists despite no intraocular inflammation and normal IOP, I will continue to treat the patient	38 (56%)	

	69%) also require resolution of corneal oedema as a clinical treatment endpoint for HSV and VZV viral AU, respectively. Do you feel it is NECESSARY for corneal oedema to resolve as a clinical treatment endpoint?	No, corneal edema sometimes may lag behind the other clinical signs such as IOP, cells, KPs, flare, which are more sensitive	0
		No, corneal edema sometimes may persist because of cornea decompensation (despite it being the first episode)	17 (25%)
		Decline to answer	13 (19%)
2	How will you alter your treatment plan for the treatment of an HSV/VZV-related viral AU that recurs as SEPARATE EPISODIC BOUTS OF HYPERTENSIVE UVEITIS - (Up to 4 separate episodes per year based on SUN criteria for recurrence)?	I agree with starting long term maintenance therapy (PO antivirals +/- topical steroids and IOP lowering drops) if there are 2 or more episodes of hypertensive uveitis per year	35 (51%)
		I agree with starting long term maintenance therapy (PO antivirals +/- topical steroids and IOP lowering drops) if there are 3 or more episodes of hypertensive uveitis per year	25 (37%)
		I agree with starting long term maintenance therapy (PO antivirals +/- topical steroids and IOP lowering drops) if there are 4 episodes of hypertensive uveitis per year	5 (7%)
		I disagree and will still aggressively attempt to treat to quiescent and taper off for each episode of hypertensive uveitis	3 (5%)
		Decline to answer	0
3	From the first round of the survey, 96% of experts will use systemic antivirals (valacyclovir most commonly used), of which 40% of them will also use a topical antiviral (acyclovir most commonly used) concurrently. When do you decide topical antiviral is NECESSARY? Please select any of the choices you deem appropriate[a]	I consider adding on topical antivirals only if there is corneal involvement	29 (43%)
		I consider adding on topical antivirals if it is a severe cause of HSV/VZV viral AU (highly inflamed, very high IOP)	9 (13%)
		I consider adding on topical antivirals as a cover to prevent corneal involvement (as topical steroids are used)	12 (18%)
		No, I do not use topical antivirals for HSV/VZV viral AU if systemic antivirals are already used	24 (35%)
4	How do you decide which systemic antiviral therapy to use for HSV or VZV VIRAL AU? Please select any of the choices you deem appropriate[a]	I prefer to use PO Valacyclovir because of its simpler dosing regimen	Yes: 52 (76%) No: 14 (21%) Decline to answer: 2 (3%)
		I prefer to use PO Valacyclovir because it is more efficacious	Yes: 40 (59%) No: 23 (34%) Decline to answer: 5 (7%)
		I prefer to use PO acyclovir because of its lower cost	Yes: 19 (28%) No: 40 (59%) Decline to answer: 9 (13%)
		I prefer to use PO acyclovir because of its larger body of published evidence i.e. HEDS results	Yes: 15 (22%) No: 44 (65%)

				Decline to answer: 9 (13%)
5	From the first round of the survey, the most common dosage and duration for INITIAL SYSTEMIC antiviral therapy for HSV/VZV related viral AU if used is: HSV: PO Valacyclovir 1g BD to TDS for 10-14 days; VZV: PO Valacyclovir 1g TDS for 10-14 days HSV: PO Acyclovir 400-800mg 5x per day for 10-14 days; VZV: PO Acyclovir 800mg 5x per day for 10-14 days OR Do you agree that this will be a GOOD GENERAL GUIDELINE for initial antiviral therapy for the following:	Yes, I agree with Valacyclovir dosage and duration	15 (22%)	15 (22%)
		Yes, I agree with Acyclovir dosage and duration	1 (2%)	1 (2%)
		Yes, I agree with both Valacyclovir and Acyclovir dosage and duration	46 (67%)	48 (70%)
		No, I disagree with both	5 (7%)	4 (6%)
		Decline to answer	1 (2%)	0
6	From the first round of the survey, the most common dosage and duration for INITIAL TOPICAL antiviral therapy for HSV/VZV related viral AU if used is: HSV: Occ acyclovir (3%) 5 times a day for 1 month; VZV: Occ acyclovir (3%) 5 times a day for 1 month Do you agree that this will be a GOOD GENERAL GUIDELINE for initial topical antiviral therapy for HSV/VZV related viral AU?	Yes, I agree with both topical dosage and duration	18 (26%)	19 (28%)
		No, I agree with only the topical dosage but prefer a shorter duration	14 (21%)	13 (19%)
		No, I agree with only the topical duration but prefer a tapering dosage (i.e. fewer times per day)	6 (9%)	5 (7%)
		No, I disagree with both	21 (31%)	20 (30%)
		Decline to answer	9 (13%)	11 (16%)
7	From the first-round survey, the most common dosage and duration for MAINTENANCE antiviral therapy for HSV/VZV related viral AU if used is:	Yes, I agree with Valacyclovir dosage and duration	12 (17%)	17 (25%)

	HSV: PO Valacyclovir 500mg BD to TDS for 3-12 months; VZV : PO Valacyclovir 500mg BD to TDS for 3-12 months HSV : PO acyclovir 200-400mg BD for 3-12 months; VZV : PO acyclovir 400mg BD for 3-12 months Do you agree that this will be a GOOD GENERAL GUIDELINE for maintenance antiviral therapy for HSV/VZV related viral AU?	Yes, I agree with Acyclovir dosage and duration	10 (15%)	7 (10%)
		Yes, I agree with both Valacyclovir and Acyclovir dosage and duration	34 (50%)	34 (50%)
		No, I disagree with both	11 (16%)	7 (10%)
		Decline to answer	1 (2%)	3 (5%)
8	Will you be comfortable starting topical NSAIDs without antiviral coverage for a case you suspect is HSV/VZV related viral AU?	Yes, I am comfortable to start topical NSAIDs without antiviral coverage while results are pending	20 (29%)	
		No, I will not do so and will give empirical topical antiviral coverage if I were to start topical NSAIDs while results are pending	8 (12%)	
		No, I will not do so and will give empirical oral antiviral coverage if I were to start topical NSAIDs while results are pending	7 (10%)	
		No, I will not do so and will give empirical topical + oral antiviral coverage if I were to start topical NSAIDs while results are pending	8 (12%)	
		Decline to answer	25 (37%)	
9	What do you think is a GOOD GENERAL GUIDELINE regarding the use of cycloplegics and mydriatics in HSV/VZV viral AU	I am comfortable with routine use of cycloplegics/mydriatics in cases of HSV/VZV viral AU	28 (41%)	
		I will consider using cycloplegics/mydriatics in cases of HSV/VZV viral AU if necessary (patient has significant AC inflammation, pain, etc., although this might be rare)	35 (52%)	
		I will not use cycloplegics/mydriatics as I worry about the possibility of permanent mydriasis	5 (7%)	
		Decline to answer	0	

*Responses coded as: 1"No treatment", 2"Only antiviral " 3" Only Anti-inflammatory treatment, 4" Both anti-inflammatory and antiviral treatment".
Open-ended question; hence options have been derived from the common themes in the answers.
Open-ended question; hence options have been derived from the common themes in the answers. The majority answered that initiation with steroids under antiviral cover would depend upon the severity of uveitis, and maintenance (i.e. slow taper) therapy will also depend on the severity.
[a]sum total not 68 since some have ticked more than one option.

Suppl Table 4. Global current practice pattern of HSV and VZV AU prognosis (follow-up and complications) aspect

Round 1 (n=76)				
No	**Question**	**Sub-questions/answers**	**HSV, commonest response (n,%)**	**VZV, commonest response (n,%)**
1	How do you define a recurrence? Please comment in terms of duration since last treatment/flare, clinical signs and symptoms etc.* Response for signs of recurrence = cells, raised IOP, KPs, corneal edema (SUN criteria for activity).	1 month	5 (6%)	
		6 weeks	2 (3%)	
		3 months	27 (36%)	
		12 months	1 (1%)	
2	What is the frequency of recurrences before you will consider indefinite therapy?	Antiviral therapy?^	Three times a year (n=24, 32%)	Three times a year (n=22, 29%)
		Steroid therapy?^	Three times a year (n=23, 30%)	Three times a year (n=22, 29%)
		Does performing glaucoma surgery alter the prognosis of the infection?^^	Not sure (n=30, 39%)	Not sure (n=29, 38%)
		If there is recurrence shortly on stopping therapy, what therapeutic approach would you adopt?^^^	Restart initial dosages, longer taper (n=52, 68%)	Restart initial dosages, longer taper (n=52, 68%)
		If the patient stops treatment, when would you restart therapy, and why?[#]	Only when disease activity is noted again (n=64, 83%)	Only when disease activity is noted again (n=65, 86%)
3	How will you adjust anti-inflammatory therapy or antiviral therapy prophylactic treatment prior to and after procedures like cataract or glaucoma surgery?**	None if Quiescent	n=6	n=6
		Topical steroid (duration 2 weeks preop)	4-6 times a day (n=18, 24%)	4-6 times a day (n=18, 24%)
		Oral acyclovir (duration 3-7 days before and 2 weeks following surgery)	400mg BD (n=19, 25%)	400mg BD (n=18, 23%)
		Oral Valacyclovir (duration HSV: 1 week – 10 days preop up to 6 months postop; duration VZV: 1 week – 10 days preop up to 6 months postop)	500 mg BD (n=13, 17%)	500 mg BD (n=13, 17%)
4	If there is evidence of active corneal involvement, how would this alter your therapy?[##]		Almost all respondents believed that topical antivirals should be added to the treatment regimen, though no one mentioned dosage or duration of treatment.	
Round 2 (n=68)				
No	**Question**	**Sub-questions/answers**	**HSV, commonest response (n,%)**	**VZV, commonest response (n,%)**
1	If there is active corneal involvement of an HSV/VZV viral AU patient, titration of topical steroids to the activity/type of keratitis, starting oral antivirals, and referral to a cornea specialist for co-management showed variation in the first-round survey. In general, is it APPROPRIATE TO CONSIDER the following?			
	a. Starting oral antiviral therapy if not already on for the HSV/VZV viral AU	Yes	67 (98%)	
		No	1 (2%)	

	Decline to answer	0
b. Titrating topical steroids to the viral keratitis (i.e. decrease if there is epithelial keratitis but increase if there is stromal keratitis)	Yes	64 (94%)
	No	3 (5%)
	Decline to answer	1 (2%)
c. Referral to a cornea specialist for co-manage	Yes	48 (71%)
	No	19 (28%)
	Decline to answer	1 (2%)

* This was an open-ended question. Only 35 mentioned intervals. Of these, 27 (77%) mentioned 3 months as the time interval of quiescence after withdrawal of previous treatment to call it recurrence.
^ Responses coded as: 0"Never", 1"Once a year", 2 "Twice a year", 3"Three times a year", 4"Four or more times a year".
^^ Responses coded as: 0"Not sure", 1"No", 2"Yes for better", 3"Yes for worse".
^^^ Responses coded as: 1"Restart initial dosages, similar taper", 2"Restart initial dosages, longer taper", 3"Restart initial dosages, indefinite maintenance therapy"
# Responses coded as: 1"Only when disease activity is noted again", 2 “Immediately, even if there are no signs of disease activity"
**This was an open-ended question; hence options have been derived from the common themes in the answers. The majority answered that they would prefer to increase topical steroids and oral antivirals before surgery and continue even after surgery for varied periods
This was an open-ended question without any specific group of answers.