

Reproductive Life Stages and Female Sex-Specific Patterns in Uveitis Activity: Data From the AIDA Network Uveitis Registry



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- **OBJECTIVE OR PURPOSE:** To investigate whether noninfectious uveitis (NIU) activity varies across reproductive life stages (RLS) according to sex.
- **DESIGN:** Observational, retrospective, cross-sectional registry-based study.
- **SUBJECTS, PARTICIPANTS, AND/OR CONTROLS:** The study recruited female patients with NIU (regardless of anatomical location or underlying etiology) as the main study group and male patients as controls to allow sex-based comparisons. They were enrolled in the AIDA Network Uveitis Registry between 2020 and 2025.
- **METHODS, INTERVENTION, OR TESTING:** RLS (prepuberal, early puberty, late puberty, reproductive, perimenopause, and postmenopausal) were approximated using age intervals derived from epidemiological data. Study outcomes were flare frequency, anterior chamber cells (ACC), anterior chamber flare, vitreous haze, new posterior segment inflammatory signs, and immunosuppressive treatment (IST) exposure.
- **RESULTS:** Four hundred twenty-five female and 275 male patients were included. Median (IQR) relapse number in 12 months was 0.8 (1.3) [min 0.0-max 2.0] in prepuberty, 1.0 (2.0) [0.0-5.0] in early puberty, 0.0 (1.0) [0.0-5.0] in late puberty, 0.5 (1.0) [0.0-8.0] in reproductive age, 1.0 (1.0) [0.0-10.0] in perimenopause, and 0.5 (1.0) [0.0-7.5] in post-menopause ($P = .014$). There was a statistically significant interaction between RLS and sex ($P = .044$), with a perimenopausal peak retained only in women. In subjects with active anterior involvement, differences in the distribution of ACC grades among RLS were observed, with a peak in prepuberty and early puberty ($P = .004$). Proportions of subjects receiving IST were higher in prepuberty and puberty than in the remaining RLS ($P = .012$).
- **CONCLUSIONS:** RLS are clinically relevant modifiers of uveitis activity and should guide patient education, risk stratification, and therapy. Early puberty and perimenopause increase relapse risk; pediatric cases show more severe anterior inflammation and require more systemic IST. (Am J Ophthalmol 2026;282: 292–304. © 2025 The Author(s). Published by Elsevier Inc. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>))

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INTRODUCTION

NONINFECTIOUS UVEITIS IS A LEADING CAUSE OF visual morbidity worldwide. Its unpredictable course, characterized by recurrent relapses and chronic inflammation, often results in irreversible ocular damage despite significant therapeutic advances over recent decades. While genetics, autoimmune predisposition, and environmental factors are well-established contributors to its pathogenesis and progression, growing evidence indicates that endocrine and reproductive factors also influence ocular inflammatory activity.¹

This influence is expected to play a critical role in women, given the complexity of the female hormonal milieu throughout life, which includes short-term cyclical variations as well as major changes during puberty, pregnancy, postpartum, lactation, and perimenopause. These reproductive transitions affect immune function through mechanisms that remain only partially understood. Experimental and clinical studies have demonstrated that high concentrations of estrogen and progesterone exert immunosuppressive effects by promoting Th2 polarization and regulatory T-cell activity, while suppressing Th1 and Th17 responses.²⁻⁴ Conversely, hormonal withdrawal phases, such as the late luteal phase, postpartum period or perimenopause, could be linked to inflammatory rebounds, partly driven by declines in sex steroids, cortisol fluctuations, and surges in pro-inflammatory prolactin (Figure 1).^{1,3,5}

Despite these insights, most existing studies are limited to small cohorts, retrospective analyses, or animal models, focusing mainly on specific uveitis types such as human leukocyte antigen (HLA)-B27-associated uveitis or juvenile idiopathic arthritis (JIA)-associated uveitis, and primarily examining disease course during puberty or pregnancy.⁶⁻¹¹ The broader impact of reproductive stages on uveitis activity across sexes and including multiple etiologies has not yet been systematically assessed.

In this context, we utilized the international AIDA Network Uveitis Registry¹² to investigate whether uveitis activity varies across reproductive life stages (RLS) throughout the lifespan, whether disease activity patterns differ between women and men, and whether specific anatomic compartments are disproportionately affected. Our ultimate aim is to identify life stages associated with heightened relapse risk and to inform individualized monitoring and treatment strategies for women with uveitis.

METHODS

This is an observational, retrospective, registry-based study. Patients with noninfectious uveitis were enrolled in the

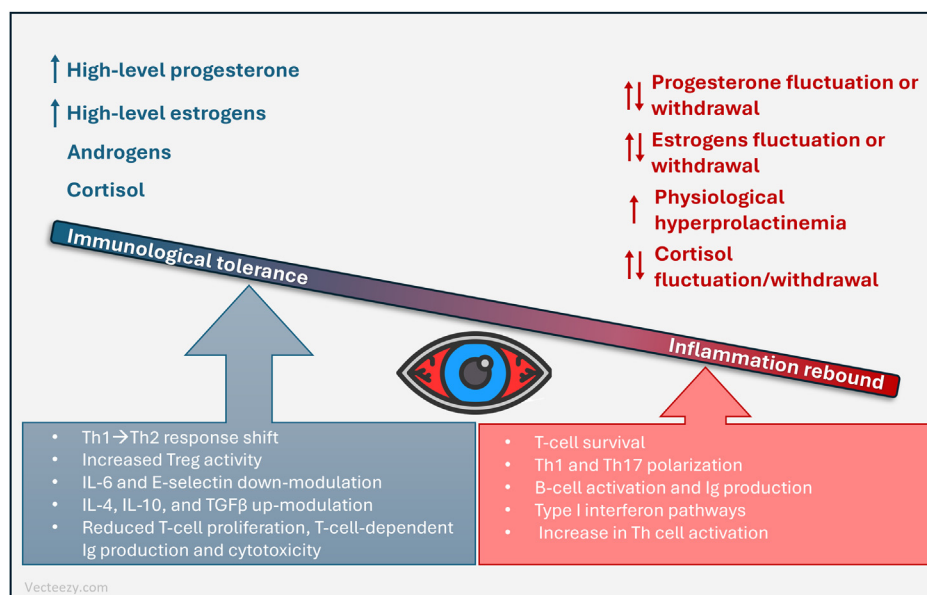


FIGURE 1. A potential interplay between reproductive hormones and the immune system in modulating uveitis course in females. List of abbreviations: Ig = Immunoglobulins; IL = Interleukin; TGF = Transforming Growth Factor; Th = T-helper lymphocytes; Treg = T-regulatory lymphocytes.

AIDA Network Uveitis Registry between 2020 and 2025 by 22 centers from 8 Countries.

The protocol of the AIDA Network registries (ClinicalTrials.gov ID: [NCT05200715](#)) was approved prospectively by the Ethics Committee of Siena University Hospital (Ref. 14951), and by the Ethics Committees of the participating investigator centers. Patients (or their parents/legal guardians) must provide written consent after receiving appropriate information to be eligible for the registry. This study complies with the principles outlined in the Declaration of Helsinki.

• **AIMS AND OUTCOMES:** The primary aim of the study was to assess the association between RLS (prepuberal, early puberty, late puberty, reproductive, perimenopausal, and postmenopausal) and the frequency of uveitis flares in the whole cohort and according to biological sex. The outcome analyzed was the total number of uveitis flares in the last 12 months reported at registry enrolment, as defined by the Standardization of Uveitis Nomenclature (SUN) criteria.¹³

The secondary aim was to evaluate the association between RLS and inflammation severity during disease activity phases in the whole cohort and according to biological sex. Outcomes were identified as follows: anterior chamber cell (ACC) grade (0-4) and anterior chamber flare grade (0-4+) at the evaluation when active anterior or panuveitis were observed according to the SUN criteria¹³; vitreous haze grade (0-4) according to the SUN criteria¹³ and presence of new active disease signs at fundus examination when active intermediate, posterior, or panuveitis were observed.

Exploratory objectives were to describe immunosuppressive treatment (IST) history across RLS and to describe the proportion of female patients with worsened, stable, or improved disease course after menarche, during pregnancy (by trimester), and after menopause.

• **STUDY POPULATION AND REPRODUCTIVE STAGE CLASSIFICATION:** Female patients with a diagnosis of noninfectious uveitis (NIU) (regardless of anatomical location or underlying etiology) were included in the main study group. Male patients were included as a control group to allow sex-based comparisons. For this study, sex was defined with reference to a set of biological attributes associated with physical and physiological features such as chromosomal genotype, hormonal levels, internal and external anatomy as designated at birth. Subjects with a history of gender-affirming hormone therapy were excluded from the study due to the potential impact of immunological effects of the therapy.¹⁴

The definition of RLS refers to the distinct phases in a woman's reproductive lifespan, characterized by physiological and hormonal changes, which influence fertility status and endocrine function. Many potential criteria have been evaluated for defining stage boundaries, including menstrual cycles, hormonal measurements, symptoms, fertility, and ovarian imaging. However, despite significant efforts, accurate staging criteria supporting the classification of women in research are still not available.¹⁵ In this study, in the absence of direct hormonal data, RLS were approximated using age intervals derived from epidemiological data: prepuberal stage <8 years, early puberty from ≥8

to ≤ 12 years, late puberty from > 12 to < 18 years, reproductive stage from ≥ 18 to < 44 years, perimenopause (including late reproductive STRAW stages $-3b$ and $-3a$, early -2 and late -1 menopausal transition stages, and early post-menopause $+1a$ and $+1b$) from ≥ 44 to < 56 years, and post-menopausal stage ≥ 56 years.¹⁵⁻²⁰ These same age intervals were applied to male patients to allow age and sex-based comparisons, acknowledging that male puberty typically begins later and andropause is more gradual and variable than menopause, while keeping the focus on female patients as the main study group.

- **DATA HANDLING AND ANALYSIS:** For the primary analysis (frequency of uveitis flares), only patients with disease duration greater than 12 months at the time of enrolment were included. Stratification by sex was applied. Sensitivity analyses were performed including only patients with disease duration between 1 and 5 years to assess the influence of chronicity and only patients undergoing systemic IST. Flares were recorded separately for each eye over the 12 months preceding enrolment. For patients with unilateral uveitis, the flare count of the affected eye was used as the patient-level value. For bilateral uveitis, because the registry did not indicate whether flares in the 2 eyes occurred simultaneously or as distinct episodes, the mean number of flares between the right and left eyes was used as a conservative estimate of disease activity. This approach aimed at minimizing potential double-counting of synchronous bilateral flares that could otherwise overestimate patient-level inflammatory burden. For the secondary analysis (inflammation severity), inflammation markers from all patients were analyzed using data from the registry visits tied to treatment initiation or escalation due to uveitis activity (onset or relapse). The eye level anatomic class was recorded, including the number of unaffected eyes for descriptive purposes. However, secondary analysis was conducted at the patient level. In cases of bilateral uveitis, the eye with the higher inflammation grade was used for analysis. Patients with no ophthalmological data collected during uveitis activity were excluded.

Treatment exposure was analyzed at the time of enrolment qualitatively (exposed versus non exposed) and only patients with disease duration greater than 12 months were included.

- **STATISTICAL ANALYSIS:** Statistical analysis was conducted in the JASP environment (version 0.19.3.0). Descriptive analysis included counts, frequencies, mean, standard deviation (SD), median, interquartile interval (IQR), minimum and maximum values. The Shapiro-Wilk test was used to assess the normality of data distribution. Associations between categories were analyzed through contingency tables and the chi-squared test. The distributions of nonparametric continuous or ordinal variables across more than 2 groups were compared via the ANOVA Kruskal-Wallis test. Multiple fixed factors were included in the anal-

ysis (ie, sex * reproductive stages) to evaluate interactions in the ANOVA test. Ethnic background was recorded for all participants (Table 1); however, due to the very low representation of nonwhite ethnicities, ethnicity was not included as a fixed factor in the ANOVA Kruskal-Wallis model, as this would have resulted in unreliable group distributions and unstable interaction estimates. Only patients with available data for the outcome of interest were included (complete-case analysis). A P -value $< .05$ was considered statistically significant.

RESULTS

- **DESCRIPTIVES:** The study included 700 patients with noninfectious uveitis (NIU), 425 women and 275 men. Among them, 444 were included in the primary analysis and 429 in the secondary analysis (total 664 evaluations during uveitis activity). Demographic and clinical characteristics of the cohort are reported in Tables 1 and 2. Anterior segment inflammation was observed in 545 patients (77.9%), intermediate or posterior segment involvement in 275 (39.3%). Uveitis was idiopathic in 337 patients (48.1%), while it was associated with a systemic disease in 280 (40.0%) (missing information in 83 cases).

- **PRIMARY ANALYSIS: FREQUENCY OF UVEITIS FLARES:** Four hundred forty-four patients were included in the primary analysis, while 256 were excluded because of disease duration of less than 12 months ($n = 130$), disease duration not available ($n = 47$), or flare frequency data not available ($n = 79$). A baseline comparison of included and excluded patients is available in Table S1. Patients were assessed for registry enrollment after a median disease duration of 4.8 years (IQR 10.0) [min 1.0-max 64.3]. Their median age at enrolment was 37.5 (IQR 38.9) years [min 5.0-max 89.9]. They were classified according to the estimated RLS at the time of enrolment based on their age (Figure 2). The key demographic and clinical features of this subgroup of patients are compared according to RLS in Table 3. A female predominance was observed in the prepuberty, late puberty, and reproductive age groups ($P = .026$). Both median age at disease onset, age at the enrolment, and disease duration were lower in the prepuberty and early puberty groups ($P < .001$).

The median number of relapses in the 12 months preceding the enrolment was 0.5 (IQR 1.0) [min 0.0-max 10.0]; it was 0.8 (1.3) [0.0-2.0] in prepuberal age, 1.0 (2.0) [0.0-5.0] in early puberty, 0.0 (1.0) [0.0-5.0] in late puberty, 0.5 (1.0) [0.0-8.0] in reproductive age, 1.0 (1.0) [0.0-10.0] in perimenopausal age, and 0.5 (1.0) [0.0-7.5] in post-menopausal age ($P = .014$). Additionally, a statistically significant interaction was found between RLS and sex in the ANOVA analysis ($P = .044$). The distribution of relapses number

TABLE 1. Demographic and Clinical Characteristics of the Cohort

Biological Sex	Entire Cohort		Primary Analysis Cohort (Number of Flares)	Secondary Analysis Cohort (Severity of Flares)
	Female	Male		
Patients, n.	425	275	444	429
Ethnicity, n. (%)				
White	274 (64.5)	193 (70.2)	330 (74.3)	244 (56.9)
Hispanic	101 (23.8)	47 (17.1)	64 (14.4)	121 (28.2)
Arab	23 (5.4)	16 (5.8)	23 (5.2)	29 (6.8)
Asian	2 (0.5)	2 (0.7)	2 (0.5)	2 (0.5)
Black	0 (0)	2 (0.7)	2 (0.5)	1 (0.2)
Native American	0 (0)	1 (0.4)	0 (0.0)	1 (0.2)
Other	2 (0.5)	0 (0)	1 (0.2)	2 (0.5)
Missing	23 (5.4)	14 (5.1)	22 (5.0)	29 (6.8)
Age at onset, years Median (IQR)	32.9 (39.1)	30.1 (37.4)	29.0 (35.7)	33.4 (33.8)
[min-max]	[1.4-82.5]	[1.1-86.7]	[1.4-86.7]	[1.1-86.7]
Age at enrolment, years Median (IQR)	38.0 (38.8)	38.9 (38.3)	37.5 (38.9)	38.4 (40.2)
[min-max]	[2.9-89.9]	[1.6-87.9]	[5.0-89.9]	[1.6-89.9]
Systemic disease associated with uveitis, n. (%)	185 (43.5)	95 (34.6)	203 (45.7)	146 (34.0)
Bilateral uveitis, n. (%)	263 (63.2)	153 (56.5)	264 (59.5)	262 (61.1)
Anatomic classes, n. eyes (%)				
Anterior uveitis	399 (46.9)	196 (35.6)	403 (46.0)	328 (38.2)
Intermediate uveitis	54 (6.4)	63 (11.5)	51 (5.7)	87 (10.1)
Panuveitis	161 (18.9)	105 (19.1)	147 (16.6)	217 (25.3)
Posterior uveitis	48 (5.7)	41 (7.5)	70 (7.9)	45 (5.2)
Missing	92 (10.8)	62 (11.3)	100 (11.3)	77 (9.0)
Fellow eyes without uveitis	95 (11.2)	78 (14.2)	105 (11.8)	99 (11.5)
Associated corneal involvement, n. eyes (%)	3 (0.4)	1 (0.2)	3 (0.3)	1 (0.1)
Associated scleral involvement, n. eyes (%)	8 (0.9)	4 (0.7)	9 (1.0)	4 (0.5)
Systemic or regional therapy up to the enrolment, n. (%)	253 (59.5)	155 (56.4)	289 (65.1)	122 (28.4)

across RLS in the entire cohort and split by sex are visualized in [Figure 3](#).

As a sensitivity analysis, number of relapses in the 12 months before enrolment was analyzed according to RLS and sex in the subgroup of patients with disease duration 1 to 5 years ($n = 230$) (Supplemental Figure S1). The median disease duration was 2.4 years (IQR 1.8) [min 1.0-4.9]. The difference in the number of relapses across RLS was not statistically significant in the entire cohort ($P = .105$). However, statistical significance was maintained when considering the interaction of RLS and sex ($P = .044$).

As a sensitivity analysis, number of relapses in the 12 months before enrolment was analyzed according to RLS and sex in the subgroup of patients exposed to systemic immunosuppressive treatment up to the enrolment ($n = 289$) (Supplemental Figure S2). Statistical significance was maintained both in the entire cohort ($P = .027$) and when considering the interaction of RLS and sex ($P = .021$). A sensitivity analysis restricted to female patients ($n = 265$) was conducted to assess the impact of male categorization. Relapse frequency in the 12 months before enrolment showed a similar pattern across RLS as in the primary analysis ($P = .086$) (Supplemental Figure S3).

• **SECONDARY ANALYSIS: INFLAMMATION SEVERITY DURING UVEITIS ACTIVITY:** 429 patients included in the secondary analysis were evaluated by an ophthalmologist during active uveitis phases ($n = 664$ evaluations). Anterior involvement in at least one eye was observed in 546 evaluations (83.0%), intermediate or posterior involvement in at least one eye in 322 (54.0%).

In subjects with anterior involvement, differences in the distribution of both ACC and anterior chamber flare grades among RLS were observed ($P = .004$ and $P = .053$, respectively) ([Figure 4A](#) and [B](#)). Differences in both ACC and anterior chamber flare grades were not maintained when considering the interaction of RLS and sex ($P = .780$ and $P = .122$, respectively).

In subjects with intermediate or posterior involvement, no statistically significant differences were observed in the distribution of vitreous haze grades among RLS both in the entire cohort ($P = .557$) and stratifying by sex ($P = .412$) ([Figure 4C](#)). In addition, no statistically significant differences were observed in the percentage of subjects with new active disease signs at fundus examination both in the entire cohort ($P = .379$) and stratifying by sex ($P = .207$ for the female sex; $P = .440$ for the male sex).

TABLE 2. Uveitis Etiology Breakdown According to Reproductive Life Stages in the Entire Cohort

Uveitis Etiology N. Patients (%)	Prepuberal	Early Puberty	Late Puberty	Reproductive	Perimenopausal	Post-menopausal
Idiopathic	9 (42.9)	43 (55.8)	49 (55.7)	93 (43.9)	59 (45.7)	84 (47.5)
JIA	9 (42.9)	23 (29.9)	30 (34.1)	21 (9.9)	—	—
SpA	—	3 (3.9)	4 (4.6)	28 (13.2)	19 (14.7)	16 (9.0)
IBD	—	—	—	7 (3.3)	5 (3.9)	2 (1.2)
PsA	—	—	1 (1.1)	7 (3.3)	13 (10.1)	4 (2.3)
RA	—	—	—	2 (1.0)	5 (3.9)	6 (3.4)
Sarcoidosis	1 (4.8)	1 (1.3)	1 (1.1)	7 (3.3)	2 (1.6)	11 (6.2)
Iatrogenic	—	—	—	1 (0.5)	4 (3.1)	11 (6.2)
CTD	—	—	—	—	1 (0.8)	5 (2.8)
Behçet's disease	—	—	—	4 (1.9)	1 (0.8)	4 (2.3)
AID	—	—	—	3 (1.4)	2 (1.6)	4 (2.3)
Vasculitis	—	—	—	2 (1.0)	3 (2.3)	7 (4.0)
MS	—	—	—	4 (1.9)	—	—
Oculo-specific clinical entity*	—	5 (6.5)	3 (3.4)	21 (9.9)	11 (8.5)	11 (6.2)
Others	—	1 (1.3)	1 (1.1)	9 (4.3)	5 (3.9)	7 (4.0)
Missing	2 (9.5)	2 (2.6)	1 (1.1)	8 (3.8)	2 (1.6)	6 (3.4)

*Oculo-specific clinical entities included the following: Birdshot chorioretinopathy ($n = 7$), Acute Posterior Multifocal Placoid Pigment Epitheliopathy (APMPPE)/Acute Multifocal Ischemic Choriocapillaritis (AMIC) ($n = 1$), Fuchs' Heterochromic Iridocyclitis ($n = 4$), HLA-B27 associated uveitis (ocular only) ($n = 4$), Vogt-Koyanagi-Harada syndrome ($n = 1$), Multiple Evanescent White Dot Syndrome (MEWDS) ($n = 1$), Ocular ischemic syndrome ($n = 1$), Pars Planitis (Idiopathic intermediate uveitis) ($n = 2$), Punctate Inner Choroidopathy (PIC) ($n = 4$), Serpiginous choroiditis ($n = 2$), Susac Syndrome ($n = 1$), Sympathetic ophthalmia ($n = 1$), Uveitis-glaucoma-hyphema (UGH) syndrome (Ellingson syndrome) ($n = 2$), Vogt-Koyanagi-Harada syndrome ($n = 16$), Not-specified ($n = 4$). List of abbreviations: AID = autoinflammatory diseases; CTD = connective tissue diseases; IBD = inflammatory bowel diseases; JIA = juvenile idiopathic arthritis; MS = multiple sclerosis; PsA = psoriatic arthritis; RA = rheumatoid arthritis; SpA = seronegative Spondylarthritis. Note that each patient may have more than one disease associated with uveitis

TABLE 3. Key Demographic and Clinical Features of Patients Included in the Primary Analysis are Compared According to Reproductive Life Stages

	Prepuberal	Early Puberty	Late Puberty	Reproductive	Perimenopausal	Post-menopausal	P-Value
Patients, n. (%)	12 (2.7)	49 (11.0)	57 (12.8)	132 (29.7)	82 (18.5)	112 (25.2)	—
Female sex, n. (%)	8 (66.7)	23 (47.9)	38 (66.7)	92 (69.7)	43 (52.4)	61 (54.5)	.026
Age at onset, years							
Median (IQR)	3.6 (1.6)	6.9 (3.2)	8.9 (5.5)	25.9 (18.5)	41.3 (10.5)	57.5 (16.9)	<.001
[min-max]	[2.7-5.7]	[2.2-10.6]	[2.0-16.4]	[1.4-41.2]	[4.7-52.7]	[6.1-86.7]	
Age at enrolment, years							
Median (IQR)	6.1 (1.2)	9.7 (2.3)	14.6 (2.3)	33.3 (11.6)	48.5 (6.8)	66.1 (12.0)	<.001
[min-max]	[5.0-7.8]	[8.0-12.0]	[12.1-17.9]	[18.0-43.9]	[44.0-55.9]	[56.1-89.9]	
Disease duration, years							
Median (IQR)	2.0 (0.6)	2.9 (3.1)	5.3 (6.1)	5.8 (10.8)	5.5 (13.2)	5.4 (13.8)	<.001
[min-max]	[1.1-3.5]	[1.0-10.2]	[1.0-13.7]	[1.0-32.9]	[1.1-50.3]	[1.0-64.3]	
Systemic disease associated with uveitis, n. (%)	8 (66.7)	21 (42.9)	25 (43.9)	62 (48.1)	40 (48.8)	47 (42.3)	.634
Bilateral uveitis, n. (%)	9 (75.0)	35 (71.4)	36 (63.2)	77 (58.3)	50 (61.0)	57 (51.0)	.156
Anterior involvement (in at least one eye) n. (%)	12 (100.0)	43 (87.8)	42 (73.7)	103 (78.6)	61 (78.2)	86 (80.4)	.254
Intermediate or posterior involvement (in at least one eye), n. (%)	2 (16.7)	20 (47.6)	22 (45.8)	53 (45.7)	26 (38.2)	35 (39.3)	.381
Systemic or regional therapy up to the enrolment, n. (%)	11 (91.7)	40 (83.3)	45 (80.4)	82 (66.1)	45 (63.4)	66 (62.3)	.012

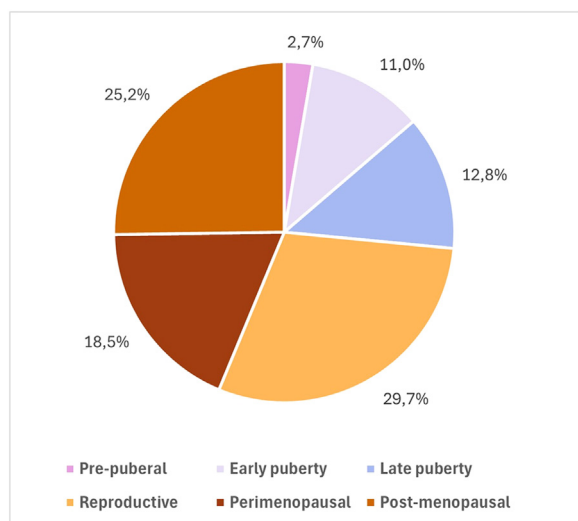


FIGURE 2. Patients included in the primary analysis classified according to the estimated reproductive life stage at the time of enrolment.

• **EXPLORATORY ANALYSIS:** At the time of enrolment, 289 out of 444 patients (65.1%) were exposed to systemic or regional IST. The proportions of subjects who received at least one systemic or regional therapy ($P = .012$), conven-

tional ($P < .001$) or biologic ($P = .002$) disease-modifying anti-rheumatic drugs (DMARDs) were higher in prepubertal and pubertal stages than in the remaining RLS (Figure 5). Table S2 compares the frequency of treatment exposure across RLS in patients with disease duration equal or greater than 12 months and affected by nonsystemic forms of uveitis.

Uveitis onset was reported during pregnancy or soon after delivery in 7 patients (4.5% of female patients with onset during reproductive age). Data on uveitis course patterns were available for 31 patients after menarche, 12 during pregnancy, and 21 after menopause. Given the limited sample size, these data are presented in exploratory form in Table S3.

DISCUSSION

Our results suggest that uveitis activity varies significantly across RLS, with a clear interaction between sex and RLS, underscoring that reproductive biology should not be considered a background variable but an active disease course modifier. Specifically, disease activity peaked at early puberty in both sexes and in the perimenopausal phase in the female group, a pattern that was retained when controlling for disease duration and for systemic IST exposure. The as-

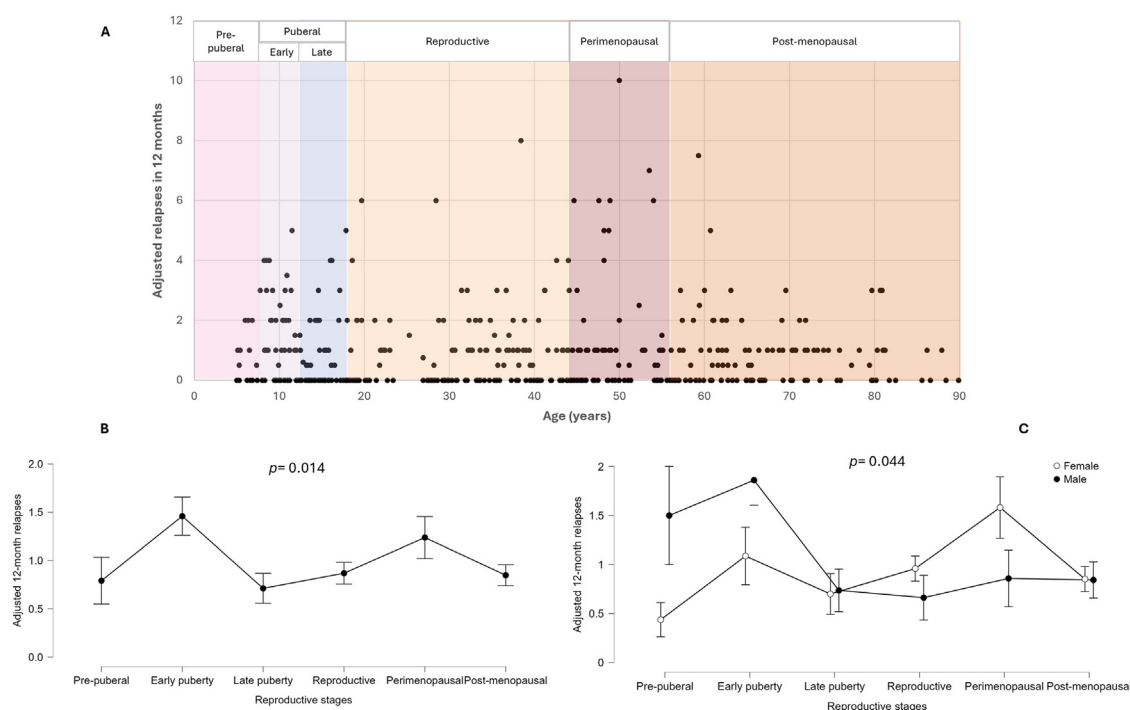


FIGURE 3. Distribution of relapses across reproductive life stages in the entire cohort (A and B) and split by sex (C). Panels B and C show means and standard deviations. The adjusted number of relapses is shown, which means accounting for the laterality of uveitis in each patient: the exact number of relapses in 12 months is shown for unilateral uveitis, the mean number of right and left eye relapses in 12 months for bilateral uveitis.

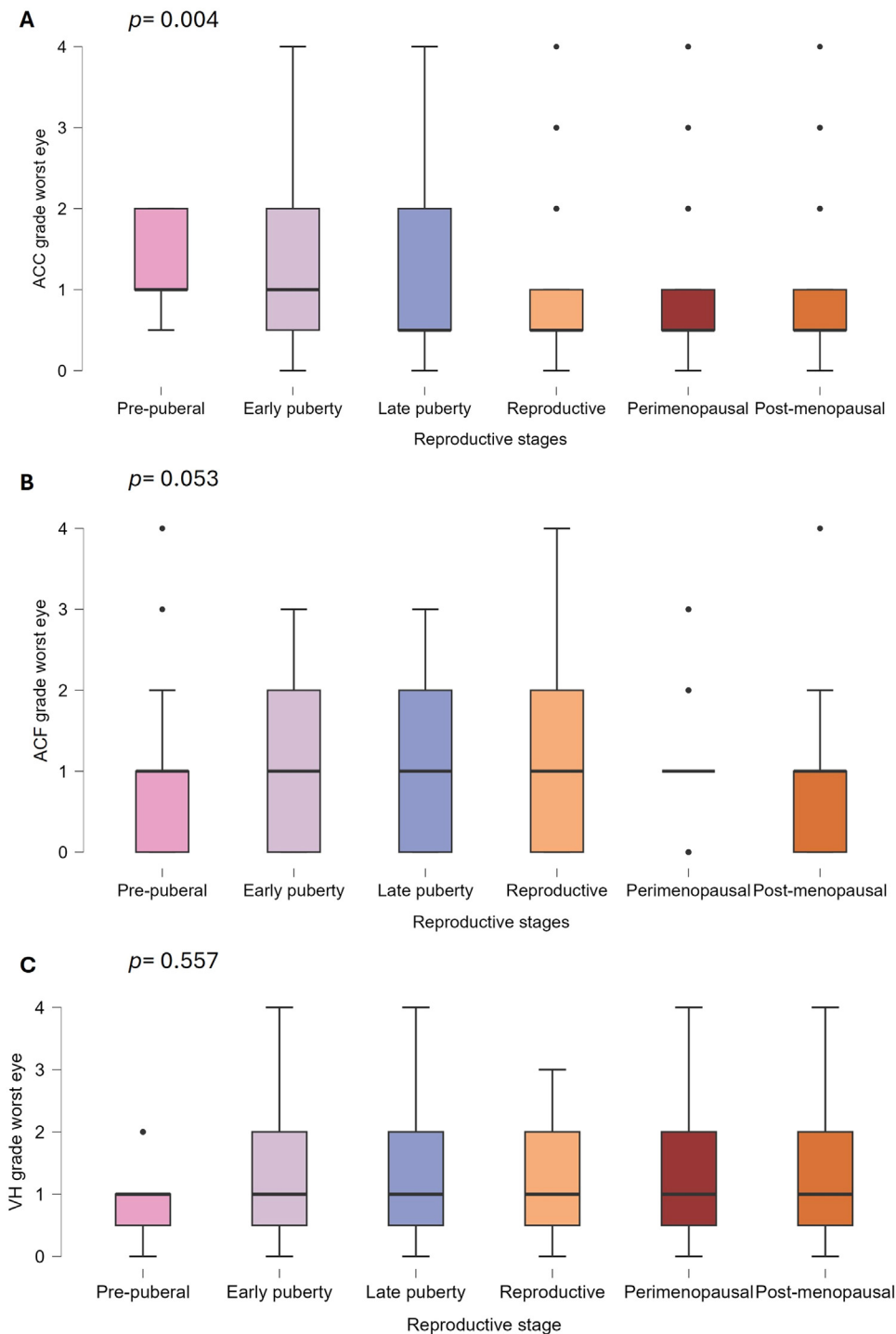


FIGURE 4. Differences in the distribution of anterior chamber cells (ACC) grade (A) and anterior chamber flare (ACF) grade (B) across reproductive life stages in subjects with active anterior involvement. Differences in the distribution of vitreous haze grades (C) across reproductive life stages in subjects with active intermediate or posterior involvement.

sociation was particularly evident in the anterior segment, where ACC and, to a lesser degree, anterior chamber flare grades differed across RLS, whereas vitreous haze grades and new signs of inflammation in the posterior segment were not influenced. Moreover, patients in early pubertal stage re-

quired more advanced IST, aligning with previous evidence that puberty is a critical period of immune dysregulation in uveitis.⁷ It should be noted that RLS categories reflect physiological transitions specific to the female sex, which are not biologically equivalent for the male one. Male pa-

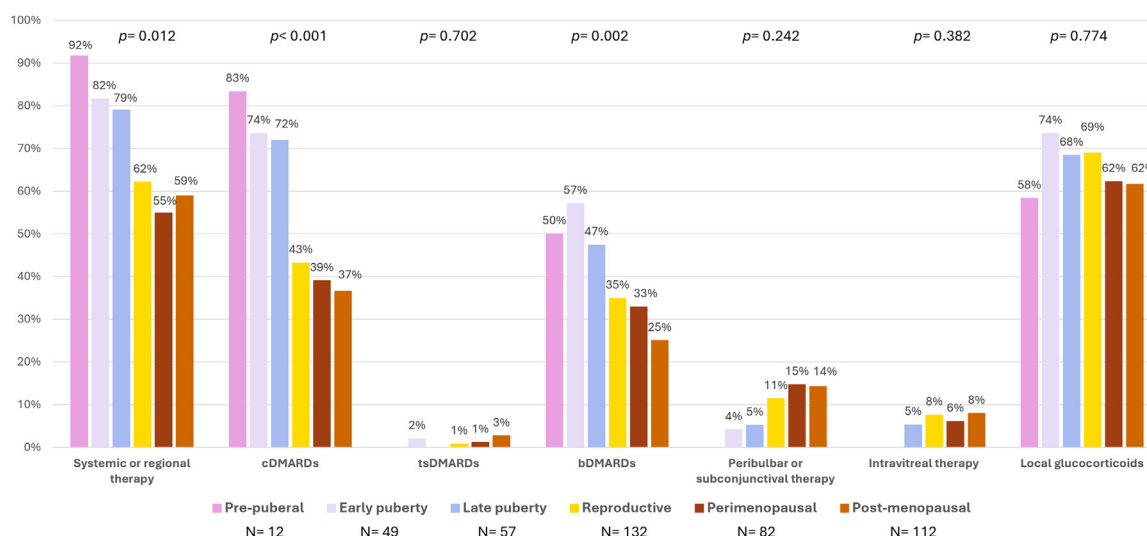


FIGURE 5. Proportions of subjects with disease duration greater than 12 months who received systemic or regional therapies stratified by reproductive life stages. List of abbreviations: bDMARDs = biologic disease-modifying anti-rheumatic drugs; cDMARDs = conventional disease-modifying anti-rheumatic drugs; tsDMARDs = targeted synthetic disease-modifying anti-rheumatic drugs.

tients were assigned to the same age-based groups for analytical consistency, but stage-related patterns observed in men should be interpreted cautiously, as they may not represent true hormonal-based variations of uveitis course.

Our findings of increased disease activity and treatment exposure at early puberty reflect the biphasic course of JIA-associated uveitis, in which disease activity decreases in late childhood but re-emerges around early adolescence,⁷ but also the emergence of specific types of uveitis epidemiologically linked to adolescence and young adulthood such as acute anterior uveitis in HLA-B27+ subjects. It has been demonstrated that pubertal hormonal transitions shape disease onset and activity in other autoimmune diseases, including juvenile systemic lupus erythematosus, JIA, autoimmune thyroid disease, type 1 diabetes, and Sjögren's disease^{3,4,21}; in addition, beyond sex steroids, puberty is accompanied by global immune maturation and sex-specific changes in the abundance of T-cell subsets, monocytes and B-cells, providing a plausible biological framework for these observations.^{4,21}

Although our registry did not capture intra-cycle variations, it could be hypothesized that, within the reproductive stage, short-term hormonal fluctuations can meaningfully alter inflammatory risk, potentially diluting stage-level associations. In this regard, a historical prospective study suggested that acute anterior uveitis attacks cluster in the late luteal phase, although the lack of direct hormonal measurements and the difficulties in identifying the actual "onset" of uveitis flares limited this approach.^{5,22} Another important potential confounder in the reproductive stage analysis is the wide range of uveitis etiologies observed in this period, as shown in Table 2. Reported causes

span from idiopathic disease to ex-JIA, spondyloarthritis, inflammatory bowel disease, psoriatic arthritis, rheumatoid arthritis, sarcoidosis, iatrogenic uveitis, Behçet's disease, autoinflammatory disorders, vasculitides, multiple sclerosis, and other systemic or ocular conditions. Such heterogeneity in underlying disease may influence the natural course of uveitis, affecting both relapse risk and exposure to IST.

Pregnancy and postpartum hormonal variations were difficult to assess in our registry due to very low counts and lack of variables confirming the exact temporal relationship with uveitis flares. Our small pregnancy subset showed a reduction in uveitis activity in the second and third trimesters, in line with prior case series.²³⁻²⁶ Given the limited sample size and retrospective information, these findings should be interpreted cautiously and considered exploratory, warranting confirmation in larger prospective cohorts. Historical studies of experimental autoimmune uveitis in mice demonstrated that pregnancy status suppresses uveitis activity via Th1-Th2 response shift and estrogen-mediated interleukin (IL)-6 and E-selectin downmodulation which reduce anterior cellular infiltration.^{11,27} Progesterone is generally regarded as an immunosuppressive and anti-inflammatory hormone as well, especially at the high concentrations measured in pregnancy. It reduces Th1/Th17 differentiation, T-cell proliferation and T-cell dependent antibody production and cytotoxicity while enhancing Treg activity and IL-10 production, thereby promoting immunological tolerance.^{2,3} On the contrary, the postpartum period was marked by new-onset disease or relapses in a small subset of our cohort, mirroring the well-established flare window within 3 to 4 months postpartum

reported in the literature.^{10,26,28} This rebound could be biologically driven not only by the abrupt withdrawal of estrogens and progesterone, but also the fall in cortisol level and rising proinflammatory prolactin during lactation.¹

In our cohort, uveitis activity across the perimenopausal period appeared variable, with a peak observed in the female sex group and a more stable course in male controls of the same age interval. Data about natural menopause effects on uveitis course are limited, but exogenous hormonal interventions suggest a link with disease activity modulation in previous studies. A large U.S. claims analysis found that female hormonal therapy modestly increased the risk of incident uveitis in peri- and post-menopausal women.²⁹ On the other hand, also aromatase inhibitors, which cause profound estrogen depletion in post-menopausal women treated for estrogen receptor-positive breast cancer, have been repeatedly associated with uveitis and cystoid macular edema.³⁰⁻³² Both in the physiological and pathological contexts, estrogens exert concentration- and tissue-dependent effects on immune regulation, which may contribute to explaining the patterns of uveitis activity across reproductive life.³ As already mentioned, estrogen pharmacological or high concentrations, such as those reached during pregnancy, promote an anti-inflammatory environment. Conversely, at physiological or fluctuating levels, estrogens may have pro-inflammatory properties by stimulating T-cell survival, Th1 and Th17 differentiation, supporting B-cell activation and immunoglobulin production, and enhancing type I interferon pathways.^{1,3} Clinically, this complex spectrum of effects is reflected in the difficulty of correlating specific reproductive life phases with an increased/ decreased risk of uveitis flares.

Our sex and stage interaction, especially in the perimenopausal stage, also likely reflects the protective role of androgens. Testosterone is generally regarded as immunosuppressive, increasing the negative selection of autoreactive thymocytes via Aire upregulation and TGF β production, enhancing Treg activity, promoting Th2 response with IL-4 and IL-10, and attenuating Th1/Th17 responses.^{1,3} Experimental and clinical data suggest that higher androgen levels may protect against autoimmune conditions, though their interactions with genetic background are complex. Interestingly, an early hypothesis proposed a link between HLA-B27 and elevated testosterone levels, potentially explaining the male predominance in acute anterior uveitis despite the broader female bias in noninfectious autoimmune disease.⁶

In our cohort, the distribution of anterior versus intermediate/posterior uveitis showed slight variability across RLS, with a nonsignificant trend toward a higher frequency of anterior involvement in prepubertal patients. Although these differences did not reach statistical significance, a potential impact of anatomical subtype on flare frequency cannot be ruled out. Observed differences in ACC grades across RLS suggest that hormonal transitions may modulate the severity of anterior segment inflammation. This

finding aligns with the well-known association of anterior uveitis, particularly in children and adolescents, with immune-mediated diseases known to be sensitive to hormonal changes, such as early-onset JIA and HLA-B27-related uveitis.¹ In contrast, the lack of significant variation in vitreous haze and active funduscopy findings across RLS in patients with intermediate or posterior involvement may indicate either that posterior segment inflammation is less susceptible to hormonal influence, or that the outcome measures used are less sensitive or more prone to interobserver variability.³³ Additionally, structural changes in the posterior segment may evolve more slowly and may not reflect short-term fluctuations in systemic hormonal states.

Our study has some limitations that should be acknowledged to allow a correct interpretation of the results. The main limitation is the lack of direct hormonal measurements in the registry. The pragmatic use of age-based categories as proxies for RLS may have led to misclassification, particularly during puberty and perimenopause, where substantial inter-individual variability exists, arising from both physiological differences and the potential effects of hormonal therapy. Furthermore, applying female-centric reproductive categories to men for comparative purposes may have obscured meaningful disease trajectories in the male group and potentially introduced spurious trends in the male group. To assess the potential impact of this approach, a sensitivity analysis restricted to women alone was performed, yielding results consistent with the primary analysis. The study primary outcome was based on retrospective cross-sectional recall and assuming that RLS at enrolment reflected the hormonal environment over the preceding year. This approach may have introduced recall bias and variability in documentation availability, potentially leading to imprecise estimation of relapse frequency and reduced sensitivity for detecting differences among RLS. A prospective longitudinal design would better establish a causal inference, but it was not feasible within the AIDA registry, which was launched in 2020. Because the registry lacked information on the timing of bilateral flares, using the per-eye mean for bilateral uveitis was a conservative approach that may have underestimated total disease activity, particularly in groups with a higher proportion of patients with bilateral disease. Moreover, the observed differences between included and excluded patients with regard to flare frequency analysis suggest a possible selection bias toward a patient phenotype characterized by white ethnicity, early-onset uveitis, systemic disease association, absence of intermediate or posterior involvement and undergoing systemic IST, potentially limiting external generalizability; future studies with more complete datasets could be designed in the future to specifically assess the impact of these demographic and clinical factors on disease course and outcomes. Although ethnic variation is known to influence both uveitis phenotypes and reproductive development, ethnicity had to be excluded from the analysis due to

limited representation of minority groups; while it would be possible to categorize participants as white versus nonwhite, such a dichotomization would provide limited insight, as the nonwhite group would remain heterogeneous. Lastly, treatment exposure was a potential confounder which was addressed in sensitivity analysis; however, details on dose, duration, adherence, and temporal relation to flares were not available. Also, the potential impact of certain immunosuppressants on reproductive function, as well as inter-center variability in treatment practices, have not been addressed in this study and should be future research objectives.

Nevertheless, our findings carry important implications for clinical practice by providing a lifespan overview of uveitis trajectories in the female population capable of informing patient management, treatment timing, and follow-up strategies. The observation that disease activity peaks around early puberty, with higher exposure to systemic IST in this age group, highlights the need for closer surveillance and cautious therapeutic planning in adolescents. At this stage, clinicians should account for the dynamic hormonal environment, along with growth-related factors and potential challenges with treatment adherence when balancing efficacy against long-term safety. The sex-specific peak at the perimenopausal stage suggests that women in midlife may represent another at-risk group, warranting proactive monitoring, patient counseling, and timely therapeutic adjustments when hormonal fluctuations precipitate disease reactivation. In our small pregnancy subset, the tendency toward reduced activity during gestation and potential relapses postpartum reinforces the importance of preconception counseling and structured postpartum follow-up to promptly detect and manage disease fluctuations. Taken together, these insights support a model in which RLS function as a clinically relevant modifier of uveitis activity, which should be explicitly integrated into patient education, risk stratification, and individualized treatment planning.

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Data availability: The datasets generated during and/or analyzed during the current study are available from the corresponding author on a reasonable request.

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