Evidence and Consensus Based Imaging Guidelines in Multiple Evanescent White Dot Syndrome Multimodal imaging in Uveitis (MUV) Taskforce Report 6

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• PURPOSE: To develop imaging and consensus-based guidelines on the application of multimodal imaging in multiple evanescent white dot syndrome (MEWDS).

• DESIGN: Consensus agreement guided by literature, and an expert committee using a nominal group technique (NGT).

• METHODS: The expert committee employed a structured NGT with multiple rounds of discussion, conflict resolution, and anonymous voting to: (1) establish imaging criteria for diagnosing and monitoring MEWDS using color fundus photography (CFP), optical coherence tomography (OCT), fundus autofluorescence (FAF), fundus fluorescein angiography (FFA), indocyanine green angiography (ICGA), and OCT angiography (OCTA); and (2) develop consensus-based recommendations for assessing specific characteristics in patients with MEWDS. These formal recommendations were derived from a structured NGT using illustrative cases of MEWDS and were further voted upon by the entire task force.

• RESULTS: The diagnosis of acute MEWDS is supported by distinct multimodal features on CFP, multi-focal disruption of the ellipsoid/interdigitation zone with overlying outer retinal hyper-reflectivity with OCT, and hyperautofluorescent spots with FAF (short-wave blue/green). In complex cases, wreath-like lesions on FFA and the absence of early hypofluorescence on ICGA help differentiate MEWDS from other chorioretinopathies. The lack of specific choroidal changes on OCT and preserved signal on OCTA on retinal and inner choroidal slabs also aid in diagnosis.

• CONCLUSIONS: Multimodal imaging is essential for diagnosing MEWDS and differentiating it from other non-infectious uveitis types, extending the Standardization of Uveitis Nomenclature (SUN) classification. These imaging criteria enable detailed assessment of disease activity and offer valuable insights into MEWDS pathogenesis. (Am J Ophthalmol 2025;278: 191–202. © 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/))

This invited article was submitted as part of the Virtual Special Issue on Multimodal Imaging of Non-Infectious Posterior Uveitis by the The International Uveitis Study Group MUV Working Group.
Accepted for publication June 17, 2025.

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0002-9394/$36.00
https://doi.org/10.1016/j.ajo.2025.06.039

INTRODUCTION

Multiple Evanescent White Dot Syndrome (MEWDS) was first described by Jampol et al in 1984 as a posterior uveitis primarily affecting young women.[1] The incidence of MEWDS is approximately 0.22 per 100,000 people per year. There is no significant racial or ethnic predilection for the disease.[2] MEWDS is characterized by the presence of typically unilateral, 50-200 μm gray-white spots in the outer retina, which can become confluent.[1,3-7] The disease typically resolves spontaneously within about 2 to 3 months, leading to recovery of normal or near-normal visual acuity. Recurrences are possible, though rare.[8] Approximately 95% of patients achieve a visual acuity of 20/25 or better after the acute phase.[1,5,7,9] The precise etiology of MEWDS remains elusive. It is hypothesized that the condition may be linked to a post-viral immune response or auto-inflammatory process, given that approximately half of the affected individuals recall experiencing a flu-like illness prior to onset.[1,5]

To provide a structured approach for diagnosing MEWDS, the Standardization of Uveitis Nomenclature (SUN) Working Group has established specific classification criteria.[9] According to the SUN Working Group, MEWDS can be diagnosed based on the following classification criteria: (1) The presence of multifocal deep retinal gray-white spots with foveal granularity. These lesions are typically unilateral and involve the outer retina; AND (2) characteristic fundus fluorescein angiography (FFA) or optical coherence tomography (OCT) findings showing individual lesions in a "wreath-like" or “bicycle spoke-like” pattern of hyperfluorescence and hyperreflective lesions extending from the retinal pigment epithelium (RPE) into and/or through the ellipsoid zone (EZ) and outer nuclear layer (ONL), respectively; AND (3) absent to mild anterior chamber and vitreous inflammation, distinguishing MEWDS from more aggressive inflammatory conditions. Additionally, conditions such as syphilis and sarcoidosis need to be excluded. The SUN criteria mentioned that the presence of bilateral simultaneous disease onset almost universally excludes MEWDS.

The SUN criteria were primarily developed as classification criteria for clinical research, with the goal of defining a homogeneous patient group by emphasizing specificity over sensitivity. With the broad availability of multimodal imaging (MMI), there is a need to enhance diagnostic accuracy, and develop consensus-driven guidelines for the application and interpretation of MMI in the management of MEWDS. MMI has been widely acknowledged as an invaluable tool for disease differentiation and assessment, underscoring its significance in refining the diagnostic process.[6,7]

The Multimodal Imaging in Uveitis (MUV) task force, an international collaboration, has developed MMI-based criteria to enhance the SUN classification for 5 of the most common conditions previously categorized as 'white dot syndromes.' This manuscript specifically focuses on the MMI criteria for MEWDS.

METHODS

The MUV project initiated by the International Uveitis Study Group (IUSG) aims to establish standardized criteria for using imaging in diagnosing and managing noninfectious posterior uveitis. In MUV, different expert groups were formed, each focusing on a specific disease entity. The consensus process employed a structured Nominal Group Technique (NGT). The study was conducted under the tenets of the Declaration of Helsinki. No clinical information or patient identifiers were shared in this study. The study was granted Institute Review Board (IRB) exemption by the Vanderbilt University Medical Center (IRB #240146).

• **MEWDS COMMITTEE SELECTION:** The MEWDS committee comprised 8 uveitis and medical retina experts with extensive knowledge and strong background in retinal imaging and uveitis. They were selected based on their academic contribution in the field of uveitis, specifically MEWDS, and for their extensive experience in managing related conditions. Each member contributed to various phases of the project, including literature review, case collection, image analysis, group discussions in multiple rounds and consensus voting. Before conducting the study, the subcommittee members performed a thorough review of the published literature.

• **LITERATURE REVIEW AND CASE COLLECTION:** A review of the literature was conducted to identify the characteristic imaging features of MEWDS across multiple modalities. The MEWDS subcommittee agreed to utilize at least 15 illustrative cases to support the development of imaging criteria. Only cases with a confirmed diagnosis of MEWDS were included, and cases had to have a full set of imaging data obtained within 2 to 3 weeks of symptom onset, aligning with the acute phase of the disease. Furthermore, cases with other potential diagnoses, particularly syphilitic posterior placoid chorioretinitis, were excluded to avoid confounding diagnostic features. The images were sourced from the clinical archives of the committee members across the world, providing a diverse and representative sample of MEWDS presentations.

While imaging played a central role in case selection, diagnosis of MEWDS was not based on imaging findings alone. Cases were selected if they met the SUN classification criteria for MEWDS, incorporating clinical features

TABLE 1. Key Research Questions for Standardizing the Diagnostic Process of Multiple Evanescent White Dot Syndrome

1. Can the disease be defined as an entity based on imaging?
2. Discriminatory imaging description of MEWDS, sufficiently differentiating it from other non-infectious posterior uveitic entities.
Color fundus photography
- Optical coherence tomography
- Fundus autofluorescence
- Fluorescein angiography
- Indocyanine green angiography
- Optical coherence tomography angiography
a. Criteria for diagnosis of active disease
b. Key imaging features that exclude the diagnosis
3. Additional information is needed to supplement the diagnosis by Imaging (demographics, laterality, context, course, laboratory testing, among others)
4. Clinical and imaging features of secondary MEWDS

such as mild/absent anterior chamber/vitreous inflammation), imaging ("wreath-like lesions" on FFA), and laboratory features (example: exclusion of syphilis and sarcoidosis). This multidisciplinary confirmation aimed to minimize selection bias. While achieving complete independence from imaging-based diagnostic criteria in MEWDS is limited by the absence of a definitive biomarker, the representative cases were evaluated by full expert subcommittee, minimizing the individual biases of the uveitis specialists.

• **NOMINAL GROUP TECHNIQUE:** The subcommittee followed a structured NGT process to guide the discussions and decision-making. The committee members reviewed the cases with color fundus photographs (CFP), FA, indocyanine green angiography (ICGA), OCT, fundus autofluorescence (FAF), and OCT angiography (OCTA). One subcommittee member acted as a neutral facilitator (MM). The subcommittee members reached a consensus on the diagnostic criteria after proposing specific imaging features for potential inclusion. To facilitate this, 3 rounds of virtual discussions were conducted in a round robin format without interruption, discussion, or criticism. Features that failed to achieve consensus during this preliminary round were re-discussed, with further exploration of their clinical relevance and specific diagnostic value. The discussion was facilitated by a detailed research questionnaire (Table 1) prepared after the initial literature review. Finally, anonymous voting was conducted after the third round of discussions, following the resolution of any remaining conflicts.

• **ESTABLISHMENT OF FINAL CONSENSUS:** The subcommittee members drafted recommendations for using imaging to diagnose and monitor MEWDS. The MUV taskforce (comprising 49 members; Appendix I) from diverse geographical regions and subspecialty training in uveitis-reviewed the draft. The taskforce members assessed the recommendations using an online platform, and any requested modifications were discussed collaboratively among the team members. Using an anonymous online survey system, the taskforce members assessed the recommendations, and any requested modifications were discussed collaboratively among the team members. Finally, a consensus was achieved by all the members of the MUV taskforce defined as follows:

Unanimous consensus: 100% participants agree
Strong consensus: >95% vote
Consensus: 75-95% vote
Majority agreement: >50-75% vote
No consensus: <50% vote (lack of agreement or divided votes)

The percentage thresholds for consensus derived by voting were reported as per the guidelines of various international associations, including Guidelines International Network (GIN),[10] European League Against Rheumatism (EULAR),[11] and Association of Scientific Medical Associations of Germany (AWMF).[12] In case no consensus was achieved (<50% vote), the guidelines were rejected. Study data were collected and managed using REDCap electronic data capture tools hosted at Vanderbilt University Medical Center.[13,14] REDCap (Research Electronic Data Capture) is a secure, web-based software platform designed to support data capture for research studies, providing 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for data integration and interoperability with external sources.

RESULTS

• **MULTIMODAL IMAGING FEATURES OF MEWDS (TABLE 2):**

Color Fundus Photography

On CFP, MEWDS lesions appear as scattered, deep and pale grayish-yellowish-white spots. These spots, range typically from 50-200 µm in size, and are often distributed centrifugally from the posterior pole and can extend beyond the arcades to the midperiphery . The lesions can be centered around the optic disc, macula or around the arcades and can be confluent. Over time, these lesions fade without intervention and may resolve spontaneously within days to weeks. While the overall fundus may appear relatively bland, a granular appearance of the fovea is a significant unilateral finding that requires high-resolution color fundus imaging for proper visualization (Figure 1). Optic disc blurring in the involved eye may sometimes be present.

TABLE 2. Imaging-Based Consensus Guidelines for Multiple Evanescent White Dot Syndrome

Imaging Modality	Consensus Criteria
Color fundus photography	Yellowish-gray/white faint, deep gray/yellow white spots (50-200 μm) Lesions distributed centrifugally from posterior pole to the mid-periphery or centered around the optic nerve/macula Foveal granularity (high-resolution imaging) Healing lesions fade over time
Optical coherence tomography	Hypo-reflective focal EZ/IZ disruption Hyper-reflective "puff balls" or pillars
Fundus autofluorescence*	Hyper-autofluorescent spots (acute phase) Hyper-autofluorescent dots (resolving phase)
Fluorescein angiography	Individual wreath-like, bicycle-spoke lesions (hypofluorescent center surrounded by circular hyperfluorescence) (mid-phase with leakage in late phase)
Indocyanine green angiography	Hypofluorescent lesions, become more prominent from the mid to late phase, may persist even in the very late phase. Dots on spots are seen
Optical coherence tomography angiography	Normal signal at retinal and choriocapillaris slabs

EZ = ellipsoid zone; IZ = Interdigitation zone.
*Short wavelength blue or green fundus autofluorescence

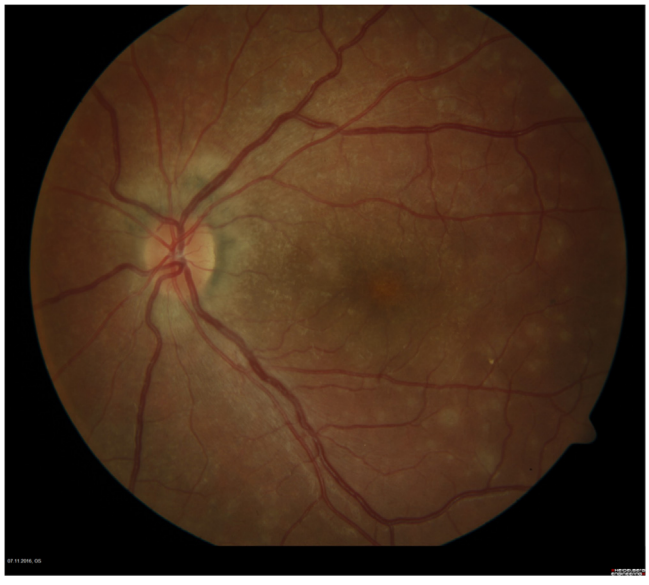

FIGURE 1. Color fundus photograph 1 week after the beginning of symptoms of the left eye reveals faint, discrete scattered white spots and foveal granularity.

Optical Coherence Tomography

OCT in acute MEWDS presents with multifocal alterations and attenuation of the interdigitation zone (IZ) and EZ (Figure 2). The characteristic focal EZ/IZ disruption of decreased reflectivity is often associated with "puff balls" or pillars of hyper-reflective material extending from the EZ to the outer retina. The fovea is often involved. Peripapillary EZ/IZ disruption may also be seen (which correspond to the enlarged blind spot). The external limiting membrane (ELM) may be attenuated or remain intact. Vertical hyper-reflective lines in the fovea can occasionally be identified that extend from the outer retinal bands to the inner retina. OCT does not typically show changes in the retinal pigment epithelium (RPE), choriocapillaris, or choroid. RPE irregularities may be rarely seen in recurrent MEWDS cases. The presence of hyper-reflective foci/cells in the vitreous or peripapillary and macular retinal nerve fiber layer thickening is not specific but may be present. Rarely peripapillary serous retinal elevations can be seen.

En face OCT. The slabs at the level of the EZ and IZ can illustrate a very characteristic pattern of hypo-reflective spots (corresponding to EZ loss) with overlying hyper-reflective dots. The spots (and then the dots) fade and normalize over time without intervention. While OCT B-scans are sufficient to accurately diagnose MEWDS, en face OCT can be helpful in providing additional details and confirming the diagnosis.

Near-infrared reflectance images. These structural en face images are usually provided alongside the OCT B-scans and often reveals "wreath"-like hyporeflective lesions ranging from 50-200 μm in size. These lesions are more likely to be visible during the very acute phase of the disease.

Fundus Autofluorescence

The subcommittee specifically focused on the characteristics of short-wavelength (SW) blue and green FAF (wavelength range: 488 and 530 nm) in MEWDS. FAF is more sensitive than CFP to detect the characteristic MEWDS

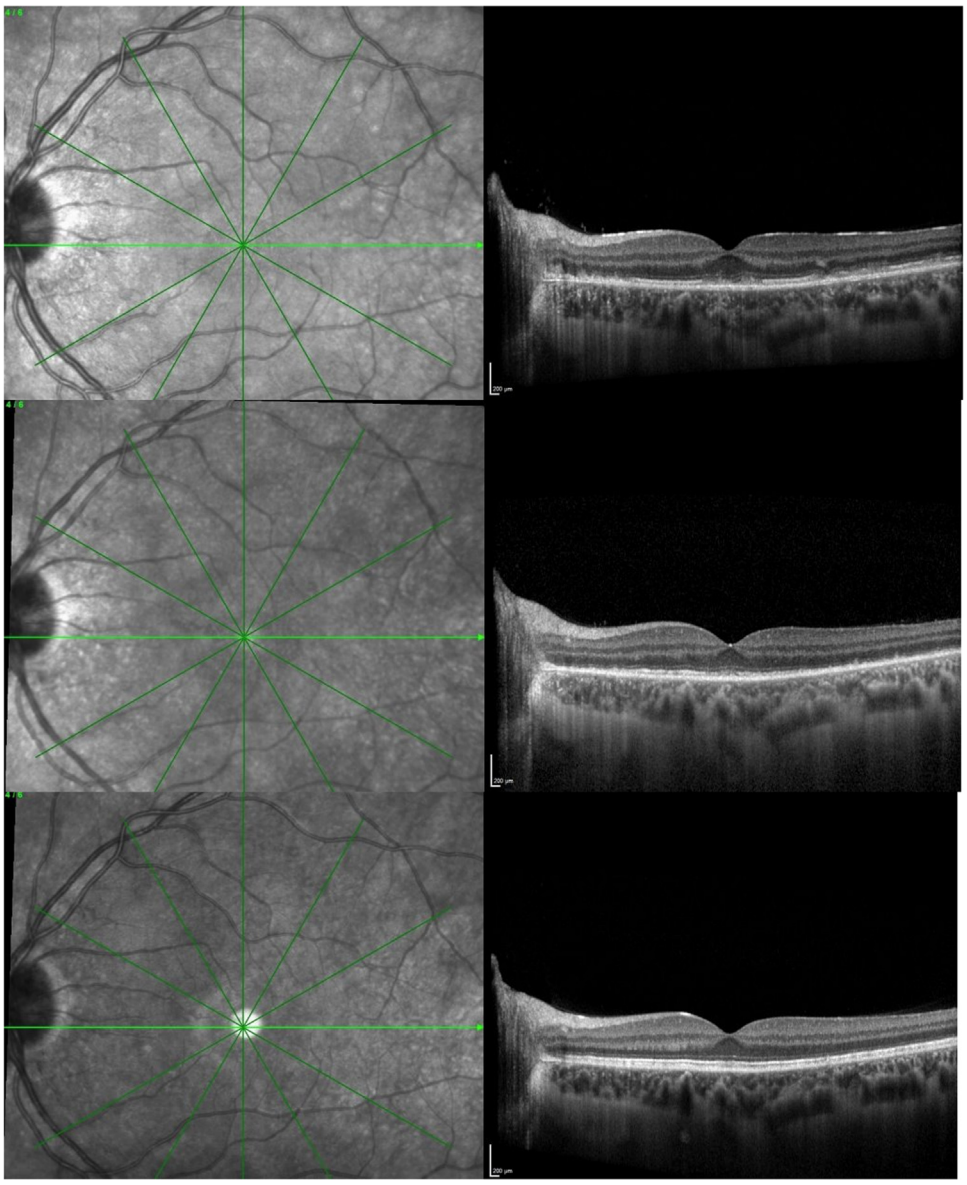

FIGURE 2. First presentation (top), 2 weeks (middle), 6 weeks (bottom): OCT from the first visit after 1 week of symptoms demonstrates disruption of the Ellipsoid zone/Inner zone (EZ/IZ). The changes fade over time (middle, bottom).

spots but in the very early stage can still be unremarkable and noncontributory. In the acute phase of MEWDS, characteristic hyper-FAF punctate spots of varying intensity with overlying hyper-FAF dots can be identified. A characteristic wreath-like (or rarely a bicycle spoke-like) pattern, commonly observed on FFA, can sometimes also be detected on FAF. These spots range from 50-200 μm in size and typically scatter centrifugally from the posterior pole (Figure 3A) and can extend beyond the arcades into the mid-periphery (Figure 3B). During the resolution phase, the hyper-FAF lesions resolve (spot resolution is followed by resolution of the dots). Hypo-FAF lesions are very atypical for primary MEWDS. Well-defined hypo-FAF corresponding to chorioretinal lesions should prompt consideration of other masquerade conditions or secondary MEWDS and are a relative exclusion criterion for primary MEWDS. The findings described are characteristic for short-wave blue FAF and may vary in presentation in respect to exact excitation wavelength, filters, and other settings. FAF is more sensitive than CFP to detect the characteristic MEWDS spots.

Fundus Fluorescein Angiography

In the early imaging frames of FFA, MEWDS changes are subtle, but the characteristic lesions become visible in the mid-phase. Late imaging frames may show leakage from the retinal lesions. Each individual wreath-like, bicycle-spoke lesion features a hypofluorescent center surrounded by cir-

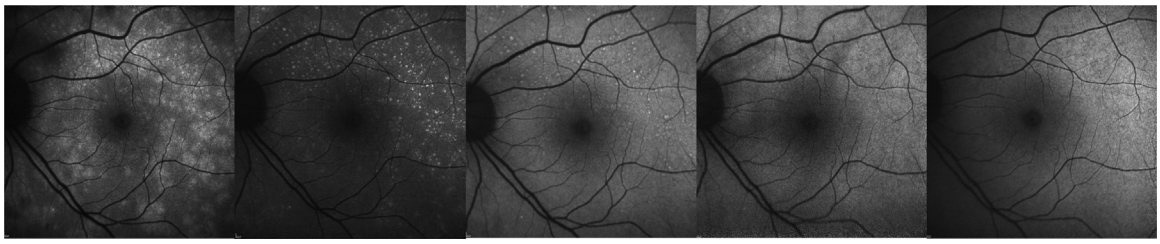

FIGURE 3A. (Baseline, 2 weeks, 6 weeks, 3 months): Fundus autofluorescence (FAF) from initial presentation showing the hyper-autofluorescent (hyperFAF) spots in a wreath-like pattern at the posterior pole. Over time, only the smaller hyperFAF dots are visible, which then also gradually fade over time.

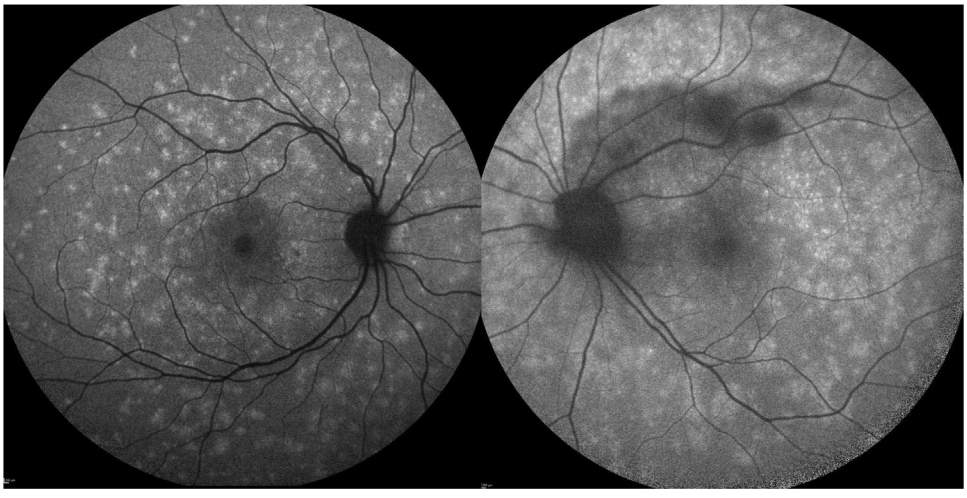

FIGURE 3B. (Baseline): Fundus autofluorescence (FAF) of 2 other cases showing the individual hyper-autofluorescent spots in a wreath-like pattern spreading beyond the arcades to the midperiphery.

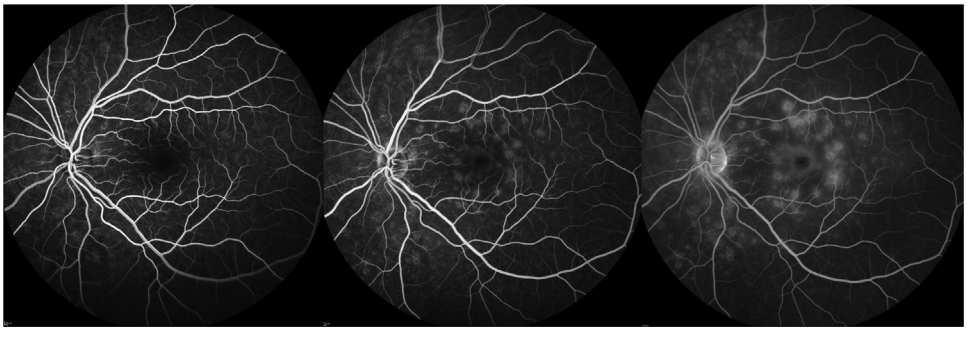

FIGURE 4A. (Early, mid, late): Fundus fluorescein angiogram (FFA) from baseline visit showing characteristic wreath-like lesions with hypofluorescent centers and hyperfluorescent borders in the mid-phase and leakage of lesions in the late-phase.

cular hyperfluorescence that can be composed of a dot like cluster, a highly distinctive appearance (Figure 4A). Optic nerve staining and focal or segmental vasculitis (periphlebitis) may also be observed, although these are not specific signs (Figure 4B).

Indocyanine Green Angiography

The early phase ICGA is typically normal in MEWDS. Prominent hypofluorescent lesions in early ICGA frames due to choriocapillaris (CC) non-perfusion is a typical feature of placoid chorioretinopathies and excludes MEWDS.

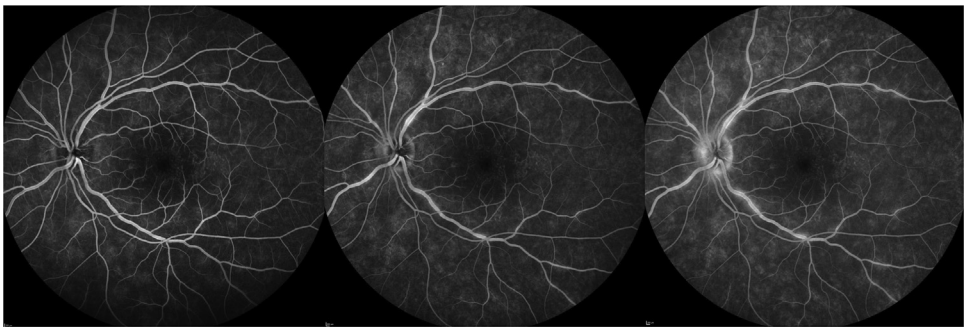

FIGURE 4B. (Early, mid, late): Fundus fluorescein angiogram (FFA) showing optic nerve staining and segmental vasculitis in the mid and late phase.

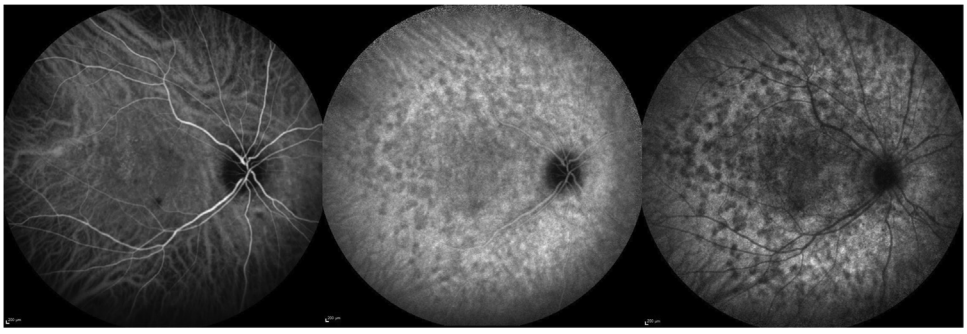

FIGURE 5. (Early, mid, late): Indocyanine green angiography (ICGA) reveals subtle changes in the early phase (left), and scattered hypofluorescent spots in the mid phase (middle) that persisted into the late-phase (right).

During the mid- to late-phase, hypofluorescent lesions are clearly visible and spread centrifugally from the posterior pole and can extend beyond the arcades into midperiphery. On some ICGA imaging devices, the characteristic dots on spots can be identified. The darker smaller dots correspond to the hyper-reflective puff balls or pillars captured OCT, while the larger hypofluorescent spots correspond to the hypo-reflectivity and disruption of the EZ/IZ. The hypofluorescent lesions may persist even in the very late phase (after 20 minutes) (Figure 5). This persistence can help to differentiate MEWDS from conditions like Vogt-Koyanagi-Harada disease and sarcoid choroiditis, where the choroidal lesions (i.e. granulomas) fade away in the late phase.

Optical Coherence Tomography Angiography

OCTA is an optional image modality in MEWDS. It typically shows no significant decrease in the OCTA signal within the retinal or CC slabs. However, OCTA can be useful to exclude MEWDS from the differential list. A significant reduction in OCTA signal at the CC level, can serve as an exclusion criterion, as it is more indicative of placoid-type entities.

• **CONSENSUS-BASED RECOMMENDATIONS:** The details of the recommendations drafted by the MEWDS subcommittee and reviewed by the MUV taskforce is presented in Table 3. The table also provides the strength of the consensus. In addition, the subcommittee discussion on secondary MEWDS (cases where MEWDS-like features occur in association with another primary condition) has also been elucidated in Table 3.

DISCUSSION

The development of standardized MMI criteria for MEWDS as part of the MUV project represents a significant advancement in the diagnosis and management of this complex ocular condition. The consensus-driven approach, leveraging the expertise of the IUSG, results in robust criteria designed to enhance diagnostic accuracy. Our exclusion criteria correspond closely with existing literature on MEWDS, reflecting the classification outlined by the SUN criteria.[9] Specifically, minimal to absent anterior chamber and vitreous inflammation are important criteria. Positive serologic tests for syphilis (via treponemal testing) and evidence of sarcoidosis are additional exclusion factors. The SUN classification lists simultaneous bilateral MEWDS as an exclusion criterion, but our expert group did not emphasize this, focusing instead on imaging characteristics over broader clinical presentations. Reports

TABLE 3. Consensus-Based Guidelines for Imaging in Multiple Evanescent White Dot Syndrome[a]

No.	Guidelines	Strength of Consensus
1	CFP to document the pattern and location of lesions in MEWDS ***(consensus)***	94.7%
2.	High-resolution CFP to determine the presence of foveal granularity in active MEWDS ***(consensus)***	81.6%
3.	OCT to diagnose active MEWDS on the basis of outer photoreceptor layer changes ***(unanimous consensus)***	100%
4.	OCT to exclude active MEWDS in the presence of significant choroidal involvement ***(consensus)***	92.1%
5.	FAF (including ultra-wide field) in diagnosing MEWDS while being mindful of the variability of FAF wavelengths ***(strong consensus)***	97.4%
6.	FFA to document the distinctive individual wreath-like lesions in the mid-phase of active MEWDS ***(consensus)***	89.5%
7.	ICGA to differentiate MEWDS from other non-infectious posterior uveitis in diagnostic challenges ***(consensus)***	81.6%
8.	OCTA in documenting normal flow signal in the retinal and choriocapillaris slab in active MEWDS ***(consensus)***	84.2%
9.	OCT and FAF in the serial follow-up of MEWDS ***(strong consensus)***	97.4%

CFP = color fundus photography; FA = fluorescein angiography; FAF = fundus autofluorescence; ICGA = indocyanine green angiography; MEWDS = multiple evanescent white dot syndrome; OCT = optical coherence tomography; OCTA = optical coherence tomography angiography.
[a]The 7 members of the expert subcommittee did not cast their votes.

of bilateral MEWDS suggest this feature alone does not preclude diagnosis, although bilaterality is very atypical of MEWDS and should raise suspicions of masquerade or secondary conditions.[15,16] Additionally, we found that primary MEWDS mainly affects the outer retina, with overt RPE involvement occurring rarely and only in recurrent cases. This differs from the SUN classification, which describes MEWDS lesions as involving the RPE, the outer retina, or both.[9]

In our analysis, we placed considerable emphasis on MMI characteristics, further refining features for each modality. For example, we specified that in FA, each wreath-like, bicycle-spoke like lesion presents with a hypofluorescent center encircled by a ring of hyperfluorescence (that can have a dot-like quality) – an appearance highly indicative of MEWDS. In addition, we reached a consensus that prominent hypofluorescent lesions in early ICGA frames and significant OCTA signal reduction in the CC slabs indicate substantial CC non-perfusion, a feature typical of placoid chorioretinopathies but not MEWDS. While some reports suggest variability in choroidal non-perfusion in MEWDS, especially in severe cases,[17,18] most literature supports our consensus that CC non-perfusion is an exclusion criterion for MEWDS.[19]

One of the primary challenges faced by the committee was the inherent variability in imaging findings associated with MEWDS. While MEWDS presents with inherent clinical and imaging variability, the consensus-based imaging criteria aim to standardize diagnostic interpretation across the majority of clinical scenarios, while recognizing that clinical judgment remains essential in atypical cases.[3,7] For instance, the appearance of hyper-FAF spots can vary depending on the imaging system used e.g. short wave-length blue (FAF) or short wave green, which led to initial disagreements within the committee regarding the inclusion of certain findings as mandatory diagnostic criteria.[20] The MUV subcommittees used the NGT technique, enabling anonymous voting and iterative discussions that encouraged diverse opinions and consensus on contentious issues. For instance, there was significant debate over the mandatory use of ICGA in atypical MEWDS cases. Some committee members highlighted the role of ICGA in differentiating MEWDS from other conditions such as placoid chorioretinitis.[21] The expert group agreed that ICGA generally shows subtle or no changes in the early phase, while the literature describes early to mid-phase hypofluorescence in MEWDS.[5,7,9] Ultimately, ICGA was included as an additional imaging modality in specific clinical scenarios.

A notable aspect of the study is that the subcommittee did not specifically include ultra-wide field (UWF) imaging in the consensus criteria. UWF imaging has become an important modality for detecting peripheral retinal changes in various uveitic conditions and may hold potential in MEWDS. Some studies suggest that MEWDS lesions may be more readily visualized with UWF imaging, which could enhance diagnostic sensitivity.[22] However, the primary aim of this project was to establish standardized imaging criteria based on widely available modalities across global clinical settings. Since our study focused primarily on building evidence-based consensus for using imaging to diagnose and monitor MEWDS, we relied on broad features of OCT, FAF, FFA, ICGA and OCTA for various entities. Incorporation of UWF imaging is an important future direction,

and prospective studies validating its added diagnostic value in MEWDS are warranted.

Our proposed imaging criteria were developed with primary MEWDS as the central focus. In contrast, secondary MEWDS, marked by MEWDS-like lesions associated with underlying conditions such as PIC, MFC, neovascular AMD, or, more rarely, other diseases affecting the choriocapillaris-Bruch's membrane–RPE complex, presents additional diagnostic challenges that cannot be fully resolved through imaging features alone.[16,23] Moreover, conditions such as vitreoretinal lymphoma can masquerade as MEWDS.[24] There was no consensus on whether an initial chorioretinal scar should exclude a primary MEWDS diagnosis. The experts agreed that secondary MEWDS is a relatively new concept that requires more evidence, and further studies are necessary before definitive MMI recommendations can be made. Future studies aimed at defining specific imaging differences between primary and secondary MEWDS are needed to refine diagnostic accuracy further.

The strength of this paper lies in its comprehensive approach to defining imaging criteria for non-infectious posterior uveitis in a standardized, broadly applicable manner, rather than focusing on a single disease. Leading retina and uveitis imaging specialists from around the world contributed to this project, employing rigorous methodologies and NGT within expert groups. The structured consensus process, including NGT techniques, created a solid framework for conflict resolution and ensured the criteria reflect broad expert agreement.

Despite these strengths, there are limitations to the proposed criteria that must be acknowledged. Although the imaging criteria outlined here facilitate the accurate diagnosis of MEWDS, the expert discussions clearly indicated that imaging alone is often insufficient for confirming the diagnosis. Regional and ethnical differences in prevalence and presentation may occur. Our study did not include experts from all geographic areas. In some regions of the world, clinical presentations may differ, with features like foveal granularity appearing less commonly. Clinical characteristics and supplementary diagnostic information beyond imaging are also essential to ensure an accurate diagnosis. Given these limitations, there is a clear need for further validation of the proposed criteria. Future studies are essential to validate the proposed criteria across broader posterior uveitis cohorts. Such validation should assess sensitivity, specificity, true positive, true negative and inter-rater reliability, ideally through prospective multicenter studies. Moreover, leveraging machine learning techniques, as successfully applied in the SUN project, could further enhance the robustness and generalizability of MEWDS imaging criteria.

The development of standardized imaging criteria for MEWDS marks a major advancement in the diagnosis and management of this complex condition. Created through a rigorous consensus process, these criteria offer a comprehensive and adaptable framework that can be applied worldwide. This standardization enhances patient care for MEWDS and supports progress in the broader field of uveitis management.

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APPENDIX I

All members of the task force provided input and full list is included in Appendix below

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Funding/Support: The open access publication of this article was supported by Optos Inc. The funder had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript. *Financial disclosures:* The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Marion Munk reports a relationship with AbbVie Inc that includes: consulting or advisory. Marion Munk reports a relationship with Alcon Laboratories Inc that includes: consulting or advisory. Marion Munk reports a relationship with Alimera Sciences Inc that includes: consulting or advisory. Marion Munk reports a relationship with Allergan Irvine that includes: consulting or advisory. Marion Munk reports a relationship with Apellis Pharmaceuticals, Inc that includes: consulting or advisory. Marion Munk reports a relationship with Avecida that includes: consulting or advisory. 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