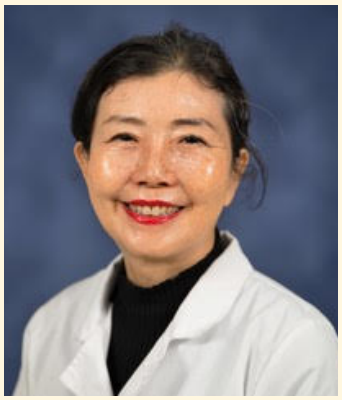
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Seasonal Hyperacute Panuveitis (SHAPU) With Adjunctive Acupuncture and Moxibustion: A Case Report

By Kyung Shin, DAOM, LAc and Catherine Vasco, DAOM, LAc

Abstract

Seasonal hyperacute panuveitis (SHAPU) is a rare, fulminant ocular inflammatory condition endemic to Nepal. Severe cases often result in rapid retinal destruction or blindness, even with vitrectomy and antimicrobial therapy.

This report presents the first documented use of acupuncture and warming-needle moxibustion as adjunctive therapy in acute SHAPU management. An 8-year-old female with late-stage SHAPU of the right eye underwent diagnostic B-scan, which revealed dense intraocular exudate and early retinal instability. Despite urgent pars plana vitrectomy, significant edema and persistent exudates remained, and vision was limited to light perception.

The patient subsequently received five acupuncture sessions over four days (October 8–11, 2025), targeting periocular points—UB1 (Jingming), Taiyang, ST1 (Chengqi), and UB2 (Zanzhu)—with warming-needle moxibustion. After the initial treatment, lid edema decreased, the eye opened spontaneously, and visual acuity improved from light perception to finger movement recognition; she was later able to count fingers.

A repeat B-scan on October 12 confirmed near-complete clearance of vitreous exudates and a fully attached retina. However, a B-scan performed approximately 44 hours after treatment cessation revealed new retinal detachment with recurrent vitreous hyperreflective material. This case suggests that adjunctive acupuncture and warming moxibustion may facilitate rapid exudate clearance and symptomatic improvement in severe SHAPU.

Keywords: Seasonal hyperacute panuveitis (SHAPU); eye inflammation; acupuncture; moxibustion; integrative ophthalmology; Nepal.

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Introduction

Seasonal hyperacute panuveitis (SHAPU) is a rare inflammatory syndrome first described in Nepal in 1975. It occurs almost exclusively in Nepalese children and is seen in cyclical, post-monsoon outbreaks (Upadhyay et al., 2018; Byanju et al., 2003; Manandhar, 2011). The cause of SHAPU is yet unclear. Proposed mechanisms include hypersensitivity to Tussock moth (Euproctis spp.) hairs, toxin-mediated inflammation, and environmental-triggered immune dysregulation (Manandhar et al., 2018). SHAPU is marked by sudden, severe conjunctival congestion, dense vitritis, hypopyon, and rapid visual loss. Although often described as painless, newer reports show patients can have moderate-to-severe pain even without systemic illness. Standard therapy generally includes intravitreal antimicrobials, corticosteroids, and pars plana vitrectomy (PPV) to clear the vitreous opacity. Dense exudate that obscures the posterior segment warrants this surgery. Despite aggressive care, many patients still lose vision. Late-presenting cases often progress to irreparable retinal detachment, macular damage, or atrophic shrinkage, known as phthisis bulbi (Upadhyay et al., 2018).

To date, no published studies have evaluated acupuncture or moxibustion as adjunctive therapies for SHAPU. This case report documents the first application of periocular acupuncture and warming-needle moxibustion in conjunction with conventional ophthalmic care, specifically targeting inflammatory exudates that frequently remain despite standard treatment.

Case Description

An 8-year-old female from Pokhara, Nepal, presented to the Himalaya Eye Hospital with an acute onset of right eye redness, leukocoria, and profound visual loss. The clinical picture was consistent with late-stage seasonal hyperacute panuveitis (SHAPU).

History of Present Illness

At first examination, the patient had severe conjunctival congestion, dense vitritis, heavy purulent exudate, and marked eyelid swelling. Visual acuity was reduced to light perception (LP). A B-scan ultrasound on October 5, 2025, showed heavy intraocular exudate and early signs of inferior retinal instability. The patient underwent urgent pars plana vitrectomy the same day. Surgeons found thick, "cottage cheese–like" exudates in the vitreous cavity.

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Table 1. Comparative B-scan and Clinical Findings				
Feature	10/5/2025 Pre-acupuncture	10/12/2025 Post acupuncture	10/13/2025 Early detachment	Key Interpretation
Vitreous Echoes	Dense echoes with marked vitritis	Echoes markedly reduced; vitreous clearer	Persistent vitreous hyperreflective material	Vitritis improved rapidly during acupuncture but was not fully cleared, leaving persistent material.
Retina	Unstable, no detachment visible on B-scan	Attached and stable	Early retinal detachment	Detachment appeared only after acupuncture treatment was discontinued.
Anterior Chamber	Hypopyon present	No hypopyon	No hypopyon	Anterior chamber inflammation resolved quickly (likely due to systemic treatment) and did not recur.
Optic Disc Signal	Obscured	Partially visible	Partially obscured	Media clarity improved due to vitreous exudate clearing.
Vision	Light perception only (LP)	Finger-movement vision (Hand Motion/FC)	Temporal finger-counting vision	Partial temporal vision is preserved, likely related to earlier functional recovery observed during the acupuncture period.

Table 1. B-scan sequence (10/5/25 - 10/13/25). (a) Pre-treatment (10/5/25): Dense, highly hyperreflective vitreous exudate filling the cavity; early inferior retinal swelling and instability. (b) Post-acupuncture (10/12/25): Significant reduction and clearing of vitreous exudate; retina is attached and stable. (c) Post-cessation (10/13/25): New early retinal detachment (TRD) and persistence of scattered hyperreflective vitreous material.

Despite urgent pars plana vitrectomy, the eye remained swollen with persistent exudates, and vision was limited to light perception. Ongoing inflammation placed the eye at high risk for phthisis bulbi, as documented in the medical records. Adjunctive acupuncture was subsequently initiated on October 8, 2025.

Diagnostic Theory and Diagnosis

In SHAPU, the sudden onset of purulent exudate and redness represented an invasion of a virulent external pathogenic factor (xie qi) into the eye. When this invasion occurs, the body's immune system (zheng qi) surges to expel the pathogen, creating an intense, localized physiological conflict: an exaggerated host immune response with a hyperacute inflammatory cascade that results in rapid, massive fibrin and purulent exudation. Physiologically, this intense inflammation triggers vasodilation, allowing plasma and immune cells to enter the vitreous chamber. In TCM pathology, this parallels the mechanism by which pathogenic heat injures the vessels, leading to extravasation (leakage) of blood and fluids. The initial accumulation of these fluids constitutes pathological dampness. However, the intense pathogenic heat "cooks" and condenses these fluids, rapidly transforming them from dampness into damp-heat and eventually into turbid phlegm (manifested as the "cottage cheese" exudate). If left unchecked, this rots the blood and flesh, leading to permanent tissue destruction.
Based on this pathology, the TCM diagnosis was turbid phlegm obstructing the orifices. The massive accumulation of exudate represented a local excess of yin substance that overwhelmed the eye's yang function of drainage capacity. Therefore, the therapeutic principle was to warm yang to transform phlegm, utilizing warming-needle moxibustion to circulate qi and clear the physical obstruction.

Treatment

Treatment focused on moving qi, removing turbidity, and warming the channels to resolve phlegm-dampness stagnation and restore circulation, facilitating the drainage of exudate. The senior practitioner used sterile, single-use stainless steel needles (0.25 mm × 40 mm; Dongbang). Periocular treatments were administered daily from October 8 to October 11, 2025.

The treatment protocol included UB1 (Jingming), Taiyang, ST1 (Chengqi), GB20 (Fengchi), and a transverse threading technique from UB2 (Zanzhu) to Yuyao. Warming-needle moxibustion was applied primarily to UB1 (Jingming) and Taiyang.



Figure 1. Moxibustion treatment on UB1 and Taiyang. Diagram illustrating the warming-needle moxibustion technique applied at the periocular acupuncture points UB1 (Jingming), located at the medial canthus, and Taiyang (extra point), located in the temporal depression approximately one finger-breadth posterior to the midpoint between the lateral end of the eyebrow and the lateral canthus. Moxa cones were placed on the needle handles to conduct heat into the local tissue.

Needles were inserted deeply enough to secure moxa cones, with retention times of 60 to 90 minutes. This approach was selected to address the urgency of the ocular emergency.

Outcomes

Immediately after the second treatment on October 8, the patient was able to spontaneously open the affected eye (Figure 2) and recognized finger

movements. Eyelid swelling was visibly reduced. In a subsequent interview, her parents reported further improvement in her ability to count fingers. By the fourth treatment on October 11, her conjunctival infection had markedly diminished, and the palpebral fissure height was nearly symmetric with the unaffected eye. Five acupuncture sessions were completed over four days.



Figure 2. Clinical progression of eye opening (10/5/25). (a) Pre-treatment (early 10/5/25): Severe palpebral edema and mechanical ptosis; the patient is unable to open the right eye voluntarily. (b) Mid-treatment (10/8/25): Following the second acupuncture session, the patient regained the ability to spontaneously open her eye. While edema is reduced, marked scleral redness (conjunctival injection) remains visible, particularly near the medial canthus (UB1 area). (c) Treatment completion (10/13/25): Near-complete resolution of lid swelling and the previously noted scleral redness near UB1. This external clearance of inflammation correlates with the internal resolution of exudates observed on B-scan.

A follow-up B-scan on October 12, 2025, showed a significant reduction of intraocular exudate, marked vitreous clearing, and a fully attached retina. Dr. Gurung observed slight residual superior exudate and recommended a repeat vitrectomy. The family, concerned about prognosis and re-operation costs, declined immediate local intervention and transferred the patient to a tertiary institute in Kathmandu for a second opinion, resulting in the abrupt cessation of adjunctive acupuncture.

Approximately 44 hours after the last treatment, a B-scan at Tilganga Institute on October 13 revealed a new retinal detachment with persistent hyperreflective vitreous material. The patient subsequently underwent a second surgery to remove pus and insert silicone oil. At present, only limited temporal peripheral vision remains.

Discussion

SHAPU is among the fastest-progressing ocular inflammatory syndromes documented. Postoperative recovery after vitrectomy is generally expected to show clinical signs of improvement within 48 to 72 hours (H. Gurung, treating surgeon, personal communication, January 26, 2026). In this case, however, the patient exhibited persistent dense exudates and significant edema beyond this recovery window. The clinical course diverged sharply from this trajectory only after the initiation of the adjunctive acupuncture protocol on

postoperative day 3 (October 8). Between October 8 and 11, the patient received four periocular acupuncture sessions. She demonstrated immediate functional improvement (new finger movement vision), a rapid decrease in eyelid swelling, and progressive enlargement of the eyelid opening. A B-scan performed on October 12 showed significant clearing of exudate consistent with areas where warming-needle moxibustion was applied, while the retina remained fully attached.

Pathophysiological Mechanisms

The present case raises an intriguing discussion of disease progression through the lens of the Shang Han Lun, or the Treatise on Cold Damage (25-220 AD). This case is best understood by first establishing the theoretical framework: in TCM, the eye is the organ through which the Liver manifests. The foot shaoyang channel begins at the eye canthus, and the Liver and Gallbladder work together in an interior-exterior relationship (Xiong 2017, Line 263). Also, the yangming channel connects to the eye, starting at ST1 (Chengqi).

The shaoyang and yangming channels are intrinsically linked: when the shaoyang mechanism is attacked by a pathogen, the disturbance readily transmits to the yangming. In the scenario of SHAPU, when the pathogen attacks along the shaoyang channel (i.e., the eye), the yangming responds explosively because the yangming channel is “abundant in qi and blood.” This anatomical and physiological linkage helps explain the rapid and severe disease manifestation in the eye.

When an external evil invades, it generates heat (Xiong 2017, Line 27). This heat enters the bloodstream, scorching the vessels and forcing the blood to flow recklessly (Xiong 2017, Line 202). This mirrors the classical mechanism of epistaxis (nosebleed) caused by blazing yangming heat in the blood level, emphasizing that the pathogen is located in the channel rather than the organ itself (Xiong 2017, Line 227).

As previously mentioned, the yangming reaction cooks the fluids, condensing them into damp-heat, and eventually turbid phlegm-heat, which manifests clinically as the severe, “greenish pus” seen in SHAPU (Byanju et al., 2003). This explains why SHAPU primarily affects healthy children with robust immune systems (Manandhar, 2011). The “strength” of the patient’s zheng qi paradoxically accelerates the destruction of the ocular structure. As noted by Dr. Shrestha, a surgeon at the Himalaya Eye Hospital, one proposed mechanism of SHAPU is an overactive immune response (E. Shrestha, PowerPoint presentation, October 2025).

Furthermore, this channel theory offers a compelling explanation for the strictly unilateral nature of SHAPU, a hallmark feature documented to cause

"unilateral blindness and phthisis bulbi in hundreds of children since 1975" (Manandhar et al., 2018). The yangming channel, functioning as a direct conduit "abundant in qi and blood," facilitates a massive, high-velocity mobilization of zheng qi directly to the infected eye. Because the ocular chamber is a confined anatomical space, this overwhelming counterattack traps the pathogen, leaving it with no escape route or means of systemic dissemination. The conflict is intense, but containment is absolute, leading to rapid pathogen annihilation before it can transmit to the contralateral eye.

The aftermath of this fierce, localized conflict is a massive accumulation of "casualties," the purulent exudate, or turbid phlegm. To use a metaphor, the "fire" of the battle has already burned out; only the "ash" (phlegm) remains. Therefore, the therapeutic goal is no longer to fight an active pathogen, but to clear the static debris of a battle already finished. This requires the warming, moving properties of moxibustion rather than cold, clearing treatment methods.

Anatomical Correlates of Phlegm Obstruction

Anatomically, the pathology of SHAPU devastates all three parts of the uveal tract: the iris, ciliary body, and choroid (Bansal et al. 2010). The iris regulates incoming light; the ciliary body focuses the lens and produces aqueous humor; and the choroid nourishes the retina. In SHAPU, the massive accumulation of purulent exudate (turbid phlegm) physically obstructs these structures, causing a cascade of failures. The inflamed iris cannot regulate light, and the choroidal obstruction cuts off retinal nourishment. Most critically, the ciliary body's function is impaired; if it cannot produce aqueous humor or maintain intraocular pressure, the globe risks hypotony and collapse (Tripathy et al., 2018). From a TCM perspective, this is not "fluid retention" but a severe stagnation where the "channels governing drainage" are blocked by solid matter (pus). Therefore, the therapeutic priority was to aggressively circulate qi and drain turbid phlegm via moxibustion to unclog these fine vascular and fluid pathways before permanent atrophy occurred.

Classically, the clinical presentation of SHAPU deviated from the classic tetrad of inflammation: redness, swelling, heat, and pain, particularly pain. As noted in the literature, patients typically present with red eyes, white pupils (leukocoria), and severe signs of inflammation, yet frequently report minimal to no pain, though a minority of studies documented severe pain (Smits et al., 2012). However, this trend has shifted in recent reports, with an increasing number of cases documenting pain (Upadhyay et al., 2018). This shift may be caused by increased disease awareness, leading to earlier detection and intervention than in historical cases.

In the present case, a discrepancy was noted: while the treating doctor's preoperative notes indicated pain, the patient subjectively reported almost no

pain by the time of the acupuncture consultation. This temporal change supports the hypothesis described earlier: at the moment of onset, the "blazing heat" caused acute pain; however, once the intense conflict resolved into phlegm, with the immune battle ended, the active heat and thus the severe pain subsided.

Therapeutic Rationale

Locally, the eye became functionally deficient in yang qi because it was overwhelmed by this accumulation of yin substance (turbid phlegm). This was clinically corroborated by the treating surgeon, who emphasized before treatment that the eye was "full of liquid," even behind the retina (H. Gurung, personal communication, October 8, 2025). As stated in the Yellow Emperor's Classic of Medicine, "Yang is the energy, the vital force, the potential, while yin is the substance" (Ni, 1995, p.17). Because yin substance is heavy and static, active yang qi - delivered via warming-needle moxibustion - was required to circulate the channels and transform the turbid phlegm mixed with aqueous liquid. This application of heat expedites the function of the eye's water drainage system. Clinically, this was supported by the patient's response: during moxibustion, she reported immediate subjective relief from deep warmth.

Clinical Implications

The implications for clinical practice are twofold. First, this case illustrates that in confirmed inflammatory ocular emergencies, acupuncture strategies must be adapted to match the urgency of the pathology, utilizing daily frequency (Cheng, 1999) and sufficient retention times to mobilize substantial pathogenic factors. Secondly, it challenges the contraindication of using warming therapy (moxa) in inflammatory conditions. When inflammation manifests as substantial fluid accumulation (pus/exudate) that obstructs circulation, local warming can be an effective method to resolve the obstruction without amplifying systemic heat.

Strengths and Limitations

The main limitation of this study is its single-case design. In the absence of a control group, spontaneous fluctuation cannot be definitively excluded, although the correlation between treatment cessation and clinical deterioration suggests otherwise. The brief, four-day intervention period also limits conclusions regarding the long-term efficacy of acupuncture in preventing late-stage SHAPU complications.

This case report is strengthened by two factors. First, serial B-scan ultrasonography provided objective evidence supporting subjective clinical improvements. While patient-reported outcomes can vary, the observed

reduction in intraocular exudates on imaging offers concrete evidence of efficacy. Second, the clinical course demonstrated a clear “on-off” effect: the retina stabilized during acupuncture and detached only after treatment cessation. This temporal correlation between improvement during treatment and deterioration after cessation supports a possible link between the adjunctive therapy and the preservation of ocular structure.
The long-term outcome demonstrates a direct anatomical correlation between the treatment site and the preserved visual field. The patient avoided phthisis bulbi and retains finger-counting vision in the lateral visual field, corresponding to the focused application of warming-needle moxibustion at UB1 (inner canthus), which targets the medial retina responsible for lateral vision. This localized preservation is consistent with the immediate visual improvement observed on October 8, suggesting the intervention cleared obstruction in the quadrant where thermal stimulation was concentrated.

Long-term-Follow-up

In a long-term follow-up interview, the patient's mother reported that the affected eye remains normal in size and appearance, indistinguishable from the fellow eye. This observation suggests that adjunctive acupuncture, by temporarily restoring metabolic function and clearing exudates, may have contributed to the preservation of the globe's structural integrity and prevented the disfigurement commonly observed in end-stage SHAPU.

Conclusion

This case describes an 8-year-old girl with late-stage SHAPU who exhibited rapid improvement following adjunctive periocular acupuncture and warming-needle moxibustion. Given the high risk of vision loss and phthisis bulbi in SHAPU, the results support further systematic evaluation of periocular acupuncture and warming moxibustion as potential adjunctive therapies.

Informed Consent

Written informed consent was obtained from the patient’s legal guardian for publication of this case report and any accompanying images.

Statement of Safety

No adverse events or unanticipated reactions were reported during the acupuncture and moxibustion treatments.

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