CASE RECORD:

Investigating a Recurrent Iritis

You are presenting this case on behalf of a colleague. Chatham House rules apply but the patient and practitioners are not present. You must facilitate a discussion about the case.

The goal is to consider our evolving roles and responsibilities. Clinical responsibilities to patients and practice structures and procedures to remain safe.

<u>Competency Framework for Independent Prescribing</u>

1) CLINICAL AND PHARMACEUTICAL KNOWLEDGE
    a. 5. Maintains an up-to-date knowledge of products in the BNF / drug tariff (e.g. doses, formulations, pack sizes, storage conditions, costs)
    b. 7. Applies the principles of evidence-based medicine, and clinical and cost-effectiveness
2) ESTABLISHING OPTIONS
    a. 1. Takes a comprehensive medical and medication history, including presenting symptoms*
    b. 4. Requests and interprets relevant diagnostic tests
    c. 5. Views and assesses the patient's needs holistically (psychosocial, physical)
6) IMPROVING PRESCRIBING PRACTICE
    a. Develops own networks for support, reflection and learning
8) THE NHS IN CONTEXT
    a. 1. Understands and works with local NHS organisations
    b. 2 Works within local frameworks for medicines use as appropriate (e.g. formularies, protocols and guidelines5. Deals sensitively with patients' emotions and concerns
9) THE TEAM AND INDIVIDUAL CONTEXT
    a. 1. Thinks and acts as part of a multidisciplinary team to ensure that continuity of care is not compromised
    b. 2. Recognises and deals with pressures that result in inappropriate prescribing
    c. 5. Establishes and maintains credibility with colleagues in the health care team
    d. 6 Establishes relationships with colleagues based on trust and respect for each others roles.

Record Card
26/6/14 : 4.30pm

Female, 35years old.

Presented with 4/7 history of red painful LE

Has had previous episode treated via HES with steroids drops.

General History – No Medication. Reported as fit and well.

Slit lamp: RE clear

LE 3+ Cells Anterior Chamber, flair and synechiae. Ciliary Injection

Dilated Fundoscopy: No signs of posterior inflammation

IOP R 11mmHg, L 12mmHg

Non-IP Optom. Rang Ophthalmology-on-call. Explained we have drugs available. Conformed with registrar treatment, commenced and letter given to take to Eye Casualty following morning.

COPY LETTER

26/6/14

Eye Casualty

Mrs attended today with a 4 day history of painful left eye.

Slit lamp: Anterior chanber Celles (3+), flair and Synechiae. Ciliary injection. No signs of posterior inflammation.

IOP R 11, L 12

After ringing on-call registrar commenced

Cylopentolate 1% qds os

Predforte 1% q1h

Attendance at Eye casualty first thing tomorrow

Full advice given. Px fully aware of possible recurrences.

Record Card
7/3/15

Professional Service Member: Patient presented without an appointment for prompt assessment.

Slit Lamp LE: 4+ Cells, Flair. No Synechiae but signs of past episodes.

Dilated Fundoscopy Clear

Confirmed with patient diagnosis. Fully aware of treatment plan and drop schedule. Reconfirmed and commenced

Cyclopentolate 1% qid

Predforte: Week 1 q1h, Week 2 q2h, Week 3 qid, Week 4 bid, Week 5 bd

General health history remains unremarkable. When asked Px reported bloods were not done at HES in June: treated as idiopathic.

Review booked 10/3/15 – advised Blood will be ordered.

Record Card
10/3/15

Much better, Flair and cells reducing. Patient informed and very competent.

Regular reviews organised but Bloods ordered via GP

10/3/15

Dear Dr

Mrs presented as an emergency on 7th March with another episode of iritis in the left eye.

We have started intense treatment with Predforte q1h and cyclopentolate.

Today it is improving well with no flair and 2+ cells in the anterior chamber. No signs of posterior uveitis are present.

The recurrent nature concerns me. She does not report any systemic, inflammatory problems. Her last episode was dealt with in ophthalmology but Mrs leads me to believe it was treated as idiopathic and blood screens were not initiated.

I feel a full blood screen would be appropriate: CBC, ESR, ANA, RPR, HLA-B27 as I am concerned about underlying eitiologies.

I will review.

Useful Resource to access up-to-date peer reviewed information on:

Overview,

Presentation,

Differentials,

Workup,

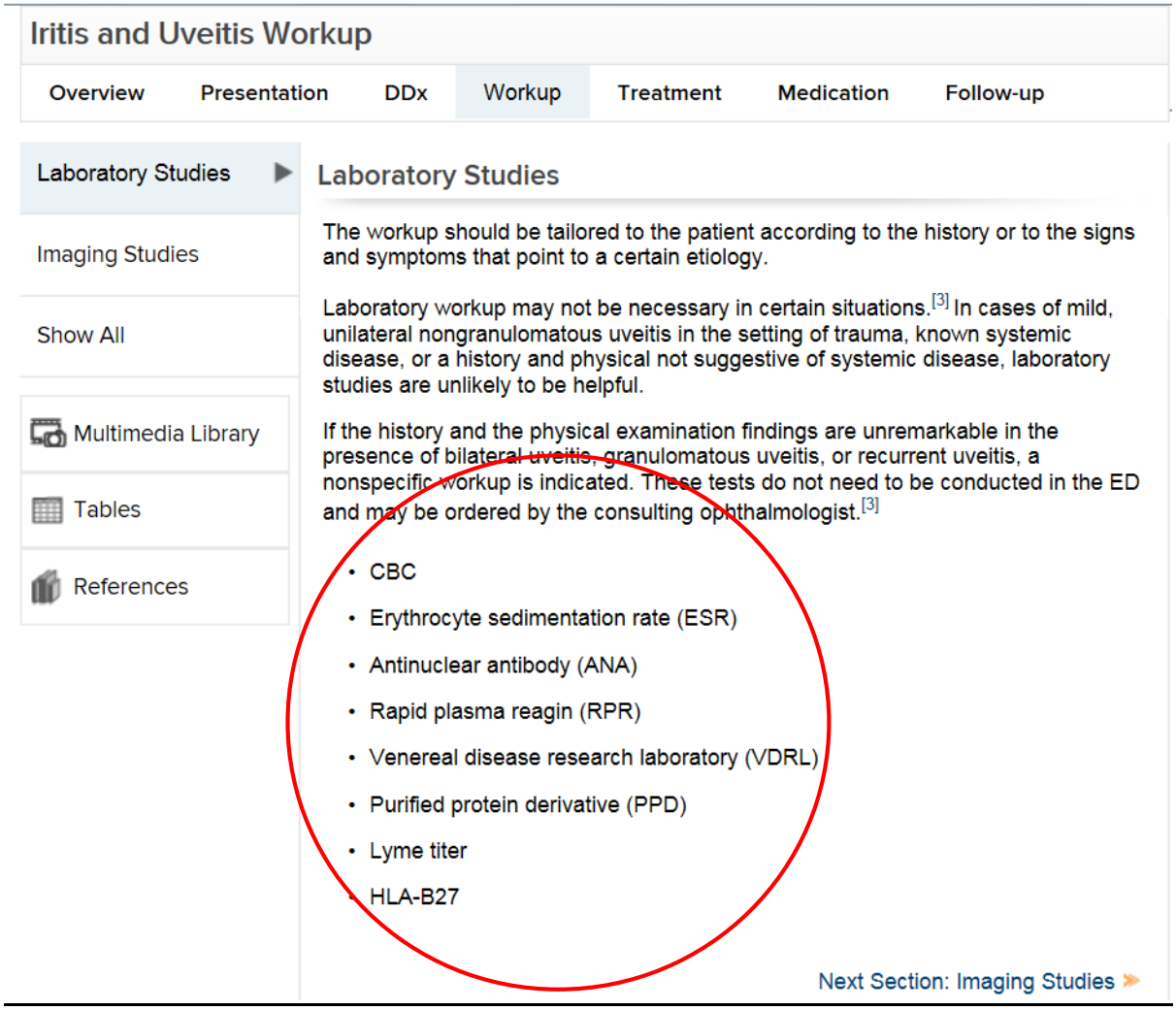
Treatment,

Medication,

Follow-up.

Medscape: http://emedicine.medscape.com

Under Work-up:



Record Card
24/3/15

Including outcome audit process.

Resolving – continue treatment to completion.

Blood test results: HL-B27 positive: seronegative spondyloarthropathies

On closer questioning. Px reports back pain and stiffness (difficulty getting going).

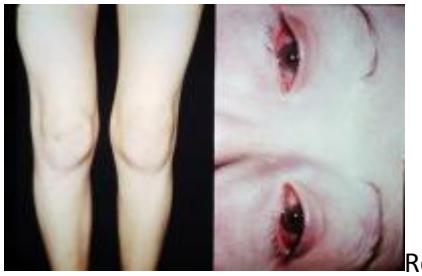
As part on ongoing outcome audit and education: Medscape HLA-B27 Syndromes:

Example extract from HLA-B27 Syndrome Overview:

Overview

The first human leukocyte antigen (HLA) haplotype association with inflammatory disease was discovered in 1972, correlating HLA-B27 with ankylosing spondylitis. This remains one of the strongest known associations of disease with HLA-B27. Since then, more than 100 disease associations have been made, including many ocular diseases and systemic diseases with specific ocular manifestations. These diseases also include reactive arthritis (previously referred to as Reiter syndrome), inflammatory bowel disease, and psoriatic arthritis.

Refer to the following image.



Reactive arthritis. Involvement of knee (left) and conjunctivitis (right). Courtesy of Paul Dieppe, BSc, MD, FRCP, FFPHM.

In ophthalmology, HLA associations are strongest in diseases of the uvea. Of patients with uveitis, 19-88% have the HLA-B27 phenotype, depending upon the study population cited. Acute anterior uveitis (AAU) as depicted in the image below, may occur as a distinct clinical entity or in conjunction with a group of autoimmune rheumatic diseases called seronegative spondyloarthropathies. By definition, patients with these diseases have a negative rheumatoid factor, hence the term seronegative.[