

# 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.

### Competency Framework for Independent Prescribing

- 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 guidelines)
  - c. 5. 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 synechia. 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 Synechia. 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 7<sup>th</sup> 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 etiologies.

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>

The screenshot displays the Medscape website interface. At the top, there is a search bar for 'Search Drugs & Diseases' and navigation tabs for 'News & Perspective', 'Drugs & Diseases', 'CME & Education', and 'Discussion'. A prominent advertisement banner reads 'HAVE 2 MINUTES? Stay up-to-date on the latest product information from Industry' with a 'VIEW NOW' button. The main article title is 'Iritis and Uveitis' by Keith Tsang, MD, with a 'more...' link. Below the title are tabs for 'Overview', 'Presentation', 'DDx', 'Workup', 'Treatment', 'Medication', and 'Follow-up'. The 'Practice Essentials' section is expanded, showing a definition of uveitis and an anatomical diagram of the eye. The diagram includes labels for the Cornea, Iris, Lens, Ciliary body, and Retina. To the right, there is an advertisement for 'BOOTSWEBMD.COM' and a 'Medscape App' promotion. The browser's address bar shows the URL 'http://emedicine.medscape.com/article/798323-overview' and the page title 'Iritis and Uveitis'. The Windows taskbar at the bottom shows the date as 28/04/2015 and the time as 20:10.

## Under Work-up:

### Iritis and Uveitis Workup

Overview   Presentation   DDx   **Workup**   Treatment   Medication   Follow-up

**Laboratory Studies** ▶

Imaging Studies

Show All

Multimedia Library

Tables

References

#### Laboratory Studies

The workup should be tailored to the patient according to the history or to the signs and symptoms that point to a certain etiology.

Laboratory workup may not be necessary in certain situations.<sup>[3]</sup> In cases of mild, unilateral nongranulomatous uveitis in the setting of trauma, known systemic disease, or a history and physical not suggestive of systemic disease, laboratory studies are unlikely to be helpful.

If the history and the physical examination findings are unremarkable in the presence of ~~bilateral uveitis, granulomatous uveitis, or recurrent uveitis~~, a nonspecific workup is indicated. These tests do not need to be conducted in the ED and may be ordered by the consulting ophthalmologist.<sup>[3]</sup>

- CBC
- Erythrocyte sedimentation rate (ESR)
- Antinuclear antibody (ANA)
- Rapid plasma reagin (RPR)
- Venereal disease research laboratory (VDRL)
- Purified protein derivative (PPD)
- Lyme titer
- HLA-B27

Next Section: Imaging Studies ▶

## 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 of an 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.<sup>1</sup>