Naval Medical Center Portsmouth
Rheumatology Referral Guidelines

Diagnosis:	**Uveitis, Acute Noninfectious (Iritis)**

Clinic Name	Rheumatology
Clinic Phone Number	757-952-2160 or 2161
On Call Numbers	757-860-5702

1. Indications for Specialty Care:

- Evaluation for a systemic autoimmune disease associated with uveitis
- Aid with managing immunosuppressive medications for refractory uveitis as directed by dedicated eye provider
- Active Service Members undergoing PEB with a systemic connective tissue disease associated with uveitis

***Referral should not be given to merely reaffirm a previous diagnosis of a non-rheumatic disease. ***

2. Quality Consult Criteria

When referring a patient, please include as much of the following information as possible (OK to cut and paste this into consult request)

1. Provisional diagnosis
2. Duration of Problem
3. Prior treatments
4. Current treatments/medications
5. Diagnostic studies obtained (imaging, labs, other tests, etc.)
6. Primary reason for consult
7. Use of referral guidelines

3. Diagnosis Definitions

- Uveitis is inflammation of the middle portion of the eye, including the iris, ciliary body, choroid and vitreous humor. Uveitis and iritis are used interchangeably (1, 2).
- Uveitis is primarily described by location of inflammation (i.e. anterior, intermediate, posterior or panuveitis), rate of onset and course of the disease (1, 2).

4. Initial Diagnosis and Management

- The initial diagnosis of uveitis requires prompt evaluation by a dedicated eye provider (i.e. optometrist, ophthalmologist), to include a detailed history and physical examination. The main etiologies of uveitis include infectious disease, inflammatory disease, pseudo-uveitis, primary ophthalmologic entities and drug-induced uveitis. Prior to referral to rheumatology, a thorough evaluation for infectious, malignant (lymphoma) and drug-induced causes should be excluded and treated accordingly. Common infectious causes of uveitis include syphilis, Lyme disease, tuberculosis, fungus, parasites (toxoplasmosis) and viruses (HSV, VZV, CMV) (1).

- Once a non-infectious uveitis (NIU) etiology is felt to be the cause, further diagnostics are typically based on anatomic involvement, detailed history and physical examination. Please note, there is no one specific algorithmic approach to the initial diagnosis and management of NIU (2).

- Reasonable initial laboratory testing would include syphilis (RPR or equivalent), tuberculin skin testing (or IFN-γ release assay). All patients with NIU warrant routine laboratory testing (CBC with differential, comprehensive metabolic panel, urinalysis, ESR, CRP) and dedicated imaging of the chest (minimum PA/Lateral chest x-ray).

- There are few studies evaluating the routine use of serology testing in the setting of NIU. A review of the literature has shown that the prevalence of systemic lupus erythematosus (SLE) is 0.47% in patients with uveitis and the positive predictive value of a antinuclear antibodies for the diagnosis is <3% (3). Routine ANA testing is therefore not recommended, unless there is other features suggestive of an underlying connective tissue disease. HLA-B27 determination is reasonable for patient's presenting with acute anterior non-granulomatous uveitis, as a diagnosis of a spondyloarthropathy (SpA) was established in 21-40% of patients presenting with acute anterior non-infectious uveitis (2, 4). HLA-A29 testing should only be ordered in select patients with posterior uveitis and an unclear diagnosis, as it has a high negative predictive value and low positive predictive value, and present in 5-7% of the general population (2).

- There is limited evidence to support other routine use of other diagnostic testing. One notable exception is the patient with intermediate uveitis (pars planitis). Several studies have shown a prevalence of multiple sclerosis (MS) ranging from 7-30% in patients with intermediate uveitis (2). Therefore, it is not unreasonable to consider additional CNS imaging in these select patients.

- Initial management of NIU is typically based on anatomic location and duration. Anterior NIU is easily treated with topical corticosteroids, NSAIDs and analgesics. Other anatomic forms of uveitis typically require systemic immunosuppression, including systemic corticosteroids. The type and duration of medication(s), are directed by the primary eye provider and based on disease response and patient characteristics.

5. Ongoing Management and Objectives

- There are a variety of factors determining the need for continued therapy versus on-demand treatment. The majority of these factors are outside the scope of this referral document, and are typically disease and patient specific.

- The goal of uveitis treatment is to suppress ocular inflammation and achieve inactive disease state or drug-induced remission.

- It is recommended uveitis be monitored by a dedicated eye provider and nomenclature according to the Standardization of Uveitis Nomenclature Working Group criteria (5).

6. Criteria for Return to Primary Care

- Diagnosis of uveitis established in the absence of autoimmune disease.
- Management questions do not require a re-referral and are preferably handled as a conversation (potentially electronically) between the referring provider and the consulting Rheumatologist.
- Patients with concomitant autoimmune disease and uveitis may be co-managed with Rheumatology.

Date Adopted or Last Reviewed:	01 Feb 2018	By	CDR Shauna O'Sullivan LCDR Jeffrey Eickhoff LCDR Terrence Kilfoil LCDR Jason Weiner
Referral Guidelines require review every three years.			

7. Resources/References

- 1. Firestein GS, et al. The eye and rheumatic diseases. Kelley's Textbook of Rheumatology 9th Edition Philadelphia, PA. 2013; 617-23.
- 2. Seve P., et al., Uveitis: Diagnostic workup. A literature review and recommendations from an expert committee. Autoimmunity Reviews 2017(16):1254-64.
- 3. Gallagher K, Viswanathan A, Okhravi N. Association of systemic lupus erythematosus with uveitis. JAMA Ophthalmol 2015; 133:1190-3.
- 4. Dick AD, et al. Guidance on noncorticosteroid systemic immunomodulatory therapy in noninfectious uveitis. Fundamentals of care for uveitis (FOCUS) initiative. Ophthalmology 2018 Jan 6.
- 5. Jabs DA, et al. Standardization of uveitis nomenclature for reporting clinical data. Results of the First International Workshop. Am J Ophthalmol 2005; 140(3):509-16.