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Letters to the Editor

Sir,

Self Diagnosis in Recurrent Acute Anterior Uveitis

It was our clinical impression that patients with a past history of iritis were able to recognise recurrent attacks. However, their level of accuracy in doing so has never been documented.

We asked all patients presenting to the Accident and Emergency Department at Moorfields Eye Hospital between May and July 1987 who had a past history of iritis to answer 'yes' or 'no' to the question: 'Do you think that your present complaint represents a further episode of iritis or do you think that it represents a different condition?' An ophthalmic history was then taken and examination was performed. This confirmed or refuted the patient's diagnosis and identified symptoms, signs, and other features of these patients related to diagnostic accuracy.

Two hundred and twenty-six eyes (218 patients) were studied. Based on the patient's assessment and the examination findings eyes could be placed in one of four groups (see Table). In 86% of eyes the patients correctly determined whether or not they had a further episode of iritis ($X = 88.9$, D.O.F. = 1, $p<0.0001$). The patient's assessment is therefore accurate.

In none of the parameters of age (mean 46.0 years), sex (M:F, 1.66:1), number of previous attacks (mean 8.8), time since first attack (mean 6.3 years) or duration of presenting symptoms (mean 3.4 days) was there any significant difference between eyes in the four groups.

Statistically significant differences are present between the four groups in terms of their symptoms. Eyes in which patients correctly felt that they had iritis (Group 1) had a very high incidence of photophobia (87%) in a red eye (78%) with ciliary injection (66%) and a miosed pupil (65%). The respective figures for the other groups were: Group 2, 18%, 24%, 6% and 6%; Group 3, 50%, 71%, 2% and 43%; Group 4, 15%, 32%, 0% and 0%.

None of the patients found not to have iritis on examination subsequently presented with iritis as a continuation of their initial symptoms.

Comment

Delayed or inappropriate treatment based upon an inaccurate diagnosis may contribute to visual loss in anterior uveitis.[1,2] For the ophthalmologist iritis is, on the whole, a slitlamp diagnosis based on the presence of cells and flare in the anterior chamber.[3] The non-ophthalmologist however will probably not have access to a slitlamp; diagnosis has to be based on symptoms and macroscopic signs, and, understandably, misdiagnoses may be more common.

Patients with a history of iritis can correctly assess whether or not they are suffering a recurrent attack of iritis with a high degree of accuracy. When a non-ophthalmologist is faced with a patient in whom a diagnosis of iritis is suspected or possible, or where there is a past history of iritis, we would suggest that they ask for, and seriously consider the patient's opinion. The patient's assessment, combined with a simple ocular examination not requiring a slitlamp, may allow a non-ophthalomologist to decide with a high degree of accuracy whether the patient has a further episode of iritis, and therefore facilitate appropriate management. For the ophthalmologist, when a diagnosis of iritis is made,

Table *Patients' assessment vs ophthalmologist's examination findings*

	Examination findings	
	Iritis	*Not iritis*
Patient's assessment		
Iritis	Group 1 154 (68%)	Group 2 17 (8%)
Not iritis	Group 3 14 (6%)	Group 4 41 (18%)

the patient and other physicians involved in their care should be informed, and its potential for recurrence should be stressed.[4,5]

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References

[1] Nussenblatt RD and Palestine AG: Uveitis: Fundamentals and Clinical Practice. Year Book Medical Publishers, Inc., 1989: 164.

[2] Rothova A, van Veenendaal WG, Linssen A, Glasius E, Kijlstra A, de Jong PTVM: Clinical features of acute anterior uveitis. *Am J Ophthalmol* 1987, **103:** 137–45.

[3] Hogan MJ, Kimura SJ, Thygeson P: Signs and symptoms of uveitis. I. Anerior uveitis. *Am J Ophthalmol* 1959, **47:** 155–70.

[4] Darrell RW, Wagener HP, Kurland LT: Epidemiology of uveitis: incidence and prevalence in a small urban community. *Arch Ophthalmol* 1962, **68:** 502–14.

[5] Oksala A and Varonen ER: On the question of recurrences of acute anterior uveitis. *Klin Monatsbl Augenheilkd* 1966, **149:** 481.