PAST MEDICAL HISTORY: , Significant for GERD, history of iron deficiency anemia, and asthma for which she takes an inhaler.,REVIEW OF SYSTEMS:, Positive for only for left knee arthritis. She has no exposure to tuberculosis or syphilis, she has no mouth or genital ulcers. She has no skin rashes. She has no connective tissue disorders.,PAST OCULAR HISTORY: , Significant for cataract and glaucoma surgery of the right eye.,PHYSICAL EXAMINATION: , On examination, visual acuity measures hand motions on the right and 20/25 in the left. There is an afferent pupillary defect on the right. On examination, there is a right hypertropia. There is dense anterior chamber inflammation on the right eye with a stagnant aqueous. There is either neovascularization on the iris or reactive iris vessels, it is difficult to discern. This seems to be complete iris synechia to the anterior lens capsule. There is a posterior chamber intraocular lens with an inflammatory debris on the anterior surface. The anterior chamber appears narrow. On the left, there is also dense inflammation at 4+ cell. There is 1+ nuclear sclerosis. Dilated fundus examination cannot be performed on the right secondary to intense inflammation. On the left, there is no evidence of active posterior uveitis. There is some inferior vitreous debris.,ASSESSMENT/PLAN:, Chronic bilateral recurrent nongranulomatous diffuse uveitis. Currently, there is very severe right eye inflammation and severe left eye. I discussed at length with the patient that this will likely take an oral steroid to quite her down. Since she has only one seeing eye, I am anxious to obtain a decreased inflammation as soon

as possible. She has been on oral steroids in the past. We also discussed, considering the aggressive recurrent nature of this process, it is likely we will have to consider a steroid sparing agent to maintain longer term control of this recurrent process so that we do not use visual acuity in the left. I anticipate we will likely start methotrexate in the near future. In this acute phase, I have recommended oral steroids at a dose of 60 mg a day, hourly topical Pred Forte as well as atropine sulfate. We will watch her closely in clinic. I am sending a copy of this dictation to her primary care doctor, she said she has had a negative HLA-B27, rheumatoid factor, and ANA in the past. At this stage, to be thorough I would ask Dr. X to assist us in repeating her chest x-ray, PPD if not current, and an RPR. Additionally, in anticipation of need for methotrexate, it would be helpful to have a full liver function profile as well as hepatitis B and hepatitis C.