This poster will discuss the clinical presentation, treatment, and management of a young black patient with bilateral pars planitis. We will also discuss etiological factors underlying this ocular condition and review proper follow up regimen.

I. Case History
A 22-year-old African-American female presented with a chief complaint of pain and redness OU with a new onset of floaters OS greater than OD. She was previously examined at three different emergency rooms and diagnosed with conjunctivitis. Treatment included sulfacetamide gtts qid OU x 5 days. No other pertinent ocular history was reported. The patient’s medical history included sickle cell trait and two full-term pregnancies without complications. No systemic medications were being taken at the time of presentation. The patient reported feeling general malaise, arthralgia, dizziness, drowsiness and headaches the week prior to the onset of ocular symptoms.

II. Pertinent findings
Best-corrected vision measured 20/20 OD and 20/25 OS at the time of presentation. Pupils were equal, round and reactive to light with OS having a sluggish response. Versions were full and smooth in all positions of gaze. Confrontation fields were full to finger count. Color vision by Ishihara plates revealed 13/14 OD, 14/14 OS. No preauricular lympadenopathy was noted. Upon slit lamp examination, mild blepharitis and meibomian gland dysfunction was observed. Circumlimbal flush was noted OU. The anterior chamber revealed trace cells and flare OD, grade 4+ cells and flare OS. Pressures by Goldmann tonometry were equal at 15 mmHg. Upon dilated fundus exam, grade 3+ vitreal cells OD and 4+ OS were observed with snowballs at the inferior midperiphery. Periphlebitis noted inferior nasally OU. Snowbanking was absent as confirmed with scleral depression OU.

Further laboratory studies revealed an equivocal lyme titer screening with further testing providing a reactive 41 KD IgG and IgM Band finding. RPR, ANA, CBC with differentials, Lysozyme, HLA-B27, ESR, and CRP studies were non-reactive or negative. A PPD conducted in May was also negative. The result of the FTA-Abs and ACE lab studies are still pending this time. A chest x-ray also came back normal with no lung findings reported.

III. Differential Diagnosis
Given our patient’s clinical presentation, our leading diagnoses include syphilis, Lyme disease, multiple sclerosis, or idiopathic pars planitis. Other causes ruled out by lab studies or radiology studies include sarcoidosis, retinitis pigmentosa, cat-scratch disease, Epstein-Barr virus, toxocariasis, toxoplasmosis, tuberculosis, and ocular lymphoma.
IV. Diagnosis/discussion
The etiology and pathogenesis of pars planitis are unknown. Approximately 55% of cases are idiopathic. Sarcoidosis and multiple sclerosis are the two most common systemic associations.\textsuperscript{1} At this time, further testing for syphilis is pending. It is possible a reactive band on the lyme titer tested reactive due to both organisms being spirochetes. Another Lyme Disease Western Blot will be performed in two weeks to compare to previous findings. False negative results are possible in the beginning stages of Lyme disease. Further evaluation will be conducted with a head MRI with contrast after receiving finalized laboratory testing in order to determine if white matter changes associated with multiple sclerosis are present. If all other follow-up testing is non-reactive or negative, idiopathic bilateral pars planitis will be considered the diagnosis. However, our patient’s complaints are not isolated ocular complaints. Her previous sickness leads us to believe an underlying infection or systemic association is likely in this case.

V. Treatment/management
At presentation, the patient was prescribed Pred-Forte 1% q30min OU and Scopolamine .25% bid OU x 2 days until her next follow-up. Day two presentation revealed worsening anterior uveitis and vitritis OU due to patient’s non-compliance and the patient was instructed to continue the same treatment regimen. At the six day follow-up, a retinologist consult was also obtained. Pred-Forte 1% was decreased to 1 gtt q1h OU. The use of cycloplegic was discontinued due to the vast improvement of the anterior chamber reaction. At this time, the overall clinical presentation has improved. Further treatment including oral steroids, periocular or intravitreal injection will be considered after completed laboratory testing and retinologist consultation. If a systemic association is found, treatment will be directed at the cause.

The treatment of pars planitis is based on severity of the disease. In some instances where visual acuity is normal and no vision-threatening complications are noted, no treatment may be necessary.\textsuperscript{2} However, macular edema resulting in VA \textless 20/40, retinal vasculitis, and vitreal haze are indicative of treatment.\textsuperscript{3}

VI. Conclusion
Approximately 55% of pars planitis cases in young, healthy individuals are idiopathic.\textsuperscript{1} Further ancillary testing can determine if an underlying systemic condition exists. If an associated systemic condition is found, the inflammation is then termed intermediate uveitis.\textsuperscript{4} Individuals with pars planitis have a good visual prognosis with visual acuity remaining at 20/40 or better in a majority (75%) of patients.\textsuperscript{2}
Bibliography


