1. There should be no history of ocular trauma or surgery

2. There should be no clinical or laboratory evidence of other ocular disease entities

3. The uveitis must be bilateral exhibiting either A or B

A) Early Disease

i) Diffuse Choroiditis with either focal or bullous subretinal fluid

ii) If fundal appearances are equivocal must have:

a) Focal Choroidal perfusion delay, pinpoint leakage, placoid fluorescence and optic nerve staining on fluorescein angiography and

b) Diffuse choroidal thickening but no scleritis

B) Late Disease

i) Suggestive history of 3A and either ii or iii

ii) Depigmentation, either sunset glow or Sugiura's sign

iii) Nummular chorioretinal scars with retinal pigment epithelium (RPE) clumping and migration and recurrent chronic anterior uveitis

4. Active or history of either meningism, tinnitus, cerebrospinal fluid pleocytosis

5. Alopecia, Poliosis, or vitiligo

Complete VKH Syndrome requires Criteria 1-5, all inclusive

Incomplete VKH Syndrome requires Criteria 1-3 and either 4 or 5.

Probable VKH requires Criteria 1-3

Figure 1: Revised International Diagnostic Criteria for Vogt-Koyanagi-Harada (VKH)

Corticosteroids
Oral prednisone 100-200 mg initially, followed by gradual taper over 3-6 months
Pulse dose of methylprednisolone 1g/day for 3 days, followed by gradual tapering of oral prednisone over 3-6 months
Intravenous methylprednisolone 100-200 mg/day for 3 days followed by gradual tapering of oral prednisone over 3-6 months
Cyclosporin 5 mg/kg per day
Azathioprine 1-2.5 mg/kg per day
Biologics
Anti-TNF-α monoclonal antibody

Figure 2: Treatment options in VKH [1]

Figure 3: SOAP note

Subjective:

- Previously healthy 34 year old Metis female
- Three week history of pain, redness, blurred vision and increased sensitivity to light in both eyes, previously diagnosed as bilateral uveitis.
- Prior to eye complaints, experienced chills and headache with acute illness. Significant family history of ankylosing spondylitis.
- Recent development of mild ringing of the ears, bilateral, and patches of pale skin appearing in her inguinal area on right side.

Objective:

- Ophthalmological exam: best corrected visual acuity 20/40 OD and 20/30 OS with intra ocular pressures of 11 and 12, respectively.
- Dilated fundoscopic exam: Anterior chamber revealed occasional cell and 2+ cells, left and right respectively. Posterior chamber revealed + cells, bilaterally.
- Significant optic nerve edema 360 degrees with serous retinal detachments in right eye. Significant macular edema with a serous retinal detachment in left eye.
- Fluoroscein Angiogram: diffuse choroiditis with focal delays in choroidal perfusion and multifocal areas of pinpoint leakage, bilaterally
- CBC, Lipids ANA, glucose, Lyme serology, syphilis, serum ACE, ESR, CRP, serum protein electrophoresis, serology for cat scratch and 120 degree Visual Field test were unremarkable.
- CSF revealed pleocytosis but culture was negative for bacteria.

Assessment:

- VKH, as patient met diagnostic criteria outlined by the American Uveitis Society
- Bilateral anterior uveitis.

Plan:

- Continue treatment for uveitis which includes diclofenac (Voltaren) drops, prednisolone (Pred Forte) drops and olfloxacin (Ocuflox) drops, bilaterally. Cyclopentolate (Cyclogyl) drops for right eye only.
- Systemic steroid therapy to treat VKH using IV methylprednisolone 1 gram x 3 days and then oral prednisone 80 mg daily on a tapering dose for 3-6 months