Allergic conjunctivitis

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Conjunctivitis is common and management can be relatively straightforward once the underlying cause is identified. While viral conjunctivitis is most common, allergic conjunctivitis is a particular problem at this time of year. Conjunctivits is considered 'chronic' if it lasts over 4 weeks.

Acute allergic conjunctivitis

This is an urticaria reaction and often presents with sudden onset of severe chemosis (swelling of the conjunctiva) and lid swelling, with most resolving spontaneously. There is no pain but pruritis is common, with clear watery discharge. It is often due to exposure to an allergen with dramatic clinical signs. Management is reassurance, symptomatic relief with cool compresses, topical antihistamines, and identifying and removing the underlying allergen.

Sometimes, periocular skin condition may present with symptoms similar to allergic conjunctivitis but accurate history and ocular assessment should differentiate the two conditions.

Allergic contact dermatitis, a cell-mediated immune response in a sensitised individual, can be caused by topical ophthalmic preparation such as neomycin or atropine. In this case, the underlying ocular surface often remains fairly quiet with none of the acute changes seen in acute allergic conjunctivitis, despite obvious changes in the periocular skin.

Seasonal allergic conjunctivitis

This is a type 1 hypersensitivity response and presents with transient attacks of itchy, red eye with mild chemosis and papillary reaction. Patients often suffer from some other form of atopic condition e.g. allergic rhinitis. A seasonal pattern (usually spring-summer) may implicate pollen allergy and is due to fluctuating levels of airborne allergens (eg. grass pollens).

Management is topical antihistamines (e.g. Patanol™, Lomide™, Ketorolac™ 0.5%), topical NSAIDS (eg Voltaren™ 1%), cool compresses, and avoidance of precipitating factors if possible.

Keratoconjunctivitis

Chronic vernal keratoconjunctivitis (VKC) occurs in younger patients usually around five years and tends to resolves around puberty, rarely persisting into adulthood. It is associated with intense itching, lacrimation, photophobia, thick ropy mucoid discharge with symptoms worse in spring and summer. In severe cases, it can be associated with shield corneal ulcers. Often seen clinically around the limbus are white spots composed of degenerated eosinophils and epithelial cells, which appear gelatinous and are known as Horner-Trantas' dots (see Figure 1).

Atopic keratoconjunctivitis (AKC), typically in young adult males, is much more serious and chronic and has severe debilitating features such as scarring of the conjunctiva resulting in dry eyes, symblepharon, entropion, etc. with associated increased risk of HSV keratitis. The eyelid skin is often lichenified, and the conjunctiva hyperaemic with a fine papillary response. There is an increased incidence of keratoconus and cataract (anterior subcapsular). Often there is a history of associated asthma or atopic dermatitis.

These two distinct ocular conditions have much more aggressive symptoms and signs, in part due to their chronic course. Both conditions require frequent ophthalmic reviews and management will depend on severity. Long term topical antihistamines (sodium cromoglycate 2%, iodoxamide 0.1%), steroids, lubricants and at times, topical cyclosporine 1% may be necessary. ■

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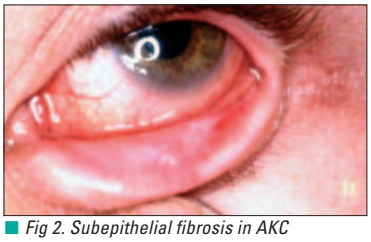
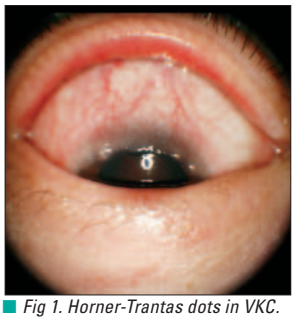


■ *Fig 2. Subepithelial fibrosis in AKC*



■ *Fig 1. Horner-Trantas dots in VKC.*