Canadian Family Medicine Clinical Card

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Conjunctivitis

APPROACH

- Always document bilateral visual acuity for any eye complaint (see video at youtube.com/watch?v=kMwy06mAV5U).
- Viral and allergic etiologies are much more common than bacterial.
  - Viral likely if profuse tearing and no discharge; usually bilateral, pre-auricular adenopathy very common. Often associated with URTI.
    - unilateral red eye + vesicles on eyelid or tip of nose suggests HSV or Zoster.
  - Allergic likely if severe itching, gritty-feeling, stringy mucoid discharge; typically seasonal, associated with other allergic symptoms; always bilateral.
- Bacterial etiology more likely if constant, crusty discharge causing lid sticking throughout day; may have blurred vision that clears with blinking.
  - Hyperacute infection: rapidly progressive (<24hrs), copious d/c (accumulates after being wiped away), thick, and yellow-green **Possible gonococcal STI

⚠ Red Eye RED FLAGS	Possible Diagnoses (should actively rule out)
Sudden decreased acuity	acute angle-closure glaucoma, corneal abrasion/ulcer
Photophobia	corneal abrasion/ulcer, uveitis, iritis, keratitis, scleritis
Headache/N/V	acute angle-closure glaucoma, scleritis, pre-existing glaucoma (often meds not being used correctly)
Lid-swelling, erythema	VZV/HSV, pre-septal or orbital cellulitis, blephartis, dacrocystitis, stye (hordeolum), chalazion
Trauma	retrobulbar hematoma, foreign body, hyphema
Chemical exposure	caustic injury (copious irrigation and check pH)
Ciliary flush**	acute angle-closure glaucoma, uveitis
Foreign body sensation	keratitis, corn. abrasion/ulcer, foreign body, blepharitis

** In simple conjunctivitis, there is a pale ring around the cornea (i.e. "peri-limbic sparing"); with flush, this area IS inflamed and may even appear as a red ring.

TREATMENT for Clinically Confirmed Conjunctivitis

Viral	- Usual etiology is Adenovirus: self-limited but extremely contagious (1wk from symptom onset); frequent hand hygiene, no school/daycare - Cold compresses, artificial tears, topical antihistamines for symptoms - Urgent ophth. assessment if HSV or Zoster is suspected (i.e. vesicles); start valacyclovir; assess eye with fluorescein (will not harm eye)
Allergic	- Cold compresses, artificial tears for symptoms; if chronic, can trial antihistamine or mast-cell inhibitor drops (e.g. Olopatadine 0.1%) - Oral antihistamines recommended only if other allergy symptoms
Bacterial	- **Adults:** usual etiologies are *S. aureus*, *H. influenzae*, *S. pneumoniae* - Moxifloxacin (G+/-) or Tobramycin (G-) 0.3% QID x 7-10d (drops) - **Peds:** usual etiologies are *H. influenzae*, *S. pneumoniae*, *Moraxella* - Ciprofloxacin (G+/-) or Erythromycin (G+) 0.5% QID x 7-10d (oint.) - Warm compresses PRN for lid hygiene, ++ artificial tears for sx relief - Oral antibiotics and eye patches are not recommended - Don't use steroids or antibx/steroids - may worsen missed viral dz
	Customized mgmt. and urgent ophth./ID assessment required if any of: ❑ Newborn <5 d (likely *Chlamydia*) ❑ Hyperacute presentation (suggests *Gonorrhea* or *Chlamydia*) ❑ No improvement after 48 hrs of topical ophthalmic antibiotics ❑ No improvement after 5-7 d of oral antivirals and suspected HSV/VZV

Key References: American Academy of Ophthalmology Cornea/External Disease Panel. (2013). Preferred Practice Pattern Guidelines. Conjunctivitis. San Francisco, CA. *American Academy of Ophthalmology*. Azari AA, Barney NP. Conjunctivitis: A Systematic Review of Diagnosis and Treatment. *JAMA*. 2013;310(16):1721–9. Frings A, Geerling G, Schargus M. Red Eye: A Guide for Non-specialists. *Dtsch Arztebl Int*. 2017;114(17):302-12.