



Courtesy of Ron Melton, O.D.

Classic case of PKC with inferior phlyctenules.

can restore ocular surface health are misleading because this has not been demonstrated by substantial evidence or clinical experience. AzaSite is indicated for the treatment of bacterial conjunctivitis. Another older antibiotic, doxycycline, also has some documented anti-inflammatory properties, but it is not considered a substitute when a steroid is indicated.

Patients with blepharitis often have dry eye syndrome as well, in which case the anti-inflammatory component of a combination drop can also be beneficial in treating the dry eye.

PKC: Diagnosis

Phlyctenular conjunctivitis (PKC) is seen most commonly as a secondary condition in young girls with staphylococcal blepharitis, although it may also be caused in rare cases by tuberculosis. Patients will present with a scratchy, foreign body sensation, ocular redness and sectoral rather than generalized conjunctival injection, mimicking episcleritis. There is typically no discharge.

PKC may be unilateral, but there is usually some involvement bilaterally. Although phlyctenular conjunctivitis can occur without obvious associated disease, patients with

phlyctenules may exhibit concurrent evidence of either dermatologic or systemic disease.

In adults, phlyctenules may be associated with rosacea, secondary to dry eye and staphylococcal blepharitis.

If the eyelid appears healthy and there is no evidence of staphylococcal blepharitis, you should query the patient about breathing problems, and perhaps even obtain a chest X-ray to rule out tuberculosis.

PKC: Management

Therapy depends on etiology. In individuals who are suspected of having tuberculosis, diagnosis should make use of a purified protein derivative (PPD) skin test, chest radiograph, and sputum cultures if necessary. These individuals should be referred for comanagement to their primary physician or to an infectious disease specialist.

Though antituberculin agents are systemically administered, the ocular lesions are appropriately treated with topical steroids. In most instances, patients respond to a potent topical corticosteroid q.i.d. for three to four days, and subsequently tapered according to the clinical response.

When patients are suspected of having underlying staphylococcal disease, both inflammatory and bacterial components can be managed with a combination antibiotic-steroid such as Zylet. Initial doses should be administered every 2 to 4 hours, depending on severity, for the first

24 to 48 hours, then four times daily after that. In most instances, patients obtain dramatic relief from symptoms and can diminish use of the drug in 7 to 10 days. If the patient is experiencing significant pain and discomfort, a steroid ointment such as Lotemax ointment at night, in addition to the antibiotic/steroid combination during the day, can help to relieve inflammation and pain.

Because of the association of *Staphylococcus* with eyelid disease, lid therapy should be instituted. Antibiotic ointments such as bacitracin or bacitracin-polymyxin B can be used twice daily in conjunction with warm compresses and eyelid scrubs. The tetracyclines are effective in treating phlyctenular keratoconjunctivitis. Doxycycline, 100 mg twice daily for 4 to 6 weeks, is another common therapy. When other etiologic agents, such as intestinal parasites, *Chlamydia*, gonococci and HSV are suspected, patients should receive appropriate systemic medications.

Non-Specific Inflammatory Conjunctivitis: Diagnosis

Patients may present with low- to moderate-grade conjunctival injection. Typically, they will say their eye "doesn't feel right" or perhaps friends have said their eyes look red. The eye is a little red and irritated but not bothering the patient too