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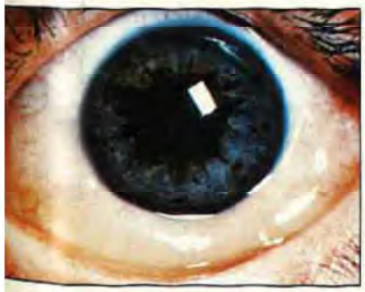

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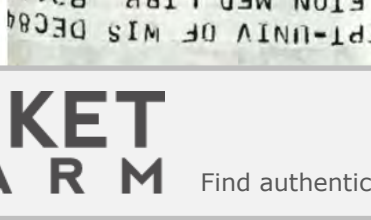

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BASED ON INDIVIDUAL INTERVIEWS WITH JAMES V. AQUAVELLA, MD; RICHARD A. EIFERMAN, MD; NEAL A. SHER, MD (SEE PAGE 92)

PREPARED BY SENIOR EDITOR CRAIG R. BORDERS

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EYE PROBLEMS

Red eye: What's dangerous? What's not?

It's probably just conjunctivitis, but can you be sure? You need quick, accurate ways to differentiate the benign forms of red eye from the devastating.

EXPRESS STOP

Red flags in the history: Certain clues in the history immediately suggest that the patient who complains of "red eye" has something more than routine conjunctivitis. These are: true pain, trauma, blurred vision, photophobia, use of contact lenses, severe reduction in vision, and the perception of halos around objects.

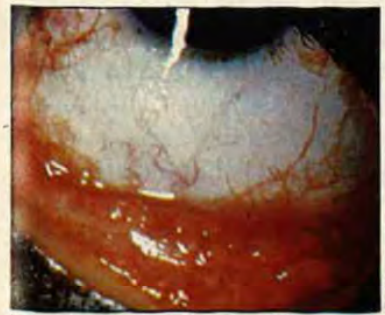
Most patients who call your office complaining of "red eye" have no more than a routine form of conjunctivitis. But the next one who calls could have a potentially blinding disorder. Are you thoroughly familiar with the historical and physical clues that differentiate the patient who must be referred immediately from the one whose problem you can manage readily and conveniently? And, just as important, does the person who answers your phones know the danger signs that mean a patient must be seen *today* (see "Eye symptoms that require same-day attention," page 88)?

Look for the following red flags in the history:

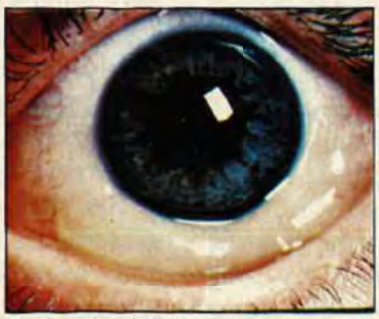
≫ *Pain* Patients with "garden variety" conjunctivitis often complain of a sandy, gritty, or scratchy feeling. Real pain, however, is a tip-off that you're dealing with something potentially more serious, such as disruption of the corneal epithelium, acute iritis, or acute angle-closure glaucoma.

≫ *Trauma* With a clear-cut history of trauma, whether from a foreign body, a chemical, or a blunt object, you needn't spend time wondering what's causing the red eye: In fact, the patient's primary complaint will probably be trauma, not red eye. But if the patient complains of a foreign body sensation but doesn't remember getting anything in his or her eye, an infectious process may have disturbed the corneal epithelium.

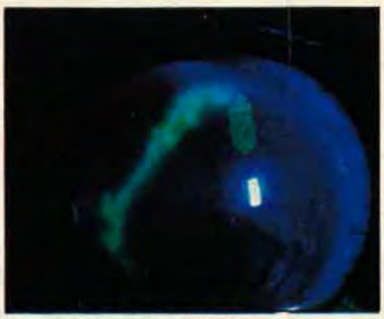
≫ *Blurred vision* Blurred vision occurs with conjunctivitis only when the cornea is



Inclusion conjunctivitis (see page 97)



Allergic conjunctivitis (hay fever) (see page 109)



Herpes simplex (see page 111)

involved as well (keratoconjunctivitis). Sometimes patients with conjunctivitis alone have a mucoid discharge so heavy they feel they're looking through a dirty windshield, but the blurry vision this causes can usually be blinked or wiped away.

≫ *Photophobia* Sensitivity to light suggests a serious condition, such as a corneal lesion, iritis, or angle-closure glaucoma.

≫ *Use of contact lenses* Any type of contact lens can cause hypoxia and breakdown of the corneal epithelium when worn too long. Extended-wear lenses are particularly egregious offenders. Since they're not removed regularly, they can cause repeated insult, resulting in a vicious cycle of red eye, swelling, and tightening of the contact lens.

≫ *Severe reduction in vision* When associated with red eye, this complaint probably is due to one of the acute forms of glaucoma or to a complication of iritis. Sudden, total loss of vision is a rare occurrence in the context of red eye.

≫ *Perception of halos around objects* This is a classic symptom of angle-closure glaucoma. It may also be related, however, to swelling of the corneal epithelium following abrasion or erosion.

Eye symptoms that require same-day attention

This list can help the person answering your telephone see to it that patients with potentially serious eye problems speak to you or are scheduled to see you as soon as possible. Symptoms listed here apply to all types of eye problems, not just red eye.

≫ Real pain (not just scratchiness)

≫ Trauma (including minor trauma such as foreign body in eye)

≫ Blurred vision (of recent onset, not helped by putting glasses on or repeated blinking)

≫ Sensitivity to light

≫ Problems with extended-wear contact lenses

≫ Double vision

≫ Sudden loss of vision

≫ Seeing halos around objects

EXPRESS STOP

Physical examination: The sine qua non of a good workup for red eye is to check the patient's vision. A Snellen's chart is ideal, but a magazine held at arm's length will do the job. If the vision of the two eyes is equal and about 20/20 when corrected, the red eye is probably benign. Strengthen your suspicion of a benign condition if the pupil is normal and you find no corneal defects. Fluorescein staining can be especially valuable. Other important clues include the color and location of injection, the presence and type of discharge, and intraocular pressure.

The first and most important step in the physical examination of the patient with red eye—or, for that matter, any other eye problem—is to check his or her vision. Failure to do so can get you into trouble both clinically and legally.

Check distance vision in each eye separately, and record your findings as specifically as possible. Measuring visual acuity in uncorrected eyes is of little use, so do the test with glasses or contact lenses in place. If the patient has forgotten to bring his glasses, or if inflammation prevents him from putting his contacts in, use a multiple pinhole card to eliminate refractive errors.

continued

Although multiple pinhole cards are commercially available in plastic, you can easily make one with an 18-gauge needle and a 3x5 index card. Punch about eight holes in the card within a 5-cm (2-in) circle so the patient can easily find one to look through.

A Snellen's chart placed at 6 m (20 ft) is the best tool for obtaining a standardized measurement of vision. If you haven't got one, ask the patient to read a magazine at arm's length. If he's unable to do so, see how far away he can count fingers you hold up, and record the distance.

If the patient's vision is equal and approximately 20/20 in both eyes when corrected, chances are good that the red eye is relatively benign. If, however, the patient is elderly and his vision is affected by macular degeneration or cataracts, the problem may seem more serious than it is.

Begin your examination of the eye by inspecting the eyelids. Swelling and discoloration suggest severe infection or inflammation. Briefly examine the lid margins. Crusts or scales suggest blepharitis. In patients over age 60, look for turning inward of the lid margin (entropion), which may cause the eyelashes to rub the cornea. Also look for turning outward of the lid margin (ectropion), which may expose the cornea or conjunctiva, resulting in chronic irritation or infection.

Next, look for irregularities in the size, shape, and reactivity of the pupil. The presence of such irregularities strongly suggests a serious eye disorder, except in:

≫ The elderly patient, who may have small pupils.

≫ The patient who has had eye surgery for cataracts or glaucoma. He may have all sorts of irregularities—from an iridectomy hole to a poorly reactive pupil.

≫ The patient who has taken pilocarpine HCl (Isopto Carpine, Pilocar, Pilocel, etc.) or another miotic for several years for chronic, open-angle glaucoma. He may have pupils that are constricted and poorly reactive.

Examine the bulbar and palpebral conjunctiva, looking for inflammation and discharge. (For a quick review of the diagnostic implications of your findings, see "Atraumatic red eye: A guide to major causes," page 108.) Is the inflammation pink, red, or bright red? Is it diffuse or segmented? Is it concentrated near the limbus or toward the fornices? Characterize any discharge. Is it watery, purulent, or thin and ropy?

Use a penlight to illuminate the cornea obliquely for examination, and compare it with the other cornea. Is the mirrorlike surface of the cornea broken by opacities, shadows, or other defects? If a purulent discharge is present, ask the patient to blink several times to clear it so you can avoid confusing that with a corneal defect.

Strongly consider making fluorescein staining a routine part of your red eye workup. It's especially important whenever the corneal epithelium seems disturbed or when something in the history suggests that it could be.

To make the patient more comfortable, consider placing a drop of a topical anesthetic, such as proparacaine HCl (Alcaine, Ophthaine, Ophthetic, etc.), into the eye before staining with fluorescein. Moisten the fluorescein strip with sterile saline or the patient's tears; if you have not already used a topical anesthetic, consider moistening the strip with it. Don't soak the strip;

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