Children < 16 years old – Primary Care and Emergency Department (ED)

Eye Infections

Conjunctivitis

Duration: until 48hrs after resolution of symptoms

First line: Recommend bathing eyes regularly with tepid water, wiping away from the bridge of the nose to the side. The patient should not wear contact lenses until symptoms have cleared. Advise strict hand hygiene; towels and pillows should not be shared.

Both bacterial and viral conjunctivitis are self-limiting and a delayed prescribing approach is appropriate. Consider starting treatment after 3 days if there is no improvement, unless the patient considers the symptoms to be distressing or signs on examination are severe.

Second line: **Chloramphenicol 1%** eye ointment topical**.** Apply 3 - 4 times a day if ointment used alone; apply at night if eye drops used during the day.

And/or **Chloramphenicol 0.5%** eye drops topical. Apply 1 drop every 2 hours initially; reduce frequency to 3-4 times a day once symptoms improve and continue for 48 hours after healing.

Please note there can be variation in the licensing of different medicines containing the same drug. Some licenses of chloramphenicol 0.5% eye drops containing borax or boric acid buffers were recently updated to restrict use in children <2 years old. The MHRA have issued a statement with updated advice for use in this age group. Please see Link for more information.

Third line **Fusidic acid 1%** eye drops topical**.** Apply twice daily

NOTES

Acute infective conjunctivitis presents with red, irritated eyes, foreign body sensation accompanied by excessive tear production or discharge, and eyelids that stick together upon waking. **Bacterial conjunctivitis** is usually unilateral with thick purulent discharge. **Gonococcal conjunctivitis in newborns** is a hyper-acute, purulent conjunctivitis affecting both eyes. **Viral conjunctivitis** is generally bilateral and preceded by a typical viral prodromal illness; the eye is profusely watery. The pre-auricular lymph nodes may be palpable and tender.

If any of the following are present, refer the patient for specialist same-day assessment - significant photophobia, reduced visual acuity, pain deep in the eye, history of recent eye surgery, abnormal pupil response, irregular pupils, corneal damage or opacity on fluorescein staining, restricted or painful eye movements, history of head/eye trauma.

Ask patients to return for review if there is visual disturbance, significant eyelid swelling, photophobia or pain in the eye, or if symptoms do not settle within 7 days.

Swab the affected eye(s) to identify a possible bacterial cause when conjunctivitis is severe or persistent.

Styes & Blepharitis

First Line: Eyelid hygiene is the mainstay of treatment for both blepharitis and hordeola. Advise application of a compress with warm (not scalding) water to the eye area for 5-10 minutes, four times a day during acute infections or flare-ups.

Second line: If hygiene measures for two weeks have not resulted in resolution of symptoms, a **6 week trial** of **Chloramphenicol 1%** eye ointment topically twice daily.

NOTES

A **stye or hordeolum** is an acute infection of the tarsal oil glands of the eyelid and presents as an abruptly developing tender swelling on the eyelid. **Blepharitis** is a chronic inflammation of the eye lids. Patients with blepharitis will most commonly complain of chronic irritation of the eye, often accompanied by redness. There may be intermittent exacerbations of symptoms. Hordeola can be associated with blepharitis due to abnormal oil secretion.

If symptoms are persistent or severe, send a swab of the lid margin.

Peri-Orbital Cellulitis – Emergency Department Treatment Only

Duration: 7 days

First Line Treatment: Co-Amoxiclav PO dosed as per BNF for Children

Second Line in Children with Penicillin Allergy:

Clindamycin PO dosed as per BNF for Children

Clindamycin liquid is unlicensed – ED CONSULTANT use only

Suspect orbital cellulitis if there is evidence of skin and soft tissue infection in the eye area with peri-orbital oedema, a displaced globe, double vision, ophthalmoplegia, or reduced visual acuity.

Primary care: This is an emergency, as it is potentially sight-threatening, and any suspected case should be referred to secondary care for assessment and treatment.

In the ED: all cases of peri-orbital cellulitis should be discussed with a senior member of ED medical staff and a maxillo-facial surgeon or ophthalmologist.

Peri-Orbital Cellulitis – Inpatient Treatment

First Line: **Cefotaxime IV** as per BNF for Children + **Flucloxacillin IV** as per BNF for Children.

Add **Metronidazole IV** as per BNF for Children if no improvement after 48 hours.

Penicillin Allergy: **Clindamycin IV** as per BNF for Children + **Gentamicin IV** as per NHS AA paediatric gentamicin unit protocol

Notes

See also: https://www.clinicalguidelines.scot.nhs.uk/media/1520/empirical-antibiotic-therapy-in-childrendec17.pdf

Refer to the Ophthalmology department's clinical guideline for advice on general management.