Blepharitis

the royal victorian eye and ear hospital

Disclaimer

SEE ALSO: red eye, chalazion, preseptal cellulitis

DESCRIPTION – chronic lid margin disease/inflammation

HOW TO ASSESS:

Red Flags:

- Consider sebaceous cell carcinoma in adult if intractable, asymmetric or unilateral blepharitis
- Consider pediculosis palpebrarum

On History:

- Itching, burning, foreign body sensation, eyelid swelling, crusting on eyelid margins
- Symptoms often worse in the morning

On Examination:

- Skin: can be associated with rosacea and seborrhoeic dermatitis
- Lids:
    - Anterior blepharitis: injected lid margins, crusting/scales at lash bases
    - Posterior blepharitis: thickened secretions, inspissated and inflamed meibomian glands, chalazia
    - May have lash loss and trichiasis if chronic disease
- Cornea:
    - Tear film dysfunction, marginal keratitis

Acute Management:

- Lid hygiene:
    - Warm compresses to eyelids to loosen crusts, 3 minutes QID, reheating clean flannel/face washer as it cools
    - Lid massage: circular motion, moderately firm with eye lids closed
    - Gentle cleansing of lid margins with dilute baby shampoo or commercial preparation from chemist with non-medicated makeup pads
- Ocular lubricants: if associated with dry eyes or corneal changes
- Topical chloramphenicol 1% eye ointment BD to lid margins for moderately severe cases for 7 days
- For intractable cases (e.g. associated with rosacea, recurrent chalazia, or recurrent marginal keratitis):
    - Doxycycline 50-100 mg (child 8 years or older: 1 mg/kg up to 50 mg) oral daily for a minimum of 8 weeks. Consider referral to a dermatologist if required.
    - For children younger than 8 years, and in pregnant or breastfeeding women consider:
        - Erythromycin ethyl succinate 400 mg (child 1 month or older: 10 mg/kg up to 400 mg) orally, daily for a minimum of 8 weeks.
- Severe/ulcerative blepharitis may benefit from a short course of hydrocortisone 1% eye ointment BD to lid margins

Follow up:

- Mild to moderate: optometrist or GP follow up
- Moderate to severe: ophthalmology review

DISCHARGE INSTRUCTIONS:

Give patient copy of Blepharitis Fact Sheet

Authors:

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Next Review Date:

16/08/2022

Evidence Table

Author/s	Title	Source	Level of Evidence (I – VII)	Comments
	Wills Eye Manual 6th edition 2012			
	Oxford Handbook of Ophthalmology 2006		VII	

The Hierarchy of Evidence

The Hierarchy of evidence is based on summaries from the National Health and Medical Research Council (2009), the Oxford Centre for Evidence-based Medicine Levels of Evidence (2011) and Melynk and Fineout-Overholt (2011).

I Evidence obtained from a systematic review of all relevant randomised control trials.

II Evidence obtained from at least one well designed randomised control trial.

III Evidence obtained from well-designed controlled trials without randomisation.

IV Evidence obtained from well designed cohort studies, case control studies, interrupted time series with a control group, historically controlled studies, interrupted time series without a control group or with case series.

V Evidence obtained from systematic reviews of descriptive and qualitative studies.

VI Evidence obtained from single descriptive and qualitative studies.

VII Expert opinion from clinician, authorities and/or reports of expert committees or based on physiology.

CPG Suite General Disclaimer

These CPGs were written for use in the RVEEH speciality Emergency Department. They should be used under the guidance of an ENT or Ophthalmology registrar, and certain medications / procedures should only be undertaken by speciality registrars.

If you require clinical advice, please contact our admitting officer for assistance:
EYE: 03 9929 8033 ENT: 03 9929 8032