

GUEST EDITORIAL

THE CHALLENGES OF OCULAR ALLERGIC CONDITIONS TODAY



When the winds of spring arrive they jostle loose minute pollen particles from several kinds of flowering plants and trees. Carried by the winds, many of these tiny yellow particles will make their way to the waiting stigma of other flowering flora. Unfortunately, some will make their way instead to the mucous membranes and conjunctivae of human beings.

Red, itchy, watery eyes will ensue, ultimately leading to patient misery and phone calls to doctors and pharmacists all over our country. To help physicians cope with and better understand allergic eye conditions this edition of *Current Allergy & Clinical Immunology* focuses on allergic conditions of the eye.

The severity of the condition can range from mild itching and redness, as manifest in seasonal allergic conjunctivitis, to the more severe, sometimes sight-threatening forms such as vernal and atopic keratoconjunctivitis.

Symptoms may be seasonal or perennial, mild or severe, just annoying to the patient or sight-impairing, easy to manage by the general practitioner or serious enough to require specialist ophthalmologist care.

Confirmation of the diagnosis is imperative. Is the diagnosis correct? Simple dry eyes often present with similar symptoms. Are the symptoms seasonal, perennial or related to some topical medication? Is the condition bilateral? Has it happened before? Is there a history of atopy? Do the symptoms appear in spring time? Does the patient wear contact lenses?

Some primary sources of allergic conjunctivitis include:

- *Airborne pollens*. Sources include: trees, such as conifers, willows, poplars, pines; weeds, including ragweed; grasses; flowering plants; palms; and nettles.
- *Mould*. Fungi are abundant and ubiquitous; they grow on dead organic material and flourish in warm, wet

climates. They produce airborne spores, some of which are allergenic.

- *Animals*. Allergenic sources include cat saliva, dog and horse dander, and rat urine.
- *Insects*. The most common allergenic insects are house-dust mites. They thrive on desquamated human skin cells found on bedding, upholstery and blankets. Cockroaches are a source of allergens, especially in overcrowded areas.¹

In every case the physician needs to ascertain what the main problem is. This may not be exactly the same as what the patient perceives the main problem to be. If the patient does not think his eyes are red, you do not have to treat the redness. If he does, the opposite is true. Developing a personal algorithmic approach to the management of these conditions is essential for any physician who accepts the responsibility of managing such a patient. The algorithm should commence at the simplest levels, e.g. avoidance of the allergen and dilution of the same in the conjunctival sac. It then progresses to treatment with potent pharmacological drugs requiring the monitoring of the patient at a slit lamp, and finally ending with surgical procedures. The pharmacotherapy of allergic conjunctivitis consists of several classes of drugs: antihistamines, mast-cell stabilisers, dual-acting agents and corticosteroids. None of the available drugs completely abolishes the development of ocular allergy. For this reason, new topical anti-allergic/anti-inflammatory agents are currently and continually being investigated in clinical trials.²

David Meyer

Guest editor

1. Bausch & Lomb Pharmaceuticals. Allergic conjunctivitis – Issues and Answers in Allergic Conjunctivitis Therapy. In *Review of Ophthalmology*, Part 2 of 2, March 1999.
2. Lonardi A. Emerging drugs for ocular allergy. *Expert Opin Emerg Drugs*. 2005; **10**(3): 505-520.

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