VERNAL KERATOCONJUNCTIVITIS

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OUTLINE

- Introduction
- Predisposing factors
- Signs and symptoms
- Management
- Complications
Introduction

- It is a recurrent, bilateral, interstitial, self-limiting, allergic inflammation of the conjunctiva
- Its occurrence is periodic and seasonal
- It is considered a hypersensitivity reaction to some exogenous allergen e.g. grass pollen
- There is evidence of personal or family history of other atopic diseases such as hay fever, asthma, eczema etc.
Predisposing factors

- Age: 4 – 20 years
- Sex: more commoner in males than in females
- Season: more commoner in summer, hence the name spring catarrh
- Climate: more prevalent in the tropics, less in temperate zones and almost non-existent in cold climate
Signs and symptoms

- Itching and burning sensation
- Mild photophobia
- Lacrimation
- Stringy (ropy) discharge
- Heaviness of lids
- Brownish conjunctiva
Management

- **Local therapy:**
  - Topical steroids – these are effective, however its use should be minimized as they could cause steroid induced glaucoma. Commonly used steroids are betamethasone, dexamethasone, medrysone & fluorometholone. Medrysone & fluorometholone are safest of all these.
  - Mast cell stabilizers e.g. sodium cromoglycate (2%) 4-5 times a day
  - Topical antihistaminics
  - Topical cyclosporine (1%) is effective in severe unresponsive cases

- **Systemic therapy:**
  - Oral antihistaminics may provide some relief from itching in severe cases
  - Oral steroids (for short duration though) for advanced, very severe, non-responsive cases
Other measures are;

- Use of dark goggles to prevent photophobia
- Cold compress and ice packs have soothing effect
- For recalcitrant cases, change of place from hot to cold area is advisable
- NB: it is a self limiting condition and the disease does not persists to adult life except in very few cases
Complications

- Corneal involvement i.e. corneal abrasion, ulcer, scarring
- Corneal perforation
- Corneal opacity
- Blindness