

Clinical features of vernal keratoconjunctivitis

Bello Ridwan

University of Benin, Benin city, Nigeria



Abstract

Vernal keratoconjunctivitis (VKC) is an allergic eye disease that especially affects young boys. The most common symptoms are itching, photophobia, burning, and tearing. The most common signs are giant papillae, superficial keratitis, and conjunctival hyperaemia. Vernal Keratoconjunctivitis is a recurrent, bilateral interstitial inflammation of the conjunctiva, of periodic seasonal incidence, self limited character and unknown etiology. It is characterised by flat-topped papillae, usually on the tarsal conjunctiva resembling cobble stone in appearance, a gelatinous hypertrophy of limbal conjunctiva, either discrete or confluent and a distinctive type of keratitis. It is associated with itching, redness of eyes, lacrimation and a mucinous or lardaceous discharge usually containing eosinophils. It has predilection for warm rather than cold climates with frequent family and personal history of atopic disease, such as asthma, rhinitis, and eczema, a higher than 2:1 frequency in males over females, an early onset, with remission by the late teens and a hereditary predisposition with exogenous factors, such as climate, season, allergen exposure. However, confirming that it is not solely an IgE-mediated disease. Th2 lymphocytes are responsible for both hyperproduction of IgE (interleukin 4, IL-4) and for differentiation and activation of mast cells (IL-3) and eosinophils (IL-5). Other studies have demonstrated the involvement of neural factors such as substance P and NGF in the pathogenesis of VKC, and the overexpression of oestrogen and progesterone receptors in the conjunctiva of VKC patients has introduced the possible involvement of sex hormones. Thus, the pathogenesis of VKC is probably multifactorial, with the interaction of the immune, nervous, and endocrine systems. The clinical management of VKC requires a swift diagnosis, correct therapy, and evaluation of the prognosis. The diagnosis is generally based on the signs and symptoms of the disease, but in difficult cases can be aided by conjunctival scraping, demonstrating the presence of infiltrating eosinophils. Therapeutic options include:

1. Mast cell stabilizers (e.g. sodium cromoglicate, nedocromil sodium, lodoxamide) reduce the frequency of acute exacerbations and the need for steroids and so form the basis of many regimens, but are seldom effective in isolation.

2. Topical antihistamines (e.g. emedastine, epinastine, levocabastine, bepotastine) when used in isolation are about as effective as mast cell stabilizers.

3. Combined antihistamine and vasoconstrictor (e.g. antazoline with xylometazoline) may offer relief in some

A 2% solution of cyclosporine in olive oil or in castor oil should be considered as an alternative. The long-term prognosis of patients is generally good; however 6% of patients develop corneal damage, cataract or glaucoma.



Biography:

Dr. Bello Ridwan has a Diploma in Health information management from University College Hospital, Ibadan, Nigeria.

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