

Editorial: Herpes simplex conjunctivitis

The average clinician's attitude to conjunctivitis is affected by his background and his work-load. If he was trained many years ago and is subject to a heavy burden of work his diagnosis may tend to be based on simple clinical inspection, although he might order a swab for bacterial culture. The likely result of this will be 'no growth.' Although he may be puzzled as to why all the bacterial conjunctivides described so abundantly in the classical texts (there are, for example, 90 pages of them in Duke-Elder's *System of Ophthalmology*¹) are so reluctant to declare themselves on a culture plate, he will nevertheless tend to accept a moderate incidence of conjunctivitis in his outpatient practice as a natural background to clinical ophthalmology.

In former days a descriptive classification of conjunctivitis into catarrhal, serous, mucopurulent, pseudomembranous, and membranous satisfied our ophthalmological forefathers, and it was assumed that most cases were of bacterial origin. It cannot be denied that this concept of conjunctivitis is still in the minds of many clinicians. Indeed true bacterial conjunctivitis should not be forgotten, since it can be an alarming condition, as anyone who has seen a case of genuine gonococcal conjunctivitis will agree. Furthermore, there is no knowing nowadays how many cases of bacterial conjunctivitis are cured so rapidly by immediate treatment with antibiotics that they never come to the notice of ophthalmologists.

However, the clinician with recent training, particularly if he is associated with an academic unit, probably thinks more about viruses than bacteria. In the last 40 years or so we have seen how the proportion of cases attributed to virus infection has increased. The change began with the epidemics of shipyard conjunctivitis which occurred during the second world war and was later named epidemic keratoconjunctivitis.² Our knowledge progressed with the recognition of the place of the trachoma virus in western urban society.^{3,4} Thus adenovirus or TRIC now features prominently in the differential diagnosis in cases of acute follicular conjunctivitis.

The paper in this issue by Professor Darougar and

his colleagues now reminds us of another virus which should be considered in this diagnosis. Herpes simplex has been known as a cause of conjunctivitis for some time. Indeed it is mentioned in standard texts as a type of acute follicular conjunctivitis⁵ or as a nondescript conjunctivitis,⁶ and Jones *et al.*⁷ found no less than 20% of their cases of conjunctivitis of viral origin to be due to herpes, but probably to many clinicians, it appeared to be a rarity. All may not agree with the prevalence suggested by the figures published in the present paper, which comes from a highly specialised unit. Indeed in Adler's textbook acute herpetic keratoconjunctivitis is described as rare, with the initial infection frequently accompanied by cold sores on the face.⁸ But the message is clear. A casual attitude to conjunctivitis is no longer justified, and the prolonged prescribing of random antibiotics and worse still corticosteroids should no longer be considered acceptable. A proper differential diagnosis of conjunctivitis ought now to be attempted in all cases which do not respond to a short sharp course of antibiotics. A period off all treatment in mild cases is usually justified, though pressure from patients or relatives to do something may sometimes be hard to resist.

References

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