STREPTOTHRIX CONJUNCTIVITIS*

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THE symptoms and signs caused by the lodgement and growth of a *Streptothrix* in one or both canaliculi, are familiar to most ophthalmologists. Except for the occasional occurrence of a limited area of vascular congestion near the inner canthus, the conjunctiva is as a rule normal and it is even possible that such limited congestion may be attributed to irritation caused by frequent dabbing of the eye owing to lacrimation when the lower punctum is involved.

It is possible however that a generalized conjunctivitis may be set up, and that this may assume a severe form. This observation, although not new, does not appear to be as well-known as it should, with the result that unnecessary suffering and discomfort may persist owing to failure of diagnosis. If only to draw attention to this relatively uncommon condition I regard the following two cases as worthy of report:

Case Reports

(1) **Married female, aged 56.**—The patient gave a history of lacrimation and discomfort for some months. This had been treated as a conjunctivitis with various remedies, and had steadily got worse.

Both eyelids were slightly oedematous. The ocular conjunctiva was uniformly congested, and the palpebral conjunctiva as well as that lining the fornices was swollen and congested and showed a rough velvety surface. A copious yellow stringy discharge was present. The eyelids were extremely tender to the touch but on gentle pressure over the canaliculi a greyish yellow mycelium appeared in both upper and lower puncta.

The condition was much too painful to allow of local anaesthesia and under pentothal the mycelium was evacuated from the canaliculi by the usual method of slitting. Without further treatment, except a cleansing lotion, rapid improvement took place and in a fortnight the conjunctiva had resumed a normal appearance. *Streptothrix* was identified microscopically.

(2) **Male, aged 35.**—Ten months' history of lacrimation and discharge. The patient produced a long list of remedial measures which had been used without benefit. The appearance of the lids, conjunctiva, and discharge was similar to that in Case 1, except that the mycelium appeared in the lower canaliculus only.

A general anaesthetic was again necessary because of pain and tenderness, and after evacuation of the mycelium the eye had resumed a normal appearance within 2 weeks. *Streptothrix* was again identified microscopically.

In both cases the mycelium was greyer and softer than is usual in uncomplicated cases, possibly owing to admixture with inflammatory exudate.

It is not clear why so severe an inflammation can occur in a very limited number of cases, and in my opinion there is no adequate evidence that this can be attributed to length of duration of the infection. I therefore put forward the suggestion that different strains of *Streptothrix* may vary in pathogenicity.

I would also urge that in any case of intractable conjunctivitis, special attention should be paid to the condition of the canaliculi.

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