Contact allergic dermatitis and contact urticaria due to topical ophthalmic preparations

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A patient with chronic glaucoma and a history of contact allergic dermatitis to topical ophthalmic β-adrenergic blocking drugs developed persistent ocular symptoms despite avoidance of β-blockers. He was further investigated for possible allergy to pilocarpine.

Case report

A 70-year-old man presented with a persistent itch involving his eyes and a stinging and burning sensation aggravated by instillation of his pilocarpine eyedrops. The patient had a long history of glaucoma and had bilateral trabeculectomies carried out in 1978. He still required therapy and had been treated with β-blockers and pilocarpine since 1984. Treatment with β-blockers had been discontinued owing to the development of contact allergic dermatitis which apparently developed sequentially to timolol, betaxolol, and metipranolol as described previously. Examination revealed periocular oedema with erythema and swelling of the lid margins. There was no evidence of conjunctivitis. Previous patch tests with the European standard series, a preservative series, a face and eye series, a contact lens series, and pilocarpine 4% eyedrop had shown a plus/minus reaction to benzalkonium chloride and a plus/minus reaction to pilocarpine eyedrops which contained benzalkonium chloride as a preservative. Treatment was changed to unpreserved pilocarpine eyedrops, and his eyelids treated with a mild topical corticosteroid preparation. After initial improvement in the appearance and swelling of the eyelids the patient re-presented with a recrudescence of the burning and stinging sensation of his eyes.

Patch testing with unpreserved pilocarpine (Minims 1%, 2%, and 4%) was negative at 2 and 4 days. Subcutaneous and intradermal testing with unpreserved pilocarpine 4% was negative at 2, 4, and 7 days, making delayed hypersensitivity unlikely. However, prick tests showed a positive reaction with the development of a 10×10 mm weal at 10–30 minutes. Prick tests in seven controls (three atopic, four non-atopic) resulted in small weals measuring up to 3 mm in diameter (four controls), or erythema only (three controls). We therefore considered that the reaction seen in our patient was significant. Pilocarpine was discontinued and substituted with levobunolol hydrochloride. The patient’s ocular and periocular symptoms improved dramatically, and his intraocular pressure was 15 mm Hg in both eyes.

Comment

It may be difficult to separate the clinical diagnoses of contact dermatitis, contact conjunctivitis, and contact urticaria owing to the heightened sensitivity in the eye and the adjacent skin. Contact dermatitis affecting the periocular skin may be irritant (toxic) or allergic in nature. The conjunctiva may be involved in similar processes either alone or associated with cutaneous involvement, so-called dermatocconjunctivitis. The conjunctiva with its lymphoid tissue may be involved in all immune mechanisms. The allergic reaction is a delayed hypersensitivity response (type IV) mediated by T lymphocytes. Antigen sensitised T cells release lymphokines following secondary contact with the same antigen. Diagnosis of type IV allergy may be confirmed by relevant positive patch tests. False negative reactions occur when percutaneous absorption is inadequate, concen-
Iris cyst after traumatic implantation of an eyelash into the anterior chamber

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Cilia may be passively introduced into the eye during a penetrating injury and are often well tolerated in the anterior chamber (AC). The decision to surgically remove the cilium is difficult and must be based on the individual clinical situation and the possible consequences of leaving organic material in the AC.

We report a case of late development of an implantation cyst from an intraocular cilium.

Case report
A 16-year-old male presented after striking his right eye on the corner of a cardboard box. His