CORRESPONDENCE

'In use' expiry date for eyedrops

EDITOR,—Geyer et al 1 found that 8% of their outpatients' antiglaucoma eyedrops and 20% of their tips had been contaminated by microbes (a total of 28%). They concluded that there was a clear correlation between medication contaminated and duration of use (for example, 19% at <4 weeks, 40% at >12 weeks). The sample size, however, differed markedly in each of the groups (for example, 17 in the 4–12 week group, 108 in the <4 week group). In addition, they did not differentiate between the proportion of bottle tip and drop contamination in their groups. They suggested that eyedrops should be replaced regularly to prevent serious ocular infections2 though they fail to stipulate what this period should be.

We conducted a small pilot study investigating the contamination of domiciliary 'in use' eyedrops at 1 month. Fifty eight outpatients were asked to bring in their own medication. We were able to culture 47 tips at 4 weeks. The samples consisted of glaucoma medication, antibiotics, steroids, antibiotic/steroid combinations, and cycloplegics. All of these contained 0.01% benzalkonium chloride as preservative. The eyedrops were cultured on blood and chocolate agar for a 48 hour period. Fungal growth media were not used. The results failed to demonstrate any growth.

We feel that it is essential to maintain and regulate 'in use' expiry dates. In the UK this currently stands as 28 days for outpatients and 7 days for inpatients. Such formal recommendations do not exist in the United States. The expiry date depicts the safe period for eyedrops, which is obviously influenced by the environment, the frequency, and technique of use. It is our nursing policy that every patient is taught to instil eyedrops adequately before discharge or first commencing treatment as an outpatient. If they fail to meet an asceptic technique then relations, friends, or district nurses are employed.

The British Pharmacopeia Commission Secretariat first introduced an in use period for eyedrops in 1966 following the results of clinical trials. The recommendation was stated arbitrarily as 1 month and for inpatients at 1 week. The maximum volume of the multidose bottle was 20 ml which was reduced in 1968 to 10 ml, while the outpatients in use period was reduced to 2 weeks; later this was increased to 4 weeks. The commission set up a working party in 1988 to study multidose ophthalmic products: contamination was reported only as 5% of 608 samples.3 The presence of preservative helps maintain this low incidence. Benzalkonium chloride is the most widely used antimicrobial preservative either alone or in combination with others. In the early 1990s the commission introduced the 'Efficiency of antimicrobial preservative in pharmaceutical products' test, which suggested that 1 ml of preservative added to a pharmaceutical product should meet the criterion of a reduction of an inoculum of 106 Staphylococcus aureus or Pseudomonas aeruginosa organisms by 104 after 24 hours.

We therefore conclude that adhering to such policies as recommended by the British Pharmacopeia Commission for in use eye-drop expiry dates and quality of preservative, has resulted in a reduced low incidence of microbial contamination and subsequent microbial keratitis for both inpatients and outpatients in the UK.

S RAUZ 
B J R MOATE 
A S JACKS 
N CUMBERLAND 
L A GOVAN

Departments of Ophthalmology and Microbiology, Frienley Park Hospital, F110mpton Road, Frienley, Camberley GU16 7DJ


Reply

EDITOR,—We appreciate the interest Rauz and colleagues have shown in our published results on microbial contamination of glaucoma eyedrops, and their effort to repeat the study in their population. They found no growth in the cultures of eyedrops used for 4 weeks by outpatients. However, in their study only the drops were cultured whereas in ours the eyebottle tip drops were also cultured. This fact could have been responsible for the discrepancy in part for the discrepancy between the two studies.

Unfortunately, they appear to have misread the data in Table 2 in our paper. They mention correctly that the sample size in the group that used the drops for less than 4 weeks was 108; however, the sample size in the 4–12 week group was 61 and not 17 as they stated. The difference between the above groups was due to that fact most patients only used the drops for a short time (<4 weeks), and therefore it was difficult to obtain data for longer periods. The proportion of the bottle tip to drop contamination in various time periods is given in Table 1. It appears to be a function of the duration of use, as high as microbial contamination (~10%) for about 4 to 5 weeks and ~1–3% for longer use. It should be noted that we counted the number of tips and drops contaminated separately for the same medications in Table 1 in this letter, as compared with the number of medications contaminated in Table 5 of the paper.

Table 1 Drops and tip contamination and length of time used

<table>
<thead>
<tr>
<th>Time in use (weeks)</th>
<th>Sample (No)</th>
<th>Contamination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Drops (No)</td>
<td>Tip (No)</td>
</tr>
<tr>
<td>&lt;4</td>
<td>108</td>
<td>5 (4–6)</td>
</tr>
<tr>
<td>5–8</td>
<td>44</td>
<td>4 (9–1)</td>
</tr>
<tr>
<td>9–12</td>
<td>12</td>
<td>4 (17–6)</td>
</tr>
<tr>
<td>&gt;12</td>
<td>25</td>
<td>4 (16–6)</td>
</tr>
</tbody>
</table>

We do agree with Rauz and colleagues that an in use expiration date is essential to reduce microbial contamination of eyedrops. Since a dramatic increase in eyedrop contamination appeared after week 8 in our study, we suggest replacing all topical medications regularly after this lapse of time. Making the patient aware of frequency and technique of use is certainly an additional method of preventing contamination of eyedrops and the potential for infectious complications.

ORN A GEYER 
STEVEN M Podos 
EDWARD J BOTTONE 
ROBERT A SCHUMER 
PENNY A ASBELL

The Mount Sinai Medical Center, Department of Ophthalmology, One Gustave L Levy Place, New York, NY 10029-6574, USA

NOTICES

Royal Society of Medicine, Section of Ophthalmology

The following meetings (beginning at 5 pm) are open to RSM members and their guests only.

LANG LECTURE, 14 March 1996
New perspective; corneal grafting Professor David Eady.

NEW HORIZONS IN THERAPEUTICS, 9 May 1996
The identification of human tumour antigens: a strategy for developing tumour vaccines; New developments in the management of CMV retinitis; The development of ophthalmic drugs; The challenge of gene therapy in the context of eye disease.

Further details: Alyson Taylor, Sections Officer, Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. (Tel: 0171 290 2985; fax: 0171 290 2989.)

REGISTRARS’ MEETING, 13 June 1996, 2 pm
For registrars to present research work and case reports. Papers to be considered for publication. Abstracts should be submitted (max 200 words) for the attention of P Murray, The Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. Closing date for entries is 12 April 1996.

First European Forum on Quality Improvement in Health Care

The first European forum on quality in health care will be held on 7–9 March 1996 at the QEII Conference Centre, London. Further details: Clare Moloney, BMA Conference Unit, BMA House, Tavistock Square, London WC1H 9JP. (Tel: 0171–383 6663; Fax: 0171–383 6478.)

Xth Symposium of the International Society for Genetic Eye Disease and VIIth Symposium of the Retinoblastoma Society

The Xth Symposium of the International Society for Genetic Eye Disease and VIIth