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clamydiae disease, for this reason, it is advisable to treat patients with additional oral antibiotics that are effective against the species of chlamydiae. 4 acute bacterial conjunctivitis are much less serious, less rapid in the onset and progress at a much slower pace than those of hyperacute conjunctivitis, the three most common pathogens in bacterial conjunctivitis are streptococcus pneumoniae, haemophilus influenzae and staphylococcus aureus, infections with s. pneumoniae and h. influenzae are more common in children, while s. aureus affects adults more frequently2,8 (Table 3). Although acute bacterial conjunctivitis is generally self-limited and does not cause serious damage, there are several reasons for id id osroc li odnaicrocca etneizap led. Atilibrrom alled enoizudir anu onodulcni itseuQ .otnemattart Disease, reducing the diffusion from person to person, lowering the risk of dangerous complications for vision as corneal ulceration and eliminating the risk of more widespread extra -ocy diseases. Crops should be obtained in some patients, including small children and debilitated people. However, empirical treatment with a topical drug is a safe and economic approach in most patients with clinically mild acute bacterial conjunctivitis. Unfortunately, no single spectrum antibiotic covers all the potential conjunctive bacterial pathogens. In choosing an appropriate topical antibiotic, the doctor should keep in mind the most probable conjunctival pathogens, as well as the costs and side effects of each drug. The most part of the adult cases of acute bacterial conjunctivitis are caused by gram-positive organisms, it is better to choose an antibiotic with adequate gram-positive coverage (in particular, good staphylococcal coverage). The clinical response to the antibiotic should be assessed after the patient has completed a short therapy cycle. If inflammation has resolved, the antibiotic should be suspended. However, if the condition has not improved, an ophthalmologist should be consulted. In such patients, laboratory test results can be used to direct changes in therapy. Examples of large-sized antibiotics currently available include an erythromycin ointment and a Bacitratin-Polimic B ointment (for example an polyisorine ophthalmic ointment), as well as combination solutions such as Trimethoprim-Polimicissin B (for example Polytrim). These drugs are well tolerated and provide excellent coverage for most conjunctive pathogens both in children and adults, 9 in general, ointments are better tolerated by small children. They are less suitable for complaining about the confusion associated with vision. The solutions are preferred by most teenagers and adults. Aminoglycosides, such as gentamicin (garamicin), tobramycin tobramycin and neomycin are economic choices for the treatment of acute bacterial conjunctivitis. These agents provide a good gram-negative cover, but have a relatively poor gram-positive cover, including incomplete coverage of the species Streptococcus and Staphylococcus. In addition, aminoglycosides are associated with a relatively high incidence of corneal epithelium toxicity (mainly with prolonged use). Neomycin, in particular, can cause local oculocutaneous allergic reactions. For this reason, current ophthalmic preparations containing neomycin should probably be avoided as first-line therapy. The sulfatimide solution of 10 percent (Bleph-10) is still a topical antibiotic commonly prescribed for conjunctivitis. This bacterium-static agent has moderately weak activity against many gram-positive and gram-negative organisms, including those that cause commonly conjunctivitis. Although sulphateamide is less effective than some of the other drugs mentioned in this article, it is inexpensive and well tolerated. A rare potential side effect of treatment is Stevens-Johnson's syndrome. In topical form, tetracycline and chloramphenicol (Chloromycetin) are commonly used to treat bacterial conjunctivitis. The tetracycline is only available in a form of ointment. The cloamphenicol, available in the form of drop and ointment, has a wide spectrum of antimicrobial activity. Although cloamphenicol is generally well tolerated, the topical application of this agent has been associated with some cases of aplastic anemia. For this reason, cloamphenicol is not widely prescribed in the United States. 10 Fluoquinolones, which include cyproflloxacin (Ciloxan), difloxacin (Ocuflrox) and norfloxacin (Chibroxin), are a new class of powerful topical antimicrobials. 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In severe cases, a short course of topical corticosteroids is often required for adequate symptomatic relief. However, corticosteroid therapy should only be administered under the direction of an ophthalmologist. Immunotherapy can be beneficial in some patients with allergic conjunctivitis.23 Other Causes of Conjunctivitis Common noninfectious causes of conjunctivitis include dry eye and inflammation of the conjunctiva related to use of medications (Figure 11) or wearing contact lenses. These entities should be considered in patients with chronic signs and symptoms that do not appear to be of infectious or allergic origin. origin.

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