Treating “Pink Eye” In Kids
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The term "pink eye" typically refers to a conjunctivitis – the most common eye disorder in young children.1 In pediatric patients with conjunctivitis, systematic determination of the cause - infectious (such as bacterial or viral) or non-infectious (such as allergic or toxic) - can help target treatment appropriately.

Regarding bacterial conjunctivitis in pediatric patients:
- the predominant causative organism is non-specific H. influenza1-4
- the disorder is usually self-limiting within one to two weeks (60 percent of cases)
- treatment options include topical trimethoprim sulfate-polymyxin B sulfate for ages 2 months and up; topical azithromycin or besifloxacin are additional options for patients older than 2 years5
- lid scrubs and a saline rinse prior to drop instillation may improve the medication’s effect

Viral conjunctivitis in children:
- Common causes include adenovirus, HSV, HZV, and enterovirus8.
- With adenovirus, treatment options include cool compresses and artificial tears along with appropriate care to reduce the spread of infection8.
- For herpes virus, topical trifluridine is approved for children >age 6 and ganciclovir for those >age 2. Management may include oral or IV antivirals; referral for co-management with the pediatrician may be warranted.

Allergic conjunctivitis is the most frequent cause of non-infectious conjunctivitis and it often goes untreated. In pediatric patients, consider treatment options such as:
- artificial tears and cool compresses for mild cases
- mast-cell stabilizers and anti-histamines (or their combinations) are typically approved for children > 4 years and are useful in moderate to severe cases6
- alcaftadine and bepotastine, if needed, are approved for ages 2 and up6
- non-sedating oral antihistamines, such as loratidine (5mg/day for ages 2-5; 10mg/day for ages 6 and up) and cetrizine as effective adjunctive therapy7
- diphenhydramine, typically dosed at night due to its drowsiness side effect

Be vigilant when treating pediatric patients presenting with acute conjunctivitis for signs of trauma and/or further infection beyond the eye. If comorbidities such as fever, malaise, earache, and/or upper respiratory infection exist, again consider referral to the child’s pediatrician for co-management5,8.

References

Dr. Sicks received her Doctor of Optometry degree from the Illinois College of Optometry. She completed a Cornea and Contact Lens residency program at Northeastern State University Oklahoma College of Optometry. Dr. Sicks is currently an assistant professor at the Illinois College of Optometry, where she participates in didactic, clinical, and research activities.

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